



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

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

3
4 CHAIR: Good morning, everyone.

5
6 Mr. wolfe.

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

10
11 MRS. VIVIENNE TOAL, HAVING BEEN SWORN, WAS EXAMINED BY
12 MR. WOLFE KC AS FOLLOWS:

13
14 1 Q. MR. WOLFE KC: It's Mrs. Toal?

15 A. It is, yes.

16 2 Q. Good morning, Mrs. Toal.

17 A. Good morning.

18 3 Q. Thank you for coming to the Inquiry to give evidence.
19 In advance of today you have provided the Inquiry with
20 a Section 21 statement, which is 49 of 22. If you
21 could just look at the cover page and the last page.
22 WIT-41007. You're familiar with that. You can see the
23 legend in the top right-hand is telling us that an
24 addendum witness statement was received by the Inquiry,
25 and I'll come to that in a moment. You're familiar
26 with that. That's your first witness statement?

27 A. Yes, that's right.

28 4 Q. We'll go to the last page, WIT-41148. The page
29 numbering tells us that it is a substantial piece of

1 work. It runs to some 150 pages or so. We can see, if
2 we scroll down, your signature, dated 25th July 2022.
3
4 would you like to adopt that witness statement, subject
5 to the changes in your addendum, as part of your 10:02
6 evidence to the Inquiry?
7 A. Yes, please.
8 5 Q. Then the addendum, which came into us on Monday
9 morning. It's dated 24th February of this year.
10 WIT-91883. You recognise that? 10:03
11 A. Yes, I do.
12 6 Q. The signature is at 86 in that sequence, 91886. You
13 recognise that's your signature?
14 A. Yes.
15 7 Q. You wish to adopt that as part of your evidence? 10:03
16 A. Yes, please.
17 8 Q. This statement deals with a number of things. It makes
18 a number of changes, perhaps minor in nature in
19 a couple of respects, one more significant description
20 of your involvement in another case of a doctor in 10:03
21 difficulty.
22 A. Yes.
23 9 Q. It provides some updated material in regard to MHPS
24 training?
25 A. Yes. 10:04
26 10 Q. And in regard to how data relating to MHPS
27 investigations is shared with the Trust Board?
28 A. That's right. That's correct.
29 11 Q. Those two latter elements are of some significance.

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

2

3 You are currently Director of Human Resources and
4 Organisation Development for the Southern Trust; is
5 that correct?

10:04

6 A. That's correct. Yes.

7 12 Q. You took up that role on a permanent basis on
8 21st September 2016?

9 A. That's correct.

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

10:04

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

15 14 Q. You were Acting Director, if I can just shorten it to
16 HR without injury to your full job title?

10:05

17 A. That's fine.

18 15 Q. You were Acting Director of HR from 15th August; isn't
19 that right?

20 A. That's correct, yes.

10:05

21 16 Q. You had been employed in what we sometimes refer to as
22 the Legacy Trust. That was one of the legacy Trusts,
23 I suppose, Craigavon Health and Social Services Trust
24 which was to, with other Trusts, morph into the
25 Southern Trust following the review of public
26 administration in Northern Ireland?

10:05

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

29 17 Q. You had been employed in that Trust from 1998 and had

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

3 A. That's correct.

4 18 Q. If we just pull up your witness statement briefly, in
5 ease of the pen of the Panel members. WIT-41015. We 10:06
6 can see that you graduated from Queen's University in
7 1996 BSc Honours in Business Administration Computer
8 Science, later studied for a postgraduate diploma in
9 Human Resource Management with the University of
10 Ulster. Then scrolling down, you set out those posts, 10:06
11 starting as a clerical officer but very quickly moving
12 into specific HR professional roles in the
13 Legacy Trust; isn't that right?

14 A. That's right. Yes.

15 19 Q. In assuming the Directorship role in September 2016 you 10:07
16 succeeded Mr. Kieran Donaghy?

17 A. That's correct, yes.

18 20 Q. Your job description for your present role, which
19 you've now held for seven years, is at WIT-41171. If
20 we pull up one line of what is a fairly detailed 10:07
21 description of your role.

22
23 "You will provide specialist HR advice to the Trust
24 Board, share corporate responsibility for the
25 governance of the Trust, and compliance with legal 10:08
26 requirements and contribute fully to the development,
27 delivery, and achievement of the Trust's Corporate
28 Plan, which will be responsive to the needs of the
29 population in line with performance targets established

1 by the HSCB."
 2
 3 You are at the top of the HR pyramid within the Trust;
 4 is that right?
 5 A. Yes. 10:08
 6 21 Q. You lead that Directorate?
 7 A. Yes.
 8 22 Q. You report to the Chief Executive?
 9 A. That's right.
 10 23 Q. You attend the Trust Board? 10:08
 11 A. Yes, I'm in attendance, yes.
 12 24 Q. There is, just briefly if we could look at it,
 13 a structure or an organigram which relates, I think, to
 14 2016. Maybe you could help us with that. WIT-41185.
 15 Yes, that was the picture in 2016 and that's your role 10:09
 16 at the top of the tree?
 17 A. That's right.
 18 25 Q. A number of your staff members were to have some roles
 19 in matters that we'll discuss today. Siobhán Hynds,
 20 she was your most -- I think you described her as one 10:09
 21 of your most or your most experienced practitioner in
 22 the area of working with doctors in difficulty; is that
 23 fair?
 24 A. In terms of Siobhán's role in legacy Newry and
 25 Mourne Trust she would have had experience with medical 10:09
 26 staff there. I would have said around 2016, however,
 27 her experience was in employee relations which was more
 28 on the non-medical side. But, yes, prior to that, in
 29 legacy days she would have had involvement with medical

1 staff, yes. In terms of --

2 26 Q. Just to remind ourselves, she was to be the HR input
3 into the investigation which was led by Dr. Chada?

4 A. Yes. That's right.

5 27 Q. Zoe Parks -- we see her name frequently. She had 10:10
6 a role in some of the matters we'll be discussing
7 today?

8 A. Yes.

9 28 Q. Where did she -- she sits on the medical staffing side
10 of the division? 10:10

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

18 29 Q. It sounds like a fairly specific role by contrast with
19 some of the other HR roles.

20 A. Yes. 10:11

21 30 Q. What's within her portfolio?

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

1 contractual issues, resourcing function because the
 2 Business Services Organisation did not provide the
 3 resourcing function for medical staffing. It sat
 4 outside of it, so that comes under Zoe's remit. Also
 5 I brought in then our medical locum team in under 10:12
 6 medical staffing as well. It's a fully integrated
 7 unit essentially dealing with all the medical staffing
 8 issues.

9 31 Q. In terms of your role, in addition to HR you have
 10 responsibility for the Trust's litigation service? 10:12

11 A. That's right, yes.

12 32 Q. That's the full range of litigation, clinical
 13 negligence through to public liability?

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

26 33 Q. Whistle blowing or raising concerns. If we look at
 27 your witness statement to see what you say about that.
 28 WIT-41009. You say your remit also includes
 29 responsibilities as lead director for raising concerns

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

10:14

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

10:14

10:15

10:15

10:15

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

11 34 Q. Perhaps later today we'll look at some concerns that
 12 Mr. O'Brien raised in respect of Patient Safety through
 13 his grievance. I want to look at that through the lens
 14 than of raising concerns later.

15 10:17
 16 Could I ask you this? In terms of the issues that have
 17 come before this Inquiry, and I know you have been
 18 paying close attention to our work, is it fair to say
 19 that none of the concerns, whether about Mr. O'Brien's
 20 practice or about governance issues in terms of how 10:17
 21 management have responded to issues or how systems have
 22 failed to, perhaps, detect the issues of concern, is it
 23 fair to say that none of those kinds of issues have
 24 come to you or your part of the system as a raising
 25 concern matter or a whistle blowing matter? 10:17

26 A. That's correct.

27 35 Q. If it's the case, and obviously we're reasonably
 28 immature as an Inquiry in terms of our receipt of
 29 evidence, there's more evidence to be received and

1 we will grow in our understanding of what people knew
 2 and what they felt able to say about it. Hopefully
 3 this isn't an unfair question. Does it surprise you
 4 that more information didn't come into the whistle
 5 blowing framework about the concerns that we are now 10:18
 6 beginning to hear about?

7 A. I think it shows we have a lot of work to actually do.
 8 Does it surprise me? Possibly. I think we were in
 9 a situation where so many people knew for so long and,
 10 for some reason, those concerns weren't resolved at the 10:19
 11 earliest possible stage. I think what we have now to
 12 do is significantly more work around enabling people to
 13 be more comfortable about actually raising concerns.
 14 This is a long-term piece of work and it is a journey
 15 that we're on to try and ensure that individuals are 10:19
 16 raising those concerns in the best interests of patient
 17 care. It is absolutely an actual journey that we're on
 18 around raising that openness, and when there are
 19 concerns being raised that people take action. I mean,
 20 that is something more down the organisational 10:19
 21 development side of my role that we absolutely need to
 22 pay a significant degree of focus to moving forward.

23 36 Q. As we proceed this morning we will come face to face
 24 with the notion that it is the Clinical Manager who
 25 should take steps within an MHPS process to carry out 10:20
 26 preliminary enquiries, etcetera.

27 A. Yes.

28 37 Q. That might tell us that it's clinical colleagues,
 29 whether management or nonmanagement and, indeed,

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

5
6 Thinking back to 2016, and even since that, because
7 these things really come to light ultimately in 2020,
8 how much work was being directed towards nursing and
9 clinicians to apprise them, if you like, of the whistle
10 blowing framework, or other ways of getting concerns
11 into the proper place so they can be actioned?

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

22
23 I mean, we do have HR business partners that would be
24 aligned to those areas operationally and, I suppose,
25 part of their role would have been to ensure that, you
26 know, policies would have been drawn to the attention
27 of those management teams. But it is fair to say that,
28 from a resource point of view, we didn't have
29 a significant resource, a line to this. So, from that

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

12 38 Q. Let me turn specifically to the MHPS Framework and
 13 spend some time looking at how the local guidelines
 14 were developed, just to set this in its fullest
 15 context. 10:23

16
 17 2005 the MHPS Framework was introduced?

18 A. That's right.

19 39 Q. 2010 you had a role in, I suppose, overseeing or
 20 providing HR commentary into what was to be the 10:23
 21 development of those local guidelines. Then more
 22 recently you've told us, borne out of some lessons
 23 learned from the deployment of MHPS and the guidelines
 24 to this case, in 2017 some changes were made to the
 25 local guidelines; isn't that right? 10:24

26 A. That's right.

27 40 Q. Then, building on that again, there's been work around
 28 training for key personnel around MHPS, and you've
 29 dealt with that in your addendum statement?

1 A. That's right.

2 41 Q. Again, similarly in recent times, new processes for
3 keeping the Board, I think through the Governance
4 Committee --

5 A. That's correct.

10:24

6 42 Q. -- apprised of what's going on in any MHPS case. In
7 the course of today we'll probably look at a lot of
8 that.

9

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

10:24

13 A. That's right.

14 43 Q. I wonder is that a curiosity of being an HR
15 professional, that, as I understand it, the MHPS
16 process resides in the HR house, it's owned by that
17 Department; is that right?

10:25

18 A. I think there is a shared responsibility for it, to be
19 honest. I mean, when we look back to 2010 it would
20 have been Dr. Loughran who was the Medical Director at
21 that stage who would have been working with

10:25

22 Anne Brennan, the senior manager at that point in his
23 office, in terms of trying to look at the development
24 of the Trust guidelines in relation to it. Then
25 I think what happened after that, Mr. Donaghy -- in
26 terms of the Director of HR at that stage -- he then
27 asked HR, through Siobhán Hynds and I then, to become
28 involved in looking at that draft and the draft of
29 another individual, Debbie Burns. I think at that

10:26

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

13 44 Q. Why would it be, then, that you wouldn't, as a key HR
 14 professional, wouldn't have had any training in the use
 15 of MHPS? 10:27

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

25 45 Q. In fact, as we will go on to see -- it's almost 10:28
 26 ironic -- you were to be part of the team delivering
 27 the training on the new guidelines with
 28 Dr. Fitzpatrick, we'll see that in the autumn of 2010,
 29 in circumstances where, I think everybody agrees that

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

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

17 46 Q. Okay. Let's just take a moment to look at the
 18 development of the 2010 guidelines and your role in
 19 that. Perhaps keeping an eye, in particular, on how
 20 the notion of the concept of an Oversight Committee 10:29
 21 developed.

22

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

27 A. Yes.

28 47 Q. It takes five years for that development. I know it
 29 was Craigavon and other Trusts in 2005, but

1 Southern Trust forms in 2000 and?

2 A. Seven.

3 48 Q. Seven. Is it fair to say that you weren't aware of any
4 local guideline in 2005 after the birth of MHPS?

5 A. No, I am not aware of any in legacy Trust or Southern 10:30
6 Trust. I think when it probably came to light was in
7 2010. I think the discussions around the Responsible
8 Officer role came in on that date, and I think that's
9 then what, presumably, prompted the conversations
10 within Southern Trust around needing to develop the 10:31
11 Trust guidelines. But, no, I don't remember anything
12 prior to that.

13 49 Q. You've told us in your witness statement that Kieran
14 Donaghy, and you've mentioned it already, sent you two
15 review documents, one authored by Anne Brennan, who 10:31
16 was, at the time, senior manager in the Medical
17 Director's office?

18 A. That's correct.

19 50 Q. And Debbie Burns, who was Assistant Director in?
20 A. Performance Improvement, I think, yes. 10:31

21 51 Q. That's right. You were asked to review that. Let me
22 just pull up Mrs. Burns' paper. Is it fair to say, and
23 I mean no disrespect to Mrs. Brennan's paper, but
24 Mrs. Burns' paper became the kind of prototype or
25 provided the architecture for what was eventually 10:32
26 adopted?

27 A. Yes, that --

28 52 Q. Her paper, just to assist you, WIT-41225. The draft,
29 obviously. If we scroll down. We can see at

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

11 A. Mm-hmm.

12 53 Q. "This assessment should be presented to decide on
 13 whether an informal or formal investigation is
 14 required".
 15 10:33

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

18
 19 It starts life, as would appear from these tracked
 20 changes, as a decision making group. Was it you who 10:33
 21 came up with the concept of an Oversight Group?

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

29 54 Q. Sorry to cut across you, there's other pages, perhaps.

1 we'll just maybe scroll down.

2 A. It is clear that it was following the NCAS 2010
3 document, and within that NCAS guidance I think that
4 come out in January 2010, which was around, you know,
5 local performance investigations, that in primary 10:35
6 care -- not secondary care but in primary care there
7 was a reference to a decision making group. That was
8 obviously linked probably to the size of, sort of like,
9 primary care, maybe GP practices, and things like that.
10 I think that is where maybe some of the confusion there 10:35
11 has come in because it was in the context of primary
12 care in that particular NCAS document.

13 55 Q. If we maybe just pause to let the Inquiry see that.
14 The NCAS guide to which you refer is WIT-41399. As you
15 say, the focus is on primary care. This is an NCAS 10:36
16 produced document that came in in 2010.

17 A. That's correct. Yes.

18 56 Q. If we just scroll down to 41399, we can see you were
19 making the point that when -- you were making the point
20 that when looking at Mrs. Burns' paper and you're 10:36
21 seeing the reference to a decision making group or
22 a DMG, you recognise that --

23 A. Yes.

24 57 Q. -- as having an origin, perhaps, in this document.
25 10:37
26 We see here in handling performance concerns in primary
27 care, NCAS suggests the use of a decision making group
28 supported by a professional advisory group with
29 membership suggestions made for both groups in

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

5
 6 In this text they're putting the function of making the
 7 decision in the hands of the DMG and, ultimately,
 8 that's not the path that was followed within your
 9 guidelines when introducing the concept of the
 10 Oversight Group. Can you just explain that for us?

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

28 58 Q. We will come in a minute to just look at the
 29 guidelines, but the concept of an Oversight Group, as

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

3
 4 "I can recall from discussions with Kieran Donaghy" --
 5 just the top of the page -- "that there was a view from 10:39
 6 the Chief Executive and Directors that a form of
 7 oversight arrangement would be needed to assure
 8 consistency of approach, and fairness across MHPS
 9 processes. Therefore, the concept of the oversight
 10 group was included by me in the Trust guidelines which 10:40
 11 were eventually published on 23rd October."

12 A. That's right.

13 59 Q. So, it's all your fault!

14
 15 The concept, as imagined at that time was, almost by 10:40
 16 definition, a group comprised usually of the Medical
 17 Director, somebody from HR, usually the HR Director,
 18 and a person from the Service, so the Directorate,
 19 usually the Director.

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

21 60 Q. Would, if you like, sit on a tier receiving information
 22 from the Clinical Manager who would have a strong view,
 23 if not a decision or a recommendation, on which way to
 24 take a performance issue, whether informal, formal, or
 25 no action required. We'll look at the fine detail. 10:41

26 A. Mm-hmm.

27 61 Q. It was the role of the Oversight Group to ensure that
 28 that was done in a way that was consistent, fair,
 29 transparent. It was a quality control type function as

1 opposed to an investigatory screening or decision
2 making function?

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

4 62 Q. It appears to have been realised that there was
5 training requirements around this. You go to 10:41
6 WIT-41326. You mentioned this earlier. 24th September
7 2010.

8
9 "The session is designed to provide an opportunity to
10 explore how we handle performance concerns about 10:42
11 doctors and dentists".

12
13 To the best of your recollection, is this the first
14 training that the Trust has brought forward in the area
15 of MHPS and the local framework? 10:42

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

19 63 Q. If we just scroll down. Dr. Fitzpatrick from NCAS
20 attends and yourself and Mrs. Hynds do a piece on the 10:43
21 guidance you have just written, or probably a better
22 word is to say you contributed to it and overseen its
23 delivery.

24
25 We spoke about training a little bit earlier in the 10:43
26 context of what the NCAS guide says and what the MHPS
27 says. It's recognised by MHPS that there are training
28 requirements in this. Maybe if we just pull up the
29 reference. WIT-18534. At the top of the page it says:

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"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."

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?

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

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

8
9 In terms of, then, the training plan associated with
10 MHPS after that, I'm not sure that was terribly 10:46
11 concrete either. Certainly when I look at what we have
12 put in place now and approved through our Trust Board,
13 it certainly wasn't that type of training plan at that
14 point in time. When I look back on the various
15 training interventions at points in time, I mean, we 10:46
16 would have had DLS training, the Director of Legal
17 Services under BSO, we had some NCAS training, we had
18 training undertaken internally. So, there's probably
19 various training interventions at various points in
20 time. Was it structured in terms of actually sitting 10:47
21 down and saying, 'right, this is what we need to ensure
22 that our people are fully conversant'? No. Therefore,
23 I mean you are absolutely right, I think there is an
24 issue with individuals being trained at a point in
25 time. Thankfully these are not -- I mean formal 10:47
26 investigations are not something that happen every day
27 and, therefore, by the time you actually maybe come to
28 being asked to be either a case investigator or a case
29 manager, it could be a significant period of time after

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

9 64 Q. We'll look this afternoon in a little bit of detail at
 10 the training programme and framework which has been 10:48
 11 very recently developed, just a few headlines on that.
 12 I can see from the documentation that a training plan
 13 has been developed for non-Executive Director.

14 A. Yes.

15 65 Q. For Case Investigator, Case Manager, and there's 10:48
 16 specific training in relation to, I think it is
 17 described as low-level concerns?

18 A. Yes. Yes.

19 66 Q. There appears to be four different packages?

20 A. Yes. 10:49

21 67 Q. We'll come to that. Just on this issue. I'm
 22 a Clinical Director within that job description while
 23 it's comparatively rare that there would be an MHPS
 24 formal investigation, but I'm a candidate for being
 25 either investigator or case manager should a formal 10:49
 26 investigation arise.

27 A. Mm-hmm.

28 68 Q. I've been to your bespoke training which you have
 29 recently developed but, looking five years ahead, I get

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

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

14 69 Q. In terms of the guidelines, then, that were developed
15 and the relationship with MHPS, you've explained 10:51
16 that -- and this is in your witness statement at
17 WIT-41033. The guidelines were intended to sit
18 alongside and be read in conjunction with MHPS. It was
19 never the intention to replace --

20 A. No. 10:51

21 70 Q. -- MHPS with Trust guidelines.

22
23 In terms of your experience of interacting with the
24 guidelines/MHPS by 2016 when you were Acting Director,
25 and then Director, and you came on to the Oversight 10:51
26 Committee, you've referred in your witness statement --
27 and I don't wish to deal with the substance of these
28 cases in any way -- but you've referred in your witness
29 statement and your recent additional statement to,

1 I think, 12 cases where you had some involvement with
 2 managing performance issues with doctors, and you've
 3 explained the MHPS role for you or for others and your
 4 familiarity with that. Is it fair to say that by 2016
 5 you had a good working knowledge of the nuts and bolts 10:52
 6 of this?

7 A. I think, on reflection, and probably just when you read
 8 down through each of the cases that I have included in
 9 my Section 21, I would have been involved in various
 10 aspects of it. I think, for me, when I got to 2016, 10:52
 11 had I carried a case through from beginning to end in
 12 that sort of HR advisory role, no. But, yes, I would
 13 have been involved in various parts of it, of the
 14 actual process. But I think there is a difference
 15 between that and being asked to do various aspects of 10:53
 16 it in comparison with I'm carrying a case from
 17 beginning to end, and that's the bit that I think is
 18 probably the difference for me.

19 71 Q. The Inquiry Panel will, no doubt, give some
 20 consideration to the 12 examples that you have cited. 10:53
 21 I think they start at WIT-41034, answer 7, for your
 22 note, Chair.

23
 24 Is it fair to say, then, when we looked at those
 25 examples you were advising on aspects of each case or 10:54
 26 performing a task within each case?

27 A. That's correct.

28 72 Q. But not sitting as an Oversight Committee member?

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

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

3 73 Q. You've reflected, in terms of your first knowledge of
 4 the issues concerning Mr. O'Brien, and you've told us
 5 that you first became aware in late August, or perhaps 10:54
 6 very early September, in a conversation with Dr. Wright
 7 that he had concerns about Mr. O'Brien's administrative
 8 practices and that he had been made aware of them
 9 earlier in the year but the situation had not improved.

10 A. That's correct. 10:55

11 74 Q. You remember him telling you that he was seeking more
 12 information as to the extent of the problem and would
 13 speak to you again. Was that a kind of typical
 14 conversation between Medical Director's office, and it
 15 happened to be you as Acting Director at that point, 10:55
 16 a Medical Director letting you know about issues going
 17 on in his domain which could potentially enter your
 18 domain?

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

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

4 75 Q. I suppose I'm raising the point in that way just to
 5 explore the nature of that relationship?

10:56

6 A. Yes.

7 76 Q. Medical Director who is a clinician and a manager?

8 A. Mm-hmm.

9 77 Q. Maybe no longer a clinician generally but a clinical
 10 background?

10:56

11 A. Yes.

12 78 Q. And will have, I suspect in many cases, accumulated
 13 some kind of sense of how to do things correctly
 14 procedurally, but you're there or the HR office is
 15 there, and should be in close working relationship with
 16 the Medical Director's office, particularly in issues
 17 around clinical performance. Is that fair?

10:57

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

10:57

10:57

27 79 Q. What you're seeming to suggest here is this was
 28 a fairly early high level conversation?

29 A. Absolutely, yes.

1 80 Q. Not descending into any detail about the further steps
2 that he was taking?
3 A. No. It certainly wasn't in any detail but it was an
4 early flag that, you know, there is an issue here.
5 81 Q. No descending into any detail of the historical 10:58
6 background to what was --
7 A. Not that I recall. Absolutely not that I recall.
8 82 Q. You say -- if I can just bring up WIT-41056, at the top
9 of the page. I'm just alluding to that conversation at
10 the very top of the page. You go on to say that: 10:59
11
12 "I believe it was during this conversation that
13 Dr. Wright made me aware that Mr. O'Brien was a friend
14 of Mrs. Roberta Brownlee, who was the Chair of the
15 Southern Trust." 10:59
16
17 what was the purpose, as you understood it, of
18 communicating that relationship to you?
19 A. I think -- I mean timing wise this was -- and I know
20 Dr. Wright alluded to it yesterday, the timing of this 10:59
21 was linked to the Chair's 60th birthday party. I was
22 a late invite to that, I suppose because I had only
23 just moved into headquarters, but I was also there,
24 along with my husband. My recall of that was -- I mean
25 he was just saying this could be awkward on the basis 11:00
26 that Mr. O'Brien had been at the Chair's party.
27 I don't think it was anything more than that. It was
28 just probably flagging that this is going to be
29 potentially awkward.

- 1 83 Q. Going to be potentially awkward because Mrs. Brownlee
2 would be expected to have an opinion on this or a view
3 that she might express? I don't wish to push this
4 artificially too far, but to introduce that into
5 a conversation when first telling you about a concern 11:00
6 about Mr. O'Brien that might have to be progressed does
7 appear somewhat odd, do you think?
- 8 A. I'm not sure it's odd but, certainly, obviously with
9 the designation of the Board member, the Chair was
10 going to know about it. It's probably unusual that 11:01
11 we'd be in a situation where a consultant where there
12 were concerns about would also have been at the Chair's
13 birthday party. It was just that awkwardness. I don't
14 think it was anything more than that.
- 15 84 Q. You go on in your statement here to say you can recall 11:01
16 asking Dr. Wright if Francis Rice, then Chief
17 Executive, knew about the concerns.
- 18 A. Mm-hmm.
- 19 85 Q. But you can't recall if Dr. Wright said the Chief
20 Executive had already been informed or that this still 11:01
21 needed to be done?
- 22 A. Yes.
- 23 86 Q. Is that you expressing the concern 'we definitely
24 discussed the need that the Chief Executive be aware'?
- 25 A. Yes. 11:02
- 26 87 Q. Just help us with why at this stage, which appears to
27 be a preliminary stage, you're not being told too much
28 about it and you don't know what actions are proposed
29 by Dr. Wright, save that he's going to carry out some

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

3 A. I mean, I can recall this, and it is linked to the fact
 4 that, from Roberta Brownlee's relationship with Aidan
 5 O'Brien. It was more or less just to be flagging that 11:03
 6 the Chief Executive really needed to know about this.

7 88 Q. The Chair of the Board should stay out of operational
 8 matters; isn't that right?

9 A. Yes.

10 89 Q. Was there a concern here, when you reflect upon it, 11:03
 11 that these conversations mentioning her and the need to
 12 alert the Chief Executive, was there a concern that she
 13 may not stay out of this operational matter?

14 A. I'm not sure whether that was in the thinking or not.
 15 It was just more the, just the awkwardness of the fact 11:03
 16 that the Chief Executive, the Chair -- sorry, the Chair
 17 was friendly with an individual who we had concerns
 18 about. I don't recall that I would have known to be
 19 concerned at that stage around whether she would get
 20 involved in the minutia of the actual detail of a case. 11:04
 21 I don't think I would have known enough about that at
 22 that stage because I was in an Acting post at that
 23 point in time. I don't think I would have been
 24 thinking along those lines.

25 90 Q. If it was any other clinician, the Chief Executive 11:04
 26 wouldn't need to know at this stage, but because it was
 27 Mr. O'Brien who had a relationship, a friendship with
 28 Mrs. Brownlee, he did need to know, or it was
 29 advisable?

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

3 91 Q. Before we look at the working of this particular
 4 Oversight Group, can we go to the 2010 guidelines,
 5 please, at TRU-83688? We will just work through them. 11:05
 6 2.1 tells us how to conduct a local performance
 7 investigation. It should go through a screening
 8 process to identify whether an investigation is
 9 ultimately needed. It says in 2.2:
 10
11:05

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

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

18 92 Q. If, however, the concern is expressed to the Medical
 19 Director, then certain steps should be followed. He
 20 should accept and record the concern but not seek or 11:06
 21 receive any significant detail, rather refer the matter
 22 to the relevant clinical manager.
 23

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

28 A. Mm-hmm.

29 93 Q. Mr. Mackle has exited the role and it's the Medical

1 Director in August 2016 making the running on this and
 2 he's told you about that. He's told you, 'there's
 3 concerns here and I'm taking further steps'.
 4

5 2.2 tells us that if this guideline is to be followed, 11:07
 6 he shouldn't be doing that. It should go to the
 7 clinical manager.

8 A. That's correct.

9 94 Q. Is that a fair reading of that?

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

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

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

25 96 Q. Is it, in other words, the clinical manager is better 11:09
 26 placed to get to a fuller understanding of the issues
 27 on the ground?

28 A. Yes.

29 97 Q. Broadly and deeply what are all these issues about,

1 what's affecting performance?

2 A. Yes.

3 98 Q. It goes on at 2.3. Scrolling down.

4

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

7

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

12 A. Yes. Yes.

13 99 Q. 2.4: "The Clinical Manager will immediately undertake
 14 an initial verification of the issues raised. The
 15 Clinical Manager must seek advice from the nominated HR 11:10
 16 Case Manager."

17

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

25 11:11

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

29

1 I suppose that imagines, does it, that a screening
 2 report performed under this process by the Clinical
 3 Manager needs to be received by the Oversight Group,
 4 and we'll look at the flowchart for that. But, it's
 5 the role of the Chief Executive anticipating, or 11:12
 6 perhaps advised, that an MHPS process might be an
 7 option, it's his role to appoint the Oversight Group at
 8 the appropriate point.

9
 10 what's your understanding in the O'Brien case, or even 11:12
 11 more generally, about the role of the Chief Executive
 12 in terms of appointing the Oversight Group that sat on
 13 13th September?

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

1 depended on the service, obviously, that the concern
 2 was housed in, as such. It was always the Medical
 3 Director, it was always me as Director of HR, and then
 4 because this was Acute Services, it would have been
 5 Esther. 11:14

6 100 Q. I suppose the point in putting some kind of formality
 7 around appointing an Oversight Group into the hands of
 8 the Chief Executive is that it underscores the need for
 9 the Chief Executive to have some knowledge,
 10 information, so he or she is apprised of what's going 11:14
 11 on?

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

14 101 Q. In terms of the process, isn't what I've just said
 15 probably right; that in all cases the Chief Executive 11:15
 16 must know what's going on before an Oversight Group is
 17 convened?

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

21 102 Q. You set out, obviously correctly, the typical or
 22 prescribed membership of the Oversight Group. The role
 23 of the Oversight Group is defined, it is for quality
 24 assurance purposes and to assure consistency of
 25 approach in respect of the Trust's handling of 11:15
 26 concerns. That, presumably, was a very deliberate
 27 scoping out and limiting of the Oversight Group's role.

28 A. Yes.

29 103 Q. On the other hand, it's the clinical manager, 2.6, as

1 well as the nominated HR case manager who will be
 2 responsible for investigating the concerns raised and
 3 assessing what action should be taken in response and
 4 the possible action could include, and it's set out
 5 there, everything from no action required through 11:16
 6 formal investigation with or without exclusion or
 7 restriction. It says, again:

8
 9 "The clinical manager and the HR case manager should
 10 take advice from other key parties such as NCAS, 11:17
 11 Occupational Health ... in determining their assessment
 12 of action to be taken...."

13
 14 I suspect it is not always necessary to go to
 15 Occupational Health, it would depend on the case, would 11:17
 16 it?

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

1 we would go, and some cases we may not.

2 104 Q. The role of NCAS is written into your guidelines.
3 Also, of course, a parent document, it's written
4 clearly into the MHPS document. Is it fair to say that
5 they are, in all cases -- of course there might be 11:18
6 exceptional circumstances -- but generally speaking
7 NCAS and the need for advice from NCAS is an inevitable
8 step in the process, particularly where there's some
9 room for debate and need for clarity on the proper
10 pathway? 11:19

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

12 105 Q. From an HR perspective, what do you see as being the
13 role of NCAS and the importance of the services they
14 offer?

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

1 I outlined in my witness statement, you know, we would
 2 have used the services of NCAS to do the performance
 3 assessments, behavioural assessments, all of those
 4 sorts of things. I think now, just through experience,
 5 probably, just the benefit of having that sounding 11:21
 6 board, and the more people that actually go through to
 7 NCAS and seek their advice, they probably see the
 8 actual benefit of that more and more.

9 106 Q. Can I just pick up on something you said in your
 10 statement about the various roles at play, particularly 11:21
 11 the membership of the Oversight Group. If we go to
 12 WIT-41052. At paragraph 11.3 you say:

13
 14 "The role, definitions for and responsibilities of the
 15 Director of HR, Medical Director and the Operational 11:21
 16 Director in the Oversight Group were not detailed in
 17 Appendix 6. They should have been, and on reflection
 18 now, if I had sought to document these responsibilities
 19 in Appendix 6, this may have led me to consider in more
 20 detail the appropriateness of having an Oversight Group 11:22
 21 at all as part of the Trust's processes for
 22 implementing MHPS. This may subsequently have resulted
 23 in me having a discussion with Kieran Donaghy back in
 24 2010 when I was involved in drafting the Trust
 25 guidelines." 11:22
 26

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

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

5
 6 "They're to be kept informed by the clinical manager
 7 and HR case manager as to action to be taken following
 8 initial assessment for quality assurance purposes and
 9 to ensure consistency of the approach in respect of
 10 the Trust's handle of concerns".

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

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

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

14 107 Q. No doubt you think what you have now is an improvement,
 15 but what you had then was fairly well defined, wasn't 11:26
 16 it? The baton was in the hand of the Clinical Manager
 17 to carry out the investigation.

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

24 108 Q. Yes. I want to ask you about how that could have
 25 happened in a moment. Within your statement you 11:27
 26 explain the various roles as you saw it. You said:
 27 Chief Executive, they weren't involved in appointing an
 28 oversight committee but he was kept informed by the
 29 Medical Director.

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

2 109 Q. Of course. Of course. WIT-41053. 11(v). No
3 documentation from the Chief Executive's office
4 directly to you about the establishment of any
5 oversight group. Instead the Medical Director would 11:28
6 have alerted you to any emerging concerns and would
7 have arranged the establishment of the Oversight Group
8 meeting depending on which of them was available.

9 A. Mm-hmm.

10 110 Q. Then the Medical Director's role is defined. You've 11:28
11 said he acted as chair of the Oversight Group.

12
13 Just on that. Dr. Wright considered you to be joint
14 chair of the oversight group. Mrs. Gishkori in her
15 statement describes you as chair. There does seem to 11:28
16 be some uncertainty about the chairing role. You saw
17 yourself as a person who provided HR, professional HR
18 advice in relation to the group's responsibilities
19 under MHPS?

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

1 CHAIR: Mr. wolfe, I'm just wondering, is it --
2 shortly?

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

5 111 Q. Pulling up your statement so you can see it. 11 (vii): 11:30

6
7 "I understood my role as Director of HR during the
8 oversight meetings and outside of oversight meetings to
9 be primarily a support role to the Medical Director in
10 terms of professional HR advice in relation to their 11:30
11 responsibilities under MHPS."

12
13 In that context and knowing what we now know about how
14 this was dealt with as a matter of procedure, being the
15 HR expert in the room, it was for you to tell 11:31
16 Dr. Wright, 'this is out with our procedures at almost
17 every stage'. Is that fair?

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

19 112 Q. You've said, if we just go to WIT-41138. It's
20 a lengthy paragraph and we'll just step through it. 11:31

21 You say that the lack of clinical management input was
22 problematic, that the Oversight Group was itself
23 driving the decision making in December '16 as opposed
24 to the clinical manager. You've said that while the
25 oversight group's role was defined as quality 11:32
26 assurance, the absence of the clinical manager at the
27 meetings meant that the Oversight Group determined the
28 actions to be taken. You say that the effect of this,
29 on reflection, was that, contrary to Section 1,

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

8
 9 Scrolling down. You say the absence of the clinical
 10 manager also permitted a divergence from what was the 11:33
 11 agreed course of action at the oversight meeting on
 12 13th September. The agreed actions were subsequently
 13 debated outside the meeting and, as a result, the
 14 agreed actions were changed.

15
 16 Scrolling down. You say ultimately: 11:33

17
 18 "I very much regret that those discussions did not
 19 happen robustly enough ... and that there was not more
 20 focus on ensuring that work commenced urgently after 11:34
 21 the meeting on 13th September to check if the patients
 22 in the backlogs had come to any harm. The issue was
 23 further exacerbated by the fact that both Mr. Weir and
 24 Dr. McAllister were off on sick leave."

25
 26 Before we go to the break, can you help us, Mrs. Toal, 11:34
 27 in terms of how, given your dedicated role as the HR
 28 professional providing advice, knowing, based on your
 29 experience, that this wasn't going down the correct

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

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

27 113 Q. In fairness to your position, you've been reflected in
 28 your evidence that you received a fairly high-level
 29 briefing, if I can put it in those terms, from

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

13 A. Yes.

14 114 Q. That had been taken without you, it seems, being asked
 15 to advise on it on the basis of your evidence? 11:38

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

29 115 Q. Even at that point it would have been feasible to

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

3 A. That's correct.

4 116 Q. That's a fair concession.

5 11:39

6 we'll leave it at that.

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

9 MR. WOLFE KC: Very well.

10 11:39

11 THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

12

13 CHAIR: Mr. wolfe.

14 117 Q. MR. WOLFE KC: Mrs. Toal, the approach that was adopted
15 in this case, excluding from the process the clinical 11:58

16 management and putting the Medical Director's office in
17 the hot seat in terms of conducting the screening

18 process and then taking a decision on that, was that
19 the way things were done generally? I ask that

20 question obviously with the knowledge this was your 11:58

21 first involvement with an oversight group meeting, or
22 your first involvement in a process from start to

23 finish, but was it your knowledge or experience that
24 this was how it was done under this Medical Director,

25 if not before that? 11:59

26 A. I probably have maybe little knowledge of Dr. wright
27 but, certainly, when I look back over some of the cases

28 that I outlined in my Section 21, certainly there would
29 have been clinical managers at those oversight -- not

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

15 118 Q. We've heard from Dr. Wright in answer to the why 12:00
 16 question, why did you do it in this way, and his
 17 evidence is on the record in terms of whether he took
 18 the view that it was a breach of the guidelines.
 19 I think his evidence ultimately was rather nuanced
 20 around that, but that's a matter for the Panel. 12:00

21 A. Mm-hmm.

22 119 Q. What it seemed to come to from him was, 'listen,
 23 I regarded this as a reasonably urgent matter.
 24 Mr. Weir and Mr. McAllister, perhaps, were busy
 25 practitioners, so it was, I suppose as a matter of 12:01
 26 expediency, to put this into the hands of Mr. Gibson'.
 27 Your observations around that?

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

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

14 120 Q. But you had no discussion with him about the reasons?
 15 A. No. 12:02

16 121 Q. You didn't challenge him?
 17 A. No.

18 122 Q. I suppose in light of your earlier evidence, when
 19 we reflect back to the reasons why this task is given
 20 to the clinical manager, and you outlined it allowed 12:02
 21 for, I suppose, the input of a person who is clinically
 22 on the ground and has an ability to broadly and deeply
 23 appreciate the nature of the performance issues and the
 24 reasons for them, if that is -- and they were largely
 25 my words -- the rationale for this, expediency and the 12:03
 26 need to do it quickly, would you accept isn't an
 27 adequate reason for departing from the Trust's own
 28 guidelines?
 29 A. Yes, I would accept that absolutely. I suppose the

1 clinical manager input, not just the clinical expertise
 2 and the importance of that. But I think it allows for
 3 clinical ownership, you know, in the actual process.
 4 I think what we see, probably, in this case, too many
 5 people involved and therefore it wasn't necessarily 12:04
 6 owned by the people that needed to own it. I think
 7 that's an important point as well as to why the
 8 clinical manager is important in this.

9 123 Q. What did you understand -- if needs be we'll bring
 10 perhaps the flowchart up if it helps you, but I'll ask 12:04
 11 the question and see how we go. What did you
 12 understand the quality assurance role meant? If I, the
 13 clinical manager, come to the Oversight Group, this is
 14 my decision or view based on this screening report,
 15 'I think we should go for a formal MHPS investigation', 12:04
 16 is the quality assurance function, does that allow for,
 17 'hold on a minute, I don't think it's appropriate.
 18 Have you thought about this?'

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

29 124 Q. The doctor who is under discussion, what is the

- 1 appropriate point to tell him or her that there are
 2 issues being discussed both within the organisation,
 3 obviously, and externally if you are seeking advice
 4 from NCAS? Mr. O'Brien obviously was wholly in the
 5 dark about these meetings, the September meeting, 12:06
 6 the October meeting?
- 7 A. Yes.
- 8 125 Q. Only on 30th December is he told about this
 9 long-running process?
- 10 A. Yes. In fairness to the clinician it should be 12:06
 11 whenever there is a case being discussed. I mean, back
 12 in September, you know, I think the appropriate point
 13 in time at that stage was to be flagging to him in
 14 September that, you know, the Medical Director,
 15 Director of HR, you know, and the Operational Director 12:06
 16 had an awareness of this and there was a screening
 17 done. Yes, absolutely, September time, in fairness to
 18 the clinician.
- 19 126 Q. Let's move to aspects of the meeting itself and the
 20 build up to it. WIT-41559. This is an email which you 12:07
 21 sent on 6th September. You told us in your witness
 22 statement on the night of 6th September after reading
 23 this screening report you emailed Wright and Gishkori
 24 to see if they were free to discuss a number of issues,
 25 and number 2 on your list was Aidan O'Brien potential 12:07
 26 MHPS case. Do you remember that?
- 27 A. Yes, I do. I do.
- 28 127 Q. You're looking to touch base with the colleagues
 29 mentioned. What's being suggested, perhaps, as an

- 1 informal get together or meeting or discussion, did
 2 that ever take place?
- 3 A. No. I think there's an email in the system from Emma
 4 Stinson. Emma would have been Esther Gishkori's
 5 personal assistant. I think there's an email there to 12:08
 6 advise. Dr. Wright was able to but, from memory,
 7 Esther had another engagement immediately after
 8 Governance Committee so that was not possible. I think
 9 Emma advised on her behalf.
- 10 128 Q. What did you have in mind for that, if it's possible at 12:08
 11 this remove to comment? You've got a screening report.
 12 It's a potential MHPS case. Do you add that comment
 13 "potential MHPS case"?
- 14 A. I suppose I knew after reading the report there was
 15 potential for that. Again, my recollection of that 12:09
 16 was, again, probably indicative of the context at that
 17 stage and that I knew that there were a couple of
 18 ongoing issues, the ED issue, so number 5 around email
 19 from Mick McCann re advertising ED consultants. That
 20 was around Daisy Hill ED issues that were ongoing at 12:09
 21 the time. We knew we had issues with escalated rates
 22 and consistency rates. There were things, I suppose,
 23 I was gathering and I was aware of at that point of
 24 time coming into that Acting post. I suppose it was
 25 really just an opportunity for the three of us to say, 12:10
 26 'right, what are we doing with these?' I think that's
 27 really, in terms of -- you know, when I look at that
 28 now, what I would have meant at that stage.
- 29 129 Q. Can we bring the screening report up, please? We find

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

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

18 130 Q. This is the January meeting between?

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

23 131 Q. Just scroll through this and go to the last paragraph
 24 of the letter. His conclusion is that:
 25
 26 "Previous informal attempts had been unsuccessful and
 27 therefore the report recommends consideration of an
 28 NCAS supported external assessment of Dr. O'Brien's
 29 organisational practice, with Terms of Reference 12:12

1 focused on whether his current organisational practice
 2 may lead to patients coming to harm".
 3
 4 Sorry to have skimmed over that report. Was that the
 5 first detailed information to you about what this was 12:13
 6 all about?
 7 A. Yes.
 8 132 Q. Was it that conclusion that perhaps led you to suggest
 9 in your email to Gishkori and Dr. Wright that potential
 10 MHPS. Did you see, perhaps, the writing on the wall as 12:13
 11 a result of this report?
 12 A. Yes, I did.
 13 133 Q. In terms of the March process, can you help us in terms
 14 of when and, if you can't just say so, you would have
 15 become aware of the fact that a letter had been handed 12:14
 16 to Mr. O'Brien asking him to produce a plan to deal
 17 with the issues referred to in that letter?
 18 A. I can't remember if I knew before 13th September.
 19 I just can't recall that at all. I think I knew during
 20 the meeting on the 13th that there had been a letter. 12:14
 21 As I said in my statement, I didn't ask to see that
 22 letter, and I should have.
 23 134 Q. Yes. You've reflected in your statement at WIT-41058
 24 that you don't recall reading a copy of the letter of
 25 23rd March at the meeting, nor do you recall that 12:14
 26 a copy of the letter was actually available.
 27 A. No, I don't think so.
 28 135 Q. Did you have a sense of whether what had transpired in
 29 March formed any kind of a process, or did you regard

- 1 it as, I suppose, a local informal attempt to get to
 2 grips with matters?
- 3 A. I think I sensed at that stage it was being dealt with
 4 operationally, so it was very much local to Acute
 5 Services and Surgery at that stage. I don't think 12:15
 6 I recall thinking that it was an earlier part of any
 7 MHPS process or anything like that. I thought it was
 8 something fairly local.
- 9 136 Q. The meeting on 13th September, if we could pull up the
 10 minutes of that or the record of that? TRU-0026. Is 12:15
 11 it fair to say that you prepared for that meeting by
 12 reading the screening report, but there had been no
 13 discussion with the Oversight Committee members prior
 14 to coming to the meeting?
- 15 A. I don't recall a discussion. There may have been 12:16
 16 a corridor conversation or in the sidelines of
 17 a meeting. I see the report is in. I don't know.
 18 I don't recall anything, certainly, significant outside
 19 of 13th September before that.
- 20 137 Q. Did you appreciate before coming to the meeting that 12:16
 21 NCAS advice had been sought?
- 22 A. I can't say. I really can't say.
- 23 138 Q. Obviously with your knowledge of the process, is it
 24 fair to say that you would have liked to have thought
 25 that NCAS advice had been sought? 12:17
- 26 A. Yes. Yes, that's fair.
- 27 139 Q. But you didn't direct that yourself?
- 28 A. No.
- 29 140 Q. Did you come to the meeting, can you recall, with any

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

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

8 141 Q. In terms of the dynamics of the meeting leading to the
 9 decision which is outlined here, the drafting of
 10 a letter, a meeting with Mr. O'Brien, and the letter to 12:18
 11 have certain content, of course, to go through Esther
 12 and her team, and the need to inform Mr. O'Brien that
 13 there would be a formal investigation if sufficient
 14 progress hadn't been made. Yes, that there would be
 15 a informal investigation under MHPS. We'll come to 12:18
 16 that. How did, to the best of your recollection, that
 17 decision -- how was that arrived at? Was Dr. Wright
 18 leading the charge or was it a group decision?

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

29 142 Q. In terms of an HR professional such as yourself coming

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

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

23 143 Q. We heard from Mrs. Gishkori that she felt unable to
 24 contribute to this meeting in the way that she would
 25 have liked. The Inquiry may have gained the impression 12:22
 26 from her that she was uncomfortable with this plan.
 27 She expressed to the Inquiry a concern that this kind
 28 of plan may not be in the best interests of her
 29 service, if Mr. O'Brien was to walk away from something

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

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

21
 22 So I think what potentially has contributed, maybe, to
 23 Esther, on reflection, after the meeting being
 24 concerned, it's around the fact that we're in a MHPS
 25 process at all, no matter how informal it was. But 12:24
 26 I don't recall it being a difficult meeting. I don't.
 27 In terms of how Dr. Wright Chairs those meetings, he
 28 has always been a perfect gentleman. It wouldn't have
 29 been a difficult meeting for her to have raised her

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

2 144 Q. When we look at this note of the meeting and consider
3 it, we can see that it doesn't mention NCAS advice.
4 When you commented on this, I don't need to bring it up
5 on the screen, in your witness statement WIT-14060, you 12:25
6 say you that you found it strange that neither the NCAS
7 letter or any NCAS advice was referred to. Now, I'm
8 conscious you said in your statement as well that you
9 only received a copy of the NCAS letter yourself in
10 September 2020 in preparing for this Inquiry, perhaps. 12:26
11 Your surprise at not seeing, or your sense of
12 strangeness that you didn't see any reference to NCAS
13 in this record, where does that come from?

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

16 145 Q. You know that now, you didn't now, you didn't that
17 pre-meeting.

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

1 featured, obviously, in the discussion, maybe in the
2 detail that it should have. And, certainly, we know
3 that the letter came in, I think, later that day. So
4 anything that Simon would have been discussing would
5 have been as a recollection of what he had discussed 12:27
6 and the advice that he had received from NCAS, as
7 opposed to having anything in front of him by way of
8 the letter that NCAS sent back.

9 146 Q. would it have jarred with you in the course of the
10 meeting if you had conducted your business without 12:27
11 reference to NCAS advice?

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

19 147 Q. If we just pull up the advice and have your comments on
20 some of the points contained therein. If you go to 12:28
21 bring up on the screen AOB-01049. And scroll down,
22 please, to the bottom of the page.

23
24 You've said in your witness statement, Mrs. Toal, that
25 on seeing this advice and seeing that it identified 12:29
26 anecdotal reports of delay referral to oncology, you
27 said if this letter had been available at the Oversight
28 Group meeting, this line in particular could and should
29 have served to reinforce the importance of the urgency

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

3
 4 First of all, had you any source or understanding of
 5 the source of those anecdotal reports? 12:30

6 A. No, absolutely none.

7 148 Q. Have you any sense or understanding of what is meant in
 8 this context by "delayed referral to oncology"?

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

15 149 Q. But you're unable, sorry to cut across you, you are 12:31
 16 unable to particularise that or provide any greater
 17 specificity about the nature of the concern and where
 18 it arrived from?

19 A. No, I'm not.

20 150 Q. Obviously, and we don't need to bring up the email, I 12:31
 21 think the Panel have already seen the point that this
 22 NCAS advice was circulated by Mr. Gibson. The email
 23 was sent on 28 September, two weeks after oversight.
 24 The reference is WIT-41573. But it wasn't sent to you.
 25 It was sent to the other members of the Oversight Group 12:31
 26 and Dr. McAllister. It wasn't discussed at the
 27 10 October oversight?

28 A. No.

29 151 Q. This piece of advice didn't feature?

1 A. No. And I think --

2 152 Q. What you're telling the Inquiry, I think, is if it had
3 been discussed, if the advice had been discussed, this
4 letter brought forward and the advice discussed, this
5 line would have stuck out like a sore thumb, wouldn't it? 12:32
6

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

9 153 Q. And whether it was tittle-tattle, as Dr. Wright
10 suggested it could have been, it required bottoming 12:32
11 out, didn't it?

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

14 154 Q. It would have been as simple as: Mr. Gibson, you said
15 this to NCAS, what did you mean by it and who told you 12:33
16 about it? And a judgment then could have been made
17 about whether further questions were merited outside of
18 the room amongst fellow clinicians perhaps or within
19 the service.

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

27 155 Q. Just over the page, please, or down the page. There is
28 reference, just scroll down. Just scroll down further,
29 please. Thank you.

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

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

22 156 Q. The decision of 13 September was then worked up into
 23 a letter to Mr. O'Brien. If we could take a look at
 24 that. TRU-251430. You are familiar with this letter?
 25 Did you see it when it was produced? 12:37

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

1 it was the 13th after the Oversight meeting.

2 157 Q. Did it appropriately reflect what you saw as the way
3 forward?

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

15 158 Q. Tell us about that. Because the Minute that we have 12:38
16 looked at talks about an informal investigation under
17 MHPS.

18 A. It does.

19 159 Q. Is it fair to say there is no such concept within MHPS?

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

1 it once and for all?

2 160 Q. Was there to be an investigation?

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

4 there was no Investigation Team --

5 161 Q. There was to be an investigation into Mr. O'Brien's 12:40

6 performance?

7 A. No. It was around what is in these particular

8 backlogs, what's the content of them, and then to work

9 through the Action Plan.

10 162 Q. So there was to be an Inquiry into or an assessment of 12:40

11 what was in these backlogs?

12 A. Yes. An "assessment" is probably the better word, as

13 opposed to an "investigation". Because an

14 investigation would have required the appointment of

15 investigators and that certainly was not something that 12:40

16 we talked about.

17 163 Q. If we could just very briefly go back to the record of

18 the meeting on 13 September please at TRU-00026. These

19 words "formal" and "informal" were bandied about in

20 this context and I just want to take your view on this. 12:40

21 There is reference to a formal letter being sent to

22 Mr. O'Brien on 23 March, the letter we discussed

23 earlier. Again, your reflections on that word. Let's

24 see what we can establish here, there was no formal

25 process commenced in March 2016. 12:41

26 A. No. No. But I think, again, I think where the "formal"

27 word has come in, it was probably the first time.

28 I think it was the first time that ever anything was

29 documented to Mr. O'Brien. So that's probably why

- 1 there is maybe some confusion over the formality.
 2 I think there was a level of formality there by putting
 3 the concerns on paper.
- 4 164 Q. Yes. So, by contrast to what we know had now taken
 5 place in previous years of ad hoc communication with 12:42
 6 Mr. O'Brien to ask him to improve or do certain things,
 7 this was putting a degree of formality around a request
 8 for the plan on the four issues that had been raised?
- 9 A. Yes.
- 10 165 Q. But you're not suggesting, and as far as you're aware, 12:42
 11 this Minute isn't to be taken as suggestion that you or
 12 the organisation with Mr. O'Brien was within, kind of,
 13 any formal structure or system or process?
- 14 A. That's right.
- 15 166 Q. I'm obliged. Thank you. Now, the next step following 12:42
 16 the production of this letter which went to
 17 Mrs. Gishkori on 13 September was that she engaged with
 18 Dr. McAllister and Mr. Carroll to consider an
 19 alternative, as it transpired, to what oversight had
 20 produced? 12:43
- 21 A. I think it was Dr. McAllister maybe, not Mr. Carroll,
 22 Dr. McAllister, is that what you mean?
- 23 167 Q. Well, I'll put it again. What I meant to say was that
 24 Mrs. Gishkori, on 14 September, met with
 25 Dr. McAllister -- 12:43
- 26 A. Yes.
- 27 168 Q. And we understand that Mr. Carroll was in attendance.
- 28 A. Yes. I think so, yes, apologies.
- 29 169 Q. And Mr. Weir may or may not have been. We're not

1 terribly sure about that, as the evidence stands. But
2 just on that issue, can you remember hearing that an
3 alternative plan was afoot?
4 A. So Esther, I think it was on the 16th, 15th? I can't
5 remember. So the Oversight was on the 13th. I think 12:44
6 then there were discussions on the 14th, and maybe it
7 was the 15th. So there is an email there that
8 basically Esther --
9 170 Q. Let me pull it out?
10 A. Yes, if you can clarify the date. 12:44
11 171 Q. TRU-263681. At the bottom of the page.
12 A. The 15th.
13 172 Q. You can see that Esther is writing to you:
14
15 "Further to our Oversight Committee, two days earlier, 12:44
16 I had a meeting with Charlie and Ronan. I mentioned
17 the case that was brought to the Oversight meeting in
18 relation to Mr. O'Brien and the Plan of Action."
19 A. Yes.
20 173 Q. "Actually, Charlie and Colin Weir already have plans to 12:45
21 deal with the urology backlog in general and
22 Mr. O'Brien's performance was of course part of that."
23
24 Moving over the page please:
25
26 "Now they both work locally with him. They have plenty
27 of ideas to try out and since they are both relevantly
28 new into post I would like to try their strategy first.
29 I am, therefore, respectfully requesting that the Local

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

3
 4 I appreciate you highlighting the fact that this
 5 long-running issue has not yet been resolved. However, 12:45
 6 given the trust and respect that Mr. O'Brien has won
 7 over the years, not to mention his life-long commitment
 8 to the Urology Service which he built up
 9 single-handedly, I would like to give my new Team the
 10 chance to resolve this in context and for good. This, 12:46
 11 I feel, would be the best outcome all round."

12
 13 Do you remember what your response to it was, at least
 14 internally?

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

24 174 Q. Yes. I think you said to him we're definitely going to
 25 need notes going forward, especially if goalposts keep 12:47
 26 trying to be changed.

27 A. Yes.

28 175 Q. Can I ask, were notes not routinely kept of these
 29 meetings at that time?

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

3 176 Q. In terms then of what Mrs. Gishkori is saying, she is
 4 suggesting that her local managers have a better idea
 5 of how to deal with this effectively. She's also 12:47
 6 putting into the mix a sense that Mr. O'Brien deserves
 7 different treatment or perhaps better treatment in
 8 light of his considerable background within the
 9 organisation. So let's unpack that.

10 12:48

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

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

22

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

1 to really what it should be, which is around assisting
 2 a clinician in terms of bringing their practice back on
 3 line or conduct or whatever. So I think it's that view
 4 that MHPS just would have been that nuclear option, as
 5 such, and the impact and the reaction that might have 12:50
 6 had.

7 177 Q. You don't seem concerned clinicians are, Clinical
 8 Managers are at least having some input through
 9 Mrs. Gishkori's initiative which, as we reflected
 10 earlier, not quite in this way but it was their role to 12:50
 11 have an input having regard to the guidelines.

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

18
 19 Actually, when you reflect on what we were asking to be
 20 done so that Simon, yes, he would draft the letter, but 12:51
 21 there needed to be a discussion amongst themselves in
 22 terms of: Right, what does this letter need to say?
 23 What way are we handling this? So it was very much
 24 making sure that operationally that the leaders within
 25 the Acute Services Directorate had an involvement. I'm 12:51
 26 just not sure that we ever anticipated then that the
 27 plan would change in the way that it did and the way
 28 that Esther then emailed Dr. Wright and I afterwards.

29 178 Q. Of course, if this had been handled in a manner in

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

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

11 179 Q. At that time, what was the sense of Patient Safety
12 issues and was the Oversight Group as sensitive to
13 those risks as it needed to have been?

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

23 180 Q. I know that, you know, we will maybe come on to your
24 reflections later, but I think we can have a snapshot
25 of that now, I think there's a sense in your 12:53
26 reflections that this prevailing narrative about his
27 excellence as a surgeon created a form of a blind spot
28 to more urgent and more effective action. Is that
29 fair?

1 A. Very fair.

2 181 Q. Just your reflections on this. Again, it may well be
 3 a complex issue, but we know from other correspondence
 4 that the Oversight Group would not have been cited on,
 5 that issues relating to the impact of not triaging 12:54
 6 patients was known to Mr. McAllister and Mr. Weir so
 7 that, for example, on that very week, 16 September,
 8 Mr. Weir was being asked to give his view on whether
 9 a particular case involving Patient 93 was well-handled
 10 and whether a Serious Adverse Incident Review should 12:54
 11 result.

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

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

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

12:56

6 182 Q. Does it suggest Clinical Managers need to be more
 7 responsive in terms of their communication of all of
 8 the relevant Clinical and Patient Safety issues to
 9 enable the Oversight Group, as it then was, to have an
 10 adequate conversation with them with a view to
 11 determining the proper response?

12:57

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

12:57

19 183 Q. Just two final points before our lunch break: First of
 20 all, you do try to address Mrs. Gishkori in relation to
 21 this initiative. If we go to TRU-263685. Scrolling
 22 down. So this is Dr. Wright telling Esther Gishkori
 23 that he has to listen to her opinion before he would
 24 concede to any delay in moving forward with the agreed
 25 position after oversight, "I would need to see what
 26 plans are in place".

12:57

12:58

27
 28 And you then take up the mantle on that and you say to
 29 Esther:

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

3
4 He explains to you that there had been a meeting with
5 the Chief Executive and that it would eventually be 12:59
6 documented. You didn't ultimately see the alternative
7 plan, is that fair?

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

22 184 Q. Finally before lunch, there's an Oversight Group
23 meeting on 12 October. You attended that. That's
24 essentially three weeks after all of this had taken
25 place. Did you have a sense that nothing had been done 13:01
26 and the energy, or the urgency, had dissipated from
27 this process?

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

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

8 185 Q. And your reflection on that, were you comfortable with
 9 that, that things could be let lie until he returned
 10 from his surgery? 13:02

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

22 186 Q. Yes. You've said in your statement WIT-41066, just to
 23 have that up on the screen, please:

24
 25 "I attended the next Oversight Group meeting arranged 13:03
 26 for 12 October. At that meeting Esther Gishkori
 27 advised that Mr. O'Brien was about to commence a period
 28 of sick leave for planned surgery at the beginning
 29 of November and would be off work for a period of time.

1 Esther Gishkori also reported that a meeting with
2 Mr. O'Brien had not yet taken place to speak with him
3 about the concerns regarding his administrative
4 practices and backlog. Esther Gishkori did not wish to
5 speak with Mr. O'Brien in advance of his planned sick 13:04
6 leave as she thought it would cause him distress in
7 advance of surgery.

8
9 Esther Gishkori gave assurances to Dr. Wright that
10 plans for the backlogs were in place to clear these 13:04
11 during his absence. I cannot recall the detail that
12 Esther provided in relation to those plans."

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

19 A. That's correct.

20 187 Q. Is it fair to say no such assurances were sought and 13:05
21 none were given?

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

23 188 Q. In fact, is it worse than that? It was known that
24 Mr. O'Brien hadn't even been approached on this
25 subject? 13:05

26 A. That's right.

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

29 CHAIR: 2.05, everyone.

1 THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

2
3 CHAIR: Good afternoon, everyone. Mr. wolfe.

4 MR. WOLFE KC: Good afternoon, chair. Good afternoon,
5 Mrs. Toal. 14:08

6
7 Just before the break we looked at the events of
8 10 October, the second Oversight meeting. Just now
9 I want to look at, I had just reached the December
10 Oversight meeting. It seemed to have been a fairly 14:09
11 quiet period, at least in terms of your involvement and
12 considerations around Mr. O'Brien until December. You
13 were advised on 30 November, you've recalled in your
14 statement, of the SAI concerning Patient 10, and then,
15 on the 6 December you were copied into an email where 14:09
16 Mrs. Gishkori explains how she is going to handle
17 matters upon Mr. O'Brien's return from his sick leave.
18 If we just briefly look at that at TRU-251827. She is
19 telling Dr. Wright that she has been having
20 conversations in relation to Mr. O'Brien's return to 14:10
21 work. We thought this would be a good time to set out
22 the ground rules from the start. At that point Colin
23 Weir and Charlie McAllister both off sick. Mark,
24 that's Mark Haynes, wondered if Mrs. Gishkori and he
25 could do this return to work since there are both 14:10
26 professional operational issues here. She feels this
27 is entirely reasonable.

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

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

6 189 Q. Matters were to change however in late December. You
 7 received a telephone call from Simon Gibson, just prior
 8 to Christmas followed by an email to invite you to come
 9 along to an Oversight meeting on 22 December. Just on
 10 that, with Mr. McAllister, and Mr. Weir out of the 14:11
 11 picture for different reasons. You've said that you're
 12 not aware who, in clinical terms, Dr. Wright was
 13 engaging with and you have said it may have been Mark
 14 Haynes, but did you ever hear of any involvement
 15 between Dr. Wright and Mark Haynes on issues pertaining 14:11
 16 to Mr. O'Brien?

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

21 190 Q. But in terms of what is coming in to the Oversight
 22 meeting, and we can pull up the record for it,
 23 AOB-01280. The driver for this Oversight meeting was
 24 Dr. Wright's of the seriousness of the Serious Adverse
 25 Incident Review, is that fair? 14:12

26 A. Yes, that is fair. Yes.

27 191 Q. The Inquiry is very familiar with this record and this
 28 meeting by now. I don't wish to dwell on it on an
 29 overall lengthy basis, albeit it was an

1 important staging post.

2

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

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

8 192 Q. I want to ask you to reflect on whether it ought to
9 have taken the case of Patient 10 to put this case on
10 this formal trajectory. If you don't do triage, you 14:13
11 risk missing a patient who should be escalated to red
12 flag?

13 A. Yes.

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

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

1 194 Q. If we scroll down through this. I just want to take
 2 you to what is said about that. So that's the triage
 3 issue. Moving down, let's just go to the bottom of the
 4 next page, please.

5
 6 The consideration of the Oversight Committee is that
 7 Mr. O'Brien's administrative practices have led to the
 8 strong possibility that patients may have come to harm.
 9 You have acknowledged that that is a realisation that
 10 could but didn't come earlier. The question becomes: 14:15
 11 Should he return to work? And the analysis is that his 14:16
 12 continuing administrative practices would continue to
 13 harm patients and, therefore, a decision was made to
 14 exclude Dr. O'Brien, at that point, for the duration of
 15 the formal investigation. 14:16

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

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

24 195 Q. As a HR professional, did you work through, in your
 25 head at least, whether there were alternatives, viable 14:17
 26 alternatives to this?

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

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

6 196 Q. We will, of course, hear from Mr. O'Brien in due
 7 course. I understand he will express the view and
 8 explain that for his patients he was coming back to
 9 work, due to come back to work in January. He had
 10 lined up theatre, he had lined up clinics. With his 14:18
 11 exclusion there was going to be this adverse effect on
 12 his patients. Was that any part of the thinking in
 13 December 2016?

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

28
 29 But, yes, with a longer term exclusion that would have

- 1 gone from immediate to formal perhaps, that would have
2 had an impact on the clinical capacity. But I think at
3 this stage actual safety trumped all of that.
- 4 197 Q. We know from consideration of this record of this
5 meeting that there were essentially three issues that 14:19
6 were going to move forward into formal MHPS
7 investigation. Private patients was to be added to the
8 list, as was a concern around the actions of
9 management. We'll come to the terms of reference in
10 a moment. 14:19
11
- 12 One of the issues that confronted you in September was
13 the review backlog list and a concern that Mr. O'Brien
14 wasn't dealing with this appropriately. We saw in
15 the October record of Oversight Mrs. Gishkori 14:20
16 explaining that during Mr. O'Brien's absence that
17 review backlog was going to be addressed by colleagues,
18 assumedly, and that, as you said before lunch, provided
19 you with a degree of assurance. In terms of
20 Mr. O'Brien's historic performance around this issue, 14:20
21 it didn't move forward into the MHPS process as
22 something being worthy of investigation.
- 23 A. Mm-hmm.
- 24 198 Q. The analysis around that or any discussion around that
25 doesn't appear in any record of Oversight. 14:21
26
- 26 A. Mm-hmm.
- 27 199 Q. Can you help me to understand whether that just faded
28 away as an issue because the live clinical issue was
29 being dealt with by colleagues, and therefore we don't

1 need to bother about it any more. why was it no longer
 2 a performance issue to be looked at possibly to
 3 determine whether there was a disciplinary issue there?
 4 A. I think, from memory, yes, it was being dealt with by
 5 others, but again, my recall on this is that he wasn't 14:21
 6 the only one in that situation, I think there were
 7 others. But my memory is not particularly clear on
 8 that aspect.

9 200 Q. Do you agree that it being an issue with which the
 10 Oversight Group was considering, that we ought to be 14:21
 11 able to go back to the record to see how that could
 12 have been resolved to the satisfaction of the Oversight
 13 Group?

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

16 201 Q. There was a meeting with Mr. O'Brien then on 30
 17 December.

18 A. Yes.

19 202 Q. Dr. Wright attended.

20 A. Yes. 14:22

21 203 Q. One of your colleagues, Lynne Hainey provided HR input.
 22 You wrote to her AOB-01297, on 28 December and asked
 23 her to attend that meeting. You use that email, if
 24 we scroll down, just to provide her with some of the
 25 background. And you're telling her what Mr. O'Brien 14:23
 26 needed to be advised of. A straightforward question,
 27 Mrs. Toal, why were you not in attendance at the
 28 meeting with Mr. O'Brien?

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

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

4 204 Q. Another development at around that time was the fact
 5 that Dr. Wright sought advice from NCAS after the
 6 decisions had been taken on 22 December. Is that, in
 7 your experience, the appropriate way of doing it or
 8 does that put the cart before the horse? In other
 9 words, should you seek advice and then bring that to
 10 the decision-making table?

14:23

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

14:24

14:24

14:25

14:25

28 205 Q. But it appears that two very important decisions were
 29 taken on 22nd December: Exclude and move to formal

1 investigation.

2 A. Yes.

3 206 Q. First of all, on exclusion, that was a decision reached
 4 at that meeting, it wasn't a decision of Dr. Khan?

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

7 207 Q. Obviously that meeting also, to add a third key
 8 decision in principle, it was decided that Dr. Khan
 9 would be the case manager and Mr. Weir the case
 10 investigator, but those people had to be spoken to. 14:26

11 A. Yes.

12 208 Q. To what extent are we to interpret the decisions on
 13 exclusion and a formal investigation as being decisions
 14 reached, in principle, by the Oversight Group but
 15 subject to NCAS advice? 14:26

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

21 209 Q. We'll come to the NCAS, we will have a look at it in
 22 a moment. I just want to show you the record for 10th
 23 January Oversight meeting. It's at AOB-01363.
 24 Mrs. Gishkori attends this meeting. She wasn't able to
 25 attend, it seems, the December meeting. If we just 14:27
 26 scroll down through it. It's fair to say, isn't it,
 27 that the NCAS advice wasn't brought to this meeting and
 28 wasn't discussed.

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

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

14:28

6 210 Q. I don't wish to bring you to any particular part of
 7 this record, but it was another important staging post
 8 of recording the up-to-date developments on the actions
 9 that had been ordered at the December meeting. Adding
 10 into the mix the private patients issue that had
 11 developed since the last meeting.

14:28

12
 13 On the issue of the NCAS advice, by this stage the
 14 advice was given on 29th December, by this stage there
 15 had been a process commenced of developing Terms of
 16 Reference. I want to ask you about that in the context
 17 of the advice. If you pull up the advice at AOB-01327?
 18 Just scrolling down over the next page, please. Go to
 19 the bottom of this page, please. Stop there. As for
 20 your observations on the last paragraph of that page.
 21 The advice is reciting what Dr. Wright is saying and
 22 there's an analysis which says that in an informal
 23 approach is unlikely to resolve the situation. That
 24 advice, we will need to obviously speak to NCAS about
 25 this, but the informal approach which was considered in
 26 September had never been implemented, isn't that right?

14:29

14:29

14:30

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

1 211 Q. Yes.

2 A. Yes. But he would not have been aware of the
3 discussion in September.

4 212 Q. We know 23rd March letter, no follow-up with
5 Mr. O'Brien on that. He wasn't cajoled or otherwise 14:30
6 directed to deal with that after he received the
7 letter. No support offered, no follow up meeting?

8 A. Mm-hmm.

9 213 Q. Then we have the NCAS advice of 7th September
10 suggesting a number of other informal options. They 14:31
11 are not drawn to Mr. O'Brien's attention and the
12 starting gun on those isn't sounded.

13

14 I wonder could NCAS have thought, based on what their
15 understanding, I mean the understanding conveyed to 14:31
16 them, I wonder could they have thought this informal
17 approach hasn't worked. That is perhaps an unfair
18 question I am asking you what NCAS might have thought.
19 But it would have been appropriate to tell NCAS, would
20 it not, in specific terms, we haven't actually been 14:31
21 able to follow your advice from September, for whatever
22 reason, and we haven't done an informal?

23 A. Yeah. It is highly, highly, unlikely that Dr. Wright
24 would have been referring. So, when we see the
25 reference there as per paragraphs 15 to 17 of Section 1 14:32
26 of MHPS, it was highly unlikely that Dr. Wright was
27 referring to that. So there was, in all likelihood,
28 reference to an informal approach. I can't say what
29 Dr. Wright, the terms of which he spoke to, I think it

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

9 214 Q. If we can go to the next page, please? You are getting
 10 some advice. First of all, can you remember receiving 14:33
 11 this advice yourself?

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

18 215 Q. Or the process is given some advice in relation to
 19 Terms of Reference which NCAS are saying should be
 20 robust and specific and in line with the relevant 14:34
 21 paragraphs of MHPS. It goes on to say:

22
 23 "The investigation should not be an unfocused trawl,
 24 but we discussed that if there are concerns that
 25 patients might not have received appropriate treatment, 14:34
 26 or if there are patients with inadequate records, then
 27 this could be managed separately with an audit
 28 look-back to ensure that patients have received the
 29 appropriate standard of care."

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

3

4 First of all, who did you understand had the job of
5 formulating Terms of Reference?

14:34

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

14:35

14 216 Q. Was he an appropriate person to give that role to?

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

14:35

14:36

14:36

- 1 217 Q. I don't get a sense that, and I asked a similar
2 question to Dr. Wright yesterday, I don't get a sense
3 that there was a sit-down meeting of any description
4 amongst relevant and interested people to commence
5 a considered development of Terms of Reference for this 14:37
6 important investigation.
- 7 A. No. And I think where the Terms of Reference will,
8 apart from Simon's work on it, largely from Case
9 Investigator and at that stage Siobhán Hynds, based on
10 what they were gleaning during January, and then 14:37
11 further supplemented by their discussion with
12 Mr. O'Brien at the end of January in advance of the
13 case conference. Obviously the Terms of Reference I
14 think took quite a bit of time to work through, and I'm
15 sure you're about to go on to it, but certainly the 14:38
16 discussion with Mr. O'Brien, then his letter, where
17 there were a number of points in that letter, which led
18 them to the standing down of Mr. Weir and then
19 Dr. Chada as the Case Investigator. So essentially
20 then those were finalised when Dr. Chada came into 14:38
21 post. And probably largely between Dr. Chada and
22 Siobhán Hynds, and with reference to Dr. Khan as the
23 Case Manager.
- 24 218 Q. I think I'm right in saying the guidelines are silent
25 on who should be the responsible person or persons for 14:38
26 developing the TOR. Do you have a view on who are the
27 appropriate people and at what stage?
- 28 A. Certainly in this case the Terms of Reference, in terms
29 of the stage, to take that part of your question first,

1 maybe, I think after that preliminary stage during
 2 January was the appropriate time to do it. When you
 3 look at the NCAS 2010 guidance document around local
 4 performance investigations, I think it does refer to
 5 the case investigator and the case manager. It might 14:39
 6 be helpful, maybe, to pull those up. I think there is
 7 a reference within that document to the case
 8 investigator, case manager.

9 219 Q. Yes. If we go to WIT-41394. Is this a particular
 10 section of that? 14:40

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

13 220 Q. WIT-41396.

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

16 221 Q. If we go to WIT-41407, please? The Terms of Reference,
 17 as finally drafted, should be agreed by the
 18 organisation's relevant decision-makers.

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

26 222 Q. It is not unhelpful to know that, that you are
 27 confused, strange as that may sound. It reflects --
 28 and, as I say, your own guidelines don't deal with the
 29 issue.

1 A. Yes.

2 223 Q. Let's broaden the issue out beyond who should have been
3 doing it. Perhaps the more important issue is the
4 process for doing it and what should be included in
5 a Term of Reference. You receive advice from NCAS, 14:42
6 which I read to you, which says that this should not be
7 an unfocused investigation. We can, I suppose, apply
8 some hindsight to know that this MHPS process didn't
9 shine the light at all of the aspects of Mr. O'Brien's
10 practice which were to be regarded by the Trust, at 14:42
11 least, as being revealing of shortcomings.

12 A. Mm-hmm.

13 224 Q. If I can approach the issue of Terms of Reference in
14 that way. Given what you did know across the four
15 issues that were to be investigated ultimately, was 14:42
16 there anything in the generality of those issues which
17 might have been symptomatic of other problems in other
18 areas of the practice that were at least worthy of
19 light-touch scrutiny before the Terms of Reference were
20 finalised? 14:43

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

1 the forest, for want of a better analogy. So if we
 2 have issues, if this clinician has issues in this part,
 3 could it be that he has issues in this part too? So in
 4 that way, you know, when you look back it wouldn't
 5 necessarily have been unfocused. It just would have 14:44
 6 been a sensible thing to do around sensing, do we have
 7 a wider problem here administratively?

8 225 Q. The concern was that the investigation would be
 9 unfocused, but what we are presently discussing is the
 10 step before that, which is let's come up with Terms of 14:44
 11 Reference that are focused, but also let's come up with
 12 Terms of Reference that are appropriate. That's what
 13 we're talking about, I suppose?

14 A. Yes.

15 226 Q. I think probably, upon reflection, you would agree with 14:45
 16 me that that jump from administrative shortcomings in
 17 the areas of his practice that we know about, it's not
 18 too clever or complex to say, well, what about --

19 A. What about other parties.

20 227 Q. -- other aspects? 14:45

21 A. Yes.

22 228 Q. If we're learning about this and if the Health Service
 23 should learn about this, would you agree that there
 24 were other pieces of intelligence, if I could put it
 25 that way, that really have been put out on a table and 14:45
 26 discussed by whoever it was, we are now confused as to
 27 who it should have been drafting these Terms of
 28 Reference. By that I mean, for example, the remark in
 29 the advice from NCAS in September about delays in

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

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

7
 8 I think there was also, and I certainly wasn't aware of
 9 it, but certainly there was an email around, I think,
 10 from a litigation perspective around Mr. O'Brien, 14:46
 11 I think having emailed Marian Fitzsimons, who was the
 12 Litigation Manager at that point in time, around delays
 13 in getting some of the information back to the
 14 Litigation Department. So there were issues there.
 15 And I suppose, again, when you try to join all of those 14:47
 16 dots together --

17 229 Q. There was a new complaint in?

18 A. Yes.

19 230 Q. I think you probably were aware of that, or certainly
 20 some of your colleagues were. Patient 16, if you just 14:47
 21 want to glance at the cipher list. If we pull up
 22 TRU-01366, 23rd December. You can see the name in the
 23 attachment line. We're familiar with that SAI which
 24 started life as a complaint from the patient's daughter
 25 in December of that year, and there is consideration 14:48
 26 being given there to whether this falls within the SAI
 27 process.

28
 29

1 I raise that simply as another example in order to seek
2 your reflections on maybe what are you doing now,
3 perhaps, that's different when you sit down to compose
4 Terms of Reference to ensure that they are sufficiently
5 broad, without doing injury to fairness or doing injury 14:48
6 to the notion that this cannot be so high, wide and
7 handsome that it becomes meaningless.

8 A. Yes, I think the difference I see now, and probably
9 Dr. O'Kane has brought this difference to it, is the
10 questions around, so what else do we know? what are 14:48
11 the complaints? what are the litigation cases? what
12 are the SAIs? So you're on, you know, there's a range
13 of data that you're trying to gather a picture around
14 whether a job plan is in place, an appraisal is in
15 place. It's trying to build a picture outside of just 14:49
16 what you are kind of currently dealing with and I think
17 that's helpful.

18 231 Q. When looking at this and listening to my raising of
19 a potential criticism around how the TR were developed
20 here, do you rely on the hindsight defence to say, 14:49
21 'we simply couldn't have imagined a need for a broader
22 set of Terms of Reference'?

23 A. No, there were things we should have checked at the
24 time. I don't look at it, oh, you know, now we know
25 what we know. I think there were questions that 14:50
26 we should have been asking. There were other problems
27 we should have sensed at the time, and we should have
28 checked those out. For me probably one of the biggest
29 lessons for us as an organisation is around that

1 problem sensing and how attuned we are to that.

2 232 Q. Is there any sense that kinds of advice, and we have
3 looked at the language NCAS used, just the culture
4 within which we look at clinical performance, is there
5 any sense of a chill factor that may have existed at 14:50
6 that time, may still exist about what employers can
7 properly do when sitting down to investigate?

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

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

28 233 Q. If you want to carry that thought away with you and
29 explore it, and the Inquiry, undoubtedly, will be happy

- 1 to hear from you if you want to add to that.
- 2 A. Yes.
- 3 234 Q. Is this around the question of who now would draft the
4 Terms of Reference?
- 5 A. The case manager drafts the Terms of Reference. 14:52
- 6 235 Q. That's the current position?
- 7 A. That is the current position.
- 8 236 Q. Does he or she do it, if you like, in the more
9 intelligent way of bringing all of the relevant
10 information into the mix: complaints, SAIs. In other 14:52
11 words, what's known?
- 12 A. Yes. So there would be much more of a, sort of,
13 joined-up approach. From a Medical Director
14 perspective I mean they would have all of that
15 information to hand. I suppose I'm thinking of one 14:53
16 case in particular, which is our most recent one, which
17 is again back to we drafted Terms of Reference and then
18 we ran the Terms of Reference past NCAS, RPPA (as it is
19 now) and their advice was, 'no, you need to narrow that
20 down quite a bit'. I think there still is that view 14:53
21 around making sure that they are as tight as they can
22 be.
- 23 237 Q. Presumably an organisation or a Trust can have a debate
24 with NCAS and say, 'look, we think this is justified'?
- 25 A. Yes. Probably, you know, there's other ways of 14:53
26 checking things out so it might not necessarily be as
27 part of the investigation, but maybe there needs to be
28 an audit of particular practices that potentially sits
29 alongside that. If there's an issue, then it can form

1 part of the Terms of Reference at a later stage. So
 2 I think we're much more attuned to that at this stage.
 3 238 Q. Two final points on Terms of Reference, please. If we
 4 can bring up TRU-267983. This is, as I understand it,
 5 the final set of Terms of Reference. Scrolling down. 14:54
 6 Scroll down to the next page, please. We can see that
 7 Item 5 is introduced.

8
 9 Have you any sense of who authored that element and why
 10 it was introduced? 14:55

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

29 239 Q. It would appear she would claim to be the author of it?

1 A. I heard you say that, yes.

2 240 Q. She says in her witness statement, WIT-23761, "that it
3 became clear to me" -- that's Dr. Chada -- "that
4 a further Term of Reference needed to be considered.
5 TOR5 was to determine to what extent any of the above 14:56
6 matters were known to managers within the Trust prior
7 to December 2016. I believe I added this Term of
8 Reference by mid March 2017."

9

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

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

22 241 Q. I'm asking more about the propriety of an investigator
23 doing it unmoored to the rest of the process. In other
24 words, could she properly take this investigation into
25 any matter which causes her concern without -- 14:58

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

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

4 242 Q. We will explore that with her. Just one final point on
 5 this area: Dr. Wright's statement, you may have heard 14:58
 6 me ask about this yesterday:
 7

8 "The Terms of Reference were agreed by Mrs. Toal and I,
 9 after being drafted by Mr. Simon Gibson, after
 10 discussion with NCAS in early January. I have been 14:59
 11 unable to clarify the exact date or details concerning
 12 any possible iterations."
 13

14 Do you recognise that process of you and him agreeing?
 15 A. No. No, I don't. 14:59

16 243 Q. There was a case conference on 26 January, you chaired
 17 it. Just in the interests of brevity, I set out
 18 a description in your presence yesterday of that
 19 process. would you agree with me that the process is
 20 provided for within your guidelines whereby the 14:59
 21 decision that's on the agenda is whether there's a need
 22 to extend exclusion or whether safety, or for other
 23 reasons, could allow the practitioner to return?
 24 A. Yes.

25 244 Q. And the process is to have a case conference involving 15:00
 26 a preliminary report from the Case Investigator and
 27 a decision to be reached by the Case Manager on that
 28 issue?
 29 A. Yes. That's right. That's right.

1 245 Q. And that's what was done on 26 January.

2 A. Yes.

3 246 Q. If we just pull up the record of that meeting briefly,
 4 please. TRU-00037. You chaired that meeting. You
 5 explained to us earlier that Dr. Wright attended 15:00
 6 remotely?

7 A. That's right. That's why I chaired it.

8 247 Q. Mrs. Gishkori didn't attend and put in her place Anne
 9 McVey, who had no prior involvement with this process.
 10 You wrote to Mrs. Gishkori in advance of this meeting, 15:01
 11 isn't that right?

12 A. Yes. Yes. She had chaired that with me on Friday.

13 248 Q. Your concern, if we can just pull up the email,
 14 TRU-366455. If we try WIT-367455. I'm not sure we'll
 15 be able to find the reference? 15:02

16 CHAIR: I think there might have been some confusion as
 17 to whether you said 2 or 4 at the start of the TRU
 18 reference, Mr. Wolfe.

19 MR. WOLFE KC: 267455? TRU-267445.

20 A. Yes, that's it. 15:02

21 249 Q. Let's scroll up so we can see the start of Mrs. Toal's
 22 email. You said:
 23
 24 "Esther, this is a very important meeting and requires
 25 senior representation from Acute Services. Given 15:03
 26 Ronan's involvement in the parallel process in relation
 27 to the scoping of the impact, or actual, or potential
 28 on patients, I think it is more appropriate to keep him
 29 separate from the oversight committee role in relation

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

3
 4 I think it might be on down this page. If we can just
 5 scroll down. I think Mrs. Gishkori had, as she 15:03
 6 describes, an unavoidable prior leave commitment. You
 7 were clearly disappointed or concerned that she
 8 couldn't attend?

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

14 250 Q. Obviously she hadn't attended the December meeting.

15 A. Yes. 15:04

16 251 Q. That was obviously perhaps a family time leading up to
 17 Christmas.

18 A. Yes, I...

19 252 Q. Were you concerned about her commitment to the process
 20 and her perception of its significance? 15:04

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

1 I thought this one in particular was an important one.

2 253 Q. Yes. Just in terms of going back to the record of this
3 meeting at TRU-00037, in terms of the business of that
4 meeting, it's right to say, isn't it, that Dr. Khan
5 decided there was a case to answer and he decided in 15:06
6 consultation with others that exclusion could be set
7 aside.

8

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

13 A. Yeah.

14 254 Q. I assume you are familiar with this record. You can
15 scroll through them if you think you need to? 15:06

16 A. No, I'm fine.

17 255 Q. But amongst those issues were the need to develop
18 a monitoring plan. There was a need for an urgent job
19 plan, a need for a comparative analysis of
20 Mr. O'Brien's work as compared with his peers, his 15:07
21 workload as compared with his peers. There was a need
22 to update NCAS. The investigation was about to
23 commence, so presumably there was a need to track that
24 investigation to some extent. Would you agree with me
25 that any or perhaps all of those issues ought to have 15:07
26 led to Oversight follow-up?

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

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

17 256 Q. If I could just pick up on one of the points that
 18 I mentioned? If you go to the bottom of TRU-00038.
 19 The bottom of page 39, if you would. Scroll down.

20
 21 As regards monitoring, first of all, were you content
 22 that it was a safe decision to release Mr. O'Brien from
 23 his exclusion?

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

- 1 around, you know maintenance of skill, clinical skill,
2 and things like that.
- 3 257 Q. Presumably that is subject to an effectively monitoring
4 plan being produced?
- 5 A. Yes. Absolutely. 15:11
- 6 258 Q. And it was agreed that the Operational Team would
7 provide that to members of the Oversight Committee.
8 Did you ever see it and approve it?
- 9 A. Yes. I mean we all, to the best of my knowledge, I
10 mean I know I did see it. So I'm assuming Esther and 15:11
11 Dr. Wright would have seen it. I certainly did. But
12 in terms of the actual detail and the working through
13 from an operational process point of view, Acute
14 Services, the devil in the detail was very much with
15 them in terms of their processes. I don't think I 15:12
16 would have known how robust it actually was.
- 17 259 Q. Is that not the important thing, if you are concerned
18 that you have a clinician who may place patients at
19 risk with his activity, even if it is on the
20 administrative side of the line activity as opposed to 15:12
21 purely clinical, is it not something that you, as an HR
22 professional and a member of the Oversight team, would
23 need to scrutinise in depth and get appropriate
24 assurances before giving the return to work the green
25 light? 15:12
- 26 A. There were other people in this Oversight.
- 27 260 Q. Of course. Of course.
- 28 A. From my perspective, you know, the importance of others
29 being able to look to see, right, from a clinical

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

5 261 Q. If we could turn to WIT-41147. If we look at 15:13
6 paragraph 3, please. You have said:

7
8 "The Return to Work action plan as a means of
9 protecting the public as per MHPS Section 1,
10 paragraph 5, needed to be much more robust, in my view, 15:13
11 with greater clarity around reporting and escalation
12 arrangements to the Case Manager and Medical Director.
13 The arrangements should not have been dependent on
14 a single person to monitor".

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

21 A. Yes.

22 262 Q. Are you saying that, upon reflection, much more could
23 have been done by Oversight Group, you and your
24 colleagues, to ensure that the monitoring arrangements
25 were going to be fit for purpose? 15:14

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

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

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

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

11 MR. WOLFE KC: Very well.

12

13 THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

14

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

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

29 MR. WOLFE KC: I also appreciate she came yesterday

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

3 263 Q. Just working through some of the other discrete tasks
4 that you had to undertake, Mrs. Toal, to get this
5 process moving, you had to speak to Mrs. Brownlee or 15:37
6 contact her to ask her to appoint a non-Executive
7 Director. Could we have up on the screen, please,
8 WIT-41592. Just at the bottom of the page, please, you
9 are telling her:
10
11 "I am aware that Dr. Wright has spoken to you regarding 15:38
12 the immediate exclusion under MHPS of Mr. Aidan O'Brien
13 and the need for a formal investigation.
14 I would be grateful therefore if a recently MHPS
15 trained NED could be identified as soon as possible to 15:38
16 enable this to be communicated to Mr. O'Brien in
17 accordance with the Framework. I will then arrange to
18 meet with the designated NED to brief them on the
19 case."
20
21 Scrolling back up. This has obviously been forwarded. 15:38
22 Is this forwarded to you? Mrs. Brownlee saying "John",
23 that's John wilkinson:
24
25 "I hope you had a quiet and lovely family Christmas. 15:39
26 Would you do this for me?"
27
28 This is Mrs. Brownlee maybe forwarding this to John
29 wilkinson. Sorry for that confusion:

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

3
4 In terms of what you knew about the relationship
5 between Mr. O'Brien and Mrs. Brownlee, that friendship, 15:39
6 had you any concern about approaching her in this way?

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

12 264 Q. Was this the sum total of your contact with her on the
13 issue. I know you had go to the Trust Board. We'll
14 come to that in just a second. Is that the contact
15 that you had with her on it? 15:40

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

23
24 I think it was in the context of this, you know, he's
25 a very hard-working, excellent clinician, that type of 15:41
26 language. Those are my words, I'm not quoting her.
27 But my response, I mean it was a very short exchange,
28 and my response to her was, 'these are serious issues,
29 Roberta, and they need to be looked at'. That was the

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

3 265 Q. In your view was that an appropriate encounter from her
 4 perspective or do you think she shouldn't have touched
 5 that issue with you? 15:41

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

8 266 Q. That's as far as it went, this expression of
 9 unhappiness?

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

13 267 Q. Is it fair to characterise that she was unhappy, she
 14 was letting you know, but there was no pressure on you
 15 to change course? 15:42

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

21 268 Q. Did any other participant in the process speak to you
 22 about any perception of inappropriate approaches from
 23 Mrs. Brownlee?

24 A. No.

25 269 Q. Thank you. In terms of your contact with the Board, 15:43
 26 can I just bring up -- you went to the Board on
 27 27th January. Can I bring up a draft record and
 28 perhaps you can help me to understand how this could
 29 have come about. TRU-263865. This is referred to as

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

2
 3 "Mrs. Toal reported that the immediate exclusion has
 4 now been lifted and the consultant is now able to
 5 return to work with a number of restrictions in place." 15:44

6
 7 You've reflected in your witness statement that the use
 8 of the word "restriction" in that context is somewhat
 9 or was somewhat misleading. Nevertheless, is that the
 10 word that would have been used to the Board? 15:44

11 A. I can't recall. I can't recall. Possibly. Possibly.
 12 270 Q. The position changes in, I suppose, what might be
 13 called the final minute of the authorised record of the
 14 Board meeting. If we go to TRU-158980. The word
 15 "restriction" changes to "controls". what we're 15:45
 16 talking about here is the monitoring arrangements.
 17 There's no restriction on Mr. O'Brien's practice; isn't
 18 that fair?

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

1 do.

2 271 Q. You arranged for that change to be made; is that fair?

3 A. Yes, from memory I think I tracked a change and sent it

4 back to Sandra Judt, who is the Board Assurance

5 Manager. 15:46

6 272 Q. In terms of Board interaction on this MHPS case, or

7 MHPS in general, at that time you report this in,

8 because, I think, under the rubric you have got to

9 report an exclusion?

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

11 273 Q. Thereafter, consideration of any concern relating to

12 Mr. O'Brien within the MHPS process doesn't feature

13 and, indeed, generally the difficulties in bringing the

14 process to an end, even aside from anything to do with

15 Mr. O'Brien's performance, doesn't feature. 15:47

16 A. No.

17 274 Q. Is that because the Medical Director's office, your

18 office as HR Director, doesn't think it appropriate

19 because of confidential employment type issues to come

20 back with that, or is it just a practice that wasn't 15:47

21 considered?

22 A. It was a practice at that stage. I mean, certainly

23 before I took over in terms of this post, I don't

24 believe MHPS cases would have been reported to either

25 the full Board or the Governance Committee. The 15:48

26 reporting of this one, from an immediate exclusion

27 perspective, was in under MHPS as that heading under

28 "immediate exclusion". I mean, I suppose what we were

29 mindful of was the actual details. There was the

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

11 275 Q. It might be convenient just to deal with it in this
 12 context.

13 A. Sure.

14 276 Q. If we pull up your Addendum Statement at WIT-91885.
 15 Maybe it's not terribly helpful to bring this up. Pull 15:49
 16 up Answer 6. What you're enclosing with your Addendum
 17 Statement Evidence of Case Reports that go to the Board
 18 when complete. Let's just look. Yes, I think the
 19 safest thing to do is to go to your original statement
 20 at WIT-41147, where you explain the current process. 15:50

21
 22 You are reflecting the view that greater reporting to
 23 the Board of MHPS case data would have added greater
 24 accountability into our Trust system. You go on to say
 25 that, at that time, Zoe Parks was developing a piece of 15:50
 26 work in relation to creating an environment where the
 27 Board would have an improved visibility of MHPS cases
 28 and the template for reporting as that time was
 29 currently being developed. What has changed? We'll

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

5 A. Yeah. 15:51

6 277 Q. If we look at the latest one, February 2023, WIT-91914.
 7 what you're telling us, I think, Mrs. Toal, is that
 8 this is one of the developments within what might be
 9 described as the Reform Initiatives that have been
 10 borne out of this case and certain conclusions that 15:52
 11 have been reached by the Trust about the state of
 12 governance in various aspects of the organisation.
 13 What now goes to the Board that didn't go to the Board
 14 back in January 2017, and thereafter?

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

24
 25 From that meeting then a report is prepared by Zoe from 15:53
 26 Medical Staffing on all of the cases. That could be
 27 informal and it could be formal. It is basically
 28 a summary of what we talk about at the Doctor and
 29 Dentist Oversight Group. That goes to the Medical

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

6 278 Q. This is one of those reports?

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

8 279 Q. Of course.

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

19 280 Q. Yes. 91915 we can see that in February there are no
 20 exclusions in place? 15:54

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

1 have.

2

3

Then it goes on down to say there are two formal MHPS

4

cases which have concluded, but continue to work

5

through MHPS resolution, so that's obviously the new

15:55

6

NCAS, in terms of trying to facilitate return to full

7

practice. We still report those through to the

8

Governance Committee because that allows the Governance

9

Committee to be assured that we have still eyes on

10

those, from an Action Plan point of view and,

15:55

11

I suppose, just gives some detail around, I mean in

12

that case, 27991, is around, you know, reintegrate them

13

back into the full remit of their role by March 2023.

14

My expectation at March 2023 is that Dr. Austin and

15

myself are given a report to say we've hit that target,

15:56

16

or there's another issue. It just allows us to provide

17

that assurance that we are on top of things.

18

281 Q. You set out some, in the bottom of the form, the

19

report, areas of concern, risk and challenge.

20

A. Yes. We say there, I mean particularly around

15:56

21

number 2, it is really just, I mean this is a template,

22

a Board cover template, so within the areas of

23

improvement we say that, we give the assurance there

24

that the designated role, those individuals within

25

those, their training is complete. Then the concern,

15:56

26

the risk and the challenge is in and around the actual

27

timescale issue, because we know we have an ongoing

28

issue generally, probably across any NHS organisation

29

around the actual timescale. We very much keep in mind

1 there, we give an explanation as to why, maybe,
2 a timescale hasn't been within the four weeks. Again,
3 it is to try and provide that assurance, we are on top
4 of this, we know what the issues are, and it is,
5 I suppose, a full and open disclosure to our Governance 15:57
6 Committee about where we are at and the challenges that
7 we have.

8 282 Q. Just going further down, there's an attachment behind
9 that?

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

11 283 Q. This gives a fuller breakdown of the two formal cases?

12 A. Yes. That's right. What we're saying there is at
13 January 2023, so that would have been the January
14 meeting of Oversight. We've had no new formal, no new
15 cases this quarter to report. So we set that out. 15:58

16 Then we give the update around previous formal cases
17 that have been reported and just give the update. So
18 the actual reference number is there, so that allows us
19 to anonymise. We say the date that the case is opened
20 so that they have full knowledge of that. Just 15:58

21 a summary of the cases there. We give them the Case
22 Manager, Case Investigator. We indicate the dates that
23 they have been trained and the non-Executive, so that
24 would be the Board member, the designated Board member
25 who has been assigned. We go through the restrictions 15:59

26 or exclusions. We confirm around NHS resolution
27 involvement, i.e. the former NCAS. GMC as well. So
28 ELA will be your liaison role, again, just to provide
29 the assurance something around that, around GMC. And

- 1 if there are any parallel SAI Review processes that are
2 ongoing. So it is really just to try and link all of
3 that. Because obviously later at Governance Committee
4 in terms of Clinical Social Care Governance Report
5 there will be reference to SAIs and those reference 15:59
6 numbers. Then the final is around the timescales.
- 7 284 Q. Presumably this goes to Governance Committee --
8 A. That's right.
- 9 285 Q. -- which is a Board committee.
10 A. Yes. 16:00
- 11 286 Q. Then the minutes, as I understand it, of the Governance
12 Committee, and any attached report will go as part of
13 the Trust Board pack --
14 A. Yes.
- 15 287 Q. -- for their monthly meeting? Presumably a Board 16:00
16 member would be saying the advantage of this innovation
17 is that it gives the non-execs on the Board greater
18 visibility and the possibility of scrutinising the
19 processing of MHPS cases?
20 A. I suppose what it does when you look at MHPS around the 16:00
21 assurance that we're adhering to process, it will not
22 give full assurance, but certainly around some of those
23 time scales, and around training that we have Board
24 members allocated, it provides that level of assurance
25 in relation to those particular aspects. 16:00
- 26 288 Q. I emphasised that you supplied three months worth of
27 this but I picked one example in the interests of
28 brevity?
29 A. And they all follow that format.

- 1 289 Q. Have you received any feedback to date from the
2 Governance Committee on the use of this format?
- 3 A. Yes. Certainly what we're hearing is that it is very
4 helpful. You know, we get quite a bit of engagement
5 from our Board members. Certainly Mrs. McCarten, at 16:01
6 the last meeting, was able to say, 'yes, I'm aware of
7 this case. I have made contact with the case
8 investigator to check where things are at'. You know,
9 there's much more engagement. They're starting to see,
10 I think, some of the concerns that are coming through. 16:01
11 They are starting to get to grips with some of the
12 issues of time scales and why those might be. The most
13 recent meeting actually there was a discussion around,
14 'why is it just the formal cases that are being
15 reported through?' I suppose what we were able to 16:02
16 confirm at that time was there is a full report in all
17 cases that goes through the Chief Executive, to provide
18 that assurance that that was happening. But what
19 we agreed to do for the next meeting was to ensure that
20 there was, within the cover sheet at least, reference 16:02
21 to the number of informal cases on our caseload.
22 That's the type of discussion that we're having.
23 I think, yes, I mean it's helpful and they have a lot
24 more awareness of what we're doing.
- 25 290 Q. Thank you for that and thank you for updating the 16:02
26 Inquiry through your Addendum Statement in that
27 respect.
28
29

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

12
 13 MHPS gives no other guidance other than what is
 14 included in paragraph 8 of Section 1 of the Framework
 15 which is that the NED is to oversee the case to ensure 16:03
 16 that momentum is maintained and to consider any
 17 representations from the practitioner about his or her
 18 exclusion or any representations about the
 19 investigation.

20 16:04
 21 Now, had you any particular concerns about the
 22 operation of the non-Executive role in the context of
 23 the Mr. O'Brien investigation?

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

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

4
5 So following some legal advice, then the 16:05
6 representations that he made then, we concluded that
7 the first set of representations, and I'm not sure
8 whether I'll get this the right-way-around, but in
9 terms of both sets of representations, one was handled
10 by Dr. Wright as the Medical Director, and one was 16:05
11 handled by Dr. Khan as the Case Manager.

12
13 So essentially Mr. Wilkinson probably acted as a bit of
14 a postbox and to ensure that they were responded to.
15 But I'm not convinced, as the designated Board member, 16:05
16 whether he would ever have had enough knowledge or
17 involvement in this particular case around, you know,
18 actually validating that those were appropriate
19 responses made. And I think the representations that
20 were made in many respects to Mr. Wilkinson were 16:06
21 appropriately handled by the Case Manager or Dr. Wright
22 as the Medical Director and some of them would have
23 been appropriate for Mr. O'Brien to have channelled
24 that way, as opposed to the designated Board member.

25 16:06
26 So I think, because there's probably not an awful lot
27 of guidance in relation to that, in fact, there is no
28 guidance in relation to the types of things, it
29 probably does leave a designated Board member who is

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

4 291 Q. Yes. Mr. O'Brien wrote on 6 March 2017. I'll just
 5 pull up the email. AOB-01464. Just on the bottom of 16:07
 6 the page, please. This is in the context of
 7 Mr. O'Brien had written to Mr. Wilkinson and the
 8 response that came back came back from Dr. Khan, the
 9 Case Manager. Mr. O'Brien's unhappiness, I think, is
 10 expressed in the line that: 16:08

11
 12 "This way of handling his correspondence implied to me
 13 that your role on my behalf does not enjoy an
 14 autonomy."

15 16:08
 16 Now, we can in due course ask Mr. O'Brien about his
 17 understanding. But it would seem to suggest in that
 18 line that he perhaps regarded Mr. Wilkinson as a man
 19 who he could rely on to make representations on his
 20 behalf and would have, if you like, the independence to 16:08
 21 deal with those matters without having to run to the
 22 employer, as Mr. O'Brien might perceive it.

23
 24 Is there a job of work to do around the understanding
 25 of the role of the NED and perhaps to better define the 16:09
 26 limits of the NED's obligations?

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

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

5 292 Q. Let's just bring that up as you mentioned it. 16:09
 6 WIT-41799?

7 A. Yes, so it is to Liz Hynes.

8 293 Q. I think 2018 the Department had a review that I think
 9 it didn't complete, but Your Trust is contributing by
 10 making a submission and you wish to add something to 16:10
 11 the submission around the role of NED. You've said the
 12 document is not clear, and that's MHPS, the Framework,
 13 assumedly, is it?

14 A. Yes. Yes, it is.

15 294 Q. "The document is not clear and at times we got 16:10
 16 completely muddled as to what their role actually is
 17 and how far they can go when contacted by a doctor
 18 through a process."

19
 20 I think you've just said, is that related to the 16:11
 21 O'Brien/wilkinson experience?

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

25 295 Q. Unmoored from the O'Brien case, and based on your 16:11
 26 general experience in this area, and knowing perhaps
 27 the limitations of NEDs, no matter how enthusiastic or
 28 experienced they might be, what would you be telling
 29 the Department if they were listening to you? Is the

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

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

15 16:12
 16 But I just think that this is something that muddies an
 17 actual process. I'm not sure that it is terribly
 18 helpful. I think in fairness to a practitioner they
 19 might have an expectation, that is that they will step
 20 in and actually do something different. 16:13

21 296 Q. Is the clinician is entitled to have his or her
 22 representation through this process?

23 A. Yes.

24 297 Q. Again, it might be convenient at this point to draw the
 25 Inquiry's attention to the training material which 16:13
 26 you have recently sent us. There's a specific package
 27 now developed for the Trust Board in the context of
 28 MHPS; is that right?

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

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

5
6 But as part of that and in discussion with our
7 non-Executives we have agreed for a session
8 specifically for the non-Executives who act as
9 designated Board members and that is to deal with the
10 types of representation that practitioners can make to 16:14
11 them. Because I think, apart from Mr. Wilkinson, the
12 rest of the non-Executives have had no cases where they
13 have had any representations made. So it is a bit of
14 a mystery to them. So our solicitor is going to try
15 and help dispel that a little bit by trying to describe 16:14
16 to them: These are the types of things that you might
17 be asked, and obviously with their support from a legal
18 perspective, they will guide them through that.
19 I suppose it is to try and demystify that. So that's
20 part of the Board level training. 16:15

21 298 Q. Bring up the document and then you can add anything
22 else to that. WIT-91891. You said Board members have
23 always had some training. What is new about this
24 initiative?

25 A. Well, it's not that it's necessarily all new, but it is 16:15
26 to try; I suppose what we were trying to do there was
27 just to set it out very clearly this will be the
28 expectation. It puts a timeline, I suppose, in terms
29 of, you know, how often. So we have agreed that it

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

3
 4 There is a reference there, and I suppose back in
 5 September we had started to think about our Trust 16:16
 6 Guidelines, you know, revising the 2017 ones. So it
 7 was anticipated that that is what we would be including
 8 within this training. Now that has been, I suppose,
 9 superseded or paused really, essentially, because of
 10 the Department's announcement around the review of MHPS 16:16
 11 and the accompanying guidance in relation to it.
 12 We thought it would be prudent to hold on that, but
 13 that was around September-time.

14
 15 But it gives you a flavour just in terms of, because 16:16
 16 it's both DLS and it's also with Trust support. So
 17 prior to this it was always DLS but it didn't have the
 18 Trust. So that, I suppose, is what is new to this.

19 299 Q. The fifth bullet point sets out to deal with the issue
 20 of the expectation of roles, responsibilities of 16:17
 21 a number of people including the designated Board
 22 member?

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

25 300 Q. I wonder what the designated Board member is told about 16:17
 26 the responsibilities if you are expressing some
 27 uncertainty about the proper limits of the role.

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

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

11 301 Q. And the expectation is that this training would be
 12 refreshed every two years?

13 A. Yes. Yes.

14 302 Q. Now, could you bring up on the screen, please,
 15 TRU-267745. scroll down to the bottom of the page. 16:18
 16 Thank you, just there. And here Mr. Wright on
 17 21 February, is alluding to a meeting which you had on
 18 the previous Friday with him after being approached by
 19 John Wilkinson. This concerns an apparent conflict or,
 20 potential conflict of interest, on the part of 16:19
 21 Mr. Weir. So he was the Clinical Director. It was the
 22 unanimous view of the Oversight Group in December that
 23 he would be appointed in the role of Case Investor. He
 24 carried out aspects of that role through January,
 25 including the preparation of a preliminary report and 16:20
 26 a submission to a case conference.

27
 28 And then, within a month or less than a month, it is
 29 being suggested that he had a potential conflict of

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

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

8 303 Q. Can I bring that up?

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

10 304 Q. I think it is TRU-01248. So 7 February. You're right 16:21
 11 to recall that Mr. O'Brien starts the correspondence by
 12 reference to the March letter. There was a meeting
 13 with Mr. Wilkinson that day as well so far as we
 14 understand it?

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

16 305 Q. Yes. You were explaining about the conflict?

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

28

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

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

8 306 Q. And obviously he gives evidence to the Chada
9 Investigation.

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

11 307 Q. Did you understand that his acts or omissions were
12 potentially caught by the fifth Terms of Reference
13 concerning management actions?

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

22 308 Q. Let me see if I can deal with one final issue this
23 afternoon on the issue of delay. We don't need to go
24 to the document to remind ourselves that the
25 expectation was that an MHPS investigation would be 16:24
26 conducted within four weeks.

27
28 Now, I think everyone who has touched these issues has
29 said it never happens in four weeks. It's the

1 exceptional case that gets through in four weeks.
 2 Nevertheless, you would accept, would you, that from
 3 a standing start and let's call it in round terms at
 4 the start of January, after the Christmas holidays,
 5 2017, through to the end of June 2018 is a staggeringly 16:24
 6 long time to take with an investigation when many of
 7 the primary facts, albeit not entirely uncontroversial,
 8 but many of the primary facts had been assembled around
 9 triage, notes at home, dictation issues. Not entirely
 10 uncontroversial. But many of these issues had been 16:25
 11 investigated and some data produced.

12
 13 Do you agree that this took far too long?

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

15 309 Q. Was it, in your mind, inevitably an 18-month process 16:25
 16 before a report could be handed to Dr. Khan, inevitably
 17 in the sense of this is just how long it was going to
 18 take because of the issues?

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

1 delays started to happen.

2

3 And I suppose my reflection of all of that is that, you
4 know, in many respects Mr. O'Brien was allowed to
5 dictate the actual pace of it throughout when there 16:27
6 should have been more control taken of it. So I think
7 right up until, you know, there were attempts even on
8 a Saturday to accommodate Mr. O'Brien. It took
9 a month, probably, you know, to actually get that
10 initial interview with him. He then wouldn't respond 16:27
11 to the last issue around the private, or the fourth
12 issue around the private practice. And there was
13 probably a delay there in arranging the next meeting
14 and then a further delay around him trying to focus
15 from an appraisal point of view, which in retrospect, 16:28
16 we should have been driving that. That should not have
17 been allowed to enter into the situation. This should
18 have taken priority.

19

20 So, I suppose beyond that initial period where the 13 16:28
21 other witnesses were interviewed, it took an inordinate
22 amount of time to get this over the line.

23 A combination of busy clinical diaries, other
24 priorities, and that lack of kind of driving the
25 process contributed, you know, to all of that. And, 16:28
26 you know, for these people this was not the only thing
27 on their agenda. They had other cases, they had other
28 clinical work. But I cannot disagree with you around
29 the inordinate amount of timing.

1 310 Q. Yes. Breaking it down, 13 witnesses were spoken to
 2 plus Mr. O'Brien, I believe on two occasions?
 3 A. That's right. Yes.
 4 311 Q. Obviously Dr. Chada has her own day job, her own
 5 practice. And it may not work that she can interview 16:29
 6 13 witnesses, you know, in a week or whatever. So the
 7 Inquiry would acknowledge that there is that frailty
 8 there. But 13 witnesses, plus Mr. O'Brien, is capable
 9 of being processed within a calender month. Isn't that
 10 fair? 16:29
 11 A. I'm not convinced that a calender month would be fair
 12 in practical terms when you consider everybody's diary
 13 and everybody's clinical commitments. Sometimes they
 14 just do not marry up. So I'm not convinced that one
 15 calender month is at all realistic whenever you try to 16:30
 16 marry all of those factors up. When you try to factor
 17 in annual leave and you try to factor in other things
 18 in terms of clinical practice. Siobhán's other
 19 commitments in terms of disciplinary processes,
 20 hearings, regional meetings. Logistically, it is 16:30
 21 really difficult practically.
 22 312 Q. One of the factors that you suggested was an issue, was
 23 that Mr. O'Brien requested at the meeting on 3 August
 24 2017 that he would see evidence around the concern of
 25 private patients. In fairness to the clinician who is 16:30
 26 the subject of investigation, that sort of thing should
 27 be pre-empted, shouldn't it? It should be recognised
 28 that for him to be able to comment on an allegation, he
 29 will need the paperwork.

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

5 313 Q. The core principle within MHPS is Patient Safety. Was 16:31
 6 the longevity of this investigation of a potential risk
 7 to Patient Safety, or should that be regarded as
 8 a general overarching concern in all MHPS cases to move
 9 these things along quickly where you have a clinician
 10 whose performance is at least questionable? 16:31

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

14 314 Q. Is it fair to say, and we know that you have written 16:32
 15 emails in, I think it was February of 2017 to
 16 Mrs. Heinz asking 'has the letter gone to Mr. O'Brien
 17 to bring this to an end', I think is the question you
 18 ask. TRU-263969. Dr. Khan is asking a similar type
 19 question on 7 February 2018. But reflecting on this
 20 now, who should have been driving this or is the 16:32
 21 answer, well, we just can't touch it because it's an
 22 independent investigation? We can't be seen to
 23 trample?

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

1 somebody out of all of those, you know, myself,
 2 Dr. Khan, the Medical Director, Mr. Wilkinson, actually
 3 sitting down and saying: Right, where are we at with
 4 this? what's the holdup? And actually taking it by
 5 the scruff of the neck and saying what can we do? 16:33
 6 where are the blockages? How can we unblock those and
 7 get this finalised?

8
 9 I think the way we are working now in terms of just the
 10 regularity of those meetings, the fact that we sit on 16:34
 11 a Governance Committee. I know before I go in to any
 12 Governance Committee, I will know where we are at with
 13 those particular cases. Our Board members will know.

14 315 Q. Sorry, would you expect to be challenged now because
 15 there is greater visibility? 16:34

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

29 316 Q. The final question for this afternoon. MHPS,

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

16:35

5
 6 Is that just not a piece of equipment that you had in
 7 place or a piece of the system that was in place at
 8 that time?

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

16:36

16:36

20 317 Q. Yes. Just for the Panel's reference to your statement
 21 in that respect, where you said not enough attention
 22 was paid to the audit and tracking. WIT-41141 at
 23 paragraph 26(vii).

16:36

24
 25 MR. WOLFE KC: I think we can leave it there for this
 26 afternoon and take it up again in the morning at 10
 27 o'clock.

16:37

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

1 tomorrow.

2

3 we also have Mr. Carroll, I think tomorrow.

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

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

7 MR. WOLFE KC: Probably another hour.

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

10

16:37

11 THE INQUIRY ADJOURNED TO THURSDAY, 2ND MARCH 2023 AT
12 10:00

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