Urology Services Inquiry

# Oral Hearing

## Day 29 – Thursday, 2nd 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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THE INQUIRY RESUMED ON THURSDAY, 2ND MARCH 2023 AS FOLLOWS:

CHAIR: Good morning, everyone. Apologies for the delay in getting started, particularly to Mrs. Toal, who has been sitting patiently waiting to get on with it. 10:44

Mr. Wolfe.

MR. WOLFE KC: Good morning. 10:45

MRS. TOAL, HAVING BEEN PREVIOUSLY SWORN, CONTINUED TO BE EXAMINED BY MR. WOLFE KC AS FOLLOWS:

1 Q. Good morning, Mrs. Toal. 10:45

A. Good morning.

2 Q. I think overnight you had an opportunity to reflect on something you said yesterday in relation to Terms of Reference issue that I raised with you yesterday. You can recall that you drew our attention to the document, 10:45 which we can maybe have up on the screen again. WIT-40407. Just while that is coming up, you'll recall I was asking you who was the appropriate person or persons to develop Terms of Reference?

A. That's right. 10:45

3 Q. I think you agreed with me that, touch wood, the MHPS Framework itself is silent on who might be regarded as the appropriate people to develop the Terms of Reference. You drew our attention to 3.1 of this

document, which says that:

"The Terms of Reference as finally drafted should be agreed by the organisation's relevant decision makers. The case manager and investigator appointed to manage and carry out the investigation would not normally be involved in this process."

The first sentence I read seems to suggest that the relevant decision makers develop and agree, draft the Terms of Reference. That might be who? The Medical Director in conjunction with the Clinical Manager who is on the ground and is aware of the performance concerns? 10:46

A. Yes, that's right. 10:46

4 Q. Making it clear that the Case Manager and Investigator are not part of that process.

As I say, maybe while we're in this document, before we go to what you provided us with this morning, if we just go down to the next page, WIT-41408. A point that Mr. Lunny kindly drew to my attention yesterday. The first main paragraph: 10:47

"It may be that as the investigation progresses the Terms of Reference are found to be too narrow or that new issues emerge that warrant further investigation." That's understandable. 10:47

"In such cases, the investigator should inform the case

manager who should seek the agreement of the responsible manager or decision making group to a widening of the terms," etcetera.

Again, it seems to be saying in this advice that the ownership of the Terms of Reference resides with the organisation as such, the decision makers, and they approve the Terms of Reference and hand them over to the case manager and case investigator. 10:48

You, as I've said, have drawn our attention, overnight and this morning, to two documents that you had in your possession arising out of recent training; is that right?

A. Yes. As I said yesterday, I had attended back -- it was actually October '22, the case manager training provided by the NHS Resolution, so formerly NCAS. Within the case manager training it did, on one of the slides, refer to the responsibility for drawing up the TOR, and that was very much in line with the case investigator and the case manager. When I looked at the slides, because we have our slides on our filing system back at the office, when I looked at both the case investigator and the case manager training, it very much had that within the role of both the case investigator and the case manager, and I had provided then just a copy of the relevant slides on both the case investigator training and the case manager training, just for clarity. 10:48 10:49 10:49

5 Q. Yes. Let's just put those up on the screen and you can speak to them. TRU-164712, and then there's a second page we'll look at at 713. The first of those pages then. This is very recent training, is it?

A. Yes, it was October '22. 10:50

6 Q. Delivered by?

A. By NHS Resolution. One of the gentlemen who was given the training would be one of the advisers that our clinicians would make contact with if they had a case.

7 Q. Dr. Fitzpatrick has since left the organisation? 10:50

A. Yes. It was a gentleman, Stephen Boyle I think, from memory. I hope I got that right.

8 Q. Did that training take place regionally here?

A. It was training that was organised by us, so it was our Southern Trust staff that actually attended that 10:50 training.

9 Q. The message put out by this most recent training by NHS Resolution is that, based on this flowchart, case manager meets with practitioner, case investigator and case manager agree on the Terms of Reference, and then 10:51 the process continues?

A. Yes.

10 Q. Then just below that.

A. I think this is a slide from the case investigator training. I think. Yes. 10:51

11 Q. Sorry, the next page. I beg your pardon. This is from?

A. This is the case manager training.

12 Q. Just scrolling down, it sets out, I suppose, a division

of labour between these two key officers. The case investigator, his or her responsibility is agree Terms of Reference with the case manager, and it is the case manager, reading across, who determines the Terms of Reference with the case investigator. 10:52

A. That's right.

13 Q. Was there anything said about the role of the key managers within the organisation who have taken the decision that there should be a formal MHPS?

A. No. I suppose whenever you look at, you know, the actual preliminary inquiry stage under MHPS, the clinical manager -- there's a line, there's a paragraph within MHPS that says the clinical manager, following the preliminary screening, has the responsibility then to determine what the next steps are, and there is 10:52 10:53 something along the lines of, 'this is a difficult decision and shouldn't be made alone and should be made in conjunction or in consultation with the Medical Director and the Director of HR'. I suppose that certainly was how that was coming across at the 10:53 training. It wasn't as if there was another tier. Very much the training mirrored the paragraph within MHPS.

14 Q. Yes. This seems to put all of the responsibility into the hands of the case manager for determining the TOR? 10:53

A. Yes.

15 Q. That's inconsistent with the document I started this morning with you --

A. Yes.

16 Q. -- the first NCAS document.
A. That's why I was probably slightly confused yesterday. But I knew that, having been at that training, and certainly any of the recent cases, that we have been involved in, it has absolutely been the case manager and the case investigator working on the TOR. 10:54
17 Q. Just to be clear, on the ground in a Trust such as yours, is it now the case manager working alongside the case investigator who drafts the Terms of Reference?
A. Yes. 10:54
18 Q. Do they have any responsibility to engage with the people, whether that's clinical manager or the Medical Director who, in essence, have given them their instructions to do this work?
A. Yes, it would be done in conjunction with them. 10:55
19 Q. So, the Medical Director is in that conversation?
A. Invariably, yes. Yes.
20 Q. Is there any confusion here? We have the first NCAS document which is inconsistent, I think you agree, with the recent training you have. You seem to be, as 10:55
a Trust, complying with the recent training. Does that work well?
A. It certainly, in the most recent cases, it has worked well. I suppose as well there has been advice taken from NHS Resolution. I can think of the most recent 10:55
case, there would have been advice taken on the Terms of Reference that were being proposed. It's very much done in conjunction with them.
21 Q. Is it a case, just to bottom this out finally, that the

Medical Director or a Clinical Manager, or perhaps both, having decided between them that a formal investigation is necessary, there needs to be an assembly or a working out of the issues that need to be investigated.

A. Mm-hmm.

22 Q. Is that done on that side of the house and then passed to the case manager to think through the issues and draft? Is that an approximation of how it works?

A. Yes. Yes. It probably depends, as well, who the case manager is as to how close they are to the actual case. The case manager could be outside of that sort of line management hierarchy as such. So, yes, but it is done very much in conjunction. 10:56

23 Q. Let me leave that issue behind us then and move to issue of the monitoring plan that was applied to Mr. O'Brien and have your reflections on how well that worked. You said yesterday that you do have concerns about how it worked in practice. It wasn't robust enough. It depended on one person, I think was your reflection, to ensure it was being monitored. That was some of the concerns you had. 10:57

In February 2018 you wrote to Mrs. Hynds. Just bring that up on the screen, please. This is about a year into the operation of the monitoring. It is TRU-263969. Scrolling down, please. Part of this letter is dealing with the delay in the investigation. Has a letter gone to him, that's Mr. O'Brien, to bring 10:58

this to an end? The next line is:

"Could you also ring Ronan? Mark Haynes advised on Thursday that his triaging was slipping."

10:59

Was that the first time, to the best of your recollection, that you heard any negative feedback about how this was going?

A. Yes. That would be my understanding. Yes. The context of that, Mr. Haynes, Dr. Wright and I were meeting in Dr. Wright's office. It was something entirely unrelated to this particular case, but Mr. Haynes did reference the triage issue, and that was my purpose then. I don't know what action Dr. Wright took, but certainly I was flagging it to Mrs. Hynds to make sure that a phone call was made to Mr. Carroll as the AD, the Assistant Director and, obviously, Martina Corrigan's AD. It was just really to flag to make sure that that was actually made known, if they didn't know already.

10:59

10:59

11:00

24 Q. Do you consider that you were at some distance from the monitoring arrangements in the sense that it wasn't your responsibility at all to be over the detail of this?

A. It wasn't. Yes, it wasn't my responsibility but, at the same time, when I heard it, I didn't want to not say anything and I wanted to ensure that it was actually flagged.

11:00

25 Q. There was an issue eight months earlier in the summer

of 2017 that Mr. Carroll and Mrs. Corrigan managed through with Mr. O'Brien for triage issues, as well as notes in office. Was that drawn to your attention?

A. I don't believe so.

26 Q. You had further input on this broad issue of the monitoring plan in May of 2018. If we can bring up on this screen, please, TRU-263976. Just at the bottom of the page. There's, I think, been some kind of communication between you and Mrs. Hynds on the issue of compliance with the monitoring plan, as we'll see as we scroll up through this. Martina Corrigan is advising Siobhán Hynds that, apart from one deviation on 1st February 2018 when Mr. O'Brien had to be spoken to regarding a delay in Red Flag, and that may well have been the cause of your earlier email in February he confirms that he has adhered to his return to work action plan which she monitors on a weekly basis and she goes through each of the matters. 11:01 11:02 11:02

She doesn't draw attention to the deviation in the summer of 2017. We'll be looking at that, obviously, with her. 11:02

Just scrolling up the page, Siobhán Hynds comes back to you, popping you into this, saying, "hope this helps". Then you go back to Ahmed Khan: 11:03

"See below regarding AOB. Have you been getting these updates on a regular basis in terms of assurance?"

Then he answers: "Vivienne, I have been receiving it until earlier this year from Ronan Carroll, haven't received it in a few months now. Have spoken to him recently and he will forward this to me. Is the report ready?" 11:03

That's presumably a reference to the investigation report of Dr. Chada. You have gone back to Dr. Khan, reading between the lines, because he has raised an issue with you. Can you help us in terms of the context for this? Was he concerned and thought you were the best person to intervene on it? 11:04

A. I don't necessarily agree that it was Dr. Khan asking me about it, though having said that, in terms of Siobhán Hynds' emailing me and saying "I hope this helps", I can't recall what I would have been asking for or the context of that. But I don't recall Dr. Khan asking me. I suppose what I was trying just to do was to flag to him, you know, this is a summary position at this stage that Siobhán Hynds has sent to me and, really, a check to make sure that he was, as case manager, still getting those updates. 11:04

27 Q. The information back from him couldn't have filled you with --

A. No.

28 Q. -- confidence that this was being approached in the kind of watertight manner which the Oversight Committee, back in 26th January 2016, might have wanted to see? 11:05

A. No.

29 Q. The point being he hadn't got reports. Would you have expected him to have been receiving regular reports?

A. Well, the actual Return to Work Monitoring Plan was reporting by exception basis. I think I referred to this yesterday. Even though it was reporting by exception, I think my expectation of Dr. Khan, maybe, as a case manager, would have been to have those sort of regular check-ins just to make sure everything was okay. I suppose that was my rationale for emailing and sending him a copy of what Mrs. Corrigan had forwarded to Mrs. Hynds. 11:05 11:06

30 Q. Do you know if anyone had a word with him to say, 'listen, this needs to be a bit tighter'?

A. I think, while it might not have filled me with a huge amount of confidence in terms of the first line, I suppose what I took from the second line was he had made that contact. 11:06

31 Q. In October of that year you were advised of deviation from the monitoring arrangements during a period when Mrs. Corrigan was absent from work due to medical treatment or ill health. Isn't that right? 11:07

A. That's right.

32 Q. If we go to TRU-251525. Scroll down the page, please. You're obviously not copied into this email but if we just scroll up through this. 11:07

The issues arises about two issues at this point, dictation as well as triage. Scrolling up, please. Dr. Khan says this is reflecting a failure to monitor

effectively.

"This is clearly an unacceptable practice from both the clinician and responsible managers. I'm meeting with Siobhán tomorrow regarding this." 11:08

Scroll down to the page before this.

Simon Gibson is writing to Ronan Carroll saying: 11:09

"What is most concerning here is that there were monitoring and supervision arrangements put in place, which we confirmed to a range of interested parties.

"If he has a backlog of clinical letters and discharges going back to June, it now being October, have these arrangements fallen down?" 11:09

Mr. Carroll responds to Mr. Gibson by saying: 11:09

"I think you are stating the obvious. With Martina having been off since June the overseeing function has not taken place and in the day-to-day activities was overlooked. But we need to understand why this dictation has gone out." 11:09

Can you remember becoming involved with this issue?

A. I think Siobhán Hynds would have forwarded me -- I'm not sure if it was this email, but certainly Siobhán

would have made me aware of it.

I suppose the significance of the timing of this was, when we look at the earlier email that you had on the screen which was Siobhán forwarding me Mrs. Corrigan's email to say, you know, apart from 1st February, you know, everything else has been okay. That was in response to a request from Mrs. Hynds on behalf of Dr. Chada, because what they were doing at that stage was actually writing the case investigation report. I think what they wanted to be able to confirm in that report was that the monitoring plan either had or hadn't been adhered to. That was around, obviously, May time. The report would have been available to Dr. Khan in June. Then because Dr. Khan, for family reasons, had to go back home, it then was September before his case determination would have been prepared. So, there was that period of time where, with his case determination he was relying on the June report which basically said there was, you know, really apart from 1st February there was no issue. If the case determination report was in a final version just right at the end of September, the significance of this was October and, therefore, during that period of time, after the assurance was sought from Martina, obviously the adherence to the monitoring plan had fallen down. I think that was a significant factor at that stage that needed to be brought back in line. I think then, at that point, I mean it was at the end of September

11:10
11:10
11:11
11:11
11:12

when Dr. Devlin, Dr. Khan and I had met about the case determination report. I think then, at that point, we agreed that it was important to flag to Mr. Devlin at the time that we have an issue here with the monitoring plan. I think it was a general update on the case and moving it forward. But, we also flagged at that stage to Mr. Devlin that there had been the issue with the compliance with the Return to Work Plan.

33 Q. I think you refer in your statement to having a video call with the Chief Executive? 11:13

A. Yes, that's right.

34 Q. Would that have been at the end of October?

A. I think so, yes. Yes. I can't just quite recall the date but it's around that time. Yes.

35 Q. If I could ask you to cast your eye on the emails at TRU-251532. Just scrolling to the bottom, please. Simon Gibson. I'm not sure what that means in that context? 11:13

A. It was sent in error to somebody else with the same name. 11:14

36 Q. Okay. Just as this develops, just scrolling up the page, please. 23rd October there was a meeting that day, it seems, and Ronan asks:

"Are we to continue monitoring Aidan O'Brien against the four elements of the action plan?" 11:14

You can see you are copied into that. Was that the meeting -- I don't see an independent or separate

record of it. Was that a meeting with the Chief Executive around these issues?

A. Yes, I believe so. Yes, yes. I think that was the teleconference meeting.

37 Q. I can see you copied into this. You attended that meeting, did you? 11:14

A. Yes.

38 Q. Just, again, scrolling up into the next page. Simon bats that issue to Dr. Khan as the case manager, albeit, by this stage, his determination has, I think, issued. 11:15

"I assume that would be an issue for you as a case manager."

11:15

Then Dr. Khan says: "The action plan must be closely monitored with weekly report collected as per the action plan. Can you also clarify that yesterday there were ... 91 outstanding dictations and today only 16?"

11:15

Then Ronan Carroll says: "Happy to ensure that the action plan is monitored. Could I ask that the Oversight Committee write to Mr. O'Brien reminding him of his obligations/responsibilities to comply with this action plan and that it will be monitored?" 11:15

As we will see, in 2019 there was further deviation and Mr. O'Brien would appear to have taken the view that the action plan had expired, and we'll look at that.

But here, and you pointed to the timing of this, Dr. Khan had reached his decision and, as we shall see, he proposed the need for a further action plan with input from NCAS. The upshot of this series of correspondence in a meeting on 23rd October is that there was some lack of clarity as to whether the action plan continued. Dr. Khan says, absolutely, this is still live

A. Mm-hmm.

39 Q. The direction is let's make this clear to Mr. O'Brien. Was that done? 11:16

A. Yes, I think there is correspondence from Dr. Khan to Mr. O'Brien on a number of things, and then I think he refers at the end of it -- I think it is by way of a question maybe more than an instruction -- which asks him -- he wants to take the opportunity to ask if he is still compliant with the action plan, or something like that. I can't just quite recall which way it is worded, but he does refer to it. I think then Mr. O'Brien then, when he responds back to him, he said he would deal with that in separate correspondence in the coming days, or something like that. 11:16 11:17 11:17

40 Q. How was the apparent failure of management to recognise that in Mrs. Corrigan's absence there was a gap in the monitoring? How was that shortcoming addressed with the service? 11:17

A. I don't know what action Mr. Devlin took but, certainly, Dr. Khan had made it very clear that that was to continue. I'm not sure what action Mr. Devlin

took.

41 Q. Again on this important issue, manager absent, the ability to monitor seemingly falls away around these important issues. Again, when you heard about it, it couldn't have filled you with confidence about the robustness of the arrangements? 11:18

A. No.

42 Q. Into 2019, 18th September, Mrs. Hynds forwards you an email. If we could put it up on the screen, please? TRU-264897. If we could just go to the bottom of the page. Corrigan informing Hynds, the red ink, I suppose, says it all. 11:19

Not adhering to concern 1. Please see escalating emails. As of Monday, 16th September Mr. O'Brien has 26 paper referrals outstanding, and on E-triage 19 routine and 8 urgent. As regards the digital dictation issue, again, not adhered to. 11:19

Scrolling up the page, Vivienne from Siobhán: 11:19

"Can we chat urgently tomorrow in relation to this?"

I can see from your statement WIT-41093 that you recall taking no personal action in relation to this. Did you have the urgent chat? 11:20

A. I'm quite sure we did the following day. I can't recall any of the detail. I knew, I think as my statement said, that Dr. Khan had already escalated it

to Dr. O'Kane at that point, so the action was taken up the medical line at that point.

43 Q. Yes. The Inquiry has seen how that developed into a meeting in January of 2020 when there was consideration of the backlog reports and all of that. 11:21

A. Yes.

44 Q. I don't need to discuss that with you particularly.

Can I have your perspective on this? If we look at the monitoring plan at TRU-00732. The top of the page, 11:21 please. It says:

"Following a decision by case conference, this action plan for Mr. O'Brien's return to work will be in place pending conclusion of the formal investigation process 11:21 under Maintaining High Professional Standards Framework."

That seems to give an end date for the action plan in terms of what was communicated to Mr. O'Brien back 11:22 in February or March of 2016.

A. Mm-hmm.

45 Q. You have said in your statement that so far as you're concerned, the monitoring plan remained live to the end of his employment. Can I just ask for your reflections 11:22 on Mr. O'Brien's position? If we could bring up TRU-275595?

It is the case, from the Trust's perspective, there was a deviation in the autumn of 2019, and Mrs. Corrigan wrote seeking a meeting with Mr. O'Brien. He says, if we scroll down that:

"When I met with the investigation case manager on 9th February 2017, I was advised, in writing, of the action plan." 11:23

He goes on to say: "The case manager concluded the investigation with his determination on 28th September '18 which he presented to me on 1st October. In his determination the case manager wrote that the purpose of this plan was to ensure risks to patients were mitigated during the course of the formal investigation process." 11:23

"In the determination, the case manager also recommended that a further action plan should be put in place with the input of NCAS, the Trust and Mr. O'Brien for a period of time agreed by the parties. It was recommended that the action plan must address any issues with regard to patient related administrative duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time and an enhanced appraisal programme." 11:24 11:24

He says: "The Trust has failed to implement this

realms to date."

He then says: "It is evident that the issues that you wish to discuss cannot be considered deviations from a Return to Work Plan which expired in September 2018", obviously with the conclusion of the formal investigation and the delivery of the determination.

In terms of the monitoring plan as communicated to him, it is quite clear that the end date for that was the conclusion of the informal investigation; is that fair? 11:25

A. Yes. I mean, I don't dispute what it says and, I suppose, on reflection it really should have been, you know, pending the conclusion of the actual process, the MHPS process in its entirety. I'm not sure that in stating that at the outset that very literal sort of view maybe was actually intended, but I can see the point that you're actually making.

I suppose the overriding thing with this was around, you know, the purpose of it, was to ensure that Mr. O'Brien complied with what he was required to actually do. I suppose I do find it odd, you know, that Mr. O'Brien thinks it expires in September 2018 when he himself knows that during '18 he hasn't been in compliance with it. Those are my initial reflections on it. You might want to probe further.

46 Q. I want to ask this. Are you clear that, notwithstanding the conclusion of the investigation and the issuing of the determination in the autumn of 2018,

that Mr. O'Brien was clear and there was clear communication to him that he remained subject of a monitoring arrangement?

A. Okay. There was no clear communication to him that it was to continue. I accept that. Nor was there communication with him to say that it had stopped either. 11:27

47 Q. In circumstances, and we'll come on to look at this now, where the organisation wasn't able, or felt itself unable to proceed with the outworkings of the determination, would you agree that, upon reflection, clear communication around these issues was important given the particular patient-related context that you were dealing with? 11:27

A. Yes. When you go back over it all I would not dispute that at all. I would completely agree with that. 11:27

48 Q. The determination reached by Dr. Khan had four elements in terms of next steps. As I've mentioned, an action plan, and Mr. O'Brien in that letter set out the aspects of the terms of it. A conduct hearing, because Dr. Khan had taken the view that this was misconduct. 11:28

A. Yes.

49 Q. An independent review of managerial and administrative actions.

11:28

You had a discussion with Dr. Khan, I think it was 27th September in the Chief Executive's office. You have said in your witness statement, WIT-41123, that your comments to Dr. Khan centred around checking

what the advice from practitioner performance advice had been, and Dr. Khan forwarded you a copy of the letter from Dr. Graínne Lynn in that respect, and you commented to Dr. Khan that he needed to reflect that advice in the report. 11:29

In terms of responsibility for carrying out aspects of the plan, you and your office was responsible for trying to establish a conduct panel and taking that aspect forward. Is that your understanding? 11:29

A. That's correct, yes.

50 Q. You've told us that the Chief Executive was responsible for establishing an independent review of administrative practices?

A. That's my view. Yes. 11:29

51 Q. Right. As opposed to your understanding of a decision that had been reached?

A. I'm not aware of the decision between Dr. Khan and Mr. Devlin, but because this was an operational issue, you know, that's my view, that it would have been 11:30 Mr. Devlin in discussion with Acute Services down the operational line.

52 Q. Is it also your view that it was Dr. Khan's responsibility to advance the action plan?

A. Yes. That's my view, yes. 11:30

53 Q. Again, no decision reached on that or no decision communicated?

A. Not that I'm aware. No.

54 Q. In terms of these issues contained in the

determination, are you suggesting to us that there wasn't an actual sit down and allocation of responsibilities in respect of them? You formed certain understandings which may or may not have been shared by others? 11:31

A. I don't have a recollection of sitting down and actually working our way through those. In terms of misconduct and the panel, it was obvious that that was one of the actions for HROD, to take that forward.

55 Q. Can we just start by looking at the recommendation or the proposal as regards action plan or a further monitoring arrangement? If we go to AOB-01921. It says that: 11:31

"It is my view that in order to ensure the Trust continues to have an assurance about Mr. O'Brien's administrative practices and management of his workload, an action plan should be put in place with input from PPA or NCAS, the Trust and Mr. O'Brien for a period of time agreed by the parties". 11:32

Then there's a provision for review and monitoring and what should be done if any concerns arise. It says:

"The action plan must address any issues with regard to the patient-related duties and there must be an accompanying agreed balanced job plan." 11:32

The grievance raised by Mr. O'Brien came into the system in correspondence dated 27th November. Do you understand why action planning of the type described here by Dr. Khan did not take place? Was it related to the fact that the grievance had come in? 11:33

A. I think because the case determination -- I mean in terms of the next steps under MHPS was around taking that to a misconduct hearing and because Mr. O'Brien had indicated and had lodged a lengthy grievance, we were then in a situation where, in effect, everything 11:33 stalled. Therefore, we couldn't get to a misconduct panel until the actual grievance had been heard. Because added -- one of the aspects of that particular grievance was around the classification of the issue as misconduct. 11:34

56 Q. We'll come to the conduct hearing and why that might have been, I suppose, stymied by the arrival of the grievance. The grievance, as we will see, is a full frontal attack on the conclusions reached --

A. Yes. That's fair. 11:34

57 Q. -- by the process. If the organisation has a concern about a practitioner's ongoing reliability in performance terms to do certain tasks related to patients that are expected of him, is it not possible for that organisation to develop further monitoring -- 11:35

A. Yes.

58 Q. -- arrangements regardless of the practitioner's concerns about the MHPS investigation?

A. Yes. I mean it was, you know, particularly around the

end of October when we knew there were issues in relation to his compliance. I mean it is a significant missed opportunity to not have gone back to NCAS at that point in time and taken that forward and sought NCAS advice in relation to, you know, what an action plan needed to look like, irrespective of the outcome of a misconduct hearing. It was a significant missed opportunity.

59 Q. If somebody took the view, and it appears, just confirm for me, you were of the view that the action plan was stymied by the grievance? 11:36

A. I think it all was, yes.

60 Q. It all was. Okay.

A. Yes.

61 Q. Upon reflection, you could have gone back to NCAS and said, 'listen, we have this grievance. You had previously written to us on 21th September to advise us on how a new action plan could be developed. We now have this grievance. Can we do the action plan in this context or is there another way around it?' That kind of advice wasn't sought? 11:36 11:36

A. No. No, it doesn't appear to have been. I think there's -- part of, probably, the issue as well and some of the challenges around this, Dr. Khan was both the Case Manager and the Medical Director at that point in time. There wasn't that other set of eyes on this too. It was one and the same person, which certainly didn't help because you didn't have another set of eyes from a Patient Safety perspective, I don't 11:37

think, on it.

62 Q. The conduct hearing was an issue for your office.

A. Mm-hmm.

63 Q. Initial steps were taken to establish a panel in October, and then the grievance arrived. As I say, it's dated 27th November. On 2nd December Mr. O'Brien wrote to ask for confirmation that no steps would be taken to bring matters to a conduct panel hearing until the grievance has fully resolved. In that respect Mr. O'Brien got his wish; isn't that correct? 11:37 11:38

A. Yes, he did.

64 Q. Just to put the time frame around this. A grievance hearing didn't start until 30th July 2020, after he had retired.

A. Yes, that's correct. 11:38

65 Q. That's a full 18 months or more later; isn't that right?

A. That's right.

66 Q. You have set out in your statement, by way of explanation, that you received multiple requests for disclosure from Mr. O'Brien; that there was industrial action and there was the intervention of the pandemic as being factors that, in part, explain this delay. 11:39

A. Mm-hmm.

67 Q. Do you think, upon reflection, that they do fully explain the delay? 11:39

A. I think the information requests, they were significant information requests. There were a number of people involved. Again, it's back to the multiple priorities

of lots of different people. The trawling of emails. We tried to -- we made contact with him to try and narrow that in terms of the actual request as much as we could, but there were sizable numbers of emails and pieces of correspondence. I think, again, in a very busy operational service the ability to get those quickly just wasn't there. I mean, in terms of the time it took, it was a significant period of time. 11:40

The industrial action. I was fully involved in it. Some of my team were involved in it in terms of the actual planning. Obviously, service perspective, because obviously the staff that are out on industrial action, either action short of strike or strike action, it had a significant impact, as industrial action does. We're currently in the middle of another round of action, and that does impact very much from a service point of view. As I've said, you know, in terms of the amount of time that I was involved from a negotiation point of view with trade unions in relation to pay, so my mind was not on many other issues. This was one of those things. You know, back at that period of time industrial action did take a significant number of months out of that period of time. What I was dealing with then at the start of January was picking up all of the other pieces that hadn't been actually dealt with. And, yes, it wasn't one of the first things that we picked back up again. By that stage we were beginning to start to plan in terms of the COVID 11:40 11:41 11:41 11:42

pandemic. Those are explanations, those are its context. You know, when you put it in terms of 18 months, yes, it's entirely unacceptable. But those are the explanations and it's all I can offer at this stage. 11:42

68 Q. Is there a more malign explanation in the sense that was it hoped this might wither on the vine and disappear?

A. No, absolutely not. We had made attempts around who would be external panel members from a grievance perspective, but the information requests and the further ones from Mr. O'Brien in relation to the Medical Protection Society had come in, that certainly was not in my mind. 11:43

69 Q. The MHPS process -- I don't need to bring it up on the screen, I'll give the Panel the reference. WIT-1515. It provides that if a practitioner considers the case has been wrongly classed as misconduct, he or she is entitled to use the employer's grievance procedure. As we can see, if we just pull it up briefly, AOB-02054, point 2.9.4 scrolling down the page, please. It was Mr. O'Brien's view, at least as regards the triage issue and the dictation, so far as I can read his grievance, it was his view they were wrongly classed as misconduct whereas he says, working through each of them, that taking the concerns at their height they might give rise to performance issues. 11:43 11:44

You've offered the reflection that it might have been possible to separate out aspects of Mr. O'Brien's grievance, deal with that one which was stymying the progression to a conduction hearing and leave the rest to be determined at another time. Is that a reflection that you think is viable? 11:45

A. I think if we could have attempted it, it might have pushed things on further. But, as I've said in my statement, I mean I think if we had tried to do that, it certainly would have been maybe prudent to at least attempt to exert pressure on it, but I have no doubt there would be many an objection from Mr. O'Brien in relation to trying to do that. That's, in all likelihood my view at the time. It was a lengthy grievance and, I suppose, it set out the history from, you know, very early March or January -- sorry, March '16. In all likelihood we might have tried but in all likelihood I don't think we would have got very far. That's my reflection. 11:45 11:46

70 Q. It is fair to say that from Mr. O'Brien's perspective he was certainly showing willingness to keep this moving. 11:46

If I can put on the screen, please, AOB-02078. This is a couple of weeks after he sent in the grievance. Accompanying the grievance was a disclosure request because he felt that earlier disclosure requests hadn't been met with a positive response. He says: 11:46

"I look forward to receiving the requested documents. On receipt of the documents, I would be grateful to meet the grievance panel to discuss the format and sequencing of the management of the grievance".

11:47

It is perhaps clear from the tone of that, albeit that further disclosure requests came in in the spring of 2019 and you had to work through those, but is it fair to say that you didn't detect anything in the tone or content of Mr. O'Brien's correspondence that 11:47
he didn't -- let me put this more clearly. There's no suggestion that Mr. O'Brien was putting unreasonable obstacles in the progress of the grievance?

A. No, I didn't detect that, though, I suppose, the further requests following his engagement with his MPS 11:48
team at that point resulted in a significant number of other requests at that point. I suppose that was his form, really, but I'm not sensing anything that he was trying to put obstacles.

71 Q. It was also his entitlement, wasn't it, to seek 11:48
relevant disclosure. One can see, for example, that the request that came in on 12th March following legal advice, 12th March 2016. The reference is TRU-264762. It runs to multiple pages and, I suppose, respectable lawyers could have a debate about whether all of that 11:49
was entirely relevant to the processing of a grievance complaint.

A. Mm-hmm.

72 Q. Nobody went back to him to say, 'we disagree that you

need any of this. Let's get on with it'?

A. No, and I think that was -- it probably paralysed us, maybe, at the time, in fairness, to the point where we probably couldn't see the wood for the trees with it. Yes, we complied with the information requests and provided him with the information. 11:49

73 Q. From an employer's perspective working through MHPS leading to a conclusion that the issues raised merit a conduct hearing, what is the importance of that for the organisation, and is there an importance in dealing with it promptly when you have that employee still in employment performing a significant consultant role? 11:50

A. It is important to get it brought to a conclusion. It puts that marker down. If there is a case to answer and there is an actual sanction, it puts that marker down clearly in terms of any repeat of that. In fairness to the individual as well, promptness is important there is no doubt. 11:50

74 Q. The third element of the determination was the need for an independent review. If I can just go back to Dr. Khan's determination on that. We find it at AOB-01923. At the bottom of the page, please. He says that: 11:51

"The investigation report presented to me focused centrally on the specific Terms of Reference set for the investigation. Within the report as outlined above there have been failings identified on the part of Mr. O'Brien which require to be addressed by the Trust, 11:51

through a Trust conduct panel, and a formal action plan" -- and we looked at that.

"The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in the practice of Mr. O'Brien. No one formally assessed the extent of the issues or properly identified the potential risks to patients. 11:52 11:52

"Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there are wider issues of concern to be considered and addressed. The findings of the report should not solely focus on one individual, Mr. O'Brien. 11:52

"In order for the Trust to fully understand the failings in this case, I recommend the Trust to educational out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system-wide problems to understand and learn from the findings." 11:53 11:53

Let's unpick that. Just before we do, the failings on

the part of management at all levels, both clinical and administrative, didn't sound in a disciplinary sense, did it? There was no suggestion or no consideration of taking disciplinary action with any of the managers or practitioners who had failed in their management activities?

A. No. No, that's not my understanding.

75 Q. Do you have an understanding, from an HR perspective, as to whether discipline in this context could have been considered and whether, upon reflection, it would have been appropriate? 11:54

A. I think the first step would have been, you know, from the perspective of trying to understand why we were in this particular situation, you know. What were the barriers maybe to actually raising some of those concerns, dealing with them? What were the factors? I think that would have been a first step. Certainly I think the report set that up in a way that gave both Mr. Devlin and Mrs. Gishkori the opportunity to actually do that. 11:54 11:55

76 Q. The criticism here is directed at both sides of management, both operational, administrative as well as medical?

A. Medical, that's right. Yes.

77 Q. Do you understand that as telling the reader that an independent review would look at both kinds of management? 11:55

A. Yes. I think when Dr. O'Kane would have arrived, certainly in terms of her picking up on some of this,

you know, there was the commissioning of the June Champion Governance Report. Dr. O'Kane looked at things like the Clinical Director roles, the Associate Medical Director roles, and they then became those Divisional Medical Director roles, so really pick up and strengthen some of those issues. That's my understanding of how the organisation tried to deal with some of those issues. 11:56

78 Q. What was specifically demanded here was a very particular independent review looking at the administrative processes? 11:56

A. Yes.

79 Q. The failures with those and the failures of escalation?

A. Yes.

80 Q. This record or this recommendation simply wasn't done until the summer of 2020 when the GMC started asking questions about it. Is that fair? 11:56

A. I think that's fair. I mean, the administrative review at that point, I think it was Dr. O'Kane who had indicated two names to try and work that through. Those two individuals, I think it was Dr. McCullough and Dr. Donnelly, and at that point I think, then, there needed to be further work taken forward, and at that point there was an individual from the Belfast Trust, from the administrative senior management perspective that tried to actually support that piece of work to get it brought to a conclusion. 11:57 11:57

81 Q. The determination from Dr. Khan is pointing to management failures.

A. Mm-hmm.

82 Q. It takes two years to look at this. The same management are still in place. Was there not an urgency recognised in what Dr. Khan was saying?

A. I think the only explanation is that the process was completely stalled on the basis of the grievance. That's the only explanation I can offer. 11:58

83 Q. That's your view, perhaps. This recommendation or this determination is pointing not at Mr. O'Brien, it's pointing at the management team and the systems. The grievance of Mr. O'Brien doesn't begin to provide any explanation for the failure to advance this, does it? Any valid explanation? 11:58

A. No.

84 Q. If we could just look at elements of it briefly, please? If we go to TRU-292466. At the bottom of the page Chris Brammel, who is an investigating officer at the GMC, is writing to Mrs. O'Kane copying you and others in. He is asking: 11:59

"Would it be possible to clarify whether the independent review of relevant administrative processes recommended by Dr. Khan on 20th September 2018 has been completed?" 12:00

Going up to the page before, TRU-292465. 12:00

Stephen Wallace, on behalf of Maria O'Kane says:

"The independent review of relevant administrative processes as recommended by Dr. Khan has not yet been completed. This is scheduled for conclusion by September 2020".

12:00

The truth of it, Mrs. Toal, is that it had not actually started. Isn't that right?

A. I can't confirm to you the exact date of when it started, Mr. Wolfe.

85 Q. That email is 21st July. If we go to TRU-292694 we can see just at the bottom of the page, please, that Stephen Wallace, 31st July: 12:01

"Please see below Terms of Reference for the review of administrative processes as per the MHPS recommendation these have been reviewed by Dr. Khan. Doctors Rose McCullough and Mary Donnelly have agreed to conduct this work and it will commence next week." 12:01

A. Yes.

86 Q. Is it fair to say the GMC weren't given an unvarnished view of this. It will be completed by September, instead of saying, 'actually, we haven't got round to starting this yet but now you're reminding us of it, we'll get started'. Is that a fair analysis? 12:02

A. I can see how you would take that from it, yes. 12:02

87 Q. The reference to Dr. Khan here having reviewed the Terms of Reference, do you understand him to have reviewed the Terms of Reference and approved them?

A. My understanding of that was to make sure that was in

line with what his intention was. That is my understanding of that.

88 Q. If we just scroll down and look at what is said about the review that's to be conducted. I want to ask you to consider whether the review that was actually 12:03
conducted was in line with the concerns reflected by Dr. Khan in his determination? Remembering that the concerns were about management performance in the context of the administrative arguments, concerns about escalation and dealing with the performance of 12:04
Mr. O'Brien, and he gave the narrative that there were default conditions adopted essentially rather than addressing things effectively. The purpose of this review is said to be to review the Trust Urology administrative processes for management of patients 12:04
referred to the Service. Okay, a broad description. The objectives are -- the review, in particular, will consider the administration processes regarding the receipt of and triage of patients referred to the Urology Service from all sources. The effectiveness of 12:04
monitoring the administrative processes, including how and where this information is reviewed. The roles and responsibilities of operational management and clinical staff in providing oversight of the administrative processes. The effectiveness of the triggers and 12:05
escalation processes regarding non-compliance with administrative processes. And, to identify any potential gaps in the system where processes can be strengthened.

A. Mm-hmm.
89 Q. Was that getting to the nub of what concerned Dr. Khan?
A. I think in terms of the core administrative processes and those escalation issues, I think it did. Perhaps what it hasn't done is around how we were in a situation where Mr. O'Brien's practice had gone unaddressed for quite some time. I think that's not the purpose of that when you look at the Terms of Reference. 12:05
90 Q. On 29th September Martina Corrigan shares a copy of what appears to be the draft report. I'm not picking on Martina Corrigan in particular, but she was one of a range of managers who had some responsibility for managing Mr. O'Brien and had actions to perform in terms of the administrative processes; isn't that right? 12:06
A. That's correct. Yes.
91 Q. Before we go to it. Are you satisfied that this review was conducted in an independent fashion as required by Dr. Khan? 12:07
A. I suppose the independence, albeit Dr. Donnelly and Dr...
92 Q. McCullough.
A. ... McCullough were employed by the Trust in terms of their role as Associate Medical Directors for Primary Care, they were certainly independent of Acute Services. My understanding of where Dr. O'Kane was coming from in considering those two ladies was because of their GP practice sort of role from a Primary Care 12:07

perspective. She thought that might have added an important aspect to it. But independent of The Trust, no, but certainly independent of Acute Services. I think it quickly became clear that once they provided, I think, their initial report, that it wasn't in the detail required. I think their lack of maybe understanding of the administrative processes as such came through, and that's when they determined that they needed that external expertise. I think they obtained that from someone who used to work in the Belfast Trust, or who still did at that point. I just can't recall. 12:08 12:08

93 Q. The initial report, if we bring up TRU-293276, at the bottom of the page, Mary Donnelly is emailing Martina:

"Just to let you know Rose is going to complete this as I have taken on some additional duties with Banview Practice. If you have any comments, would you mind emailing them to Rose at her gmail account as above as she is on leave this week." 12:09 12:09

Scrolling down to the next page, please. This is what is being sent through from the authors. Just scroll down. We'll see, in a sense, superficially how many words were built on this. That was, going back up, a page and a half. 12:10

A. Mm-hmm.

94 Q. If we go to the top of that page, 276. Siobhán Hynds comments, 'surely this can't be it", and you offer

a response.

A. Yes.

95 Q. Have you any words this morning? Sorry to be flippant.

A. No, that's fine.

96 Q. This wasn't an impressive piece of work? 12:11

A. No, it wasn't. I think that's what --

97 Q. That's what's reflected in what you say there?

A. That's what's reflected between Siobhán Hynds and I, absolutely.

98 Q. Perhaps the less said the better? 12:11

A. Yes.

99 Q. Is that what you meant?

When I asked you about independence, my concern, on behalf of the Inquiry, was to draw your attention to 12:11 the fact that that is being given to Martina Corrigan by the independent authors. Then if we look at how things progress. If we look, for example, at TRU-293812. Martina Corrigan, 25th February, so we are four months further on. She's saying to Siobhán Hynds: 12:12

"As discussed at our last Urology Oversight Meeting Ronan and I have revised the administrative review process to anonymise and make it more generic to all areas. This will be tabled on Monday morning and 12:12 wanted to give you sight of it first, and had you any comments, and had we captured what was the original purpose of this?"

Am I correct in reading that as indicating that one, and perhaps two managers, Mrs. Corrigan and Mr. Carroll, who are or ought to have been caught in the cross-hairs of an investigation or review of administrative practices, are contributing to the report and, in fact, adding content to a report which is supposed to be independent and looking at their actions?

A. I suppose this, in terms of an admin review process, this was around trying to establish what was the learning around making those technical processes more robust. That was my understanding of what this piece of work was about. It would have been absolutely helpful to have someone come in from entirely outside of the organisation to do this. So, I don't disagree.

100 Q. Let's just develop the point. If we look at a further email from Mrs. Corrigan, TRU-293880. We're now on 18th March.

"Can you have a look at the revised version of the administrative review? I have tried to capture that it was the result of one consultant in an introduction and I have changed the last column to an escalation for non-adherence. I hope that this is more what we need."

Scrolling down, we can see then how she has written up the introduction. I'll just read the first few sentences:

"Following a formal investigation into a consultant under MHPS when there were areas of concern raised over their ways of working, their administrative processes and their management of workloads, the case manager made a recommendation that in order for the Trust to understand fully the failings in the case, that the Trust should carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. It is recommended that the review should look at the full system-wide problems to understand and learn from the findings." 12:15 12:15

You can see the effort on the part of Mrs. Corrigan, and I hope it not unfair to suggest that she's tilted this in the direction of emphasising the fault of the clinician without drawing out fully the criticism advanced by Dr. Khan, where he talked about systemic failures on the part of both medical and operational management. 12:15 12:16

So, to ask you a question arising out of this. This supposedly independent review wasn't independent at all if one of the contributors to it, in authorship terms, was a manager whose activities was supposed to be the subject of consideration, at least in part. Is that a fair comment? 12:16

A. I think that is a fair comment, yes. Yes.

101 Q. Was there anything in particular learned from this exercise?

A. I am really not terribly close to those processes at all. I'm not sure I'm the best person to comment on it because a lot of this would have been, you know, taken forward outside of my responsibility. I'm not entirely sure that I'm the best person to comment on this. 12:17

MR. WOLFE KC: I see, Chairman, it is 20 past 12. I am very close to the conclusion of my questions.

CHAIR: I don't intend taking a break before lunch today, unless anyone else needs to take a comfort break, they are certainly free to leave. I would rather stay on and finish with Mrs. Toal. 12:17

MR. WOLFE KC: I'm obliged.

102 Q. You have discussed in your witness statement the initiatives undertaken by the Trust to improve systems particularly around MHPS, and we touched on an aspect of that yesterday. In 2017, well in advance of this particular MHPS process concluding, you started a body of work which led to changes of the MHPS arrangements? 12:18

A. That's right.

103 Q. Let's look at aspects of that. If we start at WIT-41141. You speak, at 27(i) about the Doctors and Dentists in Difficulties meeting. That's a meeting within the Northern Trust that Zoe Parks attended. Is that a structure, then, that was introduced in your own Trust? 12:19

A. Yes, that's right. Zoe would have quite good working relationships -- I mean all of us would have quite good

working relationships particularly from the Northern Trust perspective. Zoe had gone along -- actually Dr. O'Reilly used to work for the Southern Trust, so I think that was the contact and the connection. Zoe then had gone to sit in on one of their Doctor and Dentists in Difficulty meeting, just to get a sense of the type of structures that they had in place. I think Dr. O'Kane and I had been speaking about what are the arrangements that we really need to have? What would be effective for us? Zoe had gone to find that out and to experience, you know, how they did it, to see if there was learning for us from a Southern Trust perspective. 12:20 12:20

104 Q. I started this slightly the wrong way around. We'll come back to the 2017 changes in a moment, but in terms of this tier that was introduced, could you help the Inquiry to appreciate what is the function of it? It sits as a tier which receives information about any new MHPS case; is that right? 12:20

A. Yes, so it is that regular slot. It's a more proactive, it's in place, it's on a monthly basis, and it enables the Divisional Medical Directors, really, to have that link in to the Medical Director's office. I'm there as part of, you know, from an HR advisory perspective. It allows us that tracking function, I suppose, as one aspect of it. It allows us to ensure that we know the status of the cases, be they informal, be they formal cases. It enables then, for example, if preliminary enquiries are actually undertaken, for 12:21 12:21

example, the individual carrying out those preliminary enquiries will also come to talk through that. It just provides that, you know, that tier, that there is a regular slot every month to enable that to happen. It allows us to keep track. Zoe, from a medical staffing team point of view, will be the one who will be the secretariat to that and, you know, we will have very much sort of the timelines of cases we're dealing with. All of the information to hand will be there.

105 Q. We looked yesterday at the reports that go up to the Governance Committee. 12:23

A. Yes.

106 Q. On the formal cases --

A. Yes.

107 Q. -- of MHPS. 12:23

A. That's right.

108 Q. Is it the raw material gathered at this Doctors and Dentists in Difficulty tier that feeds into these reports and then they go up to the Governance Committee? 12:23

A. Yes. As I was explaining yesterday, the summary of all of the cases, so all of the concerns, because when we review MHPS it is about all concerns being registered with the Chief Executive. So coming from that will be the report that Zoe will provide from those meetings to the Medical Director, and the Medical Director then uses that as his basis for updating Dr. O'Kane as the Chief in terms of all of the concerns. What she will get will be informal and 12:23

formal. From that, the Governance Committee report on the formal cases comes from that. As we discussed yesterday, at the last Governance Committee there was a query around knowing some detail about the number of informal cases. They were seeking that at the last Governance meeting in February.

109 Q. In terms then of the changes that were made in 2017, as I suggested earlier, work on this really started before this Aiden O'Brien MHPS investigation really got going. Did you recognise quite quickly that there had been departures from the process and difficulties in the process that needed to be mended?

A. Yes. I think, I mean certainly the discussions around the oversight in terms of the 2010 guidance, I would have recognised at that stage, and certainly I think we would have had discussions from a DLS perspective as well. Certainly that was one of the reasons we undertook that review, really, at that point in time. Zoe had returned from maternity leave, I think at the end of February 2017, and we started to work through those changes.

110 Q. Indeed you've said in your statement, WIT-41047, that a draft was produced by 5th April 2017, then out for legal advice.

Let's just take a walk through some of the changes. If we go to TRU-21034. At paragraph 2.4 new text is written into this 2017 guidelines. It says:

"If it becomes evident that an individual or individuals were aware of a concern or concerns but did not escalate or report it appropriately -- this in itself can also represent a concern, which may necessitate intervention, particularly where there are Patient Safety implications."

It's almost familiar -- it's almost resembling, I should say, something approaching a Duty of Candour. Was that the thinking behind this? 12:27

A. Yes, I think it probably was. I can't just quite recall exactly the thinking. It was really, I suppose, to try to drive home, at that point, the importance of the escalation.

111 Q. Just so we get the context for this correct, is that something that was borne out of an early lesson learned by you from this particular case? To elaborate, was this a recognition that individuals had been aware of concerns, but there hadn't been appropriate escalation or reporting? 12:27 12:28

A. Yes, I think it probably was. Yes. Yes. It maybe was a combination, maybe, of, you know, a number of views on this. I think early on in terms of Mr. O'Brien's case we knew that, you know, given the Terms of Reference that had been added, number 5, that that was probably very much in our mind at that stage. 12:28

112 Q. Then almost spelling that out, there's a new who to tell section at 2.5. If we import part of 2.4 into this. If it becomes evident that an individual was

aware of a concern, this is what you do. A junior doctor would take it to a supervising consultant. An Associate Medical Director, at the other end of the spectrum, would take it to a Medical Director. Does the inclusion of this indicate Human Resources' concern that those charged with medical management responsibilities didn't fully appreciate the appropriate lines of reporting when concerns arose?

A. I think it probably did. Because MHPS in an earlier version, they don't necessarily deal with those arrangements, and I suppose this was our opportunity to try to give a bit more guidance in relation to that.

113 Q. This doesn't, in any way, pretend to be a comprehensive walk through some of the changes. Feel free in assisting the Inquiry to draw attention to anything that you think may be more important than I'm referring to.

If we go down to Section 3 of this document -- just on down the page -- it spells out for a Clinical Manager what action to take. That runs to four paragraphs and it sets out, amongst other things, the importance -- just going over the page -- of the screening arrangements. It says at 3.1.3:

"The purpose of this stage is to gather enough information to enable the Clinical Manager, supported by a senior HR manager, to assess the seriousness of the concern and to help inform and rationalise whether

this needs to be resolved through a more formal route or informally."

A. Mm-hmm.

114 Q. Again, that's re-emphasising by contrast to what actually happened in the O'Brien process, that the important role in starting this resides with the clinical manager. 12:31

A. That's right.

115 Q. Is that, again, a fair observation?

A. Absolutely. Yes. I think because the MHPS doesn't really set out in a lot of detail what the screening process is about, there's, I think, only one or two sentences in relation to it. That was our attempt, I suppose, based on the learning that we had at that stage to try and just flesh that out a bit more. 12:31 12:32

116 Q. At 3.2, just going on down the page, it attempts to reflect that important distinction between the two stages. Again, can you remember what the thinking was around that?

A. I suppose, really, just to try to, as you said, differentiate. Sometimes it's probably not terribly clear around preliminary enquiries how far do you go with preliminary enquiries. It really was around trying to provide a bit of guidance in relation to that. 12:32 12:32

117 Q. Then at 3.4 you set out -- before that perhaps -- support for doctors during screening.

A. Mm-hmm.

118 Q. Obviously Mr. O'Brien wasn't aware that he was being

screened, but it emphasises, from HR's understanding, that such a process and its impact on the practitioner, in terms of emotional well-being, should not be underestimated.

A. Mm-hmm. 12:33

In Mr. O'Brien's case, once he became aware of the fact that a formal initiative was to be taken at the meeting on 30th December, Dr. Wright reflected that within the letter sent to him reference to Care Call, which is a counselling service, and I think within that letter 12:34 that went to him on 6th or 7th January, a reference to consideration of Occupational Health.

A. Mm-hmm.

119 Q. There was an Occupational Health examination of Mr. O'Brien? 12:34

A. That's right.

120 Q. And he returned to work on a staged basis?

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

121 Q. Is that as much assistance as can be given to a practitioner? Do you think Mr. O'Brien was well 12:34 supported during this lengthy investigation that took place?

A. I mean in terms of the support there, that would be fairly standard support. However -- and not necessarily relating just to this case alone, we have 12:34 put into place additional guidance that we've taken through our senior management team in relation to support for any individual going through investigatory processes to really try and supplement that. That

would have been in the last six, eight months, maybe. That is in recognition of the fact that these processes are difficult. They can be distressing for a number of people, and it is to try to put in a range of other supports in terms of who your designated individual might be in terms of support, the need for regular check-ins and trying to improve the communication. We do have a guidance note very much now in place that tries to supplement just the normal Care Call, or Inspire as it is now, or Occupational Health, and that is in recognition of, I suppose, our need to increase that support for people going through all sorts of access investigatory processes. 12:35 12:35

122 Q. That wasn't available for Mr. O'Brien at the time?

A. No. That's something in terms of an improvement that we have more recently put into place. 12:36

123 Q. In terms then of 3.4, what happens at the end of the screening process.

"The clinical manager and the nominated senior Human Resources manager will be responsible for screening the concerns raised and assessing what action should be taken in response". 12:36

Then it is emphasised in line with MHPS Section 1, para 15 this decision will be taken in consultation with the Medical Director, the Director of HR, and, I think, by contrast with what's in MHPS, you've added Operational Director. That seems to have removed, am 12:36

I right in saying, the Oversight Group layer, at least it's not called that any more. But there is, nevertheless, a requirement on the part of the Clinical Manager to report to this other tier. What was the thinking there? 12:37

A. I suppose, even the way it is at the minute, I mean while I'm saying that there's those regular planned meetings from a Doctor and Dentist in Difficulties sort of process, I mean there can be those screening processes ongoing at any point in time and the 12:37 individual then who is screening can seek the advice of the Medical Director, the Director of HR at that point. It was to try and very much keep this in with the roles and responsibilities outlined in MHPS.

124 Q. Just on the oversight, the word "Oversight Group" is 12:38 erased from this process. You say in your witness statement at WIT-41427, that working through the 2010 Trust guidelines at the meeting that you had with colleagues back in 2017, the main discussion was about the need to remove any reference to the Oversight Group 12:38 to ensure our implementation of it for managing concerns were entirely in line with the MHPS Framework.

A. Mm-hmm.

125 Q. You have drawn to our attention, and I touched on an aspect of it yesterday, the training that's provided to 12:38 a number of groups of staff.

A. Yes.

126 Q. We looked, I think, yesterday briefly -- albeit briefly -- at the training which is now being more

formally, I suppose is the right ay of saying it, rolled out for members of the Trust Board.

A. That's right.

127 Q. We saw how that's a two-year refresher programme. You also put before us training for other important cadres of staff. If we could just briefly look at that and take your comments. It comes in the form of a training plan at WIT-91887. Just stepping through. If we can go down to 892. There's a formal training plan for case manager, and you can see the training objectives set out there. It includes, as we were discussing this morning, that part of that role is to write a set of Terms of Reference which are robust, meaningful and effective. That reflects your recent training with NCAS. 12:39 12:40 12:41

A. Yes.

128 Q. Over the page there's a training plan for the case investigator. Again, training objectives set out. Obviously it might involve training taking place over two full days. Then on the next page training for the purposes of managing low-level concerns. This is considered mandatory for all Clinical Directors, Clinical Leads, and Operational Heads of Service and Assistant Directors. It is filtering the training quite far down into the system? 12:41 12:42

A. It is. That's very much based on the learning and the awareness we have around ensuring that -- well, I suppose learning in relation to the fact that, I think, a number of individuals, particularly down the

management line, operational management line, had little or no understanding of MHPS. I mean, my colleague Heather Trouton, Mrs. Trouton would have given me that feedback throughout this. This was, I suppose, this is an attempt, really, to make sure that those individuals, in terms of, you know, Heads of Service, ADs, the Clinical Leads -- I mean CDs would have been trained, some of them will have been trained as case investigators, but this around just picking up on some of those concerns that come up and that just need nipped in the bud very quickly. And really trying to make sure that those are taken forward and picked up on very, very quickly. Then it also, I suppose, tries to differentiate between, you know, something -- a concern that is relevantly low-level but also then something that maybe needs escalation. That's what we're trying to achieve by that. 12:42 12:43 12:43

We haven't run this training before. This is new, and it's really trying to pick up on the actual learning that I've just outlined there. We have three dates now that are coming up; one in April and then two in May just to try to start this process aligned to that part of the training plan. 12:43

129 Q. You're aware, obviously, that the Department is planning to run -- I'm not sure if it has commenced just yet -- the review into MHPS? 12:44

A. Yes.

130 Q. The Inquiry has, from the Trust, contributions made

from the Southern Trust to earlier ill-fated consultation processes that never reached the finishing line. Hopefully, third time around this one will.

A. Mm-hmm.

131 Q. Just on that, and without stealing the thunder of what you might contribute to that process, you've obviously, in your work, reflected long and, perhaps, hard in relation to MHPS and how it's a difficult process and steps taken to make it better within your own place. 12:44

A. Mm-hmm. 12:45

132 Q. Going forward, whether in speaking to the Department or further improvements for the Trust what would be the key messages that you would put out to the Department in terms of how MHPS as a framework could be made better? 12:45

A. I think it does need to focus much more in this informal stage, would be my view. And around, I suppose, ensuring -- I mean, when I think about some of the work, for example, that we're doing down the non-medical line and working closely with Mersey Care, for example, around their restorative just and learning culture, I think there's a lot of that thinking and certainly a lot of they work do from a screening perspective that could be of real value to MHPS. 12:45

I have been on that Mersey Care and Northumbria University training, as has our new Medical Director, Dr. Austin. We're trying to read our way through, as a senior management team, around restorative just and learning culture, and I think there's a lot of that 12:46

thinking can be brought into an enhanced and improved MHPS process. But I suppose a lot of that reflects on the need, you know, for really robust psychological safety in terms of staff. It requires practitioners to be able to come forward and say where they are having difficulties, and that openness from the practitioner, but they need to feel safe to actually do that. I suppose for me, a key message that I have been giving, and I will continue to give throughout the process, is around that thinking that I think very much needs to come in to avoid us getting to a stage that we are into formal investigations. So, yes, there are other -- I think you referred to them as 'wrinkles' with MHPS, I think there are some of those, but that would be my overriding one. 12:47 12:47 12:47

Some of what I discussed yesterday around the designated Board member I think complicates it. I think that is definitely something that needs to be considered throughout this too. I have seen an early draft of the Terms of Reference. I've commented on those, you know, back to Mr. Phil Rodgers in the Department. I've had a conversation with him in relation to my thoughts. Whether those are taken on Board, I don't know, but I certainly contributed that to it. 12:48 12:48

133 Q. I think what you've just said about your key concern going forward about MHPS almost coincidentally, perhaps, aligns with one of the key reflections set out

in your statement about this particular case and how it was handled.

A. Mm-hmm.

134 Q. Just have that up on the screen, please? WIT-41136. At paragraph 26, down the bottom of the page. Picking up on the question: 12:48

"Having regard to your experience as a Director of HR... in relation to the investigation into the performance of Mr. Aidan O'Brien, what impression have you formed of the implementation and effectiveness of MHPS and the Trust guidelines, both generally and specifically, as regards the case of Mr. O'Brien?" 12:49

We don't need to read it all, but what you say is that this was a complex one to be engaged in as your first as Director. You say: The complexity, you now believe, was in the most part linked to the fact that his administrative practices had not been addressed over a number of years. That's the informal issue again. 12:49

A. Mm-hmm.

135 Q. "There was also, I believe, a view by many that Mr. O'Brien was an otherwise excellent clinician which resulted in a failure to grasp the real significance of the link between poor administrative practices and patient safety. I was not experienced enough to challenge this thinking at the time and both of these points have provided significant learning for me as 12:50

a result of this case."

Maybe that says it all, but feel free to add to that, if you wish.

A. Yes, I mean, if you just scroll back up, please. Yes, that bit around the complexity in most part linked to the fact that his administrative practices had not been addressed over a number of years. 12:50

I think back to what I was trying to say around the informally and how we need to really, really focus robust processes around that informal stage. In this case I think views were probably entrenched. Trust seemed to have disappeared. There were tensions between, probably, Mr. O'Brien and a number of others. I think that, in itself, just inevitably maybe made an informal process in 2016 almost kind of doomed to failure, maybe right at the outset. There needs to be a willingness, I think, on both sides, for both parties to be able to make the best use of that informal process. Back to the psychological safety of the practitioner, I mean it is absolutely critical in all of that. I suppose that's what I was thinking about that. 12:50 12:51 12:51

If we move down a wee bit, please, if that's okay. Yes, I think I've said this on a number of occasions just around the poor administrative practices linked with Patient Safety. I mean, that's really, really

important.

136 Q. Mr. O'Brien had intended to retire and return in a part-time locum-type capacity, but in a conversation with Mr. Haynes on 8 June 2020 he was told that a decision had been made that he could not return. Were you aware that that discussion with Mr. O'Brien was to take place in advance of it taking place? 12:52

A. Yes. Yes, I think so. Yes, I think I recall that.

137 Q. Had you had a discussion with Mr. Haynes' preparatory to that? 12:53

A. I think there was a discussion, Dr. O'Kane was involved, Mr. Haynes was involved. I think Melanie McClements, who would have been the Director at the time, so, yes. There were conversations, yes.

138 Q. It was put across to Mr. O'Brien that there was a policy of not re-engaging personnel who were the subject of ongoing HR processes. In this case of course the Conduct Hearing hadn't been reached. He had a grievance in place. Is there such a policy in the sense of a formal policy? 12:53 12:54

A. So what we had at the time, so I'm not sure if it was around policy, but certainly practices I think was the term, unless you're going to show me something otherwise.

139 Q. I stand corrected. I stand corrected. If that is the language you used, I'm happy to accept that? 12:54

A. So at the time back at that stage we had, I think they were frequently asked questions, or it was a guidance note, an employee guidance note around retiring. So

that did not specifically at that stage deal with that. But it certainly, you know, we wouldn't really have been in a situation where we would have been enabling someone to return. It certainly wasn't a right of passage that everybody would return. I mean, certainly there was a strength of feeling amongst us that if issues were still outstanding then we would not be permitting him to return following retirement. 12:55

140 Q. But was the concern, to be absolutely candid about it, was the concern not so much that there was outstanding processes to be completed, was the concern more that colleagues and management were not confident in his performance? 12:55

A. I think at that stage there were the other issues that were coming to light at that point also. I am just not entirely sure of the exact timeline, but I mean there were certainly other issues that were coming to light in 2020. 12:55

141 Q. Those issues started to come to light, according to Mr. Haynes, the next day, and obviously formed part of an ongoing transaction over the month of June. But do you think Mr. O'Brien was treated entirely fairly during this time? He had clearly had conversations about whether he could return. He certainly formed an understanding, whether it's a valuable currency as a matter of law, but certainly he formed an understanding that he could come back, and then the rug was taken from under his feet, surprisingly, by Mr. Haynes and out of the blue. 12:56 12:56

A. I think, in fairness, the conversation should have been had earlier. I think the conversations, the view of Senior Officers within the Trust should have been taken earlier. At that stage Mr. O'Brien was in no doubt at the earliest possible stage that that was not going to be position. So in fairness to him, I don't think that was communicated clearly enough to him early enough. 12:57

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

CHAIR: It is almost lunchtime but we are going to ask you some questions so we can release you today. 12:57
Dr. Swart.

MRS. TOAL WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS: 12:57

DR. SWART: Thank you very much. I wanted to ask you just a few things which are mainly about the culture and structure of The Trust. So what's come to light here is a series of serious Patient Safety issues over quite a long period of time. The Trust was very busy operationally. It is quite clear that there was fairly close monitoring of what we might call performance targets and finance. It is very hard to see a clear, automatic consistent flow of information on quality and 12:57 12:58
safety from services up to the Trust Board. There's no evidence the Trust Board would ignore any safety issues, but that flow isn't clear to us. Would you agree with that?

A. Yes. I wouldn't disagree with it.

142 Q. Yet, we know people knew about deficits in care. Now you've got, in your portfolio, the "raising concerns" title, if you like, and you have commented on the need to improve that. And I think what you're saying is, people need to understand it better and use it better, if I read between the lines of what you said? 12:58

A. Yes.

143 Q. Is there adequate resource in place for that to happen as it currently stands, do you think? 12:59

A. No. And it's an issue that has been the subject of a number of conversations internally about this. We have been looking across to England in terms of their freedom to speak of guardian roles. We don't have those in Northern Ireland. I think we have been significantly underresourced where this is concerned. 12:59

I have one post that hasn't been recruited substantively. It is almost sort of like a pilot post, but a lot of that is around the sort of nuts and bolts and technicalities of, you know, processing concerns that are actually raised. But probably less time on the cultural aspects, the OD side of this. 12:59

144 Q. So on that, is that part of your role then to help to embed Patient Safety as part of organisational development? Is that part of your role or not? 13:00

A. So I think that's part of the discussions that we're having at the minute, and certainly the discussions that we have had with Protect, as the whistle-blowing

charity. One of my team has been in touch with the National Guardian's Office. We have reviewed quite a bit of the National Guardian Office Guidance and, also, their learning of having the freedom to speak of guardian roles in place. 13:00

And whilst we hoped to have been in a position to get those advertised around the end of autumn time, we took a bit more time to consider it because in light of some of that learning, what that is basically saying is this 13:00 is better outside of HR. So there is absolutely a role from an organisational development perspective, but where it needs to sit is outside of HR.

145 Q. I think that's a fair reflection of the state of it.

A. Yeah. So where we have landed on this now is that when 13:01 we put the, we are going to try the Freedom to Speak Up Guardian role within the Trust, but we're going to put the responsibility for those into the Medical Director's office. I suppose that's from a Patient Safety perspective and to be able to, you know, in 13:01 terms of learning from other, in terms of complaints, SAIs, to try and have a better triangulation of all of that. I will still have the responsibility, I suppose, for the kind of culturally OD aspects of it, and I think that's very much in line with what the National 13:01 Guardian Office would be saying. So that's where we've landed on that and ultimately --

146 Q. So as it stands now, if people come to concerns, do you do a regular report to the Chief Executive on that

or how do you deal with it?

A. So actually John Wilkinson is our Lead non-Executive Director for raising concerns. We meet with him before every Governance Committee. What I do is put a twice-yearly report to the Governance Committee on the types of cases that come through. We, as part of that report, highlight some of the issues around from a resource perspective. We also maybe do a deep dive into learning from particular cases. We update on training that we've undertaken. But there's more, there's much more work to be done on that. But it is a work in progress and that's what we do currently. 13:02 13:02

147 Q. Thank you. The issue of support, it has already been referred to. I just want to take you back to 2016. Were there, at that time, any regular discussions with senior medical staff and the Medical Director and HR in an informal way, not about particular cases but to actually talk about how you support doctors in difficulty and to take you through illustrative cases, the sort of things you might do with NCAS but internally. 13:03 13:03

A. No.

148 Q. Is it happening now?

A. I suppose very much as part, and there's a couple of cases that spring to mind that we would be dealing with or have dealt with recently, around the more detailed sort of support, who individuals can actually go to, who their ongoing support is throughout an actual case. And as each case goes along, you know, there will be 13:03

further learning coming out of it.

149 Q. It needs to be tailored?

A. But I suppose part of that thinking is reflected in the additional guidance we have put in place because we knew it wasn't adequate. I mean, we knew we needed to increase that. We have increased our staff support service within Occupational Health. I suppose back in 2016 Occupational Health would have been Occupational Health Physician, it would have been Occupational Health for nurses and that would have been it. Whereas now we have, you know, our psychology input within that. So that, sort of, has enhanced -- 13:04 13:04

150 Q. But doctors on the ground might need practical support, might not they?

A. Absolutely. 13:04

151 Q. If you look at this particular case, if you like, it is not clear that there was clear communication, it's not clear that anybody had the job card for offering comprehensive support, seeking assurance on it, mentoring through this. I can't see that? 13:04

A. Yes, I think that's fair.

152 Q. Am I right?

A. I think that's entirely fair.

153 Q. Who should have had that job card? Who should have been responsible for providing it, designing the programme, and who should be assuring themselves it is in place in your system? How would that work? 13:05

A. For a particular case?

154 Q. Yes?

A. For a particular case: Well, I suppose what we try to ensure, the Operational Director comes along to a two-hour Doctor and Dentists in Difficulty meeting. The Medical Director will be there. There is also the Deputy Director with responsibility for workforce. 13:05

155 Q. Within 2016, who had that job card?

A. In 2016? I mean, ideally it would have been down the operational line with some support I think from the MD.

156 Q. There's a lot of talk in lots of issues here about "that's an operational matter". We've already referred to some disconnects. I don't think that's the case in every service in the Trust. But the fact that it can occur is a problem. With your organisational hat development on, what is your observation about anything in the way the management structures are set-up or anything in terms of the information flows that is not helpful and causes this disconnect that we've seen in this case? 13:06 13:06

The disconnect I'm talking about is everyone thinks someone else might be doing it and there's not enough communication and face-to-face interaction at the right time. I don't think it was intentional, but that's what we can see so far. Why is that, do you think? Is it related to the management structures? Is it related to the breadth of responsibility that individual people have? Is it related to a cultural fear of challenge? 13:06 13:06

A. I think back in 2016, I mean the Director of Acute Services, for example, I mean it's a significant role.

It is a wide-ranging role. And we have recognised that that breadth is too much in terms of is it a doable ask? That has since split and I think most of the Trusts either have gone that way or are currently going that way. So I think that has a factor in it. I think as well, probably back then, and I think I alluded to some of this yesterday, around a sense that if an issue is within that particular area, it almost stays within that area. 13:07

157 Q. You did refer to that. Why is that? 13:07

A. Possibly the strength or otherwise of an Executive Director role. I mean, I've been in this post maybe, you know, since 2016, I have experience now of three Executive Medical Directors. I mean certainly my experience of Dr. O'Kane from an Executive Medical Director role was much more around: I will intervene, I will probe, I will question, I will almost roll my tank into your lawn because it is in the organisation's interest in terms of checking, questioning, challenging. I'm not sure prior to that there would have been that sense. 13:08 13:08

158 Q. Is there any way that your work on the Just Culture and so on is intended to flatten that hierarchy a bit and not keep everything in services?

A. Absolutely. And I think in terms of from a collective leadership perspective we have much more work to do on that, but I think, you know, recently in the past number of years there's much more a sense of needing to work together and we are each other's safety net, 13:09

really, and seeking out help, seeking out support from a corporate perspective, as opposed to trying to keep it from within because they don't really want anyone to look at that.

159 Q. Finally then, you described the improvements in MHPS reporting. I think, you, yourself, suggest that's the tip of the iceberg, really, in terms of understanding all the informal issues and all the improvements you need to make. So I think from what you said that's been helpful in terms of increasing the discussion engagement at Governance Committee and, hopefully, at the Board in due course. 13:09 13:10

Have you seen any other improved engagement that fits along with the Just Culture kind of idea at Board level as a result of the work that you have had to do for this Inquiry and the work that others have had to do. Have you seen anything else filtering through that would be helpful for us to know about? 13:10

A. I think from a Board perspective, I mean there's very much that openness. There's the openness to bring problems at a much earlier stage and I think that is very much welcomed. I mean inevitably across different services, even Acute Services, there is issues and it is very much a full disclosure, there's an openness, there's engagement at an early stage to say "this is what we're dealing with". The discussion is had. There's the challenge there. There's the follow-up there. I suppose I'm seeing more of that. 13:10 13:11

160 Q. How does that feel as a Board member?
A. It feels much more comfortable and it feels much more safe, I think, because you're getting it out there at an early stage. You're seeking their views. So, yes, it feels comfortable. Probably in bringing the issues, 13:11
you know, from a Board perspective nobody wants to hear, you know, "we have an issue here". But I think it is very much seen in that light that it is helpful, it's the right thing to do, it's the open thing to do. And it is done in that way and it is accepted in that 13:12
way. I think it is a more supportive challenge, if that makes sense.
DR. SWART: Thank you. That's all from me. Thank you.
CHAIR: Do you have any questions?
MR. HANBURY: Thank you very much. Just getting back 13:12
to your comments about the success or otherwise of the informal processes back in March 2016 with this letter to Mr. O'Brien from Eamon Mackle, Heather Trouton, which is well-intentioned but ultimately didn't lead to where it should have done. Do you think you should 13:12
have been a bit more involved at that stage on reflection back or someone from Human Resources involved when...
A. I think we would have been able to contribute in a more, a tighter framework around it. I think we 13:13
would have signaled at that stage, you know, this is MHPS territory. But I think certainly at the very least, in terms of an actual letter and with a follow-up date, I think it would have been helpful to

have that in. So, yes.

161 Q. If this sort of thing were to happen now, you would be more involved?

A. Yes. Yes.

162 Q. Moving on. Recruitment and retention is a big theme. 13:13
We hear of urologists in this case obviously. There were some urologists appointed who didn't stay very long. I think latterly you've had urologists, there have been vacancies but you have not able to fill them. Why do you think that might be and are there any 13:13
solutions to that?

A. Well, I'm not sure a Public Inquiry maybe is maybe the best advertisement to come and work in Southern Trust at the minute. I think that is a factor.

163 Q. But that was years ago, it is 5 years before. 13:14

A. In terms of back then, I'm not sure. I mean medical staffing necessarily wouldn't have been my remit before taking up, but possibly it's a small; you know, Northern Ireland is a very small place. It may have been known around some of Mr. O'Brien's practices, 13:14
I don't know. I can only speculate, maybe. But I'm just very conscious that Northern Ireland is a small place in terms of awareness.

164 Q. So you think individual rather than general factors. Lastly, if I may, on a similar theme, with the theme of 13:15
support, for surgeons having not just clerical support but middle-grade support is really important, registrars, clinical assistance, obviously you can double-up a clinic, help your backlog, you can have

registrars help with your administrational duties. Again, recruitment and retention from a middle-grade point of view seems to have been a theme over the years. Any thoughts on that, at that more junior level? 13:15

A. Yes, I think there probably would have been much more work we could have done, much more innovative thoughts and ideas that, in all likelihood, you know, could have been tried at that stage. Yeah. I'm not sure, I know the rationale for maybe why, you know, more additional 13:16 support wasn't maybe sought at that stage from us, from an HR perspective, but...

MR. HANBURY: Thank you very much.

CHAIR: Just in relation to the recruitment and retention that Mr. Hanbury was asking you about there, 13:16 and you accept that maybe more could have been done if HR had been involved to come up with innovative solutions. I'm just wondering is anything being done now to try and help with the recruitment process? Because we heard from Mr. Haynes, for example, who 13:16 seems to have had a lot on his plate.

I am just wondered what is being done to try to; and I know there are resource issues and I know that there's a wider regional resource issue here, but I'm 13:16 just wondering, we've heard, for example, that people don't want to move outside of Belfast to live and to work. I'm just wondering what, if anything, is currently being looked at or done or thought about in

relation to recruitment.

A. For urology specifically?

165 Q. CHAIR: Obviously we're concerned about urology, but if the issue is wider than urology, I'm just curious to know. Is there any thinking about trying to improve the situation for the resource that you do have currently? 13:17

A. Yeah, yeah. And I suppose it is around how you can share resources across Trusts and particularly within our own Trust, in the Southern Trust perspective. Within other specialties we're looking around shared posts across the organisation. Then, obviously, from a regional perspective around, you know, the work that is going on. You know, around where you concentrate the limited resource that we have. So as a Trust we are engaged in that. 13:17 13:18

CHAIR: I'm not trying to put it on Southern Trust's shoulders, it is obviously a regional matter for the Department. But I was wondering in the interim, apart from looking at the wider why we reconfigure our entire health resource in Northern Ireland, I'm just wondering in the interim before there are any changes made? 13:18

A. There are some discussions around sort of surgical assistance, things like that, that will be ongoing from an operational perspective, yes. 13:18

166 Q. Thank you. Then if I can just ask you a couple of things about the NCAS involvement back in 2016. Would it be a fair description to think that NCAS was seen in some way as a nuisance? We don't want to go outside

the Trust. We can deal with this internally. I know we have to engage them and we're obliged to ask for their input, but, you know, we've done that now. We don't really need to look at it in any great detail. You described the holding-things-in rather than being 13:19
open about problems. Do you think that was part of the culture back in 2016?

A. I think it was done maybe not with a full sort of recognition of the absolute benefit of engaging them on a regular basis. I think it is fair to say. I'm not 13:19
sure I would accept that they were seen as an external nuisance or anything like that. But I don't think we exploited the potential in the same way that I think we would do now.

167 Q. Yes. I suppose I'm asking, really, well, we have to do 13:20
this, so we'll tick that box. It was a tick box exercise and we've done that now so we can move on?

A. Maybe the relationships with NCAS are better formed now and therefore, you know, very much it's seen as a source of expertise and guidances that is very 13:20
helpful. I mean, I suppose I would maybe compare it maybe with, you know, how we maybe view Internal Audit. Actually, Internal Audit are really, really helpful, whereas maybe some sort of sense from some, who at an earlier stage, you know, that's may be they're not seen 13:20
as terribly helpful, but actually they are. That type of thinking.

168 Q. It's about convincing people of the benefits of these things, I suppose, really.

A. Yes. Yes.
169 Q. Just in terms of your involvement in the Board, and we've heard from a lot of people about Mr. O'Brien's personal friendship with the Chair of the Board. I wonder, from an HR point of view, do you feel that that knowledge among people had a chilling affect on how things were dealt with back in 2016? 13:21
A. Yes. I think probably I wouldn't have been as aware of it as I am now, you know, working my way through this process. Yeah, I mean clearly at the time around, you know, Board meetings and certainly the very first meeting that Dr. Wright and I would have brought the paper to advise the Board of the exclusion, Mrs. Brownlee stepped out at that point. So, yes there was a chilling effect, yes, probably. Certainly it was awkward. It felt awkward. 13:21 13:22
CHAIR: When I say "chilling effect", did people feel constrained in how open they could be with the Board with her chairing it, and with how they actually dealt with Mr. O'Brien because of the relationship? 13:22
A. Well, when it came to the Board, it was obviously in 2020, apart from, obviously, that MHPS. I think in terms of potentially how people viewed that, that friendship, in terms of how they dealt with things at that earlier stage prior to 2016, it clearly has had a chilling affect and I think that that's clear to see now. 13:22
CHAIR: Thank you very much. You'll be very relieved to hear that after quite a long time we have no further

questions. But I understand Mr. Wolfe might still not be ready to let you go.

MR. WOLFE KC: At the risk of incurring everybody's wrath, just 5 minutes and apologies.

13:23

MRS. TOAL WAS FURTHER EXAMINED BY MR. WOLFE, AS FOLLOWS:

MR. WOLFE: Rather than having you come back again, it is maybe just as well finishing it off. 13:23

May I ask you to look at AOB-2059, sorry, there's a 0 at the front. AOB-02059. This is a page from Mr. O'Brien's grievance and within it he sets out his view that he wishes to take an opportunity to express 13:24 his concerns regarding the Trust's duty of care to its urology patients. Particularly, he wishes to say that that duty of care has been breached by the investigation itself.

13:24

Then, just scrolling down, he sets out the detail of that. One of the points he wishes to make is that having been excluded, his appointments for theatre and review of various staff have not been taken forward and that's increased waiting times for patients. He 13:24 suggests that aspects of the work that should have been done around those patients was performed.

Just scrolling down to the next page. The detail isn't terribly important for the purposes of the question. He's says:

"For the avoidance of all doubt, let it be clearly understood that I'm disclosing these facts, not merely in my own interests as part of my grievance, but in the interests of the public in general and these urological patients in particular." 13:25

Now, you told us yesterday that one of the limbs of your job as Director of HR is Lead Director for raising concerns. Now when you considered this grievance, did you reflect that these are the kinds of concerns that should be examined, if you like, under the whistle-blowing type rubric? 13:25

A. I think at the time, I mean we were aware, obviously, when you do take a urologist out in terms of the immediate exclusion, it would have an impact. I think I had said in relation to that that obviously that was deemed a necessary action at that point in time. And I think I used the term, you know, Patient Safety did sort of trump that at that point. So it was an inevitable issue, I suppose. 13:26

In terms of the waiting list position, in terms of, you know, in the interests of the public, I mean from a Trust Board perspective the waiting list position from a performance perspective would have been known, would 13:26

have been reported on, would have been subject to, you know, obviously it would have been, those reports would have been public. So I suppose what particularly in terms of the waiting list times, it was already, in our view, in the public at that point. 13:27

170 Q. But in terms of, that might well be so, but in terms of practitioners saying to you: I'm raising these concerns. Are you saying it because, to take the first point, there was an inevitability of the impact of exclusion on patients and, the second point, waiting 13:27 lists were well-known. Are you saying, therefore, that it didn't qualify as a raising concern issue to be further explored with the person raising them?

A. It wasn't seen in that way, I don't think, at the time. No. 13:28

171 Q. On reflection, although this is contained in a grievance, and I know there might be a perception as Mr. O'Brien says himself that it is in part self-serving, he is raising it as part of his own grievance, is this something that should at least have 13:28 been explored with him and registered?

A. Yes. I think it should have. I think that should have been; we should have been applying, you know, our own policies and procedures in relation to that, to try to understand that a bit more and see if there was 13:28 anything else to that.

172 Q. If I can find my note. Honestly, this is the last point! There it is there. Could I just have up on the screen TRU-252875. Just to orientate you, go back to

the first page. You are writing to Mr. O'Brien on 18 June in relation to this. And I come back to work issue. The thrust of it, I think, is that you cannot rescind your retirement notice. Just scrolling down, you're setting out the chronology of that. Scrolling down, please. There's no automatic right to return part-time. Just on this point: 13:30

"Mr. Young, Ms. Corrigan, and Mr. Haynes do not agree with your recollection of discussions during February 2020 when you say they confirmed their support for your return post retirement. Rather, no assurances were given to you in that regard." 13:30

Just on that point, did you speak to Young, Corrigan and Haynes to tease outed whether they had provided assurances? 13:30

A. I didn't speak personally to Mr. Young but I think Mr. Haynes and Mrs. Corrigan did. But Mrs. Corrigan and Mr. Haynes would have been involved in the conversation, yes. So I think that, I think my recollection of that, in terms of what I had said earlier around, you know, very early-on, in fairness to Mr. O'Brien there should have been a clear conversation with him in relation to it. My sense of what I was hearing was that, really, you know, there was nothing firm, you know, actually worked through at the early stage in relation to that. That's my recollection of that. 13:31 13:31

173 Q. Let's be clear, although you didn't speak to Mr. Young, did you speak to Haynes and Corrigan in this context?

A. Yes. That's my recollection, yes.

174 Q. This practice of not re-engaging those who are the subject of ongoing processes, is that a practice that has been applied to any other practitioner in your experience? 13:31

A. Yeah, it wouldn't be peculiar to medical staff only. I mean, we would have a number of shortages I suppose occupations, nursing, midwifery, et cetera. So I have no reason to believe that it would be applied, you know, by exception just to a member of the medical workforce. 13:32

175 Q. Are you conscious of other cases where you've said no, you're not coming back? 13:32

A. Personally, no. But I mean I don't deal with every retiree and return case. But I can't image we would be in a situation where, if we have known issues in relation to any staff member of any staff group, that we would be in a position where we would be facilitating their return. 13:33

MR. WOLFE KC: Thank you very much.

CHAIR: Thank you very much, Mrs. Toal. I know it has been a long day for you. It is now half-one. So half-past-two then for Mr. Carroll. Just to be clear, we will be sitting until quarter-to-five at the latest today. 13:33

MR. WOLFE KC: People here have professional difficulties that they mentioned to me. Maybe I will

discuss that with you over lunchtime.

CHAIR: Very well.

MR. WOLFE KC: We'll fix a time.

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS: 13:33

CHAIR: Good afternoon, everyone.

MR. WOLFE KC: Your witness this afternoon is Mr. Ronan Carroll. I think he proposes to take the oath. 14:33

MR. RONAN CARROLL, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC, AS FOLLOWS:

176 Q. Good afternoon, Mr. Carroll. 14:33

A. Good afternoon.

177 Q. The first thing is to introduce the Inquiry to the statements that you kindly provided in advance and for you to adopt them. The first one is registering as No. 25 of 22. We can find the first page at WIT-13086. 14:33 You'll be familiar with that?

A. Yes.

178 Q. If we go on down through it, WIT-13174. We can see that you signed it on 16 May 2022. Do you wish to adopt that statement as part of your evidence? 14:34

A. Yes, please.

179 Q. I know there are some corrections suggested and I'll come to those in a minute, subject to those corrections you're adopting this statement. The second statement

is No. 44/2022, WIT-21112. And the last page, if we go to that WIT-21135, you signed that on 24 June. Again, Mr. Carroll, do you wish to adopt that as part of your evidence?

A. Yes, please. 14:35

180 Q. Thank you. You have recently sent us a short addendum correcting a particular fact and we'll just look at that. 27 February we received that. It is WIT-91919. Just scrolling down. You say:

14:35

"Throughout my statement, I have stated that I do not recall having a meeting with Mr. O'Brien during my tenure. This is incorrect as I met with Mr. O'Brien on 25 July 2017 with Colin Weir and Martina Corrigan in attendance." 14:36

Therefore, you would like to remove a series of statements, or series of sentences, contained at those three, I think it might be a fourth place in your statement, three places. 14:36

Paragraph number 2. Again, I think you are correcting the fact that you did meet him at one point.

How did that come to your mind, that in fact you did meet him when you otherwise earlier thought that you hadn't? 14:36

A. So, it was only when I got the transcript, the audio transcript of that meeting on 25 July, that I realised

that I had met Mr. O'Brien.

181 Q. Again, do you wish to adopt this statement which I think you signed. If we scroll on down the page to WIT-91920. Do you wish to adopt that as your evidence?

A. Yes, please. 14:37

182 Q. One final piece of housekeeping before we move on. You were interviewed by Dr. Chada as part of the MHPS investigation. We'll bring that up on the screen, it is TRU-00762. Here we see the typical format of this statement. It is an interview situation. You give 14:38 answers to Dr. Chada who is assisted by Mrs. Siobhán Hynds, and then that is reflected in a statement and it you are asked to check it and sign-off on it you're in agreement with it. Was that broadly the procedure? 14:38

A. Correct.

183 Q. We see you do sign-off on it. If You go down to 00766. Again, 17 August 2017. Are you happy that that is a correct and accurate statement of your knowledge of the issues relevant to the MHPS Inquiry or 14:38 investigation at that time?

A. Yes.

184 Q. Thank you.

Now, let's begin with your employment history. You 14:39 worked for the Newry and Mourn Trust, which is one of the Southern Trusts Legacy Trusts. You worked there between 1995 and 2007 in a number of management roles; is that right?

A. Yes. I came to the Newry and Mourne Trust on 1 January 1990 and then stayed with them until 2007 evidence, then transferred across into the newly formed Southern Trust.

185 Q. You are a Master of Science in Health Service Management; is that right? 14:39

A. Yes.

186 Q. Now, as you say, you came across to the Southern Trust upon its formation in April 2007 and at that time you were appointed Assistant Director for Cancer and Clinical Services. 14:40

A. Correct.

187 Q. We can follow some of this through. If we get your statement, your first statement up on this screen, please, WIT-13181. That's your job description. Bear with us with that. Part of your role in that Assistant Directorship, I know it is an old form job description, but part of your role was to collaborate closely with senior clinicians and other disciplines to implement the Objectives of The Trust Delivery Plan and ensure effective multi-disciplinary working. So within that role you worked very closely with medical management? 14:40 14:41

A. Yes. So the Division at that time was structured. There was myself, as the AD, and I also had an AMD. That would have been Dr. Hall at that time. Below that there would have been Heads of Service for the different services within the Division. Each of those Heads of Service would be allied to a Clinical Director. 14:41

188 Q. Did that structure change at all or was that basically the same when you moved into the Southern Trust when it was formed?

A. Sorry, this job description is for my AD post?

189 Q. Sorry, that is your Southern Trust job description. 14:41

A. Yes.

190 Q. I beg your pardon.

A. So when I moved across in 2016? Sorry, is that your question?

191 Q. No, I have confused myself. That's the job description 14:42 that you received upon taking up your Southern Trust post in April 2007.

A. Correct.

192 Q. You stayed in that role as Assistant Director For Cancer and Clinical Services until April 2016 when 14:42 there was a reshuffle under the new Director or the recently appointed Director, Esther Gishkori?

A. Correct.

193 Q. Let's look at your statement in that respect. WIT-13086. If you go to paragraph 1. Just scroll 14:42 down, please. You explain the formation of The Trust. You say that in your first job within that Trust the following services fell within your remit: Cancer Services, Radiology, Lab Services, Anaesthetists, Theatres and Intensive Care, as well as Allied Health 14:43 Professionals.

The restructuring, or the change that came in April 2016, you didn't give up those responsibilities?

A. I gave up some and I kept some. So in 2010, approximately, because it was deemed that the medical portfolio was too heavy within this division, they separated out. So I became Cancer and Clinical Services and Anaesthetics, Theatres and Intensive Care, which meant whilst there was only one Assistant Director and me, I had two Associate Medical Directors. That would have been Dr. Hall who would have been responsible for Cancer and Clinic Services and Anaesthetics and Theatre and Intensive Care, which we refer to as ATICS, Dr. McAllister became the AMD for. 14:44 14:44

Then in 2016 when there was a restructuring, I kept on Anaesthetics, Theatres, Intensive Care, plus I had Surgical and Elective Care. 14:44

194 Q. Is that still the weight of the post in terms of the number of services that you carry?

A. Correct, yes. Yes.

195 Q. And you're still in that role? 14:45

A. For the next month.

196 Q. Then just scrolling down. You explain at, you set out there I think what you have just said at paragraph 2, the services that come within your Assistant Directorship. 14:45

Then paragraph 3 you explain, you give a high-level overview of what your role involves. You work closely with medical and non-medical managers in delivery of

services to the Southern Trust population.

In terms of urology then, that's one of the roles, one of the services that come within this Assistant Directorship. You say at paragraph 4, that in terms of your engagement with urology you were dealing with three broad issues. Paragraph 5, the first of them were "Performance Standards". Paragraph 8, just scrolling down, the second issue was "Workforce Challenge". You reflect that: 14:45 14:46

"The workforce issue was and continues to be a chronic, recurring issue, with the causes being complex and the solutions to fix it to date being unachievable with respect to a full complement of Consultant Urologists and ward-based Nursing Team." 14:46

I don't wish, we're here really to talk about MHPS, but if you could help us on that: Is that a problem that appears hopeless in the sense that you've struggled for solutions for some time and none appear forthcoming or are there initiatives in place trying to chip away at this problem? 14:46

A. So I think it is well-recognised across the Health Services that there are workforce challenges and urology would have been part of that, and still is, part of that challenge in that we should have seven Consultant Urologists. We currently have three full-time Consultant Urologists, we have two part-time 14:47

and one Locum. That is despite quite a regular advertising campaign, far and wide, to see could we successfully recruit any Urologists. But to date we haven't been able to increase our substantive Consultant Body. 14:47

In terms of nursing, again, it is well-recognised, I would say internationally there's a nursing recruitment shortage, for many reasons. But for the areas that I have responsibility, the 3 South Ward, 14:48 which would have been the ENT Urology Ward had particular difficulties in recruiting nurses.

Then also, within the other half of my job, in terms of Anaesthetics, Theatres and Intensive Care, we would 14:48 have recruitment difficulties in terms of nurses who would want to work in theatres. Again, that's despite regular advertising. We now have a recruitment, an international recruitment where we are taking international nurses from, mostly from India, and we're 14:48 bringing them over to bolster-up our workforce. So it is a challenge. It has been a challenge for quite a number of years and remains so.

197 Q. Is it a challenge that is peculiar to Urology or are you reflecting more broadly across your portfolio? 14:48

A. I would say it is through all the portfolios, yeah, to degrees. But I would say 3 South, which is the ENT Urology Ward had got particular nursing challenges, more than so that, say for example, trauma and

orthopaedic ward. So, yeah, 3 South had particular difficulties.

198 Q. Obviously we are looking at, as an Inquiry, looking at the response of the Trust to apparent shortcomings in the practice of a clinician. But the context here is pressures created for the Service by an inability to recruit, the inability to ensure that the patient population was managed in as timely a way as perhaps clinicians and managers would like, and the pressure that might have caused on clinicians trying to respond to that. Any reflections on that issue? 14:49 14:50

A. Well, I think if you had a full complement of consultants and you had a stable workforce, it would make the work, not easier, but in terms of delivering the services to the patients, it would be better. When you are relying on a very transient workforce in terms of locums, whether it be medical staff or nursing staff, it does pose its own unique set of problems, which are a challenge to manage. So it is always best to have a stable workforce. But unfortunately we couldn't achieve that. 14:50 14:50

199 Q. The third issue that you then highlight in this statement as being a urology issue that you had to deal with is Mr. O'Brien's administrative practice. If you could just scroll down to paragraph 9. You say: 14:51

"The third issue was Mr. O'Brien's administrative practices, came to my attention in April 2016".

You talk about being advised of the letter that was sent to Mr. O'Brien. We'll look at that in just a moment. In terms of MHPS, you've said in your witness statement -- if we just go to WIT-21114, please. You've said at 4.1 that you.

"... as Assistant Director, did not receive any training or guidance, formal or self-directed, in respect of either the MHPS Framework, 4.2, the Trust guidelines."

Obviously, come December 2016 you're attending an Oversight Group meeting at which there is a decision taken to invoke the formal limb of the MHPS Framework and proceed with a formal investigation whilst excluding the practitioner. Was that the first indication on which you became aware of MHPS?

A. The first introduction to MHPS would have been by Dr. Chada -- sorry, no, you're right. Dr. Chada was 2017. Yes, that would have been the first time I was exposed to MHPS.

200 Q. Exposed in the sense that here were people round the table, Dr. Wright, Mrs. Toal, talking about a formal investigation under MHPS as an option and, ultimately, the direction of travel. But, you didn't have opportunity in advance of that meeting to go to the Framework and see what we're talking about?

A. No. I was deputising for Mrs. Gishkori who was unavailable that day. So I was -- I attended a meeting

on her behalf. In terms of my knowledge of MHPS at that stage, it would have been extremely limited.

201 Q. The Trust, as we understand it from Mrs. Toal's evidence yesterday and today, is proposing in the not too distant future to provide training to a cadre of staff which includes Assistant Directors. If you didn't know it, you're going to be going to some MHPS training on managing low-level concerns. I just ask for your reflections on that, please? It is WIT-91894. 14:54 14:55

Do you think, before we look at the training, given the role that you played in the process, you attended that December meeting, December '16. You attended another meeting of the Oversight Group on 10th January 2017, and you carried into that meeting various reports on aspects of Mr. O'Brien's practice. Going forward, you were required to perform a monitoring role in tandem with Mrs. Corrigan which, again, was a particular outworking of the MHPS process. So various roles there, some directly engaging MHPS, some a little indirect. Do you consider that training and better knowledge of the MHPS process and the local guidelines would have been of some assistance to you during that work? 14:55 14:56

A. Yes, I do. On reflection, yes, I think it would have been very helpful. As I said, in my career up until December 2016 I have never had any reason to be involved with MHPS or the management of an

underperforming doctor. I was never exposed to that. It was always down the medical lines and I had no experience in it. But I think holding a role of Assistant Director or Head of Service where you, day and daily interact, with medical staff as part of your work, both in terms of work in performance, quality, safety of patients, having an understanding can only be a good thing. So, yes. 14:56

202 Q. We can see on the training objectives list some of the things that are likely to be brought forward through training of Assistant Directors and others. I think it is the fourth bullet point is the training is going to equip you with some knowledge of how to use risk templates to help assess and effectively identify if a concern is low-level or needs escalating. We'll go on, in a moment, to look at what knowledge you had of shortcomings in Mr. O'Brien's practice when you were Assistant Director in Cancer Services between 2008 and 2016. In terms of encountering difficulties with doctors and their practice, which may be troubling for the Service, perhaps causing difficulties for both colleagues and patients, it's important to know how to respond to those if informal approaches are not working. Is that fair? 14:57 14:58

A. No, I agree with you entirely. I think the more knowledgeable you are about the MHPS Framework, even though you may not be a doctor but you hold a managerial position, is to the benefit, ultimately, of patients. So, yes. It's just a pity I won't be 14:58

taking this training.

203 Q. Are you about to retire?

A. I'm retiring.

204 Q. Very well.

A. But I certainly do welcome it. I think it's in the interests of everybody. 14:59

205 Q. One of the things you said in your statement is, and let's bring it up on the screen. It's WIT-21135. At 28.3 you've said that on reviewing the MHPS document it's clear to you that the process falls within The Medical Directorate and HR remit. In your experience consultants respond better to management under doctors, members of the medical profession. In your opinion this is because: 14:59

15:00

"...consultants view these Medical Managers as having greater credibility and a peer knowledge base. As the MHPS is a Framework to manage a doctor who is viewed as underperforming, and to monitor their adherence to necessary requirements it should be other members of the medical profession who hold the underperforming doctor to account." 15:00

Is that a reflection of any particular experiences?

A. I suppose it is just my experience to date. I've always worked within the Health Services that doctors managed doctors. Particularly when it came to a doctor who was underperforming, it was rarely, in fact I had never been asked to be involved, up until this point, 15:00

to be involved with the management of a doctor who was deemed to be underperforming. It has always been held within the medical, four corners of the medical profession, along with support from HR.

206 Q. You've reflected in your statement how, as I mentioned briefly a moment ago, that when you were Assistant Director for Cancer and Clinical Services, you became aware that Mr. O'Brien was presenting challenges to The Trust and you recall issues around triaging which caused delays to patients starting their cancer pathway. You set this out at WIT-21117. Just look at that at 9.2. And then you say: 15:01 15:01

"I ask Mrs. Corrigan to do whatever she could to address this issue. I also escalated my concerns to Mrs. Trouton so as to ensure Mr. O'Brien complied with the triaging rules. Any further action I would have assumed lay with Mr. O'Brien's managers within SEC." 15:02

In terms of your role, you're in a senior management role as Assistant Director, this issue of either not doing triage or was it slowness in doing triage? 15:02

A. This was delayed triage. It wasn't not doing triage, it was delayed.

207 Q. It was delayed. Very well. And so that was causing a problem for your service? 15:03

A. Yes.

208 Q. And for the patients who expected to receive the benefits of that service?

A. Yes. So my role, as it was then, I was responsible for Cancer Services but the big emphasis was on cancer performers. So in terms of 14 days, 31 days, 62 days which are the National Cancer Pathway Targets. For a patient who is on the 62-day cancer pathway there is 15:03
a very tight timeframe within which we have to move the patient along so that they have the first treatment within 62 days. So each day is very precious that you lose. So, it was on that basis that we would have been chasing up Mr. O'Brien, Mr. O'Brien's secretary, when 15:04
the red flag referrals weren't coming back.

209 Q. Trying to put time parameters on that in terms of your concern about that. Was this throughout the years eight or so years that you were --

A. I suppose it ebbed and flowed. There would have been 15:04
times when Mr. O'Brien would be very compliant and he triaged on time, and there were other times when I think, in preparation for my Section 21, I was able to find between 2012 and 2015, I think I sent 21 emails to Heather, Ms. Trouton, Mrs. Corrigan, or one 15:04
or the other in relation to Mr. O'Brien and the delays in the triage coming back.

210 Q. And that way of responding to it, Assistant Director writing to the Head of Service in Urology, Mrs. Corrigan, or across to another Assistant Director, 15:05
Mrs. Trouton, your peer, but running the surgical or the Acute Services?

A. So Heather was responsible for Surgery and Elective Care.

211 Q. Within Acute?
A. Within Acute, yes.
212 Q. I'm obliged. Thank you. So rather than approaching his medical management, you brought your concerns to the attention of fellow operational managers? 15:05
A. Yes. And, to be fair, when we did that it was resolved very quickly, in that the referrals would be triaged and sent back.
213 Q. Until the next time?
A. Until the next time. 15:06
214 Q. Did you say 21?
A. 21 or 22 times within a three-year period.
215 Q. So effective in the short-term, but this was a running sore for you, is that fair to say?
A. Well, I would say Mr. O'Brien was the consultant who we had to chase most, by far. Because we would have tracked not just Urology, we would have tracked all the cancer referrals for all the cancer sites. 15:06
216 Q. And I think you said, you mentioned the emails, you had an awareness that previous Directors such as Dr. Gillian Rankin and Mrs. Debbie Burns, had discussions with Mr. O'Brien about these issues? 15:06
A. I don't know if they were about cancer referrals. They could have been the other parts of referrals, like routine and urgent referrals. So I really don't know. All I knew generally from being Assistant Director that Dr. Rankin and Debbie had reason to speak to Mr. O'Brien about his administrative challenges and shortcomings. 15:07

217 Q. As I understand your evidence, you're saying that prior to the reshuffle in April 2016, which then brought you into contact with Urology, your concern was with red flag referrals being delayed?

A. Yes. 15:07

218 Q. You didn't know anything about routine and urgent referrals?

A. No. That was my business then.

219 Q. I'm obliged. Thank you. 15:08

In terms of when you think back at that approach to matters affecting your Service, it's delayed again, I'll write; it's delayed again, I'll write, and so on. Based on your experience since then, do you regard that as the appropriate approach or would you still do it 15:08 that way today if that was the problem?

A. I don't think I would do it that way today. I think I would try and understand why Mr. O'Brien couldn't triage in the same way as all his fellow consultants could triage, and then in understanding why, you could 15:08 find a solution. I have to say I didn't do that when I was Assistant Director. I went along horizontally to the managers and the Surgical Directorate.

220 Q. Was that structure -- and we've heard from Dr. Hughes who looked at the SAI cases in 2020, and he pointed out 15:09 that the Cancer multi-disciplinary team for Urology was managed very much within the Acute Services Directorate through the Urology management, and it was somewhat divorced from Cancer Services management. Do

you recognise that problem and did that structure impede how you might have liked to deal with this issue?

A. I think the Health Service is generally very hierarchical. Whether it's a good thing, I'm not so sure, but it is. In terms of the managing patients and making sure that patients receive the best care possible, having a less rigid system, a more flexible system would serve patients better. I think, in terms of Dr. Hughes observations, I think they are well-founded in light of what he found. I think, since then, we have got better in terms of trying to coalesce the integration of -- or a marriage between the Surgical specialities and Cancer Services. 15:10 15:10

221 Q. You reflect in your statement a meeting with Mr. O'Brien in 2008. It may well have been an informal meeting but I want to ask you something about it. WIT-21117. It might be this page. Yes. Just scroll down. Scroll down to 9.5. 15:11

You say in or around 2008 you recall meeting with each Cancer Multi-Disciplinary Team, including Urology, to communicate the new Regional Cancer Guidance. This was the first time you met Mr. O'Brien following your transfer from the Newry Trust: 15:11 15:12

"I had no prior knowledge of him. Mr. O'Brien said he didn't agree with the new cancer standards and that he would continue to practise as he had always practised.

I do not recall everyone who was present at the meeting but the Head of Cancer Services, Alison Porter, and the Operational Support Lead Wendy Clayton would have accompanied me.

15:12

Mr. O'Brien's comment at the time did not raise concerns with me as I understood the cancer standards and the processes involved to achieve the required outcomes, i.e. those are the access standards, 21 and 62 days, were new to everyone, that is the Clinical Teams and the Administrative Teams alike. When we met with the other Clinical Teams we were not always received with applause. There would have been clinicians who grumbled but who did adhere.

15:12

15:13

Throughout my career and working with medical staff it was never my experience that a doctor would wilfully not adhere to guidance that would benefit patients.

Therefore, as I recall, I viewed Dr. O'Brien's comment as that of a clinician who was reluctant to change. The new Regional Cancer Guidance was a big change in 2008. I knew the Patient Pathway involved a tracking element which ensured the patients were tracked and/or managed during the first definitive treatment and there was an escalation process embedded into this new system."

15:13

15:13

Was Mr. O'Brien's comments in this context a reflecion

action but he did ultimately comply or what are we to draw from this?

A. So, this was the first time, as I say, I had met Mr. O'Brien. I suppose it stood out to me that above all the Urologists who were present in the room that day, that he was the only Urologist who said what he said. 15:14

As I said in my Section 21, when we went to some other teams we were also met with a degree of resistance. So, and again, we expected that and it was nothing abnormal. So I just took it that Mr. O'Brien, who would have been a Senior Surgeon, older than some, he would be slower to change and adapt to this new process, which was a pretty radical change. So that's how I perceived it. 15:14 15:14

222 Q. In terms of your experience in that role, was it only ever triage that you understood to be a difficulty in the context of Mr. O'Brien's practice, or did you have any knowledge or concerns about any other aspect of his practice? 15:15

A. No. Whilst I was the AD for Cancer Services it was the triage.

223 Q. As you've explained, you moved to this realigned post in Mrs. Gishkori 's Directorate in April 2016. You had a hand-over with Mrs. Trouton at that time. And if we just scroll down to 10.2. You explain that Mrs. Trouton told you that Mr. O'Brien had been issued with a letter from her and the Associate Medical 15:15

Director, Mr. Mackle. This was in relation to governance concerns associated with four elements, and you set them out there. Was that as much as she advised you about Mr. O'Brien, or did she set it out in a wider complex of concern or non-compliance? 15:16

A. No. My memory of the meeting was it was a general hand-over meeting. So Mrs. Trouton and I would have discussed many things at the meeting. Many of the things that I suppose Dr. McAllister references in his email on 29 May, the challenges which were prominent in 15:17 the Surgical Division at that time, and I think it was probably towards the end of the meeting, Mrs. Trouton said, just to let you know, Mr. O'Brien has got a letter in regard to his administrative issues. And I don't believe I got the letter at the meeting. 15:17

224 Q. Was she drawing your attention to any other clinicians? I don't want their names, but any other clinicians who were of concern?

A. No.

225 Q. In a sense was it unusual or exceptional for her to be 15:17 picking out a particular consultant who was causing concerns?

A. Well, I suppose as I came with the knowledge of Mr. O'Brien in my previous role, and knowing that previous Directors had attempted to get Mr. O'Brien to 15:17 comply, I was not surprised that she said "Mr. O'Brien has got a letter" or that she singled out Mr. O'Brien.

226 Q. As you said, again, in your witness statement at this paragraph, Martina Corrigan provided you with a copy of

the letter on 28 April. We'll just look at her email to you. It is TRU-274671. And she's saying that -- this is only a few weeks into your posting. And they are conscious that the service was without an AMD and a CD at that time. She is drawing your attention to some issues that were taken forward by Eamon, Eamon Mackle, and she doesn't want them forgotten about, saying the Medical Director is aware of these. 15:19

So she attaches the letter from Eamon and Heather to Aidan O'Brien. She says that Aidan was met with on 30 March and the issues discussed, the letter handed over. She says "we were to get a response in 4 weeks. Nothing as of yet". So this is coming up on the four-week mark. And she mentions other issues there which we don't need to concern ourselves with. 15:19

If we scroll down. I think the letter is sitting behind this email. How did this specific interaction with Mrs. Corrigan on -- as I say, the email wasn't just relating to Mr. O'Brien, another clinician is mentioned in another context. How did you regard this in terms of it being a pressing issue or otherwise? Corrigan drawing it specifically to your attention, it having been brought to your attention by Mrs. Trouton three or four weeks earlier? 15:20 15:21

A. As I said in my statement, I did not act on this letter. Why I didn't act on this letter I thought about for a long time. I think there was a few reasons

why I didn't. The first one, probably naïvely, was my working knowledge of Mr. O'Brien's habit or trend of being slow in triaging. Secondly, in the letter it says he had to come back with a plan. I suppose, thirdly was that the Medical Director was aware of it. 15:21
I suppose fourthly, was that this was three weeks or four weeks into a new role trying to understand everything that I needed to understand. I think those are the main reasons I would offer up.

227 Q. I suppose you did read the letter? 15:22

A. Yes.

228 Q. Just scrolling down through it. When you read it, were you struck by the seriousness of it in terms of the numbers?

A. Again, no, in that when we would have sat as Heads of 15:22
Service and AMDs -- sorry, ADs at the regular cancer performance meetings, the managers from the Booking Centre would have -- I wouldn't say frequently but enough that it would have registered with me that they would have said that urology was -- and Mr. O'Brien 15:23
posed them challenges in terms of referrals being received back. So, I also had that background knowledge. But in terms of the backlog --

229 Q. If we just stick with triage for the moment. Your experience of the triage issue, vis-à-vis Mr. O'Brien, 15:23
it wasn't that he didn't do it, it was always done, albeit tardily, in his own time or whatever. Here you're faced with a different calibre of problem. It would appear, if you read that at first blush, whatever

the accuracy of it, and people may have different views, you are being told there are currently 253 un-triaged letters dating back some 18 months. Therefore, it is being spelled out for you, lack of triage means we do not know whether the patients are red flag, urgent or routine. 15:24

The next line is, presumably, new information to you as well. What can we do in that situation? We put them on the list using the default system, as it became known, with no record to urgency. 15:24

A. I do accept your point. When you put the four together it does paint a problem picture. And, as I said in my statement, I do regret I never actioned it but I'm trying to provide context for why I didn't do it. But I do, and I think I said in my statement, myself and either, because we didn't have a CD or AMD, but when Dr. McAllister and Mr. Weir came onboard, we should have acted sooner. 15:25

230 Q. Is it fair to say that you didn't see any patient risk issues in the four matters that were outlined? Or put it another way, you didn't see patient risk issues at such a level of gravity to encourage an immediate response from you? 15:25

A. I think that would be fair to say, yes. 15:26

231 Q. Even though you knew that there was to be a, at least there was an expectation of a four-week turnaround from Mr. O'Brien, you didn't diary this with a view to following it up if he breached that expectation?

A. No, I didn't.
232 Q. When you think about it now, what should you have done with this letter?
A. Well, I should have acted on it. I should have gone to see Mr. O'Brien in person and said, and asked him: You've got this letter; sorry, I probably would have went with a senior doctor and we would have met with Mr. O'Brien, sat him down, spoke to him, asked him, you got the letter. Somewhere along the way the four-week time limit was introduced, and then ask him what he had done, if he hadn't done anything, what he was hoping to do and see whether or not we could move forward on it. 15:26 15:27
233 Q. Was there any sense that, you'd given him explanations upon reflection about your inaction, is there any sense that Mr. O'Brien was untouchable in that from your perspective as an operational manager, 'I can't really go there. This man is too senior, too experienced, and even if I went there I wouldn't be listened to'? 15:27
A. I think that's always the possibility you face when a non-clinician speaks to a senior clinician, that they would -- I wouldn't say disregard you but, in my experience, it is much more beneficial and powerful if a CD, a Clinical Director or AMD speaks to him. 15:28
234 Q. You received, as you mentioned earlier, an email from Dr. McAllister on 9th May. If you could just briefly look at that. WIT-14875. By this stage the Inquiry is very familiar with this. You can see scrolling down quite a list of issues. Item 6 addresses urology. Not all of these issues, as you know, are Mr. O'Brien 15:29

issues, but issues about backlog, triaging, referral letters, not writing outcomes in notes, taking notes home, are all issues reflected in the letter of 23rd March. The issue raised at the end of that sentence in relation to inappropriate prioritisation of patients who are seen privately, that wasn't an issue in the 23rd March letter that you would have recently received from Mrs. Corrigan. Do you know now where that issue emerged from? 15:30

A. Yes. From having read the evidence bundle, Mr. Haynes had raised it on previous occasions with, I think, Mr. Young and Mrs. Corrigan. 15:30

235 Q. Scrolling up to the top of the page, your response to Mr. McAllister was:

15:30

"I think it's safe to say you have a good handle on things." Was that a flippant remark?

A. No, I think it was a very comprehensive list, 21 items for a newly appointed AMD, albeit Dr. McAllister was a very seasoned clinician, so probably would have been familiar with some and heard some. But, no, I thought it was a very comprehensive list for a new MD and it captured what the burning fires were at that moment in time, Surgery and Elective Care. 15:31

236 Q. Having raised the Aidan O'Brien issue himself, that might be looked at now as saying; well, why didn't you get together with your AMD to take that issue forward? 15:31

A. Well, that's a fair question and it's one that

I thought about. I mean Dr. McAllister's letter was sent to myself, the Medical Director and Mrs. Gishkori, and whilst I put my hand up and say I didn't do it, neither did the other recipients of Dr. McAllister's letter, including Dr. McAllister, act to action the letter that Mr. O'Brien had received. I suppose when I looked at Dr. McAllister's letter I was looking at the totality, the volume and the breadth of issues. I wasn't honing in on number 6, which is Urology.

237 Q. The first Oversight Committee meeting which considered Mr. O'Brien came on 13 September. In August it appears that Mr. McAllister and Mr. Weir, recently appointed as Clinical Director, were having some discussions about how to address the issues with Mr. O'Brien. Were they drawn to your attention? 15:32 15:33

A. No.

238 Q. Do you consider that a proper managerial approach on the part of the medical side of the line, or should they be engaging with you, or perhaps Mrs. Corrigan?

A. No, I don't think there's anything fundamentally wrong with two clinicians having a discussion about a proposed plan. I don't see anything untoward about that. They probably chatted about it in theatres, but I don't know, I'm only guessing. 15:33

239 Q. But its fair to say throughout that period until Mr. Gibson contacted you, you took no steps? 15:34

A. That's correct.

240 Q. At all in relation to this issue. Mr. Gibson wrote to you on 23 August. If we just pull that email up,

TRU-251420. And he's asking, scrolling down, please, he is saying:

"I have been asked by the Medical Director to consider a range of issues in relation to Mr. O'Brien. As part of this, I would be grateful if each of you could come back to me if you have received any plans or proposals from Mr. O'Brien to address the issues outlined in the attached letter." 15:35

He is obviously attaching the letter of 23 March which you are already in receipt of. 15:35

"I am asking all four of you, due to the change in roles since that date...".

15:35

And at the end of the e-mail which is cut-off in the sequence. He is saying "This is a sensitive matter" and he would appreciate if the recipients of the email could deal with it confidentially.

15:35

You respond to it and say "no, I have received nothing from Mr. O'Brien". Was this initiative from Mr. Gibson and the Medical Director's Office, was this out of the blue? You didn't see it coming?

A. Correct. 15:36

241 Q. If this initiative hadn't happened, can you foresee any circumstances in which you would have taken any steps to address Mr. O'Brien's shortcomings.

A. Well, I would like to think I would when I had properly

settled in. I suppose not as an excuse, but as an explanation, the portfolio that I was carrying had doubled in size. I had quite a breadth of services that needed to be managed. And I suppose, just in the business of day-to-day activities, working in hospitals the greater pressure of the managers' and the clinicians' time is taken with emergency care and unscheduled care. 15:36

Well, largely we were speaking about Mr. O'Brien in an elective care and out-patient care setting. So I suppose the only explanation I can give is, just with being busy I never got round at that time to deal with it. I would have hoped I would before the subsequent actions happened. 15:37

242 Q. Is it fair to say that during this period that the shortcomings which were set out in the letter of 23 March, those issues weren't being drawn to your attention as being continuing issues?

A. No. They would have been continuing. Yes. 15:38

243 Q. So following the normal management reporting, Mrs. Corrigan would have been telling you, triaging remains an issue.

A. Yes. So we would have been having, I'm trying to think did Mrs. Corrigan escalate in terms of the four items. I don't recall that she did. But they would, I mean clearly up until the March to August, no action was taken on behalf of me to address that or Mr. O'Brien. So those four issues would have continued on. 15:38

244 Q. And you have no reason to think, as practice issues, no reason to think they had been cured or remedied?

A. Well, I think events superseded that. You know, in terms of Dr. Wright getting involved and escalating it, but in terms of -- 15:39

245 Q. I suppose the point I'm making to you, Mr. Carroll, is that a practice built on these alleged shortcomings hadn't cured itself, or at least you had no reason for thinking that it had cured itself, and yet there was no intervention on your part. 15:39

A. Yes. That's the position.

246 Q. Indeed. At the end of August 2016 a particular concern about a failure to triage was drawn to your attention after Mr. Haynes' intervention. It concerned Patient 93. I'm not sure if you have a cipher list in front of you. Just look at the email trail in relation to this and I ask for your reflection. TRU-274730. If we just scroll to the bottom of the page, please. Just stop there. 15:39

15:40

On 31st August, that is a week or so after you had responded to Mr. Gibson, Mark Haynes writes to Martina Corrigan in respect of this particular patient we're calling 93. No triage had been performed by Mr. O'Brien in respect of this patient. Had he been triaged, by Mr. Haynes' reckoning, there would have been an obvious upgrading to red flag, the patient having been referred as routine. He says that's on the basis of elevated PSA figures on repeat. He was seen 15:41

by Mr. Weir for leg pain and, at that time, having come back into the system a CT showed metastatic spread from the prostate primary. Referred back into Urology and seen by Mr. Haynes, a delay of 3.5 months. Mark Haynes is querying a serious adverse incident. That goes to Martina Corrigan. If we scroll up the page, please. He asks for a discussion with you. Can you recall having that discussion? 15:41

A. I don't. To be fair, I don't.

247 Q. Okay. On up the page, please. You write to Mr. McAllister copying him into those series of emails below. You make the point: 15:42

"Suffice to say that although the outcome for the patient would not be any different, this, as you know, is not the issue that needs to be dealt with." 15:42

You await his thoughts.

Why was Mr. McAllister the appropriate person to send this issue to? 15:43

A. Because he was the AMD. This was a clinical issue.

248 Q. I know that Mr. Haynes hasn't registered this one in the Incident Report Form, and perhaps he should have, and you're nodding your head, you think he probably have should have. He deals with it in this way, for whatever reason. You're saying to the Associate Medical Director: 15:43

"Suffice to say that although the outcome for the

patient would not be any different, that, as you know, is not the issue that needs to be dealt with."
Is that you pointing to the test for whether a case properly becomes a Serious Adverse Incident or comes into consideration for a Serious Incident Review. 15:44

A. I don't think, when I wrote to Dr. McAllister and I said what I said, I don't think I was, in my thinking, was thinking about a test. What I was thinking about was clearly this patient, Patient 93, had had a delay in their triage. To me, the issue was 15:44 the delay in triage. That's what I was thinking.

249 Q. Yes. Where did that sit with you then, there had been a delay in triage, you're pointing this out to Dr. McAllister as being the issue as you see it. The fact this patient may not have come to any extra harm, 15:44 albeit there has been a delay and he now has metastatic disease and maybe that would have been the outworking of his condition anyway. But the delay, what were you signalling there?

A. Well, I was signalling to Dr. McAllister that maybe it 15:45 was time that we; well, first of all, what did he want to do with it, really? How did he want to manage it? You'll see in the series of emails how it all unfolds.

250 Q. Yes. Let's scroll up. We can see that Mr. McAllister is saying "in the first instance this isn't for me", 15:45 that's what he's saying. He's saying put it somewhere else. Did you consider that an appropriate response or an understandable one?

A. Well I suppose Dr. McAllister not being a surgeon,

I suppose he just wanted to make sure that, to get another opinion on Mr. Haynes' view. So that's why he offered sending it to Mr. Young first. And then for the outcome of that to be sent to Mr. Weir as the CD and he would get involved thereafter. 15:46

251 Q. You don't have to be a surgeon, obviously, to know there has been a significant delay and a failure on the part of a consultant within his team to do his job, for whatever reason?

A. I wouldn't disagree with you. 15:46

252 Q. Why should it not be Mr. McAllister, who would you have singled out for receipt of this? You haven't sent it to Mr. Weir in the first instance. You haven't sent it to Mr. Young in the first instance. Why can't Mr. McAllister make the call on whether this is an 15:47 appropriate case for Serious Adverse Incident review?

A. I obviously can't answer for Dr. McAllister but I think he could have, he could have made that decision.

253 Q. In writing to him you thought he should have?

A. I thought the issue was quite clear in terms of what 15:47 the issue was.

254 Q. You said the issue was delay, but was it also in your mind a delay that merited consideration around the table using the conventional SAI screening process?

A. Yes. Yes. My view was Mr. Haynes should have put an 15:48 IR1 form in and that then would have brought about a series of actions which, ultimately, would have led to this case being discussed at a screening group, and they would have made a determination whether or not it

warranted an SAI. Similar to, as we now know, it's very similar to Patient 10.

255 Q. It is the same as Patient 10 and it is the same as the group of 5 SAIs that were to come into the system in 2017. 15:49

A. Right.

256 Q. His failure to do triage on a case that would have been red-flagged had triage been done leading to delay in diagnosis and treatment, in a nutshell?

A. I think that's a fair summary. 15:49

257 Q. If we scroll up the page, we can then see that this Ping-Pong ball gets batted from you to Martina. Then from Martina, scrolling up the page, to Michael, and then Michael takes the view, going up the page, scroll down again, please. Michael Young eventually expressed 15:49 a view, I'm not sure what the reference is. Go to TRU; I am just trying to find my note, Chair. Go to TRU-274729. That's it there. Right. Okay. So Martina is inviting Michael Young to speak with the clinical director, Colin Weir about the issue. Does 15:51 the issue ever come back to you?

A. No.

258 Q. Should it have come back to you?

A. No. I think it should have been filled in. An IR1 Form should have been filled in. I think that's what 15:51 should have happened.

259 Q. I realise that there's many hands on this?

A. Yes, I suppose are you asking me should I have gone back to close the loop?

260 Q. Well, did you ask anyone for an IR1 or did you not see that as your role?
A. No. I didn't. It would be within my role to ask for an IR1, but I didn't do it. I didn't close the loop.
261 Q. This is a clear example, isn't it, of underreporting of an incident that is properly to be regarded as an adverse incident and one worthy of further investigation. Would you agree? 15:52
A. Yes.
262 Q. The issue which was arising here at that time was running parallel in time with the processes leading to the Oversight Group meeting. Mr. Weir was to look at this issue or was to receive an email in relation to this issue on 16th September, a number of days after you were in a meeting with Mrs. Gishkori and Mr. McAllister to look at what is be done with Mr. O'Brien. To the best of your memory, is this an issue that was never discussed with Mrs. Gishkori? 15:52 15:53
A. Patient 93?
263 Q. Yes. 15:53
A. To the best of my knowledge, well I never discussed it with Mrs. Gishkori.
264 Q. If we could go to your statement at WIT-21121. You say at 12.61 you recall attending a meeting with Mrs. Gishkori where Dr. McAllister and yourself were present. Dr. McAllister and Mr. Weir wished to work locally with Mr. O'Brien to see could this style of working improve -- sorry, could this style improve Mr. O'Brien's administrative practices. There had been 15:54

an Oversight meeting on the 13th. We know that there was a meeting, Mrs. Gishkori says it was on the 14th, I think Mr. McAllister agrees and you were in attendance at that. She says that at that meeting there was discussion of the Oversight Group's plans and the decision reached the day before. Do you recall that meeting? 15:55

A. I recall being at the meeting, yes.

265 Q. If I could just draw your attention to the record of that meeting. It's TRU-00026. Were you ever in receipt of that record at the time? 15:55

A. No, not at the time.

266 Q. You can see that within the record there's a number of steps or actions that relate to you. So Simon Gibson is to draft a letter for Colin Weir and yourself to present to Mr. O'Brien at a meeting that would take place within the next week, and the letter should inform Mr. O'Brien of The Trust's intention to proceed with an informal investigation and it should set out a timescale for dealing with certain issues. 15:56

Mrs. Gishkori was to go through the letter with you and Mr. Weir and Mr. Gibson prior to the meeting. And Mr. O'Brien was to be advised that if there hadn't been any sufficient progress within 4 weeks, a formal investigation would ensue. 15:57

The meeting that took place the next day, as we understand it, were you told about these matters?

A. I'm sure they were discussed at the meeting. Probably

not in the same depth as you've just listed. But, yes, I'm sure Esther shared with us the meeting that was had and what the outcome was proposed to be.

267 Q. The meeting, doing your best to recall it, what was the thrust of the meeting from Mrs. Gishkori's perspective? 15:57

A. The meeting was, I checked my diary, it wasn't in my diary as a standing meeting so it was an impromptu meeting. I believe, I remember it being a short meeting. But the tenor of it was Esther saying what was discussed at the Oversight meeting the previous 15:58 day, and then Mr. McAllister saying, him saying, himself and Dr. Weir had a plan of how they believed they could manage Mr. O'Brien.

And I understand that, I could be wrong, but 15:58 I understand that Dr. McAllister and Mrs. Gishkori had met prior to the 13th. Esther, Mrs. Gishkori was, so it wasn't news to her that Dr. McAllister had a plan in his head.

268 Q. Was there a sense at that meeting that she didn't want 15:59 to pursue the action plan which the Oversight Committee had arrived at the day before?

A. I'm trying to remember, but I think Esther's concern was that this would now be a lengthy process. And she didn't know whether or not there would be a 15:59 positive or favourable outcome at the end and I think she didn't want to go down a formal route. She wanted an informal route to be pursued.

269 Q. As for your observations on this, she sent an email to

Mr. McAllister later on 14 September, TRU-257636. So she'd asked Mr. McAllister whether he had had any communication with the Medical Director's Office or anyone else. And he replies. Just scrolling down the page:

"Here's the only communication I received on the subject".

Then scrolling back up the page she says to Mr. McAllister:

"At least we have a starting point. I am clear that I wish you and Colin to take this forward and explore the options and potential solutions before anyone else gets involved. We owe this to a well-respected and competent colleague. I can confirm that you will have communication in relation to this before the end of week."

Obviously you weren't copied into this email, but does it reveal something of the thinking that might have been reflected at the meeting earlier that day that she wanted this out of the hands of others, to be managed locally?

A. Yes. I think the thing for me was that she didn't want it to be formal. She wanted it to be informal. And she is correct, we didn't discuss what the plan would look like, as far as I can recall. There was no

discussion of what Dr. McAllister or Mr. Weir's plan would resemble.

270 Q. There was an opportunity at that meeting for you, Mr. McAllister to say to Mrs. Gishkori: Let's just think carefully about this. Mr. O'Brien's management of triage or want of management of triage could be getting patients into difficulty. We've recently had site of Patient 93's case and this is perhaps an object lesson in what can happen if triage isn't done. That conversation didn't take place? 16:02

A. So that type of forensic discussion or triangulation of the information that we had, no, that was not discussed.

271 Q. And she is reflecting in glowing terms her view of Mr. O'Brien, well respected and competent. There's nothing on the other side of the scales it seems in terms of his shortcomings, at least in this short email. 16:03

Was there a sense at the meeting, the impromptu meeting, that a formal approach, if we could call it that, as suggested by Oversight, was unfair in any sense, or harsh in terms of Mr. O'Brien? 16:03

A. I think Dr. McAllister's thinking was that he's a newly appointed AMD, he wanted to be given the opportunity, along with the newly appointed CD, both very senior clinicians in their own right, to see could they manage another senior clinician. And to date everything, every attempt to manage Mr. O'Brien had not yielded 16:04

a positive result. So I think Dr. McAllister and Mr. Weir when they were discussing or hatching this plan, they must have thought, you know, we are clinicians, we are senior, well Mr. O'Brien will; we stand a better chance of him listening to us because we are equals. I think that was the thinking at the time and it was worth an attempt because to date nothing else had failed, sorry, nothing else had worked. 16:04

272 Q. Just a small point, do you have any recollection of Mr. Weir being at this meeting? 16:05

A. I have no recollection of Mr. Weir being present.

273 Q. Very well, thank you. We've heard something about the possible value in suggesting to Mr. O'Brien that he comes out of theatre and doesn't continue with theatre duties and that Mr. McAllister may have had that in his thinking. It is a little unclear on the evidence whether that is being thought of as a weapon, or a sanction, to cajole Mr. O'Brien into better action or whether it was regarded as some kind of assistance to him to allow him to get on with the outstanding work. Can you remember that being floated at the meeting? 16:05 16:05

A. Yes. Yes, I can. I can remember it being suggested as a way of working with Mr. O'Brien. So the only way that Mr. O'Brien, the only way that Mr. O'Brien in the short-term was going to get on top of the issues was he was going to have to stop doing something. As Dr. McAllister said in his evidence, surgeons like nothing else than being in an operating theatre. So 16:06

I think Dr. McAllister was of the mind, you know, if we stop him operating, then he is more likely to work with us. The options; because they wanted this to work in that the only other option after that was we would progress down the route on the decisions that had been made previously on the 13th, there would be a formal MHPS process.

274 Q. Were you a bystander at this meeting or were you in a position to form and express a view as to whether the Oversight option or Mr. McAllister's as yet unformed option, but certainly something less formal than what Oversight were proposing? 16:07

A. I don't recall expressing a view that -- opposing Dr. McAllister's view. Clearly I went along with it. I didn't express at that time disapproval. 16:07

275 Q. As you understood it, and I grant you on the basis of your evidence that what was being discussed at this point was, as yet, far from being fully formed as an idea or a plan, but was there enough there for you to be able to reflect, 'well, this what seemed to come from Mr. McAllister is, if you like, very much less formal than what is coming out of Oversight'. We've had, based on your experience in Cancer Services, we have had quite a lot of time spent on informal approaches and he hasn't even responded to the slightly elevated approach of the letter in March 2016. 16:08 16:08

A. Yes. I mean, in the cool light of day I can clearly see what you are saying. But, as I said, the triangulation of all the information together to come

up with the best decision, we didn't do that. At this meeting this was Mrs. Gishkori saying she wanted the process to be informal. Dr. McAllister saying, 'well, I've got a plan'. She then wrote to Dr. Wright the next day.

276 Q. We can see that the next day you are engaged in some email conversation with Simon Gibson. TRU-251443. Scroll down, please. You have obviously appreciated that there had been plans for a meeting to discuss this with the Medical Director's office and you're telling Simon Gibson, 'I received an email from Esther to say this meeting was cancelled'. Scrolling up the page, please. Simon Gibson then appears puzzled by that and asks; that is Esther Gishkori PA, is it?

A. Yes.

277 Q. Just scrolling up the page again. Yes, Esther has spoken to Dr. Wright and clearly matters take this different turn. You had discussed this cancellation of a meeting with Esther Gishkori?

A. No, I think what I said was I got an email from Esther. I got an email to say it was cancelled, so I didn't speak to her.

CHAIR: Mr. Wolfe, I'm conscious of the time, it is ten past four.

MR. WOLFE KC: I just want to finish this section. I think people need to be away, some people need to be away at 4.30 at the latest. I won't even go up to 4.30. If you just bear with me, I'll see where I can finish.

Could I have up on the screen, please, TRU-357640. 22 September you have been copied into an email from Mr. Weir. And we can bring up the email, if you like. He has written up a plan further to Mrs. Gishkori's direction and it is the black ink that is his. You've annotated the plan with some suggestions or solutions, as you put it, in the preamble to the email. Had you been invited to supervise the development of this plan by Mrs. Gishkori? 16:12

A. No.

278 Q. So your input here was triggered by what?

A. It was triggered by, when I read Mr. Weir's plan I thought it lacked, I mean, if this initiative was meant to be clinically led, I think it needed to be supported with some tangible data. So I thought that that was lacking. Also, in terms just of a manager of any help I could give them to assist them in bringing their plan together, I was happy to do so. So what I was trying to do was make the plan slightly more measurable, slightly more measurable, and also there would be tangible outcomes. 16:13

279 Q. And the word that you use in the preamble is "there needs to be a way of monitoring progress". Is that what you sought to inject into it? 16:14

A. Yes. Yes. I mean I think the plan, hopefully if you had to remove the red ink, the plan is quite bland and it lacks detail. It lacks measurables. It lacks any sort of time. I don't know how many, I can only see

four on the screen here, whatever number is on that list, I think it is eight.

280 Q. For example, at Item 2 you say "how are you going to monitor clearance of the triage backlog". Then you propose, with regard to the red flags, that you would ask the Cancer Team to monitor the triage turnaround. With regard to Outpatients you could ask Anita, that's Anita Carroll, to put a process in place to monitor. So that's the kind of practical suggestion you were making as regards the review backlog. I think, again, you ask questions about how is this going to be done? Is there going to be additional... 16:14 16:15

A. PAs.

281 Q. PAs. These kind of practical suggestions you were making. 16:15

A. Yes.

282 Q. It rather suggests that Mr. Weir hadn't fully thought that through?

A. Well, to me, it looked like he hadn't. Yes. It was obvious, to me when I read the plan, as I said, there were no measurables, there were no tangible outcomes, and it was hard to know what success would look like. 16:15

283 Q. In terms of the tone being set here and what you were hearing from Mrs. Gishkori, and perhaps Mr. McAllister and Mr. Weir, correct me if I'm wrong, but you have said in your witness statement, WIT-21121, the aim of this plan was to take a locally supportive approach to address Mr. O'Brien's, if you go down to 13.1. Go on down please. Was to take a locally supportive approach 16:16

to address Mr. O'Brien's administrative issues. But as you say:

"The plan was never enacted or discussed with Mr. O'Brien as he was going on sick leave soon after, therefore the plan was to be deferred until his return from sick leave."

Was that understanding of the deferral? How did you arrive at that understanding? 16:16 16:17

A. I think I read the Minutes of 10 October.

284 Q. The Oversight?

A. The Oversight Committee, yes.

285 Q. It would have been well-understood, would it, that Mr. O'Brien wasn't going on sick leave until the middle of November and you were adding to this plan on 21/22 September. So his sick leave was planned for just under 2 months, hence. Now, in a context where the system knows about these issues during most of this year, or is attempting to come up with ways of dealing with it through most of this year, did you reflect on whether it was appropriate to delay further, or was that an issue that wasn't in your hands to determine? 16:17 16:17

A. Well, I suppose my view is that this was Dr. O'Brien, Mr. Weir's plan. 16:18

286 Q. Mr. McAllister and Mr. Weir's plan?

A. Dr. McAllister and Mr. Weir's plan. This was their plan and they were going to lead on it. Whatever support I could give them, I was very happy to do so.

I was also conscious, I think I said it in the 22nd email, the clock was ticking towards December. So I was expecting Dr. McAllister or Mr. Weir to come back or there would be some sort of further communication of the plan. But I never received that.

287 Q. So just to finish for today. You're saying as a Senior Manager, you have a Clinician who you know is placing patients at risk if he's not doing triage. You've seen Patient 93's case come through the system. At this stage do you know that Patient 10's SAI is coming through the system?

A. No.

288 Q. You don't know at this stage. But nevertheless, you and those around you must have known that failure to grapple with this was placing patients at risk?

A. Again, not wanting to repeat myself, but that level of analysis was never done. I think it was always that this was Mr. O'Brien and his admin issues, and this was a plan that Dr. McAllister felt he could bring over the line.

289 Q. Just finally for today. Could I ask for your comments on something Mr. Weir has said to Dr. Chada. TRU-00782 at paragraph 10, please. He says, perhaps reflecting what you have just said:

"I don't think people knew the enormity of the problem...".

He adds:

"...or how far back it was going on. I know I was told at a point not to meet with Mr. O'Brien about this issue. I can't recall who said this to me, it may have been Ronan." 16:21

Do you recall speaking to him in the context, perhaps, of Mr. O'Brien going off on sick leave within a couple of months, saying, 'well the plan to speak to him is off for the time being'? 16:21

A. No, I don't recall that.

290 Q. Is it your position that it was the Clinicians who held the power here in terms of when to deal with this and you were, if not a bystander, simply there in a supporting role, if required? 16:21

A. So, yes, I viewed this as being a clinically-led supportive plan to deal with Mr. O'Brien. And anything I could do to support Dr. McAllister and Mr. Weir, I was happy to do so.

MR. WOLFE KC: Thank you for your evidence today. 16:22
I think the Inquiry will be in touch with your legal representatives.

CHAIR: We will, Mr. Carroll. But before we get to that, there's just one thing I wanted you to clarify if you can today, we'll probably ask many questions when 16:22
you come back the next time.

But when replying to Mr. Wolfe whether or not you sensed that Mrs. Gishkori didn't want to pursue the

action plan that had been agreed by the Oversight Committee, you said that you thought her concern was the length, that it would be a lengthy process and it would not necessarily have a favourable outcome.

16:22

I just wonder what you meant by the latter part of that, favourable outcome to whom?

A. Well, I suppose and, again, I'm just trying to think back to the meeting, I suppose Mrs. Gishkori wanted an outcome that allowed Mr. O'Brien to work with us and rather than being viewed as being some sort of sanction or some sort of punitive, that he would be happy to work alongside us.

16:23

CHAIR: Thank you for that. As Mr. Wolfe says, you will have to come back and speak to us again and we don't know quite when that might be, but we'll let you know as soon as we can.

16:23

A. Okay, thank you.

CHAIR: That's the end of our sittings for another couple of weeks. I think our next date is 21 March.

16:23

MR. WOLFE KC: I think it is. It is Dr. Chada that day, from recollection.

CHAIR: We'll see you all again at 10 o'clock on 21 March. Thank you very much everyone.

16:23

THE INQUIRY ADJOURNED TO THURSDAY, 21 MARCH 2023 AT 10:00