Urology Services Inquiry

Oral Hearing

Day 35 – Thursday, 30th 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, 30TH MARCH 2023, AT 8:00 A.M.

CHAIR: Good morning, everyone. Glad to see everyone's alarm clocks were working well. 08:01

Mr. Wolfe, good morning.

MR. WOLFE KC: Good morning, Chair. Your witness this morning and for the evening is Dr. Colin Fitzpatrick. I understand he wishes to take the oath, although, as I say, I'm not sure. He wishes to affirm. Thank, you, doctor. 08:01

COLIN FITZPATRICK, HAVING BEEN AFFIRMED, WAS QUESTIONED BY MR. WOLFE KC AS FOLLOWS: 08:02

1 Q. Thank you, Dr. Fitzpatrick. Thank you for joining us late into the evening for you, bright and early for us. We appreciate that you probably had a long working day prior to joining us, but given the state of Inquiry expenses, you've at least saved us the bus fare all the way to New Zealand. 08:02

A couple of introductions. You should have alongside you three documents, a designation list setting out patients and their anonymity code, which I doubt very much we'll need to refer to. Then you've two bundles. One is our core bundle. 08:02

A. Yes.

2 Q. The first document in that is the MHPS Framework, if I need to call that up, as I will, I'll refer to that as core. Then the other bundle which commences with the Inquiry's notice to you of 4th May, I'll refer to that simply as your bundle, your personal bundle. 08:03

Now, the first thing I need to do then is to refer you to your witness statements.

A. Yes.

3 Q. Our screen has gone a little bit fuzzy here to say the least. There, you're back with us, that's fine. 08:03

A. Sorry about that.

4 Q. The first document which I'll bring up is your bundle at page 45, and we have it as WIT-53474.

A. Got it. 08:04

5 Q. The last page of that document is page 49.

A. Correct, yes.

6 Q. That is a statement that you signed off anticipating that the Inquiry would need to hear from you, but you were leaving the services of NCAS at that point. It was signed off prior to the Inquiry serving a notice on NCAS; isn't that right? 08:04

A. That's correct. As you rightly say, we anticipated you'd probably want to hear from us so Gráinne and I prepared these in advance. 08:05

7 Q. Can I ask whether you wish to adopt that document as part of your evidence?

A. Absolutely. One very, very minor correction, which is at paragraph 12 where I refer to Simon Gibson as

Dr. Simon Gibson, I think that be should be Mr.

8 Q. I anticipated that, thank you. We can see at paragraph 13 you go on to refer to him as Mr. It's a small issue I'll raise with you in the course of your evidence in any event. 08:05

The next document is a supplementary statement which we find at page 65 for you.

A. Yes. Got it.

9 Q. WIT-53789 for us. 08:05

A. Yes.

10 Q. The last page of that we'll find at page 70 for you?

A. Yes, correct.

11 Q. We're experiencing another screen issue here, so let me... 08:06

A. Well, I can see you.

12 Q. It's just with our documents. Here we go, I think we're sorted now.

We have up here the first page of your supplementary statement. Could we go to the last page. Page 70 for you, doctor, WIT-53794 for us. 08:06

A. Correct.

13 Q. I'm told that all of the documents are not loaded and we need five minutes to resolve that. 08:06

CHAIR: Okay. Then we'll take a five-minute break. Sorry, Dr. Fitzpatrick. It's technical difficulties at our end but we'll get it sorted quickly.

A. No problem, I'll hang on here.

CHAIR: Thank you.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: Hopefully our technical issues are resolved. I should tell Dr. Fitzpatrick that this is not unusual. We've had a series of technical difficulties but hopefully it will be more straightforward from now on. 08:13

MR. WOLFE KC: Dr. Fitzpatrick, let's go back to page 65 at your end and we have WIT-53789. It will be typical for there to be a slight pause after I give out the references so that we get the document up on this screen at our end, just so that you're aware of that. 08:13

This is your supplementary witness statement. It is dated 6th July 2022. We find the last page at page 70. If we could have that up, please, at WIT-53794. Again, you recognise that document, Dr. Fitzpatrick, and you would wish to adopt that as part of your evidence; is that right? 08:14

A. Yes, that's correct.

14 Q. Thank you. Then finally you provide a response to a Section 21 notice. It's at page 105 your end.

A. Yes. 08:14

15 Q. It's WIT-62805. You'll recognise that. It's signed at page 109?

A. Yes.

16 Q. WIT-62809 at our end. 20th October 2022. Again, same

question, doctor, would you wish to adopt that as part of your evidence?

A. Yes. Yes, please.

17 Q. Okay. Then let's go to page 45 of your bundle, and we'll have up on the screen WIT-53474. 08:15

A. Yes.

18 Q. This is back to your witness statement. You are, by profession, a general medical practitioner, doctor?

A. That's correct, yes.

19 Q. You qualified, as we can see here, in 1992. You describe some additional professional activities outwith the normal role, I suppose, of a general practitioner. 08:15

A. Yes.

20 Q. You've had roles in medical management, first as a medical adviser with the Eastern Health and Social Services Board, as it then was? 08:16

A. Yes.

21 Q. Then in the South Eastern Health and Social Care Trust where you were a Clinical Director until early 2021? 08:16

A. Correct.

22 Q. I suppose you're here primarily to speak to us about your role as a senior adviser in NCAS. I know the name of the organisation has changed a couple of times over the years but I understand that for all relevant points in our timeline, NCAS is the appropriate term to use. 08:16

A. Yes. Yes.

23 Q. So, that's the nomenclature.

Your role as a part-time adviser, did you combine that then with general practitioner activities?

A. Yes. I've always done some part-time practice. Most of the time when I worked for NCAS, I was doing two days for them, I was doing one day in practice, and I was doing the remainder of the time working for South Eastern Trust. It was a sort of portfolio. It was a fairly flexible portfolio. I didn't rigorously stick to days. The only fixed days I had in the calendar were my booked surgeries. 08:17

24 Q. You have now left NCAS, or PPA as it is now known, and you are currently working as a general practitioner in New Zealand; is that correct?

A. That's absolutely right, yes.

25 Q. You left NCAS in January 2022; is that right? 08:17

A. Yes. End of January, yeah. That would be right.

26 Q. Okay.

Your evidence this morning, I suppose, is going to be split into two broad parts -- or the issues that we want to look at with you are split into two broad parts. Firstly, the role of NCAS -- 08:18

A. Yes.

27 Q. -- and the services it provides.

A. Yes. 08:18

28 Q. With a particular focus in a short period of time in terms of where those services lie within the MHPS Framework?

A. Yes.

29 Q. Secondly then, the role that you provided or the services that you provided and your organisation provided in the context of the Southern Trust's work with Mr. O'Brien.

A. Right. 08:18

30 Q. That broadly is the framework this morning.

A. Okay.

31 Q. NCAS Northern Ireland, it has a base and an office in Belfast; is that right?

A. Not any more. We did have but that was got rid of a few years back. We did have a base in -- actually first in Belfast, then in Lisburn. 08:19

32 Q. And we know about Dr. Lynn, who we'll hear from later today?

A. Yes. 08:19

33 Q. Were you essentially the advisers dealing with Northern Ireland Trust issues?

A. Yes, absolutely. The two of us, broadly speaking, at the time when we were both working for NCAS, dealt with just about all of the Northern Ireland issues, with a very, very small number of exceptions where there was conflicts of interest or something like that. Gráinne was full-time working for the organisation, so she had a fair number of Trusts in England that she also was responsible for. I largely dealt with Northern Ireland with a small caseload in England, usually cases that I had particular skills with or whatever. 08:19 08:20

34 Q. Help us with this. How do you, a medically qualified person, adapt yourself or train yourself to come into

a senior adviser role which, as we will see this morning, carries with it a number of components, and it probably - I don't know if you would agree with this - brings you into a quasi-legal field, employment issues, human resources issues; all, of course, focused on the medical arena?

A. Yes.

35 Q. Was there training or additional qualifications required as you came into this role over and above your medical qualifications? 08:20 08:21

A. Well, yes. Yes, yes. Basically, in order to be selected, you didn't just need to be a doctor. In fact, many of our advisers were not doctors and had other backgrounds - HR, legal, etcetera.

08:21

Maybe if I take you back to the original concept of the NCAA as it was originally, and that might help to explain things. When NCAA was set up by Alastair Scott, way back in 2001 I think it was. His idea was he would get a calendar of senior medical managers and people with experience of managing doctors who had a lot of experience and who understood the nuances of dealing with doctors as opposed to dealing with other members of staff. And that we would have high-level discussions, usually with medical directors and chief executives, about how to manage difficult situations. 08:21 08:22

NCAS, in its various names, always had workshops for all the advisers from across the UK, usually three or

four times a year, talking about and addressing the sorts of issues, you know, what the policies are, what the protocols are, how do I apply MHPS, and some other general training about performance and under performance, etcetera. So, there was a fair bit of training. 08:22

Gráinne - you'll speak to Gráinne later - she went above and beyond that and did a degree in employment law. I did various other programmes. Over the years I've also had a fair degree of management training because I suppose I went into the management business fairly early in my career, three or four years anyway in the Eastern Health Board, and there's a fair bit of training involved there as well. So I was coming in to NCAS with a fair bit of experience managing doctors -- 08:23 08:23

36 Q. Could I stop you? Sorry to cut across you, Dr. Fitzpatrick. I'm trying to check in this room and with the stenographer. I get the impression you're speaking a little fast, but I also get the impression that there's a problem with the quality of the line. I'm not sure whether we're going to be able to address that. I first want to check with the stenographer that we're getting a reasonable note. 08:23

Chair, it's a matter for you. I'm struggling a little bit.

CHAIR: Yes, there is... I think we have the connection issue fixed. Let's continue. If we encounter further

difficulties, we'll stop.

A. I will try to speak slower. If I get too fast again, please just slow me down.

37 Q. MR. WOLFE KC: Thank you for you that. You were helping us understand the background of NCAS, as it became known, and how you and Dr. Lynn equipped yourselves with the necessary skills, I suppose, to do your job. 08:24

A. Yes. So, as I say, we would have had regular training programmes internal within the organisation. We would also have had access to various external training. I mentioned Gráinne's degree in employment law. I, for example, did several training programmes in mediation which is, obviously, extremely useful in this business. I had previously done a course in leadership in Harvard. So, we had a fair range of experience and training. I can safely say that any training need that I identified to, my managers in NCAS, they were quite happy to look at what we needed to fill that gap. 08:24 08:25

38 Q. Yes. We're going to go now and look at the kinds of services your organisation through yourself and Dr. Lynn, and presumably others where specific expertise is required, was able to deliver to, I suppose, the Trusts in Northern Ireland. 08:25

A. Yes. 08:25

39 Q. Just before we look at that, do you think that the services offered by your organisation are well-known and sufficiently well-publicised amongst those who might need them in Northern Ireland, which is primarily

the Health and Social Care Trusts?

A. Well there are five -- well, six Trusts in Northern Ireland. Certainly with the exception of the Ambulance Trusts, which only employs, I think, one or two doctors we would have -- I would personally have touched base with each Trust one or two times a year through their Medical Director or other senior people in HR who were all, I think, very aware of us. I'm not absolutely convinced that everybody at a lower level in the organisation, such as even clinical directors and below, would have been aware of us to the same degree. Certainly at the higher levels there was a very clear awareness, and I would have been on first name terms with all of the medical directors and most of the senior HR people who were dedicated to work being with medics and dentists. 08:26 08:26 08:27

I think yes, we were well-enough known certainly at a high level. I'm not completely convinced that everybody who got involved in a performance procedure with a doctor would have known as much about us as we would have liked. We certainly did do a fair bit of awareness raising, and we did our best to promote our services. 08:27

40 Q. Yes. We can see and we will see as we just move through this this morning that you specifically have been involved in the provision of training to medical managers. We'll look at that in due course. 08:27

Now, you say in your statement - this is at page 46 for your purposes. WIT-53475 - that the advice service, as you call it, this is paragraph 7:

"Provides a range of core services to NHS organisations and other bodies in England and Wales and Northern Ireland such as advice, assessment and intervention, training courses and other expert services". 08:28

Now, you refer us to a service level agreement that's signed off between our local Department of Health and the NHS Litigation Authority in 2017. Let's just bring that up, please. It's page 71 at your end and for us WIT-53795. The Inquiry obviously has this document to read and digest so I don't need to go through it in granular detail this morning. It's signed off, as we can see, at page 78 your end, 53802 for us, on 10th October and 17th October '17. What was in place before that? Was it more of an ad hoc arrangement? 08:28

A. No, no, no, no. This was a three-yearly -- I think there had been SLA since we started in 2004 or thereabouts. It was a three-yearly SLA so this was the version applicable at that time. Broadly speaking, there wasn't much difference. I mean the previous ones would have been broadly similar with subtle changes, such as every time we changed our name, we had to change the SLA. 08:29

41 Q. If we just glance at the first page proper of this. This is a legal agreement between the two 08:29

organisations. Page 72 your end, 53796 for us.

A. Yes.

42 Q. We can see that the Department and NHS Litigation Authority wish to enter into an agreement under Section 28 of the Northern Ireland Act whereby NCAS will provide support to the Department and its arms-length bodies. Those bodies include, of course, the Southern Trust, which we're primarily interested in. 08:30

A. Yes. 08:30

43 Q. It sets out, at paragraph 3 at the bottom of that page, the functions of NCAS. Notably, over the page, at page 73 your end --

A. Yes. Yes.

44 Q. -- an advisory service; an assessment in intervention service; a service which are provides support to local efforts to improve good practice which provides support in relation to the resolution of difficulties and concerns, etcetera, and a provision of support for reporting at a local level. I suppose that's more fully set out across Schedule 2 of the document which we see at your end, page 81. For us WIT-53805. 08:31 08:31

I just want to pick up on three aspects of the service that was provided. We can see at the bottom then of page 81, the reference to a case management service. In that respect, the requirement is to provide expert support to local resolution of concerns about the performance of a practitioner. That's particularly 08:31

germane to the work that was done with the Southern Trust; isn't that right?

A. Yes.

45 Q. It's elaborated upon over the page where it says:

08:32

"The NCAS adviser" - in other words yourself or Dr. Lynn - "will provide expert advice and support and will be responsible for directing the management of NCAS's input to the case".

A. Yes. 08:33

46 Q.

"The level of support will depend on the nature of the case. The progress of all active NCAS cases are reviewed at monthly meetings between the adviser and a senior colleague. NCAS lead and senior advisers 08:33 provide senior support in quality assurance for the work undertaken by the adviser".

A. Yes.

47 Q. I suppose that that advice work takes place in circumstances where the MHPS Framework is relevant and 08:33 deployed, but it can be broader than that, can it?

A. That's right. I mean, we advertise ourselves as providing advice whenever anybody had a difficulty with a practitioner. So sometimes that was minor and trivial, sometimes it was much more serious and 08:34 required much more input. MHPS was often involved because we referred to them on several points of MHPS, but not always. It didn't have to go through the MHPS Framework. Some of the stuff wasn't relevant to MHPS.

48 Q. I suppose the primary method by which this expert advice and support role is provided is simply through telephone calls, and perhaps frequent telephone calls, depending on the case, every case being different, followed up generally, as we have seen in the O'Brien case, usually very quickly with a summary of the telephone call and the advice that you think is relevant and pertinent? 08:34

A. That's pretty much it. We would have a fairly, hopefully a reasonably in-depth, discussion on the telephone and then the salient points would be summarised in the letter. Yes. 08:35

49 Q. We can see a description of the work on this page. I'm just trying to see if I can see the words. Yes, at the very bottom of the page. It's described as providing a constructive challenge to the local management of concerns and support. Would you unpack that for us? Is it a case of -- 08:35

A. Absolutely. Very frequently people will have phoned us with a preconceived notion as to how they're going to do it, how they're going to solve this problem. We would frequently say is that the only way of doing it? Is there a better way to do this? Sometimes we'll come back to the conclusion that what they thought in the first place was the right way, but often we would change. 08:36

A really good example is when somebody has phoned us and they have decided they are going to exclude this

doctor or suspend them, you know. We would be saying is there another way we could do this; could we restrict his practice to ensure Patient Safety? Could we supervise a bit more closely and come up with other ideas. Because the whole point of the NCAS advice service was not that we have superb training and we're -- it's just that we're very experienced. Well, when I was working in the job, I was dealing with underperforming doctors several times a week, and the full-time advisers much more frequently than that. The average medical manager or manage in a Trust encounters these issues once or twice a year if they are unlucky. So, we had a lot of experience. 08:36 08:37

Not only that, we also then, if it got too -- if you like, too tricky for the adviser on the telephone, we then had the resource of another 20-odd advisers. So, very frequently there would an email going around saying here is a problem I've come across, anybody have any ideas? That usually dragged up a couple of good ideas. 08:37 08:37

50 Q. I skipped past a little hurriedly the reference to the internal monthly reviews of cases, if they're live. Is that a feature of the work in relation to Mr. O'Brien's case? So, for example, you were brought into the mix in September 2016. We'll look at that in some fine detail later. It was one phone call followed up by a letter, and then nothing more until Dr. Lynn was engaged in December '16? 08:37

A. Yes. That was still technically an open case. Probably a few weeks after the discussion that I had with Simon Gibson, I'll have had a chat, probably - now I can't swear because I don't remember it and we didn't keep detailed notes of these meetings - but I think I probably spoke to Karen Wadham, who's my line manager, we'd run through the case, I'd say there's this one about a urologist in the Southern Trust, here's what I've got, here's what I suggested, and she probably would have said, well, that sounds reasonable. That's the sort of level of review it was. Then when we got into more tricky ones, we'll have had more of a discussion about them, you know, if we were hitting problems. 08:38 08:38

I know certainly I had various conversations with Gráinne - I won't pretend it was monthly - when she was running the case. We had a chat about it every now and then. 08:39

51 Q. So it's really a health check on the state of the case? 08:39

A. Pretty much. Pretty much.

52 Q. Where are we at with that? Do we need to go back? Those kinds of questions?

A. Yes, exactly. The letters would, generally speaking, have been quality assured as well before they went out. Somebody else would have cast their eye over a letter before it went out to make sure it made sense, it was written in English and the advice was sensible. 08:39

53 Q. You say in your witness statement - I needn't bring it

up on the screen, it is page 46 your end if you want to look at it, paragraph 8 - you refer to the fact that your advice service doesn't rest upon a statutory power.

A. Yes. 08:39

54 Q. You're unable to require people to follow advice or cooperate with assessment functions?

A. So the only -- sorry, I interrupted you there.

55 Q. I was going to ask, the voluntary basis of the encounters, the reality is that's the only way to do 08:40 it, do you think?

A. There's only one place, if you like, in the guidance where we have, if you like, a statutory function, and that is when somebody is considering a formal exclusion under MHPS, they are required to contact us. Other 08:40 than that, it is all a bit voluntary. When that works, it works very well. But you're absolutely right, there's nothing to stop a Trust completely ignoring us and just carrying on doing what they want to do.

56 Q. I'm not suggesting you were ignored but there's 08:40 a series of emails that Dr. Lynn wrote to the Southern Trust after her engagement in December '16. The evidence before the Inquiry isn't entirely straightforward in relation to that but I think from her perspective, and perhaps your understanding as 08:41 well, those emails were not the subject of reply from The Trust, and there may not, from NCAS's perspective, have been any contact from The Trust in response to those.

A. That would be my understanding.

57 Q. Yes.

A. If you like, that is the downside of the voluntary nature of the thing, that we can't make them answer us. But on the other hand then, if we had statutory footing, that brings with it other issues and responsibilities as well. 08:41

58 Q. Just your reflections around that, if I can press you. If there was a requirement, statutory or with stronger guidance to oblige the Trust to follow-up, to address correspondence from NCAS, across your broad experience of dealing with cases like this, would this make for better outcomes, perhaps? 08:42

A. I think it probably would, to be honest with you. I suppose when you don't get a reply, you're forced into one of two conclusions. Either they are sorting it out and they really don't need our advice and they are carrying on; or they are not sorting it out and nothing much is happening. Really good -- apart from anything else we would know, well, if it's all sorted, we can close the file. If it's not sorted, then maybe we need to be a bit more bullish about providing advice. 08:42 08:42

59 Q. Have you finished? I didn't mean to cut across you.

A. Apologies. I'm finished. Apologies. No, I cut across you. 08:43

60 Q. You also make the point, paragraph 9, that you're dependent on the NHS bodies who you are dealing with providing the relevant information about the case?

A. Yes.

61 Q. Again, I suppose in one of these telephone calls you're entirely dependent upon getting a clear history, a reliable history, so that you can tailor accurate and appropriate advice. Again, any reflections upon that dependency and whether it could be improved in any way? We're going to look at the specific points you raise in relation to your engagement with Mr. Gibson in 2016. More generally, is there room for improvement around that or what can be done to secure improvement? 08:43 08:44

A. The straight answer is, yes, there have been a number of occasions over the years where I have been given an account of an event by whoever phones me and at a later stage -- often the practitioner, when they get -- what happens is they then put in a subject access request and they come back to us and say that's not what happened, or there may be other sources of information which come up with a different story. Bearing in mind that our advice depends entirely on the story that we are told, it would be quite possible to craft a story to get a particular piece of advice. So yes, that is a flaw. 08:44 08:44

On the other hand, if we were then obliged to gather evidence from both the practitioner and the Trust, for example, we're then left in the situation where we've effectively got to run an investigation to find out what happened, and that's not something we would have been resourced to do. So, you know, it cuts both ways. 08:45

We are absolutely dependent on an honest and balanced account.

Now, often when people phone me, I'll be able to ask a question to -- I'll be able to probe a bit more, as I did to a degree with Simon Gibson and find out a little bit more about what's going on because I know the sorts of questions to ask because I have done this before. So you can do a bit of probing, but again at the end of the day, you are still completely reliant on what they tell you. 08:45 08:45

62 Q. I think it's the case that when Mr. O'Brien spoke to you in July 2020, he made the point that the advice that you provided in 2016 - indeed, I suppose going back even further than that - the fact of your engagement with the Trust and the Trust's engagement with you, let alone the advice that was provided, was never shared with him. He was completely in the dark about your involvement. He made the suggestion to you -- it's at page 61 for you, WIT-53490 for us. 08:46 08:46

A. Yes.

63 Q. At the bottom of the page, please. You write: "You and your wife met [made] a helpful suggestion that our organisation should have an early discussion with practitioners who have been referred to us. Whilst there are some practical difficulties with this, I can see that it has benefits. In particular in your case, I suggested that had I spoken to you early in the process, I would probably have advised you to contact 08:47

the MPS early".

That is if I had spoken to you early in the process, you would probably have advised this?

A. Yes. 08:47

64 Q. Would you accept this as a broadly correct proposition - you'll take a view from management, whether that's the Medical Director phoning you or, as in this case Mr. Gibson, and they will provide a diagnosis or account of the problem which could be analysed in 08:48 a wholly different way by the clinician concerned?

A. Yes, yes. They're going to give a completely different -- in almost every case they are going to give a different story to the clinician concerned. There were a few things when I spoke to Mr. O'Brien in 08:48 2020, I was a little bit surprised and shocked at. I mean, for example, the fact that he had never heard of my discussion with Simon Gibson was shocking to me. That was something over the years we realised was happening, these letters and the fact of our 08:48 involvement was not being shared with practitioners. If you look at Gráinne's final letter in this chain of letters, you'll have noticed that I think she does say we advise that this letter be shared with the practitioner, or words to that effect. Because 08:48 we started to add that as a standard phrase in our letters to try to make sure that the practitioners knew what was going on.

65 Q. Yes. I can see that it isn't in your 2016 letter, but

that was a development or a learning --

A. That was a learning point. We pretty much -- well, I started doing it fairly early. I think by the time I left, everybody was doing it.

66 Q. Yes. 08:49

A. Yes.

67 Q. Getting back to, I suppose, the thrust of my point, just reflections on this again, if you could. You're speaking to management, you're dependent upon them giving you a reliable history and I suppose an accurate 08:49 diagnosis of the problem, but you're not speaking to the clinician at that point, and sometimes -- and perhaps rarely are you speaking to the clinician. Does it really then depend upon the intelligence and sometimes the good faith of the Trust organisation in 08:50 terms of taking your advice and ensuring that in their dealings with the clinician, a proper and accurate understanding is achieved of the issue and that, really, NCAS can do very little about that?

A. Yes. I mean, you have to take somebody's word for what 08:50 had happened. I suppose we have traditionally always taken the word of the management person who has contacted us. On the occasions where we also get involved and speak to the practitioner, we often -- sometimes we get the same story; that has happened, 08:50 believe it or not. But often we get subtly different story and you sort of have to make a judgment call in terms of your advice as to what way you couch that advice, given those two differing accounts.

68 Q. Just to maybe go close to dealing with the particular facts of the Mr. O'Brien scenario --

A. Yes, go ahead.

69 Q. -- but in broad terms, a Trust is saying to you, he is just not doing the work that's expected of him, triage, validation of reviews, he's bringing notes home, he's failing to dictate. 08:51

A. Yep.

70 Q. From his perspective it's "I'm running to standstill in theatre. I'm not being given the support I need". Do you see how that becomes slightly black and white? 08:51

A. Well, it does and it doesn't. Actually that's a really good example, because if you look at my letter of September 16th, I suggest that Mr. O'Brien requires fairly significant support. Because I got an impression, just even from what Simon told me -- Simon may not have spotted this himself but I got the impression this was a man who was struggling. You know, the sort of behaviours that were being described, somebody with a huge backlog. How he got the backlog was irrelevant, the fact is he has a backlog and he has to clear that and that's a huge piece of work. Simon mightn't have quite comprehended what that involved. 08:52 08:52

So actually, I think if I had spoken to Aidan O'Brien at that time, I mightn't have changed my advice. I'd have probably -- I might have been a bit stronger on the "he needs more support" line of things. 08:52

71 Q. I think, if I can interpret that and complement you to

some extent, that was your sixth sense and experience as an adviser saying "I wonder if there's some systems issue or support issue here in that he's not doing the work but it may not be just as simple as that". Is that fair? 08:53

A. Exactly. I mean I've dealt with hundreds, at least, of doctors in difficulty. Most of them are well-meaning, they have the best interests of their patients at heart but they are struggling for whatever reason. I have met a small number of people where that's not true, but 08:53 that's a small number. Generally if somebody is struggling in that way it's not because they are a bad person, for lack of a better term, it is because they are struggling, so they need support. Most of us go into medicine to help people, not to harm them. 08:53

72 Q. Mr. O'Brien suggestion, which you comment upon here at the bottom of your page 61, you think it's a helpful suggestion but you could foresee practical difficulties around that. Is that something that might be worth thinking about from the Inquiry's perspective - they 08:54 have to make recommendations - what are the practical difficulties? Is it simply resources in terms of getting involved with the clinicians at the point or shortly after the point when the Trust contacts you?

A. I think so long as it is reasonable -- so long as 08:54 there's a clear understanding, for want of a better term, whose side you're on; that you're there to provide advice to try to progress the case and you're not there to adjudicate between a practitioner's

version of events and the Trust's version of events. There's no way we have resources to do that. Certainly looking at the practitioner's viewpoint is not an unreasonable suggestion. I think that's probably a good idea. You'd need to apply a bit of thought as to how it was done.

73 Q. Yes. I think you are accepting that you don't have a fact-checking mechanism?

A. No, we don't. We never pretended we did.

08:55

74 Q. Yes. It might be interesting to put to you some of the perspectives that we've received already in terms of how NCAS is perceived by the organisation you are trying to assist. Mrs. Toal has given evidence; she's the Human Resource Director. I think she has a fuller title than that but she's the Head of Human Resources now in the organisation, having taken up that role in September 2016, coincident in time with when your advice was first sought. She reflects that the NCAS advice service is a useful sounding board. She said probably back then, that's 2016/'17, maybe we weren't as an organisation availing of their advice as much as we should have. Does that resonate with you?

08:55

08:56

A. Yes, they weren't -- the Southern Trust weren't --

75 Q. Is it more or less than what you would like to think you were regarded as?

08:56

A. No. Sounding board, I think, is reasonable. That's very much as I say, we would bounce ideas around with whoever phones us. To a degree, one of the problems that happened over the years was when our organisation

was first set up, I largely spoke to medical directors, chief executives, people who were very senior in the organisation, as organisations got bigger and things changed, we wound up being phoned by less senior people. Now, Simon Gibson is a very sound man but he's not very, very -- he's not senior enough to take decisions off his own bat. It is much easier to bounce these things around when you are talking to someone who can take a decision at a high level. I suppose that was one thing that was a bit of a problem. If you talk to somebody that's senior enough to actually decide, well, that's what we're going to do, it was much easier to bounce ideas around. But the sounding board thing, yes, I can accept that. That's fine. 08:57 08:57

76 Q. Would you like to see a return to that time when it was the senior decision-maker who made the call -- 08:57

A. Yes.

77 Q. -- for the good reasons you explain?

A. In a word, yes. I don't want to sound like an old fogey, talking about the old days. But yes, you got further in those days; you could take a decision. Because otherwise you are having a discussion with somebody who is going to go off, talk to a committee or somebody senior. That's an extra stage in the process which makes it more difficult. It is much easier to talk to someone who is actually senior enough to take a decision and also understands the clinical background. So, that's the advantage of talking to a clinician, they actually understand the clinical 08:58 08:58

background. If I was to have been speaking to the Medical Director, well, he's probably had backlogs in the past so he knows what it's like, if you see what I mean. So yes, that, I think, was better. I think the move where we've had less senior people phoning us has not been a good thing.

78 Q. Indeed when you think about it, a senior clinician and perhaps a senior person from the HR side who has an experience of what's doable in terms of process?

A. Absolutely. I would totally agree. Senior HR professionals are excellent; they are generally speaking excellent. As you say, the senior ones who have dealt with doctors over the years understand what it's like, and they know the nuances of managing senior clinicians.

79 Q. Dr. Wright offered a reflection. He was the Medical Director at the relevant time in 2016 and he directed Mr. Gibson to you and then Mr. Gibson was reporting back to Dr. Wright and others. He told us that his experience of NCAS would be that:

"They often want us to conclude" - I think conclude on a formal MHPS process is the context - "to go through the MHPS process. And they would want to be informed at the end of the process what the recollections were. They would often be prepared to then help with possible solutions to an issue, if that was appropriate".

I think that takes a little bit of interpretation.

I think the point he was driving at was from an NCAS perspective, yes, there would be some initial advice but his sense of it was that you would want the Trust to get on with it and then come back in at the end.

A. No. I think that's a misunderstanding. That certainly would not have been my impression, and I suspect Gráinne would say something similar. Because we would like to be there whenever they hit difficulties. You've seen this MHPS process here. You know, difficulties will emerge and we want to be there to help them through whatever difficulties there are. We'd much rather get an update every month on a case than, you know, them go away and do a MHPS process and come back to us a year later. We'd much rather know what's going on; we feel much more comfortable that way. Even if they're struggling, I'd rather know about it. 09:00 09:01 09:01

80 Q. Do you think that's reflected in the level of attempted activity on the part of Dr. Lynn in the early months of 2017? She heard in December '16 and provided advice around whether there was a need for exclusion and whether there should be a formal investigation. Then, as we'll see later, a number of attempts on her part to come back in to the process and, for whatever reason, appears to have been thwarted around that. 09:01 09:02

Does that, in part, explain your view that your advisory service wanted to be active at the start of the process and not just at the end?

A. Yes. Gráinne's activity -- Gráinne is very efficient. She obviously diarised that and chased them every month or so. That was sort of what we expected to do, was to chase them and see what -- just keep up to date what was going on so we have something on the file. So if somebody asks me what's going on with the Mr. O'Brien case, I could answer that question. Because we liked to know what was happening with all of our things. 09:02

I don't know, have I just disappeared off your picture? 09:02

81 Q. You have, indeed, yes.

A. If I reset my camera, that will help. There we are.

82 Q. Okay. That's all I want to ask you in relation to the advisory service at that theoretical as well as practical level. 09:03

If we go back to the Service Level Agreement, your page 83, our WIT-53807. This run-through this morning doesn't pretend to be an exhaustive examination of all the services provided by NCAS. Another service as well as advisory is a performance assessment. Now, we saw at the end of this MHPS investigation a determination reached on the part of Dr. Khan, who was the Case Manager, that there being no clinical concerns in association with Mr. O'Brien's practice as revealed by the investigation, it was unnecessary to have an NCAS performance assessment. That's just part of the specific context here. 09:03 09:04

Help us, if you can. The document says:

"In a small proportion of cases NCAS will advise the use of a performance ascertainment".

09:04

Is that specifically in the context of cases where there are clinical concerns?

A. Largely speaking, it was -- the performance assessment, I suppose, assessed people's performance as a doctor. So, yes, you're absolutely right. It would largely have been where there were capability concerns about somebody's ability to practise. It wasn't really designed to look at conduct issues. I mean, I'm happy to talk to you a little bit about performance assessments if you want me to. 09:05

83 Q. Yes. If you can, just help us with that.

A. Okay.

84 Q. Where does that typically come in? Can it come in without an MHPS investigation?

A. Oh, yes. Yes, absolutely. 09:05

I mean, we would have -- right. The performance assessment, the original performance assessment as it was away back in the early 2000s, was a very big affair where we assessed everybody's -- we would do 09:05 a psychological assessment; we would do an occupational health assessment; we would observe their practice; we would do a case note review; we would do a patient and colleague feedback; we would speak to their patients.

The actual visit took several days, and the report would take some weeks to write and would be quite a thick report with some fairly significant proposals.

Over the years we discovered that certain elements of 09:06
that were more valuable than others, so we actually started to offer what is described here as modular assessments where you simply take single modules of that and provide that alone, because if we'd looked at the issue and we say actually if we do an occupational 09:06
health assessment alone or a psychological ascertainment alone, that will probably answer the question. The whole idea was the performance assessment is a diagnostic process; we are trying to make a diagnosis about what's going on with this 09:06
doctor's practice, so we would pick the tool we thought would give us the right diagnosis. Yes, typically it was doctors who appeared to not be performing as well as they could.

09:07

I'll give you an example of a radiologist whose error rate had crept away above his colleagues and had been involved in some significant high-profile missed diagnoses. We then did a full assessment on him and we were able to identify what it was about his practice 09:07
that was causing this difficulty, and able to make some recommendations and, as far as I know, that radiologist is still in practice and is having no difficulties.

85 Q. I suppose more specifically - I just want to see where

this sits in the services outlined here - we know that, obviously as distinct from a performance assessment, very much distinct from a performance assessment, you offered the potential for an intervention in September 2016 in the context of a notes review? 09:08

A. Yes.

86 Q. It was being suggested to you that there was a problem with Mr. O'Brien's record-keeping; I put it in those general terms. There's some difficulty, perhaps, around how that was expressed to you, and we'll look at 09:08 that. But that kind of service, that kind of bespoke service, where does that sit? Does that just suggest to you --

A. Well, I mentioned the modular assessments. That's one of the modules, basically. That would have been part 09:08 of what would have been in the big performance assessment, and we just say, well, we'll just do that bit because that's the issue that's being addressed here. We would have put in -- obviously there would have been a certain amount of bespokeness to it, we 09:08 would have tailored it to the situation. But, largely speaking, we'd have got an assessor who would have reviewed the notes according to a standard template and given us a report as to their quality.

87 Q. That suggests as an organisation it's perhaps an 09:09 infinitely flexible approach. You can manage --

A. Yeah, we were pretty flexible. I mean, I remember, for example, doing an assessment on a doctor who worked in the GP Out-of-Hours Service, a very, very different

scenario where all the work is done by telephone. So, we had to design a bespoke assessment for that doctor.

88 Q. Another feature of your services as set out at the bottom of your page 83 is professional support and remediation services? 09:09

A. Yes.

89 Q. That's where action plans may be developed following a review in a case?

A. Yes.

90 Q. We know that that was a service offered by Dr. Lynn after the MHPS investigation had reached its determination stage. Again, is that a service that's regularly deployed by your organisation? 09:09

A. Yes. It was one of our more frequently used services. We had a team who had got good at developing these action plans and they had a range of tools at their disposal, if you like; things we could put into our action plans. Our action plans were very different from the action plan Southern Trust developed for Mr. O'Brien. Their action plan was just a list of things he was to do, more or less, for want of a better term. Our action plans would have included support, training, retraining. Often somebody, for example, who had been out of practice for an extended period of time, we would have a structured process of getting them back into practice. They'd start off with dong observing practice and then start doing a little bit under supervision, and the level of supervision would be reduced as the time went on. So, a very structured 09:10 09:10

approach; very supportive. The whole idea -- and milestones that each doctor would have to pass before they moved on to the next stage of the process, with a clear understanding if you fail your milestones, we went back to the last stage and redid that last stage because, you know, you obviously hadn't progressed through it.

But the idea was that it was a very supportive process and intended not to set unachievable goals but usually to steer people back into practice. It usually required quite a fair bit of resource from the employer but, on the other hand, these are expensive members of staff, they're very hard to replace, it is worthwhile investing in them. 09:11

91 Q. We'll maybe have a moment later just to look at the Trust's action plan that you refer to. Perhaps in more general terms is what you are describing -- say, for example, a clinician was found to have a shortcoming in a particular area, whether that was clinical or whether it was an administrative type task or skill associated with the clinical, does NCAS have the wherewithal to provide, I suppose, a retraining element or an upskilling element, or would it simply work with the Trust to focus on that and -- 09:12

A. We would have developed the action plan and worked with The Trust and the practitioner - generally speaking, the practitioners are very involved - to develop what we suggested was the way to deal with it. We didn't

deliver the content of the actual plan, that he was down to the Trust. We would often help, say we know somebody -- for example, one of the big things was coaching and we had a list of people who would help us with that. So, we would do things like that, do what we could to assist. But we didn't take the responsibility for delivering it, we just designed it in conjunction with the Trust and the practitioner. 09:13

92 Q. Yes. Over the page then, this is the last aspect of the services I wanted to touch on. It's education services, workshops and conferences. We can see through the evidence of several witnesses that they've attended training at which you have been a person delivering workshops or what have you. 09:13

A. Yes. 09:13

93 Q. 2010, I think September 2010, you delivered a training in the context of management leadership for the Southern Trust.

A. Yes.

94 Q. We've heard from Mr. Gibson that in August 2016, he attended MHPS case investigator training; is that not right? Perhaps I've picked it up wrong. 09:14

A. No, that was case manager training.

95 Q. Case manager training. I beg your pardon, you're absolutely right. 09:14

Then in March 2017, I think we've heard from Dr. Chada and Dr. Khan that they attended case investigator training in which you were the deliverer or the

teacher, I suppose. So, training is a not insignificant part of your role; is that right?

A. That was -- that's absolutely true. We had a suite of training programmes. We had one which we called - what was it called - Recognising Concerns. It was, if you like, the introductory programme. Usually we ended at newly appointed Clinical Directors and folk like that who were new to the idea of managing doctors. That was to teach them how to identify issues and what were the sorts of factors that affected doctors' performance. We then moved on to case investigator training, which was a two-day programme that won various awards, actually. It was a standard programme delivered right across the UK with subtle changes in different territories because the rules were slightly different. But broadly speaking, it was a two-day programme centring on a dysfunctional surgeon called Dr. Purple. We would walk the candidates through how would they recognise that Dr. Purple had a problem; how would they go about investigate it; how would they gather evidence. We had lots of material which we would provide to them as their evidence. They did role-play in terms of how to interview a witness. Then we had a session where we asked them to draft part of the report. So, they had a very hands-on experience how to investigate. So that was a two-day programme.

09:15 09:15 09:15 09:15 09:16

Then the third, the other one was the case manager training, which was a one-day programme. That was the

one that Simon Gibson went to on 30 August.

We delivered these programmes in two ways. We had a series of public workshops - for want of a better term, public workshops - which were open to anybody working in Northern Ireland in the Health Service who could attend. The one that Simon went to in August was one of those. The others are where the Trust commissioned us to provide the training. The Southern Trust commissioned us to provide a training in March of '17, I think it was. So we went down and delivered a programme to their people. 09:16

We were sort of hoping -- I think we did go round all of the Trusts in Northern Ireland. The idea was that each Trust would have a group of people who were trained as case investigators so that they would have that resource available when they needed something. And I think we went round -- yeah, we did, we went round all of the Trusts in Northern Ireland at various points over the sort of few years around that time. 09:17

96 Q. Yes.

A. The case investigator training, actually I was just counting there, I delivered it six times in the year prior to the Southern Trust one. 09:17

97 Q. Yes. Helpfully, Dr. Fitzpatrick, you've supplied us with the slides for the training that you have provided. They're at WIT-62815, page 115 at your end. I don't need to work through them, they're there for

the consideration of the Panel.

In broad terms can you help us with this: In terms of MHPS, how well do you think the Trusts in Northern Ireland are served by the training provision that's available? Is there room for improvement around that, or can training be over-emphasised in terms of its importance to the safe conduct and the safe operation of the MHPS arrangements? 09:18

A. I think training is critical. Training is very important, and it needs to be the right training. A lot of it is even just around allowing medical managers and others to discuss how they would implement MHPS and what would they do. We use a lot of case studies to say, well, what would you do in this situation? That was always very interesting and people learned a lot from that. So yes, training is critical. 09:18 09:19

Another thing is just because you went through a training in whatever it was, March '17, doesn't mean that in March 2023 you are still up-to-date and sorted in terms of conducting an investigation. There needs to be -- and that's probably an area where we don't do enough of, is coming back and reviewing it. It's okay if you have been doing investigations constantly since 2017, you probably reasonably up to speed, but quite frequently people do this course and three years later someone asks them to do something and they have forgotten everything they learned. 09:19 09:19

98 Q. In terms of those who have attended your training workshops, what have you, do you receive any feedback from those attendees, particularly amongst those who have conducted MHPS investigations or have acted as case manager? Do you receive any feedback in terms of how comfortable or how adequate they perform their duties, or in relation to the kinds of difficulties that they face when trying to operate the framework?

A. Well, we do, as you do in every course, have feedback forms at the end of the course which are handed out. Of course, the candidates are all on a high because they've just had a great few days and they've enjoyed it. They write very nice things about us. Gráinne and I, generally speaking, had very good feedback. But you're absolutely right, probably we should be doing is go back a year later after they tried it out a bit and getting more feedback. NCAS nationally have done a little bit of that work. I'm not totally up to speed myself but I know they have done a little bit of work. You might want to ask them. Certainly that would be an area, how useful was this training, not when you were leaving and you were saying what a nice fella Colin is, but when you actually used it in practice, you know.

09:20 09:20 09:20 09:21 09:21

99 Q. One of the issues that I suppose we've heard from the Trust they grappled with in 2010 when they were developing their own guidelines to sit as, I suppose, a sister piece on an accompaniment to the MHPS Framework proper was in relation to something that they decided to call the Oversight Group. I suppose the

development of those guidelines put the onus on a clinical manager to identify the problem with the clinician, follow that through and present his or her view of the world in the next steps to this Oversight Group who would then, in the language of the guideline, quality assure that. So the Oversight Group wasn't the decision-maker, it was made up of the Medical Director, the director for the service, operational director for the service, and an HR component.

A. Yes. 09:22

100 Q. As it happened in Mr. O'Brien's case, the clinical manager wasn't brought into this process, as it appears from the evidence we received. The decisions were taken and led by the Oversight Group.

A. Yes. 09:23

101 Q. First of all, did The Trust ever seek your view when it was developing the guidelines around any aspect of the guidelines?

A. I have no recollection of them asking my views. I know this was suggested, we had been involved. I have no recollection. I have find no documentary evidence, nor apparently can the Trust, found any documentary evidence that we were asked. My memory, the first time I saw these guidelines was when I presented the meeting in 2010. We then had a discussion about the application of them and I participated in some of the discussions. They used case studies. I had given my presentation, which was about MHPS and NCAS and all that stuff, and then they presented on their new

policy. I was still there so I had a bit of a chat. But I think my memory is that is the first time I saw it; I suspect the only time I've seen it, apart from in the witness bundle.

102 Q. Certainly by the time you came to the September leadership training, the Trust's local guidelines had been finalised and Mrs. Toal came to the same training as you and delivered a workshop around that? 09:24

A. That's right. I remember that.

103 Q. This is at page 22 of your bundle. WIT-41278. Let me just have that up, please. 09:24

She says in the first paragraph:

"When you're talking to Kieran, can you ensure he is happy with the role of Oversight Group in that they are endorsing the decision of the clinical manager as to the action to be taken. In light of NCAS formal advice, I think this is safe enough and they can have a sufficient challenge function". 09:25 09:25

So, that's where we derive the suggestion that NCAS had some role in advising around that.

A. As I've said, this obviously was some years ago. I have absolutely no memory of it and I was unable to find any documentation of it. That's all I can say, I'm sorry. 09:25

104 Q. Thank you for that.

Can I ask you about one specific aspect of the message that is given out at training. It concerns the issue of terms of reference and who within the organisation should be responsible for developing them and finalising them. 09:26

A. Yes.

105 Q. My question will derive from the evidence that this Inquiry has received to date which suggests that aspects and significant aspects of the terms of reference were developed within the Medical Director's 09:26 office with perhaps some contribution from the HR side.

A. Yes.

106 Q. Those terms of reference are then handed to the case manager and case investigator.

A. Yes. 09:26

107 Q. Before the investigation commences but after some consideration of the documentary material that had been supplied to the case investigator, she added a further element to the terms of reference which she sent through to the case manager for his approval. 09:27

A. Yes.

108 Q. It doesn't appear on the evidence so far received that that addition proposed by the case investigator made it as far as the Oversight Group, the Medical Director and what have you. 09:27

A. Yes.

109 Q. We wondered whether it's an issue that its problematic for the case investigator to be adding to the terms of reference without it going back to the key

decision-makers within the organisation. I'm anxious to take your views on that.

Before I ask you the questions around that, can I just take you to what the training says in relation to this. 09:28

A. Go ahead.

110 Q. Page 208 your end, and if we could have WIT-62908, please.

A. Terms of reference, I see that. Yes. Sorry, I need to turn it round. Go ahead. 09:28

111 Q. The terms of reference are agreed by the case manager and issued to the case investigator to define the issues to be investigated, boundaries of the investigation, etcetera.

A. Yes. 09:29

112 Q. It appears from Mrs. Toal's evidence that that remains the training that is provided to Trusts when they come to NCAS training.

Could I ask you to look at page 50 of your core, your other bundle. 09:29

A. Yes, 50. Hold on a second.

113 Q. Page 50, at our end it is WIT-41394.

A. Yes. Page 50 is the cover sheet for how to conduct an performance investigation. 09:30

114 Q. That's your orientation, that's the document you're in. If we could just look at page 63 of that. If your bundle is anything like mine, the pagination disappears into some blue ink.

A. It disappears and I can't actually see it. What's the WIT-number you want?

115 Q. WIT-41407. If we could have that up here, please. It is chapter 3 of the document Managing an Investigation.

A. I see it, yes. 09:30

116 Q. At the top of the page, it says:

"The investigation starts once its terms of reference are finalised and when a case manager and investigators have been appointed. Once the decision is taken to 09:30 hold an investigation, there should normally be a discussion about with the practitioner to secure as much engagement as possible. The practitioner should be made aware of the terms of reference and who the proposed case manager and investigators are so any 09:31 objections can be raised".

A. Yes.

117 Q. Then in terms of finalising terms of reference down the page: 09:31

"There will have been agreed an outline at the time a decision was made to carry out the investigation, but some final drafting may be needed. The terms of reference as finally drafted should be agreed by the 09:31 organisation's relevant decision-makers. The case manager and investigators appointed to manage and carry out the investigation would not normally be involved in this process".

A. That's a contradiction.

118 Q. I'm wondering whether in terms of the training that's provided by NCAS which seems to say that it's a matter for the case manager and investigator to deal with terms of reference, whether there's some disconnect or inconsistency with the document and the passage I just read with you? 09:32

A. I can tell you what our training says. I was not involved in developing this, the other document, and know very little about it. It predates the training, I think. I'm pretty certain it is a much older document than training. But the training was quite clear. The final response -- the person who signed off on terms of reference would be the case manager, because they are responsible for managing the process and making the process move forward. 09:32

Now, generally speaking, I would expect if the case manager isn't the Medical Director that, they go have a chat with the Medical Director and the Medical Director has an input there. That's what I would expect to happen in practice. Occasionally the Medical Director is the case manager, but not so much in the large Trusts that we have these days. That would be the process. 09:32 09:33

But, finally, if you like, in our teaching it was always the case manager. For the case investigator to

draft, they might make suggestions, as you've just described, but they wouldn't be responsible for signing off on the case terms of reference, that would be clearly for the case manager to do. That was the teaching that we did when we were doing it. The other document, I can't answer to why it contradicts because I had nothing to do with it.

119 Q. First of all, you could readily see dangers in an overeager case investigator suggesting or perhaps making changes to the terms of reference without approval. That would be wrong? 09:33

A. That would be wrong, you're absolutely rightly. That's why we say the case manager, who has the overarching responsibility for organising the thing, would do it. As I say, from a practical point of view, I would expect them to keep the Medical Director updated on that. 09:33

120 Q. Just in terms of the document that I've read from where it suggests that the case manager and investigator appointed to manage would not normally be involved in the process, as I understand this document remains extant. It was certainly shared with us on that basis. That line within it is worthy of some attention, would you agree, in terms of clarifying -- 09:34

A. I hadn't spotted that line until you pointed it out to me, and it concerns me because I think -- my personal view is it disagrees with what we have been teaching for years. 09:34

121 Q. Yes. Thank you.

If we could turn specifically then to the MHPS Framework and the Trust Guidance. Again, the Inquiry is obviously familiar with this document. It suggests that the role of NCAS is integral to the working through of various aspects of the MHPS process.

A. Yes.

122 Q. If we go then to page 10 of your core bundle.

A. Core bundle. Yes.

123 Q. Yes. 09:35

A. Page 10. That's MHPS Action When a Concern First Arises. Yes.

124 Q. Yes.

A. Go ahead.

125 Q. Just allow me a moment. 09:36

It states that one of the key actions needed at the outset is to consider discussing the case with NCAS. This is paragraph 10.

09:36

You, I think I'm right in saying, when you contributed to the Department's review in 2011, had some difficulty with how the role of NCAS was described there. Is that right?

A. I did send an email to Paddy Woods. Off the top of my 09:37 head, I can't remember exactly what I said.

126 Q. Let me see if I can help you with that. Just allow me a moment, please.

A. Take your time.

127 Q. Page 44 of your bundle, not the core. Sorry, we're jumping in between bundles.

A. You're all right. Not a problem.

128 Q. For our purposes WIT-43152.

A. Yes. I remember send being sent this email. I think it was my sole contribution to the various reviews of MHPS. 09:38

129 Q. Yes. You've said, it is the penultimate contribution before the line saying:

09:38

"Finally, the description of NCAS and its services would also benefit from revision".

It's a case, was it, that by 2011, the MHPS document being six or seven years old, that NCAS services had developed. 09:38

A. Basically, I think I was probably referring to paragraph 9, Lists of Services. It was really just that we had moved on and we were doing slightly different things, and that could benefit from rewording. 09:39

130 Q. Thirteen years further on, we're still sitting with -- 12 years further on, we're still sitting with the same description.

A. Exactly. The same document. 09:39

131 Q. What needs changed there by reference to the services provided by NCAS?

A. Well, obviously I no longer work for NCAS but certainly at the time I left, I would have added in a little bit

more about -- a little bit more detail with performance assessments and a little bit more about what was available, and emphasise perhaps the flexibility which we referred to earlier in terms of how we can design services, almost bespoke services for individual situations. I'm not quite sure how I would have written it but I would have rewritten it in those broad terms, you know.

132 Q. Paragraph 11, does that accurately capture the sense of NCAS's involvement in the opportunity which is available for Trusts at an early stage? 09:39 09:40

A. Yes. Actually yes, to be honest that paragraph has worn well. It is probably still applicable, yes.

133 Q. Although, as we discussed earlier, you do see opportunity, perhaps, to think through whether at this initial stage, perhaps after the contact with the Trust, whether there would be room for some engagement between NCAS and the practitioner. Would that require some thought? 09:40

A. Yes. Again, if you were rewriting MHPS, you might want to put something to that effect in. 09:40

134 Q. Paragraph 15, again the role of NCAS is mentioned. Informal approach is being discussed.

A. Yes.

135 Q. We need to bring this up on the screen. WIT-18501. 09:41

A. Yes. I don't like the word "informal" in this context because it is interpreted as meaning, well, a bit too informal. I would have said "preliminary assessments" on something like that, or "preliminary work", which

maybe gives it a better feel. My experience has been "informal" sometimes means not recorded and very, very informal. If you look back at my understanding -- I'll give you an example. My understanding is that, according to what I've been told, Mr. O'Brien was spoken to about some of the issues way back in 2014. In fact, Simon Gibson told me this, he had been spoken to before but nothing had been written down. Well, that's just a bit too informal for my liking, you know. 09:42

136 Q. Yes. In fact, if you just glance back at your email to Mr. Woods in 2011. It is too cumbersome to bring it up on the screen again here but just for the Inquiry's note, we're back at WIT-43152. If I could just read it out. You say that: 09:42

"We feel that the word 'informal' in the flow diagram at page 43 of the process to be counterproductive. We have found this encourages an overly relaxed attitude to process and could be replaced by another term such as at 'preliminary'". 09:43

That captures your point.

A. It continues to be my view.

137 Q. If we go to page 48 of your document. For us it is WIT-18536. 09:43

A. Oh, sorry, 43 of the main bundle?

138 Q. Sorry, page 48 of your core bundle. I beg your pardon. Core bundle.

A. Core bundle. The big bundle.

139 Q. Yes. It's internal 43. That's the point you were making to Mr. Woods perhaps --

A. Yes, the flow diagram.

140 Q. The flow diagram, you said, is titled "Informal Process". That's unhelpful, it carries with it the risk that it encourages an overly relaxed attitude and "preliminary" is the better word? 09:44

A. That would be my view. I mean, it doesn't matter whether you are at that stage or what is subsequently called a formal process, this is serious stuff and we need to do it properly; we need to record it properly. Sometimes informal is interpreted as meaning you bump into somebody in a corridor and you say, "You really need to pull up your socks". There still has to be a process. 09:44

141 Q. Yes. What we see in Mr. O'Brien's case is that after advice from you in September 2016, the Oversight Committee met and they developed the idea of pursuing an informal MHPS investigation, a term that a witness has said wasn't all together helpful. "What is an informal MHPS investigation" was the question to him, and it was recognised that it doesn't exist within the process. But that might be supportive of your view that informality can be dangerous -- 09:45

A. Yes. 09:45

142 Q. -- and that there's a need to recognise that although the process might be called "informal", it is serious business that requires proper organisation and record-keeping?

A. Absolutely. That's absolutely my view.

143 Q. If we go to paragraph 20, it says:

"NCAS must, where possible, be informed prior to the implementation of an immediate exclusion. Such exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis... ", etcetera. 09:46

I just want to, because it's an issue, go back to WIT-18502 for the screen. Just the timing of advice being sought from NCAS, in your experience do Trusts sometimes make decisions and then come looking for advice to reinforce their decisions, or sometimes take decisions in principle subject to NCAS advice, and is that an altogether helpful way of doing it, in your view? 09:46 09:47

A. Yes. It would not have been uncommon for me to get a phone call - and I think my colleagues would have echoed this - more or less saying 'we've decided to exclude this bloke but we need to contact you first', and they had made up their mind. Now, that wasn't universally true and there were a number of instances where that didn't happen, quite a lot of instances where that didn't happen, but there were occasions where they quite clearly had made up their mind before they phoned us. You know, apart from being a bit irritated being, you know, being asked to act like a rubber stamp, we felt that we weren't getting the opportunity to offer the alternatives as we often 09:47 09:47

would. If somebody phones me and says 'sort of thinking about excluding or suspending this chap, what do you think are the alternatives', because we had a fair bit of experience, we could run through the alternatives. Sometimes people hadn't thought of simple things, like, for example, we have concerns about this surgeon's ability to take out gall bladders so we're going to suspend him. I went, why are you doing that, why don't you just stop him doing gall bladders until you've sorted this problem out and get him to do other things. So sometimes they hadn't even thought through the simple things. We were often able to produce alternatives because we were coming to this afresh from the outside, with a different viewpoint, and lots of experience of having done this before. 09:48

144 Q. Yes. We know, and perhaps it is more for Dr. Lynn to comment upon, that the Oversight Group made a decision at its meeting on 22 December to exclude for the duration of the investigation, as it was described in their decision. That was to be subsequently revised. The second part of their decision was to have a formal MHPS investigation. But then the advice was sought; the advice was then sought from her on 28th December. 09:49

In general, while there's nothing to prevent that approach, you consider that to be the wrong way round and unhelpful? 09:49

A. I would agree. It is the wrong way around, it is unhelpful. What's the point ringing us if you want us

to rubber-stamp a decision you have already taken.

Just take that example, and I'm not going to second-guess Gráinne's advice here but I'll just give you an example of the sorts of discussions you could have had. I don't know what discussions she had. You could have said why are you excluding him when you could restrict him to administrative jobs or work only. You could put all sorts of restrictions on him which would avoid the problems that you're trying to avoid. It may well have been that the only answer was exclusion, and I'm assuming that's the conclusion they came to, but we would have a discussion about what are all the alternatives. One of the founding principles of NCAA, as it was in the old days, was that we were there to get rid of some of the scandals that happened in the '90s where we had doctors suspended - particularly in England, but also in Northern Ireland - for extended periods of time; what we would refer to as 'suspend and forget'. We have a problem with a doctor, we'll suspend him and then we'll forget about it. The whole point OF MHPS and our organisation was to keep that stuff under review to make sure that you didn't suspend the most expensive member of staff in your organisation and forget about him; that you were actively managing the case. 09:50 09:50 09:50 09:51

So we were there to try and -- I wouldn't say one of our performance indicators but certainly something

we measured was the number of active suspensions in place across the UK. A lower number was better, as far as we were concerned.

145 Q. Just picking up on a few further threads relevant to NCAS's role within the MHPS document. We can see then, 09:51 if you turn to your page 17, or core 17 I should say, and if we go through to WIT-18505. It says that one of the determinations that a case manager might make is where there are concerns about the practitioner's clinical performance which require further 09:52 consideration by NCAS.

Is that the junction at which consideration ought to be given to an NCAS-led performance assessment?

A. It's one of the places you could consider that. Many 09:52 assessments were done where the practitioner volunteered to take part in them because they wanted the answer as much as the rest of us did, so you didn't have to go through this extensive MHPS process because everybody was in agreement that this was what we were 09:52 going to do. There were a number of other situations where people got into assessment. Obviously, the assessment doesn't work if the practitioner doesn't agree to it because if they don't participate and participate fully, it won't work. It is hard work for 09:53 a practitioner to be assessed. But, on the other hand, very often they came out of it with a plan which got them back on track and got them into safe and effective practice. So, there was a good outcome for many

practitioners in assessments. Not always, there were a few that weren't just so good.

146 Q. At page 26, this is WIT-18514. Another role for NCAS is in misconduct cases. Paragraph 4 on that page tells us: 09:53

"Employers are strongly advised to seek advice from NCAS in misconduct cases, particularly in cases of professional misconduct". 09:53

As we saw here, in this case Dr. Khan was thinking along the lines of misconduct and a conduct hearing, and he sought advice from NCAS and Dr. Lynn advised. What is the importance of NCAS input at that point? Is there sometimes conclusion, for example around the 09:54 proper categorisation of the shortcoming?

A. Yes. I mean I suppose from the point of view of my job, those were the easier ones because, to a large degree, what we were saying is, first of all, we need to be satisfied that it is a conduct issue and not 09:54 a capability issue, and you would have that discussion. But once we had agreed it was a conduct issue, the advice was relatively straightforward, which was, well, what would you do if this was another member of staff? Well, whatever that is, do it, follow your own conduct 09:54 procedures. Because there was always -- to a degree there was a bit of confusion, and maybe MHPS contributed to this confusion, that things were different for doctors. But at the end of the day,

conduct is conduct, and if you have a misconduct case, you deal with it under your conduct procedures. To a large degree, the advice referred to in that paragraph would basically be that, you know.

147 Q. As we can see from this document, plenty of roles for NCAS across the MHPS journey. Only one, I think you said, is obligatory; that's returning to NCAS in the context of extended exclusion. 09:55

A. Formal exclusions, we were supposed to be contacted in advance. If you remember -- if you think through the process, the organisation has immediate exclusion for the emergency. It is Friday afternoon, this guy is on-call over the weekend, we need to do something now. So, they have immediate exclusion available to them. They don't have to contact us for that, although usually they did because the Friday afternoon phone call was a fairly common feature of our lives. But then they've got four weeks to think about what they were going to do next, and that's where they would bring in the formal exclusion and that's where they would have to speak to us. 09:55 09:56 09:56

148 Q. Has NCAS done any work around the extent to which there is, if you like, good compliance by the Trusts in Northern Ireland with, if I can put it in these terms, the suggestions made in the MHPS document as to when NCAS should be contacted, or are you in that position of being in the dark because you may only know about the organisations that contact you and you don't know what you can't know? 09:56

A. That would be the situation. We only know what we know. If they phone us, we know about it; if they don't phone us, we don't know they had a problem and didn't phone us about it. You can have a bit of suspicion in that you get low levels of activity from certain organisations, but we have no proof really. The Department of Health might have a better handle of that one.

149 Q. Yes. It's coming up 10 o'clock our side of the water. I have about another hour to go. I'm conscious that we started early and a break might be useful.

CHAIR: Dr. Fitzpatrick, I realise it is very late in the evening for you already, but if you were content if we took a 15-minute break and then come back and finish off your evidence, would that be fine with you? 09:57

A. That would be super. A cup of tea would be lovely right about now.

CHAIR: Let's take 20 minutes to give you time to boil the kettle. 10:20 our time and 11:20, I think in the evening for you, is it? 09:58

A. No, it will be with me coming up to 10:20.

CHAIR: Okay. A 12-hour difference.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS: 09:58

CHAIR: Welcome back, everyone.

MR. WOLFE KC: Good to go, Dr. Fitzpatrick?

A. Yes, all good.

150 Q. If I could start with a mea culpa. There was a fourth

statement you provided to the Inquiry which I omitted to refer to this morning. I'm not sure it's on the bundle we sent you. If we can put it up on the screen here, WIT-91049. It's a further supplementary from you dated 10th December last year. If I can just ask you to recall that in substantial part, it concerns the contribution you made -- or your comments on whether you made a contribution to the 2010 Trust Guidelines. If I could just scroll down to the bottom of that, please. Apologies you don't have it in front of you. I assume you don't have it in front of you? 10:22 10:22

A. No.

151 Q. If we go to paragraph 5, and you already dealt with this in evidence this morning, it said:

10:22

"If I had been asked to provide formal advice on the 2010 guidelines, I would have expected a formal request to comments on a draft or to be part of the group developing the guidance. I have no memory of either and cannot find any documentation to suggest that either happened". 10:23

I think that's in keeping with what you said earlier in your evidence. That's dated 10th December. Are you content to adopt that as part of your evidence as well? 10:23

A. Yes. Yes, I am. I must have actually made that when I was in New Zealand. Yes, of course. Of course, yes.

152 Q. Apologies for how that was handled.

A. No problem.

153 Q. We looked this morning already, I suppose, at part one of your evidence. That was the NCAS services and how they fit within the MHPS structure. I now want to turn to the second part of your evidence, which was your involvement in providing advice to the Southern Trust in respect of Mr. O'Brien's case. 10:23

A. Yes.

154 Q. If you could turn to page 50 of your bundle, not the core bundle, your bundle. It is WIT-53479.

A. Yes. 10:24

155 Q. I think you are familiar with this document. Is this a typical pro forma used by Jill Devenney within your organisation alerting you to the fact that you've had a contact that requires followed up from the Southern Trust? 10:24

A. That's the standard process. So, Jill would probably have telephoned me earlier in the day and said 'I've got one for you, are you available'. Then she would have followed up with that, yes.

156 Q. We can see then two pages further along -- page 52 for you, 53481 for us. Scroll down two pages, please. This is your advice encapsulating, I suppose, your record of the telephone discussion with Mr. Gibson. Mr. Gibson was somebody you knew from your professional past; is that right? 10:24 10:25

A. Yes. I'd met Simon in a previous life when he was in a different job and so was I.

157 Q. Could you - whether you need to rely on this document or otherwise - just take us through your memory of what

you were told during this encounter, what advice you provided and, generally, the thinking that underpinned that advice?

A. Okay. So, consultant urologist. It was explained to me that he was experienced. I think it may have been pointed out he was the most senior urologists, or oldest in the service - I remember getting the impression he had been around a long time - but there had been a number of issues. Simon mentioned this thing about a backlog of 700 patients, which was different to everybody else. We discussed the issue around triaging referrals, and it was mentioned up to 18 weeks of triage a referral, whereas this is something that's expected to be done there and then -- you know, very, very quickly. So he was way behind, very different to his colleagues. 10:26 10:26 10:26

This thing about taking charts home was mentioned. I distinctly remember that. There was a suspicion that he had a large number of charts at home because there were large numbers of charts missing. Then he mentioned this about note-keeping not being terribly good. He clearly said there were occasions where there was no record of a consultation, which of course --

158 Q. Just on that, I think that the shortcoming there, as the Inquiry understands it from the evidence received to date, is that it's not so much the notes as it's described there, not a case of the note-taking being poor, it's more a case of a failure to dictate on some 10:27

outpatient encounters. In other words, the follow-up letter for the general practitioner or for the patient and for the file.

A. Yes.

159 Q. But it's not a criticism per se of the absence of a note. That's how you've recorded it. 10:27

A. Well, no, sorry, that nuance didn't come across to me. I'm fairly certain that I understood him to be saying that the notes were not very good.

160 Q. In ease of yourself and the record that you have made, can I just put before you for your observation, jumping across to the other bundle 158. 10:28

A. There we go. Yes, 158. Yes, I see that.

161 Q. We can have it up on the screen, TRU-251424.

A. That's the second page of Simon's screening report. 10:28

162 Q. Yes. He would, in his evidence, say that he had that in front of him as he is speaking to you. No suggestion that you would have seen that at the time or at any time prior to the Inquiry knew it.

A. I didn't see it. 10:29

163 Q. How he has recorded it, he has said:

"Mr. O'Brien may not always record his actions or decisions regarding a patient following a period of in-patient care or outpatient consultation", albeit he was working without a formal audit at that stage. If he spoke in those terms to you, not mentioning dictation it might appear, do you think your record is broadly fair? 10:29

A. Yes, I agree, I do. Because reading his screening report, he doesn't mention dictation at all. If I were to read that, I would assume that that meant the primary notes were not being recorded. Because if he had recorded in the notes what his decisions or his actions were going to be, then Simon wouldn't have written it in those terms. That would be my understanding. 10:30

Having said that, it sort of doesn't matter because both are failings and both equally serious. 10:30

164 Q. If you go back to your page 52 where you were summarising your encounter with Mr. Gibson. If you allow us a moment to put up on the screen here, back to WIT-53481. 10:30

Could I just ask you before you continue with your recommendations of that encounter with Mr. Gibson, do you approach this on a structured basis? When you're being asked for advice, you knew this call was coming, you perhaps made it back to Mr. Gibson, do you approach it with a mental structure as to what you need to get out of it from the querier to enable you to formulate some thoughts around advice? 10:31

A. Well, I suppose, yes. I would have a rough structure in my head. To a degree, it is sort of based on medical practice, you know take a history, find out what happened, what is the story? So I would ask, you know, why are you phoning me, what are the issues. 10:31

I might probe a little bit around some of the things, the statements, that the caller is making. We would then look at what are the options open to us. Well, I suppose the other thing is, and one of the first questions I tend to ask, particularly of more senior callers, is what is it you want to be the outcome with this? Where are you going with this? We would then talk about what were the realistic options available to us and how would we ensure. 10:32

I mean, there's a number of set points in any of these calls. One of them is the Patient Safety issue. Does this represent a threat to Patient Safety? That's the sort of question I would ask in, well, all but the most trivial of cases. There are a number of set questions you would always ask. But yes, it's around take the history, explore, check there's no Patient Safety issues, what are the options open to us, come to an agreement as to what it is we're going to do. 10:32

As I said earlier in earlier evidence, that discussion is much easier when you have somebody who is of the seniority where they can actually take a decision there and then.

165 Q. Okay. In terms of your description then, you're at that part of your process where you are taking the history. Part of the history is the inadequate note-keeping or note provision, if we can put it in those more neutral terms. As you say, it may not have 10:32

mattered too much to the advice that you would give, both issues, if you like, being serious.

A. Both are serious. Obviously, if you haven't written the primary notes, you have nothing on which to dictate a letter. I suppose you might say that's more serious. But as a GP, I tend to think that the letter to the GP is quite important. 10:33

166 Q. Yes. It is maybe stating the obvious, if it had been presented in that way to you as a failure of dictation, what does that failure do to the primary carer such as the general practitioner? 10:33

A. First of all, obviously the GP, who is looking after the patient on a day-to-day basis, doesn't know what is going on. He doesn't know what the plan is. When the patient comes in and says 'that consultant up in the hospital, he was awfully nice but I didn't understand anything he said, can you explain it to me', you have nowhere to go. 10:34

The other fact is generally often the other consultants will use the letter as being their primary -- that's the thing they look at when they are taking over care. Or the patient comes in the Outpatients clinic and they have previously been seeing Mr. O'Brien, they will look at the letter because, quite bluntly, it is easier to read. It is a primary method of communication. With electronic record these days, the bit that is kept on the electronic record is the letter, so if there is no letter there will be nothing on the electronic care 10:34

record. Handwritten notes don't get uploaded to that.

So, yes, the letter is important; it's an important part of the process. So yes, if I had been told, well, he writes handwritten notes but he doesn't dictate letters, it wouldn't have made an awful lot of difference, maybe a subtle change to the advice but not much.

167 Q. Okay. I'm just glancing at your page 52.

A. Yes. 10:35

168 Q. You've dealt with note-taking just now. An issue at the bottom of the page --

A. Yes, that's the --

169 Q. You say:

10:35

"It is a standard question to ask about harm to patients".

A. Yes, and that's why that's in there. Simon said to me that he wasn't aware of any patient harm although he mentioned some anecdote about a delayed referral but it 10:35 all seemed awfully vague. If it was one incident, one incident isn't enough to say a doctor is underperforming. So, that was there.

Again, if I'd been talking to a senior clinician, 10:35 I might have had a more in-depth analysis of Mr. O'Brien's performance, but Simon was a layperson who probably wouldn't have had a lot of knowledge on that.

170 Q. That line about anecdotal evidence of delayed referral to oncology, did it in any way spook you or concern you in terms of that sounds particularly serious? If it did, was there any follow-up around that?

A. Well, in judging the seriousness of something like that you have a balance of if this was true, how serious would it be, and what is the evidence that it might actually be true? On this basis, I had a sort of very, very vague reference to, well, more or less there was a rumour about a delayed referral to oncology, so the level of evidence was pretty low. 10:36 10:36

Yes, a delayed referral to oncology might be very, very serious or it might not be. It might not actually have made much difference to the patient's outcome. If it was one single incident of a delayed referral, we all make mistakes. Every single doctor in the country makes mistakes and one mistake isn't enough to say you have an underperforming doctor. 10:37

171 Q. In terms of the substance of what that might mean, are you able to help us beyond what you have written there? 10:37

A. No memory of it other than that, I'm sorry. I can't help you.

172 Q. Over the page then, if that assists your memory in terms of how the conversation continued. 10:37

A. Looking at that, I then recount a little bit of what's been done so far. He has been spoken to a few times but nobody kept a record, which goes back to what I said about informal processes.

"He was written to in March of this year seeking an action plan to remedy these deficiencies but to date there has been no obvious improvement".

173 Q. I've been told to slow you down, Dr. Fitzpatrick, just for the stenographer. 10:38

A. As I said, he had been spoken to on a number of occasions about the behaviour but no records were kept. That goes back to what I said earlier about informal processes. He was written to seeking an action plan to remedy these deficiencies but no obvious improvement to date. That, I suppose, concerned me, that he had been warned. We're now six months later and he hasn't really made any difference. To me that implies a doctor who really isn't taking the process seriously. 10:38 10:38

You know, if I had been warned in that way and not having read -- now having read the letter in March, if I had been on the wrong end of that letter, if I'd received that letter, I would have been assiduously trying to improve my practice. But I got the impression from that that this was somebody who wasn't taking the process seriously, which sort of leads into a later part of my letter. 10:39

174 Q. I suppose, Dr. Fitzpatrick, one can interpret what is written there in the way that you have, the doctor isn't taking it seriously. I suspect if the doctor was in front of you, he would offer the perspective that in the six months since that letter was handed to me, 10:39

no Trust manager has approached me to further discuss that letter; I've been offered no support against a background of overwhelming work and pressures.

Now, I'm not sure what you can say by way of response but is it incumbent upon you, perhaps, to keep an open mind that there's perhaps at least two sides to the coin when the history is being revealed? 10:40

A. Absolutely. As you will see later on, I do say that this doctor will require some support. 10:40

175 Q. Yes.

A. And, absolutely, that was there -- okay, maybe I was being a bit trite there saying he wasn't taking it seriously, but certainly he wasn't doing anything, or there was no evidence he was doing anything about it. 10:40 Maybe to say he wasn't taking it seriously was inappropriate.

176 Q. The reasons for that were unknown to you, I suppose, is the fairest way of putting it?

A. But nothing was happening, so we need to do something to move this along. 10:40

177 Q. This then brings you to, I suppose, the analysis and advice part of the conversation; is that right?

A. That's where we're going here. So, I talked about it. The policy on removing charts from the premises, to me that seemed a pretty straightforward one. You know, there's a clear policy which says what you do with charts, it is being breached. My understanding was the letter in March was a warning and we can debate whether 10:41

it counts as a warning or not, but he had certainly been told that it wasn't appropriate to do way back in March. Nothing had happened.

Now, that's not a difficult thing to solve. You have a whole pile of charts sitting on your dining room table, you just put them in the boot of your car and bring them in. That's not a huge piece of work. That puzzled me why nothing had been done there, you know. 10:41

As I said, that's a straightforward disciplinary process. If you recall, when we were talking about MHPS and the conduct bit of MHPS, I said that my advice tends to be what would you do if this was a nurse or a porter or somebody, you know somebody else, and that's what you do. Effectively what I'm saying here is just apply the disciplinary policy, you know, because that's a straightforward disciplinary issue. 10:42

178 Q. Yes.

A. That's that bit. 10:42

The poor note-taking. With regard to the poor note-taking, I suggested an audit. It all sounded a little bit anecdotal, the note-taking issues. As you said, Simon didn't have an audit available. He was dealing with what other people told him about the notes so to do an audit would give us a bit of evidence as to how good the practitioner's note-keeping was and we could then decide what to do after that. If the 10:42

quality of the notes was poor, I suggest that we could do a notes review and come up with suggestions as to how the practitioner could improve the quality of his notes. So, I thought that was a reasonable suggestion.

10:43

The triage thing, new patients to triage, I suggested meeting with him and agreeing a way forward because, again, this is a backlog of 700 patients. That's a phenomenal backlog. You know, I don't know how many patients he sees in a clinic but if you say he sees 10 10:43 patients in a clinic, that's a huge number of clinics that he's behind on. So, how you would clear that.

179 Q. I think in fairness the issue around the backlog in the clinics was around the issue of validation. There was an exercise to be performed around how these patients 10:43 in the backlog stood in terms of the urgency of the care that they required. However it was defined, there was a piece of work to be done, and you saw it --

A. Absolutely, yes. You know, obviously I can only advise on the information I'm given and that was the 10:44 information I was given. I absolutely agree there's lots and lots of issues around waiting lists and validation and things like that, but at the end of the day he still had a big piece of work to do. To ask him to do it on top of his day job and continue with the 10:44 day job was a huge ask. It doesn't really matter how he got into the situation, that's something else we could address. But just to ask someone to clear that level of backlog was going to require some resource.

I believe I say that.

"Such a backlog would be difficult to clear and would require significant support".

10:44

We talked about why don't we take him out of theatre. That was just one possible suggestion, take him out of theatre and that would free up a bit of time to clear all this stuff.

180 Q. Just to be clear, you weren't being, I suppose, prescriptive there? 10:44

A. No.

181 Q. It was a suggestion of the kind -- first of all, in principle it was an indication that you thought some support and assistance was required. This is an example, not necessarily one that you would hold them to? 10:45

A. Absolutely.

182 Q. But an illustration of what might be done?

A. That's exactly correct. That's exactly what I was thinking. You know, let's think about this creatively, there are different ways we can do this and here is one possible way. I'm not saying that's one we have to do. 10:45

I then offered to attend a meeting. I would be a bit of a fan of me going to meetings with practitioners simply because my experience was that if an external person such as myself came in, suddenly the practitioner, who possibly wasn't taking this with the 10:45

seriousness he should have, starts to get serious, particularly if, as I normally would do, I insist that they bring their Protection Society representative with them. I find them to be immensely helpful in that situation, because they will also recognise we have a big problem here and we need to work together to solve it. That's the approach. I would have always had a very good relationship with the Protection Society representatives because as far as I was concerned, we were all on the same side, we were trying to get this practitioner into effective and safe practice, you know. Except he had the ear of the practitioner, I didn't. 10:46 10:46

183 Q. Can I offer the following summary then of what appears in this letter. First of all, you were suggesting an element of stick in the sense there's a disciplinary component to this? 10:46

A. Yes.

184 Q. But, at the same time, you recognised that there was a requirement for some element of support, whatever that might ultimately look like after a period of engagement, meeting or discussion with the practitioner, which isn't stick, it is more support. Is that fair? 10:46

A. I think that's a fair analysis, yes. 10:47

185 Q. You were also thinking, am I right in saying, that this was not only a conduct issue but there was an aspect of that. There was also an element, although you may not have been entirely clear as to the detail, there was

also an element of perhaps capability concerns?

A. Yes, I think so. I just had a feeling that, you know, the level of backlog and some of the stuff we were talking about, and also the poor note-keeping, you could say it's conduct but at the end of the day people don't do that willingly. They get themselves into a situation. Quite frequently I've seen practitioners get themselves into a hole where they don't know how to dig themselves out and you have to help them. 10:47

186 Q. Yes. Can you remember whether Mr. Gibson was presenting it as that mix of conduct and concern about capability, or whether his view was less nuanced than that? 10:48

A. I don't think he had done that analysis, to be honest with you. I think he just had a problem and he wanted me to come up with some answers. 10:48

187 Q. Now, there is a relatively complex evidential picture in terms of what happened next. I don't particularly need to go into that with you and it might be unfair to ask you to comment, but it is the case that no contact was made with Mr. O'Brien in respect of those issues until December, and late December, 2016. I don't wish to build in the complex ingredients to what was going on on the ground but, in general terms, where there are shortcomings or perceived shortcomings in a practitioner's practice, whether that's a conduct issue or a capacity or capability issue, and where the Trust has sought advice from you, or NCAS in general, it would be good practice, would it not, to advise the 10:48 10:49

practitioner that these engagements are happening so they are no longer behind the scenes, they're upfront and direct with him?

A. I absolutely agree. As I think I may have said earlier, in later years we actually wrote specifically in our letters, we put in a phrase which said 'please make sure you share this with the practitioner', because we were come to a realisation that that wasn't happening in many cases, and it clearly didn't happen in this case. It is a sort of fundamental principle of justice that if you are being accused of something, you have a right to know what it is and who is accusing you. 10:50 10:50

So yes, they should be involved early and informed and informed of their ability to phone us. Quite often we would find out that that had happened because the practitioner would phone us and we'd have a chat. Yes, it was disturbing to discover that Mr. O'Brien didn't know anything about this until quite sometime later. 10:50 10:51

188 Q. Now, just if I could pick up on one accuracy issue that you may wish to comment on.

A. Go ahead.

189 Q. You spoke to Mr. O'Brien in July 2020. We already opened the letter briefly this morning. It is your page 61, our WIT-53490. 10:51

A. Yes, got it.

190 Q. In the second paragraph, the second sentence is:

"In particular you told me that my initial advice given in September 2016 had not been shared with the decision-making group when they decided how to address issues which were raised at that time".

10:51

You say you were disappointed to hear this.

A. Yes.

191 Q. As a matter of accuracy, your advice following your conversation on 7th September is dated 13th September and only arrived with the Trust after their meeting had taken place that morning. Why was your advice delayed by a week? Are you able to comment after this passage of time?

10:52

A. Administrative delay is the only excuse I can give you. The process after I wrote the letter; so I would have written the letter probably the following day or maybe the same day or not that long afterwards, bearing in mind that I only work two days a week for the organisation so I sometimes didn't have time for a few days to write. So, I don't know exactly when I wrote it. But then the next thing was it would go off to be QA'd by another adviser. Somebody would have a read of it, see that it made sense and it was a reasonable letter. Then it would go back to Jill for dispatch. By the time all that happened, you were going to build in a couple of day's delay. I assume there was a weekend in there somewhere. So that would all contribute to what was a five day delay or six days.

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10:53

192 Q. In fairness to Mr. Gibson and the evidence he gave, he

told us that the advice you gave verbally was shared with Dr. Wright, the Medical Director, in the first instance, and then at the meeting of the Oversight Group on the 13th. That later that month he circulated your written advice to all members of the group, with the exception of the Director of HR who seemed to be missed out on the email. I suppose the point is that your advice was known to the decision-makers but wasn't implemented for reasons too detailed to go into? 10:53

A. The letter to Mr. O'Brien of July 2020 was based on what he had told me. I was quoting back to him what he told me and he said that it hadn't been shared, to which I said well, that sounds disappointing. Again, this is back to you take the word of the person who is speaking to you. 10:54

193 Q. That's fully understandable. I just wished to give you the opportunity to comment on it.

A. No, absolutely. It is unfortunate. I don't remember whether Simon told me there was an Oversight Group meeting, in which case I would have tried to make sure he had the letter in time because, as you know, you can always push things through. 10:54

194 Q. Could I move quickly on to some reflections that you've offered in your witness statement about the conversation and engagement with Mr. Gibson in September? 10:54

A. Go ahead. Yes.

195 Q. If you go to page 66 of your bundle, and if we could have up on the Screen, please, WIT-53790.

A. Yes.

196 Q. You say at paragraph 8:

"It occurs to me that there were a number of missed opportunities by the Trust with Dr. O'Brien's case. Initially when Simon Gibson telephoned me on 7th September 2016, I recall asking if there were wider concerns with regards to Dr. O'Brien's capability and I was told that there was not". 10:55

Just on that. Looking at your letter, does that question and his answer feature in your letter?

A. Well, the issue about Patient Safety, I suppose. I don't remember the exact words I used when I spoke to Simon, but that was around other -- well, capability issues are likely to represent a danger to Patient Safety. I think that is probably what I was talking about there. Paragraph 3 is me pontificating with the benefit of hindsight knowing what I know now, not what I knew when I spoke to Simon Gibson. 10:56

197 Q. Let me read the remainder of the passage:

"My observation is that Simon Gibson cannot have been fully informed at the time he contacted me because - you - find it difficult to believe that there were not prior concerns about capability before this call took place". 10:56

You go on to say:

"Anecdotally I understand that there were individuals who worked with Dr. O'Brien who had concerns about his capability for a long time. I do not have any documentary evidence that these concerns were ever raised formally". 10:57

In terms of capability, what were you thinking and capability as distinct from what?

A. Okay. When Dr. O'Kane spoke to me in 2020, July 2020 I think it was, she mentioned a review of, I think it was 300 cases in which there were 40 something percent, 46 percent, perhaps, where there were matters of concern about the management of the patient. That sounded to me like a significant capability issue. 10:57
I mean, those are big numbers. Looking back, I just find it difficult -- and as somebody who has quite a few years of experience of managing doctors as well as working for NCAS, I just find it hard to believe that somebody could have that level of poor performance 10:57
and somebody not know about it.

This is not the first time I've given evidence to this effect to an inquiry. I was involved in a neurology inquiry and I was similarly dumbfounded as to how these 10:58
things could have gone on so long and nobody seemed to know about it, you know.

198 Q. We'll go on in a moment just to look at the screening stage which should take place before a formal

investigation and try to tease out whether there is anything to be gained by better defining that stage of a process. In terms of capability, just to be clear, at the time when Mr. Gibson was speaking to you, and you're saying that he mustn't have been aware or cannot have been fully informed, again you're looking at that with the benefit of some hindsight; you've had your discussion with Dr. O'Kane by the time you have written this. You refer also to anecdotal understandings brought about from individuals who worked with Dr. O'Brien. What did you have in mind there when you wrote that and who had you been talking to?

10:58

10:59

A. Again, this was something that occurred long after my discussions with Mr. Gibson and also long after my discussions with Dr. O'Kane, by which time this was all in the newspapers. The problems were all over the newspapers and everybody knew about it. I had a meeting with a doctor who happened to be a urologist about an entirely unrelated issue, nothing to do with this, and I suppose as part of the chit-chat in around the meeting, I asked did other urologists have concerns. This particular urologist described a number of incidents which had occurred when he was a junior doctor working in the same unit as Mr. O'Brien, and he described some rather odd forms of treatment, which I don't recall because I'm not a urologist and I didn't go into it in any great detail. But it sounded odd to me and he certainly thought it was odd. So that's, I suppose, where that comes from.

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11:00

199 Q. Just to be clear, who was that?
A. That was a urologist in Belfast, Mr. Hagan.
200 Q. Mr. Hagan?
A. Yes.
201 Q. What's his first name? 11:00
A. Chris.
202 Q. Chris Hagan. Thank you.
A. If you want more information about his views, you'd have to talk to him.
203 Q. Of course, of course. That's very fair, you're not 11:00
a urologist. I suppose what you took from that, in some respects, caused you to construct this paragraph that more must have been known within the Trust.
A. I just find it hard to believe that somebody can have
gone off normal treatment to the level which I've seen, 11:01
not so much in this but also read in the newspapers and in other places, and nobody really seemed to know about it. I just find that hard to believe. This is not the first -- as I just said, it is not the first time I've
come across this situation. As somebody who has for 11:01
many years managed quite a number of doctors, I like to think I had a handle on who was good and who had problems, and was able to intervene when I had somebody with problems.
204 Q. You talk in your statement as well, if we go over the 11:01
page, to page 67 for you.
A. Yes, go ahead.
205 Q. And it's paragraph 13.
A. Yes.

206 Q. You talk, helpfully I think, that categorisation of the initial concern can make a significant difference to how a case progresses with the distinction between capacity with options for assessment and remediation and conduct which can lead to disciplinary. If Simon Gibson, you say, did not know about any capability, clinician capability concerns in September 2016, that avenue under the MHPS Framework effectively disappeared. 11:02

As I say, we're going to go on just in a moment to look at the issue of screening and the availability of, if you like, soft intelligence or soft information. What you may not know is that Simon Gibson is asked to perform this screening exercise effectively off the back of the March 2016 letter which identified the four issues that were rehearsed to you. 11:03

A. Yes.

207 Q. Is there a problem, or can you help us in trying to assess whether there's a problem, in that he gathered the information for that screening report -- 11:03

A. Yes.

208 Q. -- by speaking to operational management. He was feedings back to this group that I've called the Oversight Committee, and there was no intervention, no contribution from clinical colleagues of Mr. O'Brien, I think it's fair to say. So, the Associate Medical Director was not brought into that loop; the Clinical Director wasn't brought into that loop; the Clinical 11:03

Lead was not brought into that loop; none of his colleagues who don't hold managerial roles but are on the medical side and are senior clinicians were spoken to. Is that the kind of information that needs to enter into the system at the earliest possible stage in order to get the categorisation correct? 11:04

A. I think that's reasonable. Sorry, my camera has frozen, I'm going to reset it.

Yes. Simon went to the operational managers because that's Simon's world. Simon is an operational manager, do he went along and he would have got the feedback around delayed triage, the things causing bother to the operational managers. You're absolutely right, if he had gone along to the medical colleagues, he would have probably got a different bit of feedback. He might have got some of the same stuff but he would also have got a more nuanced feedback on capability. 11:04 11:05

I suspect if a medical person had been asked to do the screening report, it would have probably looked a little bit different because they would have gone to the medics. So, you're absolutely right, and I think that's a reasonable observation, that, you know, somebody should have asked his medical colleagues. 11:05 11:05

209 Q. On the face of the letter - and I don't need to open it again unless you need me to - you refer to a review date of 7th October 2016. I don't think you made contact with The Trust and The Trust didn't make

contact with your organisation until December. What's the significance of a review date and in the particular circumstances of this case where your advice was being given to be digested by the Trust and applied, if appropriate? Should there have been a review? 11:06

A. There should have been a review. The records aren't very good here. I have no access to my emails from that time. So I should have, if I hadn't heard from The Trust within, I don't know, six or eight weeks, chased them to find out what is going on. Whether 11:06 I did or not, I don't know. My system for record-keeping at that time usually involved spreadsheets which are no longer available to me. I actually don't know whether I tried to phone Simon or I emailed him, or what happened or whether I just 11:07 dropped off the radar. I actually don't know the answer to that question.

But in terms of what should have happened, I can tell you what should have happened, which is we should have 11:07 tried to make contact with Simon and find out what had actually happened which would give us a chance to provide further advice.

210 Q. Okay. The next stage in this story brings in your colleague, Dr. Lynn. 11:07

A. Yes.

211 Q. As I've explained to you this morning, on the 22nd December, Oversight Committee met and decided that there would be a formal investigation, that there would

be exclusion, albeit that Dr. Wright would seek advice from NCAS. By that stage, the Trust was in receipt of the findings of a Serious Adverse Incident review that was to be signed off completely in the early months of the new year. The Trust had reached the view that on the basis of that primarily, there was now a significant Patient Safety concern from their perspective, and that the earlier advice from you, which hadn't of course been implemented, was no longer appropriate; they needed to move to a more formal approach. I think I have summarised that accurately. 11:08 11:08

Do you understand or follow the rationale for the approach that's being suggested?

A. So, now there is a Patient Safety issue. I know when I looked at the case after Gráinne had given that advice, I actually thought the SAI related had happened something in between when I spoke to them in September and heard discussion with them in December. Turns out it actually predated that by quite some time. 11:09 11:09

But yes, there's a Patient Safety issue now so we need to ensure Patient Safety. Now, whether exclusion was the only or the most appropriate thing, I wasn't involved in the discussion so I'm not going to comment on that. Certainly there are alternatives available. Sorry, my screen keeps freezing here. 11:09

212 Q. Yes.

A. So, you know, certainly the fact there's now a Patient

Safety issue does change the game. Whether that automatically means exclusion is a different question.

213 Q. Is it not the case when you think about it or reflect back on it, the fact that triage wasn't being done, except for red flag referrals, that was known for some time; that's what you were being told in September. To the extent that a failure to triage raises the potential for patient jeopardy, is that an issue that ought to have been recognised and grappled with earlier, even if it didn't lead to a formal investigation? 11:10 11:10

A. On reflection, yes. On reflection when I think about it now, failure to triage must involve some risk to patients, and the fact of the subsequent SAIs and things proved that. Perhaps I should have probed that a little bit more with Simon when I spoke to him. Whether that would have changed the advice is a different question. 11:11

214 Q. Yes. You have offered some reflections on this changing of the circumstances in your witness statement at page 66. 11:11

A. Yes.

215 Q. We can bring up WIT-53790.

A. Okay. Go on ahead.

216 Q. Paragraph 10 at the bottom of the page, if we can start there. You talk about what you describe as the substantial shift between the initial call and the 28th December engagement, by which stage there was a more sizable problem as by that point a Serious Adverse 11:11

Incident had been identified and there was concern about patient harm.

I want to jump to paragraph 12 because this brings in the issue of screening: 11:12

"Upon being informed of a Serious Adverse Incident and patient harm, I would expect a medical director to carry out a soft investigation in relation to wider concerns around clinical capabilities, which would then 11:12 inform the Terms of Reference of any subsequent investigation. This might be considered as another missed opportunity".

You go on to say, and I think did I read this out 11:12 earlier:

"The categorisation of the initial concern can make a significant different to how a case progresses..."

11:13

I ask these questions, albeit with a degree of hindsight available to us arising out of the revelations which Dr. O'Kane brought to your attention in 2020. There were these clinical problems emerging at that time, and you got some of the detail of that. 11:13

A. Yes. Go ahead.

217 Q. What should be done, in your view, by, for example, the Medical Director if a decision has been made on the basis of certain information that an MHPS

investigation, a formal investigation, is necessary? How do you set adequate but fair terms of reference? Adequate in the sense that we need to get to the bottom of the practitioner's shortcomings and any attendant risk to Patient Safety.

A. Obviously we have the information in Simon's screening report which is going to form a core of the terms of reference. But then, I suppose probably what I'm talking about here in terms of a soft investigation is a look-around and see are there any other issues of other practitioner's practice we need to look at. Well, I can tell you what I would do if I was the director. I would maybe do a quick look at some notes; I would talk to some colleagues; I would say are there any other issues that we need to think about, and decide whether those justified putting in the terms of reference. That's what I mean by soft investigation; let's just see if there's any other issues here. Something might have emerged, I don't know.

11:14

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Again, yes, you would have spoken to admin people and secretaries and things like that but they would have come up with the issues Simon came up with. You are looking more at the quality of care. That's where you need to talk to medical colleagues about that.

11:15

218 Q. Do you think, on the basis of your experience, taking into account this case as well, is this important and, you might suggest, fundamental part of the process involving a good attempted or ensuring there's a good

attempt to categorise what the concerns are before you investigate fully; is guidance around that within the MHPS Framework somewhat lacking?

A. I think that's a fair statement, yes. It wouldn't be immensely helpful in drafting terms of reference. 11:16
Certainly in our training, we would have emphasised quite a lot about terms of reference and how to draft them and how to make them fair and specific. We also had a process - and this often happens and has happened to me when I'm doing investigations - where halfway 11:16
through an investigation, you suddenly discover another issue. I mean, I recall doing an investigation, which was a disciplinary issue, a conduct issue. About halfway through it, we discovered there was an enormous capability issue to do with this practitioner and 11:16
we then had to have a discussion with the case manager as to whether to change the focus of my investigation to include the capability issue or commission a new investigation, which was actually what they decide to do because it was so far distant from what was 11:16
I investigating.

But, you know, there is a process where, if you find something in the course of an investigation, for changing and either commissioning a new investigation 11:17
or changing the focus of your investigation. We do teach that in the case investigator training and case manager training.

219 Q. Because obviously, doctor, where we had in this case

a lengthy investigation, it took some 18 months to bring it to a conclusion, and where it didn't identify the kinds of shortcomings that were to come to life in 2020, the public will obviously be concerned about the MHPS process and whether it is fit for purpose for discovering these kind of things. Or perhaps the reflection is the MHPS is only as good as the people using it and if they don't take effective stock at the beginning, then it's not going to deliver the kinds of outcomes that are important from a Patient Safety perspective. 11:17 11:18

A. Absolutely. MHPS is a flawed process; there are many flaws in it. We could sit down and have a long discussion about how it could be improved. At the end of day, it is a process and if we don't follow it, it's not much use at all. So, it's not rigorously followed. It also doesn't replace common sense. You know, you still need to apply common sense occasionally. You know, yes, there are terms of reference and investigators are expected to stick to the terms of reference but that doesn't mean they can't listen to anything that's told to them. 11:18 11:19

If I go back to my example of the conduct investigation I conducted. During this, various witnesses said 'that's all very well, but I wouldn't let this guy operate on me'. When people say things like that to you, you have to go back to your case manager and say, hold on, there's a whole different issue here which you 11:19

need to be aware of and you need to decide what to do about, you know.

220 Q. On the other side of the equation, of course, from Patient Safety is the concern that nobody on the employer's side should be allowed to conduct an unfocused trawl because that would be unfair on the practitioner because, as you pointed out this morning, none of us are prefer and mistakes might be found on a cursory examination of anybody's file block. 11:19

A. Yes, absolutely. Yes. 11:20

221 Q. The advice that Dr. Lynn - and I don't think I need to bring this up on the screen - but Dr. Lynn advised in her letter, just using those words - this is AOB-01328 for your note, Chair - that the investigation should not be an unfocused trawl. 11:20

A. Yes.

222 Q. I suppose the point I'm making to you is that there's a step before the investigation --

A. Yes.

223 Q. -- so that screening as distinct from the investigation is what we're talking about here? 11:20

A. Yes.

224 Q. Is it fair to suggest that there should be an allowance for a degree of wide-ranging exploration at that point in order to safeguard patients, but then, after that trawl or after that the screening is performed, then you make your terms of reference very focused. 11:21

A. Absolutely. That's a reasonable process, that we look and see are there wider concerns. In many

practitioners, you'll do that un -- well, not unfocused but you'll do that initial assessment and actually you'll say there's no other issues here, it is just about the things we already know about. But yes, again if you have terms of reference which encompass all the initial failings, it does make life a lot easier.

225 Q. Are you still at page 67 of --

A. Yes. Go ahead, yes.

226 Q. Thank you. 11:21

At paragraph 14 you said:

"Even when the case was thought to involve clinical issues and apparent patient harm, there was a failure to progress a timely effective investigation within the Trust". 11:22

"We sent three separate emails chasing progress to the Trust..." - and you set them out - "which were not responded to and as a result the file was closed." 11:22

This goes back to what we were talking about this morning: You're a demand-led organisation, if the employer doesn't wish to respond, you can't make it respond. 11:22

A. That's correct, yes.

227 Q. Given that this investigation took the best part of a year and a half, and given that at the start of it there was a requirement on the part of the Trust to

develop an action plan and monitor Mr. O'Brien's practice, do you see that there were opportunities which the Trust could have used in order to improve their approach to this?

A. Well, not taking 18 months to do an investigation would be a good start. MHPS is largely, I think, to blame in this because MHPS puts an entirely unrealistic target of four weeks. I have rarely seen an investigation completed in four weeks, and only the simplest investigation is completed in four weeks. But what that does, this unrealistic target, is everybody knows they're not going to meet it, so it's worse than not having a target at all. Nobody expects you to meet it so the investigations just drag on. 18 months is, I will confess, exceptional but certainly it's certainly not the only one I've seen. So yes, completing it on time would have been a good thing. 11:23 11:23 11:24

The action plan, perhaps providing a bit more support to Mr. O'Brien at that stage, would have been helpful as well. So yes, there was a number of things that didn't go terribly well. The other thing is because the investigation is ongoing, everybody sits back and thinks well, this is all in hand, we're investigating it. 11:24 11:24

228 Q. I think you've had an opportunity, you mentioned this morning, to look at the action plan. It's at page 429 of the core bundle and TRU-02732 for us. I don't wish to go through the fine detail of it. I think you

adequately described it this morning in terms of it's a plan that tells Mr. O'Brien what he has to do; this is what you are required to do.

A. Yes.

229 Q. It is prescriptive in that sense. But you think that had NCAS been brought in to provide some advice around this, a different and, perhaps I take it from what you are suggesting, a better or more appropriate action plan could have been developed. What did you mean by that suggestion? 11:25

A. Obviously, we would like to think it would be better. Yes, we would have almost certainly looked at what support was required to help him achieve these things and we would also have had a much more staged process. So, in the first so many weeks, you will do this; in the next few weeks you will do the following and in a very staged process. This was just sort of you will get on with it and do all this triage and clear your backlog, but no suggestions as to how to do that and no support for him in how to do that. 11:25 11:26

I would suggest not setting up to fail -- well, it is setting up to fail, to be honest, it would be difficult to achieve these things. From what I've read in the bundle, he made a good go at it but failed on a number of occasions. He was able to keep up for a period of time, you know. 11:26

230 Q. Yes. Of course, the action plan itself is narrow in its scope.

A. Yes.

231 Q. It addresses the issues which are the subject of the MHPS investigation but, for all of the reasons we just discussed, it doesn't engage with the clinical concerns which were perhaps hidden below the surface at that time but which were to emerge in 2020. 11:27

A. Yes.

232 Q. Is there anything over and above what you've said already in relation to screening that you wish to add in terms of what NCAS could have provided had it been involved? 11:27

A. Again, perhaps if we had been involved at that stage of the process, we might have asked a little bit more in terms of what do we know about his clinical practice, his abilities, things like that. It's hard to know/speculate what we would have done but I suspect we would have asked more questions. I think you referred to us as a sounding board - somebody did anyway - and that would be bouncing ideas off us and we would be challenging to a degree what the assumptions were, because that's part of our role. 11:27 11:28

233 Q. Just a discrete point at paragraph 23 of your statement. This is page 68 of your bundle; WIT-53792. You say that an unusual feature of this case that we might need to think about is the number of medical directors or interim medical directors who had some responsibility for the case over a short period of time. Obviously Dr. Wright in 2016, he went off unwell. At the start of '18, Dr. Khan came in as an 11:28

interim in '18, handing the reins over to Dr. O'Kane At the start of '18 start of '19.

Is that a recipe, are you suggesting, for perhaps people taking their eye off the ball or a lack of -- or a less than optimal flow of information, or what are you suggesting? 11:29

A. I'm suggesting-- Richard Wright had come in, he had not previously worked in Belfast and had no experience in the Southern Trust, nor had Maria O'Kane. I think Dr. Khan had previously worked in the Southern Trust. So, there's a loss of organisational memory there. I mean, the Trust that I worked in, South Eastern Trust, in all the time I worked in the organisation, we had the same Medical Director, and he knows everybody. He's still there and still knows everybody, you know. Whereas if you are in post and move on very quickly, that memory isn't there and it's not written down. It should be all written down but it isn't. The turnover just means that you get into post, you start to get a feel for what are the issues, you start to address them and then you're gone. 11:29 11:29 11:30

234 Q. The remainder of that paragraph deals with - this is the top of your page 69 - it appears some of the gaps in communication were compounded by Dr. O'Brien's sick leave. His sick leave was a relatively short period of time between 15th November '16 and 3rd January '17. He was spoken to for the first time about these issues obviously in March but, after March, on the 28th 11:30

December 2016. I'm not sure I understand your point. I would ask you to just clarify, if you can, how his short period of sick leave --

A. On reflection, the word "extended" shouldn't be in there. That's an error on my part. Probably due to understanding. 11:31

235 Q. Thank you.

A. Having said that, the sick leave won't have helped matters. My understanding, and I could be wrong here, is that the issues -- that sort of was another thing that delayed raising the issues with him. 11:31

236 Q. I think you're right. Certainly what we've heard, what the Inquiry has heard in evidence is that following the advice that you provided in September 2016, there was an intervention on the part of the Director of Acute Services to, if you like, stay the process of dealing with this because Mr. O'Brien was going off on sick. From that perspective, you don't think that helpful? 11:31

A. No. No, I don't. I think you need to address these things. I mean, after I spoke to Simon Gibson in September, I was sort of expecting a phone call a week or two later saying 'can we get that meeting organised'. I was a little disappointed when that didn't happen. 11:32

237 Q. Now, we know that come the end of the MHPS process in September 2018, your colleague Dr. Lynn was contacted by Dr. Khan and further advice was sought.

A. Yes.

238 Q. Were you out of that loop at that point?
A. Well, I wasn't out of the loop in that I was Gráinne's line manager so we would have probably discussed the indicate at various points. But, largely speaking, she was taking the lead. 11:33
239 Q. Yes. You were contacted by the Trust in 2020, not in an MHPS context per se, albeit you did provide advice that these new matters that Dr. O'Kane was raising with you should be viewed through an MHPS lens; is that fair? 11:33
A. I'm trying to find the letter in question. Hold on a second. Do I have it here? Well, I mean, from memory Maria phoned me and told me that there had been further developments, that a review of a number --
240 Q. This is - just to assist you - your letter to Dr. O'Kane is 9 July 2020. 11:34
A. Sounds right.
241 Q. Page 54 of your bundle. If we could have it up on the screen, please, WIT-53483.
A. 9th July 2020, my birthday as a matter of interest. Yes, we discussed him in the past and I recounted some of the previous issues. She specifically said she was concerned with the lack of insight. I remember her saying that. The issue around private practice, and she'd referred him. She told me a little bit about the grievance, which appears to be another thing that delayed everything. Then she told me about this review they had done of 300 records where there were matters of concern in 46 percent, which were things like 11:34 11:34

unusual treatment, scan -- well, I've mentioned scan results; not entirely on the matter but I vaguely remember unusual forms of treatment and things like that being mentioned, and a number of SAIs in the treatment of the things. So, at this point now alarm bells are starting to ring in my mind and I'm start to think this is a bigger issue because those figures are quite startling. At this point I said this is a big issue here. 11:35

She was talking about doing on a preliminary inquiry, etcetera, etcetera, and I then said, well, we need to look at Patient Safety, and also then highlighted the fact that this was -- because it was clearly a bigger issue, I thing suggested that the Department of Health would want to be informed of it because it had significant potential to cause embarrassment. 11:35

242 Q. Yes. Well, the early alert to the Trust sent to the Department came at the end of that month. Are you suggesting in your answer that Dr. O'Kane, and perhaps the wider Trust, hadn't yet grasped the significance of this, or is the fact that she's calling you at this point indicative of a concern on her part that this has got exponentially more significant? 11:36

A. I may have misjudged Dr. O'Kane here, but my impression was that she hadn't actually thought through this issue, that this had a potential to be a huge issue and that she would need to inform the Department of Health. That was my impression. Again I can't read her mind so 11:36

I don't know exactly what her thinking was. But my impression was when I said that to her, it was sort of news to her. Well, the rest is history.

243 Q. Yes. Certainly we can see it at your page 55 and our 53485, just scrolling down, that you said: 11:37

"If the patient numbers indicated by your initial inquiry of 300 cases are supported by further investigation, this has potential to cause significant public concern. I therefore suggest that you alert the 11:37 Department of Health".

A. Yes.

244 Q. Did you raise the issue of private patients?

A. I do mention it somewhere there , don't I? Concerned about the interface of health service and private 11:38 practice. I then suggested:

"He will be asked to voluntarily refrain from seeing private patients which you believe he has previously done at home". 11:38

My understanding from this discussion was that he didn't function -- he didn't do his private work in the way many doctors do and see people in the Independent Clinic or wherever it happened to be, that 11:38 he actually would have people come to his house and basically did outpatients private work; he didn't do any operative private work. I said I suggest you stop asking him to do that. If he then left employment,

she would no longer be his responsible officer so she would then have to talk to the GMC about that. At this stage, he was about to retire.

245 Q. You may have appreciated that in 2018, Dr. Lynn had provided advice in respect of private patients, that he should be asked to desist from private work. Have you any understanding as to why the Trust hadn't been able, to put it at its most neutral, to implement that advice? 11:39

A. No, I've no idea why not. To be honest with you, I didn't read Gráinne's letter in great detail before speaking to Maria, so I didn't spot that at the time. 11:39

246 Q. You were able to close the case from an NCAS perspective. We can see at page 382 of your bundle -- this is WIT-534746. 11:39

A. Oh yes, that's an email.

247 Q. Yes. Karen Wadman is --

A. Karen Wadman is my boss.

248 Q. Yes.

A. She's second-in-command at NCAS (inaudible). 11:40

249 Q. So there's nothing unusual around you closing the case at this point; matters were in the hands of the GMC and, as you were shortly to find out, there was to be a public inquiry following announcements at Stormont.

A. Exactly. At this stage we're advising the Trust. The Trust have no longer any action they can take so there's not much point keeping the file open. The GMC had it in hand. Generally speaking, once the GMC took an active interest in a case, we would tend to close 11:40

it.

250 Q. At page 384 of your bundle, we find an internal note.

A. Yes.

251 Q. It's WIT-53754.

A. Yes. 11:41

252 Q. This is a chronology prepared for the Practitioner Performance Advice Core Operational Group. Is that an internal group or committee within NCAS?

A. That was basically our senior management team. I'm not quite sure why it's called a core operational group but 11:41 it's basically a senior management team. After a number of cases that we were involved in over the years, Patterson, Watt and various others, there was an awareness that there were certain cases that were likely to achieve a higher profile, a higher public 11:42 profile. Basically we set up a system of flagging those to the senior management, that here's one that I think might go further.

253 Q. Yes. We can see -- just to cut across you but just to assist you, over the page, if we can scroll down, that 11:42 what you are providing within this document is a chronology to assist your senior management group?

A. Yes.

254 Q. The reason the chronology is ticked as being significant concern and a high-profile case. 11:42

A. Yes.

255 Q. Is there any sense of this being a document, because NCAS was concerned, that questions might be asked about its role in all of this and that it might be the

subject of criticism around the services it provided?

A. I don't think so. I think, certainly -- well, that's not the way I took it. Certainly you wanted to be prepared. If somebody is going to come along and ask you what you did about this case, senior management wants to know about it. I suspect there's also a certain amount of let's have a look at this chronology and see did we miss anything along the process here. Yes. But I was simply asked to prepare this chronology, which I did, and it was then put in this format and submitted to the COG. 11:43 11:43

256 Q. Thank you.

In terms overall, your reflections on the NCAS role in this case, is it a case that you think between yourself and Dr. Lynn, the advice provided at the various interventions was appropriate, or do you reflect that this was a case that might have been done better from your perspective; we might have been more proactive or we may have touched on various other issues or methodologies that might have assisted the Trust to get to the bottom of all of this somewhat quicker? 11:44 11:44

A. Well, first of all, you have to remember that the responsibility for managing doctors doesn't rest with NCAS, it rests with the Trust. So, that's important. But could we have done it better? Just to analyse, I think actually my initial advice I would stand over and I would give the same advice today, more or less. There might be subtle difference but generally 11:44

speaking.

When Gráinne agreed with the suggestion to exclude, that was a reasonable thing to do. There might have been options there, I don't know, and I wasn't involved 11:45
in that discussion so I can't actually answer to that. Then we chased them. Then you could question is our policy - and this was our policy - that if we didn't get any response, we didn't keep the file open, we just closed, assuming that the Trust would get back to us if 11:45
they needed us again. That's back to the voluntary involvement Trusts have with us. You know, if they don't want to speak to us, we can't make them. Whether that policy is correct or not, I think we could debate that forever. Then you would have to ask if that 11:45
policy is not correct, what's the alternative. Do we just keep the file open forever? Because we have obviously got limited resources, like everybody else.

What else? The later part of involvement, I think my 11:46
involvement at the end - just to speak to my involvement - with Dr. O'Kane, I think was reasonable and appropriate. Again, I don't think I would advise significantly differently now. 11:46

I can't really speak very much to the advice that Gráinne gave Dr. Khan. I think you'd probably want to talk to her about that.

257 Q. Yes, I think that's fair.

MHPS generally then; I think you've offered up some thoughts already. Page 67 of your bundle, if we go to WIT-53791.

A. Of my bundle? 11:47

258 Q. Yes, page 67 of your bundle.

A. Got it.

259 Q. You will find at paragraph 16, if we scroll down, please, something I think you've said already. One of the problems which the Inquiry has heard through 11:47 a number of witnesses is that those charged with the responsibility of taking MHPS investigations forward are, inevitably, busy practitioners in the main. Some take on a second role in senior medical management. In this case it was an Associate Medical Director 11:47 investigating, and an Associate Medical Director soon to become an Interim Medical Director holding the case manager role. They are assisted by a human resources skill set but, again, she had her day job and all that that entailed. For whatever additional reasons, but 11:48 that being a large part of it, the absence of preserved time to allow them to get on with it caused this matter to stretch over 15, 18 months.

You highlight that a four-week timeframe as set out in 11:48 the framework is almost always unachievable. I think you are sympathetic to the view if it's almost always unachievable, it shouldn't be in the framework as that kind of aspiration?

A. Yes, absolutely. I would agree. I've said 12 weeks here, which I think is probably pretty reasonable. If you asked me to design the time scales, I would say 12 weeks with the possibility of extension but you have to justify your extension every four weeks. That's sort of the way I would do it, because you want some pressure on to keep it down but you need to be achievable. 11:49

Twelve weeks. The other problem - you referred to this - the other problem with the process is they pick the busiest person in the organisation and ask them to do it. The best investigations I've seen done have been done by externally commissioned investigators who come into the organisation and worked full-time on it and cleared it. That works well, that level of resourcing. There are many -- I've seen, for example, retired consultants, they're a pretty good resource, recently retired consultants doing investigations. I've seen independent -- there are companies out there who will do these investigations for you and will do them very well, and there are a number of independent consultants who will do them. The advantage is, yes, it costs a couple of thousands pounds to get the investigation done but it is an awful lot cheaper than letting it go on for 18 months, and the damage that does to the service, to the practitioner, and just general overall costs. Giving an external person is few thousand pounds is nothing compared to the overall of these 11:49 11:50 11:50

processes. I would suggest that you need -- it is about putting proper resource in and making investigations happen.

The same applies, if you look at the grievance, how long did it take? It took the best part of maybe two years to be cleared and the SAI took the best part of a year. Those things should have been done much, much quicker and that would have moved things forwards a lot better. 11:50

260 Q. Yes. I think many of those other examples, or those two other examples you referred to, are at least in part trapped by this requirement quite often to use medical management resource to progress them.

A. As somebody who has been a medical manager, it is not an easy job and we don't have a queue of people wanting to be medical managers, I'll tell you that. Most clinical director jobs basically -- well, one of my clinical director jobs, I was more or less bullied into taking because nobody else wanted it, you know? 11:51

261 Q. Just a couple of other points before we finish, doctor. Paragraph 25, if you scroll down or turn the page to page 69 for you. It is WIT-53793 for us. I think this is relevant to something you've said already. There's only one requirement and that's in the context of exclusion, or suspension as you've called it here, for NCAS to be contacted. You've made the point that there's no requirement for other notifications. 11:52

A. Yes. In this one, I think I'm actually referring to

the escalation -- at six months' suspension they're supposed to inform the Department, but also you are absolutely right, the other point is where they have to contact us before a formal exclusion. So those are two points in the system where things have to be done. Again, if I was rewriting MHPS, I'd put a few more of those points in because it is about holding to accounts.

262 Q. You go on to say and recognise at paragraph 26 that whether it is a grievance or whether it is sick leave, that has the potential to hold up the process. Sometimes from a Patient Safety perspective, perhaps, that isn't helpful. Sometimes from the perspective of the organisation being able to move on, I'm sure, that's not helpful. No doubt these matters, if they're still hanging in the air, aren't helpful for the clinician him or herself.

Have you any particular or specific thoughts around that? You suggest that this needs to be looked at and greater guidance given.

A. I think there needs to be great guidance. One in particular is where you're in the middle of an investigation and the practitioner launches a grievance. And often investigations are halted and left sitting until the grievance is cleared. Sometimes that's appropriate. In this case, it probably was appropriate because the grievance was actually about the process of investigation and commissioning the

investigation, etcetera, but often the grievance is unrelated and still the investigation process is stopped. The only guidance out there that I'm aware of really, there's ACAS guidance on this which is reasonably good but that can probably be put into -- 11:54

263 Q. Did you say ACAS guidance?

A. ACAS, not NCAS. Another lot. The opposition.

264 Q. We'll perhaps look at that and thank you for pointing that out.

11:54

You make the point at paragraph 33 - this is page 70 of yours and 53794 of ours - that overall, the MHPS Framework probably needs updating and recalibrating. You say:

11:55

"However, of greater importance is the implementation of the MHPS Framework by the Trusts themselves".

That's a little cryptic for me. What are you getting at there with the latter part of that sentence? 11:55

A. Just that if you have a guidance, we need to be very clear that it's definitely being followed, certainly in spirit and preferably down to the letter. Sometimes people -- that doesn't always happen.

265 Q. Yes. This particular trust, the Southern Trust, we can see, perhaps by contrast with other Trusts in Northern Ireland, developed a set of local guidelines in 2010, held training around those for key managers, as we can see taking steps to regularly use your services to 11:55

train staff; has developed a new set of local guidelines complement MHPS; adopting lessons, they tell us, from the experience of the O'Brien case. I'm not asking you to give them a score out of 10 but is that degree of proactivity around MHPS, is that by positive contrast to some other organisations?

A. Well, I suppose the first thing I'd say is that in the year or two prior to me leaving NCAS, things had improved significantly. Most Trusts now had basically followed more or less the process you've just described. We had provided training to, I think, all Trusts in Northern Ireland, bar the Ambulance Trust who don't really have any doctors. They had all, for example, acquired -- this is actually one of the things that's quite useful. They had all developed a role for an administrative person to make sure that all of these processes were being followed. You know, ticking all the boxes, here's this case, where is it in the process and what's the next step. That's an administrative task. You don't need a medic to do that, you need a good administrator to do that. I think all of the Trusts now have people in place to do that and that is really helpful, just to make sure things keep moving. Quite often we would have had discussions with whoever the person in the relevant Trust was about where a case was and what to do next. So yes, things have improved but that doesn't mean MHPS doesn't need some revision.

266 Q. As we saw earlier, we have your suggestions, albeit dating from 2011 to the Department. I don't need to

11:56 11:56 11:57 11:57 11:57

open those again. But do you consider that the failure on the part of the Department to bring revision through the MHPS arrangements, for whatever reason, is regrettable and something that does need to be addressed? 11:58

A. It is disappointing. MHPS was written in a different era when the health service was in a different place and was doing different things. It needs updated in many, many, many ways. I sat down and went through it last night - sad person that I am - and came up with about 20 areas where I think it could be improved. Even a simple thing: Why is MHPS about doctors and dentists? When it was written, doctors and dentists were the major autonomous practitioners in the health service. Now we have nurse practitioners, we have paramedics who are practising autonomously, so should we be including them in this process? MHPS was about fundamentally about dealing with autonomous practitioners because managing them is different to managing people who follow protocols and guidelines. 11:58 11:59 11:59

267 Q. Obviously, as you know, the Department is now engaged in the review of the framework.

Just to finalise. We have it on the screen, just to go back to this line "greater importance is the implementation of the MHPS framework by the Trusts". Is that alerting us to any particular aspect of the framework which are the Trusts are not following? Are you saying that there are cases where they should 11:59

follow it but they don't, for whatever reason, follow it?

A. Well, when I last worked in this field, which is several years ago now, there were occasional cases where, you know, you discovered that MHPS hadn't been as rigorously followed. There were things like -- I think I mentioned earlier that notification to the Department at six months' exclusion. I wouldn't be convinced -- now, I don't know for certain because only the Department could answer this question for you, but I wouldn't be absolutely certain that that happens without exception, you know. That's just an example, just one example of something I just have a feeling maybe isn't as rigorously done as it could be. 12:00

268 Q. Thank you. 12:00

Thank you again, doctor, for your answering my questions this morning. The Chair will now speak to you, and she and her Panel member and her assessor may have some additional questions to you. But thank you for taking the time to speak to us this morning. 12:01

CHAIR: Dr. Fitzpatrick, I appreciate it is midnight with you; at this point it is well beyond the working day for you. If you bear with us, hopefully we will have a few short questions for you to answer. I'm going to go, first of all, to Mr. Hanbury, who is the Inquiry's urology assessor. 12:01

We just have to switch the screens here so that we can

see Mr. Hanbury and make sure we hear from him.

MR. HANBURY: Thank you. Are you hearing me?

CHAIR: Yes, we can.

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS: 12:01

269 Q. MR. HANBURY: Thank you very much for your candid and helpful evidence. I have three short questions, I promise. 12:01

The first going right back to the March 2016 letter with respect to your initial approach to the diagnosis process of the problem. There were those four things that the managers were concerned about . Do you think, 12:02 looking back, what you would have offered had you been involved at that point is to have recommended things re triage, dictation, notes at home, PPs, and sort of done it in a sort of short, sharp fashion? I guess that's my question. 12:02

A. You mean if I had been involved in March 2016, would I have advised --

270 Q. Yes.

A. Okay. Yes, is the straight answer. I would again -- which reflects what I said in September, is this is 12:02 a massive piece of work, you can't just ask him to do it. You need to provide him with the resources to do because it would be very, very difficult to do it any other way. Sorry, I'm going to reset my camera here.

Yes, I would have advised differently and more along the lines of providing resources and support, and probable more careful monitoring.

271 Q. In fact, with more support there may have been a better outcome at that point, I guess is where I'm driving at? 12:03

A. Yes, you'd like to think so. Yes.

272 Q. Just moving on, you made an off-the-cuff comment about - moving on to September 2016 - expecting a call back from Simon Gibson following your initial contact with him, rather hoping for a meeting. 12:03

A. Yes.

273 Q. We heard from other witnesses that there's this reluctance to actually engage with Mr. O'Brien face-to-face. Had a meeting been set up, would Mr. O'Brien have been there or would that have just been with Mr. Gibson and the Oversight Group? 12:03

A. No, no, no. The point I was trying to make is we need to meet with Aidan O'Brien and have the discussion with him. There would be no point me meeting with the Oversight Group. The idea of the meeting would be to get him engaged and get him on board and, you know, get him to realise that we have a shared problem here and we need to solve it. 12:04

274 Q. The third one. Yes. My other point is when you are speaking about your initial discussion with the senior decision-maker, i.e. preferably the Medical Director, once that had been done and you'd sorted out an action plan, do you think you would have had to have spoken 12:04

again with the Medical Director, or would someone like a clinical director who has more operation knowledge of the problems would be a good person to talk to?
I suppose what I'm asking does it always have to be the most senior decision-maker or can you go down the sort of food chain later?

A. I think that's probably reasonable. Certainly at the beginning, we need to have a discussion, I think, with somebody who can take decisions and decide the way forward. Yes. When you are just monitoring progress, I suppose you could, as you say, speak to someone whose a bit more operational, with the proviso that if we say, hold on, there's a big decision to be taken here, it's not working, you can go back up the ladder.

MR. HANBURY: Thank you very much. Those are all my questions. 12:05

CHAIR: Thank you, Mr. Hanbury.

Dr. Swart then.

DR. SWART: Can you hear me? 12:05

CHAIR: Yes, we can.

275 Q. DR. SWART: Thank you. I can identify with a lot of your views and recommendations having had the privilege of multiple interactions on most of these things. 12:06

It is my observation, particularly in the Southern Health Care Trust, that there was a huge fear in relation to managing doctors, some of it because they had this view that everything had to be done under

MHPS; rather a lack of understanding about what I would call normal medical management. Much like in the old days, you just called someone into your office if you were Clinical Director and said come on, we can't do this, and if they don't do it you write them and email, a letter and help them do it, you don't think you have to go down a big framework. But it is still management.

Now, I don't think there's a good understanding about this, certainly at the Southern Healthcare Trust at the time this happened and probably in other institutions. Whose role is it to deal with this in your view? Where does the responsibility lie and is it a combined one, and is that something that NCAS could help with since you see what happens when it goes wrong?

A. Yeah. I mean, one of the problems is the way we get into medical management, which is usually by accident. There's not really a lot of lot of -- in recent years, the faculty of medical leadership, or whatever they're called, and other people have provided a bit of training, but there's precious little training out there for people to be medical managers. You're absolutely right, they sort of get scared by processes like MHPS. It's not helped by defence organisations who scare them as well. They don't realise, as you say, you can apply common sense and just do it. Quite often - I mean back to what I think I said earlier, particularly with conduct issues - the best advice

I can give is just do what you would do if it was someone else.

What can we do? There needs to be training. Whether that's for NCAS to provide or somebody else, I'm sure NCAS, if you asked them nicely and paid them enough money, they would do it. 12:08

276 Q. Do you think it would be helpful to have a warning in the MHPS Framework to say 'by the way there is normal medical management'? 12:08

A. That wouldn't go amiss. That wouldn't go amiss.

277 Q. Because actually the number of times people, in any experience, would come to me and say we have doctors, we have to use this, and I would say no, it's common sense. 12:08

A. I agree with you.

278 Q. In this case, and I'm sure you found it in other places, there clearly are multiple issues with the whole investigation, with the whole interaction with NCAS but it seems to me that they basically ignored lots of things in terms of the NCAS advice. That's what it appears to me. I don't know if it was entirely deliberate or if part of it was accidental but it indicates as a cultural problem, I think. In your experience over the time you've been doing this, what are the cultural issues at play that cause this sort of attitude? Or do you not think there are any? 12:08 12:09

A. Oh, there are. First of all, I think you pointed this, there's this fear of -- you know, they treat doctors

differently when they shouldn't. They're just employees. And doctors, many of them often think they should be treated differently, which doesn't help matters. Doctors are senior people, they're well-paid. Many of them, particularly surgeons, are fairly dominant. So those are all issues that make it difficult to manage doctors.

You're absolutely right, there are a number of cultures around. I mean, there's a terror of MHPS. If you look, for example, there's the formal and informal processes in MHPS. Everybody is terrified to go to the formal processes, whereas actually there's not that much difference. 12:09

279 Q. Would you agree all of that needs to be more clearly defined, because people seem to have got their knickers in a twist about it? 12:10

A. Yes, yes. They do. That's a reasonable suggestion. Yes, they have. They've got really messed up with it. They get terrified of going "formal", whatever that means. As I say, I'm not entirely sure that there is that much difference because you are still applying common sense; you're defining the concerns, investigate concerns, you're deciding what to do about it. 12:10

280 Q. Another thing I think it would be helpful for your observation on this, the administrative issues, as they were called in this, are really very extensive, yet there was a blindness because people felt it was totally unrelated to clinician capability. In your 12:10

experience is there quite often a link between very severe administrative issues, conduct and capability, or do you think it's possible to separate them like this, like they have done?

A. No. Actually, I suppose I have to confess, reading through this bundle I was getting increasingly irritated by referring to these issues as administrative because not writing notes, not triaging patients on time, not writing letters to GPS are not just administrative issues in sort of the way that -- you know, it's not the same as not having, you know, put your parking sticker up on the car. It is a different type. This goes to the core of clinical care. Because when you're a surgeon, only a little bit of your work is cutting, the rest is it is what has been referred to as administrative in this. There is an overlap. People who are bad at one area of their practice are often not terribly good in other areas as well. So, yes, there is a connection and an overlap. 12:11 12:11 12:11

I suppose if I was to criticise myself, probably in that discussion about Simon Gibson I should have majored a little bit more on that.

281 Q. Finally, there's a little bit of hiding behind 'we can't do an unfocused trawl, therefore we can't look too widely'. But an unfocused trawl is different from no trawl. It would appear to me that in this case, there was very little objective information available about the quality of work in this department because 12:12

there's no audit, there's no metrics. Everybody just said he's a very nice guy who works very hard, which I'm sure is true.

Is this a common problem in Trusts, that they don't know where to look because they don't have enough automatic data and information? 12:12

A. It is less common than it used to be. It is actually, interestingly, more common for them not to have data in other specialties. In surgery, I've always found they tend to have reasonable data because surgeons do things like count the number of operations they have done and how many patients have died, things like that. Try doing that in psychiatry. So, it is a little unusual for a surgical specialty not to have any decent data at all. My experience is they generally do have. Whether it is part of a national database - I have seen cardiac surgeons who have been called up because their failures on a national database went over a line - or be it local data. But surgeons tend to have better data, so this is unusual. 12:13 12:13 12:13

282 Q. Do you think the term "unfocused trawl" could be qualified a bit in the various advices so that people actually realise they do have to ask, they do have to enquire, because not knowing is not an excuse, is it? 12:13

A. Again, when you are rewriting MHPS, we need to put in something about we need to have a wider look, a wider look at a practitioner's practice to see if there are other issues which might require investigation.

283 Q. Okay. Thank you very much. Very helpful.
A. Thank you.
CHAIR: I won't be very long with you, Dr. Fitzpatrick, but I was interested to hear you had received some training yourself in the use of mediation. I just wondered is that something that might have been of assistance, certainly with regard to some of the aspects of this case? 12:14
A. Yes. Well, I'd like to think so. That was sort of part of my offer to meet because I felt that those skills could be very useful in terms of coming to some sort of common ground that would advance this case. My mediation training was one of the most useful things I've had, apart from doing pure mediations which I have done on quite a number of occasions, usually with warring practitioners. But even just the skills that come with mediation make it easier to manage a meeting and get a result. 12:14
284 Q. Do you think it would be a useful training for medical managers generally? 12:15
A. Yes. Yes, I think so. I think some of the skills, even if they don't want to go off and be mediators as such, the skills acquired are very useful.
285 Q. One of the things that we have heard, you were saying about -- you give the example of an investigation that you were involved in where everyone was saying, 'well, I wouldn't let that person operate on me', and that led you to go back to the case manager and say there's a wider issue here. 12:15

A. Yes.

286 Q. The opposite was true in this case. Everybody was saying he is a great clinician, he's a great surgeon, there's no problem there. That seems to have blinded people to perhaps doing a more focused trawl. 12:15

Is that one of the problems that there are in terms of carrying out these investigations? I think Dr. Wright summed it up by saying it was -- I'm paraphrasing what he said but basically it was an overreliance on 12:16 deference?

A. Yes, I think that's fair. I mean, this is somebody who was very senior. He had obviously done great things in the past and he had set up the service and run it and there was significant deference to him. Certainty from 12:16 my experience, having spoken to Mr. O'Brien, he's an awfully affable, pleasant fella. All of those things would make it more difficult for people to suggest that there was an issue with his practice, yes.

287 Q. Is that all the more reason then, where you do have 12:16 someone of that seniority and that reputation, that it is important to bring in someone external to lead this investigation?

A. Yes. Again, an external person won't be blinded by the fact he's the most senior surgeon and he has been there 12:16 forever and everybody likes him. They will stick to -- they will actually do the investigating. I'm a great fan of external investigators because they don't have the baggage that comes with being part of the

organisation.

Also, if they are externally commissioned, they are on a commission, they are going to do it on time, they are going to do it in whatever timeframe you agreed with them. 12:17

288 Q. Obviously with the budgetary constraints that Trusts have, and we know that the Health Service have at the moment, what would your view be on a regional resource perhaps provided by the Department of Health where you have a pool of people with requisite experience and expertise who could be drafted in externally to a Trust. 12:17

A. That would work, that would work. Interestingly we have a similar sort of model in HSC at The Beaches where they have a number of consultants. I'm actually on their list of consultants of people who are available to do things like SAI investigations, etcetera. So they could expand their repertoire to cover performance investigations, so that would work. But yes, that's a good idea; externally commissioned but available. 12:17

CHAIR: Thank you very much, Dr. Fitzpatrick. I'm sorry that it's twenty past midnight and I'm sure you want to get to your bed. The rest of us are going to get some lunch before we start the afternoon session, but thank you for attending remotely. 12:18

A. Thank you very much. Thank you for starting a couple of hours early to facilitate me.

CHAIR: We did realise it would be very late when we were finishing.

I think we're due to start at one o'clock but I'm going to say 1.20 before we start this afternoon. Yes, it's Dr. Lynn. 12:18

THE INQUIRY THEN ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

13:20

CHAIR: Good afternoon, everyone. Mr. Beech.

MR. BEECH BL: The witness wishes to take the oath.

GRÁINNE LYNN, HAVING BEEN SWORN, WAS EXAMINED BY MR. BEECH BL AS FOLLOWS: 13:20

289 Q. MR BEECH BL: Thank you very much, Dr. Lynn. You should have water on your table if you need it. Hopefully any documents needed for this afternoon should appear on the screen for you to consider. 13:21

Before we start, a brief health warning. I'm well aware that NCAS has now become Practitioner Performance Advice. I suspect I'll end up using the two terms interchangeably. 13:21

A. That's absolutely fine.

290 Q. Just to confirm then, but for the change of name from NCAS to PPA, has there been any substantive change to the role played?

A. No.

291 Q. Thank you very much.

If I could start by referring you to a copy of your witness statement, then, which appears in the bundle at WIT-53449, please. First and foremost, are you familiar with this document? 13:21

A. I am, yes.

292 Q. I'm just going to ask you a quick question about the formatting of that, perhaps. The top of it, it is entitled Independent Inquiry Into Mr. Aidan O'Brien. Now, there is correspondence from Field Fisher PPA explaining the circumstances but can you explain how and when this witness statement came into existence? 13:21

A. Well, the witness statement was undertaken before I retired from NCAS. I think that it was realised that there would be, obviously, questions asked but they thought if I put a statement in, that that at least would give the Inquiry some idea of what had happened. 13:22

293 Q. Just to clarify then, although it says on the top of it, Independent Inquiry Into Mr. Aidan O'Brien, you're well aware of the terms of reference of this Inquiry? 13:22

A. Yes.

294 Q. If we can jump to the very last page of that, WIT-53454, please. Go down to the bottom where your signature is. Do you confirm that that's your signature? 13:22

A. Yes, that's my signature.

295 Q. As you've just indicated, this was dated and signed

23rd December 2020. That was maybe just after the Minister made an announcement about the Inquiry?

A. That's correct, yes.

296 Q. If having read that witness statement, are you content to adopt that witness statement as your evidence to the Inquiry today? 13:23

A. Yes, I am.

297 Q. On your reading of it, do you wish to make any changes, amendments or corrections?

A. No, I don't. 13:23

298 Q. Thank you very much.

I know you have been sitting here this morning and perhaps followed a bit of Dr. Fitzpatrick's evidence. 13:23 I intend to spend a bit of time on the actual practical advice that you were offering to the Southern Health and Social Care Trust. Before we get there I think it is important to understand a bit about the role you understand NCAS played. Okay? 13:23

A. Yes.

299 Q. We refer back then to the first page of the statement. It is WIT-53449. Just the first paragraph there. You outline you qualified in dentistry in 1983, and in 1990 you obtained Fellowship of the Faculty of Dentists. 13:24 From that point on, could you just outline a bit of your background and experience up until you becoming involved in NCAS?

A. I worked for a couple of years in Hospital Service

before I qualified, and then I moved into a post in Foyle Trust, or its predecessor, in the community. I also worked part-time in general practice. I was appointed as the Clinical Director in Foyle Trust and had been Clinical Director I would say, from 1996 until 2005. I think that it's the Clinical Director experience that enabled me to be eligible to meet the essential criteria to work with NCAS. They required you to have management experience of working in the Health Service. 13:24 13:25

300 Q. You outline in paragraph 1 then that you started working for NCAS on a part-time basis in 2005. You've already confirmed today you've since retired. When did you retire from your role at NCAS?

A. 2021, January 2021. 13:25

301 Q. I'm afraid my maths is sketchy on my feet. Would that be 17 years then perhaps?

A. 16, is it? I said 15 previously but I think it's 16.

302 Q. I'll take your word for it. 13:25

During your time, you were involved in NCAS for 16 years, you mentioned you had a part-time involvement; is that correct?

A. I was part-time originally, yes. A group of us were appointed as advisers in 2005. As dental advisers. 13:25 Originally we were only involved with dental cases but then the role became broader. I think they realised that if you had experience of working in the Health Service and you also had experience of management, then

the management of these problems was similar.

303 Q. Okay. You mentioned you started part-time; are you implying that you then moved into a full-time position?

A. I did move into a full-time position but I did go part-time again in the year or two before I retired. 13:26

304 Q. So perhaps your involvement with The Trust this time was 2016, 2018, 2020, so at that time you were full-time with NCAS?

A. I would have been full-time, yes.

305 Q. Can you just outline what training did you receive to discharge your functions as an NCAS adviser? 13:26

A. We got quite a lot of training. There was a very engaged Director of Clinical Services there who was a dentist by background, and she recognised that even though we had management experience within the Health Service, that we would still need a comprehensive induction programme. We did have that, you know. I went to London for a week of induction. Then we travelled over every week for some time, you know, to address really what she felt would be any deficits 13:26 13:27 in our knowledge. I think that was very valuable. I know you talked about this earlier, but when I was appointed as a Clinical Director, there definitely were significant deficits in my knowledge. I think, you know, that that would be relevant in most people who 13:27 are appointed into management positions, certainly the time in which I was appointed.

306 Q. I can see then from paragraph 1, which is still on the screen, that you also obtained an LLM in Employment

Law. Was that primarily to assist with your role in NCAS?

A. Yes, it was.

307 Q. We'll come on to the specifics of the type of queries you were fielding from the Trust, but in general did you feel well-equipped in your role at NCAS to address often complicated and complex issues about a practitioner's performance? 13:27

A. I think initially it was a huge challenge when I was first appointed, but we had great support. There were other advisers there and there was a good network. So if I didn't feel I could answer a query or needed assistance, there were people you could ask. 13:28

308 Q. You've mentioned other advisers and you're well aware we spoke to your erstwhile colleague, Dr. Fitzpatrick, this morning. How many other advisers were there in Northern Ireland? 13:28

A. Just Colin and I in Northern Ireland.

309 Q. Would you and Colin, as the two advisers in Northern Ireland, been able to link in to a larger group of advisers? 13:28

A. Yes. There were about 20 advisers in England, not all of whom were full-time, but they had a range of backgrounds as well. So we had advisers from legal background, HR background, and who had been working in the Health Service as well. So they would have legal experience of working in management and Trusts as well. 13:28

310 Q. Just perhaps generally - we'll come on to Mr. O'Brien and the Trust in a minute - but your relationship with

Colin - Dr. Fitzpatrick, forgive me - would you have been sharing information, discussing complex cases, discussing best practice?

A. Colin became my line manager when I was relatively late in my career in NCAS. I was managed within the dental team originally so I would have brought my queries to them, you know. If we needed the expertise from outside of that, we could have accessed it. I remember we would have had monthly reviews of cases and that would have been undertaken by other advisers, Stephen Peece, he was an adviser with a legal background. I would say I was mentored and supported by others and later by Colin. 13:29 13:29

311 Q. You mention the monthly reviews. Perhaps if we could have a look at WIT-53769, please. This is an aspect of a larger document, which is a Service Level Agreement between the Department of Health and NCAS. Are you familiar with this document? 13:29

A. I am familiar with this document, though not as familiar as Dr. Fitzpatrick, because he was the lead adviser and he would have been required to sign it off. 13:30

312 Q. If we look at the second paragraph there. Perhaps I'll start halfway through and we'll come back. You mentioned there monthly reviews. This paragraph refers to: 13:30

"The progresses of all active NCAS cases are reviewed at monthly meetings between the adviser and a senior colleague".

Whenever one reads that, it makes it sound like a relatively formal process. Was it a formal process or more of a discussion between you and a colleague?

A. It wouldn't usually have been a formal process. You brought your list of cases. Certainly if any case, if any practitioner was subject to exclusion, that would have been a formal case. You know, that would have been managed more formally. But you would have discussed them, or you would have discussed anything you were concerned about. 13:30 13:31

313 Q. Would these have been formal minuted discussions? Would there be a paper trail of notes?

A. No, there wouldn't be a paper trail, except about the monitoring of exclusion. 13:31

314 Q. We'll just use this opportunity to discuss briefly your role and how you saw your role. If we go to the first sentence of that paragraph. We are still on the second paragraph here:

13:31

"An NCAS adviser will provide expert advice, and support will be responsible for directing the management of NCAS's input to the case. The level of the support will depend on the nature of the case".

13:31

A. Yes.

315 Q. We're going to open up a series of letters that you send to the Trust and Mr. O'Brien.

Whenever it stays "The level of support will depend on the nature of the case", what does that mean? Is it always done by letter? Is there some type of other process?

A. I suppose it is the potential risk at the initial call would be what would determine how significant. If you have a practitioner excluded, that would have meant it was automatically considered a more serious case. We had responsibilities to monitor exclusions as well. 13:32

316 Q. If a case was considered particularly high-risk or particularly serious Patient Safety issues, how would that affect its management? 13:32

A. There was an operational group within NCAS and any significant issue had to be flagged through them.

317 Q. If we could just scroll down please to the bottom paragraph of this page. It starts: 13:32

"As a competent advisory body in this work, a key feature of NCAS involvement is to bring constructive challenge to the local management of concerns and support the resolution of disputes between practitioners and their employing/contracting organisation". 13:33

I really want to focus in on the constructive challenge aspect of that. How would you, as an NCAS adviser, bring constructive challenge? 13:33

A. Well, if I can use this case as an example. When Dr. Wright spoke to me in December of 2016, I think

we all know now, the decision really had been made in principle to exclude. When I spoke to Dr. Wright, we talked about the alternatives to exclusion and the ability to use an immediate time limit exclusion for four weeks if that was appropriate. In the end, I didn't actually know they had used the immediate exclusion because, obviously, we didn't have a follow-up call. But I can see that they used it instead of formal exclusion and then they moved to restrictions, although I only know that now with hindsight, I didn't know it at the time. 13:33 13:34

318 Q. I keep telling you we'll come to the specifics, and we will. Your way of constructive challenge would be via a discussion with the Medical Director, whoever is in the organisation. 13:34

A. Yes.

319 Q. That perhaps brings us then to a slightly different point. If we could go back to your witness statement at WIT-53450, please. Principally we're going to look at perhaps 9 and 10. I'm aware that you were present for much of Dr. Fitzpatrick's evidence this morning. The last sentence of paragraph 9: 13:34

"In respect of its advisory functions, all of the assistance that we provide is based upon information we receive from NHS bodies and other parties, such as the practitioner concerned". 13:34

In practice, would your ability to constructively

challenge a referring body, anyone who phoned NCAS, it is really, in fact, limited to what they are telling you about a situation.

A. That's correct. Although we do -- you know, in the letters that we sent out more recently we also encouraged the letter to be shared with the practitioner, and then we often talk to the practitioner as well.

320 Q. At the time in which, let's say -- again, we'll get on to specifics of Mr. O'Brien later this afternoon. But at the time in which a Trust phones or makes contact with NCAS, would it be standard procedure to contact the practitioner or reach out to the practitioner? 13:35

A. No, we don't do that. It originated, I think, because originally the calls were made to us in confidence, and there was some difficulty when we used to want to copy the letters to the Chief Executive of the Trusts. I think when it was set up originally, that was certainly our practice, to copy in the Chief Executive. The role sort of changed a little bit and it became is -- you know, the issue of keeping confidentiality the Trust changed in that you have to be open with practitioners, and we found that a lot of that wasn't happening. It sort of evolved. 13:35 13:36

321 Q. You then go on at paragraph 10 to say that: 13:36

"As a result the advice service is dependent on NCAS bodies providing the relevant information about a case".

In practice - again, we're talking generalities here - if a Trust phoned you, would you be sitting listening or would you be asking questions, providing some type of probing exercise? 13:36

A. Well, you would ask questions. If I didn't agree with what they were suggesting, you know, I would challenge that. You know like, if they wanted to exclude and I didn't there were grounds, or if, for example, they were saying it isn't a clinical issue but there is the 13:37 potential for harm, you know, I would challenge that too.

322 Q. Would that challenge or probing ever go so far as perhaps requesting documentation or evidence?

A. That's not something we have ever done. We're an 13:37 advisory body, we're not a regulator. In our own organisation, I don't imagine -- we would have accepted information if they had wanted to send it to us, and they frequently did, but we would never force them to do anything because we're not a regulator. I don't 13:37 know if that would be within our power.

323 Q. You're drawing a distinction here between NCAS as a regulator and NCAS as an impartial adviser?

A. Yes.

324 Q. Dr. Fitzpatrick this morning drew a different 13:38 comparison this morning; he said we're not an investigator. Would you agree with that?

A. We don't do the investigation, no. We rely on the organisations doing their own investigation. But

I completely agreed with the suggestion that the investigation should be done externally.

325 Q. Just scroll down, please, to paragraph 11. It's at the very top of the screen there, you touched on it already: 13:38

"Letters to an NHS body are not routinely copied to practitioners but we advise the NHS bodies to share with the practitioner unless this is deemed inappropriate". 13:38

Has that always been NCAS's approach?

A. We would always have encouraged NHS Trusts to be open with the practitioner. I mean, the first person who should know about the concern is the practitioner. 13:39 Sometimes in the early days we would have been talking to employers who hadn't told the practitioner of the concern but they were on the phone talking to us. That would have become apparent when you say what does the practitioner say? 13:39

326 Q. In practice, does NCAS ever or has it ever received any information about whether or not these letters are routinely shared with practitioners?

A. Well, I think now we put it in our letters that they should be. I think we do know a lot of times they 13:39 weren't, previously.

327 Q. Just so we're clear, what exactly do you think is the benefit or the importance of letters being shared with practitioners?

A. I think they know exactly what has been said and what has been negotiated, really, between the employer and NCAS. And it gives them then the opportunity, if they feel that there's a misrepresentation, to come to us themselves. 13:39

328 Q. You were an NCAS adviser for 16 years perhaps. During that time, what type of individuals were contacting the service.

A. There was a very big range of individuals contacting the service - HR Directors, Medical Directors. We did 13:40 get a lot of calls from practitioners, especially more recently. More recently than when we did the case investigator training, we also told the case investigators we were Happy to give them advice on investigations on sort of help, not on specifics but on 13:40 generalities. If they had queries, we were happy to do that as well.

329 Q. And having delivered that training - again we're talking general - but did any case investigators during your time at NCAS phone the service? 13:40

A. Yes. Yes, they did. Just with general queries about what they could or couldn't do.

330 Q. In your mind, if a Trust or any type of healthcare body is contacting you, is it more helpful than not to be speaking to the decision-maker, i.e. the Medical 13:41 Director or the person who is actually going to be making a call on a practitioner's practice?

A. I mean, I take Colin's point about the Medical Director having authority but I did have some very useful calls

with people who would not have been as senior as that. That would be my experience. They sometimes weren't -- didn't have as definite a view about what should happen if they were more junior.

331 Q. We've discussed, really, this afternoon so far what would be called the advisory side of NCAS or PPA. There really appears to be two other kind of broad limbs then. There's the educational type services involved with NCAS. Would you have been involved in delivering workshops or training? 13:41

A. I was, yes. I was involved in one in the Southern Trust which took place just after the investigation was organised.

332 Q. Would that have been a case investigator training about March 2017? 13:42

A. That's it, yes. That was the one. I hadn't been involved in the case manager training, which was earlier than that. That was my first time in Southern Trust. It wasn't a Trust I would have been usually involved with because I used to live in Derry. 13:42

333 Q. Then there's what I'm going to call, forgive my rather loose language, the third limb of NCAS, which might be called performance assessments?

A. Yes.

334 Q. When and in what circumstances would that performance assessment limb kick into gear? 13:42

A. Performance assessments could be useful where there was a substantial concern about how a practitioner undertook their job. They're very expensive, as you

can imagine, so there were a limited number approved but really we're talking about a capability concern. Now, Colin did talk about assessment this morning in some detail. He talked about the performance assessment involving health and behaviour and a clinical component. For some cases, we then moved on to provide, you know, a break-up of that. We would have found sometimes behavioural assessments very useful, so they would have been undertaken in some cases. 13:43

335 Q. In terms of that performance assessment limb, in your experience how often is it utilised?

A. Well, there were several of them undertaken. I don't have the figures, you know, but my impression was possibly about 1 percent of the cases that we did. 1 to 3 percent maybe, but that's -- I don't know the figures exactly. 13:43

336 Q. We'll come on to discuss more specifically, I suspect, about -- is it the PSR scheme, Professional Support and Remediation. Would that be under that performance assessment? 13:44

A. That can be done after an assessment or without an assessment. If it comes after an assessment, obviously it will be based on the conclusions of the assessment report, but it can be done. If you already know what the problems are, you don't need an assessment. It's really very useful, a performance assessment, if you don't know the scope or the scale of the performance -- the alleged performance deficits. 13:44

337 Q. I'm going to ask you again, in your experience as an NCAS adviser, are those, what I'm going to term PSR type assessment, are they actually used in practice?

A. They were used a lot, I would say. They were used more often in England; I don't know why that is. Certainly I was involved with a lot of Trusts in England who were undertaking PSR plans. 13:44

338 Q. I keep promising we'll come back to discuss some stuff later this afternoon, but that's another one.

13:45

The Inquiry is obviously very interested in your reflections. You're a very senior adviser in NCAS and you had a number of years under your belt. Before perhaps I move on to NCAS under MHPS, is there any further reflections you wish to offer about the general rule of NCAS, perhaps in light of anything Dr. Fitzpatrick might have said? I want to give you an opportunity to comment if you have any comments you wish to make? 13:45

A. I can't think of any at this stage but if they come to me, I'll let you know. 13:45

339 Q. Can you describe to me then what in your mind is the relationship between NCAS and the MHPS framework?

A. It's very close. You know, everything that the employing Trust does really should be done with the knowledge of that in the background. Of course, their local policies should be compliant. That was an issue, you know, at the start, that local policies and MHPS conflicted. 13:45

You know, you talked today earlier about conduct hearings, and in the paragraph above which you discussed with Colin, I mean the conduct hearings in MHPS, professional misconduct, must have a professional member of the panel. If their local policy doesn't have that, then they'll be in conflict with MHPS, which will give them some trouble.

340 Q. I'm going to ask you a broad enough question. In what scenarios do you understand the Trust is required to seek advice and consult with NCAS? 13:46

A. They are required to seek advice if they are considering exclusion, a formal -- it is mandatory for formal exclusion. When we do our training as well, and I think this might conflict with evidence given earlier by some people from the Trust, we like to be contacted early. You know, we don't like to get intractable problems. 13:46

When NCAS started up in 2001 - I wasn't there at the time - but a number of issues which came to them, which were very long-standing and very difficult, therefore, to resolve. Our director, Alastair Scott at the time, was very keen that we would get problems at an early stage, then it might be potentially much more straightforward. I think that was what we found. 13:47 13:47

341 Q. I'll just unpack a couple of elements of that. If we could call up, please, WIT-18502 on the screen. Focus on paragraph 20. This is the section of MHPS on

immediate exclusion. As you described there, it says:

"The NCAS must, where possible, be informed prior to the implementation of an immediate exclusion".

13:48

The "where possible" caveat on that, what is that designed to cover?

A. Well, when NCAS first started, it was available 24 hours but that changed. I presume that something can happen in a Trust that, you know, you want the practitioner out of the site immediately and you may not be able to make contact with NCAS. It might be late on a Friday night, for example. Whilst originally we were a 24-hour service, that changed. So I suppose it covers that. 13:48

342 Q. That's really covering perhaps a scenario where there's something so urgent, but they can't get hold of you.

Then WIT-18500, please. I think it should help a couple of points you were referring to. Down to paragraph 10, please. It says: 13:48

"Employers or practitioners are at liberty to make use of the services of NCAS at any time they see fit. However, where an employing body is considering exclusion or restrictions from practice, the NCAS must be notified so that alternatives to exclusion can be considered". 13:49

It is the thrust of these two paragraphs, isn't it, that NCAS are consulted with before a decision to exclude has been taken?

A. That's correct.

343 Q. Then you were talking about NCAS's ability to get involved at an early stage. I think paragraph 11 might help with that. 13:49

"The first stage of the NCAS's involvement in a case is exploratory - an opportunity for local managers or practitioners to discuss the problem with an impartial outsider, to look afresh at a problem and possibly recognise the problem as being more to do with work systems than a doctor's performance, or see a wider problem needing the involvement of an outside body." 13:49

Is that what you were describing there about NCAS getting involved in an early stage?

A. Yes, that's what I would mean.

344 Q. In your opinion, does that paragraph accurately summarise the benefits of NCAS getting involved at an early stage? 13:49

A. Well, it could probably be expanded but since there -- you know, it has never been rewritten. There are a lot of problems, as you know, with the document. This wouldn't be one of the major ones, as I see it, but it definitely could benefit from some rewriting. 13:50

345 Q. If I might then turn to some of the specifics then in this case. My understanding is that your first

involvement was on 28th December 2016. There's an internal NCAS note as WIT-53523. This is, in fact, an internal NCAS note of a call from the Trust; is that correct?

A. That's right, yes. 13:50

346 Q. It says:

"Time taken: 11.30 on 28 December."

That was shared with you, I believe at 11.44. Is this 13:51
all the information you would have had prior to contacting the Trust?

A. Yes.

347 Q. It says here "RB", I assume that's refers to referring body? 13:51

A. Yeah.

348 Q. "...had a serious adverse incident investigation that flagged up a problem with this doctor's review of a patient with cancer. The patient came to some harm. Due to delay they may have come to more harm. The 13:51
review has highlighted some issues with the doctor's review system and lack of updating the system with patient notes, possibly taking the notes home and not returning."

13:51

You received this page at 11.44. You do then speak to Dr. Wright that day. Can you recall what time you spoke to Dr. Wright?

A. No, I don't recall the time.

349 Q. Whenever you spoke to Dr. Wright and before you spoke to Dr. Wright, were you aware that Dr. Fitzpatrick had looked at this case some three months?

A. I can't remember that specifically.

350 Q. If we call up your advice letters, this is at WIT-53455. I'm hoping this will assist. If you would scroll down to the first substantive paragraph. This is the following day. In this letter you refer to advice which your colleague Dr. Fitzpatrick had previously discussed with Mr. Gibson? 13:52

A. Yes, but it had then been flagged up to me that this was already a case that we had. There was a mistake, I think, with the number. I think that's on the file somewhere. So we didn't automatically match them as we would normally do. They're matched on case number when a new case comes in. So I may well have done the call without knowing that Dr. Fitzpatrick had -- but it's not something I recall. I know by the time I did the letter, obviously, which would have been fairly soon afterwards, I would have thought, that I did know but I can't be sure whether I knew or didn't know. 13:52 13:53

351 Q. Your letter goes out the following day. So, clearly you gave this some urgent attention. Just so I'm clear, you're saying that normally, in normal circumstances if a case comes back to NCAS the system in some way links it? 13:53

A. It links it, yeah.

352 Q. And in that scenario would you have the ability to easily and quickly pull up previous advice?

A. Yes. Yes.
353 Q. You're saying there may have been an issue with linkage, if I can use that term this case?
A. Yeah, that's right. If you don't have the right number the case won't be linked. And we do link cases that come from the same employer. It goes back to the same number. If it's a new employer we would get a new number linked to the case. 13:53
354 Q. So, this time you can't say whether or not you'd seen Dr. Fitzpatrick's advice? 13:53
A. I don't know, really.
355 Q. In a perfect world would you --
A. Obviously, yes, in a perfect world I definitely would.
356 Q. On that note then, Dr. Fitzpatrick obviously had dealt with this in September or at least taken the call. You outlined in your witness statement that you believe Dr. Fitzpatrick wasn't available as he works part time. Would it have been preferable had this been kept with Dr. Fitzpatrick do you think? 13:54
A. Well, we do try to make keep cases with the same adviser. It makes for continuity of care. But it wouldn't be uncommon for an adviser not to be available an then it to be allocated to somebody else and then it would be a judgement call about who keeps it. 13:54
357 Q. I don't particularly want to labour the point. If we go to AOB-01049, please. This is a copy of Dr. Fizpatrick's initial advice. I fully accept what you're saying, that you may not have seen this at the time. Having reviewed this since, do you consider that 13:54

there's perhaps quite a lot of useful information which you could have used going into that phone call?

A. Yes.

358 Q. If we look at the very bottom of that page, there's reference to as well as perhaps a series of issues there's also reference to delayed referral to oncology. What you're told about the SAI subsequently is perhaps the outworkings of such a process; would you agree? 13:55

A. It could have been, yes.

359 Q. If we go over the page, Dr. Fitzpatrick offers a series of advices or suggestions about how to deal with the problem. He suggests that removal of charts could be dealt with via disciplinary action. That there could be a audit of what's described as poor note-keeping or note-taking. Then he says: 13:55 13:56

"The problems with the review patients and the triage can best be addressed by meeting with the doctor and agreeing a way forward.

We discussed the possibility of relieving him of theatre duties in order to allow him the time to clear his backlog. Such a significant backlog will be difficult to clear." 13:56 13:56

At the time you speak to Dr. Wright, so far as you can recall are you aware of these recommendations or advises from Dr. Fitzpatrick?

A. I don't recall.

360 Q. I suppose if the system is working appropriately you should have been linked to this and then in the course of your call with Dr. Wright you could have almost -- I don't want to use the term marked the Trust's homework, but you could have ticked off, you could have asked them what's been done about issues about notes, issues about triage, whether or not support was offered. You weren't able to do that on your call? 13:56

A. Well, I'm presuming that's the case. 13:57

361 Q. Forgive me for the jumping around. We're going to go back to WIT-53455, please, which is again your letter of 29 December.

What can you recall Dr. Wright telling you in that phone call? 13:57

A. I do recall that he seemed very concerned and I recall that he was very keen on formal exclusion when he spoke to me.

362 Q. The first thing you mentioned there was very concerned. What was he very concerned about? 13:57

A. Well, the allegations, as he set them out to me, sounded very concerning. You know, slowness of triaging. The removing of a substantial number of charts, that worried me a lot, as did the reappearance of a chart. 13:58

363 Q. Just scroll down, please.

What was discussed with you about a Serious Adverse Incident?

A. Just that the patient a had come to harm. I didn't realise this was an historic event. I thought it was relevantly recent. That's how I described it, I think, "a recent Serious Adverse Incident." 13:58

364 Q. So, we're looking at the third paragraph. You say:

"A recent Serious Adverse Incident has caused concern that there is potential for patients to be harmed by the ongoing situation." 13:58

As you say, your understanding of "recent" was that the incident itself had happened recently?

A. Yeah. That was my understanding, yes. 13:59

365 Q. Can you recall in any way what Dr. Wright said to you about the incident?

A. I can't recall.

366 Q. I do appreciate there's been quite some passage of time, okay? You're now aware that the failure to triage happened around late September 2014 and that this was picked up by another consultant urologist in January 2016. When did you become aware of the fact that the SAI perhaps wasn't as recent as you thought it was? 13:59 13:59

A. Only when I got the information recently for the Tribunal.

367 Q. Would you have expected Dr. Wright to make it clear to you that the SAI, although it was in the process of

reporting, in fact happened some time ago?

A. Well, yes. I suppose I would, really. I can't imagine I categorised it as recent if -- but he might have said the recent -- you know, it's hard to know now whether he said a recent Serious Adverse Incident or maybe he said the recent Serious Adverse Incident Report, and I didn't make the designation, although the report you would have expected to be concluded in a little bit more timely fashion. 14:00

368 Q. Had you known that the SAI, in fact, was perhaps a bit more, I don't want to use the word historic but a bit further back in time, would that have changed your advice to Dr. Wright in any way? 14:00

A. Well, I might have asked why he was so worried now. But, again, if it was the report coming, presumably there was something in the report that worried him more. 14:00

369 Q. Can you recall if you were provided with any specific details about the SAI and what it uncovered?

A. No. I can't remember. 14:00

370 Q. I think, given perhaps what we've discussed already this afternoon, would you have asked?

A. I don't remember whether I would have asked or not.

371 Q. Thank you. We'll just keep working our way through this letter. I think that's the bottom paragraph on the page then, where it states: 14:01

"As you're aware, the concerns about Dr. 18665 should be managed in line with local policy and the guidance

in MHPS. We discussed that as the information to date, no noted improvement, despite the matter having been raised with Dr. 18665 suggests that an informal approach is unlikely to resolve the situation, a more formal process is now warranted." 14:01

I want to ask you some questions specifically about the phrase "no noted improvement, despite the matter having been raised with Dr. 182655." 14:01

What did you understand had been going on in the Trust here with this doctor?

A. I understood that he had been made aware of the concerns but that there had been no improvement. He was still not keeping proper records, he was still slow 14:02 to triage, he still was removing charts and not bringing them back.

372 Q. As we discussed, you may or may not have been aware at the time of your call about Dr. Fizpatrick's advice, but at the time of drafting your letter you're 14:02 definitely aware of Dr. Fitzpatrick having offered advice?

A. Yeah.

373 Q. When you say "no noted improvement, despite the matter having been raised with Dr. 18665", did you think the 14:02 matter had been raised recently with Mr. O'Brien? Was that the impression that you were given?

A. That would have been the impression I had. I thought it was recent.

374 Q. While there was various, perhaps, attempts in the Trust to start some type of informal process or engage with Mr. O'Brien, for one reason or another Mr. O'Brien was spoken to in March 2016 and then wasn't actually spoken to again by senior management in the Trust about these concerns until the day after this letter. What are your reflections on that with regard to the advice you offered to the Trust here? Would you have offered the same advice that a formal process was now to follow had you known no one had spoken to Mr. O'Brien for some nine months at this stage? 14:03 14:03

A. That's a difficult question. I think it was very regrettable that nothing substantial had been done but I must say that the matter -- you know, he should have had the opportunity to address these issues. And I think had he been given the opportunity, things might have been different but I still felt that the allegations were quite serious on a first off. There was the real potential for harm here. And if you scroll down the letter further you'll see about a chart appearing, that troubled me greatly. You know, I was -- I thought, you know, that the allegation there is that, you know, the unspoken allegation, I suppose, is that that chart was brought back by him and I thought there was something, you know -- well, something unprofessional about that if, indeed, it had been him that left the chart back. 14:04 14:04 14:04

375 Q. Again, the complicating factor here is whether you were or were not aware of Dr. Fizpatrick's advice. But

definitely in September 2016, Dr. Fitzpatrick, on looking at a very similar set of concerns, advises that the Trust, at least in part, should engage in some sort of informal process - he doesn't use these words, I'm paraphrasing - or a supportive process with Mr. O'Brien. Your advice here, at the end of December, is that a more formal process is now warranted. What exactly had changed?

A. Well, even with the benefit of hindsight the SAI is worrying the Medical Director enough that he wants to formally exclude him, you know. So, presumably his situation has changed between September and December and he's the one that's medically qualified and possibly better qualified to make that judgment than I am, in those circumstances, with the SAI. 14:05

376 Q. I might just ask you to expand on that. Is there any suggestion there that there was a bit of a power imbalance between you and Dr. Wright here?

A. I think we have different skills. I don't have any difficulty challenging people where I think it's inappropriate, but if they are worried about a clinical issue, a specific event - and I haven't seen this SAI myself, you know - I think that does make you reflect in the world in which we live. You know, if he's so worried that he wants to formally exclude him. You know, it would be easy for me to say now maybe you should have done an informal process, but I think if patients are being harmed, well then, you do have to bear that in mind as well. 14:06

377 Q. It's your evidence to this Inquiry that you really didn't really have any further details on that SAI but for the fact there had been an SAI and that Dr. Wright was concerned?

A. Not that I can recall but we wouldn't have gone into -- even if he had told me the details of it, I wouldn't have necessarily put them in the letter because you don't really envisage that, you know, that your letters will be... Dr. Wright and I obviously had a fair idea, we had the conversation, so it reflects where we got to in that conversation but now, looking at it with the benefit of hindsight, it's very difficult for me to say. 14:07 14:07

378 Q. Dr. Lynn, I do appreciate that we are looking at a number of years after the event. 14:07

A. Yes.

379 Q. My final question on this specific is whether you knew at the time or not, the SAI really related on one level - I think there is some dispute about this - to a failure of triage or a missed triage. It was really on one reading could be no more than the natural outworkings of the types of concerns reported to Dr. Fitzpatrick, i.e. patients might not have been triaged, there might have been delayed in patients receiving treatment. Looking at these two letters with the benefit of hindsight, was there sufficient escalation, perhaps, in the nature of concerns to justify a formal investigation. To be clear, I'm asking you to reflect with the benefit of hindsight. You couldn't know what 14:07 14:08

you didn't know at the time.

A. Well, you know, I think you could have given an informal process a try. Obviously that's something that Dr. O'Brien was very upset about. So, it may have -- you may have been able to work through it more favourably if it had been an informal process. I don't honestly.

380 Q. On the call, or what you can remember of the phone call, can you remember Dr. Wright informing you that an informal process had, in fact, been tried? 14:08 14:09

A. No, I don't recall.

381 Q. The last sentence there then is "a more formal process is now warranted".

A. Yes. I suppose it was the "no noted improvement despite the matter having been raised with him". They haven't gone to a formal process without having spoken to him and given him an opportunity to address it. I agree that he wasn't supported to address it but he certainly had an opportunity in March. 14:09

382 Q. I suppose what I would like to ask you about now is you say there a more formal processes is now warranted. At the time of your phone call with Dr. Wright, were you aware that a decision, whether in principle or otherwise, had already been taken to start a formal investigation into Mr. O'Brien? 14:09 14:10

A. No.

383 Q. Where I'm getting that from is minutes from an Oversight Committee which took place on 22nd December 2016. If we could have a look at TRU-251442, please.

Just down toward the very bottom under the heading "Consideration of the Oversight Committee". This is 22nd December, the meeting attended by Dr. Wright, the HR Director Ms. Toal, and others.

"In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr. O'Brien's administrative practice had led to the strong possibility that patients may have come to harm. Should Mr. O'Brien return to work, the potential of his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr. O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach". 14:10 14:10 14:11

That's 22nd December. Were you aware at all of those?

A. No, not at all.

384 Q. Would you have been expected to be advised that the decision had already been made? 14:11

A. To be honest, no, because it flies in the face really of what's an MHPS. So, you know, I'm not surprised he didn't tell me that they'd made the decision already, although, as somebody pointed out, it might have been a decision in principle. 14:11

385 Q. In fairness to Dr. Wright, his evidence to this Inquiry was that had anything contradictory come back from NCAS, he would have considered that.

But under the MHPS Framework, should NCAS have been advised there was to be a formal investigation or they were considering a formal investigation before that decision was made? 14:12

A. I think that would be better. D to be fair to Dr. Wright as well, he did change his mind in that it was an immediate exclusion and it only lasted for four weeks. Again, that's something I only discovered more recently, that the doctor returned to practise with restrictions then. 14:12

386 Q. I'll come on to the exclusion aspect of this in a moment. You mentioned it would have been preferable for Dr. Wright to have sought advice before making that decision. In your opinion, in what way would it have been preferable? 14:12

A. Well, I think it's just -- it may not have changed the outcome but I think, you know, it's better then that you can go back to your Oversight Committee with the information before they make the decision. 14:13

387 Q. If we look then, just the next sentence of that Oversight Committee meeting:

"It was agreed for Dr. Wright to make contact with NCAS to seek confirmation of this approach". 14:13

Then he goes on about a meeting of Dr. O'Brien -- Mr. O'Brien. On that call did you understand that Dr. Wright was seeking confirmation or was he seeking

advice?

A. I thought he was seeking advice, given I didn't know the decision had been considered at Oversight Committee.

388 Q. I would like now to just return to your letter of 29th December. We're making progress, we're on the second page. WIT-43456 this time, please. Your final comment on the previous page was a more formal process is now warranted. At this stage you're offering the Trust perhaps some information on how to set up that process. 14:13 14:14

The first paragraph I'm particularly interested, about four lines down where you offer the suggestion or advice: 14:14

"The investigation should not be an unfocused trawl of Dr. 18665's work...."

What was your thinking in offering that advice? 14:14

A. I think it's very important to have terms of reference which reflect the allegations that have been raised. I know this was discussed in some detail this morning with my colleague, but the other thing that I did talk about was a lookback, and I think that's something that people don't think so much about. So, had the lookback been done, probably the information would have been found at that point which are supported adding to the terms of reference. When we do our training, this is 14:14

something we talk about a lot, the investigation should be to a focused terms of reference. Patients coming to harm is obviously the main priority, so you don't want to have to investigate huge -- I mean, the investigation took them some 18 months. You don't want to make the job any more difficult than it already is.

But the patient then lookback focuses on if there are any issues for Patient Safety. That might have flagged up that there were other issues that should come into an investigation and could properly have come into an investigation had there been a patient lookback.

389 Q. You do, quite rightly, point out that your advice doesn't stop at the words "unfocused trawl". If goes on to suggest that if there are concerns about adequate treatment or adequate records, this could be managed separately with an audit lookback to ensure that patients have the appropriate standard of care.

Are you proposing, in fact, a separate process, a parallel process?

A. Parallel but separate, yes, absolutely. Because if you give that job to the case investigator, it would be far too broad. It's a priority, obviously, to identify any patients that have been inappropriately managed.

390 Q. On this comment about the unfocused trawl, Dr. Wright offered some evidence about this, and this appears at TRA-02622. This is Dr. Wright's evidence to this Inquiry. At the very top of that page he's here saying

"the investigation should not be an unfocused trawl", so that is in reference to your advice.

"My experience is that it was virtually always their advice. They were very against a wide net because you're more likely to run aground in the investigation and it can be considered unfair, so you need really hard evidence for that".

First of all, do you agree with Dr. Wright's statement there? 14:17

A. I do agree with it.

391 Q. This advice about unfocused trawls, is that standard advice from NCAS to a body such as a Trust?

A. It is certainly what we talk about in the case investigation training, so yes. 14:17

392 Q. If you expand to me what the thinking is underneath that advice. Is it to protect patients, is it to protect practitioners, or is it to protect Trusts?

A. As I mentioned earlier, the unfocused trawl is to concentrate on an investigation that can be done in a timely way. Its primary purpose is to establish facts. Protecting patients is more important but it is something which should be done separately, either with restriction of practice, should that be necessary, or exclusion, and then things like lookbacks that can be managed separately. 14:17 14:18

393 Q. In your opinion is the NCAS advice too conservative in these scenarios in advising --

A. Well, I'm not sure because if you investigate too widely, you know, you'll be criticised for that. I mean, we can see this investigation ran aground anyway. You know, it's very, very difficult for Trusts to get a balance. You could say with hindsight did they ignore things; was the unfocused trawl relied upon to make the investigation too narrow? But you have to bear in mind the investigation gave the case manager the ability to think the matter should go to a conduct hearing. It did get a result, albeit there were other things going on that should have been addressed. But I think, and I still think, that those should have been addressed with a lookback at that time. I think that's essentially what eventually happened. I wasn't involved in the case really more recently obviously, but my understanding just from what I've seen in the media, really, is that that's what eventually happened, there was a lookback. 14:18 14:19 14:19

394 Q. There's a definitely more formal perhaps lookback in 2020. During the course of the investigation, I suppose clinics are looked at in terms of issues of dictation, stuff like that. Is that what you are referring to? Which of those two exercises are you referring to there? 14:19

A. Well, I don't know the detail of them, really. Either of them, I suppose. 14:19

395 Q. In this scenario you have a Trust coming to you with what you describe in your letter as increasing performance concerns. There's an escalating,

seemingly, concern here?

A. Yes.

396 Q. There's poor record-keeping, slowness of triage referrals and arranging reviews, substantial number of charts at home, and then you're being told about an SAI where there's at least potential for patient harm, presumably which could be repeated. 14:20

In this scenario would NCAS ever say to a Trust, listen, I think perhaps a formal investigation is merited but you need to go away and conduct a fuller screening at this stage just to make sure all the issues have been identified? Would that ever form part of NCAS's advice in this scenario? 14:20

A. I think it's a reasonable thing to suggest, that they have done a screening. But I think my view in this case was that the screening had been done but I think it is a fair point, it's something that might need addressed in more detail in future, that has the screening been properly done at the start? 14:20

397 Q. I suppose this Inquiry and the circumstances which directly led to the establishing of this Inquiry was the uncovering of additional concerns in 2020.

A. Mm-hmm.

398 Q. And one question the Inquiry would have to consider is why those concerns weren't uncovered earlier as part of the MHPS investigation, which took place over 18 months. An angle which could be taken might be that the parameters of that investigation, the terms of 14:21

reference were set too narrow from the start. That in effect the Trust were only looking at what they knew, as opposed to establishing or satisfying themselves that there's no patient safety concerns or any further patient safety concerns and NCAS advice may have played into that. What do you say in response?

A. Well, I wouldn't really agree with that because I'm still back to the point of, you know, they did come to a conclusion that the matter should go to a conduct hearing which would have given them an opportunity to draw a line under it and presumably monitor Dr. O'Brien's performance to ensure it didn't happen again. I mean, if patients were still being harmed, that's a completely separate issue and we need to look at why the restrictions that were in place weren't sufficient to prevent that. If you're saying to me that patients continued to be harmed whilst this investigation was going on and after it concluded, obviously that's a huge problem. The biggest problem is why were the restrictions removed? The problem had never been addressed. They never got to a conduct hearing. They never really got to an acknowledgment that there was anything -- I mean I don't think Dr. O'Brien acknowledged that he accepted the findings. You know, in those circumstances, how was he continuing to work without some sort of supervision in place? That, for me, is the biggest issue.

399 Q. We'll maybe get on to some issues of that nature.

I would just like to continue working through your advice from 29 December. If we call up on screen WIT-41394, please. Are you familiar with this document? This is produced by NCAS, it's entitled "How to conduct a local performance investigation"? 14:23

A. Yes. I know we discussed this document this morning with Colin. I thought this was a document that wasn't in use anymore. It's not a document I've seen. It wouldn't be on our website. But trust me, I have it. It definitely was a document that we used and that NCAS drafted. And it's very worrying that some of what's in it conflicts, obviously, with what we now are telling people to do. 14:23

400 Q. We're talking about 2016 here and I think at the time the Trust internal guidelines referred to this specific document as a useful source of guidance. Would you have ever relied on this? 14:24

A. I would have used it more when I was advising in primary care. So, I wouldn't really have used it in any secondary care setting. Primary care, you know, obviously the practitioners are independent contractors so, you know, they don't have the MHPS format. 14:24

401 Q. So it's your understanding -- are you saying this is primarily for primary care or are you saying just in your experience you used it for primary care? 14:24

A. In my experience I didn't use it really for secondary care and I haven't seen -- well, I'm retired since a few years but I haven't seen it in a number of years. Certainly, since we started the case investigator

training. So, I'm not sure -- obviously if it was never withdrawn -- I don't know whether documents get withdrawn once they're out of date. I can't see a date on that here. Is there a date on the document?

402 Q. It's dated 2010. I do believe it's still available on the NCAS website. Perhaps that's a question more for PPAs as opposed to for you today, Dr. Lynn. 14:25

If we could look at WIT-41407, please. If we look at just above a rather large orange box. Scroll down. Yeah, perfect. 14:25

"Terms of reference should be tight enough to prevent an unfocused general investigation of everything concerning the practitioner." 14:25

So, that reflects the advice which you put in your letter. But if we move back, almost, into the document, to WIT-41399. Scroll down, please, to 1.1, the second paragraph. It says: 14:25

"Terms of reference have to be determined based on what is known at the time an investigation is set up. If, later, a substantial issue comes to light that is outside the initial terms of reference, the terms can be reviewed and, if necessary, changed to ensure that the investigation covers the new issue." 14:26

Now you've already gone into your discussion about

having some type of audit and lookback --

A. Mm-hmm.

403 Q. -- but that's almost sounded like a separate process?

A. It can feed into terms of reference, I certain am aware of situations where it does and where practitioners would have known that that was happening. And when they expressed dissatisfaction about that, we said well it's a very reasonable thing to do. You know, they're not widely investigating, they're doing the lookback in patient's best interests. But if something comes out of that well then, of course you're entitled to adjust your terms of reference to reflect that. 14:26 14:26

404 Q. Would that have been the tenor of your advice on the phone to Dr. Wright do you think?

A. We didn't have that -- I don't think we had as detailed a conversation about it as we've had today. 14:26

405 Q. I'm just going to take you to another section of this document which is actually on the next page, so it's 41400. Now, I fully accept this is entitled: "What should be considered in making a decision to investigate?" It states there: 14:27

"Before deciding whether a performance investigation is necessary, consider what other relevant information is available. This could include: Clinical or admin records; serious untoward incidents; earlier statements or interviews; clinical audit; clinical data; the views of appropriate professional advisers; and earlier occupational health reports." 14:27

So, there does appear to be scope here for advice to be offered for bodies to go and, in effect, have a bit of a look.

A. Mm-hmm. 14:27

406 Q. Do you accept that?

A. Oh, yeah.

407 Q. But that didn't form the nature of your advice to Dr. Wright on 28 December 2016?

A. No. 14:28

408 Q. We've covered some of this ground today but just again can you explain why, specifically, you didn't advise the Trust to engage in a slightly larger look or to satisfy themselves?

A. Because I think I thought that the threshold had been crossed. 14:28

409 Q. I'm going to bring you back to your letter now which is at WIT-53456. I want to explore with you -- if you can scroll down a couple of paragraphs, please. Thank you very much. I want to explore with you what discussions you had with Dr. Wright about exclusions. So, whenever I took you to this letter first you were very clear to me that you used the words that Dr. Wright was very keen on a formal exclusion. Is that a fair summary of what you told me earlier? 14:28

A. Yeah, that's a fair summary.

410 Q. What exactly did he tell you about a formal exclusion?

A. Well, he told me that they were considering exclusion and I think that he felt that that would be a formal

exclusion. I don't know, so we talked about the criteria for formal exclusion, as set out in the document, and then we discussed whether an interim or immediately exclusion would be better because it would give them the window of opportunity to see whether there was really necessary to go ahead with.

411 Q. In terms of a formal exclusion, what do you understand the criteria to be to impose a formal exclusion under MHPS? 14:29

A. Well, there are three grounds, really. You know, that somebody might interfere with an investigation; patient safety of grounds or staff concerns about safety; or if there's a complete breakdown in relationships, sometimes in a team then it can be necessary as well. 14:29

412 Q. So, it's your recollection that Dr. Wright was very keen on a formal exclusion. What advice did you offer him? 14:29

A. Whether an interim exclusion would allow them to time to think about whether they could safeguard the situation with restrictions. That would be the line. I mean, I don't obviously specifically recall this telephone call, I'm just basing it on what I would normally have gone through. 14:30

413 Q. The paragraph which is reflected in your letter says you did discuss the criteria for formal exclusion and the option of an interim exclusion. 14:30

"The latter would allow for further information to be collated and to take account of Dr. 18665's comments

about the allegations, before deciding whether there are reasonable and proper grounds for formal exclusion."

At this time again, were you aware that a decision had already been made to exclude? 14:30

A. No.

414 Q. When did you become aware that Mr. O'Brien had in fact been excluded and that it was an immediate exclusion?

A. I don't think I knew that until relevantly recently because he was -- obviously, I never was in discussion with Dr. Wright again. And I think I've now established that when I was in the case investigator training, when we were doing it, in March I spoke to the case investigator, because we were training people and she told me she was doing an investigation and she was aware of our involvement. So. I would have known that - that would have been Dr. Chada, I think. We certainly knew then that the practitioner was working with restricted practise. So nobody had ever told me that he had been immediately excluded. 14:31 14:31 14:31

415 Q. Would you have expected to have been told what was the follow-up to this?

A. Well, to be fair to Dr. Wright, it's not a requirement once you've had the discussion to notify -- we don't have the requirement to monitor the way -- because it's such a time-limited thing. You know, the conversation that we'd had would probably satisfy that requirement. But, obviously, because the concern was being viewed so 14:31

seriously, we did expect that we would have heard back. But I did know, because I did the case investigator training there, that there was an investigation and that the practitioner was restricted.

416 Q. The very bottom of your letter then lists a review date of 27 January 2017. What's the significance of the review dates in these letters? 14:32

A. Well, when you've a case that there are serious concerns about, such as, you know, exclusion is being considered, the case would be open and it would be reviewed every month. If there wasn't exclusion, it wouldn't be unusual for us to close cases to allow the investigation to continue with the proviso that they're welcome to contact us during, or the case investigator is welcome to contact us during the life of the investigation. 14:32 14:33

417 Q. You stated there that the case would be reviewed every month, whenever it's open. Are you referring to the that internal review process that we were discussing earlier this afternoon, or are you referring to intended communication with the Trust? 14:33

A. Intended communication with the Trust. The file remains open and the case is open on our system and we would review it usually monthly.

418 Q. Was it for you to contact the Trust or was it for the Trust to contact you? How was it left? 14:33

A. It was -- I would have usually called or emailed my contacts because it was less likely that the time scale would slip.

419 Q. That review date is 27 January 2017. I just want to check one matter. If we could have a look at TRU-285015 please. This is an email from Dr. Khan who had been appointed the Case Manager, it's dated 26 January 2017, and it's at 18 minutes past one. The significance of that is I believe that that afternoon the Trust held a case conference in relation to Mr. O'Brien, both the investigation and the exclusion. Dr. Khan is saying here, "Siobhán", which is a reference to Mrs. Siobhán Hynds "I have tried to contact Dr. Gráinne Lynn, the NCAS adviser but couldn't get through. Is there any direct number we can try? I'm now leaving for Craigavon Area Hospital." 14:34 14:34

Can you recall ever discussing this matter with Dr. Khan on 26 January, prior to that case conference? 14:34

A. No.

420 Q. So far as you're aware, is there any records from NCAS or anything which might show that he tried to --

A. Nothing. We've no record. Although he would not have known my direct line. When I emailed Dr. Wright I would have been sending him my direct number as well. But Dr. Khan, I think, would not have known that, so... 14:35

421 Q. If we can have a look then at you're witness statement, specifically at WIT-53451. Can we scroll down to paragraph 16, please? You state: 14:35

"I left it that given the possibly exclusion I would review the case with the Trust in about a month's

time", which is when any immediate exclusion which would have been imposed would have been up".

Is that your thinking there?

A. Yes. 14:36

422 Q. "I then sent follow-up emails in January, March and May 2017, and in August 2017 our file was closed as there was no response to my emails". 14:36

You then go on to repeat that NCAS don't really have a proactive role.

If we have a look at your emails then. Is we start at your email of 27th January 2017. If we go to 14:36 WIT-53537, please. This is an email from you yourself to Dr. Wright.

"Good morning, Richard. I was hoping for an update on this case. If there is anything you wish to discuss, 14:36 I am available today and on Wednesday, Thursday, Friday of next week".

Can you recall receiving a response to this email?

A. No. 14:36

423 Q. Are you aware of anyone else in NCAS received a response or an update from the Trust to this email?

A. No.

424 Q. As I pointed out, I think the date perhaps is

significant as the day before, on 26th January, the Trust held a case conference. If we look at the very last page of that minute, which is at TRU-00040, please. I think we're at the very bottom of the page again, please. While various things were agreed at that meeting, including to lift the exclusion and to bring Mr. O'Brien back on some form of restriction, the final action was it was agreed to update NCAS in relation to this case. The action is listed as for Dr. Wright. 14:37

At that time did you receive any type of update from Dr. Wright?

A. No.

425 Q. Dr. Wright's evidence to this Inquiry can be found a number of places. He gave a response to a Section 21 notice. If we look at WIT-7834, please. WIT-17834, please. If you could go down to the very bottom of the page again. This is Dr. Wright's written evidence to the Inquiry, where he states: 14:38

"I informed NCAS of these developments by telephone over the next few days".

If we just jump briefly to Dr. Wright's oral evidence to the Inquiry at TRA-03232. Look at line number 13, please. He says: 14:38

"I do recall having a phone call and I think it may

have been with Gráinne Lynn. The reason I think I recall it is because we discussed conditions in which Mr. O'Brien would come back from work after his temporary exclusion."

Can you recall ever receiving a update from Dr. Wright?

A. No.

426 Q. I'm well aware you are retired but are you aware of any type of internal NCAS notes or correspondence which might indicate that Dr. Wright provided you with an update? 14:39

A. No.

427 Q. In response to the pieces of evidence I've shown you there from Dr. Wright, what do you say in response to that? 14:40

A. I think his wording at the bottom, which is why I'm pretty sure it happened, and then he talks about it could have been another case. Does he mention that or is that...

428 Q. He does say "I'm pretty sure that it happened". He is far from certain, perhaps. 14:40

Could we have a look then at WIT-53538, which is an email from yourself on 30th March 2017. Now, you're again here seeking an update. It is copied to a Ms. Thompson, who I believe was a revalidation manager in the Trust, as well as to Dr. Wright. Why would it have been sent to Ms. Thompson? 14:40

A. I think because I hadn't heard from Dr. Wright. That

would be I would normally try to copy it to somebody on the board in the hope they might come back to me.

429 Q. The email reads:

"Hi Richard, I called for an update on the case but you were unavailable. As I understand it, there is to be an investigation and there are restrictions on the practitioner's practice". 14:41

Perhaps this is referring back to a discussion you had with Dr. Chada? 14:41

A. Chada, yes, on her case investigator training. I know that, you know -- I've seen information in the file obviously that, you know, they decided they would need this training. So we were called in at fairly short notice in March to provide training. I know that the case investigator and the case manager, that's when I met them both for the first time. They were just, you know, were saying they had a case. But that isn't something I would have discussed obviously with the case investigator which is why then -- but obviously Dr. Wright would have known we were in. He wouldn't be at the training, he had done it before. As I understand it, because he would have known that I had probably spoken to the staff that were there. 14:41 14:42

430 Q. You weren't receiving perhaps a formal communication from the Trust but you did have information, if I may say, down informal channels perhaps from a discussion from Dr. Chada?

A. Yes. And Dr. Wright would know about this. Obviously I copied him this email. Maybe that's where he thought he had updated me. If I had received a call from Dr. Wright, I would have recorded it, as in taken notes, not overtly recorded him. 14:42

431 Q. I'm particularly interested by your reference here to the word "restrictions".

"I'm aware there is to be an investigation and there are restrictions on the practitioner's practice". 14:42

Could we call up TRU-77032, which is a copy of the return-to-work monitoring arrangements for Dr. O'Brien. Are you familiar with this document?

A. No. 14:43

432 Q. Can you recall if this document was shared with you at the time?

A. No. If it was shared with us, it would be on our file.

433 Q. I'm not convinced there's much need to go into the precise minutiae of what this says, but you were 14:43 understanding that Mr. O'Brien had been restricted. I would suggest that this plan is perhaps much closer to monitoring than a restriction on Mr. O'Brien's practice. Would relevantly intense monitoring of this nature, in your mind, be defined as a restriction for 14:44 the purposes of MHPS?

A. I think restriction and monitoring are different, obviously. But I think, you know, I got the news from the case investigator who would not have been as

familiar with terms, maybe, as Dr. Wright so, you know, may not have made that distinction. From my point of view, I was just happy that there was something in place so that it implied that the Trust had safeguarded the position. 14:44

434 Q. You refer to restrictions in that letter - or that email, rather, forgive me - to Dr. Wright on 30th March. We already discussed today the provisions of MHPS at paragraph 10 which says: 14:44

"Where an employing body is considering exclusion or restriction from practice, the NCAS must be notified".

Whenever Dr. Chada told you that Mr. O'Brien had been restricted, were you shocked or surprised because NCAS had not been notified? 14:45

A. I think because it was an open case, I still thought that I would be getting -- that I would be hearing from Dr. Wright. I think our view would be if a case is open, very often we had covered the thought processes of the options of an informal exclusion, about what was available to them. From that point of view, restrictions would have been an option to him. So he may well have thought he met that criteria by the conversation we'd already had. 14:45 14:45

435 Q. Just go to TRU-267753, please. 267753, sorry. This is an internal Trust email between Ms. Siobhán Hynds again and Dr. Khan, who was the case manager of 22nd February.

"It was noted that the action plan agreed for AOB's return to work requires to be shared and discussed with NCAS at this point. Can you please discuss with Dr. Lynn".

Can you recall the specifics of the plan ever being raised with you?

A. No, I can't. I wonder did it fall between the two stools of Dr. Khan and Dr. Wright, because the previous action was for Dr. Wright, yet Dr. Khan had tried to call me on 20 something of January. So, there does seem to have been a bit of confusion about who was taking it forward with me. I don't know. I don't want to say. You'll have to ask them. 14:46

436 Q. Finally, can we go to WIT-53539, which is your last chasing email to Dr. Wright at this stage, 30th May.

A. Because as far as I was aware, Dr. Wright was still in charge of it.

437 Q. You say: 14:47

"Hi Richard. I was hoping for an update in this case. If you don't need any further NCAS input, I can close the file; it can easily be reopened at any stage".

14:47

Quick question perhaps, what is the significance of a closure of a file within NCAS?

A. It means that we really stop, you know, following it up with them. So we don't know where the -- we don't know

exactly what is happening. I think it is not uncommon in cases where they are doing an investigation because they know they can contact us if they need to, but it stops us ringing them every hour or emailing them, and the problems of them potentially not coming back to us. 14:47

438 Q. In this case then you sent three chasers to the Southern Trust. You never received any official feedback or update, although you do accept that you had some discussion with Dr. Chada, you believe. Would it be normal for a Trust to go quiet on the official 14:48 channels? Would it be normal for NCAS to chase so much and then have to close a file?

A. Reasonably normal.

439 Q. What does that say about the service; about NCAS? Or is it simply a reflection of the realities that NCAS is 14:48 dependent on engagement from the Trust?

A. I think that's so. I think as well it tells you something about the challenging conditions in which they are working in the Health Service, and it is very difficult for a busy medical director to find the time. 14:48 Sometimes in their investigation, they are inclined to contact us if they have a problem but if the investigation is continuing and there's nothing to report, well then, they might go very silent.

440 Q. Silent this went until we get to September 2018; is 14:48 that --

A. Yes, that's correct.

441 Q. In fact, essentially, over 18 months passed from your communication with Dr. Wright to your contact with

Dr. Khan. When this came across your desk were you shocked or surprised to hear the name again?

A. Well, I was very surprised that it had taken so long. I mean we're used to investigations taking a long time but this had obviously taken a very long time. So, yes, I was surprised that it had come back. 14:49

MR. WOLFE KC: If we could have a look then at TRU-251925. I think we're having slight technical difficulties. I have just jumped 18 months forward in time. I don't know if now's a good moment to have a brief five-minute break? 14:49

CHAIR: It's just after ten to three, we'll take until three o'clock then.

MR. WOLFE KC: I'm very much obliged. Thank you. International 3 o'clock. 14:50

THE HEARING ADJOURNED SHORTLY AND RESUMED AS FOLLOWS:

442 Q. MR. WOLFE KC: Dr. Lynn, thank you. Just before the break I jumped us forward a fair bit to September 2018. 15:00 Could I just check one point? Obviously Dr. Wright's evidence is that he did discuss this with you, and by "this" I mean the MHPS investigation. Is there any possibility that Dr. Wright and you may have had a discussion on 7 or 8 March 2017, whenever you were in 15:00 the trust, can you recall?

A. I don't recall that Dr. Wright was there, and that's Colin's recollection too.

443 Q. So although you were on Trust premises, you don't think

you actually encountered the Medical Director over those two days?

A. No, he had already had training.

444 Q. Can we talk then about your interaction with Dr. Khan, who's the Case Manager. You speak to him on 20 September 2018. If we could just look at TRU-251925, please. Thank you very much. This is an email from Dr. Khan to yourself, on 20 September 2018. He says: 15:01

"Dear Gráinne, 15:01

Thank you so much for taking my call and providing very useful advice.

As discussed, please find attached my draft notes for this MHPS case recommendation. I will await your you thoughts on this." 15:01

So you've clearly already spoken to Dr. Khan by this stage? 15:02

A. Yes.

445 Q. And he's sharing with you what he calls his draft notes. We'll maybe have a brief look at them a bit later but what it really is is a draft of his determination. 15:02

A. Mm-hmm.

446 Q. Why was he sharing that with you at this time?

A. I presume that he thought it might be helpful for me.

447 Q. This is your recollection that he thought it would be

helpful for you?

A. It would be unusual enough that we would receive the investigation or something as detailed as that, but...

448 Q. Do you recall being -- Dr. Khan sharing it with you. Do you recall requesting it in any way from him? 15:02

A. No, I don't recall requesting it.

449 Q. Was this the only document you ever saw with regards to this MHPS investigation? So for example, you never saw Dr. Chada's investigation report or Mr. O'Brien's rather detailed comments in response? 15:03

A. No, I don't recall that. Anything we have would be on our file so I don't...

450 Q. I think in fairness to you, from a look at NCAS's papers, I don't believe there's any copies of those two documents. 15:03

Can I then turn to your letter at WIT-53458? This is dated 21 September 2018. So, again, it's the next day you're following up in writing. I don't propose to spend as much time on this letter as I did the earlier December letter. 15:03

If you scroll down, please. Interestingly, this letter starts, the first paragraph is:

15:03

"PPA encourages transparency in the management of cases and advises that practitioners should be informed when their case has been discussed with us."

So, it was very perhaps towards the end of your previous advices but here this request or suggestion to share this with Mr. O'Brien is front and centre.

A. Yes.

451 Q. Was that normal practice or was that specific to this case? 15:04

A. It had become normal practice, I think, because we thought it was very important and we were aware that it wasn't happening in every case.

452 Q. Did you ever check to see if this letter was in fact shared with Mr. O'Brien? 15:04

A. No.

453 Q. Scroll down then slightly, please. We'll stop there.

You note in this third paragraph: 15:04

"An investigation for which you are the Case Manager has now completed. It was very delayed because of the complexities and extent of the issues."

15:04

In your discussion with Dr. Khan, can you recall querying or probing about the nature of that delay or the reasons for it?

A. No. That wouldn't really be something I would do normally because the delay has already happened. If 15:05 they were asking for advice on doing another investigation you might say, you know, that the delay was very protracted and they might want to have some learning out of it. I wouldn't -- you know, it's a bit

like if you see terms of reference in the completed investigation, there's not much point in saying you don't like the terms of reference, because that's what it is.

454 Q. I don't want to incorrectly paraphrase what you're saying or put words in your mouth, but really what you're saying is that you're advising the Trust going forward -- 15:05

A. Exactly.

455 Q. -- that was, to a certain extent, in the past? 15:05

A. Exactly.

456 Q. Over the page please then. WIT-549. Your letter includes a relatively detailed list of issues or concerns, specifically fully detailed consideration, you noted that, and the list concerns (a) to (g) there. On being told of these concerns (a) to (g), can you recall your level of concern or intrigue? 15:05

A. Yes. I felt there was very real concern here but Dr. Khan also was very concerned.

457 Q. On that call then, what specifically can you remember Dr. Khan being concerned about? 15:06

A. The risk. Risk to patients and the risk of harm and the fact that they hadn't really been aware of it. He addressed some of the issues which he felt were important. They're set out there really, you know. Because Dr. Khan was such a senior member of staff, that he was in a very -- he should have ensured that the Trust were aware that he wasn't undertaking triage as expected. He was very concerned about the private 15:06

patients taking priority over NHS patients.

458 Q. We'll come on momentarily to the private patients. You said that Dr. Khan was concerned. On reading those list of issues, what were you concerned about?

A. I thought it was -- I thought it was a very concerning report. You know, there were a lot of issues I was concerned about. 15:07

459 Q. In terms of your experience as an NCAS adviser, by this stage you had been well over 10 years, I suspect, did you ever come across investigations perhaps with seemingly so many headlines. We have paragraphs (a) to (g) there? 15:07

A. It was very detailed. You know, it was unusually detailed.

460 Q. You mentioned the private patients. I would be grateful if we could scroll down, please. You say: 15:07

"We discussed the current situation and the overriding need to ensure patients are protected. I note you have a system in place within the Trust to safeguard patients but we discussed that this needs to be mirrored in the private sector. You explained that Mr. O'Brien saw private patients at his home and did not have a private sector employer. I would suggest that as paragraph 22 of Section 2, MHPS states that 'whereas the HPSS employer has placed restrictions on practice, the practitioner should not agree not to undertake any work in that area of practice with any other employer". 15:07 15:08

It was your view then that Dr. 18665 should not currently be working.

You said Dr. Khan -- on this phone call was Dr. Khan concerned about this aspect of the private patients or was this reflective of your advices and your concern? 15:08

A. That was reflective of my advice and my concern. I think Dr. Khan had plenty to worry about with the patients he was responsible for. 15:08

461 Q. From what you've seen of this case, what made it necessary in your mind to suggest or to advise that Mr. O'Brien needed to stop practising privately?

A. There was no ability to put in place any safeguards because there was nobody there. You know, if you are working in private practice where there is a medical director, well then, you know, the Medical Director can be informed of the concerns and take a view as to what restrictions or supervision they need. But Dr. O'Brien was working at home so there was no ability to do that. 15:09

462 Q. Perhaps, as a lawyer I'm conditioned to read things overly literally but it says:

"Where HPSS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer". 15:09

Mr. O'Brien didn't have an employer. He appears to

have operated a limited enough private practice in the sense that it was outpatient consultations from his own home. Does paragraph 22 of that section of MHPS actually apply or cover this situation?

A. Well, you know, it didn't really -- to be honest, I wasn't thinking about what the law might say, I was thinking about the risk to patients. But that's something we've come across before. I felt he shouldn't be working privately so I put it in the letter. 15:10

463 Q. I'm just curious about this little kind of quirk, perhaps, in the framework. If we go to WIT-53825 and what I'm going to take you to is an email which you prepared in December 2019, not in the context of Mr. O'Brien but you engage in a comparative exercise of the English and Wales framework and the Northern Irish framework. WIT-538125, please. So far as I'm aware, this is nothing to do with Mr. O'Brien; is that correct? 15:10

A. That's correct. 15:11

464 Q. Scroll down to where it says Section 2, please. You say:

"The NI version would appear to suggest that the person could undertake paid or voluntary work when excluded in time not paid for by the employer, although they must not engage in any medical duties consistent with the terms of the exclusion. In England you must seek consent to work". 15:11

You've clearly done some type of comparative exercise.

A. Yes.

465 Q. In your opinion, I was going to say which is clear but perhaps which is more effective of protecting Patient Safety, if there are concerns? 15:11

A. I suppose when you point that out to me, in England where you must seek consent to work, that seems to be clearer.

466 Q. In your opinion, the current phrasing of paragraph 22 there, is that a regional, almost kind of kink or issue in our system which could perhaps be ironed out? 15:11

A. It would be one of those that could be addressed.

467 Q. If you then look at TRU-292465, please. This is, again, very much in the context of your advice regarding the private patients. You were advising the Trust then in September 2018 that Mr. O'Brien should not be working privately. An undertaking or assurance that Mr. O'Brien would not be working privately was, in fact, secured, but it wasn't until 21st July 2020 when further concerns had arisen. What's your reaction to that, that action was taken but not perhaps for another 18 months plus? 15:12 15:12

A. Well, I mean I felt that it should have been taken at the time. We don't have any authority. As you know, the only people that would have had the authority to stop Dr. O'Brien doing that was the GMC. I mean, Dr. Khan wouldn't have any ability to stop him doing that, especially after he retired. 15:13

468 Q. If we perhaps use that in a context of back to your advice in September 2018. You're advising the Trust that Mr. O'Brien should not be practising privately. At a very similar time the GMC ELA was offering perhaps similar enough advice to Dr. Khan. Would you have expected action to have been taken at that time? - 15:13

A. It would have been, I would have thought, up to the GMC. They're the regulator. They could have put conditions on his practice.

469 Q. But you are advising in September 2018 the Trust that Mr. O'Brien should not be practising privately. Whose responsibilities was it to deal with that? 15:14

A. Well, normally a Trust has a responsibility to contact the private employer. Of course here we don't have a private employer, which is a gap and was something, I think, was flagged. You know Joanne Donnelly, she's the GMC ELA, was to check with RQIA is that even possible. So I don't really feel -- I don't think really Dr. Khan can be criticised here. I think this was an issue beyond his -- there was nothing he could do. But I put it in black and white I felt he shouldn't be working. 15:14

470 Q. Thank you for that. Now if we go to WIT-53459 which is back from the letter we are currently discussing. Down towards the bottom of this page, please. 15:15

"We discussed that the issues identified in the report were serious, and whilst there are clearly systemic issues and failings for the Trust to address, it is

unlikely that in these circumstances the concerns about Dr. 18665 could be managed without formal action.

We also discussed while itself the issues did have clinical consequences for patients, as some of the concerns appear to be due to failure to follow policies and protocols and possibly also a breach of data protection law, these might be considered to be of conduct rather than capability". 15:15

Is this you advising Dr. Khan that these issues are appropriately regarded as matters of conduct as opposed to capability?

A. I thought so, yes.

471 Q. Could I just ask you to expand on your thinking there? I'll give you a bit of context in that subsequently a grievance is lodged with the Trust on the basis that the Trust have miscategorised this as a conduct issue, and that's from Mr. O'Brien. 15:15

Can you outline to me your thinking about why this was a conduct as opposed to what's termed there, as a capability issue? 15:16

A. Well, conduct is behaviour and capability is about can you do the job. I mean, I think the issues with Dr. O'Brien were a failure to follow processes, the processes the Trust had put in place. And they had clinical consequences for patients but it was because of his behaviour and conduct. You know, if a surgeon, 15:16

for example, if his treatment of patients on the operating table had been deficient, that would be a capability. I thought this was quite clearly a conduct matter, but they always argue about this because it's much, much easier to manage a conduct process than a capability process. So, challenge around this is inevitable, as far as we were concerned.

472 Q. If you could expand on your understanding there. Using your experience, you've said it is much easier to -- what way did you put it - easier to argue a conduct? 15:16 15:17

A. It is much easier to manage a conduct process than a capability process. Clinical performance they call it in the Northern Ireland version.

473 Q. Just again, I'm relying on more your general experience as an NCAS adviser. Why is that the case that it is preferable for a Trust to go down conduct but practitioners wish to go down the clinical performance route? 15:17

A. Well, we had a court ruling in England that you couldn't go to capability without an NCAS performance assessment. I think it was a misunderstanding, really, around the process. That was eventually overturned and it was if the capabilities issues are clearly understood, then you can go directly to a clinical performance, but it's very -- that's quite difficult and much more difficult to prove. 15:17 15:18

A conduct issue is very straightforward. If somebody isn't doing what they have been asked to do, well,

that's misconduct. If you are taking charts home that you've been asked not to bring home, that's misconduct.

474 Q. This is you, as you've just said, summarising your advice to Dr. Khan. What was Dr. Khan's position on the call? 15:18

A. Dr. Khan's position was very, very much that he regarded it himself as a conduct issue. They considered him a capable clinician, he just wouldn't follow the Trust instructions.

475 Q. Scroll over to the next page. This is the perhaps the key issue I want to explore with you in this letter, please. The very top of this page. 15:18

"Dr. 18665 could also be offered support going forward to ensure that in the future he is able to meet and sustain the required and expected standards". . 15:19

A. Yes.

476 Q. You quickly move on in the next paragraph to say:

"I told you that whilst there are no noted clinical performance concerns, practitioner performance advice could offer support via the professional support and remediation team by drafting a robust action plan with input both from Dr. 18665 and the Trust to address some of the deficiencies which have been identified". 15:19

You then state:

"The purpose of the plan would be to ensure oversight

and supervision so the Trust is satisfied there's no risk to patients, but also to provide support to Dr. 18665 to afford him the best opportunity of meeting the objectives of the plan. We know this might involve job planning and enhanced appraisal". 15:19

What you are describing there is an invocation of the PSR service, which we discussed earlier.

Is it standard advice in all cases for NCAS to suggest involvement of the PRS team, or was this specific advice and recommendation you made based on what you heard about this case? 15:20

A. This was specific really related to this case, but I had seen it in a couple of other cases. So the conduct issues. You're going to a conduct hearing, that was the open anticipation, but the conduct issues are not likely to lead to termination of employment. Therefore, you want to be sure you give the practitioner the best chance to come back to work. So that some of the objections, for example, that might have been open to the Panel would be a warning along with a requirement that he go through a plan. The plan, as was pointed out this morning, is very, very detailed so it is very well monitored, so there's a lot of evidence underpinning it. They either make it through the plan or they don't, in which case the options are much more straightforward. 15:20 15:20

477 Q. On reading the suggestion it appears to offer almost

the best of every world. It offers the Trust a chance to protect patients, to ensure Mr. O'Brien is working to required and expected goals and, as you said there, he is regarded as a very capable surgeon. It also offers Mr. O'Brien support in order to work through his issues. So, it would appear to be a pretty good potential solution to this? 15:21

A. Yeah. That's the thing, these were not -- given his track record and everything he'd done for the Trust, this was never going to be a dismissal kind of situation. But obviously they felt very strongly about -- Dr. O'Brien felt very strongly about not going to a conduct hearing. 15:21

478 Q. You mentioned there: 15:21

"Since we spoke, I've talked to the PSR team and will arrange for the forms, which must be completed to formally request the PSR support plan."

Those forms were, in fact, sent out that day on 21 September 2018. Did NCAS or PPA, as it was then, then ever receive a request from the Trust to engage that PSR process? 15:22

A. No.

479 Q. On the call -- you mentioned the suggestion on the call with Dr. Khan? 15:22

A. Yes. Yes.

480 Q. Did he appear to be supportive or interested?

A. I think he was, yeah.

481 Q. Did you have any further discussions with Dr. Khan specifically about this PSR process? We're going to come on shortly to you speaking to him on 31 October. But did you ever speak to Dr. Khan again about using this process? 15:22

A. Not that I recall.

482 Q. As I said there, you did end up speaking to him again in October.

A. Mm-hmm.

483 Q. On that call did you say: 'Dr. Khan what about those forms?' Did you raise it with him? 15:22

A. I can't remember. I'd need to see -- I don't remember raising it with him again because I think there were so many additional issues arising at that time. I mean, to use the PSR forms to their best effect they would have been combined with some sort of conduct process. So, if they couldn't get him to a conduct hearing they would probably -- I mean I can't second guess what they were thinking, but possibly they wanted the two to go together. 15:23

484 Q. Well, we know that the grievance only comes in, I believe, at the end of November --

A. Mmm.

485 Q. -- so there is a period of time here before -- we'll come on in a very brief moment to Dr. Khan's determination, but is there anything stopping this PSR process running alongside a wait for a grievance or a conduct hearing, as in could the two processes, while informing each other, run in parallel; i.e. we could 15:23

have started the PSR process but still just waiting or the conduct, and subsequently grievance hearings? Was there anything stopping that?

A. No, there's nothing to stop that.

486 Q. If we look at your advice letter again, we're still there actually so scroll down to the very bottom, please. You've a review date this time of 24 September 2018. That's a very tight kind of time. 15:24

A. It's probably an error, I would say. What date's on the letter? 15:24

487 Q. 21 September?

A. To the 24th? That would be an error, I would imagine. We would usually review in a few days because it doesn't give them enough time. So I'm assuming that's an error. They are both September. 15:24

488 Q. So the fact that the review date says 24 September 2018, it doesn't indicate some desire on your part to keep this under active review, it's more likely just an administrative error?

A. I think so, yeah. I'll see when I next spoke to him. 15:24

489 Q. Now, we discussed, very briefly there, Dr. Khan's approach to this on the call. You said he sounded relevantly interested, is that fair, or...

A. Yeah. I mean I found him very engaged and keen to resolve matters. 15:25

490 Q. If we look at TRU-251931, please. What this document is, this is Dr. Khan's draft determination or his notes which he shared with you before the meeting. Do you recall me referring you to that a couple of minutes

ago?

A. Yeah.

491 Q. If we look at point (b) there, it says:

"Possibly restrictions on action plan." 15:25

So, that's Dr. Khan's view before he speaks to you.

If we jump then to his final determination, which is at AOB-01921. This is Dr. Khan's final version of the 15:25 determination. What he's recommending is:

"In order to ensure the Trust continues to have assurance about Mr. O'Brien's administrative practices and management of his workload, an action plan should 15:26 be put in place with the input of the PPA, the Trust and Mr. O'Brien for a period of time agreed by the parties."

If you scroll down. It then provides a bit more detail 15:26 about how that would be reviewed and monitored. That sounds very similar to the PSR plan that you were suggesting, doesn't it?

A. Yes.

492 Q. But just so you're clear, it was never followed up on 15:26 by the Trust?

A. No. We never got the forms back. Obviously for the team to work on it they need to have all the information.

493 Q. For the avoidance of all doubt, was any input from NCAS or PPA requested at that time or subsequently for an action plan with regards to Mr. O'Brien, even if it didn't formally tick the boxes of that PSR process we've been discussing? 15:27

A. Not that I'm aware of.

494 Q. We're going to come on to some discussions you had with Mr. O'Brien presently. You spoke to him on the 1st, 11th and 30th October, so three times in a relatively short sequence. 15:27

A. Mm-hmm.

495 Q. Did you discuss with Mr. O'Brien taking an action plan of this kind forward?

A. I don't think so.

496 Q. Why would you have suggested to the Trust but not floated the idea with Mr. O'Brien? 15:27

A. Because Mr. O'Brien, when he was on the call, mostly he was talking to me. And I think I saw the action plan as something that would go hand in hand with the conduct process and Mr. O'Brien seemed to have some trouble with thinking about going to a conduct process at all. 15:27

497 Q. So, you never discussed it with Mr. O'Brien?

A. No.

498 Q. You can't recall if Mr. O'Brien was keen and willing to engage in such a monitoring process? 15:28

A. No.

499 Q. I'm just going to discuss a bit about your interaction with Mr. O'Brien. So, if we could look up your letter,

please of WIT-53461. This is a letter from you to Mr. O'Brien, on 17 October. Can you just scroll down please. It refers to discussions that you had with Mr. O'Brien on 1st and 11th October 2018. Was it unusual in any way to be contacted by practitioners? 15:29

A. No, it's not unusual.

500 Q. Was it usual to be contacted by a practitioner so late in the process, i.e. almost coming up two years since your first engagement in this?

A. That is quite late in the process. 15:29

501 Q. Before I dive into your letter, I think you've subsequently learnt throughout this Inquiry process that Mr. O'Brien actually recorded one of your discussions which I believe must have been your second discussion on 11 October 2018. At the time you were 15:29 offering that advice, were you aware that the discussion was being recorded?

A. No.

502 Q. I would just like to give you an opportunity to perhaps, on finding out that that was recorded to offer 15:29 some reflections to the Inquiry about how you felt about that?

A. I feel it was unprofessional. I feel it was -- Mr. O'Brien was very concerned about the process. He felt that the process had been unfair and certainly the 15:29 Trust had made a lot of mistakes but I felt that what he did was unfair. But, having said that, like I can stand over what I said. I said maybe I'd have done less humming and hawing. If I'd known I was on record

but, you know, I don't think it would have been substantially different from the conversation that we had. I mean, I had a great deal of sympathy for his position. I mean, I know that there was a risk to patients and all those things but I was aware of the background and how successfully he had worked for a long period of time. So, you know, I felt very sorry for Mr. O'Brien. But I also was beginning to feel frustrated in that he didn't -- whilst the Trust had made a lot of errors he really couldn't see the Trust point of view in any way. 15:30 15:30

503 Q. I do intend to move relatively quickly through these communications with Mr. O'Brien. The paragraph on screen, about halfway down it says 'specifically you allege' - this is Mr. O'Brien's instructions to you - "you allege that the Trust has misled PPA service (formerly NCAS) by implying that you were supported to address concerns in 2016." 15:30

Is it normal for practitioners to raise allegations that NCAS have been misled? 15:31

A. That's reasonably normal.

504 Q. And what action do NCAS take on being informed that they've potentially been misled?

A. Well, we really -- it's not something we can adjudicate on so we always tell -- we keep, obviously, the records on file and then if we go to meetings with them, with all parties, we can sometimes get some sort of meeting of minds. But that didn't happen in this case. 15:31

505 Q. I think the letter goes on, and you direct Mr. O'Brien towards making a subject access request --

A. Yeah.

506 Q. -- I think that's to NCAS, is that right?

A. Yes. Well, we would prefer the organisations to give the practitioner the information to which they're really entitled but the problem is a SAR is a lot of work for the team in NCAS and we get a huge amount of requests. I know the information team much prefer the Trust to provide this information. But if they're not, well, we usually will. 15:31 15:32

507 Q. You go on variously to advise Mr. O'Brien to exhaust his internal options, i.e. speaking to a designated Board member, the Chair of the Trust and the Chief Executive. And the letter ends with you saying that you will advise Dr. Khan of your conversations with Mr. O'Brien. Did you speak to Dr. Khan at that stage? 15:32

A. I did go back to Dr. Khan and talk to him about it, yes.

508 Q. Was that at that stage or was that on 31 October 2018? I can bring up the letters in due course. 15:32

A. You'll need to, I couldn't recall the date without it.

509 Q. You ended up speaking to Mr. O'Brien again. If we look at WIT-53463. I don't want to downplay at all what Mr. O'Brien was telling you, but it's perhaps information from a similar vein before any allegations that NCAS had been misled by the Trust, but perhaps further information provided. If you can scroll down, please, and on to the next page. 15:33

Again you advise him of his right to make a subject access request. Then the final sentence here:

"We discussed that it may be helpful, with the Trust's agreement, for all parties, including PPA, to meet. I told you that I would liaise with Dr. Khan to ascertain dates." 15:33

What was your thinking behind the suggestion of a meeting? 15:33

A. Well, I think the fact that the Trust and Mr. O'Brien were so far apart, really, it had the feel of a case that was going nowhere, you know. So we thought if we could get them around the table we might be able to achieve something. Now, we didn't talk about mediation. I have been trained as a mediator as well but we didn't offer that. I felt there was too much conflict at that stage, really, for mediation. 15:34

510 Q. So, your intention was not so much to mediate but to try and find some degree of common ground, is that it? 15:34

A. Yeah. Yeah. The Trust had admitted -- I mean obviously those allegations that they had misled us were worrying, but the Trust had admitted, I mean Dr. Khan -- from that point of view I commend the investigator and the Trust. They did, very unusually, say we weren't -- I mean they're on record as saying they weren't as proactive as they should have been. It's unusual to see that in an investigative report. 15:34

511 Q. Was any part of this meeting concerned with an action plan, the likes of which you and Dr. Khan had discussed previously?

A. Well, if we'd got to the meeting, yes. But we didn't get there. 15:35

512 Q. Before we get on to why you didn't get there, on this phone call or these phone calls, was Mr. O'Brien supportive of having a meeting with The Trust?

A. Very.

513 Q. So, he seemed to be keen? 15:35

A. He wanted a meeting, yes. He wanted a round table conversation.

514 Q. This letter here I believe is dated 31 October and I understand that you spoke to Dr. Khan on that very same day. We can have a look at WIT-53467, please. If 15:35 we scroll down to Dr. Khan's email, please. This is an email of 5 November from Dr. Khan to yourself. He is copying in Mrs. Hynds and Mr. Gibson, who I understand may also have been on your phone call. Do you have any recollection of that? 15:36

A. Of talking to Dr. Khan?

515 Q. Of talking to Khan, Hynds and Gibson?

A. Yes, yes. Absolutely.

516 Q. He says: 15:36

"Further to our telephone conversation on Wednesday 31 October"

-- it is a relatively detailed email, I will not read

it out entirely verbatim. He has clearly been informed of your discussion with Mr. O'Brien, in particular the concerns the formal investigation was inappropriate. Sorry?

A. I don't think I have that in front of me, have I? Are we looking at two different things? 15:36

517 Q. It should be an email of 5th November. It's from Dr. Khan to you. Sorry about that if I caused any confusion.

15:36

In this email, Dr. Khan is setting out the Trust stall really that a formal investigation had always been merited and they'd provided submissions to Mr. O'Brien addressing this issue in the past, and given the serious nature of the concerns it was considered 15:37 appropriate to pursue a formal investigation.

If you go to the next page, please. He says:

"I was encouraged to hear from you that Mr. O'Brien and 15:37 his son are not in dispute of the issues of concern. The findings from the formal investigation further outline that the concerns under investigation and which are now founded are very serious in nature."

15:37

The final two paragraphs:

"I appreciate your offer of a meeting between the Trust and Mr. O'Brien with you in attendance. Having

considered this, we remain unclear as to the purpose of this meeting at this stage. As always, we are happy to be guided by NCAS and if you feel it is useful to meet, we are happy to do so.

15:37

"We would be very grateful for your advice on the best course of action in this regard and what you feel could be achieved by such a meeting".

Now, on a reading of this, and while the Trust are robustly enough setting out their stall about what they understand the circumstances to be, Dr. Khan here isn't saying he's against a meeting, is he, he is saying we're just unclear about what a meeting will achieve.

15:37

15:38

What's your reading of that email?

A. Yes, I agree he was unclear about what a meeting -- but the issue of concern to me was they were determined that the conduct hearing would go ahead and the practitioner was equally determined that it wouldn't. They didn't mind a meeting, but it was in the context that the conduct hearing would have to proceed.

15:38

518 Q. I suppose the key sentence which I didn't actually bring your attention to there is at the bottom of the first paragraph:

15:38

"As previously discussed and agreed with you, the next step is this process to hold a conduct hearing following conclusion of the formal investigation."

A. That's right. So the next step had to be the conduct process. They would have seen the PSR, as I explained earlier, as probably coming after that but then we never got to the conduct hearing.

519 Q. Can we go back to 53467, please. It is just the first page, and Dr. Lynn's response. You do respond to Dr. Khan on 5th November 2018. You say: 15:39

"Thank you for this. In the circumstances I am not sure anything further could be achieved by a meeting". 15:39

So having considered the Trust's submissions, you're now completely off the notion of having a meeting?

A. Well, yes, at this stage.

520 Q. You're reasoning for that, just so that we're clear? 15:39

A. The reasoning for that is they wanted the next step to be the conduct hearing, and Mr. O'Brien didn't want a conduct hearing. There was no process, really, of getting an action plan together without a conduct hearing. I think they weren't opposed to a performance 15:39 improvement plan but they were determined that the matter was significant enough that it needed to go forward to a hearing.

521 Q. You subsequently write then to Dr. Khan that day, or on 6th November, in fact confirming your position that no 15:40 hearing will go ahead.

You write to Mr. O'Brien on 9th November. Can we have a look at that, WIT-53472. This isn't a letter you

write to Mr. O'Brien on 9th November. You say:

"Following our conversation I contacted the Trust to explore further with them and to offer to meet".

15:40

You set out the Trust position.

A. Yes. So the last paragraph -- the second paragraph, last sentence, you see:

"I note it is also likely as per earlier correspondence with the Trust that they will want to support you moving forward". 15:40

But it was in the realm of after a conduct hearing.

522 Q. Then the final paragraph of this page: 15:41

"These decisions made by the Trust are ultimately matters for them as your employer and PPA cannot arbitrate on these decisions or take on the role of your advocate". 15:41

Did you consider that Mr. O'Brien or the Trust were asking you to become an arbitrator here.

A. I thought that Mr. O'Brien certainly would have wanted that. 15:41

523 Q. Did you consider that Mr. O'Brien or the Trust wanted you to advocate for their position in any meeting?

A. Well, I got that impression.

524 Q. What was to be the NCAS follow-up to this? If we go

down, I believe there is a review date attached to this letter. There might not appear to be. What was to be the NCAS follow-up to this?

A. I can't remember. I mean, we do have follow-up, I know, but I can't remember. Specifically, I would have been waiting then for the conduct hearing but then the conduct hearing got derailed because of the grievance. That's what I recall, but I haven't got... 15:41

525 Q. In your opinion and perhaps your experience as an NCAS adviser, given the nature of the grievance did it mean that it was impossible for the conduct hearing to go ahead? Did everything have to grind to a halt? 15:42

A. It didn't really have to grind to a halt but, yes, I think the Trust were finding it all very difficult. I'm sure Mr. O'Brien was finding it very difficult too. In fact, I know he was because I was speaking to him on the phone. 15:42

526 Q. If we just look WIT-53453, please. Paragraphs 27 and 28. You say you followed up with the Trust on 2nd January. You were asking if any process has come to a conclusion. Dr. Khan replied there was now a formal grievance which had to be dealt with. You say there at paragraph 28 you emailed again in February '19, emailed again June '19, emailed again September '19 before the file was formally closed in February 2020. 15:42 15:43

Is that an accurate summary, you think, of the involvement?

A. It is an accurate summary.

527 Q. You'll be pleased to know I am almost done; do rest assured I want to ask you one or two questions.

This case comes back before NCAS, or PPA as it was then, around the summer of 2020. At that stage it goes to Dr. Fitzpatrick primarily. Why again, had it switched from initially Dr. Fitzpatrick to you and why was it now switching from you back to Dr. Fitzpatrick? 15:43

A. I think I was probably on leave but I had also given notice of my intention to retire so they were trying to re-direct some of my caseload. So, the Northern Ireland cases would have been heading to Colin. I think I was on leave but I can't be sure. 15:43

528 Q. Then you did speak to Mr. O'Brien and his wife, I think, on 15th July 2020. You followed this up with a letter which can be found at WIT-53720. About two-thirds of the way through this paragraph you state -- this is again, I think, you're reflecting on what Mr. O'Brien told you: 15:44

"You think that our organisation is being manipulated with misleading information and that you have been victimised whenever you have raised concerns". 15:44

Just on that, in a sense Mr. O'Brien is suggesting he may have been some type of whistleblower and was being punished or victimised. Is that a fair description of what he was telling you at this time? 15:44

A. That's a fair description.

529 Q. What, if any, role does NCAS have whenever these type of whistleblowing issues are raised?

A. It's not uncommon for the practitioners to raise this. But his employment with The Trust had terminated, so, you know, I'm not really sure what we did with that, to be honest. Normally if people raise whistleblowing, then it escalates through our organisation. He felt that -- was this after the review, the lookback had started? 15:45

530 Q. I believe this was after the further concerns had been raised in July 2020, so we're relevantly far through the story at this point. 15:45

A. I think how we saw it, like we knew that there were these concerns. He'd agreed that there were -- he always had agreed that there were issues of concern. So, it didn't seem unreasonable for Dr. O'Kane to be doing a lookback. I wasn't sure that there was evidence to support what he was saying, that he was being victimised for doing that. 15:45

531 Q. Would it be NCAS's job to investigate whether he was a whistleblower? 15:46

A. No, no. That would be for his defence organisation, you know, to raise.

532 Q. I promise you, I've got three questions left. Hopefully they're not the hardest you faced today but who knows. 15:46

You've more experience than most of dealing with the MHPS Framework given your unique enough position. You

obviously heard some of Dr. Fitzpatrick's reflections earlier. Does the process or does the framework work? Can it work? What might need to change in order to make it more effective?

A. I think there's a number of problems with MHPS. 15:46
I think there's great difficulties in Trusts in managing concerns. I mean, we've seen this a few times now. You know, you pointed out earlier -- and it is something that we address in case investigative training but it's not getting any better. They don't 15:47
have people freed up really, they add it on to their day job. I think they're completely -- I think the situation in which the Health Service in isn't going to make it any easier any time in the near future. As you can see, this was taking up an enormous amount of time. 15:47

533 Q. Those issues you describe, I don't personally have a view on it and I'm not expressing the Inquiry's view by any stretch, are they issues with the framework itself, are they issues with almost the structures, the funding or the infrastructure around the framework in 15:47
how it's implemented?

A. I think there are problems within MHPS but I think there are problems within organisations as well.
I think there are difficulties -- there's a lot of tick boxing goes on in the Health Care system at the moment. 15:48
I think there's a real nervousness around managing performance concerns. You're dammed if you do and dammed if you don't. There's real concern. I see it as people doing things just so that though can say they

did them. It has become increasingly bureaucratic, and that has an influence on patients as well in that the time taken to do everything is hugely extended because of the need you are making sure that you're adequately covered, that you're not exposing yourself to risk. 15:48

I think there's a lot of -- there's a huge amount -- I don't even know how you begin to fix it.

534 Q. That's probably not welcome news to the Inquiry at this stage. 15:48

A. I know but it's true.

535 Q. I'll ask you about your reflection on NCAS's role. Do you think NCAS's role was sufficiently clear in these processes?

A. I think it's reasonably clear but I think, you know, we don't have any authority. I think that's the problem. We have no ability, you know, to make organisations do anything. We rely on them engaging very much with us. Again, you know - and I'm not saying necessarily in this case - but people engage with us really so that they can say they engaged with us; you know, that they've met that requirement. I'm sure you will have seen in the bundle I saw that somebody even suggested 'we better get them down to train us so that we can say we're trained'. That is the prevailing atmosphere in the Health Service. 15:49 15:49

536 Q. A final question. Dr. Wright, in his oral evidence, offered a reflection that there wasn't a great awareness of the goal of NCAS and the potential it had

to assist and help with difficult cases. That reflection, I believe, is from his interpretation at the time, which was about 2015, 2016.

In your view, is there sufficient -- let me ask you two questions. Was there sufficient knowledge of NCAS's services and ability to help back then, so let's say 2016, whenever this process started? 15:50

A. I would have thought that there should have been. I think, you know, by 2016 they were already in very real difficulty. It turned into -- it was almost an intractable problem because it had preexisted. 15:50

537 Q. I suppose Dr. Wright's reflections may be a slightly broader one. Generally within the system, did you view that people knew who NCAS were, what they could offer and what assistance they could provide? 15:50

A. I don't know whether practitioners on the ground are very aware of it. I know the medical managers would all be aware of it. I know that the nonmedical managers would not. So, I think you would find teams within organisations where their HR departments would have a very sketchy idea of MHPS. 15:51

538 Q. And at the time you retired did you consider there had been any improvement in that situation?

A. I'm not sure that there was. 15:51

MR. BEECH BL: Thank you very much, Dr. Lynn. I've no further questions for you, I'm sure the Panel might have one or two. Thank you.

CHAIR: I know you've been here from early morning too,

Doctor, so we'll try to be quick but I'm going to go first of all to Mr. Hanbury and I'm sure he might have something he wants to ask you.

DR. LYNN WAS QUESTIONED BY THE PANEL AS FOLLOWS: 15:51

539 Q. MR. HANBURY: Thanks very much for your evidence. I hope you can hear me.

I've just have got two short questions, hopefully. I'm 15:51
still struggling slightly with the classifications of shortcomings and just two things with respect to, firstly, the dictation and, secondly, the triage. We know Mr. O'Brien could do it but he on occasion didn't do it. How do you classify that as 15:52
capability or performance or something different and how do you work that out?

A. Well, I think if you have the ability to do something and you don't do it, that's a conduct issue. So, as I understand it, Mr. O'Brien didn't really agree with 15:52
the triage that was a put in place but he was instructed that that was to happen but he didn't want to do it like that, so that led to the backlog. So it was as a direct result of decisions he was making about how he behaved. So I viewed that very much as conduct. 15:53

540 Q. What's the place of mitigation there, pressure of work, and things, would that change?

A. Yeah, I agree entirely with that. I think that was -- you know, there were mistakes made there about not

freeing him up to do it. But I think even -- when it was drawn to his attention, you know, and it had become a big issue, that was the time that he could really have, even for himself he could have stopped -- I imagine if he had told the Trust I'll stop doing X, Y and Z, to do that. There would have been very little they could do about that. But he didn't. So I think that had he -- you know, I realise he did a huge amount of work and a huge amount of hours but he wasn't following specific instructions and he didn't make any -- well, he used to get the better for a while and then slide back which sort of as well implies conduct. He could do it when he had to but he couldn't consistently do it, probably because he didn't believe in it. 15:53 15:53 15:54

541 Q. And do you say the same about the dictation issue?

A. The dictation issue?

542 Q. That is dictating after patient contact?

A. Well, I said, when he talked to me about that I didn't have an issue with whether it was dictated or not, as long as it was recorded in some way. So I'm not -- you know, I didn't say -- he had in our telephone conversation together, and that's on record, I said to him, you know, as far as I know there's no requirement either -- I don't know that the Trust had a requirement, there's certainly no requirement that you must dictate but you need to keep a note, a contemporaneous note because obviously at the end of the week you'll never remember what you did. Or at 15:54 15:54

least most of us wouldn't remember what we did.

543 Q. Thank you. Just harking back to the March '16 and the first warning letter and could more have been done in that case. We've heard from Dr. Fitzpatrick that if he'd got a letter like that he would've taken it very seriously and, in his words, pulled his socks up. I mean is that something that you agree with or do you think at least you would have raised it if that had come to you? What would your comment be about that? 15:55

A. We didn't know about it in March 2016. But I think when a concern is raised with a practitioner, usually they try to do something about it. And the cases we see that don't go well, it's usually when the practitioner adopts a defensive position. Because really, mostly what the Trust wants is that the problem goes away, so that their concerns are addressed. But I think Mr. O'Brien felt, you know, I think possibly outraged, really, that with all his work, you know, that he was -- his performance was being called into question. And I think it would have been helpful if he had shown a little bit more flexibility. 15:55 15:56

544 Q. In retrospect, if he felt he couldn't get anywhere at his Trust, would NCAS have helped him then?

A. I'm not sure I followed that. Sorry.

545 Q. Well, if he felt he wasn't getting anywhere with his local medical managers, what other options could he have explored? Would there be a place for him to call your services? 15:56

A. Well, as I say, we can't arbitrate. I mean that falls

to his defence organisation. I'm not sure if he was a member of a defence organisation. I know he was -- he had access to legal support but I'm not sure that he was a member of a defence organisation. We never -- I certainly never spoke to a member of a defence organisation and I wonder was that an issue for him because the defence organisations are used to trying to meet trusts halfway, which might have been, you know, might have been helpful in the circumstances.

MR. HANBURY: Thank you very much. I've got no further questions. Thanks, Ms. Smith. 15:57

CHAIR: Thank you, Mr. Hanbury. Dr. Swart.

546 Q. DR. SWART: Thank you. Looking the evidence relating to MHPS and this Trust and this practitioner, it's clear that we had everybody trying to do the best they could and somehow it didn't go well. Supposing that the case investigator had contacted you personally a few months in and said, 'look, this is quite a complicated case, there's a number of issues that I find quite difficult, I'm not sure how to balance things,' would you have advised at that point, would you have signposted them? Do you think it's clear to people that that route is open? 15:57 15:58

A. Well, when we do our investigation training we do tell them that. But I do think these investigations are very complex and they are being delegated to people, you know, with very little experience. They don't do investigation often and I'm sure having done one NHS investigation you'd probably never want to do another 15:58

one.

547 Q. That's about it.

A. I think -- and they're not -- I mean we provide training for them, obviously, but, you know, other people spend a very long time learning to be an investigator. 15:58

548 Q. Yes. I mean, what I'm saying is you get the training but it's not the same when you come and do it --

A. No.

549 Q. -- and you've all these competing things. There are quite a lot of moral, ethical, practical issues, and I see a sort of slight reluctance of people to ask for help and maybe a little bit of insecurity about who they can safely ask. 15:58

A. Yes. 15:59

550 Q. Would it be helpful to be more explicit about that in both MHPS and in case investigator training? I mean accepting that in the fullness of time there'll be more external investigators, I think, and that kind of thing. But this is not easy to do. 15:59

A. No.

551 Q. It's very easy to get it wrong and there's a huge burden on you in the balance between patient safety, professional reputation, if you like, confidentiality. I don't know any sensible person who does it and doesn't find it quite tricky. 15:59

A. Yeah.

552 Q. So, do you think it would be helpful to be more explicit about that in formal guidance, not just in the

training but in the documentation?

A. Yes, I agree it would be. I think it's an incredibly difficult job to do and I think the people involved in this investigation certainly did their best.

553 Q. Then there's an ongoing issue here which is around the scope of the investigation, which you've talked about and we asked Dr. Fitzpatrick about it this morning. If you just look at dictating letters, for example. With the benefit of hindsight we have someone who is unable to dictate on large numbers of letters and doesn't see it as his job. This means he's not communicating people to the members of the multi-disciplinary team - whether it's a GP or colleagues who pick up the notes - and this is a risk to patient safety because it indicates a uni-professional practice which is contrary to modern safety and multi-professional theory. So, if you look at that now and we look at the things that eventually happened, surely we could specify a little bit more, or MHPS could specify a little bit about the scope and about what the warnings signals are? There are a few here. There's a doctor who doesn't take note of that letter, for whatever reason. That is unusual. Large numbers of undictated letters, it is very unusual. Difficulty in dealing with it is very unusual. It's almost inconceivable that there's not another problem. It may be a problem brought on by pressure of work, there may be lots and lots of causes of it, but with the benefit of hindsight what could NCAS have done more in that situation, now that you

16:00 16:00 16:00 16:00 16:01

look back?

A. That's a very difficult question too. I think if we'd possibly gone out to meet at a very early stage it might have helped, if we'd gone out and -- at the very initial -- even back in September '16. But it's very difficult to call, at that stage, because obviously you only know how difficult it's going to be at the end when it didn't seem that unusual at the start. 16:01

554 Q. I think that's the theme that's gone through this. People sitting down with the practitioner, whether it's within the Trust or someone else, to actually try and determine the diagnosis, if you like: What is going on here? What is impacting on this person, cause this behaviour. So thank you for that. 16:02

A. Thank you. 16:02

DR. SWART: That's all from me.

555 Q. CHAIR: Doctor, just so that I'm clear in my own head, NCAS is a service which has the service agreement with the Department of Health. Presumably somebody pays your wages. Is it right that the Department of Health then pays NCAS for the service provided, is that it? 16:02

A. They pay a lump sum, as I understand it, and then separately -- the lump sum, as I understand it, includes a number of things. And then if they go over a certain number of assessments or -- for example -- then they would have to pay for those. 16:02

556 Q. Would the Trust be asked to pay for those directly or is it just the Department of Health?

A. I imagine it would be the Department. It's normally

free to the Trust.

CHAIR: To the Trust at the point of usage.

Thank you. That's really very helpful. It has been a very long day and I'm sure you'll be glad to get home, as I'm sure everybody in this room will be glad to get home. 16:03

Can I say to everybody, thank you for starting so early. I think it was important that we did do that. It is appreciated and I do appreciate how long a day it's been for all of us. And can I just wish you all a very healthy and happy Easter and I'll see you after the break, such as it is, because we're straight back in. Thank you very much. 16:03

THE INQUIRY WAS THEN ADJOURNED UNTIL TUESDAY, 18TH APRIL 2023