Urology Services Inquiry

Oral Hearing

Day 46 – Wednesday, 24th May 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

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INDEX

	PAGE
Ms. Tracey Boyce	
Examined by Mr. Wolfe KC	3
Lunch adjournment	92
Questioned by the Inquiry Panel	147

THE HEARING COMMENCED AT 10:00 A.M. ON WEDNESDAY, 24TH DAY OF MAY, 2023 AS FOLLOWS:

CHAIR: Good morning, everyone.

MR. WOLFE KC: Good morning. It's Dr. Tracey Boyce. To take the oath. 10:05

DR. TRACEY BOYCE, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS:

10:06

MR. WOLFE KC: Good morning, Dr. Boyce. Your doctorate is not as a medical doctor; isn't that correct?

A. No, it's a doctor of pharmacy practice.

1 Q. I thought I'd clarify that at the outset. It arises discreetly at a point in the evidence. Let's put up on the screen, please, your witness statements the Inquiry, starting with your primary witness statement, WIT-87630. You'll recognise the first page of that being. The Inquiry has annotated it on the top right-hand corner to indicate that you also sent in an addendum statement. 10:06 10:06

A. Yes.

2 Q. Let's go to the last page of this at WIT-87674. Again, you'll recognise your signature dated 18th November 2023? 10:07

A. Yes.

3 Q. Subject to the additional remarks made in your addendum statement, would you wish to adopt this statement as part of your evidence?

A. Yes, I do.

4 Q. Your addendum statement then, which is signed off on 19th May this year, WIT-96617. Again, there are some minor amendments, typographical errors and that type of thing. Then as we scroll through it briefly, just down to the third page, please. Keep going, right on to the fourth page, is it. You set out more significant, more major amendments which particularly relate to -- you step through the chronology really in the build-up to the Oversight Group meeting on 22nd December? 10:07 10:08

A. Yes. I must apologise, when I wrote it back to November and then I reviewed it in May, I realised that it had got the chronology slightly wrong so I wanted to correct that. Apologies for having to take that. 10:08

5 Q. Then if we go to the last page then, please. Scroll down scroll down to 23 in this series. Again, your signature dated 19th May.

A. Yes.

6 Q. Would you wish to adopt that statement as part of your evidence? 10:09

A. Yes. Thank you.

7 Q. Now, let's deal with your employment background, Dr. Boyce. Happily there's a copy of your CV; I think it's up really to date? 10:09

A. It is, yes.

8 Q. I don't need the bring it up, but in ease of the Inquiry's note it can be found at WIT-87677. In short form, you were appointed Director of Pharmacy and

Medicines Management for the Legacy Trust --

A. That's correct.

9 Q. -- which predated the formation of the Southern Trust. So, you were appointed in 2006?

A. Mm hmm.

10 Q. And then took up the same role in the newly formed Southern Trust in 2007; isn't that right?

A. That's correct.

11 Q. You held that post, Director of Pharmacy, until the 31st January 2022, when you retired?

A. That's correct.

12 Q. You have explained in your witness statement that the Director of Pharmacy role was at the same organisational level as an assistant director role within any particular directorate?

A. Yes, that's correct.

13 Q. We aren't particularly interested in your Director of Pharmacy duties for the purposes of this Inquiry, but the Panel will find those set out in your statement at WIT-87633. You have explained that, for operational purposes, your line management goes up through to the Director of Acute; isn't that right?

A. That's correct.

14 Q. You set that out helpfully in a table. If you bring up on to the screen, please, WIT-87636. That's Mr. McCall was in place at the start of your employment, and then we start to recognise and have familiarity with some of the names that are further along the chronology, ending with - if we scroll down - Mrs. McClements was the last

director in post as you retired?

A. That's correct.

15 Q. Professional issues, if they arose, you reported up through the Medical Director's office and the Medical Director him or herself; is that right? 10:12

A. That's correct. Then I was unusual, I had sort of line management through the Director of Acute Services for operation, like my leave and appraisal and so on. But for professional issues, because I was also the Trust accountable officer, I had a dotted line, as they 10:12 called it, direct to the Medical Director, who I would have liaised with if they were investigating a drug theft and there was professional staff involved and so on. So, I had sort of a close working relationship with both of them. 10:12

16 Q. Yes. If we could turn to paragraph 4.4 of your statement at WIT-87633. I want to spend some time at the start of your evidence, Dr. Boyce, looking at how you fell into a governance role out with your pharmacy duties, and I am also going to seek your observations 10:13 on the state of governance as you experienced it within Acute Services, the Acute Directorate. What you say in 4.4 is that in October 2014 you were asked by the then Director of Acute Services, Mrs. Deborah Burns, to manage the Acute Governance Team for a few weeks while 10:13 the Acute Governance Lead post was being recruited. This was because the previous post-holder, Margaret Marshall, had moved into Corporate Governance Lead role. You were asked to take this on as, out of the

six Assistant Directors in the Acute Directorate, you had the most governance experience, and you set that out.

You had set up the Northern Ireland medicines governance pharmacy team in a previous post, and you also had completed a postgraduate doctorate -- 10:14

A. That's correct.

17 Q. -- of pharmacy practice on the subject of the medication related to patient safety, hence Dr. Boyce. 10:14

A. Yes.

18 Q. In relation to that, your governance experience for taking on what you thought was to be a temporary role is set out there; it's in the context of pharmacy, it's in the context of medicine management and patient 10:14 safety. Were these relevant experiences and relevant skills for what you were being asked to take on?

A. Yes.

19 Q. Or, as you suggest there, is it the closest fit amongst other Assistant Directors in Acute? 10:15

A. I think it was because -- I mean, basic governance, understanding of clinical governance, is the same no matter what speciality you are applying it to. So, I think I was able to transfer the experience I had got from setting up that team that run across all five 10:15 Trusts in Northern Ireland, each with a pharmacist. We set up a governance process. So, I had that experience of being proactive in governance as well as the reactive bit. So I had those skills, understanding of

how clinical governance worked. I was also quite a lot of links to the various governance officers the Trust and also in other Trusts as well, so it allowed me then to step into that even though it was a very wide remit. I had those skills that I could then bring to that. 10:16

20 Q. You came into this role without much notice; is that fair?

A. Yes. It all happened quite quickly, the sort of reshuffle after Dr. Rankin left. Mrs. Burns, Debbie Burns, had been the Corporate Governance Lead and she 10:16 moved into the Director of Acute Services, so obviously then there was a gap immediately at the Corporate Governance Lead, so Margaret Marshall of Acute Governance went to that, so then we had the gap in Acute Services with no governance lead. The intention 10:16 at that point was it would have been recruited. It was almost like a sort of oversight keep an eye on, assist and facilitate until the new person came into post.

21 Q. You understood, and perhaps it was intended, that this would be a stop-gap? 10:16

A. Yes.

22 Q. As it transpired, as we'll see in a few moments, the post of Acute Governance Lead was not replaced --

A. No.

23 Q. -- until the spring of 2016? 10:17

A. April 2016 someone came into post, yes.

24 Q. Yes. Even after that, you continued to hold a governance interfacing role?

A. Yes.

25 Q. I suppose what I am struggling with here is were you ever given any formality around this role? Were you given a job title; were you given a letter of appointment; were you given a job description?

A. No. At one point there was a move, in Mrs. Gishkori's time, to put it in my job description but I refused because I already had a massive job in terms of Accountable Officer and Director of Pharmacy. It just wasn't doable. My Director of Pharmacy post had been bandied under changes in Band 9, so I was at the max in terms of responsibility and remit; financial, clinical, all sort of things that a Director of Pharmacy sort of covers. To add, it was wrong to add in it because it just was not doable. There needed to be a proper post in Acute Services and more development of the governance team. So, all I could do was try to keep it ticking over and facilitate the guys, the team members, who were already in governance. So, just it was never a part of my remit. 10:17 10:18 10:18

26 Q. Yes. Hopefully I don't need to pull this up; I think your CV describes the role as Governance Coordinator? 10:18

A. That's what I call myself to try and -- I mean, basically I met the team; I think I explained that I met the governance team. I freed up my Tuesday morning in my diary because it was a day I didn't have regional meetings and other pharmacy-related stuff. They met me; initially the actual whole team I met them. Then later when we got the Governance Coordinator post reinstated in April 2016, I would have 10:18

met the Governance Coordinator mainly and almost helped her facilitate. So, she would have told me issues, or the team would have told me things they were up against, you know, maybe a particular SA Panel wasn't meeting. Because I had a good relationship with the consultants and people, I would have maybe met them in the corridor and said by the way, what's happening with that Panel, you know, I tried to facilitate, and had those sort of corridor conversations and smooth things in the background or address things to try and facilitate them. 10:19 10:19

Also at the beginning, the whole structure when I took over in October '14, it wasn't just me coming into role. There had been quite a bit of change. The lead nurse role in the Trust had been - in Acute Services, sorry - had been changed so there was displaced lead nurses. Because we had a gap because some of the team from Acute went to the corporate team, there was also a gap in the services, so I was given two lead nurses, Connie Connolly and Mr. Smith joined us as well. They had no experience in governance. Part of my initial work with them was trying to find training for them, you know, guiding them in terms of what needed to be done. 10:19 10:20 10:20

I also then realised that there was no real reporting coming out of the Governance team to try and make it easier for the other Assistant Directors. One of the

first things I did was work with the admin support. They were excellent, they were really good staff, David Cardwell and so on, who really understand the Datix system. I asked them to come up with a report to show the Assistant Directors how many ones they have, what hadn't been opened, that sort of thing; how SAIs are running. Very quickly we got weekly reports set up for the Assistant Directors. We were doing that sort of thing. 10:20

I have to say at that initial stage, because Mrs. Burns herself was very experienced in governance, she was doing it with me. At that initial stage, it was sort of a joined effort between us --

27 Q. Yes. 10:21

A. -- which made it easier to cope with the lack of the Governance Lead role.

28 Q. You are describing, I think you are describing, some of the tasks that an Acute Governance Lead would have performed -- 10:21

A. Yes.

29 Q. -- had he or she been in post?

A. Yes.

30 Q. But what we have is a situation that, from October '14 through to April '16, that person wasn't in post. Can you outline for us what the full range of duties - albeit do it in brief terms - what would be the full range of duties of the Acute Governance Lead, and, by dint of the absence of a post-holder, what wasn't being 10:21

done?

A. Okay. So the Acute Governance Lead, I think you can the split Governance into two sections; there is the reactive and the proactive. The reactive bit was being done to a certain level. So, the IR1s were being reviewed. The IR1s are your incident reports that go on to the Datix system which manages the whole of the governance data and so on. That was being done to a certain level in that the incidents were being reviewed by the members of the team. But obviously those incidents, you need to keep an eye, are the ward managers opening them in time. That was one of the issues we had found at that very early stage; they weren't being opened. So, the team are reactive that way to the incident reports coming in. 10:22

As well as that, then there was the whole complaints side of things. Obviously the complaints are coming in as well. There is also reactive work in terms of providing information up the system to the Corporate Governance team. Obviously they were very small as well, so there was all the reporting that had to be done for them. Production of reports for like the Corporate Governance meetings and so on. There was also equipment control came under governance; controls for sharing standards for various levels of risk management. Risk management itself as well. There was a lot going on, also with questions. Questions from the MLAs came in; they all came in through the 10:22 10:22 10:23

governance services. Standards and guidelines came in. That's starting to get into the proactive side of governance. So, the Governance Coordinator would have managed the standards and guidelines work. That was massive in Acute. I think when I retired, there was over 1,000 standards and guidelines listed on our spreadsheet for the Trust, and about 75% of them were Acute, so Acute had a massive piece of work. You would have been proactively appointing one of the consultants to be the change lead for each of the standard or guideline came in, so they would have led then the scoping and implementation of that new standard or guideline the Trust or to Acute Services. 10:23 10:23

Equipment control was massive; it should be proactive rather than reactive as well. You are making sure that any new piece of equipment - and you can imagine how much equipment is in Acute Services - proper servicing, training, all that sort of stuff goes with it. Proactively training all your staff. At that stage there was no corporate programme for training staff on incident reporting, risk management, because if you don't train staff on how to report an incident, you get a lot of unnecessary work later on, you know, if they grade something either catastrophic that wasn't; or vice versa, you can miss the importance. 10:24 10:24

The coordinator should also have a role in terms of themeing your incidents that are coming in, and really

pushing near miss reporting. We just weren't doing any near miss reporting at that stage. You want to get your near misses reporting done because that's your opportunity to fix systems before there's harm done. That wasn't happening; there just wasn't the capacity to do it.

Then off those themes then, you should be developing proactive governance initiatives. A couple of things: Towards the end of my involvement we were starting to -- when Trudy Reid came into post, I was lucky enough to be able to pull the pharmacists, my governance pharmacists, to help, so we were starting to see themes of insulin incidents coming through, so we were able to set up a safe use of insulin programme, trying to be a bit more proactive, and doing brief interventions with staff on wards and things to try and get in their heads key themes. It is a massive post if it is being done well, but unfortunately with a half day a week, all I could do was try to do my best to smooth and keep things going, and direct and sort of facilitate the staff that were in the governance team.

31 Q. If we scroll down to just the next paragraph of your statement where you reflect the fact that you were told that the post of Acute Governance Lead was not going to be replaced?

A. Mm-hmm.

32 Q. The salary had to be given up as a cost-efficiency saving.

"I was not happy about this decision as I had been told that I would be managing the team on a temporary basis."

You reflect that you had an extremely large workload as Director of Pharmacy. Who would take the decision to not to replace this post? Was this a Trust Board decision or was this a local decision in the Acute Directorate? 10:26

A. I think it was probably like a corporate. When you say decision, at that time we were under severe financial pressure, extreme financial pressure as a Trust. I mean, I remember even back if you had funded pharmacist posts, if you want to replace them if they moved or were promoted, you had to make a case why you were replacing them, why you couldn't do without them. So, because we were under such significant financial pressure, to get a post replaced you had to not only make a case, but finance had to agree because you couldn't recruit unless, on the recruitment system, they had to tick a box to say, yes, the money is there. 10:27

I think it was the actual corporate pressure, the extreme -- obviously the statutory duty to break even for the Finance Director was real. I don't think if there was an actual decision, it was more we just couldn't afford it at that point in time. If we had funds, it had go on patient-facing because the Acute 10:27

Services can never say no; our door is always open. When you are in such financial pressure, the money that there was had to go direct to patient-facing services.

33 Q. If we go to WIT-87672 and go down to -- maybe just back one page please, sorry. You say at 43.5: 10:28

"The fact that the Governance Lead post had been given up as a saving in 2014 demonstrated a lack of understanding of the importance of good clinical governance in my opinion." 10:28

Before I brought you to that, your answer suggested that really because of the financial climate, the Trust had no choice but to eliminate the post to make the saving? 10:29

A. Hmm.

34 Q. Here you suggest, and perhaps I'm reading too much into it --

A. No.

35 Q. -- that there was a choice to be made, either understand and respect the important tenets of good clinical governance, or save the money. Your suggestion is that people just didn't understand that there was a lack of understanding of the importance of good governance. 10:29 10:29

A. I think it was a lack of understanding. I mean, certainly I suppose from my pharmacy background, in pharmacy it's very much all the safety drives efficiency. If you get it right first time, if it's a

safe system, you actually are more cost-effective in the long-term. I suppose that's where I am coming from in that. I understood the financial pressure the Trust was under, you know, it was extreme. If I had been making the decision, I'd probably have gone at the risk and appointed the post because I think in the long-term it would have paid for itself.

36 Q. So, what you are suggesting is this was a post that was fundamental to the ability of the directorate to provide good governance across its operations? 10:30

A. Yes.

37 Q. I think at some point you say that, at the point of retirement on the pharmacy side of your role --

A. Mm hmm.

38 Q. -- you were managing circa 250 members of staff, I assume it was little different in 2014/2015 when you had taken on this role? 10:30

A. Yeah. It would have probably been maybe 220, or 210/220, yes. But it was above 200 at that point, yes.

39 Q. That gives an indication of the scale of your main job? 10:31

A. Yes.

40 Q. As you have said, you could only commit a small amount of time to this additional role?

A. Yes.

41 Q. You paint a description sometimes of corridor conversations, taking a chance to nudge and cajole and counsel in these kind of informal ways to keep staff properly directed and interested? 10:31

A. Yes.

42 Q. As opposed to sitting behind a desk or being in that governance environment at all relevant points?

A. Yes, that's correct, because I mean obviously with the financial pressure the Trust was under, a big part of my role was obviously the financial side of pharmacy. 10:31 I have maybe a £50 million budget to procure drugs, specialist drugs, oncology, haematology. So, the heads of pharmacy worked together to contract. In those years I would have been given a target of maybe saving £1 million out of the pharmacy budget. 10:32 I couldn't not do that; my pharmacy had to come first. Particularly obviously I am a registrant, I had to make sure the pharmacy was safe as the Superintendent Pharmacist.

10:32

The only opportunity for me was then was to -- it also afforded me an opportunity because I would have been in meetings with maybe the oncologists and haematologists about our contracting for cancer drugs. So it then gave me that, by the way, we were having a coffee, how 10:32 is that SAI going, what's the issue. It did afford me opportunities. I was sort of peppered throughout the week. Once I had had that Tuesday meeting, I knew what the issues were for the team. It allowed me then, if I had met someone in the coffee queue in the morning, 10:32 I could have had that, you know, almost off the record conversation which then allowed. So it was sort of very much an official catch-up with the team on a Tuesday morning, and then using the influence that

I could during the week to try and make things happen for them.

Also then my one-to-ones, monthly one-to-one with the Director of Acute Services and also the Medical Director, those were opportunities to discuss issues as well. 10:33

43 Q. Yes. Did you make the Director aware of the concerns that you have related to us today about how this was impacting on the safety of the operations if we couldn't do governance as well as we should? 10:33

A. Yes, obviously in my one-to-ones. As I said earlier, initially it wasn't as bad because obviously Deborah Burns was very experienced and she was doing it too. She was part of helping because of her experience with corporate governance. Obviously when Ms. Gishkori came along, it was much more obvious that it just wasn't doable just with me that half day a week. So, very much in my one-to-ones with Esther I would have raised it. Then obviously she then realised, come late 2015 I think it was, that Easter then agreed that we could recruit the post. Sorry, maybe it is December/January. Then in 2016, Trudy Reid, we were able to recruit Trudy into the governance post. 10:33 10:34

44 Q. Yes. So, you made a pitch to Mrs. Gishkori that this post had to be replaced? 10:34

A. Yes.

45 Q. Before Mrs. Gishkori comes in, I think it was September 2016, a bit earlier --

A. Yes.
46 Q. -- before that, Mrs. Burns was the Director?
A. Yes.
47 Q. You have said that her experience in particularly corporate governance -- 10:34
A. Yes.
48 Q. -- meant that, in combination with you, the problems was less --
A. Less.
10 49 Q. -- acute, if I can use that word, than it was to be become when Mrs. Gishkori came in? 10:35
A. Yes.
13 50 Q. Nevertheless, did you have conversations with Mrs. Burns about the need to replace the post and reinstate the budget, or did those conversations not take place at that point? 10:35
A. No, I think they did. It became obvious quite quickly that we had a backlog situation, which again added to the pressures. When I came into the post and we set up the reports I mentioned, we realised that there were I think 300 from memory plus IR1s that hadn't been opened at all by the teams. 10:35
23 51 Q. I am just going to come and deal with that issue separately.
A. Yes. So, that added to the pressure at that point so we had to do a backlog -- a catch-up exercise. You know, I think there was a lot going on in the Trust at that moment in time as well, not just the financial, there was a lot of movement. I think there was a 10:35

change of Chief Executive and so on at that point as well.

52 Q. Yes. Going back to your statement to WIT-87634, Mrs. Gishkori agreed to replace the Acute Governance Lead, we can see at 4.6, and Trudy Reid was recruited into the role and started in the role on 4th April. 10:36

You say in the next paragraph that Mrs. Gishkori was not prepared to take back direct responsibility for interfacing with the Acute Governance Lead despite it being part of her remit. Just help us out with that. Mrs. Gishkori is obviously the top of the pyramid within Acute, being the Director. In this context, you are saying she should have been, as per her job description, interfacing with the Acute Governance Lead. What does that interface involve and why is it necessary? 10:36 10:37

A. That interface would have been regular meetings with the Director, so the Acute Governance Lead would have had a personal one-to-one with the Director of Acute Services. That was the opportunity for the Governance Lead then to brief the Director in terms of what was happening. That would have been through the official part of the briefing in terms of what our risks were, what issues the governance team were covering, what new SAIs had been screened in that month, particularly key ones. But there would have also been then a very reactive -- so if something very serious had happened in Acute Services, the Governance Lead would have 10:37 10:37

immediately contacted the Director so that they were never blindsided to anything. It was really important that that happened. Obviously the Acute Director sat at the Trust senior management team at Trust Board, so they needed to be over their governance risk and their governance activity because they were going to have questions. So, they really needed to be in the game in terms of what was happening, so that was a very direct link. 10:38

Also, those meetings should have been sort of a safe space for the Governance Coordinator to discuss, to get advice and guidance from the Director in terms of issues they were facing, or thrash out an issue that they could then move forward on jointly. They were very important in terms for both sides, both for the Governance Coordinator but also for the Director of Acute Services so they knew what was happening in their section. 10:38

53 Q. You describe a situation where you're told that. What you're reflecting is that one consequence of Mrs. Gishkori electing not to take back direct responsibility meant that you had a continuing role in this arena, whereas it had been your expectation that before Trudy Reid's appointment, you would step back into your normal world and leave these responsibilities behind? 10:38 10:39

A. Yeah. Well, I understood Trudy Reid came into the post and she hadn't been in a governance role before, so

I understood there would have been a period of me facilitating, helping her, handing over, and then I would gradually step back once she was up to speed. But, as I say, I continued then to do that sort of discussion space for Trudy every Tuesday morning. It came down to maybe an hour, an hour and a half on Tuesday morning at that point once Trudy got up to speed where she could bring what do you think we should do with this, or this isn't happening, do you think you could help me with this. We had that conversation that I would have had -- in fact, when Mrs. McClements took over, it immediately stopped. So, Melanie wouldn't, she wanted to know what was happening in governance and had that direct. So I then was able to step back completely at that point because Melanie couldn't see doing the Director post without that direct... I'm jumping ahead, sorry. 10:39 10:40 10:40

54 Q. I think you are a bit and maybe confusing the Panel.

A. Sorry.

55 Q. Let me steer it back. What you have just said is that when Mrs. McClements came into post, so she replaced Mrs. Gishkori as Acute Director in June 2019? 10:40

A. Yes.

56 Q. It was at that point she took on, I think you are suggesting appropriately, the interface role with the Governance Lead? 10:41

A. Yes.

57 Q. Which Mrs. Gishkori had decided wasn't for her?

A. Yes.

58 Q. What were Mrs. Gishkori's reasons, to the best of your understanding, for deciding that she wouldn't take on this direct interfacing role?

A. From what I observed and understood, I think Mrs. Gishkori, Esther, was overwhelmed with the post. It was a massive post, the Acute Director post. Also maybe a level of inexperience in terms of the governance, leading governance in a very big, very vast wide-ranging directorate. I think the fact that I was there and had already been doing it sort of allowed her not to maybe take it back fully. It did make me nervous on her behalf because obviously then Esther was then going into the senior management team, the corporate governance meeting and so on, without that interface, so I was always nervous about how she could then represent, talk about her risks and so on. 10:41 10:41 10:42

I started with, put a short briefing meeting in her diary every Tuesday morning for half an hour first thing, like at half eight in the morning before the day started. I would have went with Trudy if I could, or one of us made sure we went to try and brief Esther on what had happened in the week past, because on Tuesdays at that point, the senior management team was on Tuesday morning, the corporate senior management team, so it meant then that Esther could have gone briefed to that and the senior management team had a rolling programme. So, once a month their agenda was fully governance. It was to make sure that Esther knew what 10:42 10:42

was happening. There was an attempt to try and keep her in the loop as best we could.

59 Q. Okay. Just to recap slightly. The appointment of Trudy Reid reduced your level of involvement in this governance arena? 10:43

A. Yes.

60 Q. But because of Mrs. Gishkori's, the busyness of her post, perhaps, coupled with her lack of comfort or experience in the governance world, as you perceived it -- 10:43

A. Yes.

61 Q. -- she wouldn't take on the responsibility of interfacing, and that did require activity on your part to ensure that governance worked as well as it could in those circumstances? 10:44

A. Yes.

62 Q. Is it fair to say, and we'll go on to talk about your description of governance as not being fit for purpose, but is it fair to say that notwithstanding Mrs. Reid's appointment, the governance within Acute was and 10:44 continued to be fragile and difficult?

A. Yeah, that's fair. I mean, there was a lot of movement in the team as well. There was obviously an admin team behind Governance that managed all the complaints and so on. They were pretty static. Then in terms of the 10:44 Band 7 staff you'd have had who were the ones to interface with the ward managers and did the training and so on, they moved quite a bit. So, we had a high level of inexperience amongst that team as well. It

was almost a few times maybe people left or retired or went elsewhere, and we were given people, like I think at one stage -- I mean, they were really good staff just didn't have the experience. Maybe a ward manager who had a health issue was displaced, so because I had a gap, the team had a gap -- and don't get me wrong, they were very good but they just didn't come with the experience or they maybe didn't necessarily want to do governance; not everybody is comfortable in investigation and so on, and you are having to ask awkward questions. It was always sort of a bit of a shoestring team what we had and what we could use to make it work. 10:45 10:45

63 Q. You have said in your statement that notwithstanding your attempts to ensure that there was a mechanism there by which Trudy Reid could interface with Mrs. Gishkori, so you put meetings in the diary, and that was for the purpose, was it, of ensuring that Mrs. Gishkori was well-briefed on governance developments so that she could then go to Trust Board committees and Trust Board itself -- 10:45 10:46

A. Mm hmm.

64 Q. -- and properly and accurately reveal the full picture. But you have said those meetings were unfortunately often cancelled by Mrs. Gishkori. Again, was that because she didn't have an appetite for governance issues or was it just because she was overwhelmed, running to standstill elsewhere in her portfolio? 10:46

A. I think it was probably being overwhelmed. It was

probably because it was sort of an informal briefing, it was probably the first thing to go in her diary if it was under pressure. I don't know that maybe the understanding was there of the importance of that.

10:46

Around the same time I remember being shown one of the non-executive directors came on a visit to pharmacy at the point she was getting ready to take over the chairmanship of the corporate governance. At that stage I would have attended corporate governance in my 10:47
Director of Pharmacy role. The first item of the agenda was to present the Medicines Governance report, which was a report of my work and the team and my accountable officer's role, and then I left corporate governance, I wouldn't have been present for the rest 10:47
of the meeting. But at that time Mrs. Mullan asked me during that visit would I mind --

65 Q. Mrs. Eileen Mullan?

A. Eileen Mullan. That she would like me to attend the full meeting from then on. I was then after that 10:47
actually able to assist Esther at that meeting with Acute Governance, even though I was there for pharmacy, because I was sort of involved still. If a question came up around the governance issues for Acute, I was able to assist Esther in terms of answering it. 10:47
Obviously I wasn't there at the other meetings like Trust Board and SMT and so on.

66 Q. Yes. Mrs. Gishkori, in her evidence - and her evidence is part-heard - she said a number of things around this

area which I just want to clarify with you. If we could have her, this is Mrs. Gishkori's transcript or an extract from her transcript on the screen, please. It is TRA-03070. Just at the bottom of the page, please. She's explaining that when she came into post: 10:48

"Governance was the only thing that I didn't have an Assistant Director to report to me on. I felt that was very important because I wanted to keep all of my services the same. So actually, Kieran Donaghy, 10:49 Director of -- who was the previous director, told me that Tracey Boyce, who was the Director of Pharmacy, had just done a Diploma in Governance, a post-grad diploma, I think, I am sorry, it may have been a post grad, but it was a post grad anyway qualification in 10:49 governance, and he said "You know, you should use that as a starting point". So I spoke to Tracey and I was happy enough to do it" - just scroll back - "she was happy enough to do it based on the fact that hers was a very busy job as well, but she was then able to appoint 10:49 a Band 8B and then, more importantly, three Band 7s who did the legwork, if you like, of the governance team. They were the people who went and gathered the information and brought it together and got the Review Team sorted out et cetera, and then there was a team 10:50 below that."

She explains the 4, 5 and 6s, and they were admin and all those people.

Is there anything in that evidence that you disagree with?

A. Yeah. That's not how - certainly from me doing the role - that was already -- I was already in the coordinating role for governance before Esther came into post. 10:50

67 Q. So was she --

A. That's not correct.

68 Q. She seemed to suggest - and maybe we'll go back to her on this when we hear from her again - she seemed to suggest that when she came into post, she saw a gap, spoke to Mr. Donaghy and then approached you to fill that gap, and because you had a Diploma in Governance et cetera you were content, notwithstanding your other duties, to take that role. 10:50 10:51

You are saying that you were already in that role, as you have described already this morning?

A. Yeah. October '14 was when I started, when Mrs. Burns was the Director, who was before Esther Gishkori. When Esther came into post, I was already in the middle of that in terms of... 10:51

Also three Band 7s, we didn't recruit three Band 7s, certainly in my time. There were people displaced who were already on the team. We did get -- Esther did get the funding for the 8B to be reinstated, but no other posts at that time. 10:51

69 Q. Do you have a Diploma in Governance?
A. No. I assume she's referring to the doctoral research I had done on governance and medication safety, I had done when I was in my Medicines Governance role. I sort of finished it off. My last year of that was when I joined the Trust in terms of my finding stuff for my research. Yes, most of the work had been done previously but it wasn't a diploma.
70 Q. She makes the point you were able to appoint an 8B. That is Trudy Reid, she was an 8B; is that right? 10:52
A. Yes, yes. There was almost a year into Esther's, when I had petitioned that year to get that post reinstated.
71 Q. There is another aspect of Mrs. Gishkori's evidence that I want to look at with you; we'll do it in sequence a little later. 10:52

Let me turn now to what you have said in terms of the governance arrangements and the Acute Directorate not being fit for purpose. If we go to WIT-87671 at 43.1, you say that overall in your opinion, the governance 10:53 arrangements in the Acute Directorate were not fit for purpose.

"This was because the Acute Governance team was chronically underresourced for the size of the tasks 10:53 expected of them."

You say:

"Clinical staff did not have protected time for governance activities. When they were under severe patient role bed correctors, the governance activity had to be put on hold.

When I was asked to look after the Governance Team for a period of time, I realised there was then a backlog of unopened incident reports."

We'll look at that in a moment. Scrolling down: 10:53 10:54

"The fact that the Governance Lead post had been given up in 2014 demonstrated a lack of understanding of good clinical governance."

You have explained that already. You explain that: 10:54

"The two Band 7 Governance officers on the team were very inexperienced and I had to identify training for them."

Over the page. You raised a number of numbers with the Director of Acute Services throughout the period as did other Assistant Directors within the Acute Services team, and you submitted a number of proposals to augment the team. 10:54 10:54

A. Yes.

72 Q. And we'll look at that. In terms of how governance was done structurally, there was a monthly Acute Governance

meeting; isn't that right?

A. That's correct.

73 Q. There was a monthly Acute Clinical Governance meeting; there was a fortnightly standards and guidelines group?

A. Mm hmm. 10:55

74 Q. So, those structures were in place --

A. Yes.

75 Q. -- and they met regularly. We can see from some of the papers that have been exhibited to your witness bundle that they tended to be fairly full agendas? 10:55

A. Very.

76 Q. People were getting through the work and seemed to touch on a lot of the issues of importance to the operation of the Trust.

10:55

In terms of what you say, that the governance arrangements were not fit for purpose, what was missing? In terms of activities, what was not being done which, to your trained eye, meant that it looked and felt as if it wasn't fit for purpose? 10:56

A. I suppose everything we were doing at the time was reactive. We were acting where patient harm had occurred. The serious incidents were coming through. But even with that, when those were screened -- so each division within the Acute Directorate had a screening 10:56 group, so we set that up to try and get consistency of approach as well. Debbie and I got involved because obviously one division within Acute might have not something forward as an SAI whereas another would, so

we set up screening groups in each. There would have been the AMD, the Associate Medical Director, the Assistant Director, and they were supported by a member of the governance team to be the consistent voice through each of the screening groups. They would have looked at the serious IR1s, the incident reports that had came in, and looked at them. We also set up as well that the governance team would have done a very brief timeline, because you can't really screen; an incident report might look innocent but actually underneath it's not. So, you had to go to the screening meetings. The Governance team, I got them to do a brief timeline and the Trudy and I worked on that so when the AMD and AD were screening, they had something more meaty to look at and understand what was happening. They would have screened that, and off that went then to become an SAI. 10:57 10:57 10:57

One of the issues which we faced at that time was firstly getting Chairs which had to be from the consultant body. In the Trust by and large it was the consultant's team who led the review group. Obviously in their very busy workloads, there was no protected time for them to do governance as such. Once you'd secured a Chair then, there had been very little training of the consultant body in terms of how to Chair an SAI. So, towards the end of my involvement there were like standardised training courses available regionally that we could send staff on who were going 10:57 10:58

to be Chairs. It meant you had a very inconsistent approach to how the SAIs were being done.

There was also a real nervousness amongst some of the Chairs and panels to actually interview people. There is this reticence to actually get in. A lot, from what I had obviously previously, was being done by note review. So they would have got the notes and just instead of -- when you are doing an SAI properly - I am sort of doing them in retirement now - actually you need to talk to the people because you need to understand the situation they were in, what was happening around them when they made particular decisions and so on. Otherwise, you don't really get to the root cause. From what I observed, there was a reticence in terms of some of the staff to get in there and talk to people and interview. Again, it was time pressure, you know, that takes time. 10:58 10:58 10:59

Trying to get Chairs, trying to get a consistent approach. Then getting SAI reports that maybe needed revision because they weren't really quite right in terms of they were too technical, that you couldn't have shared them with the family. 10:59

The other thing we really weren't doing at that stage was the proper family engagement piece around those SAIs. You really need to meet the family at the beginning of an SAI to understand what they want to

know. There is no point writing a report for a family if you don't answer their questions. Again, we hadn't the resource to really engage with the family. There was that whole side of doing dealing with the reactive piece. As I mentioned earlier, we should have been much more proactive, themeing our incidents or complaints as well, because quite often complaints are a good way to spot an emerging issue before real harm happens. Then, developing proactive things. 10:59

The other thing that came under governance at that time was audit. Clinical audit had completely collapsed within Acute Services in terms of there used to be an excellent audit committee led by one of the anaesthetists, Gail Brown, which was really good. I think there was some confusion as well because quality improvement had come along and there was sort of where does audit fit, you know, and it had sort of lost support. Then, because the consultant team who were running it weren't getting the buy-in, then it just sort of petered out. That's a shame because audit is really useful in governance as your assurance piece. So, if you had done a piece of work and you've decided on your recommendations, then you should be able to use your audit capacity. So maybe your junior medical staff, or like my pharmacists or whatever, you would have directed them to audit something for you because they need to, they have to do audits as part of their job and their training. So, you use that resource if 11:00 11:00 11:00

you are doing it properly to then assure yourself that a recommendation either (1) is fit for purpose but (2) continues to be followed.

It was very much we weren't doing anything well. It was doing the basics but not really doing the stuff that meant long-term things were going to be safer. 11:01

77 Q. Of course, the concern from those kinds of shortcomings, ultimately it is in and around the safety of clinical practice -- 11:01

A. Yes.

78 Q. -- and risk of harm to patients. Is it fair to infer from what you have said that the absence of these activities in the governance arena led you to be concerned that the Trust didn't have available to it the full picture? 11:01

A. Yes, I think so. I think that would be a fair point. I mean, I would say the lack of governance wasn't making anything more dangerous, I think it was more we could have be making it safer. Also protecting the staff because, I mean, staff are very traumatised if they are involved in an incident. If we get it right, they don't have to go through that. Obviously, patient safety is the key priority but it is assistance to the staff as well in terms of their experience at work. 11:02 11:02

79 Q. Your description just now suggests that there was no lack of appetite --

A. No.

80 Q. -- and no lack of knowledge --

A. No.

81 Q. -- in terms of how to do this properly, it was primarily a resource issue?

A. Yes. I mean, particularly -- well, just the Governance team but also the consultant body. I had seen models, and I proposed it at one point, that we could have tried to offer maybe a half PA to a number of consultants. 11:02

82 Q. I'm going to bring you through that.

A. Yes. 11:03

83 Q. Just before I do - maybe just scroll up to the top of this page again - you say you raise concerns with the Director throughout the period, as did others Assistant Directors within the team. Help me if you can just through this, perhaps, snapshot in time reflected in a series of emails which involved you and the Assistant Director, Mr. Carroll, and Mrs. Gishkori. You can help to guide us perhaps in terms of what was going on. 11:03

If we go to WIT-14748. Sorry, I've got this the wrong way around. If we go to WIT-14751, please. You can see that the first email in this series is from Ronan Carroll to Esther Gishkori, and a number of people, including yourself, copied in. Mr. Carroll is perhaps highlighting something that you have indirectly touched upon in one of your recent answers; it is what we're doing with SAIs. You talked more specifically about the lack of resources to engage properly with families. 11:03 11:04

A. Mm hmm.

84 Q. Here is maybe another aspect of the problem. He is saying:

"Please find attached three, there are possibly more, SAIs where there is no evidence that the recommendations have been actioned."

He said:

"We agree to have three governance managers working to each"

and the particular departments within Acute. He names the staff and he asks for an update on the above subject. So he is pointing out, is he, that it is an important part of the SAI programme of work -- 11:05

A. Mm hmm.

85 Q. -- that appears to be unfinished, or at least there is no evidence that it has been finished; we need staff to do this. Is that it? 11:05

A. Yes. What he is referring to there, so that is finished SAIs, so they have been completed, the Panel has made a number of recommendations. It's then over to the team to action plan those recommendations; how are they going to implement them. Ronan is obviously following up there, as his responsibility as the Assistant Director for Surgery. He's checking, and found that that hasn't happened. Obviously he can't -- he's overwhelmed as well, he can't do that personally. 11:06

The governance team, it should have been part of their role to work with his ward managers, or whoever the recommendations were pertinent, to implement them. It wasn't peculiar to Surgery. What we did, we started a spreadsheet of all our recommendations, ,obviously something that might have happened in Surgery doesn't mean it couldn't have happened in Medicine. So, Trudy Reid and the team set up a spreadsheet that would have come to Governance of all our recommendations so that the other divisions in the Acute could look across and think, well, that could happen to me. They could then take that recommendation, even though it wasn't their SAI, and implement the learning. Ronan is referring there to, you know, we just didn't have the -- you could ask the ward managers, but again some of them were inexperienced, they needed somebody who knew what it would look like and help them through it, and also to assure that it had happened. 11:06 11:06 11:07 11:07

86 Q. If we just go up then to the previous page. It's now into September. He says he has received no update on the issue. I think he means more directly to staffing -- 11:07

A. Yes.

87 Q. -- issue. He's proposing to bring in somebody to replace somebody else? 11:07

A. That's right.

88 Q. The circumstances of that are somewhat complex. Was it the case sometimes of trying to make the best of it and grab staff, if that's not too aggressive a verb --

A. No.

89 Q. -- where you could find them?

A. Yeah. I refer to them as [redacted] there; they had unfortunately quite serious ill health and had had to go off. They were already a displaced person who had been given to the Governance team to fill a gap. They then had ill health. Ronan had a sister, an ACR, who due to family circumstances couldn't return to her full post. Ronan was even suggesting that she could then plug the gap in the Governance team to keep us going. In that period that's what it was like, who was available could do it. But again, no experience, not necessarily comfortable in a governance role, but they had been displaced. 11:08 11:08

90 Q. Yes. Just scrolling up, I think this is the flavour. You come back on that in September, agreeing, delighted to have her. I'm noting this subject title to these emails, it's "Governance Structure Within Acute Services". You are saying we currently don't have a budget for governance? 11:08 11:09

A. No.

91 Q. How would the funding work. Is that the funding in the context of this particular staff member?

A. Yes. That staff member was actually a member of Ronan's team. What I am probably alluding to there was would he keep paying for the person even though they were coming into a governance role, because there wasn't a budget line that would have covered them moving into the Governance team. 11:09

92 Q. Yes. Just scrolling up. Mr. Carroll says:

"We're 18 months into the restructuring. It would be great to get this finally bottomed out with the Assistant Directors clear who they have reporting to them."

Again, was there a restructuring initiative, and is he right to suggest that the progress of it was being hampered or delayed? 11:10

A. In 2016 I'd worked with the other Assistant Directors to come up with a proposed what we thought it should look like at that point. We put that proposal to Esther, and then obviously Mrs. Gishkori's role would have been to fight our corner at SMT to get that funded, to get the funding into Acute so we could move forward. It didn't happen; we weren't able. This is obviously Ronan saying 18 months later we are still no further on, basically I read that as. The plan was at that point, the proposal was to give each of the divisions one/two, depending on their activity, governance activity, of the Band 7s so they were embedded in their team but yet they reported -- sort of a bit like me, they had two bosses - they worked within the divisional team but they reported as well to the Governance lead - so they had that tied up, tied together. They could embed training and things within the division and help the ward managers with their governance activities, at the same time being part of

the Acute Governance team. That's what we were trying to get to at that point.

93 Q. In order to make governance fit for purpose?

A. Yes.

94 Q. If we scroll up, I think you can sense Mr. Carroll's increasing frustration perhaps? 11:11

A. Yes.

95 Q. "Three months further on, we're now in January, the structure we all signed up to has not materialised", and he is unsure of what the structure is. 11:11

Then if we scroll up again, he refers to very specific engagement with Mr. McGurgan, a coroner, and the coroner's view was that, "Trusts regularly fail to document comprehensively, communicate openly and with an understanding of patients or relatives, and train, update and provide evidence of learning." 11:12

He, that is Mr. Carroll, assumedly recognises some of those coronal concerns in practice the Trust. He says: 11:12

"This again brings me to the concern with regard to the above; approximately 19 months now into restructuring and no further forward." 11:12

Again, just scrolling up, Mrs. Gishkori responds to that, saying:

"Governance is everyone's business, especially

documentation, communication and communication with relatives and patients."

"Training has to be initiated at operational level."

She agrees everyone does need some help with the whole process of information of learning "which I feel we could get better at". Then she says that a recruitment process is under way to bolster the Governance team, but there would only be "one of them per division. There would still be responsibility for the operational teams to deliver." 11:13 11:13

Can you help us with that? Can you remember what that is speaking to? 11:14

A. My recollection of that was that it was replacement of an existing member of staff. I don't remember in my time having any major recruitment apart from the replacement of the Governance Lead during Esther's time. 11:14

96 Q. This wasn't new structure, new staff, this was filling an existing vacant post?

A. Yes. Now I think, it was to be fair, it was filling the post officially rather it being someone displaced. It was advertised as a governance role with a job description and someone actively applied for it, rather than the team being given someone who maybe had been displaced from another role. It was a recruitment process but it was to firm up what was there with 11:14

people who actually were interested in being part of the Governance team.

97 Q. Yes. Just scrolling up, Mr. Carroll says he is totally unaware of any recruitment to these positions, and as this person would be part of the same -- sorry, will be part of the surgical division, he would want to be part of the process. 11:15

A. Yes.

98 Q. Maybe he was at cross-purposes with Mrs. Gishkori?

A. I think so. I mean, I certainly don't remember. It was more, as I say, firming up the team that was already there. 11:15

99 Q. Yes.

A. The IWMH, that was the Integrated Women in Maternity Services, they had appointed Band 7 midwife, which was sort of along the model that we wanted for all the other divisions. That's why Ronan could see that was working for them, and wanted... 11:15

100 Q. Yes. We can see, and part of the reason I brought you to this snapshot in time through the lens of Mr. Carroll primarily, was that within a couple of months of this you had put on paper an enhanced governance structure proposal? 11:15

A. Yes.

101 Q. If we could just look at that. It's at WIT-14755. It's dated 31st May 2018. If we just scroll up one page, it might be easier for you to talk us through this by reference to this organogram or structure. The red posts, so those labelled red in terms of your 11:16

proposal --

A. Yes.

102 Q. -- would be new money, new posts, and blue is the existing structure?

A. Yes. 11:16

103 Q. First of all, you talk about a proposal being made in 2016 to enhance governance, and it was away being discussed, Mrs. Gishkori had to sell it. We have seen how Mr. Carroll was bemoaning the lack of progress on that. Is this more of the same in terms of what had 11:17 been proposed in 2016 --

A. Yes.

104 Q. -- and if so, why the timing, why now?

A. That's me having another go at it in terms of enhancing what we need. We hadn't got really anything. We maybe 11:17 had a couple of people join the team at that point because, yes, if you see on the very left it says, "Patient safety, quality, and equipment, point of care testing", POCT. Between the labs and ourselves, we managed to go at risk. So that was a new person. They 11:18 weren't new to the Governance team. There was a whole new role had to be covered, so that's where they came from. But the rest of the team hadn't really changed.

At that point I suppose I had another go at it because 11:18 it was becoming increasingly difficult to get -- the Governance team were finding it difficult to get consultant time either to lead the standards and guideline changes or to investigate the SAIs.

I enhanced it by not only having the red posts that Ronan - and the other ADs, it wasn't just Ronan at our meetings, they were all pushing for this - but that was to try and get... If you see the nurse, the right-hand red box, and it's nurse, three whole time equivalents Band 6. It was pretty obvious we weren't going to get Band 7 funding, so as Assistant Directors we talked about it and thought, well, if we could embed governance nurses into the team, that might be more practical. So, we'd gone for that. Then at the same time, the audit we were trying to -- Esther was very keen on trying to get to audit back up and running. She had seen a model - from memory, it was Esther was really keen on that - seen a model in the South Eastern Trust where she'd come from, and felt that would have been very useful. We were keen for that as well. 11:18 11:18 11:19

Then the little boxes down the right -- the left-hand side, sorry, were a proposal that I had seen elsewhere, I think in our Mental Health Directorate, where they had a number of consultants who had protected, I think it was a half PA, and that's what I had proposed. They had a half PA protected for governance. The way it would work, I proposed that we would take these consultants in Acute, train them through the available regional programme to be Chairs of SAIs and Governance, and it would be a system where the next SAI came up, unless they had a conflict of interest, they did it so they got a lot of experience. That's how it worked in 11:19 11:19

Mental Health, from my understanding. That way we had -- we were building their governance experience for the whole team not, just for the SAIs. We thought that would be a good way. Also, if you had a half PA, you're able to hold to account in terms of delivery, whereas if it is not someone in someone's job plan, it's not fair to ask them, you know, they are doing it as a favour or goodwill on top of their already full role.

105 Q. That proposal - sorry to cut across you - perhaps dovetails quite nicely with some of the evidence that the Inquiry has heard about the difficulties around SAI; first of all, getting somebody prepared to do it? 11:20

A. Mm hmm.

106 Q. The time commitment in the context of an otherwise busy clinical practice. Perhaps some issues around independence. 11:20

A. Mm hmm.

107 Q. Some issues around getting the right person in terms of expertise for the areas. Were those the kinds of problems that you were aware of? 11:21

A. Yes, certainly. I mean, although the consultants would have helped, but they just didn't have the time; they knew they didn't have the time. A lot of them didn't want to do it halfheartedly. If you were going to do it, it had to be done well. Particularly, the reports are being -- you are the advocate for the family when you are leading an SAI, so they had to be fit for purpose. So, that's what we were facing. 11:21

That, plus then we couldn't get -- increasingly we were having to go back corporately and said we couldn't get any of the consultants to lead the implements on new standards in guidelines. We just couldn't do it.

108 Q. Thank you. I'll just point this out to the Panel. Below this table is a two-page report, quite a concise report, which speaks to much of what Dr. Boyce has just said orally. I don't think I need to go to it directly but it is there for the Panel to read.

I am almost afraid to ask this question: Was this delivered during your time?

A. No. I think that was around 2018 when Mrs. Gishkori had various periods of ill-health. The plan was that Esther was taking this. That's why the two-page briefing note was with this, so that Esther could take it to the Chief Executive at her one-to-ones and pitch to get it funded. I understand from the timings that Esther was off for periods of time. At one point during that phase, Anita Carroll was acting into the role with other Assistant Directors. To be fair, Anita, she chased it up; she realised we didn't know where it was because Esther was off. You know, was the Chief Executive, I think it was Mr. Devlin at the time, aware of it or not. So then Anita took it to Shane, I understand, to check. But it was never funded certainly in my time.

109 Q. You were able to step away from these extra governance

duties in June 2019 --

A. That's right.

110 Q. -- when Mrs. McClements replaced Mrs. Gishkori on a permanent basis?

A. Yes. 11:23

111 Q. And, in fact, into interfacing role with the governance lead.

Was there any development between the date of this paper, which I think I have said already was May '18 11:23 through to June '19 --

A. No.

112 Q. -- were there any developments to ease the burden in governance?

A. Not that I recall. Now, Trudy might be better in terms 11:24 of her being hands-on but certainly not... No.

113 Q. Okay. One of the symptoms, I think, or one of the incidents that emerged, as you have been describing in your evidence already, because of the resource issues in governance was you found a series or the team found 11:24 a series of incident reports that had not been opened?

A. Mm hmm.

114 Q. You mention this in your statement. Maybe it's convenient to go to that.

CHAIR: Will we take a short break or do you want to 11:24 deal with this issue first?

MR. WOLFE KC: Five minutes and then deal with this. Thank you. WIT-87671. At 43.4 you describe the issue. When you took over this governance role in October '14,

you realised there was a backlog of unopened incident reports.

"This backlog had not been estimated before and was unknown to the Director, Debbie Burns. These incidents once reviewed led to a backlog of SAI reviews."

What had happened? Was there some technical mishap or was it a case of staff not opening what had been sent?

A. So, the IR1s had come in and obviously the IR1 system, the Datix system, when an incident report is made, there is an automatic email based on what the staff have ticked. You know, if it is surgery, if it is medicine, it automatically e-mails. It is then incumbent on, say, the ward manager to open the incident, look at it, escalate if necessary. When I started to help out in October '14, I mentioned I think previously one of the first things we did was try and get some rigour into reporting of data so that the Assistant Directors could see what they were dealing with every week. When we did that and we started to -- I wasn't an expert on Datix and I never was, but the admin team, I found, had really good working knowledge so I left them to develop a report, weekly report, that showed the IR1 reports in terms of what was unopened, and when it was opened, it was called "under review" and then closed. Every week the Director started to get like a little table that showed how many IR1s in their area, their division, were unopened, under review

and so on. Once we ran that -- we ran that in the first couple of weeks and immediately came to notice that I think there was over 300 sitting unopened. When you think it wasn't just one person, it was spread across the whole. So it might have been each ward manager, maybe they had five or six or something different departments, but the total was 300 or three something, three hundred and... Yeah. Obviously that's a risk you don't know what's in there. There could have been obviously some very serious incidents in there. Once we realised that - and it had been building up over a period of time, maybe six/nine months some of them, looking back - so we had to decide at that point we needed -- so myself and Mrs. Burns, Debbie, had a plan with the other Assistant Directors to get those opened. Once they were opened, i think approximately around 10%, maybe around mid-20s, SAIs came out of that. 11:27 11:27 11:27

115 Q. Yes.

A. Obviously that immediately put us on the back foot in terms of it was already challenging getting the SAIs done, but to add 20 in a matter of weeks was a big challenge. I would say it probably took a number of years, maybe two years, to get back, get those done and get back to the point that we were doing the ones that were coming in, you know, reviewing them in a more contemporaneous position. 11:28 11:28

116 Q. I don't need to bring it up on the screen but this was the subject of discussion at the Acute Directorate

meeting?

A. Yes, very much so.

117 Q. It was that meeting, if you like, superintended the process of bringing a solution to this; isn't that right? 11:28

A. Yes.

118 Q. The reference, just for the Panel's note, is WIT-88169. It's agenda item 9. Reports were generated to ensure that members of that meeting were appraised of what was going on and how it was being progressed? 11:29

A. Yes.

119 Q. What had happened to cause it in the first place? You say it was spread across different wards, different units, it wasn't just one place that wasn't opening these. 11:29

A. Mm hmm.

120 Q. Was it a lack of supervision for the reasons that are now well-rehearsed in your evidence? You didn't have enough governance people on the ground to push this?

A. I think so. I think as well it was almost hidden 11:29 because we didn't have that suite of reports that make it immediately visible, because as soon as it was visible, all the Assistant Directors -- so we had, first Tuesday of the month in our Acute meetings was our governance focus. Once we started to bring those 11:29 reports, obviously the Assistant Directors saw, they took on board their sections and with their team then addressed it and got them opened. But I think it had just built up gradually. Again, because there was

that -- (1), the lack of visibility but also the lack of resource to prod from the Governance team, to go what's happening and to do that.

I think the biggest thing was the lack of visibility, we didn't have those reports regularly running. After that, they ran every week. The administration team, and Governance and the Acute were excellent, they were very, very good. They took those reports on and developed them themselves, and they became even better. They've developed different reports for us as well. 11:30 11:30

121 Q. Yes. Beyond the delay that you have spoken of in ultimately finding the resources to progress the twenty something SAIs that emerged from that 300 case backlog, apart from the delay were there any other implications arising out of this shortcoming? 11:30

A. I don't think so at that time because we caught it. I mean, obviously 300 was a lot. Obviously one of the things would have been obviously maybe it could have been a six-month delay in a family being told that their loved one, or their own case, was going to be a SAI, which isn't -- that's not good in terms of family engagement. If someone has maybe dealt with an issue emotionally and then we come back and tell them actually something had gone wrong in their loved one's care, that's not good. 11:31 11:31

122 Q. Sorry, finish your answer.

A. You're okay.

123 Q. I was going to ask did the Trust learn any particular

lessons as a result of discovering this?

A. I couldn't say on behalf of the Trust but certainly I think at the time it was a particular acute problem. It wasn't, the other Directorates of the Trust, their governance, maybe apart from Mental Health but the others were much smaller. They didn't get anywhere near the number of complaints and IR1s that Acute does. I think it had just been a backlog that Acute had developed. I think in the other directorates, the governance was much easier to keep on top of with the resource. 11:31 11:32

124 Q. Can I beg the Panel's indulgence and completely finish this off? I know that Mrs. Gishkori has provided some evidence around this and if I can have your response to that in much the same way as you responded to the earlier Mrs. Gishkori evidence I raised to you. It's the transcript at TRA-03071. If we just go down, she is here talking about different governance issues that she had to face when coming into the post. If I can take it up at line 17: 11:32 11:33

"...for example, when I came into my position there were more than 200 Serious Adverse Incidents that hadn't been reported on, more than 200. But this team began very quickly to look at those serious adverse incidents to get teams together. It was difficult because there had to be one of the surgeons or physicians or whoever it was on the team, so by the time I pulled the team together and then they sat, they 11:33

looked into it and they followed the SAI procedure, and by the time I left most of those SAIs had been reported or were being dealt with."

She goes on to deal with another issue. 11:33

Were there 200 SAIs not reported on?

A. No. I think maybe she's got a little confused. I think she maybe is harking back to the fact that there was the 300 plus unopened incidents which then 11:34 led to a number of SAIs, and those SAIs obviously we had -- the backlog would have still been in Esther's time. So, we discovered the 300, and then Debbie and the team came up with a plan to get them opened. Then I think it was an additional 21, 22. Sorry, I can't 11:34 remember exactly.

125 Q. Yes.

A. It's always approximately 10%, 8 or 9% will convert to something more serious. I think maybe Esther has got it little confused there and it was actually the 11:34 backlog from the 200 IR1s that were dealing with. We had a backlog of approximately 20 SAIs that we were still working through. Yes, by the time Esther left the Trust, we had that cleared. We were back on to doing current SAIs. 11:35

126 Q. I think you suggested that it was an issue that was known about and well known about and being dealt with before Esther Gishkori took post. It was an issue during the time of Mrs. Burns, for example?

A. That's correct.

127 Q. She says, as I have read out, at line 21, "It was difficult because there had to be one of the surgeons or physicians or whoever it was on the team."

11:35

She is suggesting she pulled the team together to address these issues.

A. That wouldn't have been my understanding. The way we did it at the screening meeting -- remember I mentioned that we set up screening meetings in these divisions. 11:35 When the screening team decided that it was an SAI, they decided on the level of the SAI, whether it was going to be Level 1 or 2, or it needed to be referred corporately if it looked as though it was going to be a Level 3 which is the most serious that maybe had other 11:36 Trusts involved and so on. They would have decided the level, but also they would have proposed the team at that point who needed to be on. With the AMD present, they would have allocated the Chair from one of the consultant body, obviously taking into account 11:36 conflicts of interest and so on. The AD quite often would have suggested the other Panel members. We always try to keep it three/four; not let the Panel get too big.

MR. WOLFE KC: Okay. We can close that issue here and 11:36 take our break.

CHAIR: Come back at 11:55, everybody.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS

CHAIR: Thank you, everyone. Mr. Wolfe.
MR. WOLFE KC: Dr. Boyce, could I bring you to your witness statement at WIT-87673 and at paragraph 41. Just scroll back. Paragraph 41. Sorry, let me just check the reference. 44. The proper reference is paragraph 44.1, WIT-87673. Here you detailed what you say was the inadvertent witnessing of a telephone conversation between Mrs. Gishkori and the then Chairman of the Trust Board, Mrs. Brownlee. I think in your addendum statement, just looking at the use of the word "investigate" in that last line of 44.1, you have changed that to "addressed" or "address". 11:57 11:58

A. Yes.

128 Q. What this sentence should read as: 11:58

"I would like to add information about a telephone call that I inadvertently witnessed as I think it may be evidence of some level of pressure on one of the Acute Services Directors who did not fully address Mr. O'Brien's practice." 11:58

That Acute Service Director was Mrs. Gishkori?

A. That's correct.

129 Q. Why did you change the word "investigate" to "address"? 11:58

A. When I re-read it, I just felt I'd picked the wrong word, you know. It wasn't really her role to investigate but obviously to address. You know, I felt it was more appropriate. It was just when I read it

again, I felt uncomfortable with what I'd written the first time.

130 Q. Yes. Just in terms of your sense that she didn't fully address Mr. O'Brien's practice, you are writing this statement in 2022, I believe? 11:59

A. Yes.

131 Q. What was your sense of her failure to address or fully address Mr. O'Brien's practice? Where did that come from?

A. I think now that I have become more aware of other issues that were happening certainly that I wasn't aware of around the time I was involved in maybe escalating to concerns I had, there was other stuff going on obviously in the background that I was unaware of. Now I am aware of that. From just looking at it, it was almost as if nobody really took charge of what was going on and led it. I think it was just circumstances at the time, changes of personnel. It was just -- I think I have explained my understanding later on. 12:00

132 Q. Yes.

A. But, you know, that was sort of looking at it now. Last year, that was sort of the impression I formed.

133 Q. So it's an impression you formed, not in realtime, certainly not at the time of this witnessing of a telephone call? 12:00

A. No. No.

134 Q. But looking at all of the papers, you have formed the conclusion, with the benefit of those papers, that

Mrs. Gishkori did not fully address Mr. O'Brien's practice?

A. Yes.

135 Q. On to the nub of what you are saying here. You say you cannot remember the date of the meeting, you didn't make a note of it. 12:00

"However, I note that it must have been after the concern in relation to Mr. O'Brien's triage practice was identified." 12:01

Let me see if we can help place this in chronological order. We know that the Oversight Group, which included Mrs. Gishkori amongst its membership, met for the first time in September 2016, 13th September 2016, 12:01 to consider a screening report which had been prepared by Simon Gibson which addressed aspects of Mr. O'Brien's practice. That's one temporal pillar. Another might be a 22nd December Oversight Group meeting, 2016 again, that you attended -- 12:02

A. Mm hmm.

136 Q. -- at which concerns about Mr. O'Brien's practice were clearly further discussed and a decision made to commence a formal MHPS investigation. Doing your best, you think it was sometime between those two pillars or after? Have you any sense of what is more likely, reflecting upon it? 12:02

A. It would have definitely been after, because when, obviously inadvertently, I was in the room when the

conversation happened on the phone, and then Esther Gishkori said what she said to me afterwards, because obviously I didn't hear both sides of the conversation, I understood the context in terms of the situation with Mr. O'Brien's triage at that point. So, I only became aware of that in November 2016 --

137 Q. Mm hmm.

A. -- when the Patient 10 SAI was brought to my attention and the action I took after that. So the first Oversight meeting I was in attendance at - I wasn't a member - was December 22nd, and then I was at a second one in attendance in 10th January 2017. Then that was me out of the process.

138 Q. Yes.

A. But certainly in my trying to get it in the chronology, it would have been after that second oversight, so maybe sometime in the spring.

139 Q. We'll come in moments to look at what was said or what you understood was said during that telephone conversation that you witnessed. Are you telling the Panel, in terms of trying to date-stamp it, that what you became aware of during that conversation was something that you had some knowledge of because of your involvement at the Oversight Group meetings?

A. Yes. My involvement in escalating a concern from an SAI Panel that then resulted in me being invited to attend two of the Oversight meetings. I was actually unaware -- I actually, I think, in my statement called the December 22nd the first Oversight meeting because

I didn't realise there had been one in December. I was totally blinded to that. My first experience or knowledge of an Oversight meeting was late December 2016.

140 Q. Mm hmm. 12:04

A. To me, that conversation, if I place it at all, had to be after that point.

141 Q. Yes. Let me just test that recollection or that, it's probably fair to call it an approximation, that it happened after that second Oversight Group attendance 12:04 by you.

A. Mm hmm.

142 Q. There is a document which comes from one of Mrs. Gishkori's red book notebooks. We can find it at WIT-164694. Sorry, it should be TRU-164694, I beg your 12:05 pardon. This is an entry from Mrs. Gishkori's notebook. We found it in this notebook located between a dated note of 5th September 2016 and another dated note of 13th September '16, so it is an entry in the notebook between those two pillars. This entry isn't 12:06 dated, but of relevance we can see that the name Roberta is mentioned, the use of the word "inappropriate", and we can see that your name, Tracey, is included. Your meeting with Mrs. Gishkori where Mrs. Brownlee, you said, said something 12:07 inappropriate to Mrs. Gishkori as witnessed by you, could it have taken place between 5th September and 13th September 2016, or can you otherwise help us by way of explanation as to what the entries on this

notebook might mean?

A. I don't think it is that record but I can help you understand that note. After it was included in my bundle last week, I done a bit of sort of looking at dates and meetings and so on. That word "omitted/delayed" is actually, you can see it there, there is like circles, sort of slight circles around it. That is the title of a required audit that Trusts have to do. It is related -- it's a very pharmacy driven audit, so I am over that a lot or was over it. It came before the back of an MPSA report in 2010 about the harm done by medicines being inappropriately omitted and delayed. That ties in with the word "inappropriate" as well. 12:07 12:08

Every year, the pharmacist and the ward managers complete a large audit across the Trust of omitted and delayed medicines. So they looked at patient/inpatient prescriptions and records of administration, and look for where patients hadn't received their medicine for whatever reason, and looked at why they had not received. It is actually a very complex audit to understand because there are times where it's appropriate not to give a medicine, and then there are times where it's inappropriate because it's just been forgotten or whatever, and it can have significant consequences. 12:08 12:08 12:08

We were doing that audit every year, and when I checked

the dates around that time, I presented the high level findings of the annual audit at the Acute Governance meeting on 6th September in 2016. So, I would have given the other Assistant Directors an acute heads-up in terms of what was coming out of that audit, and 12:09
obviously Esther was in attendance that day. Later that week, 8th September was Trust, the corporate governance meeting. Now, I went on leave on the Wednesday, so there was the Tuesday, then the Wednesday. So I wasn't there on the Thursday, 12:09
8th September, to present my medicines governance report.

So when that happened, it happened very occasionally, Esther, as my director, would have introduced the 12:09
report and then asked the non-executive directors or the other directors if they had any questions, to e-mail them to me and I would deal with me when I came back from leave. I checked, and with some of the team's help, I believe the Chair was in attendance at 12:10
that. She wasn't a member of the meeting but she would have attended in her role as the Chair of the Trust. So, she was in attendance on 8th September.

Putting things together, I have checked the minutes and 12:10
it's not recorded in the minutes, and the delay and omitted audit wasn't in my report to the meeting, so I am assuming Esther maybe mentioned it at that meeting and that's how the Chair heard about it around that

time, in early September. I don't ever remember Esther ever mentioning it to me. As I say, it ties in with the wording there because it is a tricky audit to understand, there is a lot of detail in it.

143 Q. Very good. So this note doesn't purport to record -- 12:10

A. No.

144 Q. -- the meeting that you attended?

A. No.

145 Q. So far as you are concerned, you think it must have been much later, and probably in 2017 -- 12:10

A. Yes.

146 Q. -- when you witnessed the telephone call.

A. That's correct.

147 Q. Let's go to the substance of the telephone call. If we go back to your statement, please, at WIT-87673. If we 12:11 scroll down to 44.4. Just up a little bit. It was a one-to-one meeting between yourself and Esther. In her office?

A. Mm hmm.

148 Q. On the administration floor. You were updating her on 12:11 pharmacy responsibilities. The telephone rang and you realised that Esther was speaking to Mrs. Brownlee. You indicated that you would leave --

A. Mm hmm.

149 Q. -- to maintain privacy, but Esther said you should stay 12:12 or you could stay. So, you remained?

A. Yes.

150 Q. Did you remain throughout the duration of the telephone call, to the best of your knowledge?

A. Yes. I mean, it wasn't a long conversation. Yes.
151 Q. Yes. You state that you couldn't hear what Mrs. Brownlee was saying. However, you recall that Mrs. Gishkori did not say very much in response to Mrs. Brownlee during the call and that she became very flustered. Is that she became very flustered during the telephone call? 12:12
A. Yes.
152 Q. How was that manifested?
A. Hmm, when Esther became flustered, she was very red. You know, she became very red in the face. Just experience of working with her, you knew someone well, you know, you knew that they were uncomfortable. 12:12
153 Q. She didn't say very much?
A. No. 12:13
154 Q. I'm not asking you to guess but can you remember what, if anything, she said or the general gist of what she said?
A. No. To be honest, she hadn't told Mrs. Brownlee I was in the room, which if I was taking a call from someone during a meeting, I would have told the person I was taking the call from there was someone else in the room out of courtesy to the person. So, she hadn't. I almost purposely didn't take in, I think, what was being said because it was private between them. 12:13
155 Q. Yes.
A. You know, it was only really after the call then that Esther told me what it had been about.
156 Q. Yes. You pick that up in the next paragraph at 44.5:

"When the call ended, Mrs. Gishkori told [you] that the Chair had asked her to leave Mr. O'Brien alone as he was an excellent doctor and a good friend of hers who had saved her life, the life of one of her friends." 12:14

Just in relation to that, was this volunteered to you by Mrs. Gishkori?

A. Yes.

157 Q. Immediately after the call ended? 12:14

A. Yes. I mean, I obviously didn't ask what it was about but Esther immediately told me that. That phrase has always stuck in my head, the bit in quotes because that's the actual bit I could remember in terms of wording, because obviously it wasn't something I was 12:14 expecting to hear.

158 Q. There's a piece in quotes and the rest of it "Mr. O'Brien being an excellent doctor and saving the life of one of her friends" isn't in quotes?

A. No, it's more the gist of what I remember. Yeah. 12:14

159 Q. This part of the conversation about that call, how long did that persist?

A. I mean, it was only literally a sentence or two. Then, obviously it was quite an odd situation. To me, the appropriate thing was that she needed to tell someone 12:15 that that conversation had happened in terms of her line manager, which would have been the Chief Executive obviously. It just didn't sit right with me that she was getting a phone call like that. Obviously I only

have what Esther told me was said. I didn't hear any of the conversation.

160 Q. Yes. She was flustered on the telephone call itself. Did she remain ill at ease during her conversation --

A. Yes. 12:15

161 Q. -- with you?

A. Yes.

162 Q. Did you sense that she was taken aback about what had just transpired?

A. Yes. I think, yeah, that would have been my impression. 12:16

163 Q. But for your own part, you didn't listen to --

A. No.

164 Q. -- or take a particular interest in what she, if anything, said back to Mrs. Brownlee? 12:16

A. No, I didn't.

165 Q. What view did you form yourself about what had been reported to you?

A. It was inappropriate. Obviously, as I say, I didn't hear both sides of the conversation and, as I say, 12:16 Esther didn't say very much in reply during the conversation from my recollection. I mean, if that was what was said, that's not appropriate. There should be no outside influence on any. Obviously I was aware there was a process at that point, that's why I can 12:16 sort of place it. I was aware of a context in terms of the process going on around Mr. O'Brien's practice. Any undue influence from outside would have been inappropriate.

166 Q. Mm hmm. Depending on the timing of the call. It might have been after the governance, so the Oversight Committee, had taken a view that this needed to be formally investigated within MHPS?

A. Yes. 12:17

167 Q. Did you form the view that this is what Mrs. Brownlee was phoning in relation to? Did you join those dots or how did you rationalise it?

A. I suppose those are the only dots I was aware of, if you know what I mean. To me, that was my understanding 12:17 of the context because I was only had those two Oversight meetings that I was at in attendance. Then after that, I wasn't really aware. I knew, I suppose from being representing or covering for Esther, corporate governance, occasionally I would have seen -- 12:18 the agenda would have been the shared and there was a confidential section on Corporate Governance. Because I wasn't a Service Director, even though I was covering for Esther, I wasn't present for the confidential section but the whole agenda was shared and 12:18 occasionally you would have seen update on AOB. I suppose I did know in the back of my head there was still something happening but I wasn't privy to any detail as to what it was.

168 Q. You told her, and we can see it at 44.6, to document 12:18 the call and speak to the Chief Executive. If we just go over the page, you say you don't know whether that was done --

A. No.

169 Q. -- by her, and it was never mentioned to you?
A. No, no, it wasn't.
170 Q. Did you mention it to anybody?
A. No. As I say, I shouldn't have been in the room, you know, so it wasn't my place to mention it any further. 12:19
171 Q. We have not received an account from Mrs. Gishkori in relation to that call and we'll no doubt hear her recollections of it when she comes to give evidence again.
12:19
Could I just put up on the screen Mrs. Corrigan's recollection of how it came to her notice. WIT-26225. She reflects in her statement two episodes where Mrs. Brownlee is said by her, or she's heard that Mrs. Brownlee has intervened. The second one is where 12:20
she says:

"I also understand that in mid-2016 Mrs. Gishkori received a phone call from the then Chair of the Trust, Mrs. Brownlee, and was requested to stop an 12:20
investigation into Mr. O'Brien's practice. Once again I did not witness this but I was told later by Mr. Carroll that it happened as my understanding is that Mrs. Gishkori had told some of her team."
12:20
She has it in mid-2016, although she wasn't obviously directly party to either the conversation or a direct report from Mrs. Brownlee. She heard it from Mr. Carroll.

You say you didn't report to anybody or converse with anybody about it.

A. No.

172 Q. Did you hear the story of the call coming back to you from others amongst the team or the staff? 12:21

A. No, not at that -- no. No.

173 Q. Just to be clear, we'll put it up on the screen, WIT-90894. Just scrolling down, this is the Section 21 response from Mrs. Brownlee. Here she is responding to what Mrs. Corrigan has said, and I have just opened Mrs. Corrigan's evidence to you. If you scroll on down. She said that this account from Martina Corrigan is third-hand. 12:21

12:22

"Martina states that she heard from some unnamed member of Mrs. Gishkori's team. I would never interfere in due process" says Mrs. Brownlee, "in this way. Patient Safety was always my top priority and I have absolutely no doubt that Esther will confirm that this never happened. I never made any call to Esther Gishkori about Mr. O'Brien." 12:22

We probably didn't have your statement when Mrs. Brownlee was asked to give an account about this but she is plainly saying that anybody who says that I phoned Esther about Mr. O'Brien is wrong, it never happened, I have never made any phone call to Mrs. Gishkori about Mr. O'Brien. In other words, you 12:23

must be wrong as well, Dr. Boyce. Your response to that?

A. Well, I mean, I was in the room when that phone call was received. Now, to be fair to Mrs. Brownlee, I didn't hear what she said to Esther; I only was aware of what Esther told me afterwards. But I do recall it, definitely. As I say, it stuck in my mind and it was something when I was asked was there anything else I should disclose, in the interests of being open it was something I witnessed during my time in that role. 12:23 12:24

174 Q. Yes. Very well. Thank you for that. You have indicated within your witness statement that you had two concerns, or two concerns concerning Mr. O'Brien came across your desk metaphorically during your time within the Trust. The first issue I want to explore with you is a concern was drawn to your attention about his prescription or use of an antibiotic known as gentamicin? 12:24

A. Gentamicin, yes.

175 Q. Let's look at how this came to your attention. If we go to WIT-87655. If we pick up at 27.2, you have said that one of the experienced clinical pharmacists who is based in Craigavon Area Hospital surgical wards asked to speak to you about a clinical concern she had not been able to resolve herself. She was aware of a number of patients who had been admitted for five or more days to receive an infusion of gentamicin at Mr. O'Brien's request. 12:24 12:25

Doing the best, can you recall who this experienced clinical pharmacist was?

A. I am 90% certain it was a pharmacist called Claire Ward.

176 Q. Claire Ward? 12:25

A. Yes. She was based on the surgical wards at the time. We didn't have a pharmacist for every surgical ward, we just had one, and another pharmacist who would have worked more on gynae surgery and so on who would have covered. I would be 99% certain it was Claire Ward. 12:26

177 Q. You described her as experience?

A. She was an excellent pharmacist, clinical pharmacist.

178 Q. Her account to you was specifically in relation to Mr. O'Brien's conduct; is that right?

A. That's correct. 12:26

179 Q. No other clinician or consultant was reported to you?

A. Not that I was aware of at the time.

180 Q. Did you subsequently gain an understanding that, in terms of this practice, Mr. O'Brien and Mr. Michael Young were engaged in it? 12:26

A. Yes. Obviously in the bundle of papers I received and I have read, obviously I now understand that Mr. Young may have been, or was, also admitting patients for gentamicin.

181 Q. She says that, you recall -- if it was Mrs. Ward? 12:27

A. Yes.

182 Q. Hadn't been able to resolve the issue herself. Do you recall what actions, if any, she may have taken to try and resolve it?

A. Well, experienced pharmacists like herself based on the ward would have addressed it directly with the admitting consultant and their team. Obviously she could see that the patients weren't ill at the time of their admission, they had no underlying infection, and they were also receiving subtherapeutic doses of gentamicin. Obviously, that's a big risk from all sorts of angles in terms of promoting future resistance to that antibiotic, which, if the patient did admit get admitted with a life-threatening infection or so on, the antibiotic mightn't have worked at that moment they needed it. Even though the patients weren't being harmed at the time, they were being at risk. 12:27 12:27

Also having read the bundle, I understand some of the antibiotics were being given by central lines as well which I had no awareness at the time. Again, I don't understand why a central line would have been needed. Again, that's a big risk. But obviously that wasn't part of my understanding at the time. 12:28 12:28

183 Q. Yes. Were you told that she tried to address it or sought to address it with Mr. O'Brien but it wasn't resolved? Was that your expectation of what she would have done?

A. My expectation, and also that's why she was coming to me, because that was our sort of escalation. If a pharmacist was concerned about a clinical issue, they were expected to deal with it directly themselves with the consultant because that's where the relationship 12:28

was, they are part of the clinical team on the ward. If something that was concerning them persisted, then they escalated it to myself to try and address on their behalf.

184 Q. Tell me a little about gentamicin. Is this a regularly used antibiotic; is it particularly potent or toxic; what's the concerns around it? 12:29

A. It's quite an older antibiotic but it's still in use. It's an aminoglycoside antibiotic. It can have particularly nasty side effects in higher doses or prolonged doses. It can cause deafness, kidney damage. When we use it to treat an active infection, we actually monitor the blood level of gentamicin to make sure that it doesn't creep up, or the patient is not retaining it so it doesn't become toxic. It's in common use. It would be held as a stock item on most of the surgical wards. 12:29 12:29

So, the way the front pharmacy works - or certainly in our hospital works - was all the wards had a basic level of stock that they kept in their medicines cupboards. We would have had experience in pharmacy, we knew what a general surgical ward needed every week. Rather than the nursing team having to order every item they needed on a daily basis up and down to pharmacy, we would have held -- stocked the cupboards on the ward for them. If they needed to start a gentamicin infusion, they didn't need to contact pharmacy, they had it available in the cupboard. Once a week then the 12:30 12:30

pharmacy technical team would have gone up and, as it is called, topped up their stock. They had an agreed level they would have held every week. My team would have gone up, saw what they used and replaced it, basically. Gentamicin would have been a stock item on a surgical ward.

185 Q. Yes. If we just scroll down a little. I think in 27.3 you say in short form what you have just said. At 27.4 you outline the pharmacist's concerns. You say that: 12:30 12:31

"The dose was subtherapeutic. There was no sign of infection with the patient who was being treated with it. Patients appeared clinically well. She had spoken to staff and understood that the dose was to be used as specified by Mr. O'Brien." 12:31

What does subtherapeutic mean in that context?

A. Obviously based on patient's -- an adult patient, their weight and so on, there is a dose that you would start at to make sure you don't overdose, but you also don't want to underdose, to make the antibiotic work. There would be a therapeutic dose in gentamicin that you would initiate with a patient. As I say, you would have done what's called a trough blood level so many hours later to see how that individual patient was managing the gentamicin so that the next dose could be tweaked if necessary to make it higher or lower. But these were below. From memory, and I can't remember exactly but from memory, they were well below what you 12:31 12:32

would start gentamicin at in an average patient.

186 Q. Now, I don't think we need to delve too much into the rights or wrongs of this, but the Trust clearly took a view, and we understand that Mr. O'Brien took a different view and continues to take a different view, as to the efficacy of this practice. In terms of his rationale, as we understand it, the claim is that this intravenous therapy can be beneficial for a carefully selected patient with recurrent UTI. 12:32

12:33

In your experience, had you seen the drug gentamicin used in this way at that time?

A. No. No. This was the first time I became aware that that was happening. Certainly I wasn't aware of any evidence base to support its use, you know, in terms of published evidence. As pharmacists, obviously that's what we would look for in terms of the evidence base to support a practice such as that. 12:33

187 Q. If we scroll down, you said that, in your view, the pharmacist concerned were valid, and you set out your thinking - patients were being exposed to side effects unnecessarily, being cannulated for no reason, and being put at risk of acquiring an infection during hospital stay. There was also the risk of antimicrobial resistance could develop as a risk, as you saw it? 12:33 12:34

A. Yes, I think so.

188 Q. There was also the issue of, unnecessarily as you put it, using hospital resources.

To the best of your knowledge, did you come across any suspicion that patients who had been subject to this treatment had suffered antibiotic resistance, or are you just outlining risks here? 12:35

A. It was more the risk because obviously that would be in the future. I mean, resistance to gentamicin in certain parts of the world can be as high as 40%. Obviously, we need to preserve the antibiotic stock that we have in the world. Basically because there aren't many new antibiotics coming on line, it's really important that we don't abuse them so that they are there for patients in the future if they really need it. 12:35

189 Q. If we scroll down to the action that you took. You escalated this to the then Medical Director, Dr. Loughran, and you did so verbally? 12:35

A. Yes. At one of my one-to-ones with him.

190 Q. You cannot say when this stuff was done but you give a date range, January 2008-December 2010. You didn't make any record of this? 12:35

A. No, unfortunately I didn't. My meetings with Dr. Loughran were very much him assisting me, facilitating. As we talked earlier about the one-to-ones being a supportive meeting in terms of discussing issues and so on. It was a verbal discussion; I brought the issue to him and basically he said, okay, that sounds important, leave it with me. 12:36

191 Q. Given your concern about the issue, its implications,

it being out with conventional practice, as you saw it, is this not a matter that ought to have been dealt with more formally such as by raising an incident report, or do you consider that raising it directly and verbally with the Medical Director was the appropriate course? 12:36

A. I mean, looking back, yes, it should have been reported formally. I think at the time I wasn't aware of any harm having come to the patients. Yes, it wasn't appropriate but like I certainly wasn't aware of any of them succumbing to a line infection or anything like 12:37 that. I think, trying to think back, that was probably my thinking, that nobody has come to any harm but it's not right. It's a practice that needed to be investigated further to see. Maybe there was evidence but certainly I wasn't aware of any. I suppose that 12:37 was the sort of context that I took it to the Medical Director as the sort of almost like the line manager for the consultants in terms of.

Also, Dr. Loughran would have chaired the Drugs and 12:37 Therapeutics Committee at the time, and I would have been sort of like a secretary to the committee. Obviously that was starting to fall into our remit in terms of drugs and therapeutics, in terms of the use of the drug in that way. 12:38

192 Q. Yes. Then at 27.8 you record that a few weeks later, Dr. Loughran gave you an update about the actions he had taken, in informal conversation again. You have no record of it?

A. No.

193 Q. But you recall him telling you that he had spoken to Mr. O'Brien and told him that his practice of prescribing an infusion of gentamicin to patients was to cease immediately. He also advised you that he had spoken to ward managers to make them aware that Mr. O'Brien was no longer allowed to admit patients for this purpose. So, the message you got back was your concerns and the concerns of your pharmacist were shared and that the Trust had responded? 12:38

A. Yeah.

194 Q. Were there any consequences for the patients that you were aware of?

A. In terms of consequences clinically, not that I am aware of. I do know from obviously Dr. Loughran telling me the feature that there was a big patient backlash. The patients weren't happy that the treatment had been stopped, that they were no longer to be admitted. I do remember that. In terms of harm, future harm to the patients, not that I am aware of. 12:39

195 Q. Yes. I suppose I should have asked the question more carefully. In terms of withdrawing this treatment from patients, did you apprehend any adverse consequences for patients in removing them from this regime?

A. No. Not that I was aware of, no. 12:39

196 Q. Now, your statement doesn't suggest that you were told that there was a process in train, led by Dr. Loughran but engaging a number of both external and internal professionals in the examination of this issue. We

know, the Inquiry knows, for example, that the Trust had sought advice from a urologist based in Great Britain called Mr. Fordham; a microbiologist based in GB called Dr. O'Driscoll that Mr. O'Brien was met with and Mr. Young was met with in September 2010, and that a confidential paper in relation to this was brought up to the Board in September 2010 and again in November. Was any of that drawn to your attention? 12:40

A. Not at all. I only became aware that other people already maybe knew - I don't know if they knew before me or after me - when I read the documents that had been included in the bundle that I received. Certainly Dr. Loughran, he hadn't mentioned that to me at all at the time. 12:41

197 Q. Indeed, a protocol appears to have been developed? 12:41

A. I see that.

198 Q. If we just bring that up on the screen. It's a document that I think the Inquiry has considered previously. It's TRU-251143. It sets out the steps required as part of a process to review all cases of patients currently and intermittently receiving IV fluids and antibiotics. It goes through a number of steps, and I assume you have familiarised with that. But again, not something that was drawn to your attention at the time? 12:41 12:42

A. No.

199 Q. You were not a junior member of staff?

A. No.

200 Q. You were at Assistant Director level?

A. Mm hmm.
201 Q. This was an issue that you had escalated?
A. Mm hmm.
202 Q. It was clearly a parallel process that was taking practical steps to address. It was drawn to the attention of the Board. Can you think of any good reason why you wouldn't have been told that this is an issue that had come into the Trust separately through the Commissioner? 12:42
A. No. I mean, unless maybe I raised it and then after I raised it, because obviously I can't remember exactly when I first said. The only thing I could think of is maybe it came afterwards, but then you would have thought maybe I would have been updated in the future. It's a shame because obviously the pharmacists on the ward are a resource to keep an eye out to make sure it had stopped. I don't know why I was not updated or included at that point in terms of -- nor why Dr. Corrigan had become aware of it somehow as well. 12:42 12:43
203 Q. Could I ask you just a systems issue, a systems question? 12:43
A. Mm hmm.
204 Q. You described gentamicin as a stock medicine. This is surgical wards, so the stock would be there, without the need for a prescription? 12:43
A. No.
205 Q. Is it written into the Cardex?
A. Yes, a prescription on the ward is made into what we call the Cardex. It is the inpatient prescription.

So, one of Mr. O'Brien's team or one of the surgical junior doctors would have written the prescription according to Mr. O'Brien's instruction on the Cardex, and then that leaves the nursing staff to administer the medicine in accordance with that instruction. 12:44

206 Q. Yes. It seems to have been somewhat accidental, albeit you're an experienced pharmacist who clearly became alert to the problem. Would you agree with the analysis that this practice appeared to have been in place for some years and it was in a sense stumbled upon? 12:44

A. My staff stumbled upon it?

207 Q. Yes.

A. Yes. I think because back in that time we really only had one surgical pharmacist for three -- I think were there four surgical wards? Maybe three anyway. Obviously Claire was spread very thinly in terms of her role on the role. The pharmacist's role is, as best they can, to review all new prescriptions and make sure they are correct and appropriate, and obviously take 12:44 12:45 the patient's medication history as well to make sure that, if they have come through ED, the history that was taken from the patient about what their existing medication is has been correctly translated onto that inpatient Cardex and reviewed. Obviously with only one 12:45 pharmacist for three wards, that obviously didn't always happen, so Claire obviously wouldn't have seen any patient admitted for therapy, but she saw enough of them over a period of time that it became a concern for

her, which then came to my attention at that point. Nowadays we have a pharmacist for every ward so it would be much tighter surveillance.

208 Q. Again, the system for spotting what the Trust has called irregular prescribing, is it down to the alert pharmacist on the ward spotting the problem or is there a more sensitive way that these kinds of issues could be spotted if they were to occur again? 12:46

A. Unfortunately, at the minute it is still down to alert staff, whether it is the pharmacist or obviously the nursing staff or other medical staff. Our prescribing system in Northern Ireland based on wards and medicines administration system is paper-based, so there is no way of sitting back and having an overview. Now, I'm sure you have maybe heard already from other witnesses about Encompass that is coming. It's unfortunate. Back in 2015, I was sitting on a working group. They were going to introduce electronic prescribing and medicines administration system to all Trusts back, I think, 2015. In 2015/2016 that work was stood down because they thought at that point Encompass was going to come quite quickly and there was no point in investing in a standalone system when a bigger system was going to knock it out, you know, knock its position. So, that work was stood down. 12:46 12:47 12:47

Today, we still have a paper-based system until Encompass starts in the South Eastern Trust later this year. If you have a full electronic prescribing system

administration, you can sort of set safety alerts and safety nets for your junior staff and your senior staff as well into the system. If someone tried to prescribe subtherapeutic gentamicin, it would either stop them or they would have to put in a reason why. It would allow 12:47
you then to sit back in my role or my team's role to run reports and overviews. There is an antimicrobial monitoring team in Trust now; that would be very useful for them. At the minute they have to hand collect the data. There was no way of sitting back and having 12:48
alarms ringing, shall we say, that there was something unusual happening.

209 Q. Let me come back to that in the context of the Bicalutamide issue in just a second or two. Just to finish off the gentamicin issue, could I bring up 12:48
AOB-10091. I said before I don't wish to delve into the merits or the demerits of the use of gentamicin in these particular cases. You have expressed your view as to its propriety or conventionality, and you remain of the view, is that right -- 12:49

A. That's correct.

210 Q. -- that it's not something you would endorse?

A. No.

211 Q. Mr. O'Brien, for his part at the top of the page, this is an extract from his contribution to the MHPS 12:49
investigation. He's responding here to what Mr. Mackle said in his statement, but it neatly encapsulates his view of the propriety of using the practice. He said:

"This issue related to the practice of both Mr. Young and I electively re-admitting patients who regularly suffered from recurring urosepsis for intravenous hydration and antibiotic therapy in order to minimise frequency and severity of infection." 12:50

You accept that it was both him and Mr. Young?

A. I understand now, yes.

212 Q. What you are dealing with is what came to your attention, and it was simply Mr. O'Brien. 12:50

He goes on to say that:

"This practice was disapproved by the Trust. However, our experience was subsequently published, having 12:50 proven to be successful in its purpose and without emerging antibiotic resistance."

He draws attention to the fact that it was published. If we could just briefly look at that, bring it onto 12:50 the screen. WIT-82743, a thesis published in 2011 in the journal Inspection. It runs to, if you scroll down -- scroll down, please, to the next page. Published in the names of Vincent Good, Michael Young, Aidan O'Brien, 16th August 2011, just after these 12:51 issues had been addressed the Trust. Just scroll up slightly. They record:

"From our preliminary results, we conclude that IVT is

beneficial for carefully selected patient with recurring UTI, and their treatment should be individually tailored. We do not claim to know the optimal duration of treatment."

12:52

Scroll right down to the next page, please:

"And regularity of IVT regime but suggest that it should be adapted to patient's condition."

12:52

Did you appreciate the rationale for the treatment when you reported in?

A. In terms of the rationale for the infusion?

213 Q. Yes.

A. No, because, I mean, it was well accepted that if someone maybe had recurring urinary tract infections, the oral route would have been the prophylactic route. Providing antibiotics, either low dose, even that wasn't really advised. Having patients at home with a supply of antibiotics, that if they started to get the early symptom of urinary tract infection, they could self-start. Certainly I wasn't aware of any research that supported the approach being taken with a low dose gentamicin infusion.

12:53

12:53

214 Q. Reflecting on all of this now from a governance perspective, do you think the systems of governance worked well or otherwise when addressing this issue?

12:53

A. I suppose in terms of how we identified it, it didn't work well because we were relying on that paper-based

system to spot unusual practice. In terms of afterwards, certainly from what I was told, it was addressed by Dr. Loughran, and then was fed back to me that the practice was stopped. I was asked if the pharmacist saw any more patients, I had to let him know, which they didn't.

In terms of my reflection on it, as far as I was concerned it had been dealt with, but I now know obviously there was maybe some other stuff going on in the background that I wasn't party to that maybe wasn't as straightforward as Dr. Loughran led me to believe at the time and what I was told at the time in terms of addressing it. 12:54

215 Q. Yes. Could I briefly deal with the issue, if I could, and perhaps a little out of sequence. 12:54

A. Okay.

216 Q. It is convenient to address it in light of what you have just recently said about systems. If we go to WIT-87665. At paragraph 8.1 at the bottom of the page, you say that you are aware that Mr. O'Brien was recommending the prescription of subtherapeutic doses of Bicalutamide for men diagnosed with prostate cancer. You became aware of this when Mark Haynes, Associate Medical Director, asked you for Trust Pharmacy help in auditing these prescription recommendations. 12:54 12:55

Over the page, please. You said, in summary, that you weren't able to assist Mr. Haynes --

A. No.

217 Q. -- directly with his request. What you did do, at 38.3, was refer him to Mr. Brogan. He's the lead pharmacist in the commissioning body?

A. Yes. 12:56

218 Q. It was there that Mr. Haynes was able to extract the data concerning patients who had been through the Southern Trust who had received prescription of Bicalutamide; is that right?

A. That's correct. When Mr. Haynes, Mark, phoned me that day, he, I think, thought that I would be able to run a report on the pharmacy system to identify patients. But in outpatient prescribing in Northern Ireland, we don't dispense the outpatient prescription in a pharmacy. It's slightly different than what happens in the mainland in that a lot of outpatient prescriptions come to pharmacy to be dispensed. In Northern Ireland when the consultant sees a patient at outpatients and once they instruct the GP to start the prescription, by and large - there is a few exceptions, if it is a life-threatening situation, of course they come to us immediately - but by and large, they don't. I mean very rarely they come to us. 12:56 12:56 12:57

So the prescription - it's not really a prescription, it's called an advice note - the consultant would complete it at the time and say please start Bicalutamide. There is a duplicate copy. One copy is ripped off and handed to the patient, the second copy 12:57

goes into the note, the patient's clinical notes. The patient takes that to their GP surgery and hands it in and then the GP creates a prescription for the patient to take to their community pharmacy. Anything prescribed in outpatients is sort of blinded to the Trust.

Part of another piece of work I did, it was like an efficiency savings programme we were doing regionally in the last few years, I led on trying to audit outpatient prescribing, because there was some feedback we were getting in the Trust that maybe GPs were annoyed that the Trust were using expensive versions of drugs instead of the cheaper. I tried to audit it and it was extremely difficult; it just couldn't be done. So what I did was, I was aware that data was available in the community through the pricing, the payment system for community pharmacy, so that's why I put Mark in touch with Joe, because Joe could then authorise interrogation of the community pharmacy payment system to identify patients who were getting longer term prescriptions for 50mg Bicalutamide.

12:57
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12:58
12:58
12:58

219 Q. Yes. The Inquiry is probably interested in this suggestion that an advice note is written by the consultant, taken away by the patient to the general practitioner and out through the door of the community pharmacist?

A. Yes.

220 Q. So your systems, the Trust systems are, as you say,

blinded to prescribing decisions?

A. Yes.

221 Q. I suppose that is potentially a worry, is it not, because you could have, worst example, a clinician in the employ of the Trust prescribing dangerously, irregularly, unconventionally and placing patients at risk? 12:59

A. Mm hmm.

222 Q. Is it right to say that you currently have no system which would supervise that transaction? 12:59

A. That's correct. Until the new all-encompassing IT system comes along, it's at that point that data will become obvious because the outpatient prescribing will be done through the Encompass system within a direct link into the various GP systems. Our only failsafe in the current situation and the situation we faced then was the actual GP themselves. So, it did happen - now it wasn't dangerous situations but occasionally we would have maybe had a locum consultant who wasn't aware of the agreed formulary between ourselves and the GPS and would have maybe used an expensive brand of medicine when there was a generic. Quite often the GP would have lifted the phone or e-mailed me or the consultant in charge or whatever to raise a concern. I did think, when I saw this, I realised what had been happening that well, maybe they did phone in, but, you know, the GP was probably the only one who would have realised that a long term of -- because obviously short term 50mg Bicalutamide is used, you know, cover for 12:59 13:00 13:00

your LHRH implants and so on before and after, but long-term you would have thought maybe they might have. Maybe they did phone in and there was a reason given that it was okay. Certainly, I wasn't aware of any calls querying it. But that was our only sort of safety mechanism for outpatient prescribing, because the GP wasn't required to prescribe. It was known as an advice note, because the way it works legally is the consultant is advising the GP that I think this is the right thing to do. Then it is the GP's professional choice whether they follow that advice or not and write the prescription. 13:01 13:01

223 Q. Yes. In the particular context in which the Inquiry is interested, there may have been other safety nets or there perhaps ought to have been other safety nets within the parameters of the MDT discussions - if a specialist nurse had been in place, if action was being taken by, for example, the Oncology Department external to the Trust. There were other safety nets which the Inquiry is obviously looking at. 13:01 13:02

One query in this area emerges from what Mrs. O'Kane has referred to in her statement, just to take your comments on it. If we go to WIT-20088. She has inserted into her statement the Bicalutamide audit report. Just help me with the accuracy of this, if you could. So she says - sorry, she doesn't say - the Bicalutamide audit says: 13:02

"The following identification that patients have been prescribed low dose - 50mg Bicalutamide - outside of late licence indications or standard practice. Contact was made with the Trust Director of Pharmacy, Dr. Tracey Boyce, with a view to identifying the patients currently receiving a prescription for that Bicalutamide. The data was provided on 22nd October 2020. The data provided identified all Health and Social Care Trust patients who received a prescription for Bicalutamide, any dose between March and August 2020", et cetera. 13:03 13:03

Reading those two paragraphs, it rather suggests that you provided the data on 22nd October. Am I right in saying that's not correct? 13:03

A. No, that's not correct. I made the link for the team to -- where the data could be sourced but I didn't. I didn't see the data when it came back; I wasn't involved in that at all. I think it would be more correct to say that I facilitated them getting in contact with the person who had the data in the community. 13:04

MR. WOLFE KC: Okay. That brings us to lunchtime, I probably have another hour or so after lunch.

CHAIR: Back again then at five past two, ladies and gentlemen. 13:04

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Thank you. Mr. Wolfe?
MR. WOLFE KC: Good afternoon. Good afternoon, Dr. Boyce.

I now want to turn to the events leading up to the Oversight Committee meeting that occurred on 22nd December 2016 and to seek your observations about the aspects of that you had some involvement in. If we can start with your addendum witness statement at WIT-96621. At the bottom of the page at 27.11, where you're amending your earlier narrative, you relate for us that on 9th November 2016: 14:06 14:07

"One of the lead nurses who had been transferred into the Acute Governance team in 2014, Connie Connolly, spoke to you at the weekly meeting which you held with the Governance team about a SAI that she had been working on. The SAI Review was considering the case of Patient 10" - we'll call her Patient 10 - "and Ms. Connolly is a Panel member in an investigation which is being chaired by Mr. Anthony Glackin." 14:07 14:08

You believe that Connie informed you that the Panel had the following concerns. You say: 14:08

"The root cause of the SAI was Mr. O'Brien's lack of action in relation to the triage of Patient 10's referral letter from her general practitioner. That

there were seven other patients general practitioner letters that were not triaged that week by Mr. O'Brien."

Scrolling down please: 14:08

"That the secretaries appear to be aware that triage not been completed and were putting patients into the routine appointment list as a way of ensuring that they were kept in the system. They had kept a record of 14:09 those patients which revealed that 318 letters had not been triaged by a consultant urologist."

Then you delete the rest of that because that information came to you later. 14:09

A. It did, yeah.

224 Q. Then, scrolling down:

"Connie informed you that the SAI Review was nearing completion and because of the concern about the 14:09 implications of the finding that Mr. O'Brien had not triaged any of the urology referrals that had arrived during the relevant week in 2014, you asked Ms. Connolly and Ms. Trudy Reid, the Acute Governance Lead, to track the 17 patients other than Patient 10 14:09 from that week to ensure that they had not to harm", and that afternoon you also e-mailed Mrs. Gishkori to escalate the concern and to advise her of the action you had taken.

Just a couple of things emerging from that. Was there no awareness at your level, or indeed with Mrs. Gishkori, that there was in place a system whereby if triage wasn't performed, if the referral didn't go back to the booking centre, that the booking centre was using the general practitioner's designation? 14:10

A. I'm not sure what Esther's understanding of it was at the time, but that basically was what -- I wasn't aware of this issue at all until 9th November. When Connie explained it to me - pardon me, my hayfever is playing up today - when Connie explained it to me, the way she explained it to me was like as a failsafe, everybody was being put on routine if they weren't being triaged. I now understand that wasn't quite right in that the patient was put on at what the GP had triaged them at or, you know, indicated on the referral, so that the patient was put in the correct chronological place on the waiting list to be seen. But at the time when it was being explained to me by Connie on that day, it was the fact that it was almost like the secretaries had come up with a failsafe system. I didn't realise there had been an issue before, and there was a plan to manage it and the patient was put on chronologically to allow the teams then to chase to get the correct triage done so the patient could then be correctly triaged at some point in the future. It wasn't that they weren't going to be triaged. The Trust, from my understanding now, was that it was being pursued to get the triage 14:10 14:11 14:11

done correctly, but that workaround was to make sure the patients didn't lose their chronological place because of the lack of triage, the lack of timely triage, shall we say.

225 Q. The evidence around this hasn't been fully related to the Panel because there's other witnesses still to come. 14:12

A. Okay. Sorry.

226 Q. But one position such as articulated by Mrs. Corrigan, in her contribution to the MHPS investigation, was to the effect that Debbie Burns, when she was Acute Director, had been involved with others, including Mrs. Corrigan, and Mrs. Trouton I think as well, and came to the view that this use of GP designation in the absence of timely triaging was a system that should be used so that the patient wouldn't lose their chronological place, but that wasn't something that you were aware of? 14:12 14:12

A. No, I wasn't involved in that.

227 Q. So far as you can recall, it's not something that Mrs. Gishkori discussed with you in the sense of telling you what she did or didn't know about it? 14:13

A. No. No.

228 Q. Plainly, something perhaps as significant as this should have been well known within the Governance environment and should have been known by the Acute Director? 14:13

A. Yeah. You mean in terms of Mrs. Gishkori or in general?

229 Q. Yes.
A. Oh, in terms of Esther. Now, I don't know if she did know or not but it was certainly that was never discussed at our governance meetings. It wasn't a subject at the Acute Tuesday afternoon governance meeting. It was never discussed, so I was totally unaware that there was an agreement in the background for these cases. To be honest, as Director of Pharmacy, I wouldn't have been involved in triage really. 14:13 14:14
230 Q. Of course. If the system knew that triage wasn't coming back, and, as we know by the commencement of the MHPS investigation, the count on non-triaged routine and urgent referrals stood at several hundred --
A. Yes. 14:14
231 Q. -- positions might differ about what precisely it amounted to, but it ran into several hundred on anybody's count.
A. Yes.
232 Q. That was something which one of the governance forums should have been the discussing and debating and resolving? 14:14
A. I think certainly it should have come across the governance table in terms of a known risk. It could have been an item certainly on the Acute Governance Risk Register, whether it would have made the corporate register or not. Certainly, that way there would have been an awareness and we would have been all been part of the plan for it. I often found the discussion we 14:15

had at Acute Governance with all the ADs and their experience was very useful. Even when I was dealing with a pharmacy issue sometimes, the combined experience of that team was very strong because a lot of the ADs had not -- they'd stayed within Acute for the whole time I was the Trust. So, we had a good strong team ethic between us all in terms of helping each other debate problems and solve issues and so on.

233 Q. Because judged by your response to this, it was a - maybe earth-shattering moment is to exaggerate it too much -- 14:15

A. Yes.

234 Q. -- but you said to yourself what's going on here, there were eight patients that week who had not been triaged, one is the subject of an SAI, I better go and investigate what's happening to the other seven. Whereas, in fact, the system had known for two to three years that this was the way things were being done? 14:16

A. I suppose my immediate reaction was instant concern because the way it was explained to me was every patient was being put on as routine, which we know now it wasn't. They were being put on... Still, when it was explained to me, it was a concern because I could immediately see the risk to Patient Safety. That's why I was very concerned to check immediately that those seven were okay. At that stage I didn't realise -- I thought maybe this was a lost week because I didn't know of anything else at that point. Now obviously I learned more over the weeks after this. At that 14:16

point I thought the first thing we need to do is make sure the other seven are okay or being seen or do we need to find them. That's why I asked Trudy, who was the Governance in post, who was the Governance Lead, and then Connie, to go and find those patients and see what had happened to them to make sure they were okay. Then, obviously immediately that afternoon I let Esther know (1) what I had done with the issue, and what I had done in the immediate aftermath to get some sort of assurance that those patients were safe. 14:17

235 Q. Now, we know that Mr. O'Brien's practice had been the subject of some scrutiny earlier in the year, starting in March when his failure to triage routine and urgent was one of four items placed on the agenda with him in a meeting. Then the same four items were then discussed by the Oversight Committee in September, and a decision was ultimately taken to do nothing until he returned from sick leave, his sick leave commencing sometime in or around mid November. Were you alerted to those developments by Mrs. Gishkori? 14:17 14:18

A. No. Certainly any meetings I had been at, that wasn't discussed. I wasn't aware of it literally until 9th December, until that discussion with Connie, when Connie raised the issue with me. That was my first awareness of this situation. 14:18

236 Q. It being known, plainly, from at least March by Mrs. Gishkori that triage was not being done, or at least that was the case being made?

A. Mm hmm.

237 Q. Would you have thought that that was the time within which to carry out an assessment and to gain a full understanding of the implications of this triage gap for patients and their safety?

A. Yes. I would have thought so in terms of certainly reviewing the risk of the safety measures in place. If previously thought it could be managed, why was it building up now in terms of trying to get a handle on how big the risk was? 14:19

238 Q. In other words, it shouldn't have needed the arrival on your respective desks of Patient 10's SAI to trigger a grappling, an assessment with this, to work out its full implications. I don't mean you personally, because you didn't know. 14:19

A. No, I didn't. I think with the benefit of hindsight yes, definitely the risk of not triaging patients, especially when we knew at that point our waits to be seen at outpatients were so long, which obviously intensified. If you were on the wrong triage list, that would have a significant impact on your safety. 14:19 14:20

239 Q. Yes. We can see from the email that you say you sent to Mrs. Gishkori on 9th November, WIT-88151. If we particularly pick up on the last paragraph, you are saying:

14:20

"Although this was an SAI but a single case, it has come to light that the other seven received that week are also missing".

As an initial action, you have asked Trudy and Connie to try and track vis PAS, check that they have been seen and pull their notes if necessary.

"I haven't asked the question yet whether we know of that other consultant's weeks triage letters have been lost but it's something we need to discuss." 14:21

You say in your statement you subsequently attended the admin floor and you spoke to Mrs. Gishkori and Mr. Carroll? 14:21

A. Yes.

240 Q. Was that around the same time?

A. It was either that afternoon or the next day.

241 Q. Yes. 14:21

A. Yes.

242 Q. What was the tone of the discussion in light of these developments? Mrs. Gishkori had enabled the earlier process to be parked awaiting Mr. O'Brien's return from sick leave, as I have just said. Was that revealed to you at that point at all? 14:21

A. No. The first time I knew there was a process ongoing was an email Esther sent me on 23rd December in response. When I got the - I think we call it the Dear Tracey letter when people have been talking about it - but when I received that, I obviously e-mailed Esther immediately. Esther responded that day, I think. Apologies, I think it was 16th December. So, Esther replied to me to say as you are aware, there is an 14:22

Oversight process ongoing. I wasn't aware. That was my first sort of introduction that there had been a formal process happening around this situation. I definitely don't recall anybody mentioning process when I went upstairs to the admin floor to make sure Esther had seen my email, and also make sure -- bring Ronan in out of courtesy.

243 Q. What was the purpose of that conversation and how were things left?

A. Well, I think it was more to make sure the email had been seen. In the busyness I knew -- I mean, all of us were getting hundreds of emails every day and emails could be lost and not opened for days. I suppose my urgency was either if Esther wasn't there in person -- I can't remember whether Esther was there in person; I think she was when I went upstairs. Quite often I would have used -- Esther's PA was excellent, so I would have said you need to make sure Esther has seen that email. So if Esther came back into the office, if you needed something seen urgently, I would have walked just from the back of the hospital up to the admin floor and made sure it was brought to the fore. Obviously I made sure that Ronan was aware of it as well, because their offices were there, whereas the pharmacy is at the back of the building, so my office wasn't along the corridor where everybody else's was.

14:22 14:22 14:23 14:23 14:23

244 Q. Yes. What was the upshot of it in terms of action? Was it a case of we'll wait and see what Connie and Trudy produce and what the SAI produces?

A. Yeah. Well, they were facilitated. So, obviously Ronan facilitated Martina Corrigan, helping them in terms of tracking, as far as I remember. Obviously Martina could... My memory is that Ronan then brought Martina into track, making sure that they could find those seven patients. 14:24

245 Q. Yes.

A. You know, helping Connie and Trudy do that for us.

246 Q. That was the immediate concern, to get to the bottom of those seven cases? 14:24

A. Yes. Then obviously to start to look to see, as I hinted at in that last paragraph, are there more. Obviously we were immediately concerned, or I was immediately concerned about those seven because we knew already that week the team, the Patient 10 team, they knew that week hadn't been triaged at all. That was my immediate concern. Then obviously the conversation about we need to look to make sure it's a one-off. 14:24

247 Q. Yes. Then if we look at some of the developments that flow from that. If we go to AOB-01342. That's not what I intended; if you allow me a moment. I may not have the reference to hand but you will recall writing to Dr. Wright at around that time, he was the Medical Director, and you indicated to him that you discussed the SAI with Esther, I think that morning? 14:24 14:25

A. Is that the email of 2nd December?

248 Q. 2nd December, yes.

A. I just saw that in my bundle.

249 Q. We'll try and find a reference when I'm on my feet. It

may allude us for now. What was this development?

A. I don't remember that email now at all, but when I read it in the bundle, from what my interpretation of it was, Esther, obviously after I emailed her and escalated on 9th November, she obviously had told Richard. 14:26

250 Q. Yes.

A. Or Dr. Wright, that this had happened and we were in the process of starting to look further into it. I'm assuming from that email, obviously I maybe had a meeting with Richard and he knew I knew what was going on, and he was checking to make sure things were happening even in terms of the lookback and see what was going on. My interpretation of that email was me giving him assurance that we were working through it, you know, urgent action was being taken to try and track the patients. Obviously I can see in that the team had already encountered missing notes. I think is that the email where it mentions that there was notes missing? 14:26 14:26

251 Q. We'll maybe have to come back to that. Could I just put alongside that sort of sequence Dr. Wright and Mrs. Gishkori's arrangement. TRU-251827. It is 6th December. Let's just go back and deal with this in sequence in case it affects your answer to these questions. 14:28

A. Okay.

252 Q. If we go to TRU-01342. This is the email to Richard Wright, 2nd December. You had a chance to speak to

Esther that around about the SAI.

"She said that she got some assurances from Urology team that notes had been returned. However, she asked me to get the Acute Governance team to go through the spreadsheets the secretaries have been keeping to make sure every patient had been triaged and that all missing notes are now accounted for." 14:28

I think what that must really mean is that there was one of the seven patients, one out of the eight patients -- 14:29

A. Yes.

253 Q. -- where no account could be found of what had happened to him or her -- 14:29

A. The notes couldn't be found.

254 Q. -- and the notes couldn't be found?

A. Yes.

255 Q. Nobody was able to say for sure whether he had been seen or treated? 14:29

A. No.

256 Q. What appears to have transpired is that Mr. O'Brien was dictating on that case during his sick leave at home, and out of the blue, perhaps, the notes arrived back and the dictation arrived back and the case was capable of being closed. Is that what this means? 14:29

A. Yes, I think so. From the 9th, when I asked the team to start looking on 9th November, my understanding is that on 16th November, obviously they immediately found

that that set of notes for, say, the 8th patient or whatever - the eighth patient - were missing, so they couldn't assure themselves that that patient had been correctly treated and seen. They were obviously asking where were the notes, and the notes, I believe, were tracked to Mr. O'Brien. But then a week later, during that week of asking questions, they appeared back with a dictation dated, I think it was the 6th. Now I couldn't be sure but I think it was around 16th November. So, a week following me asking the Governance team to start finding those people, that appeared back. But I think the patient's actual appointment had been made a number of months before that, so it wasn't that they had just been seen on 16th November. I can't remember exactly, I am sorry. I think it was months previous that the appointment had been, but there had been no communication with anybody about what was to happen to the patient? 14:30 14:30 14:30

257 Q. Yes. That's a partial resolution --

A. Yes. 14:31

258 Q. -- of the issue. But the bigger picture, as alluded to here, was whether any other patients going back over a lengthy period of time for which there has been no triage and no further action.

A. Yes. 14:31

259 Q. So, that was work in progress?

A. It was. I mean, I think that was the start of the team that I had put in motion realising this was a lot bigger than just the eight patients, because they

asked. Then more information obviously became available, about like the missing notes and delay in dictation and so on, started to become obvious.

260 Q. Yes. If we go then to where I was going to, TRU-251827. You can see, if we scroll down, Mrs. Gishkori to Dr. Wright. She is indicating that she's been having conversations in relation to Mr. O'Brien's return to work interview. Whoever she's having the conversations with isn't wasn't made clear. 14:32

"We thought this would be a good time to set out the ground rules from the start." 14:32

First of all, were you having conversations with her about when Mr. O'Brien would be approached about the ground rules? 14:32

A. No. No, I wasn't.

261 Q. It does appear, if you scroll up, we'll see Dr. Wright's response. He says:

"That sounds very reasonable. Any ideas when that is likely to be." 14:33

In a context where you're reflecting a fear that there may be unknown quantities of cases sitting out there un-triaged and perhaps un-actioned, this might strike the observer as a somewhat relaxed approach to the problem? 14:33

A. Relaxed, or maybe premature in terms of -- certainly

I knew at that stage the Governance team were still working on trying to pull out the extent of the problem. So, it was only two weeks later on 15th December when I received the letter from them when they were very concerned; obviously a panel member. So I think it was probably in my view premature to discuss a plan at that point. 14:33

262 Q. Yes. In other words, perhaps looking at it with the benefit of some hindsight, what it should have been saying is we're keeping the situation under careful observation, awaiting the results of the investigations to see whether there is something that needs to be done before Mr. O'Brien's is able to return to work? 14:34

A. I would have thought so. I mean, Esther would have been aware the team were still working on exposing -- not exposing but finding the extent of the issues that had been uncovered. 14:34

263 Q. If we go back to your statement then at WIT-96622. You see at the bottom of the page at 27.13 that on 16th December, you returned to your office and found an envelope on your desk. Inside the envelope was a letter of concern dated 15th December about [Patient 10] SAI and the outcomes of the additional actions that you had requested. 14:35

14:35

The letter was unsigned. In other words, it lacked its third page, and this has been subsequently located. You emailed a copy of the letter immediately to Esther Gishkori and Ronan Carroll suggesting that you needed

to meet urgently to discuss "which I believe we did the following week".

This was the Dear Tracey letter and we can look at that. WIT-96627. If we just scroll through it to observe its full form. Right down to the third page. 14:35

While we're doing that, have you any understanding of why the third page containing Connie Connolly's signature wasn't included in the pack that you received? 14:36

A. No. I mean, I only found out maybe last week that there was a third page. I almost took it as, not anonymous because obviously I knew where it had come from, I mean obviously now I know. I wrongly assumed it was due to a level of uncomfortableness maybe with the panel members about what they had found. I'm guessing now it was just an administrative mistake, that only one page had come out of the printer and the third page was on another sheet and it didn't make its way into the envelope. I obviously knew the context of the letter when I read it and what it was about. So I really didn't need a signature, it was serious enough to take it as it was. 14:36 14:37

264 Q. Yes. If we could scroll back to the first page of the letter and stop at the bottom. It is annotated. Is that your writing? 14:37

A. No, that's not my writing.

265 Q. It says - could it be Esther's writing - "discuss

Ronan-Tracey-Esther 20th December".

A. I don't think so. I would imagine, if you check, it may be Connie's writing. That's maybe, I believe, her copy.

266 Q. Yes. 14:37

A. Obviously that would have been - the 16th - that would have been the middle of the next week, "discuss with Ronan and Tracey". I would have had another Governance meeting with the team that Tuesday/Wednesday, around that time. Obviously I came back into my office late 14:38 on a Friday and the envelope had been hand-delivered and it was on my desk. So, by the time I opened it, it was the close of play on Friday and I scanned it to Esther and to Ronan. We weren't able to meet until -- wasn't in the hospital on the Monday because I had a 14:38 regional meeting, so I believe that the earliest we discussed it, the three of us, was the Tuesday, which would have been the 20th, I understand. Yeah, the 20th.

267 Q. It's your understanding that this was hand-delivered to 14:38 your desk by Connie Connolly?

A. That's right. I learned that afterwards, that Connie had hand-delivered it to the pharmacy for my desk.

268 Q. Yes. The Panel is fairly familiar with this letter. What, when you discussed with it the following week 14:38 with Mr. Carroll and Mrs. Gishkori, were the implications of it as far as that triumvirate were concerned?

A. Obviously the identification of the significant risks

that it identified in terms of the potential that there was patients out there that had potential to come to harm in terms of the extent of the triage that was --

269 Q. Just go to the second page, I think it is the summarised. 14:39

A. Yes.

270 Q. These are the themes that were emerging from the SAI?

A. So, they had gone to check on the other seven patients and then realised that this was much bigger. In checking and obviously talking to the secretaries in 14:39 trying to track those seven patients, they obviously then found that there was, like, it says there 318 patients' letters. When I say not triaged, well, they weren't triaged so they had been put on the system according to the GP referral. 14:39

271 Q. The first paragraph sets out the history to that process. It was formally - the default triage approach was formally implemented, it says, on 6th November 2015?

A. Yes. 14:40

272 Q. We have had other evidence on that that it might have been earlier, but working with that. It says:

"Currently the Trust can't provide assurance that the urology non-triage patient cohort are not being exposed 14:40 to harm while waiting 74 weeks for routine appointment or 37 for an urgent."

It goes on to say that a manual lookback had taken

place.

"After informed queries, it is understood the patient notes are not being transported back the Trust and there is sufficient cause for concern that Trust documentation may be leaving the Trust facilities and the process of recording the transportation needs to be urgently addressed."

Then, thirdly, there is clear evidence that a particular patient -- this is the eighth patient, if you like -- 14:41

A. Yes.

273 Q. -- hadn't been triaged. The matter arrived back, typed 15th November 2016, when in fact the patient had been seen in clinic almost two years earlier in January 2015. It says that this has the potential to be confounded if patient charts are leaving the facility. 14:41

What was the action that flowed from that? 14:41

A. So I obviously shared that. Scanned the letter, emailed it to Esther and Ronan. We met. So that was the first time then I was invited to the Oversight Committee on 22nd December. Obviously I then -- Esther emailed me back and said as you are aware there is an Oversight Group, which I wasn't aware. But I was then -- initially I don't think I was due to attend that Oversight Group on 22nd December. Esther was going to represent what had happened. So I prepared a 14:42

briefing note, which I think is in my documents, for Esther to take with her. Then it transpired that Dr. Wright invited me to come along, or the Panel invited me to be in attendance to summarise what had been happening. So the note went. The briefing note was included within the documents anyway, even though I was going to be present. That was the start of certainly my understanding of the Oversight Group. Then there was that meeting, and then there was a subsequent meeting, I think on 10th January, and then I wasn't involved after that. 14:42 14:42

274 Q. Yes. Let's just look at some of the developments between those two pillars. You were in attendance --

A. Yes.

275 Q. -- at the meeting on 22nd December. I think you have said that you were there to relate the concerns of the Governance team. We have the minutes for that meeting, if we maybe just bring that up while we're talking about this. This is WIT-88153. 14:43

Was there any particular reason, Dr. Boyce, why these issues weren't brought to a head sooner than 22nd December? When answering that question, could you try to explain what it was that drove the meeting of 22nd December? 14:43

A. I think what drove the meeting on the 22nd was the information about the scale of the missing -- the notes that were missing, the triage, the un-triaged. So, the sheer volumes of what it stated in that letter drove

that meeting, from what I understand. It wasn't just one or two, it was significant and was going to require a significant lookback to make sure that those patients were safe. This wasn't just something you were going to be able to do within a small team, it was going to require a reasonable resource to sort. 14:44

276 Q. If we just scroll down a little to the context. You under issue 1 are describing some of the background to this?

A. Yes. 14:44

277 Q. What were, in essence, the concerns from a Governance team perspective that you were rehearsing?

A. Really the lack of correct triage. With the big numbers, there was bound to be a number of patients within the ones that the GPs had referred through as routine who weren't routine. If they had not been properly reviewed, there was a number in there who were potentially red flag patients who were sitting on a very long routine waiting list. Obviously, if they were actual cancer patients, or significant disease, they needed to be seen urgently and picked. That wait, even that year and a half wait, could have been catastrophic for them. Whereas if they had disease, that maybe could have been treated early. 14:45 14:45

278 Q. So your focus was the triage and implications of that? 14:45

A. Well, obviously the dictation was equally as concerning because, I mean, if a patient seen a clinic and needed referred to another service or to the Cancer Centre in Belfast, Oncology, I mean was that eighth patient,

nearly a two-year wait for that again would have the same impact on the patient's risk of disease progression.

279 Q. As we can see, if we just scroll down to the summary section on the second page. Just there, thank you. 14:46

"Concerns crystallised around the strong possibility that patients may have come to harm and a decision was made that Mr. O'Brien should be excluded for the duration of a formal MHPS investigation." 14:46

Did you speak to the need for that or was that out with your role?

A. No, that was out with my role. I was obviously presenting the situation that the Patient 10 SAI had 14:46 led to the subsequent exposing that it was a big issue. After that, I really was after the meeting, I wasn't contributing after that. As I say, it was the members of the Oversight Group that were having those discussions. 14:47

280 Q. Obviously, at that time the SAI report in virtually its final form was available, and it spoke to Patient 10 having a probable cystic renal tumour. In a sense was that development - an awful expression - was that the game-changer here in terms of this matter coming 14:47 forward? One could make the argument that the risk to patients because of this process was as obvious as the nose on your face and should have been obvious from a long way out. Certainly, by the middle of that year

when Mr. O'Brien was being tasked with these questions, that was the time to do the deeper dive.

Can you explain, and I know you were unsighted on this until relatively late in the chronology, but can you explain or help us to understand why what appears so obvious now wasn't obvious to the likes of Dr. Wright and Mrs. Gishkori? Was it a case of waiting to see if harm developed? 14:48

A. I don't know. I don't think so. I don't think it was a waiting. To be honest, obviously the decision to maybe use that method of triage was before their time. So, there had been a turnover in the Director of Acute Services and a change of Medical Director potentially. Maybe not Medical Director. 14:48

281 Q. There certainly had. Dr. Wright came in in the middle of '15, I think.

A. Yes, it could have been a decision made before they both were in post. So I don't think it was anything -- I just think they were unsighted to the risk that was there. Patient 10 was unfortunately, like, proof that actual harm could happen and did happen to patients. Significant harm. 14:49

282 Q. Yes. The description in front of us suggests that Dr. Wright was then to contact an organisation called NCAs to seek advice in relation to all of this. Have you ever used the services of NCAs? 14:49

A. I am aware of NCAs because pharmacy started to have the option of using NCAs a number of years ago so I am

aware of the NCAs service. I've never used it myself. I never had a need to.

283 Q. Do you have reflections to offer on the fact that advice has been taken after a decision - one might call it a decision in principle perhaps - after a decision has been taken? 14:50

A. In hindsight, I mean it would be better -- obviously I think I think Mr. O'Brien was still off sick.

284 Q. Yes.

A. So there was opportunity to gather more advice in terms of the way forward because he imminently -- maybe he was imminently due to return, actually. 14:50

285 Q. Early in the new year?

A. Yes, sort of thing. But certainly if I was making that decision, I think I would have gathered as much information as I could and advice before me, and then come up with a formal plan as to what to do next. 14:50

286 Q. Yes. If we scroll back up the page, we can see just there that a particular action was directed for your attention. 14:50

"It was agreed to consider any previous IR1s and complaints to identify whether there were any historical concerns raised."

14:50

The suggestion that this would be done. Why does this need to be put in a historical context; what is the purpose of gathering this information?

A. I assume -- I mean, I actually don't remember that

action, but it was there. My interpretation of that was they were checking to see was there anything else in the system going back in terms of IR1s or complaints that could have given a heads-up as well as to what was happening.

287 Q. Yes. We've looked at the minutes for 10th January, the next Oversight Committee meeting. The minutes for that, just for the Inquiry's note, is WIT-88160.

They don't pick up on this action; it's not recorded that anything was done -- 14:51

A. No.

288 Q. -- around it. Was this issue, this action, forgotten about by you and no steps taken?

A. I doubt it. I wouldn't be in my nature not to act to complete an action, particularly -- and again when I reflect on it, it was the first time I had ever been to an Oversight meeting, so if Dr. Wright had given me something to do, if that was to happen again, I would have probably left the meeting and immediately actioned it. Obviously I was conscious that this wasn't common knowledge, it was being kept confidential within the group so it wasn't that I could use everybody to action that. To do that, you would have to interrogate using free text search on the Datix system, which wasn't something I was particularly competent at. I had a working understanding of Datix but not the in depth you would have needed to do a free text search. 14:52 14:52 14:52

Initially when I looked at that, I thought right, I would have either asked Trudy to do it for me, Trudy Reid the Governance Lead, or a gentleman called David Cardwell who was a real expert in the Governance team. I have since seen an email which makes me think that it wasn't David that I asked; if I asked anybody, it was Trudy Reid. 14:53

The fact that I have no documentation, or if we found something, there would have been a spreadsheet of the list, and there's nothing in my emails that I sent Richard back. I can't say for definite but I imagine what happened was that I phoned Richard and said there's nothing there. I got a report back to say they couldn't find anything, whether it was Trudy. It's probably worth asking Trudy does she recall that. I would have been nervous about doing the search myself because that wasn't a search I would have routinely done. 14:53

289 Q. We'll go to the email you have just referred to in a moment. 14:53

A. Mm hmm.

290 Q. It's clear on our searches of material produced for the Trust and by yourself for us that quite apart from there being no record in the minute of action being taken on this matter, there's no other material such as a report or a note -- 14:54

A. No.

291 Q. -- that you are aware of to suggest that any steps were

taken. Your evidence is if I was told to do something, I generally do it, I just can't produce for you proof of what I done?

A. Yes, and that makes me think nothing was found, which wouldn't have surprised me, to be honest, because at that stage we were using a much older version of Datix and it wasn't straightforward to search.

292 Q. Yes. The email to which you refer, I think, is found at TRU-01366. This the Inquiry will be aware of. The patient referred to within the email is Patient 16. The Inquiry has heard from his daughter as part of our patient hearings. 14:55

Let me just scroll down a little bit to get this in the right order. So, 22nd December, Trudy Reid, Governance Lead in Acute, has written to you as regards Patient 16, querying whether this should be -- it was a complaint from the daughter concerning a stenting issue and a failure of communication. "David has asked is this a potential SAI." 14:55 14:56

David Cardwell is who?

A. That's correct. David, at that time his role was the most senior of the admin team who supported Acute Governance. He would have dealt with complaints coming in; he would have looked at them and assigned them to the correct team to do a response, to investigate and respond. David obviously was experienced enough to see that coming in and realised that it was significant. 14:56

But as you see higher, he wasn't aware of the work we were doing in terms of looking at Mr. O'Brien's triage and so on, and the cases. So, that's what makes me think, if you scroll up, you will see in fact --

293 Q. Scroll up. We can see you writing back to -- 14:57

A. That was the day after I had been asked to complete that action. When I saw that email, I thought, right, I didn't ask David to run that report because he didn't have any knowledge of what was going on. If anybody, it would have been Trudy that I asked to run the 14:57 report.

294 Q. One of the issues that the Inquiry is grappling with is the question of whether the Trust could have done better in terms of setting the parameters and the terms of reference for the MHPS investigation. That question 14:57 arises because self-evidently in 2020, four years after the MHPS investigation, other issues of concern pertaining to Mr. O'Brien's practice emerged. The question is could those issues have been identified earlier and examined as part of an examination. So, 14:57 the action that was directed to you to gather whatever information there might be out there in relation to incident reports, complaints and what have you is relevant in that context.

A. Yes. 14:58

295 Q. You believe that you didn't approach David Cardwell, but isn't he the very person, when you think about it now with his knowledge of incident reports and what flows from them, he's the very person perhaps should

have been approach?

A. He would have been but Trudy actually had been working with the governance system. She was our Governance Lead. She had an excellent knowledge, because at that stage she was starting to work to develop dashboards with David, so the two of them had been -- ward-based dashboards for governance risk which the Datix system could do. So, Trudy had a very good knowledge of the -- I mean, David would have been better but given that it was to be kept in a confidential group of people who were aware of what was happening or what had been discovered, Trudy was in the loop. That's why I think if I ask someone to run a report, it would have been Trudy. 14:58 14:59

To be honest, the Datix system, there was no space at that point or it wasn't routinely that the doctor's name was recorded on it. To search, the only opportunity to search was a free text search, and you would have had to search under all the ways that maybe Mr. O'Brien could have been named in a document to try and find. So, the Datix we were using at the time, it wasn't the web-based one, I don't think, at that point. So it was unwieldy in terms of trying to find data. 14:59 14:59

296 Q. Although the Inquiry is aware of complaints, at least one incident report leading to a SAI which predated all of this, nothing of that nature was brought to the attention of the Oversight Committee because it simply wasn't found? 14:59

A. I assumed that is what happened, that it wasn't found. I am sure there were reports in there. I suppose the failsafe to that would be when a Datix goes in, then the team, the surgical team get emailed. Whether there was a memory amongst them involved that there had been others, if that had come out, then we could have more proactively tried to search the system. Obviously I wasn't asked to pursue it any further. As you say, it wasn't mentioned then at all in the next set of minutes of the meeting I attended in January. 15:00

297 Q. Plainly, Patient 16's case, the complaint from his daughter, made its way into the SAI system after screening?

A. Mm hmm.

298 Q. Was that not material which should have been considered to see if there were any other concerns in relation to Mr. O'Brien's practice that merited investigation? 15:00

A. I think in that action, part of it was to check the complaints. All the complaints were kept obviously on a massive database as well. But again, it would have been a free word text to try and identify -- 15:01

299 Q. This one is on your desk?

A. Sorry, this one? This is on the next day. Apologies.

300 Q. My question is --

A. Yes, I see what you mean. 15:01

301 Q. I'm not saying necessarily anything would have flown from it, but is this not the kind of up-to-date material that should have been considered by the Oversight Committee to see is there anything in that,

are there any behaviours arising out of that complaint that merit a deeper look?

A. Well, my understanding is that was an SAI.

302 Q. Yes.

A. And obviously that next day, that was Ronan's team it was in the system. It would then have been screened and went on to become an SAI. I had been asked at the thing to look for historic ones, previously. That was the next day and that then went into the actual SAI process to look for the -- to be investigated and find out what had happened. But certainly when I tried to find historic ones, in the past, well, I am assuming I found nothing because there is no spreadsheet of cases. 15:01 15:02

303 Q. Yes. 15:02

A. Unfortunately, which it's a shame I didn't email rather than...

304 Q. Word of mouth?

A. I regret not having some sort of email to show that that action was complete. 15:02

305 Q. Very well. Your attendance on 10th January at the Oversight Committee was your last involvement in the case?

A. Yes.

306 Q. Could I then ask you just some general issues arising out of the SAI activity that was taking place and which you had some involvement with. If we could go to WIT-88155. You will recall that Mr. Glackin was the lead clinician on Patient 10's -- 15:02

A. Patient 10.

307 Q. -- SAI. You had been given a direction by Dr. Wright to ask Mr. Glackin to share the report with Mr. O'Brien to invite his comments on the factual accuracy and what have you. Would you just scroll down. That's your email to him. As I have said, Dr. Wright has asked you to share the report. His answer up the page, please, is that: 15:03

"Draft 8 of the report was completed this evening, 10th January. I will be not sending the report to Mr. O'Brien. I am his colleague and not his manager." 15:04

If we go to 257719 in this sequence. TRU-257719. You explain, in response to Mr. Glackin, you totally understand 15:04

"But the normal process would be that the Panel Chair shares the report with the key people involved, and we are very careful to stay within the Trust SAI guidance, but I think if either Esther or I send a final report to him and ask for his comments, it would still be okay." 15:05

You've set out what you understood to be the process; Mr. Glackin protests, saying I'm his colleague, not his manager. He was also, in this context, Chair of the SAI Review. What did you make of his response? Did you sense that he was simply uncomfortable because 15:05

Mr. O'Brien was a close colleague and presumably possibly a mentor? Was there a discomfort around this?

A. I got the impression he felt very conflicted. In your role as Chair of the SAI, that is one of your tasks. You know, when you get to the final working draft, that a courtesy to the staff who have been named in it, you share it with them to ensure when you have spoken to them or captured their -- it's like an accuracy check, they don't get to change the outcome. It is only fair to make sure they get the opportunity to comment on the accuracy of their involvement and if they have been quoted or whatever. So, it is a normal step in the process and it is the Chair's responsibility to do it. 15:06 15:06

Obviously in this one, Mr. Glackin, I understood, was very conflicted, as you say, being a colleague and I understand now that he saw Mr. O'Brien almost like a mentor, as you said. When I had been asked to do that and it came back, obviously I went back to Esther and Richard and it was taken. The MHPS Panel, I understood, took on that. How they shared it, I wasn't involved in sharing it after that. 15:06 15:06

308 Q. Is this a problem you frequently encounter, where somebody from the same department or the same service is the Clinical Lead on the review, and you are placed in this position? 15:07

A. It was the first time I had a Chair not do it or refuse to do it. There's been Chairs not do it maybe because they didn't realise they should do it. In terms of

refusing to do it, I think it showed the level of uncomfortableness that Mr. Glackin found himself in.

309 Q. You have described here in this email your view that this was not a normal SAI. It was perfectly normal in the sense that there had been a missed triage, if I can 15:07 put it in those terms, an IR1 is raised by Mr. Haynes and a process is in the conventional form. Why wasn't it normal?

A. I suppose what I was trying to allude to there was it had triggered the MHPS process. Normally SAIs tend to 15:08 be a mixture of things that have happened, almost like you see those Swiss cheese models, for instance. It's a mixture of how things all went wrong that allowed an incident to happen, whereas this one was very different because the root cause was a sole person. Well, that's 15:08 not fair, actually. There was an issue with the radiology report, but actually the key thing was in terms of the lack of triage. It was unusual in that it involved a person rather than a set of actions and systems that had gone wrong. 15:08

310 Q. You have explained in your witness statement again that following the lookback at triage, five further cases were identified for review, and Dr. Julian Johnson led on that. He was external to the Trust; is that right?

A. That's correct. I think Dr. Johnson had been an 15:09 anaesthetist in the Belfast Trust. He certainly was from the Belfast Trust; recently retired.

311 Q. Your role in that was simply to support Trudy Reid with correspondence and administrative steps?

A. Yeah. I was still meeting Trudy on Tuesday morning and she was then supporting Dr. Johnson in getting the five SAIs completed.

312 Q. You say something about the governance response to what was being revealed by these SAIs in terms of previously the system having an awareness of things not being triaged but it not ringing any alarm bells. I just want to tease this out with you. WIT-87668. At 40.2 you say that the learning that you are aware of is that such important parts of the patient care system that rely on individual actions should be made visible so that activity can be monitored regularly so that problems can be identified and addressed quickly. 15:09 15:10

So, you presumably agree that it's not enough that the booking centre was in some sense aware that triage wasn't coming back, it needed to be more visible than that? 15:10

A. Yes. It's a bit like when I took over the Governance team in 2014, the fact that we didn't have reporting allowed the unopened incidents to be invisible. To me it is the same thing. If you had regular reporting on something like this where you knew you maybe had a risk that you were managing, a regular report to show how far behind the triage was getting, something that was much more visible than relying on, as you say, more junior staff who maybe didn't always feel able to escalate or understand the importance of the risk. 15:11 15:11

313 Q. You explain there that a report was developed by which

triage activity against GP letters was documented for each speciality. Would that reveal outliers or, if you like, inactivity where activity is suspected?

A. Yes. Obviously the Assistant Directors could quickly, at a glance, make sure their team were up to speed. 15:12

314 Q. If we go to WIT-87669. Just down on to the next page, I think. At 41.3, you're explaining that -- just up a little bit please, sorry. You're saying that you think that as regards the triage issues that emerged in 2017, there was a failure by the Medical Directors and the 15:12 Director of Acute Services to engage fully with and address the problems identified at the time. You say in your opinion:

"Both of these roles had a leadership responsibility to 15:13 make sure that a robust process and monitoring system were in place and to seek ongoing assurances."

What exactly did you mean by that? Obviously the issues around triage went back much further than 2017; 15:13 others were responsible for the system that was implemented which allowed in some sense the requirements of triage to be bypassed. Why would you say there was shortcomings on the part of Medical Directors, plural, and the Director of Acute Services? 15:13

A. I think obviously I wasn't aware that there had been issues before I came into it in 2016/2017. I think once that became obvious, you know, having any witnesses, with hindsight, now that I have read some of

the other stuff that has been shared with me, there always need to be someone take charge and make a plan. I think there was an intention to do that, but with the turnover of staff and the inexperience of some staff. I think Dr. Wright was very experienced from my understanding; I haven't worked with him. I believe he managed big cases in Belfast before he came to us as Medical Director. Sadly, Richard had quite serious ill-health issues at the time so he didn't get to finish. Esther then was inexperienced. Then Dr. Khan came along as our Medical Director for a period of time. Again, my sort of impression was a level of inexperienced. He was very experienced with quality improvement but not necessarily maybe with clinical governance. The Children's Directorate he had come a from was much smaller and he wouldn't have the big cases potentially that Acute would have dealt with sometimes. 15:14 15:14 15:14

315 Q. Yes.

A. I think it was almost like, again the Swiss cheese model, the coming together of weaknesses which meant there wasn't a driving force that kept the process going. 15:15

316 Q. Are you talking about the MHPS process. This appears to be -- 15:15

A. I suppose I mix up the MHPS, because to me that was how this was being sorted, if you know what I mean. It was never really discussed at governance or anything. The Governance team weren't involved after that. In my

head, certainly in my understanding, the issue, including the triage and everything that was going on, moved to MHPS. It was never at our table for the Acute Governance discussions or team, apart from Trudy supporting subsequently the resulting SAIs that came out of the lookback exercise.

317 Q. Yes. In fairness to the three people you have named, if we take 41.1 and your reference to the 2007 triage concerns. It's that description I'm picking up on. Dr. Khan, for example, he was the case manager for the MHPS investigation, which became a lengthy investigation. Although he became Medical Director because of Dr. Wright's illness in 2018, I am curious in terms of what could he have been doing about triage at that point? 15:15 15:16 15:16

A. I may have worded that wrongly. I suppose I call it the triage issue, that was the moment where the triage brought the issues with Mr. O'Brien to a -- so I'm probably not meaning -- I don't mean the triage there, it was the actual his practice. The management of Mr. O'Brien as a risk in terms of his practice is what I am alluding to there. It isn't particularly the process of triage. Sorry, because that was the only bit that I was involved in and in my head it was a triage issue. 15:16 15:17

318 Q. Yes.

A. But I probably worded -- now that I read that from your understanding, it was more how they were going to address the issues identified with Mr. O'Brien's

practice.

319 Q. Yes.

A. Sorry about that.

320 Q. Just a small number of other SAI issues before we conclude with your reflections. AOB-01619. Just at the bottom of the page, please. You're writing on 7th June 2017 to Ronan Carroll. This is in relation to the sharing of SAI reports. You say: 15:17

"Once the final report is signed off, it should then be shared with the staff involved in the incident." 15:18

"Previously this was the relevant Associate Medical Director's role but the team" - is that the governance team? 15:18

A. Yes.

321 Q. - "was getting feedback that this step wasn't happening consistently. So recently, following approval by the Associate Medical Director, they started sending the report to the list of key staff agreed with the Panel Chair." 15:18

I'm just picking up here on what you appear to be saying, which was a practice had grown up whereby those who really should receive the final SAI report, those who need to see it to understand the implications perhaps of the error or whatever it is, they weren't getting to see the report -- 15:18

A. Yes.

322 Q. -- for a period of time?

A. What was happening at that point, obviously the process was the Chair, as I mentioned, when they were getting to their final draft, shared it with the staff named in the report for an accuracy check. Then the next step, 15:19
once that was completed, was the draft went to the Friday morning Acute Clinical Governance meeting once a month. That's where the AMD responsible for that division in Acute presented the report to the other AMDs, and the ADs. It was a good meeting, it was a 15:19
good opportunity. It was a bit like a Dragon's Den situation where the others challenged it and made sure that it was a good report, that was easily understood, were there any flaws in it and things that needed to be addressed. Then at that point, that was the final step 15:19
and it was finished and it was ready to go to the family. Obviously as well as going to the family and the Board, the staff involved should receive a copy so that either reflect on it, or it could have been part of their appraisal. Out of courtesy, they should have 15:20
received a version of the final redacted report.

The Governance team had sussed that that wasn't -- obviously the AMD's busyness, the having to start and share that, because when it came to Acute Clinical 15:20
Governance, it was already redacted so that they then would have had to go back to the key for the staff involved. So, it was actually easier for the Governance team to do it for them. Obviously we had to

get permission for them to allow that to happen. Ronan is just checking, obviously, in that email the background to that.

323 Q. I understand. A final IR1 point brings us back to David Cardwell, who you mentioned earlier. This is a case that we have mentioned at various times through our hearings and it concerns Patient 102. I preface my questioning by acknowledging that you have no direct knowledge or interest in this case, but I ask you these questions from the perspective of you having an understanding from a governance angle of the IR process and what should generally happen. 15:21 15:21

If we go to the incident report that was raised in respect of Patient 102, it is to be found at WIT-54874. You can see, just scrolling down, that the incident date is given as 20th November '14, and the description is that the patient was discussed at a urology MDM on 20th November 2014. The recorded outcome was a restaging MRI scan has shown an organ-confined prostate cancer for direct referral for Dr. H. for radical therapy and for outpatient review by Mr. O'Brien. 15:21 15:22

"Was reviewed by Mr. O'Brien in Outpatients on 28th November 2014. No correspondence created from this appointment. A referral letter was received from the general practitioner on 16th October 2015" - that's a year later - "stating that Patient 102 had not received any appointments from Oncology." 15:22

That is the incident report that enters the system.

The Inquiry has been told by the Trust that there's no record of a screening decision for this case and it has concluded that the case was never screened. What we can see, if we scroll down to 54879 in this document, four pages down, and just at the top of 79, it's described as a feedback message from David Cardwell. The feedback is: 15:23

"Hi Martina, Helen Forde has asked me to send this to you with the following message: I think it should go to Martina Corrigan as it says there was no correspondence for the appointment, so it wasn't that the secretary didn't type it, I think it was that it wasn't dictated, so that would need to go to Head of Service for Urology to discuss with the consultant.

Regards David Cardwell". 15:24

When a case enters the system via an incident report, what should generally happen to it?

A. Well, what happens is the member of staff who puts the report in - I think when I looked at this, it was the Mr. Haynes himself. On the Datix system there is a number of boxes you tick to say where did the incident happened; did it happen in surgery and so on. When you tick those boxes about location, the system 15:25

automatically generates an email alert to say the gist of the incident, the text that he'll have put in about what happened; e-mails the designated people that surgery, for example, have chosen to be the recipients of the Datix message. When Mr. Haynes put this in, I think you can see - if you scroll down - you can see who got those. Sorry, maybe scroll up. 15:25

324 Q. One of the earlier pages?

A. Yes, one of the earlier pages lists the email recipients for that Datix. It's usually there somewhere. They are not the easiest to use when they are printed like this. 15:25

On the Datix - yes, here we go - on the Datix system, each team decides who is to receive Datixes for their section. That's in Datix, you put the email addresses and stuff in. Automatically if surgery gets ticked, you can see Heather Trouton, who would have been the Assistant Director of Surgery, she would have got an alert from Datix, and her team. Likewise then, if Urology was ticked, then Mr. Young got a copy as well because he was the Clinical Lead for Urology. That's the way Datix works. 15:26

Sometimes what happens is -- obviously when I read that one, I could see -- when you see the changes at the bottom of it, it came in and obviously it was immediately looked at and they assumed it was a dictation issue, i.e. someone forgot to dictate it or 15:26

type it. So, it was moved from surgery to functional services, which then generated another set of emails to the likes of, I think, Helen Forde and the people -- Katherine Robinson, because they manage the typists, the audiotypists and so on. At that stage they're obviously think it was the missed and never got typed. Obviously when Helen and the rest of the time investigated, you can see -- and I am picking this all up just reading the Datix, just for understanding it. They obviously thought no, it was never presented for dictation in the first place. So, it was like a failure to act on the MDM action. So, they put it back and the Governance team then swapped it back to the surgical team to act. Obviously that's where Martina and David, who was administrating, and also Vivienne who is an administrator in Governance as well, moved that IR1 back into the surgical list of incidents to be addressed. Then that puts it back into the Assistant Director Head of Service to look at that IR1 and say, right, this is serious and put it on the list, and classify it as a potential SAI for screening. 15:27 15:27 15:27 15:28

So, David would not be a decision-maker. He's not clinical, he's an administration person.

325 Q. I read it out to you a short time ago. Where it's put back from David to the Head of Service, Martina Corrigan, to speak to Mr. O'Brien about an absence of dictation, are you saying that's not a decision in the sense of the matter; it was intended that the matter 15:28

should go further?

A. Yes. I would understand reading that that was back for them to look at to see why -- to list it for screening or to assign it a severity of incident that would then lead it to be screened. 15:28

326 Q. Clearly there were two issues. One issue was whether the City Hospital had received a direct referral, and there is information there that suggests that the referral had been made --

A. Mm hmm. 15:29

327 Q. -- but hadn't been received in Belfast. Then there is this issue that you focussed on in your answer, which was the absence of dictation?

A. Dictation.

328 Q. Why are both those issues not capable of being considered as part of this incident report at the same time? Why does the one about dictation get bounced back, if your analysis is right, back to -- 15:29

A. My understanding, I would interpret that David or the admin team didn't appreciate. They would have seen the dictation and not really understood the consequences of the failure to act on the MDM referral or the MDM decision. I think it was probably just in their understanding, the lack of dictation would be an issue. I think they probably just missed the nuance of the implication of the MDM decision not being acted. 15:29

329 Q. Yes.

A. I don't think there was any -- it was just their understanding. Obviously there is clinical people

involved who would have - when reading that report - would have understood the risk that that presented.

330 Q. But your understanding of this is that issue of a failure of dictation, if that is what it was, should have been screened and somebody should have made a decision whether it warranted an SAI? 15:30

A. Certainly, yeah, because the adverse outcome of a year not seen by oncology for a patient, yes. It's quite a good one, that SAI, to illustrate why free text searches were so difficult on Datix at that time. 15:30
I notice, it just caught my eye at the beginning, how Mr. O'Brien was named in it and it is certainly not any way that I ever seen him named in anything. So, someone who was searching free text in that would never think to put Mr. O apostrophe B in. You can see it 15:31
caught my eye when I saw that. I hadn't seen him called that. It's always AOB.

331 Q. If I was to portray this or describe it as an example of underreporting or a failure to follow through on what should have been an SAI review, whether that's 15:31
right or wrong do you have a sense of the extent to which the Trust had a problem with underreporting or a failure to grapple correctly with the applicable test for opening the door into the SAI arena?

A. I wouldn't have been aware of a big issue, I have to 15:31
say, between everybody. People were good when they saw something in a complaint, or bringing it to the fore in terms of having it screened. Because obviously there's people in this email who would have understood the

context of that, clinical people. So I'm not -- I don't understand why that one didn't come up for screening.

The problem is there's so many Datix because they are for all sorts of things and there's lots of them. So, it's very difficult for the Governance team and the coordinator to see every Datix, it's just not doable, they would spend their time doing it. You rely on the specialist teams going yes, that's a concern, and bringing it forward in terms of needing further work. 15:32 15:32

332 Q. Yes. Just finally, Dr. Boyce, you set out some reflections or learnings within your statements. If I could just come to some of those, please. If we go to WIT-87667. Let's go to the top. Scroll up slightly. You say in your opinion there was a combination of factors that have contributed to what went wrong within Urology Services. 15:33

Could you define for us, first of all, what do you think was wrong within Urology Services? Is your diagnosis specific to Mr. O'Brien; is it broader than that? Do you consider the systems of management and governance as things that went wrong? 15:33

A. I mean, I answer that in relation to Mr. O'Brien, because the question to me was what went wrong within Urology. 15:34

333 Q. Yes.

A. Certainly that is what I was aware of was in terms

of -- I was answering in terms of the management of the issues that came to the fore in terms of his practice.

334 Q. Yes. Before we get to that, do you recognise that there were significant shortcomings in the management and governance of the systems within Urology that weren't right, weren't properly focussed and weren't well supported? 15:34

A. I mean, I obviously was never in Urology, working closely within Urology so I couldn't comment on the specifics of Urology. Obviously we spoke this morning about my concerns about the lack of general governance, support and resource available to all the teams within Acute Services. That probably was my underlying concern for everybody. It meant then when there was an issue with a certain practice, it obviously was more of an issue in a particular speciality. 15:34 15:35

335 Q. Yes. Looking at what you have said here, you have explained that, in your view:

"Mr. O'Brien was responsible for ensuring his own practice was of the highest standards. If something in the organisation was stopping him from doing this, in my opinion he should have escalated it through the correct panels whilst continuing to do his best to ensure patient safety until it was resolved. He was a senior member of the profession and, like all senior registered staff including myself, he was responsible for ensuring that his practice was evidence-based and in line with current best practice." 15:35 15:35

In terms of that reflection, is that directed towards triage in particular or is it broader than that?

A. I think it's broader than that in terms of administration and all the things that I have since read in terms of Bicalutamide prescribing. Obviously I'm a senior member of staff and a registered professional, but I don't expect someone to be watching me all the time. That's why I'm in that position, because I have to -- I am being trusted to deliver my practice at that level. If I have a problem with resource or whatever, I don't stop doing the thing, I keep doing it to the best of my ability or putting my hand up and saying I need help here. But I don't... 15:36

I think, for example, in my practice ending up helping with governance was not something I ever anticipated having to do, but it had to be done so you get on with it. I got the impression from some of the stuff I read it was maybe because Mr. O'Brien felt he wasn't being properly resourced, he just didn't do it. When people's safety is at risk, you can't as a professional do that. 15:37

336 Q. To take triage in particular, maybe other issues as well, Mr. O'Brien has made the case that his difficulty with triage, his difficulty with the administrative aspect of his practice was well known, and he protested to the Trust. 15:37

what's the basis for your impression or belief that Mr. O'Brien didn't escalate issues through the correct channels?

A. The fact that there were so many, for example, un-triaged or undictated, and the fact they weren't being done, and that he wasn't coming forward. At the end of his week, he could have emailed to say I didn't get these done. To me that would have been the proactive thing to do. If he had literally run out of time, he should have immediately flagged an issue so that if there was any other way of dealing with it, immediately it could have been dealt with rather than letting it build up and build up unknown to his line manager, for example, Mr. Young. 15:37 15:38

337 Q. Yes. Of course, the other side of the coin is that -- 15:38

A. Yes.

338 Q. -- the Trust either should have had systems to detect these shortcomings, or it otherwise knew about them and let them go. Maybe to some extent the reason for letting them go is reflected in some of your other observations. These are your perceptions, of course, or your opinions . 15:38

"Mr. O'Brien was a senior member of the medical staff. He trained younger members and this led to a reluctance to critically review his practice and challenge him when abnormal practice was identified. And perhaps linked to that, his seniority, well-respected by other experienced consultants and these people may have 15:39

discouraged others from challenging him."

Is this again borne out of your reading the evidence, or was this something that has been the subject of discussion and reflection in your company before you left the service? 15:39

A. It's probably a bit of both. Obviously, reading the evidence in terms of -- and obviously my experience of asking Mr. Glackin to share the SAI report and his reluctance. To me, it showed his conflicted situation that Mr. Glackin found himself in in terms of having to address that with Mr. O'Brien. 15:40

But also, I mean, it was -- I can't even tell you how I know this but it was common knowledge that Mr. O'Brien was well-connected within the Trust. I don't know how I knew but I did know he had relatives who were barristers. You know, it was well-known amongst senior staff that he was connected. When I look back and think why didn't -- was there a more robust, I think there was a level of nervousness in terms of addressing as aggressively as we maybe would have with others. 15:40

339 Q. At (d) you reflect an excessive workload on management and leaders? 15:40

A. Very much so.

340 Q. The inquiry has heard some evidence about I suppose the difficulties faced by medical managers, those in the AMD, CD Clinical Lead cadre; busy clinical practices

but also a heavy job description that goes with these managerial roles?

A. Very much so.

341 Q. Any particular reflections to offer on how that might be done better? 15:41

A. Again, I suppose it came back to when I put the proposal in about giving protected time for, particularly, clinical staff to focus on governance. I would still have that opinion, either that or maybe outsource some of it to - what I am doing at the moment - recently retired people who are still experienced enough that they can bring their recent knowledge to Chair SAIs and take that pressure off Trusts. 15:41

But I think the Assistant Directors were slaughtered at the time, and they still are in terms of their workload. So things like this were a tiny -- I know they weren't -- in terms of significance, they weren't tiny but in terms of their massive workload. Also, the 15:42 Assistant Directors as well would have been carrying a one-in-six on-call rota on top of their day job. In terms of the operational management of the hospital and the out-of-hours and weekend period, there wasn't such a thing as compensatory rest for that level of staff. 15:42 It was massive. Even though, yes, for those poor patients, it's a huge impact, in terms of the daily workload, trying to find time to focus and keep on top of meetings and things, it was just huge for the

Director and the Assistant Directors as well.

342 Q. Is there a sense or do you have an experience of is it left to those in operational management to give informal nudges to clinicians to get things done, and get things done better if there were shortcomings, but really it's up to the medical management, the AMD, to take more decisive action if the operational managers are not able to achieve a successful outcome, and at least exhibited through interactions between some medical managers and Mr. O'Brien, there has been a slowness about taking robust action so that things are allowed to drift. Is that part of a culture that you recognise more generally? 15:43 15:43

A. I wouldn't call it a culture as such but it is probably a symptom of how job plans and things are arranged in terms of obviously the medical staff, their focus is their patient-facing activity. Obviously the operational staff see the issues starting, and they see -- the admin team and the governance would have known that maybe a panel wasn't meeting, so they would have nudged. Actually if then there was some reason that there was a decision not to meet, they couldn't make the consultant meet or run that panel, because they weren't in any sort of line management control. So it had to go back to the medical management line if the nudges weren't working. 15:44 15:44 15:44

343 Q. Yes.

A. So, it was out with their scope of control to make it happen.

344 Q. I know that you mention obviously the turnover of medical director lead is an issue as well. I think I'm going to leave my questions there. There are other reflections that you have offered the Inquiry around, for example, whether the image PS investigation might have benefitted from input from the Acute Governance team, and there are reflections such as that which the Panel can read and take a view on. 15:45

Thank you for your evidence. 15:45

THE WITNESS: Thank you.

CHAIR: Thank you very much, Dr. Boyce. I think I am going to hand you over first of all to Mr. Hanbury, who has some questions.

15:45

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

MR. HANBURY: Thank you very much, Dr. Boyce. That's very interesting. I just have one or two clinical, mainly pharmacological questions, so you can relax a bit hopefully. 15:45

A. I don't know.

345 Q. Outpatient prescribing, first of all. If I was a urologist and I want to start someone on hormones for prostate cancer, how will I be sure with the advice note procedure that you have described that that hormone treatment would start relatively quickly? 15:45

A. You probably wouldn't, but I would say 99 times out of

100, it happened. It's very rare for a GP to challenge. Obviously that would have gone -- from the Outpatients, the patient would have taken the advice note with them, gone to the surgery and left it in. There would have been a subsequent follow-up letter which was much more detailed coming as a result of the Outpatient appointment, maybe with more rationale and plan for the patient. But to make that happen quickly, the patient would have taken it to their GP surgery, who would have then booked potentially a nurse appointment and also handed the patient a prescription. We call them HS21 prescriptions. So they would have gone to community pharmacy, come back with their Zoladex, or whatever they were going to get, and then the practice nurse would have administered it for them. 15:46 15:46 15:47

346 Q. For example, Bicalutamide in the standard way to prevent the flare, that might have been given for a few days, for example?

A. Yes.

347 Q. And then the Zoladex or the LHRH, I think the first one is administered in the community or hospital, that is correct, is it? 15:47

A. By and large. Unless the patient was an inpatient at the time when it was maybe recognised that cancer been diagnosed. From my experience, it would have all been done as an outpatient or in the GP surgery, the actual first (inaudible). 15:47

348 Q. So that was really handed over to the general practitioner first of all? Okay. Thank you. There

was a potential for delay, so if the urologist really wanted, if they had someone with lots of symptoms, you wanted to start Friday lunchtime, could I do that?

A. You could. You could have written in an outpatient hospital prescription and brought it to the pharmacy. It was very rare. It was more routine. Obviously their Outpatient clinic mightn't have been set up the administer the Zoladex, for example, there and then. 15:47

I don't think I have ever seen a prescription come from Outpatients for an LHRH to be administered there and then. 15:48

349 Q. Thank you. You make a good point that it's the responsibility of the senior clinicians to know their standards and guidance. Off-label and non-standard prescription, I mean there are certain drugs. What's your opinion on off-label prescribing and the additional responsibilities that puts on the clinician? 15:48

A. Obviously in our Trust, off-label prescribing happened and obviously it has to in certain. Particularly in paediatrics it has to. The responsibility lies with the clinician who decides to do it. Obviously those prescriptions would have been screened in the pharmacy. Usually the rationale is given as to why they are doing it. Obviously, if it's a consultant that is understood. Quite often it's seen as being -- the pharmacist will know their consultants and know that's what they are doing and there is an evidence base behind it. 15:48 15:49

If something came to the dispensary or they spotted something on the ward and it looked odd and it was maybe a more junior member of staff, it would have been challenged, you know, if it came to the pharmacy and was being screened by the pharmacist for rationale. 15:49

350 Q. Thank you. You are not aware of the community pharmacist ever coming back to the Urology Department with a challenge?

A. I am certainly not aware of that. I think the challenge with community pharmacy is there's no requirement for patients to keep using the same community pharmacy. It is a weakness because the community pharmacy could be another safety net for things like that where things go wrong. But patients can choose their own community pharmacy. They might go to a different one every time. 15:49 15:49

When I was thinking about the Bicalutamide, that's why I thought the GP might have been the only safety net because they are the constant in terms of seeing repeated prescriptions for the 50mg Bicalutamide from the same patient. 15:50

351 Q. Thank you. Moving on. The urology cancer nurse specialists, some of them were nurse prescribed; is that correct? Is that your understanding? 15:50

A. I don't actually know them that well. There were -- yes, you are right, there were a number of the cancer nurse specialists who were prescribers, when I think

back.

352 Q. Mr. O'Brien is saying they shared some of the prostate cancer follow-up with him?

A. Okay.

353 Q. If someone was on a non-standard dose, were you ever escalated concerns from the Urology cancer nurses about anything? 15:50

A. No.

354 Q. Would there have been a mechanism --

A. Oh, yes. 15:51

355 Q. -- had they been worried? Not necessarily first to you.

A. No but there would have been a mechanism, obviously. I mean, we ran a medicines information unit in pharmacy where staff, if they had a concern about an unusual medicine or you wanted evidence base and things like that, it was available to them. There was also the clinical pharmacist based around the hospital who they would have had access, and surgery. Also, we had a non-medical prescribing committee, and we would have had governance events and things where they would have got together to discuss just general points, not specifics but, you know, opportunities to discuss issues and so on. Certainly I'm not aware of it ever being raised. 15:51 15:51 15:51

356 Q. Okay. Thank you. Moving on to sort of ward pharmacy. Obviously you have told us about the gentamicin situation. Just about specifically did either the ward pharmacist or yourself have sort of personal chats to

Mr. O'Brien or Mr. Young, both of whom were doing this, just to say why are you doing it, have they not responded to other treatment, was there rationale? What was the dialogue?

A. My understanding was that the clinical pharmacist based on the ward had had those discussions without success in terms of being given an evidence-based reason that that treatment was being used. So that's the point they escalated it to me to deal with it further. 15:52

357 Q. Okay. Were you surprised, with your research background seeing the paper that was published and justification, for possibly there was no control group or -- 15:52

A. No.

358 Q. -- or a group with oral antibiotics, for example, compared to the new proposal? Did that go through a research committee -- 15:52

A. Not that I was aware of.

359 Q. -- or as a trial?

A. There was a research committee certainly and we had a clinical trials pharmacist, but I wasn't aware of that being -- I probably wasn't even aware it was happening to know to look at it, if you know what I mean. 15:52

I assume the Research Governance team in the Trust had a record of it back then. I certainly wasn't aware of it. I don't think -- I can't for definite but I am pretty certain that pharmacy weren't involved in making a trial medication or identifying it. It was quite a short period of time in terms of trying to identify 15:53

resistance from what I read as well. You'd have to track those patients for a significant period of time. You'd have needed them to have had urosepsis and then challenged them with the gentamicin later to prove that they hadn't. You couldn't say just because nothing had happened to them; you needed to prove that they had an incident where they needed gentamicin to prove that they weren't resistant to it in the future. I thought it was like a preliminary heads-up this is something we're trying, rather than an actual full paper. 15:53

360 Q. That's my point really. You mentioned gentamicin but obviously there are lots of other antibiotics that can be given intravenously. Was that the only antibiotic used in that group of patients?

A. Yes. From what I understood, yes. It was just literally gentamicin and nothing else. 15:54

361 Q. And nothing else. Again, you weren't convinced that the levels were doing well, and the titration and all the other normal clinical?

A. No, my understanding was it was a set low dose. So, it wasn't that there was -- 15:54

362 Q. Can you remember what the dose was?

A. Sorry, I can't. I just know it was subtherapeutic to the point that it didn't even require therapeutic drug monitoring. It was given very every day once a day at a very low dose. I mean, you can probably pull a chart and they must still be about, some of them, if we needed to find it. 15:54

MR. HANBURY: Thank you very much. I have no other

questions.

DR. SWART: I have just got some general governance type questions to move on.

You got into this helping governance out roll particularly because of your background, I think, in the patient safety research, and governance alongside that. What was the biggest thing you learned from that research? Then, if you had been able to do something really that would have made a big difference in the Trust, what would that have been based on that, because it's bound to have changed your outlook considerably. 15:55 15:55

A. Hmm, that's a good question. Probably for me, the thing I learned the most was the value of near miss reporting or no harm incident. I think for me that was one of the biggest things because the number of times when you look at something serious, for example if you take the case of the -- the thing that really got me interesting was the case of Wayne Jowett, if you know it? 15:55 15:55

363 Q. Yes, I know it well.

A. So, that piqued my interest way back in 2000 in terms of how that could have happened. When you read into his case, he was the tenth child or adult to die as a result of that incident. The fact when you start to look into that and you get into the background to that, the number of times there have been near misses with heterocycle chemotherapy like that, where luckily someone had spotted it. To me, that was a big driver 15:56

for me in all the work I did, to try and encourage staff to tell you when it nearly happened. For the staff, particularly telling you about something that nearly happened is a lot less scary than having to come forward and say someone has been harmed, so it was win-win. It was win for the staff; they felt more comfortable telling you about it. Then for the Trust, the organisation, you had that opportunity to fix it. 15:56

364 Q. What would you done with that, if you had been able to? Do you see that as something that could have made a difference to the culture at the Southern Health Care Trust, and what were the barriers for doing something like that? 15:56

A. I think the barriers were resource. As I say, the vast majority of incident reports we got, harm had occurred, or a level of harm. You would have needed a big resource in terms of training, encouragement and facilitation of staff. I think it would have rolled as it did, we found in pharmacy. Once staff understood what you were trying to do with near miss reporting, it wasn't scary, they could see the benefits, it then took on its own role, because certainly you'll have seen in some of my papers, we started a newsletter -- 15:57 15:57

365 Q. Yes, I have seen that.

A. -- in the medicine safety. They used to be called cheese news, which was very -- we had a wee cheese thing on it but we changed that. Staff looked forward to getting that. Again, we were trying to be proactive, what nearly happened, and share with them, 15:57

make it interesting news articles, fun, to try and pique their interest and get them to look forward to reading it every week. I would like to try to get into --

366 Q. When you look at the Acute Governance meetings, for example, that you went to and seeing some of the papers on that, what I don't really have a sense for is what were those meetings like, did they really work? It is a big area you are covering. It's all very well doing that in pharmacy, but the Acute Governance meetings, did they work; did you have the right people there; did you have the right amount of time; were they data driven in the way that makes it a bit easier; what's your feel for them? 15:57 15:58

A. They could be very difficult because there was so much to cover. We covered everything from -- like, the Medical Director's team would have come and presented - and it could be quite lengthy - A&C pod involvement. Those had to be covered to make sure they were on track. 15:58 15:58

367 Q. So that's information coming down, is it?

A. Yes, sort of thing. Making sure right through to were staff doing their mandatory training. You will see the agendas, they were massive.

368 Q. That's what I am trying to get a feel for. How did you get through that and still have a meaningful discussion? 15:58

A. It was difficult sometimes to have a meaningful discussion. It could be quite challenging. Sometimes

we would have focussed on a particular issue. For example, we were trying to get our VT E prophylaxis sorted so we would have used a lot of the meeting for one thing, but there were so many things.

369 Q. Did you have the data for the right things? For example, really you didn't talk about, as far as I can see, at those meetings about any of the issues that we have focussed on in this Inquiry. So, how would you know that you hadn't got another issue like this lurking? 15:59

A. That's what I mentioned, that we weren't themeing our incidents and things to try and identify trends, apart from, to be fair, Trudy Reid managed to get an insulin theme going, which was useful in terms of that because we were definitely seeing that. Even the coordinator having dedicated time to actually sit and plan and come up with proactive events and -- 15:59

370 Q. Did you get any outcome data in terms of complication rates for surgery, or particular outcomes via department of key things that might come out of a national audit, for example, at that meeting? 16:00

A. Not in the level of detail, no.

371 Q. Because there is a lot of data around on a national basis that can be used for improvement but if you don't look at the numbers, you won't know what's happening? 16:00

A. I think there were offshoots of that meeting. Each division obviously had their own governance meeting --

372 Q. I realise that?

A. -- for their ability, like we did in pharmacy. We had

pharmacy-specific governance discussion of our incidents. Each of the divisions were doing a simple thing supported by a member of the Governance team, trying to break the big thing --

373 Q. Was it a standard agenda provided from Acute Governance down to the divisions so that you knew they were covering the right things? 16:00

A. No, no. They would have led their own governance. Though having said that, the governance coordinators were in attendance at those meetings. 16:01

374 Q. The other thing that's been interesting is that we have heard from Shane Devlin and Maria O'Kane, and others actually, about the need for investment in governance, and some work also around supporting the structure for medical management, the structure for governance. 16:01 Audit particularly has come out several times as a big area for improvement. They have described things like a weekly governance meeting for the whole Trust and a change approximate in the attitude to governance. How much of that have you seen? How much of that is coming through in a way that feels different? 16:01

A. Yes. That had started before, and I was aware of that because my governance pharmacist would have attended the weekly meeting. From my understanding of it, it was sort of a very heads-up high level what's happening in your area so that the Medical Director was aware if there had been a big incident, what was happening. It was starting. 16:01

375 Q. I can't understand how you could do that, the whole

Trust every week and make it sensible?

A. I don't know how effective. From what I understood, they were working their way into it. There was also an initiative, I think when Dr. O'Kane was the Medical Director before the Chief, where she had started, not like a grand round type thing but trying to -- because we were getting a feeling that a lot of staff were looking maybe -- if we had shared an SAI report, they would look at it and think oh, that couldn't happen here, not realising it had happened. She had started a Lessons Learned Committee. It was in its infancy, I have to say, and then the pandemic -- 16:02 16:02

376 Q. I couldn't see that a lot of people went to it?

A. No. Then the pandemic came along and obviously it stopped. It was the start where each directorate was to present a catastrophic or major SAI that had happened to try and -- and also, I think the aim of that was to try and again, we were very much siloed in governance until she came along in terms of how we did SAIs, with Associate Medical Directors challenging each other. It was almost a bit like M & M, that's the way we did it, to try and make sure the report was as good as it could be. I don't know that other directors weren't doing that, so theirs were different. 16:02 16:03

377 Q. I think we have heard that there is an attempt to make it more consistent and to learn the best. Quite a lot of people, when we have asked about how you actually make the action plans to make serious incidents a real thing, they have said basically it's a struggle? 16:03

A. Mm hmm.

378 Q. And given the agendas of the governance meetings, you can see that would be the case. There are a few attempts to share it. What is your view on how those actions could be implemented more quickly, especially when you have got the serious incident investigation going on two years and an MHPS going on a long time as well, how do you think people could pick out those learning points and get on with it and rather wait to the end of the report, have you seen any of that happening? 16:03 16:04

A. Certainly before I retired, no, I haven't seen that, but I know there was discussions about it. It's how you get the team on the ground to own that, isn't it, they need to own it. But there is a risk that area where that happened own it, but you have to share the learning across the organisation, not even just in Acute but obviously you have in-patients and mental health and older people. Again I think that's why that lessons learned committee, part of the plan for it was to try and make, share those big cases across the whole division. But it is a challenge, in the work I'm doing at the minute it's challenging for... 16:04 16:04

379 Q. It's a challenge for everybody?

A. Yes. 16:04

380 Q. So your view is that that challenge is recognised now?

A. No, I think it is.

381 Q. People are thinking about ways to do it?

A. Yes. I think, too, in reflection, when I got involved

in governance we inherited recommendations you just couldn't have done. So I think the recommendations themselves must, we need to be better at smart recommendations.

382 Q. I think that's always the case, I agree with you. 16:05

A. And there needs to be process for challenging recommendations, if they really aren't going to be achieved what's the point of setting yourself up to fail and they are not going to help the patient in the long run if you can't actually deliver them. 16:05

383 Q. No. How do you think that can be achieved, do you think there is room for learning across Northern Ireland to try and help trusts with this because it's not confined to any one trust this problem?

A. No. I mean, certainly all the SAIs in Northern Ireland 16:05 go back to the board SPPT. I think they would have had - I'm not going to be able to name - they had someone who would have looked at SAIs coming in from trusts, I can't remember, was it a Responsible Officer, they had a name for the role and they would have challenged 16:05 the trusts back. Now the problem is sometimes the challenge back, the person doing the challenging didn't maybe understand the -- but it could have been good. If they went back and said, well, really, how are you going to make sure every nurse in the Trust knows how 16:06 to manage a central line when they only see one once a year. That's just one that sticks in my mind that we had a massive problem because we inherited it. You just couldn't do that, you couldn't keep every nurse in

the Trust up to speed with central line management every day. So a smarter recommendation would have been picking a ward where patients with central lines would have been, which is what we did in the end to try and manage it. If that had been challenged when that went up a few years previously, really could you do that.

384 Q. It's very difficult, wasn't it?

A. Yes.

DR. SWART: Thank you. I won't torment you any more.

385 Q. CHAIR: Just a couple of questions. You talked about the loss of the Acute Governance Lead role and I just wondered if you have any recollection whether anyone made the case for retention of that role, fought for it. You were saying that if a role needs backfilled because someone leaves, then you have to have sign-off from finance. But finance aren't going to sign off on that, surely, unless they understand the value of the role, you talked about making the case for it. So I just wondered have you any recollection as to whether anyone did at that time?

A. I don't, to be honest. I do remember the severity of the financial challenge at the time, because obviously in pharmacy I was under the same pressure. Every time someone left you had to -- I think there was an actual form you had to complete at the time to try and explain why you couldn't do without that post. So unless potentially there was a -- I don't know whether there was a form completed, it was completed by the line manager of the person.

386 Q. I suppose if that line manager didn't fully appreciate the value then they are not likely maybe to make the case?

A. And to be honest it was so bad, all the focus had to be on patient facing posts, people who had the face to face contact, because that was the only way we could get through it safely, you know, day to day, not thinking of the longer term picture. 16:08

387 Q. I mean, I think everybody would recognise the need for more doctors, more nurses and more treatment of patients and to try to reduce the waiting lists, all of those patient facing issues are bound to take focus. But I think one of the learnings from this and I wonder if you would agree with it, is that it's two sides of the one coin, you can't have good patient services unless you have got good governance and vice versa, would that be fair? 16:08

A. I agree. I think, from my experience, when you asked to bid for a new service, and I would have put in from pharmacy what I would have needed. So obviously if a new service was opening, not only you have the patient facing but, for me, obviously, that service had to be provided for. So I had to purchase for them, I had to retain the store, it had to work. So I would have always built in an element of the bookroom staff, not just the clinical staff. But quite often when the case came back from the board all those staff have been stripped out of it and you got funded for -- so it wasn't even, the Trust was trying, it wasn't that the 16:09 16:09

Trust wasn't trying to get the staff, it was the fact that things were so tight. From above, in terms of commissioning, they were going, well, you can't have those staff, you can have this, you can still open the service, but you can't have the totality of what we understood we needed to run it.

388 Q. Do you think then that there is a lack of understanding on the part of the Commissioner as to what is required in providing a patient-facing service?

A. Well whether it was understanding or they were also under the same pressure to make savings, I don't know. I imagine they understand the importance of governance. And the other, I mean, for example, admin quite often was always stripped out and yet you can see how important administration is in a big organisation. 16:10

389 Q. Just talking about the administration, how do you feel Encompass is likely to improve the system?

A. I'm hopeful. I mean big IT systems are always problematic, I think that's the challenge. But a lot of work is going into it and I know there's been investment in staff. So there is, from my point of view, there's a pharmacist in each trust because the prescribing will sit on top of the pharmacy stock control system, it's the way those things work. So obviously we have a big input in terms of maintaining that side, because then obviously the drugs that are stored or what the prescribers see when they come to prescribe. And also, in terms of building the system, putting in the different pathways to make sure they are

nice and compliant. There is a huge amount of work going on at the moment. Electronic prescribing has its own risks as well because, when it's paper based, certainly as pharmacists you have a sixth sense, you look at a prescription, you think that looks strange and you will challenge. But from what I have read, when you go electronic the prescriptions look right, because it won't let you do an odd thing. You can't have, if something is 50mg you can't prescribe 80, you have to prescribe 50. But from what I have read about it the risk is that you could potentially, you have to be very careful you don't end up with more serious problems because you lose that odd look, they look right. But it is based on how you build the system in the background. But it should help junior medical staff definitely in terms of you build in your failsafes, your doses, your warnings, your interactions, so you don't rely on them remembering them. So it should be good. 16:11 16:11 16:11

CHAIR: Well, thank you very much, Dr. Boyce, your evidence has been very helpful. 16:12

THE WITNESS: Thank you.

CHAIR: I am sure you will be glad to know that you can leave us and we'll see -- I think Ms. McMahon is taking tomorrow's witness? 16:12

MR. WOLFE KC: She is, indeed.

CHAIR: Thank you. Ten o'clock tomorrow everyone.

THE INQUIRY ADJOURNED TO 10:00 A.M. ON THURSDAY, 25TH MAY 2023 16:12