Urology Services Inquiry

Oral Hearing

Day 53 –Wednesday, 14th June 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

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THE INQUIRY RESUMED AT 9:30 A.M. ON WEDNESDAY, 14TH JUNE 2023 AS FOLLOWS:

ESTHER GISHKORI, HAVING PREVIOUSLY BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS: 09:03

MR. WOLFE: Thank you for coming back to the Inquiry.

CHAIR: We will start over, Mr. Wolfe.

1 Q. MR. WOLFE: Okay, Mrs. Gishkori, you were last with us on what we call Day 26 of the Inquiry's business. That 09:39 was 23rd February.

A. Yes.

2 Q. Just for the purposes of the record, your transcript is available to the public at TRA-03059 through to 03137. This morning, and in the course of today, we will take 09:39 you to a number of issues. First of all we'll finish what we started during that short afternoon session on Day 26, where we began the process of looking at your involvement in the build-up to the MHPS process or investigation, and we'll continue with that today. 09:39 We're then, for the purposes of the Inquiry's business, again into a module that is looking at governance issues, Governance in Action. I know that on the last occasion again, we looked at some aspects of your role or interest in governance and we'll take you further 09:40 into that as the last part of your evidence today.

Focusing on September 2016, you will recall that we spoke on the last occasion about the Oversight

Committee meeting on 13th of September. We went through the decisions that were made at that meeting, and you explained to us that you weren't brave enough to challenge the decision reached at that Oversight meeting, and you had reservations about it. You were concerned that the plan that was developed at that meeting had no real involvement for Mr. O'Brien. You were concerned that he might walk away, leaving the service with a backlog which he was best placed to clear, in your view. You thought it might be better to have direct intervention from his colleagues such as Mr. Weir and Dr. McAllister, and you wanted to review the position and speak to them. 09:40 09:41

We also dealt with your conversation with, I think you recalled it as Dr. McAllister and Mr. Weir on 14th September? 09:41

A. I know that I spoke to Mr. Weir at a point in time, but on that day I think it was just Ronan Carroll and Mr. McAllister. 09:41

3 Q. Yes.

A. Because that would have been -- normally Ronan Carroll was my AD for Surgery and Anaesthetics.

4 Q. Yes.

A. So that would have been my choice. And I do believe, having read some of the papers here, that it was Ronan, and I do believe it was the two of them. 09:42

5 Q. Yes.

A. Ronan was easily accessible, if you know what I mean.

He was on my floor.

6 Q. Yes. Just in terms of what happened at that 13th September meeting --

A. Mhm-mhm.

7 Q. -- and you leaving the meeting, apparently part of the decision but not having spoken up -- 09:42

A. Yes.

8 Q. -- about your concerns about it. I want to put, just for your observations in fairness to you, something Dr. Wright has said about that. If we go to TRA-03281. 09:42 Scrolling to the bottom of the page, please, and just over the page. Yes.

This is the question from the chair I want to explore with you, which we heard last week from Mrs. Gishkori. 09:43 Just over the page. The thing that he says, just scrolling down, and this is in respect of 13th September meeting:

"I would normally expect a director to come to a 09:43 meeting like that on the 13th fully briefed on what was going on on their patch, having considered the outcome they would want from the meeting and with a plan for resolving the issues. So for whatever reason, Mrs. Gishkori didn't have the time to put that 09:43 together, but that's usually what I would expect and usually that's what would have happened. I can't think of another situation where somebody would come to a meeting not knowing the degree of the problem and not

knowing what their preferred potential solution would be. So I am at a loss?"

Dr. Wright, my impression, was frustrated --

A. Yes. 09:44

9 Q. -- by the approach you adopted. Is it a fair criticism to make of you that you were part and parcel of a decision-making body but, as it transpired, didn't put across to that meeting on 13th September your thoughts on the issue and then took that issue in another 09:44 direction after the meeting?

A. Well, I think it would be fair to say that I came to the meeting in a very different place to everyone else in that room, because the first I heard of this was in March when Heather Trouton and Eamon were going to send 09:45 this letter. I hadn't heard anything else in relation to Mr. O'Brien before that. Even on that day, and you know retrospect is a great weapon, I should have said "Can you show me the letter", but the letter hadn't been written. 09:45

So, the letter was sent. Then I understand that there were meetings between Heather Trouton, Eamon Mackle, Dr. Wright, maybe Martina was involved as well. So, they all were having these meetings outside of my 09:45 knowledge completely. They all knew, you know, what the extent of this was. Plus something else I noticed: I began, I started my work there in September 2015 and in November 2015, there was Heather, Heather was

involved in it, I think possibly maybe Martina, but they set up this fail-safe system whereby if patients hadn't been triaged, then they were to go back on -- chronologically back onto the list where the GP had referred them. So, if it was routine, it was routine, whatever. 09:46

Now, I would have thought whenever that letter was mentioned, that should have been told to me but none of it was. So, when I made it to the meeting in September, I thought it was a little bit heavy-handed. You know, they had sent him a letter which, to be fair, I felt was tokenistic. I felt that may be perhaps Mr. Mackle was finishing off his business before he left, because he did leave shortly after that. 09:46

So, here I am thinking, well, they are going to send another letter to this man, number one. Number two, his line managers aren't here in the room. You know, the people who managed him professionally -- yes, Richard was the top, but there was Charlie McAllister and Colin Weir below that. To be perfectly honest, I was sitting saying to myself what have I missed here, there is something that I haven't seen. I really wanted to get back to my office, and that's the truth, just to look back to see if there was anything else that I had missed in terms of developments in the case. 09:47

So, it is a rare occasion but at the same time I was

left out of a lot of things, Mr. Wolfe, in the Southern Trust, an awful lot of things. I can give you some examples of that perhaps later, it is maybe not appropriate now. Certainly, if you look at the knowledge base that I had, I'm hoping people can understand why I did what I did.

Also, and I mean I have to put my hand up here, probably the best thing to have done would have been -- would have said, look, stop right here, can we please have Charlie and Colin in this meeting, please, that would complete the circle. But I didn't.

10 Q. Okay. Is it fair to say you felt taken by surprise with the turn of events --

A. Yes. Very so. 09:48

11 Q. -- at the meeting on 13th September. That was notwithstanding that you, as we saw on the last occasion, had knowledge of the fact that Mr. O'Brien was an issue, if I can put in those terms --

A. Yes. 09:48

12 Q. -- from as far back from December 2015 when Mrs. Trouton approached you. You had meetings with her in March 2016?

A. Yes.

13 Q. And you knew that the letter was going to be handed over to Mr. O'Brien and him met with in March 2016? 09:48

A. Yes. I --

14 Q. Notwithstanding all of that, you hadn't arrived at a knowledge that things were still to be problematic?

A. Well, to be fair, my knowledge was -- again as I tell you before, I had heard he was slow, he wasn't a team player, he was someone who did his own thing, he messed up the theatre list, he kept charts for longer than he should have. It was a generalisation that I felt was easily fixed. If you had given him somebody to sort of mentor him and his own colleagues to sit down and say to him, look, do you know what, if you don't get this sorted out, these people are going to come down on you with a heavy hand. Honestly, the patients are always, every single time, the patients are the foremost in my mind. I was saying to myself who is going to do all of these dictations in the -- if this man bolts, as it were, because he was difficult. Who is going to do those dictations? Those patients are all going to have to be seen again because the only person who can do the dictation is the person who has seen them. 09:49 09:49 09:50 09:50

15 Q. Yes.

A. And I felt it was perfectly within his ability and capability and job description to do it himself. 09:50

16 Q. Yes.

A. That's what I thought.

17 Q. Let's just briefly step through some of the correspondence that was going back and forth at this time and invite your comments on that. 09:50

A. Okay.

18 Q. If we go to an email sent by you, assumedly after you had met with Mr. McAllister, Dr. McAllister, 14th September. TRU-257636. This is you writing to

Dr. McAllister, lunchtime, 13.17, 14th September. What you're saying - just scrolling down - you've possibly asked him a question in terms of what --

A. Do you know.

19 Q. -- information does he have about Mr. O'Brien and the issues? 09:52

A. Mhm-mhm.

20 Q. He says "Here is the only communication that I've received", and that is the question that Mr. Gibson had put round in August of 2016 at the bottom of the page. 09:52 That was the question in relation to whether there had been progress on the March issues.

Scrolling up the page, you're saying to Dr. McAllister: 09:52

"At least you have a starting point. I'm clear I wish you and Colin to take this forward and explore the options and potential solutions before anyone else gets involved. We owe this to a well-respected and competent colleague. I can confirm that you will have 09:52 communication in relation to this before the end of the week."

Is it fair to say that your meeting with Dr. McAllister hadn't arrived at a fixed plan in terms of how to deal 09:53 with this issue? It was embryonic, perhaps.

A. It certainly was. I think -- look, I had asked Charlie and Ronan to come in, and I had said to Charlie, "Charlie, do you know anything about this", because by

that time I had looked through my emails; there was nothing. I said "Charlie, do you know anything about this?" I mean, Dr. Wright has asked for -- even that first email you showed me at the bottom just now. You know, everybody - Dr. Wright, Simon, Heather - 09:53
everybody knew this was all going on but I didn't. I just said to Charlie have you heard about this. He said no, he hadn't, just showed me that letter that Simon had sent. But he said that he and Colin already had had thoughts -- they were both new in post, by the 09:54
way. He and Colin had had thoughts on how to solve this. I said "Well, how do you think do it?" He said, "Well, you know, if all else fails, we can always take him out of theatre", because he loved theatre and didn't like admin. So, they were more or less going to 09:54
say to him somebody else will do your theatre list while you get your admin sorted out. They felt he would do it very quickly if that was the case.

However, I did feel from that conversation, because we 09:54
didn't talk about this much, that they could talk him round to getting it done. You know, he hadn't had a job plan done and they thought it was a good idea to start there with the job planning and have the discussion, because job planning is one thing that they 09:55
all have to do.

21 Q. Yes.

A. So it wasn't calling him in for a different reason, 'let's talk about your job plan' and introduce the

whole thing sort of in, as I think Colin said, supportive nonobtrusive way.

22 Q. Let's just look at some of the language you've used here. You're saying I want you and Colin to explore the options before anyone else gets involved. 09:55
Obviously, the Oversight group were involved by that stage. Was this in a sense you trying to nip the Oversight group's approach in the bud before it developed too far?

A. Well, I wouldn't put it that way. No, I wouldn't say I 09:55
was nipping it in the bud. What I wanted to do was just stall it until his own line management, his own professional line management dealt with it. I did -- I am being honest with you, I did have every confidence with Charlie McAllister because he was a straight, to 09:56
the point, get the job done man. That was why I asked him to take that role on. He also didn't -- there were people that were a bit -- I'm not going to say frightened of Mr. O'Brien but felt him to be overpowering, I suppose is the best way to put it. But 09:56
Charlie wouldn't have been that at all. Not at all.

23 Q. You say, just going through the email: "We owe this to a well-respected and competent colleague."

A. Yeah.

24 Q. In what sense were you meaning that? What was 09:56
Mr. O'Brien owed? Why was he owed anything if he wasn't doing his job properly in the eyes of the Trust?

A. To be honest with you, that's absolutely a fair point. But the conversation always came round to the fact that

he was an excellent surgeon, he set up the service, this man knew the service better than anybody. You know, he has, in recent years, become a bit slower but doesn't everybody when they get older; all that sort of thing. I am thinking to myself, well, he has put a life sometime of service into this particular urology, which he had and set it up together with Mr. Young, but that's another story. So I thought, do you know, I think we owe it to this man to try this first of all, because it was win-win for me with my patients thinking, well, you know, approach him nicely, get it done. 09:57 09:57

All the triage, the triage was my biggest concern because you don't know what you don't know in triage. Everything else, well, he has already seen the patient with dictation et cetera. But with triage, you know, they are all sitting there, nobody -- so I wanted them done. In the meeting that was my first feeling, I just want these done right now. I haven't time for letters and people talking about things, I just want this done. And I put that across to Charlie very... Yes, I did. 09:57 09:58

25 Q. Help me on this. Is it fair to say that you didn't have a sense that patients were being harmed or were at significant risk of being harmed -- 09:58

A. Of course they were.

26 Q. -- when you made this intervention?

A. Of course they were. That's why I really made it because I felt that we could get it done quicker. I

know Charlie said three calendar months, but he told me that the triage -- because I said to him I would like those triage patients triaged right now. Of course there were patient safety risks here. I mean, that goes without saying and that's the only thing that gets me fired up, to tell you the truth. Whenever it comes to a patient having an adverse reaction or... At the very least we should do -- I mean, Mr. O'Brien would have taken a vow when he became a doctor, "First, do no harm"; primum non nocere, I think it's called. So, at the very least he should be looking at the triage to see is there anybody in there that would be harmed had he left them. 09:58 09:59

27 Q. Yes.

A. And, later on, I believed that he just he knew rightly what he was doing. At this point, I thought he needed help. 09:59

28 Q. Yes.

A. Because there was a previous email that Richard said to me - and I'm sorry I can't remember when it was, it has just come into my head now - you know, this man is crying out for help, Richard said. 09:59

29 Q. Yes.

A. I'm thinking well, here we are again now, and maybe Richard is right, let's try and get this done. I would have done that for nearly any of them. 09:59

30 Q. Yes. Obviously, and I don't want to jump too far ahead, your view, I think, changes by December 2016 when you became aware of Patient 10 and the SAI?

A. Totally. I lost all -- honestly. Well, do you want to talk to that when we come to it or would you like me to talk about it now?

31 Q. We'll come to it. At this point in time, you didn't know about -- 10:00

A. No.

32 Q. -- the developing SAI in Patient 10?

A. No. No.

33 Q. Could I also at least put to you that there was another patient who had come to Mr. McAllister and Mr. Weir's 10:00 attention. I want to ask you about him. It's Patient 93, if you just look down your list. If we have up on the screen, please, TRU-274751. If you just scroll down a few pages, please, to 53.

10:01

At the bottom of 53, this is just a few weeks before the Oversight group meeting, and Mr. Haynes is writing to Martina Corrigan in relation to Patient 93. What he in essence is saying is that a GP referral came in as routine but the patient or the referral was not 10:01 returned from triage, so the patient went on the waiting list in accordance with the doctor's, the GP's, classification of routine. If the patient had been triaged, he would have been red flagged, he would have been upgraded because there was a high PSA on repeat? 10:02

A. Mhm-mhm.

34 Q. The patient, according to Mr. Haynes, saw Mr. Weir recently for leg pain and the CT showed metastatic disease from a prostate primary. He is asking the

question should there be an SAI.

If we just scroll up just so that you can see this. This goes to Ronan, and then it's drawn to Mr. McAllister's attention and he asks for input from Mr. Young. Then up the page, it's referred over to Mr. Young, if we just go to the top of the page. 10:02

Is that a case that was drawn to your attention in August or September, do you know or do you remember? 10:03

A. I don't remember, no. No.

35 Q. Because --

A. I understand --

36 Q. -- I ask about it because you are developing or wanting to develop an alternative to what -- 10:03

A. Yes.

37 Q. -- the Oversight Committee has decided?

A. Mhm-mhm.

38 Q. Two of the people who you are confident in helping to develop an alternative are Weir and McAllister. They have knowledge of the cold reality of a failure to do triage. A patient has gone on to develop secondary disease, not because of referral but in circumstances where a referral had not been triaged leading to a delay in diagnosis and a delay for the onset of treatment. So, that is something in these conversations that ought to have been drawn to your attention, do you think? 10:03 10:04

A. Probably at Ronan -- because, yes, whenever I had -- I

had one-to-ones with Ronan, so if he felt this was completely -- I always told them you deal with the everyday ordinary and tell me about the things that are out of the ordinary. So, I would have assess this to have been out of the ordinary. 10:04

I also had a monthly governance meeting where risk and SAIs were talked about. So, I didn't know about this, nor did the Oversight Committee know about it because it wasn't mentioned at it either. So, this was dealt with probably through the channels of, you know, an incident, an SAI and dealing with it. No, I mean -- and you're absolutely right, you know. I mean it's unforgivable, isn't it? 10:05

39 Q. Well, I want to ask you, did you get any sense -- 10:05

A. No.

40 Q. -- from Dr. McAllister that this kind of conduct - maybe it was blatantly obvious to you - but this kind of conduct in not dealing with routine triage referrals was likely or potentially could put patients at risk? 10:05

A. He told me that he and Colin already had plans to address Mr. Weir's performance, among other things. But he didn't go into the detail of any specific SAI. Though I do recognise the name, to be honest with you, but that was probably just as things went forward, you know. 10:06

41 Q. Yes.

A. I recognise the name.

42 Q. So you notify -- if we go to AOB-1053. I'll say it

again, AOB-01053. At the bottom of the page, please, you're telling Richard Wright and Vivienne Toal that you have had a meeting with Charlie and Ronan?

A. Yes.

43 Q. You've mentioned the case of O'Brien, and you say: 10:06

"Actually, Charlie and Colin already had plans to deal with urology back log in general", and Mr. O'Brien's performance was of course part of that. "Now that they have both work locally with him, they have plenty of 10:07 ideas to try out, and since they are both relatively new into post, I would like to try their strategy first."

Mr Wright's response to that is he has to listen to 10:07 your opinion but before he would consider conceding to any delay in moving forward, he would need to see what plans are in place to deal with the issues.

On top of that then, scrolling up, you copy McAllister 10:07 and Weir and Carroll in. You say to them, "and my response will be". That's indicative of the fact that a plan has not been fully developed at this stage?

A. I hadn't seen one.

44 Q. Yes. 10:08

A. But, you know, again I suppose this is the backdrop to absolutely everything we talk about. In this room we might say, my goodness, that was a week later or two weeks later, but when you were firefighting every

single day, it didn't seem a long time that, you know, went. So what I am trying to say is I didn't doubt that they wouldn't do something, put it that way; I didn't doubt for one moment. In many ways I feel a little bit betrayed that things maybe didn't go the way. But whenever Richard said delayed, what I was trying to do was get it done very quickly. I wasn't trying to delay anything. I need to make that very clear. I wanted them to, as I used to say to them, get their thumb out and do it; just get it done. 10:08

45 Q. Yes.

A. So.

46 Q. When you think back on this, is there any sense of or appreciation on your part that dealing with an issue as important and as big as this can't be done properly if you're doing it on the hoof, if you like, if things are spreading out in such a way with a degree of informality outside of the proper channels for marshalling these issues? 10:09

A. Knowing what I know now, absolutely I agree with you. With the information that I had at that point in time, I felt I could deal with it. How the problem was in my mind, I felt it was very doable at operational level. But, you know, hindsight is a wonderful weapon to have, Mr. Wolfe, I didn't have it at the time. Plus again I will tell you, and I will maybe get a chance to tell you later, I was left out of an awful lot of communication and information, and there was, I believe, a reason for that. But I'll tell you about 10:09 10:10

that maybe later.

47 Q. Let's hear it. You have introduced this point twice now and maybe we should just deal with it. As regards --

A. And after this, can I take a break after I tell you? 10:10

48 Q. Of course. I was going to help you to address it by saying the following to you.

A. Yes.

49 Q. We heard on the last occasion how this matter reached the Oversight group on 13th September. In the build-up 10:10 to that, Simon Gibson, at Dr. Wright's direction, went out and got information and prepared a screening report?

A. Mhm-mhm.

50 Q. In the build-up to 13th September, there was an email 10:11 inviting you to pre-discuss these issues with Dr. Wright and Vivienne Toal on the edges of a governance meeting --

A. Another meeting.

51 Q. -- and it would appear that that opportunity, for 10:11 whatever reason --

A. Didn't happen.

52 Q. -- wasn't taken up.

A. Yes. Yes.

53 Q. You arrived at the 13th September meeting with all the 10:11 relevant information under your arm but you hadn't had an opportunity to carefully read it in advance. I think you told us that you essentially read it on the way down the hill?

A. Yeah.

54 Q. What was being held back from you of significance that you are now aware of that might have affected your approach to these things?

A. Well, clearly the fact that there had been an add-on to the process by Heather, and I think it was Debbie Burns, just before I took up post. That because of the issue of this triage - this was in 2014 - because of the issue of this triage, they added on this where if they weren't triaged, then they were put back onto the list. So, that was known by Heather, who was two doors down from me. That was known, apparently now, by Dr. Wright who had had meetings with Heather and Simon and Mr. Mackle before the meeting of September Oversight Committee, which, by the way, was a committee with other people on it as well. Mr. O'Brien was put down as an extra item, if you like. 10:12 10:12 10:12

55 Q. Yes. You're telling the Panel that what we call the default arrangement for triage, whereby if a referral isn't triaged by any doctor, it's added on to the waiting -- 10:13

A. Yeah.

56 Q. -- you didn't know about that?

A. No.

57 Q. When did you become aware of that? 10:13

A. I became aware of it when I read this that said that -- I think it was possibly Dr. Boyce's account because she said, well, that's all very well to do that but what happens when you put somebody back on routine that

isn't routine; you know, that should be red flagged, upgraded to a red flag? So, while they did that, I didn't think -- and perhaps at the time, in their defence, it was the best they could do. But what I am trying to say to you is there was a massive, massive history here. Debbie Burns was my predecessor. She could have told me about all of this because it was only implemented in November 2015 and I joined a month before that. So, there would have been a lot of people who knew. She would have known. I didn't get any hand-over from her for whatever reason. Heather certainly didn't tell me about it. So, I could only make my decisions based on the information I had. 10:14 10:14

58 Q. Are you now aware of anything in particular that was kept back from you? Leaving aside, you've mentioned the triage issue and the default arrangement, but what was held back from you that would, as you know it now, have affected your behaviour around the management of Mr. O'Brien? 10:14

A. Well, that for sure, because I would have known that this actually was a longstanding issue, it was an issue that wasn't going to go away. I mean, there was Oncology mentioned in this as well, in this letter, which I only saw when I read the letter and then maybe panicked a little bit and that's why I tried to sort it out immediately. 10:15 10:15

But, you know, it's very hard to know what you are left out of until you discover you have been left out, if

you know what I mean, but this was more about my treatment by others in the Trust. I'll tell you what else I was left out, and this is very petty --

59 Q. We'll step through them one at a time. If you go to the screening report -- 10:15

A. Yes.

60 Q. -- at TRU-251423. The first issue under consideration is triage. The first paragraph addresses the issue of the default arrangement. This was introduced - as you say, the evidence varies - but perhaps by Debbie Burns, 10:16 but certainly within Acute, whoever took the decision, sometime before you took up the post. But, as is explained here by Mr. Gibson in this screening report, "If triage does not take place, then health record staff schedule the referral according to the priority 10:16 given by the GP."

That was something you were aware of or ought to have been aware of as you went into the meeting on 13th September. But leaving that aside, isn't the 10:17 important issue - leaving aside the system, this is the system - is the important issue not how is Mr. O'Brien behaving within that system and what is the risk for patients?

A. Yes. 10:17

61 Q. You knew that as a result of this account, and the statistics vary about the number of untriaged, but they are saying here that as of the end of August, there were 174 untriaged letters dating back 18 weeks.

A. I remember that all right.

62 Q. Yes. While you may have a concern that other aspects of your work were inhibited because information was being kept back from you, does any of that relate to the Mr. O'Brien case? 10:18

A. You mean in information being kept back? Yeah, I think it possibly does. But the thing is this is my -- this is just me thinking and putting all the pieces of the jigsaw together, so I am telling you what my -- this is my diagnosis, prognosis, this is my theory. So, I'm 10:18 not sure. You know, can I answer the question you asked me on this first?

63 Q. Of course.

A. The first paragraph, I believed that this was the process. So, I believed that everybody who came in 10:18 that wasn't triaged for whatever reason went back, be it gynae, be it surgery, be it medicine. This was a fail-safe, not just for Mr. O'Brien, to be honest. I concentrated on that second - and there was more in the letter - but I concentrated on that second paragraph 10:19 that said, you know, up until August he hadn't responded to the letter of March and this was the result. In my mind, you see, I was thinking to myself -- well, I was thinking a couple of things but the first thing I was thinking is anybody who is 10:19 intelligent, like he is, anybody who knows what they have agreed in terms of systems would see the writing on the wall there, even in that letter that was sent. So, as time progressed and I started to become aware of

the issues as they actually were in reality, then, I'll be honest with you, I lost -- well, I needn't say respect but I just completely regretted the fact that I had put my neck on the line, not to save him really, to get it sorted out. But because, you know, he went off sick, Charlie went off sick and Colin went off sick, like who could have dreamt that would ever happen, the whole thing fell done. But there you go, it happened. So, I would still have wanted Charlie and Colin to be part of the Oversight group, for sure. 10:20

64 Q. Yes.

A. Period.

65 Q. Maybe my question took you off track. Are you content with the answer that you've given?

A. About? 10:20

66 Q. In terms of you being deprived of information or being kept out of things?

A. No. There is a big story.

67 Q. Well, I would ask you to think about it carefully. Is it relevant to your handling of the Mr. O'Brien case, if I can put it as broadly as that? 10:21

A. Well, not my handling of it because I didn't know about this at the time. This all came to me later on as I started to put the pieces together because it was one of the reasons I left, but I didn't really know why I left because I was never told. Well, so I was dealing with it just as I saw and as I felt as the director was best. So no, it wasn't at that point. No, it wasn't. I didn't know about what I didn't know. 10:21

68 Q. Yes.
A. So everything that happened to me came at a later date. I do think now, with the benefit of hindsight at that point, yes, I think there were reasons why people left me out. 10:22
69 Q. I'm going to put the question to you again and hopefully as clearly as I can. You keep alluding to discovering later on that you had been left out of things, okay, and no doubt you've valid reasons for saying that. 10:22
A. Mhm-mhm.
70 Q. But in terms of the steps that you took in September 2016, which were scrutinising now --
A. Yes.
71 Q. -- is there anything you wish to tell the Panel that you discovered subsequently which would have affected how you approached matters -- 10:22
A. Yes.
72 Q. -- in September 2016?
A. Yes. The fact that Heather and Dr. Wright and Simon Gibson, and it seemed the world except me, Charlie, Colin and Ronan, they were talking about this ad nauseam. They had also put systems in place before I joined and I didn't know about those either. So had I known about all of that, the fact that he had done this before, look at the SAI on 2nd September, had I had all of the information, I am fairly sure that I would have not put my neck out and asked to try and get this fixed quickly; I would have let the Oversight Committee deal 10:22 10:23

with it but ask Colin and Charlie to come in. So yes, absolutely.

73 Q. Okay. On 16th September you write to Mrs. Toal by email. Just if I can bring that up on the screen, please, TRU-263683. The top of the page you're telling Vivienne told that you spoke with Richard Wright that morning, he is happy with the direction of travel, and you will be asking the AMD, Mr. McAllister -- 10:23

A. Yes.

74 Q. And the CD, Mr. Weir, to record their plans and actions? 10:24

A. Mhm-mhm.

75 Q. You explain "Mr. O'Brien isn't back on-call for 6 weeks. However, work will begin immediately to address the backlog." 10:24

What backlog is that you are referring to?

A. Just everything he hadn't done, the triages, the dictations. Well, triage and dictations, really the main two. 10:24

76 Q. Yes.

A. There was Outpatients as well, but the conversation I had with Charlie was I wanted those two dealt with first as urgency.

77 Q. Can I work through this email with you? 10:24

A. Yes.

78 Q. Is it fair to say that when you say Richard is happy with the direction of travel, what you are referring to there is Dr. Wright indicating to you that he would

require a written plan, a written indication of what you and Mr. McAllister have in mind?

A. Yes. That's what he said.

79 Q. Yes. He wasn't happy with the final plan; you couldn't say that because there was no final plan in place? 10:25

A. No.

80 Q. He was happy that you would explore this; is that a better way of putting it?

A. Yeah. Well, he wasn't happy with me at all because he said "Typical Esther", which I wasn't sure what he 10:25 meant because I don't remember ever a situation. This is another thing, you know. There was a great big band -- I am going to be metaphorical talking here. There was a great big bandwagon going around the Southern Trust, Mr. Wolfe; big, massive. The title of it was 10:26 Let's Blame Esther and Get Rid of Her. Lots and lots of people jumped on that bandwagon; it was big enough for everybody. The talk down in headquarters was all around me, it was great to have somebody to blame. It was because, I believe, they all thought that I was 10:26 Mrs. Brownlee's eyes and ears; that's the bottom line. Nothing could have been further from the truth. I don't know where they got it; it must have been from her because it wasn't from me. Simon Gibson himself said in his -- that was actually what made the penny 10:26 drop for me. He said "Sure, Mrs. Brownlee appointed her herself". So, he said it.

81 Q. Okay.

A. There was an awful lot of I was undermined really at

every point. But he did have the conversation with me, he did say -- Richard did say, look, you know -- and Francis Rice was also involved, by the way, the Chief Executive.

82 Q. Yes, we'll come to that. 10:27

A. He says you are the operational director and, as such, we'll have to listen to you or whatever. I was very sure, honestly, that Charlie McAllister would deal with it. I really was.

83 Q. Just going back to your last answer in relation to 10:27 bandwagon, I don't wish to - and no doubt the Chair and the Panel doesn't wish to restrict your evidence unduly - we are dealing with a very specific issue here and we need to ensure that the evidence that you give is relevant to the issues. 10:27

A. Well.

84 Q. We know that you left the Trust, as neutrally as possible, in unhappy circumstances. What you have just said about you being blamed for everything, is that an impression that you formed? 10:28

A. An impression I formed, and information that other people gave me as well.

85 Q. Yes.

A. Other people, some people, felt that they should tell me too. I mean it wasn't all me thinking. You know, 10:28 it was very, very plain. I was bullied to within an inch... Sorry, I am going to get through this, okay.

86 Q. Of course?

A. And then we'll take a break.

At every SMT meeting, which was -- that was the corporate SMT meetings, the Chief Executive chaired it and all the executive directors were at it. They systematically, brutally, just everything I said was turned down, mocked. They whispered behind their hands. You know, a silly thing, a really silly thing like the Trust awards, it was a good day and a light day, and all of the directors, the female directors, were up there on the stage with a wig on being the Dragon's Den, and I wasn't even asked, you know. I know that's silly but it really does... 10:28 10:29

I would have come in to meetings and heard about, you know, somebody's leaving do or whatever, and I never even heard about it. I had been in post three months, in December 2016 -- sorry, going back to the meeting, I was told in the meeting, you know, by Stephen McNally, "Don't you dare ever say anything in Trust Board that we haven't discussed here", which made me panic. 10:29 10:29

87 Q. Again, Mrs. Gishkori, you're saying things which I have a sense are maybe not germane to the issues within the terms of reference. I'm content that you --

A. I think they are.

88 Q. I'm content that you broadly reflect your sense of concern that you were treated, but if you wish to descend in specific allegations about named individuals, I am probably going to have to stop you, subject to the Chair? 10:30

A. Okay, I'll not name anybody then. But, you know, when I had my interview for that job, I went -- when I had my interview for the job, I was told that I split the Panel and that my period of, what do you call it, would be a year instead of six months. You know, I would be monitored, whatever. I said right, well, okay, and how are you going to monitor me. They didn't know so they give me a list of things. But given Simon's comment in your papers that she employed me herself, I'm assuming that whenever she worked with me in prison health care, the Chair saw how I worked; probably thought it was a good idea to get me in; maybe everybody else disagreed and she was the only one, I don't know. But because she was so -- everybody says she was very friendly with Mr. O'Brien, in my mind I'm thinking, well, maybe think I am in on that too. That's the relevance of this. 10:31 10:31 10:31

89 Q. Yes. To summarise, you were recruited by a Panel that included Mrs. Brownlee?

A. She was the Chair.

90 Q. You had a history of working with her in Prison Service? 10:31

A. Not even with her. She worked for the prisons and I worked for the Trust.

91 Q. There was a perception, and you think an incorrect perception, that you were her favourite? 10:32

A. I don't even know a favourite. That I was giving her information.

92 Q. And you think that wrong, that's wrong?

A. Absolutely wrong.

93 Q. And you think that other people viewed you negatively as a result of that?

A. Yes.

94 Q. Okay. You are right to point out - and I don't think we need go there or bring it up on the screen - but because of this backward and forward, we know that Dr. Wright tells Simon Gibson "Classic Esther", and in his evidence he explains that he was frustrated; there had been a number of occasions when decisions were changed after discussion with you. 10:32

In fairness, I'll invite you to comment on that. Do you recognise that criticism?

A. No, I don't and I would like to know. I would love for him to give an example because I don't recognise it. I mean, we were all professionals and we didn't always agree. So, you know, my comments would have been me turning the thing round. I was always seen as kind of a thorn in the flesh. It was commonly known, you know, all over the place. 10:33

95 Q. Notwithstanding that you had taken this matter in a different direction --

A. Yes.

96 Q. -- after 13th September, and notwithstanding the evidence that you've just given about not being supported, perhaps not being respected by other people, you went to a meeting with the Acting Chief Executive along with Dr. Wright?

A. Yes.

97 Q. Amongst the other issues you had to speak about with Mr. Rice that morning, the issue of how Mr. O'Brien should be managed was the subject of discussion?

A. Yes.

98 Q. If we could bring up -- you have a note of that meeting; it doesn't refer to this issue itself. Just bring it up just so that you can see it. TRU-164696. It was 16th September and we don't get a sense of any particular discussion - just scrolling down - any particular discussion about Mr. O'Brien; is that fair? 10:34

A. Yeah, that's fair. That note was sort of just laying out the boundaries between Richard and I, which were very difficult, there was a lot of cross-over, but that he would deal with all the professional things and me with the operational. And we would try -- Laura was his secretary, so it was my secretary and his trying to bring us together at least fortnightly. 10:35

99 Q. Then could I draw your attention to what Dr. Wright says about that meeting. If we go to TRU-263685. At the top of the page he is telling Vivienne Toal: 10:35

"At a meeting scheduled with Francis and Esther this morning and this topic came up. Esther agreed in principle to provide the information requested and to ensure there was a documented meeting with", that should say Mr. O'Brien, "outlining the implications of not getting this sorted within three months. Francis was keen to pursue this under those circumstances but not to let it run further than the three months if 10:35

non-compliant."

It was a condition, was it, that this had to be sorted out within three months?

A. Yes. And that's what Charlie asked for, three months. 10:36

100 Q. Later that day then, Mr. Weir drafts a plan and sends it to Dr. McAllister. We can see that at TRU-257641. That's his outline?

A. Mhm-mhm.

101 Q. If we go to TRU-257640, we can see, just at the bottom of the page, Mr. McAllister welcomes this as "absolutely excellent". You're copied into this email obviously. Then at the top of the page, Ronan Carroll embroiders into the plan, copying you in again, some additional elements which he has explained to the Inquiry were designed to ensure active monitoring and timely monitoring of the various steps. 10:37 10:37

Now, I don't see in any of the correspondence that we've looked at any input from you in relation to this plan. Was it something that you yourself considered and commented upon? 10:38

A. No. Well, of course I considered it and looked at it. To be honest with you, I thought it was fair enough as a starter for 10, if you like. The theatre bit wasn't in it, and I noticed that, you know, leaving him out of theatre if he didn't get his triage done. That was Charlie's initial thought of how he would sort it. But whenever I spoke to Charlie later, he said, yeah, but I 10:38

think they were actually hoping to get him to sort the thing out before that it would ever come to that. I think I'm in absolutely no doubt about the fact that probably the discussions that started to have with Mr. O'Brien maybe mentioned that, because I did say to Charlie, this is really serious, this could go to informal if we don't sort this out fairly quickly. I told him what the Oversight meeting had said. I was, to tell you the truth, maybe naively now, I was quite happy with it. 10:39

102 Q. Perhaps I misheard you there; did you suggest there had been discussions with Mr. O'Brien in relation to this?

A. No, no. What I think is that some way or other, Mr. O'Brien had got to know that this was happening.

103 Q. Right? 10:39

A. You know, because he went off sick. Let's face it.

104 Q. Well...

A. Okay, that's an assumption.

105 Q. Yes. Indeed, Mr. O'Brien, as we see from the papers, had, on his account, been holding off for a long time -- 10:40

A. That's right, from being ill.

106 Q. -- from seeking surgical intervention. So I don't think there is anything to suggest that Mr. O'Brien's decision to go off in mid November was anything other than for genuine, and perhaps quite grave, medical reasons. 10:40

A. Yes. I understand from reading it. I didn't know this myself at all. I didn't know he was ill, I didn't know

he was waiting for surgery at all. I just think the timing was, in my opinion, a little bit strange, you know, because he had been holding off and holding off. I understand he was a man that really just kept on working and working and kept doing things and didn't want to get off the wheel you, if you like, at all.

107 Q. Can I suggest to you, in all fairness to Mr. O'Brien, that it is an unfair assumption, or put it this way, a baseless assumption to seek to put it across that his going on sick leave was in any way connected to any form of plan to challenge his work, whatever you may think?

A. Okay, I accept that. I accept that.

108 Q. What do you view as the key distinctions between the plan outlined here and what the Oversight group had in mind?

A. The only difference was that it was going to happen colleague to colleague. I had hoped it would happen very quickly, even though they asked for three months, and I had also hoped that it would be accepted by Mr. O'Brien more than an Oversight Committee, you know, influencing and calling the shots, as it were. That's really the only difference, because Mr. Weir said that he had to implement a clear plan to clear triage backlog. The triage was the one thing that I felt had the most -- had the highest risk attached.

109 Q. We know that the Oversight group had placed at the heart of their approach what was described as an informal MHPS investigation. That was the language

that you, as a member of that committee and the committee in general, used to describe what was to happen, with a potential for a formal MHPS investigation?

A. Yes. 10:42

110 Q. Is that perhaps more readily appreciated as the key distinction between the plans?

A. Absolutely, yes. It was MHPS. You know, it was MHPS. It wasn't anything like an IR1. They called him Datix, I'll have to start using the right language. Yes, it 10:43 was MHPS investigation no matter what it was. I know, yeah. So I think that is the main difference. This was being dealt with. If I had been Mr. O'Brien, I would have grabbed at this with two hands because this was trying to sort it out before anybody else became 10:43 involved, and NCAS and all the rest of it; just get it done. I really believed that was the best solution.

111 Q. In that sense, and I know you've spoken about the primary factor here being triage and looking after or protecting patients, but in a sense was what you were 10:43 proposing through this plan a softer landing for Mr. O'Brien as compared to the spectre of an MHPS process?

A. Yes. Well, if you want to put it softer landing, yes, well, then that's fair enough. That's why one of the 10:44 reasons was I thought he would grab it. You know, I really did believe he would have thought this is a good idea because it's my line managers -- and you'll see on further where Colin asks him can we arrange to do your

job planning. I know from Charlie that that was one of the avenues they would explore because everybody gets a job plan. Yes. But also, I mean, a softer landing for him; also, you know, not a big drawn out -- and for patients. Again, I mean they came first and I just wanted to get that triage sorted just as soon as possible. 10:44

You know, whenever you mention sending people letters, and MHPS and taking advice from NCAS and all of that, it does prolong the thing. As we see later on, it did get a bit prolonged. I wanted the doctor who saw the patients to do the dictations, that's it. 10:45

112 Q. As well as the softer landing, just to summarise you're explaining you thought this might be no less effective or no less efficacious compared to what Oversight were proposing? 10:45

A. Yes. Plus also then it would be more acceptable to him so the situation would be sorted out, I just felt.

113 Q. Let's leave this outline of 22nd September. Can I ask you to comment on something Martina Corrigan has told the Inquiry. It's at WIT-26224. If we go to paragraph 30.13 at the bottom of the page, please. She says: 10:45

"I have an awareness of at least two occasions where managers had been asked to step back from managing Mr. O'Brien." 10:46

If we scroll down. The first manager she is referring

to is Mr. Mackle, and I don't propose to deal with that with you.

A. No.

114 Q. She then says, half way down this next paragraph:

10:46

"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 investigation into Mr. O'Brien's practice. Once again I did not witness this but I was told later by 10:47
Mr. Carroll that it happened as my understanding is that Mrs. Gishkori had told some of her staff."

We have heard from Mr. Carroll. I needn't bring it up on the screen but the reference is TRA-04486 to 89. He 10:47
recalls that you told him; he thinks it was you that told him about this telephone call; you were annoyed by it?

A. Yep.

115 Q. And he thought that it had happened, the telephone call 10:47
had happened, around September 2016. We're going to look at the fine detail of this but can I ask you a number of preliminary questions. First of all, did you receive at any point in time a telephone call from Mrs. Roberta Brownlee, the then Chair of the Southern 10:48
Trust, in connection with Mr. O'Brien?

A. Yes, I did.

116 Q. Do you think that that telephone call could have occurred in September 2016?

A. No, I don't, to be honest with you. I think it was much later on because if it had occurred in September 2016, I would have been at the point of trying to get it all sorted out, you know, myself. Although, yeah -- leave him alone. I'm really sorry that I can't remember this and I have tried very hard but I think it was later on into 2017 somewhere. 10:49

117 Q. Okay. I ask you about whether it was September '16 quite obviously --

A. Yes. 10:49

118 Q. -- because you approached the Mr. O'Brien problem, if I can put it like that --

A. Yes.

119 Q. -- in September 2016 --

A. I know. 10:49

120 Q. By taking a softer landing approach, as you have just accepted?

A. Yes. Yes.

121 Q. Was that in any shape or form influenced by any intervention by Mrs. Brownlee? 10:49

A. Not at all. Not at all 100%. In fact, I remember the phone call and I can remember thinking to myself you know, all of those SAIs. Whenever this phone call took place, there had been SAIs and all this had started to open up. I know that much. 10:50

122 Q. Okay. Apart from Mr. Carroll's evidence that, to his memory, it might have been September 2016 --

A. Yes.

123 Q. -- can I ask you about a note that you had written in

what appears September '16, and ask for your comments on that.

A. Okay.

124 Q. It's TRU-164691. We can see this is one of your red books, of which there are many. This one relates to the period June '16 to October '16? 10:50

A. Yeah.

125 Q. If we go then to TRU-164694. This entry rests some several pages in the book before a dated entry of 13th September. Plainly, there is no date on this page. 10:51

A. No.

126 Q. Looking at the content of this page, we see the name "Roberta" with a double question mark, and we see above it at the top of the page the word, "inappropriate". 10:51

A. Mhm-mhm.

127 Q. We also see reference to Tracey. That's Dr. Tracey Boyce; isn't that right?

A. It is.

128 Q. I will outline to you in a moment what Dr. Tracey Boyce says about what she witnessed in terms of a telephone call that you received from Roberta Brownlee. But in terms of this note, which appears to have been written at some point in September 2016 -- 10:52

A. Yes. 10:52

129 Q. -- can you help the Inquiry understand what this relates to?

A. So, what this relates to, I remember this quite well. I was having a chat to Tracey about governance in

general, and also there had been audits done or whatever in relation to omitted and delayed medications and the percentage of that was quite high. The two things I was talking to Tracey about were omitted and delayed medications on the wards, what could we do about it, what sort of an audit we were going to do et cetera, and she was telling me all about that. Then I was saying to her about, as a Trust, our response to complaints; people writing in for any reason, because I always read, not so much -- I always read our response because I had to sign it on behalf of the Chief Executive. Most of the time I read the response and, for me, I thought, you know, the language was very defensive; the language was sort of trying to make the patient feel as though they shouldn't have written in, make the patient feel unworthy and they shouldn't have bothered us really with a complaint. I very, very often, very often changed them or sent it back to get it rewritten. So, that was the inappropriate bit and that was defensive language bit. Now, Roberta -- 10:52 10:53 10:53 10:53

130 Q. Just if I can help work through this then. Where it refers to the defensive language --

A. Yes.

131 Q. -- is that word "percentage"?

A. I wanted to find how many of those I sent back with the comment on it "this is defensive language, please" whatever, because I felt it was a lot, you know. 10:54

132 Q. Yes.

A. But I didn't count them myself.

133 Q. So, that's the patient complaint issue?
A. It is.
134 Q. Above that, you refer to omitted delay?
A. Yes.
135 Q. We see those words written down. Is that part of the pharmacy audit on the wards? 10:54
A. It was. That was the medicines management issue.
136 Q. Where does "inappropriate" come in? Does that relate to the language of complaints?
A. Sorry, yes, it does. The "inappropriate" relates to the language, some inappropriate language I felt we were using in complaints. I was saying to Tracey, is there any -- because I just felt the culture was defensive all the time; is there any way we can get a wee bit of training done for people who respond to these, and maybe just have a thought. I just felt that most of our responses, not all of them but a lot of them were inappropriate. 10:54 10:55
137 Q. We'll ask you about one example in a moment. Just getting through this page, the name "Roberta" with a double question mark, have you any sense of why that's recorded there? 10:55
A. Yeah. I think because Roberta had a habit of phoning me directly. So, whenever an MLA or somebody important in the community or somebody she knew had a complaint, they would have phoned her and, you know, instead of her referring them to the proper complaints procedure, she would have phoned me directly and said, right, could you investigate this, please. Well, first of 10:55

all, I didn't have all the information. Secondly, I didn't feel as though anybody's complaint should have trumped anybody else's complaint. Thirdly, it wasn't part of the system. So if anything went wrong, the person -- you know, everything responded. So, in other words, she didn't follow the system often.

If somebody complained to her, she wanted me to go and find out what it was, come back and tell her, and she would either -- I don't know what she did, whether she wrote back to them or phoned them. But I was saying I wonder is there any way we could, you know, get the Chair to start conforming with the processes. I remember having that conversation with Tracey. I'm just wondering does she remember that. 10:56

138 Q. Let's go to what Tracey Boyce does remember. We will start with her witness statement and ask you to comment on that. It is WIT-87673. At 44.1 she refers to inadvertently witnessing a conversation, a telephone call. It may be evidence, she says, of some level of pressure placed on one of the Acute Services directors. Of course, that was you, as she goes on to explain. She says she cannot remember the date of the meeting and didn't make a note of the incident at the time. However, she knows that it must have been after the concern in relation to Mr. O'Brien's triage practice was identified, as she understood the context of the call without it having to be explained. 10:57

She goes on in her evidence to the Inquiry, when she came to this room, and she says the timing of the call, she thinks, was probably into 2017 because she was, by that stage, aware that an investigated been launched.

10:58

Is that something you concur with?

A. Yes, I agree with that. I would concur with that. Isn't it funny because I can remember the room and I can remember all -- my office had windows the whole way around and the curtains were closed and the windows were open, so I'm thinking it must have been spring, coming into summer because it was warm. You know, just the way in your mind you remember the environment? But I think she's right, it was in 2017. That makes more sense to me.

10:58

139 Q. Yes. Just scrolling down. 44.3, she recalls it was a one-to-one meeting with you in the Craigavon Hospital administration floor?

A. Yeah.

140 Q. She's updating you on her pharmacy responsibilities?

10:58

A. Yes.

141 Q. You say the meeting was broader than that?

A. We did mention complaints as well, to tell you the truth. Oh, yes we did. No, the previous one, the note that you have just put up.

10:59

142 Q. Sorry, I'm confusing the matter. The meeting that she is remembering --

A. Yes.

143 Q. -- in she thinks 2017 concerned her pharmacy service?

A. That's right.
144 Q. The difficulty is we don't have a note of that meeting.
A. No.
145 Q. You didn't record anything in association with Mrs. Gishkori's call, the one we are now talking about? 10:59
A. Yep. Mrs. Brownlee's call, yes.
146 Q. Sorry, Mrs. Brownlee's call, of course.

She recounts that the telephone rang and you answered it. Mrs. Boyce, Dr. Boyce, realised that you were 10:59 speaking to Mrs. Brownlee, and she indicated that she would leave the room but you told her to stay.
A. Yeah.
147 Q. She couldn't hear what Mrs. Brownlee was saying to you. However, she recalls that you did not say very much in 11:00 response to Mrs. Brownlee during the call but that you became very flustered.
A. Mhm-mhm.
148 Q. Does that --
A. I was very angry; extremely so. It made me -- the 11:00 phone call made me very angry, or what I took out of it.
149 Q. Okay. Let me just finish what Dr. Boyce has said.
A. Yes, please do.
150 Q. And then you can explain to us why it left you feeling 11:00 angry.

"When the call ended, Mrs. Gishkori told me 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 the life of one of her friends."

In her evidence to the Inquiry, she explained that she put speech marks around it, the words "leave Mr. O'Brien alone" because she is very confident that that is exactly how you described what Mrs. Brownlee had said to you. The rest of it she accepts is paraphrasing of the nature of what you explained to her. 11:01

Do you recall explaining to Dr. Boyce that Mrs. Brownlee had asked you to leave Mr. O'Brien alone?

A. I might have said to her, you know, she wants me to leave him alone. I know what the conversation entailed. You know, I was as angry as anything and as would be -- Tracey Boyce is the soul of discretion. I'll tell you that now. I put the phone down and said "Tracey, you'll never believe the phone call I've just had". 11:01 11:02

151 Q. Let's then just have your account of the phone call. Mrs. Brownlee phoned you?

A. Yes.

152 Q. Is that right?

A. Yes. 11:02

153 Q. And it wasn't a call you had solicited?

A. Oh, no.

154 Q. What did the call involve?

A. So she came through my secretary, Emma. She phoned

into the office. Emma phoned in and said can you take a call from the Chair. I excused -- to be honest with you, I don't normally like conversations in meetings and I always tell Emma, but I suppose she checked. Because it was the Chair, Emma checked with me, look, would you like to speak to her, given her importance and all that from her position, I suppose. So I took the call. She said to me, "What's all this going on with Mr. O'Brien"? And I didn't speak, just listened. She said "You know, Esther, that man saved my life once". It wasn't a friend, it was her; she said Mr. O'Brien saved her life. This is how I know it was later on because I just was so angry. I said, well, he may have saved your life but he has potentially harmed a few others so you may let the GMC deal with it. Period. That was it. I just ended the call. Very angry indeed. 11:02 11:03 11:03

155 Q. So it was a short call; is that fair?

A. Yes. And I never spoke to her or her to me again about it, ever. 11:03

156 Q. You've explained that in terms of what Mrs. Brownlee said to you, it was "What is all of this going on" --

A. With Mr. O'Brien.

157 Q. -- with Mr. O'Brien?

A. Mhm-mhm. 11:04

158 Q. Whereas in terms of how you explained it to Tracey Boyce, it has become "Leave Mr. O'Brien alone."

A. Leave him alone. Well, that's how I interpreted it, and I probably didn't completely just say word for word

what was on the phone, you know. It was just my interpretation but I would need --

159 Q. Let's take this in stages. Why did you interpret Mrs. Brownlee's words as suggestive of "leave Mr. O'Brien alone"? 11:04

A. Because she was -- because I felt I believed she was saying to me because he saved her life, that was enough. You know, he saved her life, we should save him, despite the fact that there was others. It appeared to me she was telling me leave him alone 11:05 because he saved my life. That's what I felt. She was very quiet in the phone call and extremely... just very quiet as she said the thing, you know.

160 Q. Yes.

A. But, you know, Mrs. Brownlee did this before with 11:05 other... I mean, that's why I thought here she goes again type of thing, because she did it as well with cardiology, you know. She did it with one of the gynaecologists who asked her could he have an extra theatre list. He met her in a country lane in a jeep 11:05 or something, she said. She thought that all she had do was say and I would do the thing, which is really not how my job worked, you know. But she did do it a lot.

161 Q. So you received other calls from her that you felt were 11:05 inappropriate about operational matters; is that what you're saying?

A. Yes. Yes.

162 Q. Going back to this one. You explained to the Panel

that you responded to her by saying, well, we'll just let the GMC deal with it?

A. GMC deal with it.

163 Q. The Inquiry is aware that Mr. O'Brien was referred by the Trust to the GMC in early 2019? 11:06

A. Yes.

164 Q. Albeit during 2017, the Employer Liaison Officer of the GMC, Mrs. Donnelly, was appraised of some of these issues?

A. Yes. Yes. Yes. 11:06

165 Q. Why at that point did you respond by using reference to the GMC?

A. I said it because I was basically saying to her this man has professionally slipped up, so do you know what, just let the GMC deal with it. It wasn't really -- it 11:06 was said a bit tongue-in-cheek, I suppose a wee bit. But I told her just let the GMC deal with it, don't you bother even trying type of thing. I would have said to a nurse "Do you want to stand in front of the NMC". That was the type of way I spoke; especially I was so 11:07 angry, honestly, with her.

166 Q. Yes. Then after the conversation with Mrs. Brownlee ended, you accept that you did explain to Tracey Boyce how you felt?

A. I did. I noticed from her she said I was flustered 11:07 because I went red. I also go very red when I am angry because I'm a red head.

167 Q. Why were you angry?

A. I was angry because I believed she was saying to me

that it doesn't matter all about these other people, as long as he saved my life, leave him alone. That's why I was angry.

168 Q. Do you recall subsequently telling other members of your staff, perhaps Mr. Carroll, about it? 11:08

A. Because Ronan was involved then in the whole thing with Charlie, Colin et cetera, I probably did say to him. But, you know, Chinese whispers are Chinese whispers, and then there's the speed of Chinese whispers in the Southern Trust. Probably I don't 11:08 imagine Tracey would have told, so I probably did tell Ronan.

169 Q. Could I then just put up on the screen what Mrs. Brownlee has said. If we go to WIT-80894. Sorry, I called it out wrongly, it is WIT-90894. If we just 11:08 scroll down, please. She, that is Mrs. Brownlee, has been asked to respond to the evidence that the Panel, the Inquiry, had received from Mrs. Corrigan. This is Mrs. Brownlee's comments.

11:09

"This account from Martina Corrigan is third-hand. Martina states that she heard from some unnamed member of Esther Gishkori's team that I had asked Esther to halt an investigation into Mr. O'Brien. I would never interfere in due process in this way. Patient safety 11:09 was always my top priority, and I have absolutely no doubt that Esther will confirm that this never happened. I never made any phone call to Esther Gishkori about Mr. O'Brien."

In blunt terms, Mrs. Gishkori, Mrs. Brownlee is saying that on no occasion did she ever make a call to you about Mr. O'Brien; you are wrong, she is saying, in the evidence that you have just given?

A. Well, I had a witness. There was a witness in my office at the time; she heard it. I mean, I'm not dreaming here, you know. I'm really not. 11:10

170 Q. Just to be clear, that intervention that you have described from Mrs. Brownlee --

A. Yes. 11:10

171 Q. -- did it affect your behaviour towards Mr. O'Brien, or any process --

A. Not at all.

172 Q. -- as a result?

A. Not at all, not in the slightest, I am not that shallow. I might be many things but I am not that shallow. Do you know what it made me do, it made me more determined to get the thing sorted out very quickly. So, I don't know. I mean, Mr. O'Brien was at her birthday party and everything else. I don't know. 11:10 11:11

No. The answer to your question is no, it never influenced me at all. I was used to her phone calls, to tell you the truth, about everything.

173 Q. Yes. 11:11

A. So.

174 Q. Okay. It's 11:10, we have been going for an hour and 40 minutes. Can we take a break?

CHAIR: We'll come back at 11:30, Mrs. Gishkori.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: Mr. Wolfe.

175 Q. MR. WOLFE: Welcome back, Mrs. Gishkori. Just shortly before the break, I drew your attention to the note which we believe was probably written in September 2016, judged by its position in your red book. 11:31

A. Yes.

176 Q. When, with Tracey Boyce, you discussed your concerns about how patients, patients' complaints were being dealt with. You described in your evidence that the language in response to complaints was sometimes defensive; might have made patients feel as though they shouldn't have written in; that they were in some sense unworthy. Those were the sentiments you expressed in your evidence just now. 11:31 11:32

A. Yes. Yes.

177 Q. If I'm right, that note was around about September 2016. I want to invite your comments in relation to Patient 84. Patient 84 came to the Inquiry and gave evidence about how he felt he had been treated, both on the clinical side -- 11:32

A. Yes.

178 Q. And he protested and complained about the delay he had suffered in association with the removal of a stent. He suffered some significant degree of ill-health, infection and what have you because the stent was not taken out in as timely a fashion as he thought it ought 11:32

to. That was his concern. But he also explained to the Inquiry that he felt his complaint, which he had written in to the Trust, wasn't well handled. Let me just draw your attention to that. As I say, we'll refer to him as Patient 84. 11:33

A. Okay.

179 Q. Is it a name you are familiar with?

A. I vaguely remember this for one reason, because whenever I read the beginning, I normally, to tell you the truth, I always read the response because I really 11:33 wouldn't have had time to thoroughly read the two. Sometimes I did. I thought to myself oh no, is this Mr. O'Brien phoning people to come into hospital inappropriately; is he doing that now; is he just phoning people up to come in and there is no place for 11:33 them. But when I read it and when I checked it out, this was considered -- the gentlemen's admission was considered an emergency. He would have used the emergency theatre so that didn't put anybody else out or push anybody else off. The only thing was people 11:34 felt that he could have admitted the gentleman in the morning instead of coming the night before. Also, he should have really phoned the ward, you know, instead of e-mailing them.

180 Q. So, in preparation for today -- 11:34

A. Yes.

181 Q. -- when you saw the complaint letter and complaint response --

A. Yes.

182 Q. -- it had a familiarity to you?
A. Yes.
183 Q. If we look at the patient's complaint letter, if we bring it up at PAT-00225. If we just scroll down, he says he is making an official complaint about neglect towards himself, "resulting in total dissatisfaction on how I have been treated over the past few months". He sets out confusion or miscommunication in terms of the timing of his admission. He came to the hospital on Easter Sunday and really nobody had heard of him was his account? 11:34 11:35
A. Yep.
184 Q. Then he has his surgery. As he explains, scrolling down, he was informed that the stent should be removed in six weeks' time, and he felt that this was fine and it would time well with his planned holiday. Then scrolling down, he sets out his experiences in the presence of the stent. Over the page; he tried to make contact with Mr. O'Brien but got as far as the secretary. He sets that out. He had made several contacts with the secretary. Then scrolling down, he found that on holiday the pain was unbearable. He phoned the secretary again on his return from holiday and was told to contact his GP, which he did. Scrolling down, he said that he was made to feel like a nuisance making contact with the secretary. He then explains that after medication through antibiotics, he was admitted. Over the page, he was under the care of Mr. O'Donoghue. Scrolling down, he had to be 11:35 11:36 11:36

readmitted to hospital and eventually treated. Just scrolling down to the end if there are any other points to pick up on. That, in essence, is a synopsis of what he was saying.

11:37

You were the person who responded to the complaint, and we can see your response at PAT-000231.

So are responding on 1st December. It might be noted that you're responding roughly three months after you discussed with Tracey Boyce what you viewed as the problem around defensive responses to complaints? 11:38

A. Yes. Yes. Yes.

185 Q. It's in this context primarily that I want to ask you some questions.

A. Surely. 11:38

186 Q. Maybe just before we look at the letter itself, what would have been the method or the process that was followed within the Trust when a complaint came in, and at what point do you become involved?

A. I became involved at the very end when it was ready to send, and it came to me for signature only. What happened was the complaint comes into the Trust, goes to the Complaints Department; the admin people in Complaints then allocate it to where -- this would have been allocated to Ronan's team in Surgery. Somebody in that team takes it on, goes and speaks to the consultant involved, looks through the notes and formulates a response. Then, whenever they have formulated all of that, it would come to me for 11:38 11:38

signature and I would sign it or not, depending.

187 Q. We know in this case - I don't need to bring you to it - that Mr. O'Brien prepared a written response to it. So that would be a not unexpected part of the process, would it, that somebody in your team would seek the views of the clinician -- 11:39

A. Yes.

188 Q. -- and ask for chapter and verse in terms of what happened?

A. Well, sometimes, or else they went to see them and, you know, they had a conversation and it was written down. It was like a flow chart, what they did. Mr. O'Brien did write on a lot of occasions in response to complaints and incidents, et cetera. It is just how he worked. 11:39

189 Q. I think you have told us in your witness statement that you read and signed off every complaint?

A. I read the response and sign it off, yes. Not always the whole complaint, unfortunately. The file does come -- I mean, the file comes with a complaint on the top and there could be a pile of maybe 10 or 15 every day to sign off. I would have trusted those who were replying to put down whatever was true. I would read it just to make sure it was grammatically correct and to make sure that we weren't really, as I said, being defensive for the patient. So, yeah. 11:40 11:40

190 Q. Dealing with your response to this one. Mr. O'Brien's position is outlined there. He sets out in familiar detail the steps that he took. Just scrolling down,

please. Just on over to the next page, I think. Just there, please. Part of the account that the patient was giving was at the time of his request to have the stent removed, Mr. O'Brien had 232 patients awaiting inpatient admission, of which 136 of them were categorised as urgent. 11:41

"Mr. O'Brien apologises that you" that is the patient, "had to contact him on a number of occasions but with his clinical commitments and the number of patient inquiries that he receives daily, it is not possible for him to do so." 11:42

If you scroll on down. I think that's how it ends. If we can go to the patient's response. Maybe just scroll down to the end. Yes, that's signed off by you. The patient responds to this letter. If we go to PAT-000234. He appreciates the apology. He says at third paragraph: 11:42

"I fully appreciate the demand is unrelenting on the Urology Service with an increased number of patients with suspected and confirmed cancer diagnoses requiring progression along their cancer pathway and the result of cancer urgent demand is that the waiting times for other procedures such as yours are increasing on a monthly basis." 11:43

I tried to see that in your letter but I must have

missed it. That's a quote or a lift from your letter.

A. Okay.

191 Q. He says:

"However, to me this is all the more reason to deal with my issue so that the Urology Service can concentrate their time and efforts to these cancer patients." 11:43

11:43

He goes on. He says in the next paragraph:

"I should not be made to feel guilty because of the more urgent cancer demand as I waited in excess of three and a half months more than I should have and endured the pain for the length of time, which is ample time to wait for this situation to be rectified for me." 11:44

Then, when the patient came to give evidence to this inquiry - I needn't bring it up on the screen - he echoed that point at TRA-00094, which is a transcript reference. He basically said your letter and the contents of your letter in response to his complaint by highlighting the needs of the cancer list caused him to feel guilty, or had that effect on him, whether intended or otherwise, and I'm sure you didn't intend that. But do you take his point? 11:44 11:44

A. Yes, absolutely. I take that clean on the chin. You

know, because it doesn't matter what anybody else's condition is, yours is yours. Yours is important to you and you are the person who has pain and is suffering at the moment. It doesn't matter what cancers are around you, you are you. So I take that on the chin.

I did sign the letter perhaps in a very, very busy clinic where I just scanned over it and signed it. But I do take the patient's... There is one thing that came out of this complaint for me as well, was that there is -- there was work started and work ongoing - and I think in retrospect it should have went on - to work with GPs and the hospital a bit more. For example, in gynae there was what they call the banner, where the GP -- these are all the things that you can deal with yourself and these are the things you need to refer the patient through to. For the patient to know, because there is no other way do it, when the patient is at home, the GP is their first point of reference. You know, him phoning and phoning and phoning the hospital and getting nowhere, he should have been told initially please go to your GP, he will examine you, he will assess you and then he will make the referral in whatever way, even send you to the Emergency Department if that was appropriate. But yes, I take it on the chin. I understand why he felt like that.

11:45 11:45 11:46 11:46 11:46

192 Q. You spoke earlier, when we looked at the note, that you were asking Tracey Boyce what percentage of responses

do I send back because I'm not happy with the tone or the content of it?

A. Yes. Yes. Yes -mhm.

193 Q. Is this one, when you think about it, that you ought to have amended or revised in some shape or form? 11:47

A. Yes. Yes, it is. I mean, the process was explained perfectly well, and it is true that stents stay in longer than normal, so do urinary catheters because it is urology. It is a vicious circle because if you took them out earlier, there wouldn't be -- the problem is 11:47 ongoing et cetera. But that really wasn't the patient's business, to tell you the truth. That should have been either -- I suppose whoever composed that sort of felt we need to explain here what the reason behind this is, but I don't really -- I can understand 11:47 the feeling that that patient had when he experienced that and when he relayed it to you. I apologise for that wholeheartedly.

194 Q. Thank you for that. Complaints in general, was that a significant issue for you in terms of the management of 11:48 them or was that something that was really somebody else's primary concern?

A. Well, the complaints procedure was one of the governance issues that was well enough managed. You will have heard perhaps David Cardwell and Vivienne; 11:48 those were two people who were very experienced, and they dealt with the complaints as they came in, they knew who to allocate them to. They also knew when they were reading them this is quick, we need this to sort

out very quickly. Things like that, they would have scanned it over. So I have no problem -- but then it had to go to my Assistant Director for sign off. All my assistant directors were the one person before me to sign the complaint, it came to me at the end, but I still had issues with grammar, with defensiveness. There I have signed one, the very thing I am talking about, I have signed it. Again, as I say, I apologise. 11:48

The process perhaps was okay but it was just the content really, yes. 11:49

195 Q. You've accepted the point that in the efforts to explain the context to patients in which their treatment is delayed --

A. Yes. 11:49

196 Q. -- the Trust, and here's an example, has gone too far in explaining the needs of other patients when, I suppose, the primary focus should be on the suffering of the complainant?

A. 100%. 11:49

197 Q. In terms of how -- and we see the secretary at the heart of this perhaps, she is the front door of the hospital when people are phoning in, if you understand the metaphor?

A. Complaints Department, yeah. 11:49

198 Q. Was there any training or advice given to secretaries in terms of how they would be best placed to field complaints or queries?

A. Well, I think the people that were in that department

preceded me, so they have been there quite some time, and were, to be honest with you, very experienced. I do know that Tracey, through the governance team, did deliver some training on governance in general, you know, how to write an incident report, how to do a complaint or whatever. So yes, there were -- they did have training. If I can say again about the firefighting that we all had do, this was only a very small task for me in the round that I had to do on a given day. There could have been a pile of them sitting in my in-tray and I would have looked at the clock and saw it was 5:30, "I'd better sign these". Maybe tired, maybe things on my mind about the day. I've told you before the job was too big, it wasn't doable. Sitting here in the quietness of this room and reading that, I can see what the response should have been. 11:50 11:50 11:51

199 Q. Going back to the points that you were making to Tracey Boyce, in a nutshell let's do this better, were any initiatives taken forward? 11:51

A. Yes. Tracey organised training; so did Trudy. There were people came from England from wherever they sourced the training and that training was delivered. I couldn't tell you who the people were or when it happened but it did. 11:51

200 Q. What was the focus of that training?

A. Complaint handling.

201 Q. Can I step back onto the pathway which we were on and bring you to the events around October then, October

2016.

A. Okay.

202 Q. We know that NCAS had provided advice in association with the O'Brien case but it wasn't available for the 13th September Oversight meeting? 11:52

A. Yes.

203 Q. Just bring up on the screen, please, WIT-41573. This is Mr. Gibson sending the advice round the various participants at the Oversight. I think he has left out Vivienne Toal from this, for whatever reason. He says: 11:52

"You will recall that as part of the collation of evidence in relation to the above, I sought advice from NCAS which was discussed when the Oversight Committee met. The written advice from NCAS has now come in and 11:53 is attached. Whilst the informal work is under way with Dr. O'Brien, this NCAS advice will be placed on file for reference should we need it at the end of the informal piece of work."

11:53

Clearly, his expectation was that the informal piece of work, as he has described it, which is assumedly the plan that had been developed through you by Mr. Weir, contributed to by Mr. Carroll --

A. Yes. 11:53

204 Q. -- would be pursued. Can you remember looking at the advice that came down from NCAS?

A. Yes, I can. I can remember, and I can remember reading it also and, you know, for me I can remember thinking

yeah, well, they want to keep it -- I think at that point it was as informal as possible, maybe support him, sit with him while you're sorting it out, things like that. So yes, I did read it but it escapes me now. It was very much just keep it as informal and support him while he goes and keep us informed. Sorry, I can't remember.

205 Q. Would it assist to you have a look at it?

A. Yes, it would be great.

11:54

206 Q. I think if we scroll down. I may be wrong. Allow me a moment please. If we go to AOB-01049. It's dated 13th September, the day of the Oversight Committee, but as I've said it wasn't distributed by Mr. Gibson until two weeks or so later.

11:54

11:55

One point our eye has been drawn to at the bottom of the page, which say:

"To date you are not aware of any actual patient harm from this behaviour but there are anecdotal reports of delayed referral to Oncology".

11:55

Did that catch your eye when you read it?

A. The Oncology bit certainly did, yes, but then by that stage I had seen the letter. What date was that?

11:55

207 Q. This is 13th September 2016.

A. So it was the same day as the Oversight. That came in in the afternoon; isn't that right?

208 Q. This came in in the afternoon, as I have explained.

Mr. Gibson wasn't able --

A. He sent this out.

209 Q. He didn't distribute it until 28th September?

A. Yes, but there was another very -- there was another... I'm not thinking about that one. There was another report from NCAS as well, which I can't remember. It was maybe later on by Colin Fitzpatrick or something. But this one, yeah. "No actual patient harm but the anecdotal reports of delayed referral to Oncology". 11:55

210 Q. If that did catch your eye when you read it in September or thereafter -- 11:56

A. Somewhere after.

211 Q. -- did you ask about it? Did it cause you any alarm?

A. No, because -- well, it did cause me alarm, of course it did. Between it and the triage were the two things. But, by this stage, the letter that Eamon and Heather had sent in March had become -- I knew about it then at this point. 11:56

212 Q. Yes.

A. Yeah, I think I spoke to, I am going to say Fiona Reddick because she looked after the oncological MDMs and things. I spoke to her, I think. Do you know something, Mr. Wolfe, I can't remember who it was. I do remember it. 11:56

213 Q. What I am perhaps suggesting to you is this: This is a concern that doesn't appear to be set out -- 11:57

A. Yeah.

214 Q. -- in any other document?

A. Yes. Yes.

215 Q. It reflects a conversation which Mr. Gibson --
A. Simon.
216 Q. -- had with NCAS?
A. Yes.
217 Q. If there is anecdotal reports of delayed referral to Oncology, it possibly begs the following question: What does that mean? How significant is it? What are the implications of it? I suppose what I am asking you is - and I am not asking you to speculate, and if you can't remember -- 11:57 11:58
A. Yes. No, I can't.
218 Q. -- then that's the appropriate answer - did that catch your eye and did you do anything about it?
A. It did catch my eye because of Oncology. I'm very sure I did something about it because I would never not do anything about something like that. But I cannot tell you what it is I would have done, whether it was back to Simon or to Ronan or to Fiona. I know Fiona came into it somewhere because there was nobody to represent. Anyway, I'm going on. No, I can't remember. Sorry. 11:58 11:58
219 Q. If we look over the page into the substance of the advice provided by Dr. Fitzpatrick, we can see in the second paragraph:

11:58

"We discussed possible options to you. The first option in association with removal of charts from the premises is the possibility of taking immediate disciplinary action."

You can see that?

A. Yes.

220 Q. With regard to what is described as poor note-taking, and I think this is a reference to the absence of dictation in association with some clinical encounters, it is suggesting that an audit could be useful. It is also suggesting it may be a serious matter that may merit disciplinary action and possible referral to the GMC, and a notes review by NCAS maybe appropriate. Those are a number of options in relation to that. 11:59 11:59

Then it is said:

"The problems with the review patients and the triage could be best addressed by meeting with the doctor and agreeing a way forward. We discussed the possibility of relieving him of theatres in order to allow him time to clear this backlog". 11:59

It is indicated that he would require some significant support. 12:00

Do you recall reading that then?

A. Yes, I do. Yes, I do recall reading that. Thinking, especially with the last paragraph, it was sort of what we had planned already to do. 12:00

221 Q. Did this, in a sense, reinforce for you --

A. A little bit, yes.

222 Q. -- the correctness of your path, as you saw it?
A. At least somebody else was saying sit down with him, relieve him of theatre duties - that definitely came from Charlie because he told it to me - and support him. But at the same time there was the possibility that this could get much more serious if he doesn't toe the line, as it were. That's sort of way where we were, or I believed. 12:00
223 Q. Then in the middle of October, or just before the middle of October, the Oversight Committee met again? 12:01
A. Yes.
224 Q. If we go to AOB-01079, just at the bottom of the page. You're reporting to the committee that:

"Mr. O'Brien was going for surgery which was planned for November and likely to be off for a considerable period. It was noted that Mr. O'Brien had not been told of the concerns following the previous Oversight Committee. It was also noted that a plan was in place to deal with the range of backlogs within Mr. O'Brien's practice during his absence." 12:01 12:01
A. Mhm-mhm.
225 Q. You then give an assurance that:

"When Mr. O'Brien returned from his period of sick leave that the administrative practices identified by the Oversight Committee would be formally discussed with him to ensure there was an appropriate change in behaviour. It was agreed that this would be kept under 12:02

review by the Oversight Committee."

Some questions arising out of that Mrs. Gishkori. Mr. O'Brien didn't go on sick leave until the middle of November. 12:02

A. Yes.

226 Q. You had met with Mr. Francis Rice on 16th September and he urged upon you a meeting with Mr. O'Brien to get this sorted out, and there was a three-month deadline associated with that. You had a plan finessed by 12:02 Mr. Carroll, as we saw earlier, on 22nd September?

A. Yes.

227 Q. It is now 12th October. Why had no one pressed on to draw Mr. O'Brien's attention to the concerns and to initiate the kind of action set out in, let me call it 12:03 Mr. Weir's plan?

A. So I'm not really sure of the dates here but very soon after, I spoke to Charlie McAllister. A process ensued with him where he had to stand aside, as they say it, or go off. I think that was October. Colin Weir then 12:04 didn't tell -- hadn't told Mr. O'Brien the exact concerns but he had arranged a date to meet Mr. O'Brien and he had said, you know -- and that was in at the beginning of October, I think. He had said, do you know, let's do your job plan. I was in no doubt, and I 12:04 heard that from the team, that Colin was going to speak to him then.

228 Q. We can see, just to assist you with that, TRU-281300. Scroll to the bottom of the page, please, into the next

page. Mr. O'Brien and Mr. Weir, four or five days after the Oversight, in correspondence with each other to discuss the job plan, the point you have just made?

A. Yes.

229 Q. You were saying Mr. McAllister had gone off? 12:05

A. Yes.

230 Q. Mr. Weir had intent to meet with Mr. O'Brien to discuss a job plan?

A. Yes. Then he unfortunately became sick as well, so he went off too, and then Mr. O'Brien was the third one to 12:05 go of that triangle. He went off too. Then we had to very quickly scramble up four consultants that acted up in the meantime. So, there was a big communication.

Plus also - just if you don't mind me commenting back 12:05 on the letter where he was going off sick - I certainly didn't expect that to happen, I was completely blind sided, although I think his colleagues knew he was unwell and needed surgery. But it wasn't me who suggested to him not to tell him until he came back. 12:06 That was discussed, I think, at the Oversight Committee in general with all of us because I noticed from Ronan's account that he thought it would be better to tell him before he went off; there were others who thought let him go off, deal with his sickness and his 12:06 surgery and then we'll lift it when he gets back. That was a communal decision, it wasn't just mine.

231 Q. One recognises the difficulties caused by McAllister and Weir's issues?

A. Yeah.
232 Q. Was there no discussion to the effect that this matter is sufficiently grave and urgent that, regardless of the problems caused by the absence of the AMD and CD, we need to grasp this nettle sooner rather than later as per the Chief Executive's directions -- 12:07
A. Yes.
233 Q. -- and put a substitute into their roles to advance this?
A. Yes, and there were substitutes put in. What happened, there were four of them and they rotated; their job rotated. What I do know is, I mean, plans were set in place for clerical and admin team to go looking for these missing triage -- to sort of start looking at what we were dealing with and see could we retrieve some of the charts, see could we look at some of the referrals we were talking about. I know there were other consultants who were doing it under WLI, which is Waiting List Initiatives. 12:07
234 Q. Just in light of that answer, let's just take you back to the minute of the Oversight Committee. AOB-01079. Just scroll down to the bottom and highlight the bottom please. You're explaining that some work was commenced -- 12:07
A. Yes. 12:08
235 Q. -- around trying to retrieve what?
A. Just the range of -- the first one was triages and trying to find those on the system, where they were, and then get some other Urology consultant to deal with

them, as they often did.

236 Q. I want to just pause you on that. We know, and we'll come to it in a short period of time, that in light of the report in respect of Patient 10's serious adverse incident -- 12:08

A. Yes.

237 Q. -- that in November and into December, there was focused work around other patients who had not been triaged?

A. That's right. 12:09

238 Q. Is that what you mean?

A. So, there was -- just for me to be clear with you, there was the letter of March, and that told us about the four issues of concern. Then there were SAIs that started very soon after October; November, I think one 12:09 of them was, I just don't know what the dates were. But there were a couple of SAIs that really started the ball rolling in relation to the magnitude of this problem.

239 Q. The main SAI -- just to help you along with this and 12:09 then I can ask you a question. We know that Patient 10 --

A. Yes.

240 Q. ---and you are familiar with her case?

A. I do. Just to make sure I know it, yes. 12:09

241 Q. We know that from the papers that are available to the inquiry that her Datix was raised by Mr. Haynes in January 2016?

A. That's right. Okay.

242 Q. Because she hadn't been triaged in October 2014, and the case was screened for SAI purposes?

A. Yes.

243 Q. It came into the system in March 2016 and was reported, the report being available to you, at least in preliminary form, in December? 12:10

A. '16.

244 Q. 2016?

A. Yep.

245 Q. What we are focusing on is you are suggesting to the Inquiry that notwithstanding the failure to speak to Mr. O'Brien, as is recorded in this minute -- 12:10

A. Yes.

246 Q. -- and you have explained some of the reasons around that, notwithstanding that, you are suggesting that steps were being taken nevertheless to try to get to grip with aspects of Mr. O'Brien's practice without speaking to him? 12:11

A. Without speaking to him? It was the admin, it was the backlog, it was looking for charts; all the things that you can do without actually speaking to anybody. It would have been an admin task. 12:11

247 Q. Okay. If that's correct, could you explain in some better detail who initiated that and -- just if you wait for the question. 12:11

A. Sorry.

248 Q. Who initiated that, that step of taking a look at what Mr. O'Brien had been doing and trying to remedy it in some way? Who initiated and who carried it out?

A. So, that would have been Ronan and Martina and their team of clerical. There was Wendy; there was Vicki, I think. But their clerical team would have started looking at when a referral -- you know, all the issues we were talking about in the letter. So despite the fact that Mr. O'Brien wasn't there, they were still trying to (a) stop the rot but look at referrals that might need to be looked at again by another consultant. 12:12

249 Q. So, a referral has come to Mr. O'Brien?

A. Yes. 12:12

250 Q. He hasn't triaged it?

A. Yes.

251 Q. It has gone onto the default system in accordance with the general practitioner's classification.

A. Mhm-mhm. 12:12

252 Q. Are you suggesting that you are aware of the admin team, led by either Mr. Carroll or Mrs. Corrigan, were nevertheless going to these referrals and seeing that work had been done or seeing if work had been done?

A. No, not if work had been done. The thing I understand from this, and I actually didn't know this until I read it, that the secretaries kept a list of those people. The secretaries -- the clerical would have been Mr. O'Brien's secretary and all the other clerical girls also kept a list of people that they put back onto the system. So, it would have been looking at those as well to see is this a referral that is routine or is it urgent or should it be upgraded or what, so that at least those people would be in the appropriate 12:13 12:13

box, if you like, because I understand the secretaries kept lists.

253 Q. It is the Inquiry's understanding that that work didn't commence until after the SAI reported in respect of Patient 10 after it had formed certain concerns around the triage issue. They went and looked at the other seven patients who hadn't been triaged -- 12:14

A. Oh, yes.

254 Q. -- in the same week as Patient 10. Then we had the MHPS commenced and there was a lookback then at all of the cases for which there was no triage, but that wasn't until 2017? 12:14

A. Yes. I didn't mean the Patient 10 and the subsequent seven. I wasn't thinking about those, I was thinking more about everybody knew what was -- you know, they were going looking for notes. Anita Carroll's team were searching out notes and trying to get them. Once they knew these notes were missing, then they went to look for them to see where they could get them. Am I... 12:14 12:15

255 Q. You are not making yourself clear to me.

A. Sorry.

256 Q. What you're saying is that there was a process.

A. Yes.

257 Q. Your focus is now on Anita Carroll's team going to get notes once they realise they were missing? 12:15

A. Yes. Going searching for them, where are they. Going through all the systems. Searching them out, yeah.

258 Q. So this is missing charts?

A. This is missing charts, mhm-mhm. They were all brought in again then one by one and drift by drift when Mr. O'Brien was sick. I think that's when it happened.

259 Q. Yes. What we know is that after Mr. O'Brien went off sick -- 12:15

A. Yes.

260 Q. -- he continued to work --

A. That's right.

261 Q. -- in dictation?

A. That's right, and then deliver them back, yep. 12:15

262 Q. We're speaking over the top of each other.

A. Sorry, sorry, sorry. I beg your pardon.

263 Q. When he went off sick, he didn't stop working, he dictated on cases which hadn't been dictated on before, and charts did start to come back? 12:16

A. Yep.

264 Q. But what I am at with you, Mrs. Gishkori, is your description of a process which you say was in train from at or about the time of this October Oversight Committee meeting. You are trying to suggest that 12:16 there was -- am I right in thinking you were suggesting there was a deliberate process of trying to get to grips with the problems?

A. I would have thought, to be honest - although maybe I am very naive - that once I told Charlie and Colin and 12:16 Ronan, that they would have started immediately to look at those issues.

265 Q. Did they tell you that they had?

A. No.

266 Q. Did you see any report or product suggesting that steps had been taken?

A. I didn't see any report or product. There was a spreadsheet at a time but I think you're probably -- I'm referring to the one you've said earlier when he was off sick. 12:17

267 Q. Yes.

A. So no, I didn't see a report but I know that Ronan and Martina were aware of the issues because Ronan was always in all of the meetings with Charlie and with Colin, and I did ask that they address it very quickly. But I didn't see any reports, no. 12:17

268 Q. So, your evidence, to summarise, is that although there was a plan available from 22nd September to challenge Mr. O'Brien in terms of his practice, that wasn't put into effect. The best explanation of it from your perspective is that you lost Mr. McAllister and Mr. Weir, and the replacements for them or the substitutes for them weren't directed to take that forward? 12:17 12:18

A. Yes.

269 Q. The minutes record that, if you look at the last line of the first paragraph:

"A plan is in place to deal with the range of backlogs within Mr. O'Brien's practice during his absence." 12:18

Do you know what that means?

A. That's what I was talking about. I feel as though I

knew there was a plan to address the backlogs. I mean, it's inconceivable that everyone knew that these backlogs were there and nobody did anything about it when Mr. O'Brien was off. You know, that was what the whole plan was about; me telling Charlie and Colin, the Oversight Committee, the everything.

270 Q. If we went to the screening report, one of the backlogs was in triage.

A. Mhm-mhm.

271 Q. The figures in the screening report - forget them off the top of my head - 12:19

A. 200 and something.

272 Q. They talk about, as of September 2016, 174 untriaged letters. That figure was to increase by the time of the MHPS investigation. 12:19

A. Mhm-mhm.

273 Q. In terms of those 174 letters, are we to read that record here as to suggest that it was your belief that somebody was going to interrogate those 174 untriaged cases and work out what had happened with them? 12:20

A. Put it this way, Mr. Wolfe: This is seven years ago; I can't actually remember the details but if I wrote that down on an email, I wouldn't have been writing a lie down. Now, that's the truth. I can't really remember at this point in time, unless I would go back and look 12:20 at emails and letters and, I don't know, discussions, it is a long time ago. That's the best answer I can give you. I don't know what the plan was. But I wouldn't have written it down if there hadn't been one.

274 Q. You saw no product or no response to such a plan?
A. I just can't remember. Perhaps I did and perhaps I asked. There was an awful lot of flurry around this at the time.
275 Q. In the absence of any report or product that you can point to, and I have to say the Inquiry is unsighted on that, can I suggest to you that you did not, nor did the Oversight Committee, engage in any assessment of the risk to patients in terms of what had been uncovered? 12:20 12:21
A. I don't remember doing an actual risk assessment, no, nor did the Oversight Committee, I believe. But the other side of that coin is that the risks were plain to see. There was no point making out a risk assessment when we knew this thing needed to be dealt with very quickly. A risk assessment at this point, sometimes you write a risk assessment to make sure you understand what risks are going to be, but at this point in time we knew exactly what the risks were. 12:22
276 Q. Did you? Because it wasn't until 2017, when the other clinicians in Urology sat down and began to look through the untriaged referrals, that a picture began to emerge that in excess of 20 cases, the referral into the system was wrong and triage would have led to an escalation of the referral from routine or urgent into red flag. So, it's fair to say that while you may have had the instinct that untriaged patients could be coming to harm, no work was done to assess in any individual case the extent of any harm? 12:22 12:23

A. Until the consultants, which you say is January 2017. I wasn't, to be honest with you, sure of that date but that's when they started to do the waiting list initiatives and look at the triaging. The patients were then seen by them. Yes, you would be quite correct in saying that.

277 Q. How do we explain that, because the information was in the system that Patient 10's case was the subject of an SAI, and I don't think you were aware of that until later in the year. But you would accept that even the absence of knowledge of a particular case, it would be obvious that if you don't triage routine and urgent referrals, that lurking in that pile will be patients, perhaps many patients, who have been wrongly categorised and who have more significant disease that needs diagnosed and treated. 12:23 12:24 12:24

Thinking back on things now, the failure to carry out that kind of assessment, what do you put that down to?

A. Honestly, from my point of view, it probably was you couldn't see the wood for the trees. There was just so much going on. Urology was one -- and I know this was so, so important and so serious, but there were so many other things that took up my time, that drew my attention to other things, that it was just the mania that was my job. I can only just say that. I am apologising for that. You know, it was something that was missed by me - and others, not just me - and it just wasn't good enough. But then, there should have 12:25 12:25

been two of me instead of one. In fact, there probably should have been three. Not of me, you know what I mean, three people. I think one was probably enough for the Southern Trust, but three people doing -- maybe one to do medicine, one to do surgery or whatever. The job was too big. My day was filled continuously just fighting fires and just trying to keep up with the pace. Because I suppose the clerical and admin bit of it wasn't in my mind, then it wasn't done until the consultants started to look at it in 2017. Again, I apologise for it and say I'm sorry. But I was a victim of the circumstance also. 12:26 12:26

278 Q. Yes. Dr. Boyce considered that you had a lack of governance experience?

A. Yes. 12:26

279 Q. I wonder does that in part -- and I realise that you were part of an Oversight group who also failed to take a deep dive into the implications --

A. Yes.

280 Q. -- of not triaging; didn't look at the implications of the dictation not being done; didn't look at the private patients issue in any depth. All of those issues weren't examined until the MHPS kicked off. Is that because you were lacking in governance experience and didn't think through the implications for patients, particularly in relation to triage? 12:27 12:27

A. I would have to make it very clear to you - and when I read Tracey's report, I was quite astounded - I can only compare when I joined to the last Trust I worked

in. I worked in the Governance Department i.e. it was called Safe and Effective Care. I managed audit, standards and guidelines. I also looked at complaints in a different way; standard 48 and ISO. Then I moved to prison healthcare, where I was the governance lead for two years before becoming the assistant director. I felt very, very comfortable in that Trust with the amount of governance support that was around me; I knew I needed that. But when I joined the Southern Trust, there was really none of it there. There was nothing that I could... 12:28 12:28

So Tracey thinks that I wanted to hold on to her because I was inexperienced. That is not the case at all. I wanted to hold on to her because I actually did rate her as excellent. She had a lot of experience in governance and I needed, as a starting point, an assistant director to be in charge of governance. Doesn't matter if she delegated all of her work to Trudy, that didn't matter. I just needed an assistant director to be answerable to me, the way everything else was. I did ask for a whole time equivalent assistant director, but the finances. You know, governance was the bottom of the pile, to tell you the truth, in the Southern Trust. You know, the finances just weren't there. We had to work with whatever we had. It was all about putting money into front-facing, which was important. 12:29 12:29 12:29

281 Q. Yes.

A. But then how do you ensure quality, you know?

282 Q. So, you wouldn't accept that any failure to deal with these issues --

A. No.

283 Q. -- and to take a deeper dive into the implications of them was due to lack of governance experience? 12:30

A. Absolutely not. Absolutely not. I had plenty. I was new and there could have been a wee bit of the bandwagon stuff going round, and the talk, but I had plenty of experience in governance. Plenty of it. 12:30

284 Q. Let me move forward then. On 9th November, just a month after this last Oversight Committee meeting, Tracey Boyce writes to you. If we could bring it up on the screen, please, AOB-0224. She is explaining that on the edges of a weekly update with the governance leads that day, a draft of an SAI had been shared with her. She, in the content of this email, begins to explain in summary form the Patient 10 SAI as it was unfolding. 12:30

A. Yep. 12:31

285 Q. In the last paragraph there on the page, she says, penultimate paragraph:

"Below this was an SAI about a single case. It has come to light that the other seven Urology referral letters received that week are also missing. As an initial action I've asked Trudy and Connie to try and track them via PAS to check they have been seen and pool their notes if necessary. I haven't asked the 12:31

question yet whether we know if any of the other consultants' weeks' triage letters have been lost but it is probably something we need to discuss."

She wants to bring it to your attention before it's shared with anyone else. Did you know anything about that SAI before this? 12:32

A. Not before it but the way SAIs worked normally was that I wouldn't -- only because Tracey brought this to my attention at this point. But I would have seen -- when I had my Friday morning clinical governance meeting, the complete SAIs would have been brought there. I have had them in advance and always did look over them and read them, but they would have been brought there to be passed. Tracey describes it as the Dragons' Den, it was like everybody in the room, and that was all of the AMDs, and I brought the CDs as well because they often knew. Everybody commented on them, said no, we need to change that. Then it was signed off and then that's what I knew about it. Then it was sent off to the family or wherever it needed to go. So, I wouldn't have known about SAIs until that point. 12:32 12:32 12:33

If there was something really outstanding that we needed to deal with, or if there was press involved or whatever, then she would have told me. On this case, you know it was sooner than expected; sooner than normal. 12:33

286 Q. So, after a screening decision is made in a particular

case, this is going to be an SAI --

A. Yes.

287 Q. - review?

A. Yes.

288 Q. Is that hidden from your view? 12:33

A. Oh, no it's not hidden. Anyway, well, the Datix system was terrible to look at. I would have been able to inquire. Trudy and Tracey met me every Tuesday morning. I know there was lots of them cancelled but they were on the same floor as me and I always tried to 12:34 keep just in contact with them. They met me normally on a Tuesday morning and told me -- one of the points on the agenda was to tell me about the SAIs that were current. I would have known about them, not necessarily in detail because I really wouldn't have 12:34 had the time, but we looked at them in detail in the clinical governance Friday morning meeting and that's whenever they were signed off.

289 Q. I am conscious that the September decision, the September Oversight has happened. You are not aware of 12:34 the patient I referred you to earlier, I think it was Patient 93.

A. It was Patient 84.

290 Q. You weren't aware of patient - I think it was Patient 93 I referred you to - you weren't aware of that case. 12:35 That was a case that was familiar to Mr. Haynes. It had been brought to Mr. Carroll's attention, Mr. Weir's attention, Mr. McAllister's attention but not to yours?

A. No.

291 Q. It didn't ultimately become an SAI, as we understand it although the reasons for that are nowhere explained. You are not aware of Patient 10 until November. Is that the kind of information that should have been available to the Oversight group in order, to use that word, to enable you to triangulate the implications of these shortcomings in practice? 12:35

A. It certainly would have helped the Oversight Committee, that is for sure. But there wasn't -- there wouldn't have been a system whereby automatically those would have gone to the Oversight Committee. Unless someone on the Oversight Committee asked to see them at any point, that could have been produced. They didn't go to Oversight Committees normally, you know, because Oversight Committees were about everything and anything. 12:36 12:36

292 Q. Yes, but what an Oversight Committee can presumably do, if it's trying to work out, in accordance with the MHPS process and the Trust guidelines governing doctors in difficulty or clinicians in difficulty, what the Oversight Committee can do is it can take a look at what is known and of concern about a clinician? 12:37

A. Yes.

293 Q. And that can inform the direction of travel?

A. Yes, I agree with you. 12:37

294 Q. Do you accept that?

A. Absolutely. Any of those would have been a help. Of course they would.

295 Q. When you receive this email telling you about the

implications for Patient 10 and pointing out that this isn't just about a single case, was that an eye-opening moment?

A. Absolutely. I think I phoned Richard immediately then. I think I did. 12:37

296 Q. I think that possibly comes later.

A. Okay. Sorry.

297 Q. Let me ask you, what was this telling you or, if you like, bringing to your attention in a more blunt way that hadn't come to your attention before? 12:38

A. It was starting to paint a more gruesome picture than originally had been painted, as if it wasn't enough. When you hear of these seven and you wonder oh. The poor patients, I am just thinking about just the patients that had been left for so long; the leg pain 12:38 and then it turned out to be secondary cancer. You can't even condone that; it is just awful. I am admitting that.

So yes, the picture started to come out as in here is 12:38 somebody -- again, triage comes up; here's somebody who hasn't been triaged and then came to harm.

298 Q. Yes. This is 9th November. Dr. Wright - if we bring up TRU-251826 - he is thanking you - this is now 30th November, three weeks later - thanking you for 12:39 keeping him informed of some issues that have come to light from an ongoing SAI investigation. He says that he is sure you are disappointed.

His focus, at least on the face of this email, seems to be on data-related issues, a patient data breach as he describes it. Do you understand that? Is that as a result of what is now known or drawn to your attention by Tracey Boyce, that these referrals have gone to Mr. O'Brien and haven't come back into the system because he hasn't triaged; is that the concern here?

A. Yes. I think Richard was concerned because he was the data guardian for the Trust, so any breach of data in any kind of way, he would clearly need to know. I would have to say that didn't enter my mind until he wrote it there. I was just concerned about the patient and getting them seen very quickly and making sure we did what we could as quickly as possible. So I wasn't thinking of data breach at all really. 12:39 12:40 12:40

299 Q. Plainly, Dr. Boyce had arranged for two of the members of the governance team to look --

A. To start looking, yes.

300 Q. -- at the other cases?

A. I think I might have asked her to do -- as soon as Tracey told me and Ronan, we just got the ball rolling very quickly because it was just rolling out in an unbelievable way, really. 12:40

301 Q. Yes. On 2nd December, Dr. Boyce writes to Dr. Wright following a conversation with you. If we look at that please, TRU-01342. Dr. Boyce has had a chance to speak to you that morning about the SAI. You have informed Tracey Boyce that you had received some assurances from Urology team that notes had been returned. 12:41

"However, asked me to get the Acute Governance team to go through the spreadsheet the secretaries have been keeping to make sure every patient has been triaged and that all missing notes are now accounted for." 12:42

I think this is what you were at pains to describe earlier?

A. Yes. That's it now.

302 Q. This is your instruction at this point? 12:42

A. That's right. That's right. It was a little bit premature but I remember it now.

303 Q. Again, is it fair to say that the work in relation to every other patient who had not been triaged, that that work didn't bear fruit in terms of a report to you or 12:42 any product to you until into 2017?

A. Yes, that's fair to say. It was dribbles of information. You know, I would have asked Ronan on a weekly basis, sometimes Martina. So I would have been updated but there wasn't a written weekly or monthly 12:42 report on it, no. Absolutely not, there wasn't. But there was a spreadsheet, you know, keeping notes of what had come in, what had gone out. Anita and her team were really heavily involved to try and go into PAS and find things in different ways. So, there were 12:43 a lot of people working on it trying their best. I just wanted assurances from Tracey that the governance team were also involved in it.

304 Q. Yes.

A. Yes.

305 Q. On 6th December, you wrote to Dr. Wright in terms of how this process was developing and how Mr. O'Brien would be approached upon his return to work. If we could look at TRU-251837. You are explaining, first paragraph, in relation to Mr. O'Brien's sick leave. Then you are saying: 12:43

"Patient notes are being returned as requested from Mr. O'Brien. However, Trudy Reid is not sure of all notes taken off the premises have been returned." 12:44

Can you help us with that. We know that in early January 2017, after the launch of the MHPS investigation, circa approximately 300 sets of patient notes were returned from Mr. O'Brien's home -- 12:44

A. Yes.

306 Q. -- via Mrs Corrigan to the Trust?

A. That's right.

307 Q. What do you mean here when you're saying that patient notes are being returned? 12:44

A. So they were coming in, I believe, in dribs and drabs coming in. They were all stacked up because I remember seeing them clearly, seeing them they were all stacked up in the AMD office at the bottom of my corridor. Then they were to look at those and see had those been tracked out to Mr. O'Brien; how many were tracked out to Mr. O'Brien that weren't there. From memory, I think most of them came back except a few, and they 12:45

were satisfied that those weren't lost by Mr. O'Brien. Am I jumping --

308 Q. I think you are getting that the wrong way around. What I am asking about is this email start of December, and you have expressed some satisfaction that patient notes are being returned as requested. That's distinct from what happened in January when a large quantity of notes... 12:45

A. Yes, that's right.

309 Q. So what are you expressing some satisfaction about here? Is this simply that when somebody in the team realises that a chart is needed by another clinician, a request is being made and it's being brought back? 12:45

A. Yes, but also I understand that whenever Mr. O'Brien was off, you know in his sickness, he was completing dictation and triage and things and they were coming in in dribs and drabs. Also, he knew he had to complete his dictations and he was taking the opportunity of being off to do it. 12:46

310 Q. So you were seeing some progress around that issue; is that fair? 12:46

A. Yes. Mhm-mhm.

311 Q. But what was not understood, as accepted here, is that Trudy Reid cannot be sure of all notes taken off the premises have been returned. Well, it would have been very obvious -- 12:46

A. Yes, it would.

312 Q. -- if a report had been run?

A. That there was hundreds.

313 Q. That there was hundreds. Absolutely.
A. Absolutely.
314 Q. What that perhaps suggests, help me to understand this, is that for reasons that are unknown, there was no active steps taken, even at this stage, to measure the full implications of what Mr. O'Brien had been doing, if you can't even run a report to work out -- 12:47
A. Yes.
315 Q. -- what had been returned and what hadn't been?
A. Yes. I mean, I cannot speak with any sort of -- I don't know what the clerical and admin team, what their processes were. I do know that there was major issues with them and I do know that there were charts everywhere all over the place, and I do know also that they didn't know a chart was missing until somebody went to get it and then it wasn't there. This came from Trudy Reid to me. She said there are some coming back, they are coming back in drib and drabs. Yes, you are right, there obviously wasn't any sort of a conscious effort to go knock his door and say can we take all the charts away, please. Yes. Then he was off sick you see so I don't know. It's hard. 12:47 12:48 12:48
316 Q. We then have reference to the SAI report. The SAI review continues and will no doubt produce its own recommendations. 12:48

6th December, even at this point knowing that Patient 10 has got into difficulty and that there are other patients not triaged, which was, I suppose, more

broadly obvious to you, there is no suggestion from you or Dr. Wright that this needs to go an MHPS route or to be put up onto a different level; it is a case of wait and see?

A. Yes. When I think -- and I suppose this is very linear, again maybe I apologise for that. When I think about an SAI, the first thing I think about is, right, has this patient now -- there has been awful things happened here; have they been seen; have they been taken care off; are we confident that they are on the right treatment path et cetera. The SAI comes secondary to that, that they write it up, because there will be learning from it. 12:49 12:49

Yes, again, as I say, it would never have occurred to me, or Richard probably either, although he chaired the Oversight Committee -- so I don't think it occurred. We knew about it but it didn't occur to put it on the agenda, you know. Again, I am sorry for that. It is just something -- the SAI process was just a different thing altogether, and my focus was always about the patient, getting them seen, get them sorted now. 12:49 12:50

317 Q. In terms of how it has been left then, and I am trying to explore with you and I am going to explore in a moment, how it becomes an MHPS investigation because here, 6th December, you are saying the SAI review continues. You know some of what it will tell you because you have had the heads-up from Tracey Boyce early in November? 12:50

A. That's right.
318 Q. What is being suggested here is that we will deal with all of this when Mr. O'Brien returns to work. If we scroll up the page, Dr. Wright is saying that sounds very reasonable. I take his response to be the 12:51
entirety of your email?
A. Yeah.
319 Q. Is that the way it was, that there was no sense of a greater gravity to this, no sense that these are matters that are going to need formally investigated 12:51
outside of the SAI?
A. No. I was very clear that at that point, the Oversight Committee needed to be involved and needed to be involved very closely and monitor him heavily. But I suppose whenever -- and the SAIs had started to happen 12:51
now and Tracey was looking for the patients et cetera. But for me, to be honest with you, the SAIs for me -- and this is probably my learning because, you know, Mr. O'Brien was off sick so there was no -- if you like, he wasn't doing anything, any more harm; he 12:52
wasn't here now we were dealing with these patients that we knew about to make sure that they were properly seen. So, in my mind we needed to concentrate on all that and then deal with it all when he came back, of course via the Oversight Committee and of course via 12:52
MHPS. So, I was in absolutely no doubt in my mind that these SAIs would come up and be looked at.
320 Q. Well, one SAI at this stage.
A. Mhm-mhm. Looking at everything in the round.

321 Q. Yes. What changed then? Let me bring you to an email between yourself and Tracey Boyce on 16th December. WIT-96625. At the bottom of the page, this is late on, as we understand, a Friday evening. Just scroll down a little further. She is sending through to you a letter marked "Dear Tracey" which she -- 12:53

A. Oh, yes.

322 Q. -- received from Connie Connolly, as I say late in the afternoon Friday, 16th December. Scroll up the page, please. She is saying: 12:53

"Can we have a chat about this next week. Monday is not going to suit her, perhaps we could get together on Tuesday."

12:53

Then up the page. You are saying:

"Yes, I think we had better. You may know that there had been an Oversight Committee established in relation to this doctor and it had been stood down as he was on sick leave. I do, however, think we now need to inform the committee as things do seem to be fairly serious and potentially harmful for patients here. We will try to meet on Tuesday." 12:53

12:54

A number of things in that. Tracey Boyce has given that evidence that she was wholly unaware of the involvement of an Oversight Committee in respect to this case. Is that fair enough?

A. That is fair enough.

323 Q. Why would you not have discussed that with her and sought her view, given her proximity to governance issues?

A. Because governance teams didn't normally attend - this is just in my linear mind again - the governance team didn't normally attend Oversight Committees. The Oversight Committees were very HR sort of drift on them and Medical Director, I suppose, and staff side. I mean, again I didn't set up the attendees to the Oversight Committee. You may want to ask someone -- 12:54 12:55

324 Q. I am asking you why --

A. That's for me.

325 Q. Why didn't you tell her about that issue and all of these issues, given that she was, from early November, telling you what was coming into the system from the SAI? 12:55

A. Yes. Well, it has taken me little while but I am telling her on 16th December. So time, you know, passes very quickly. 12:55

326 Q. Your conclusion. You've perhaps had an opportunity to read the Dear Tracey letter when you are sending this. You say:

"We need to inform the committee as things seem to be fairly serious and potentially harmful for patients here." 12:55

Again, that's probably something that, upon reflection,

was either obvious to you or ought to have been obvious to you before receiving a copy of the Dear Tracey letter?

A. It was a bit truistic. I do take that.

327 Q. Let's just take a look at the letter itself. If we go to WIT-96627. If we scroll down, it is explaining that the remit of the SAI was to look at one case, but there was more than one case that attracted their attention because there was more than one case that wasn't triaged in the relevant week. Again, that wasn't something that would have come as a surprise to you, presumably? 12:56 12:57

A. No, and especially since Anthony Glackin was on the Panel. He would have known a lot of the issues that were going on too. 12:57

328 Q. But from your perspective?

A. From my perspective, no, I wasn't surprised.

329 Q. It's explained that they've now been able to look at six of these cases in some detail and seen that the patient had either been discharged or a management plan was in place. 12:57

The seventh patient was only recently the subject of a dictated outcome from Mr. O'Brien, arriving into the governance office on 28th November, notwithstanding that that was a referral that had gone in November 2014, some 18 months or so or almost two years earlier. 12:57

If we scroll down, please. The Review Team, upon

conclusion, have identified a number of concerns. If we go over the page, they are set out. There they are: There is a backlog of untriaged cases; they have put a figure of 318 on them. Then going down to the second bullet point, they raise the question of notes being transported around the place and are not available. Then thirdly, the dictation issue says:

"This issue has the potential to be compounded if patient charts are leaving the Trust facilities. The SAI Panel are anxious that assurance is sought that there is reasonable compliance in relation to the timely dictation letters by Mr. O'Brien."

This summary, again your observations, I think you should accept, or would accept I should say, is not telling you anything terribly surprising? 12:59

A. No.

330 Q. It's bringing into, I suppose --

A. Focus. 13:00

331 Q. -- one place and bringing into focus issues that ought to have been obvious to the Oversight Committee in September and to the Trust long before that?

A. I would agree with you.

332 Q. You made contact with Dr. Wright in relation to this? 13:00

A. Yes.

333 Q. And an Oversight Committee met on 22nd December. You were not able to attend that meeting?

A. No. It was my father's birthday; the last one before

he died so I am very glad I went.

334 Q. You deputized Ronan Carroll to attend in your place.

A. That's right.

335 Q. Tracey Boyce prepared for that Oversight Committee a number of documents? 13:01

A. She did.

336 Q. Including a record of the untriaged cases and a summary of the Dear Tracey letter, and provided the Oversight Committee with a copy of the SAI report?

A. Yep. 13:01

337 Q. Did you speak to anyone about your view of what should happen now that you were aware of all of these further details?

A. Yes, of course I would have. I mean, there would have been an opportunity for Ronan to tell me at his 13:01 one-to-one, or Tracey to tell me at hers, or at our own SMT meeting. But I understand that the team, the Oversight Committee, made recommendations at that meeting, which I wholeheartedly agreed with because by this stage I believe I'd had my fingers burnt trying, 13:01 so I was going to be compliant with things, the MHPS that went along now, without a doubt. I felt he had just scuppered all his chances.

338 Q. Just before the lunch break, let me try to summarise it. The Oversight Committee 22nd December decided that 13:02 Mr. O'Brien should be the subject of exclusion, and that there would be a formal investigation pursuant to MHPS, and that they would seek advice from NCAS?

A. Mhm-mhm.

339 Q. Did all of those decisions gain your support?
A. Yes, absolutely.
340 Q. What was it by this stage, 22nd December, that had, if you like, caused you to reach that view as compared to the position you had adopted back in September or October? What's changed? 13:02
A. What had changed was I believe I had been, to some degree, let down by Dr. McAllister and Dr. Weir. Then, the circumstances were completely unpredictable that happened. I was left then really on my own. I was the one that always preached let the system take the pressure, not you, and here I was on my own with something. Albeit I phoned Richard again and, I mean, he was fine with it. I mean, I was all right with Richard, the two of us had a good working relationship. I just felt that I had tried, it hadn't worked. 13:03 13:03

Mr. O'Brien himself was very aware of things, I believe, and chose, deliberately chose, not to comply. I thought you know what, I have tried my best, we need to take this a step further now. 13:03
341 Q. What, to your mind, merited exclusion and a formal investigation? What was it?
A. Everything, all of it. My goodness, there were trends, there were patterns, there were patients who were harmed. How much more do you want me to go on? Ignoring, ignoring the system, doing things his own way. Mr. Wolfe, that's the one thing I always used to say to my team, follow the system and let the system 13:04

take the pressure, not you. If you follow a system and something goes wrong, you will be fine; you follow a system or if you go off adrift and something goes wrong, you are on your own.

13:04

I feel very strongly that yes, there were lots of other issues that played into it, but that's what he did, he made his own choices.

342 Q. But was that rationale not available to you in September? 13:04

A. No.

343 Q. Why not?

A. Because I just thought he hadn't seen the letter; I just thought he was slow; he wasn't a team player; he was really messing around with the rotas and just did 13:05 his own thing and used the emergency theatre when he wanted; all of those things. But to me those things didn't really warrant a big investigation, but it turned out that wasn't the thing.

MR. WOLFE: It is 1.05, Chair. 13:05

CHAIR: We'll come back at 2.05 everyone.

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon, everyone. 14:08

344 Q. MR. WOLFE: Good afternoon, Mrs. Gishkori.

With the decision made on 22nd December, subject to advice from NCAS that a formal investigation under MHPS

would be progressed, what was your role going forward, as you saw it?

A. There was a point, and I'm not quite sure if it was at that point but I think it might have been, where most of it was taken, you know. The whole running of it, asking people, inviting people, came from Simon, and Richard came from the corporate team. I didn't have very much, given that I was off for a while and you know, things. In 2017 I was off for bereavement. I was just part of the Oversight Committee, yeah. 14:09

345 Q. Yes. I don't think Mr. Carroll meant this unkindly when he said that you seemed to be at arms length --

A. Yes.

346 Q. -- in terms of communication and correspondence and moving things forward after the December Oversight decision. Is that fair from your perspective? 14:09

A. I'm not surprised that he said that and I am not surprised that others have made comments as well. The culture of the Southern Trust in terms of how they manage things and how people interacted with each other was very much a micromanagement style. I just felt I couldn't do that given the magnitude of the job. I sort of had very clear lines of communication, tried to keep to those; made sure that Ronan did his job; that through him his team were doing and asked him to feed back. That's probably what he means with arms length. But if you get very, very engrossed with any one thing, it's really hard then to get back to the overall picture again, I found. 14:10 14:10

347 Q. Yes. There was a further Oversight Committee or group meeting on 10th January. If we could briefly look at the minute of that, AOB-01363. You attended this meeting?

A. Yes. 14:11

348 Q. We can see that the meeting was updated on the developments since 22nd December. If we can scroll down, please. Certain appointments had been made for the purposes of the investigation. Analysis of the untriaged issue had produced now a figure of 783 14:11 untriaged referrals, according to this. Certain actions to be taken and followed up; there is an action here for Ronan Carroll to follow up. Consultants, it says, would be participating in a review around this. I want to ask you some questions about the impact of 14:11 all of this on the service shortly.

Issue 2, "notes at home". We can see again that the figures are now clear. There are 307 charts returned from home, according to this. I think Mr. O'Brien's 14:12 figures are slightly lower than that but it's around the 300 mark.

Over the page, please. The issue of undictated clinical outcomes is dealt with. It records that there 14:12 are 668 patients who have no outcomes formally dictated from Mr. O'Brien's Outpatient clinics; a figure that Mr. O'Brien, in the MHPS investigation, robustly challenged and provided contrary evidence.

A. Okay.

349 Q. Then with private patients, this is a new issue that had come on to the agenda following input from Mr. Haynes at the last Oversight group meeting.

Just generally on the issue of private patients, had you any appreciation generally, not specific to Mr. O'Brien, that the transfer of private patients into the NHS system was something that was worrying from a Trust perspective? 14:13

A. I believed it had stopped. That would have been because --

350 Q. What had stopped, sorry?

A. Transferring private patients. Just as you have said, transferring private patients over to the NHS list. 14:14 Years and years ago that was custom and practice, where the patient saw, paid privately for example, to see the consultant in the consulting rooms, and then they would have been seen in the hospital perhaps sooner but on the NHS list. That happened years ago but I was under 14:14 the impression -- I mean, there was a very, very strict clampdown on that, probably I would say maybe 10, 15 years ago. I was under the impression that it had stopped until I saw this, but there you go.

351 Q. Specifically to Mr. O'Brien's case, if I can put an 14:14 issue this way. There was, and the Inquiry has seen it, a requirement upon clinicians to complete a patient transfer form when patients were moving from private over to the public health system, and a requirement to

give some indication of clinical status and what have you?

A. Yes.

352 Q. That had to be, if you like, completed and posted through the Medical Director's office and approval had to be given. Were you familiar with that procedure? 14:15

A. Yes. I think, yes, I saw where Mr. Young had reviewed such a list from Mr. O'Brien, and of course --

353 Q. I'm not talking about Mr. Young's work, I am talking about that procedure. 14:15

A. No, no.

354 Q. The need for that.

A. I wasn't aware of that procedure, no.

355 Q. Before this private patients issue attracted the attention of the MHPS process in Mr. O'Brien's case, were you aware, had you any concerns, that the transfer of patients into the NHS system, into the Trust system, was the subject or was suspiciously the subject of abuse? 14:15

A. No, no, not at all. 14:16

356 Q. Thank you. When we look at the record of this Oversight meeting on 10th January, there is no record of any input from you. Could I ask you this, were you content with the process as it was moving forward at that stage; satisfied that it was an appropriate process still? 14:16

A. Yes, absolutely. I mean, I just took part of the process just the way everybody else did. Yeah, I did.

357 Q. One issue that did arise shortly after this meeting was

a bit of a controversy, and I wonder whether there were crossed wires in it, in relation to whether Mr. O'Brien would shortly return to work from exclusion. The issue arises in this way, if I could bring you to TRU-251505, and at the bottom of the page, please. Just below that again. 14:17

You are writing, Mrs. Gishkori, to Simon Gibson on 19th January. As we can tell from the content of the email, you've just had a conversation with Ronan, Ronan Carroll? 14:18

A. Yeah.

358 Q. Ronan was telling you that Simon Gibson had been in touch to say that Mr. O'Brien would be returning to work. He said that the investigating panel has made this decision after a barrister's letter came into the Trust. You are asking him to update you on this. You are saying you: 14:18

"Need to know how the issue of potential harm to patients will be managed should Mr. O'Brien return. We've not yet had time to scope the potential impact on our patients or organisation yet." And so it goes on. 14:18

Can I ask you this, you were satisfied that it was an appropriate decision to have Mr. O'Brien excluded from work at this time? 14:18

A. Yes. I went with the Oversight group's decision, yes. Yeah.

359 Q. As is seemingly implied here, you thought it important from a patient safety perspective until things were better clarified?

A. Exactly. I didn't feel as though perhaps it was just time for it to happen. I would have preferred to wait until just everything had been scoped out and we just knew our position. 14:19

360 Q. The barrister's letter referenced here, do you think that could have been a mistake or misapprehension on your part? The Inquiry is certainly unaware of the Trust receiving a letter from a barrister. 14:19

A. That was probably word of mouth, I would think, from someone to me. You know the way Chinese whispers go. It might have been someone saying - this is just my thought - perhaps he needs to come back or whatever. But I wouldn't have written that down unless Ronan had said that to me. But it could be a misunderstanding because I don't know what barrister's letter I'm talking about there myself. 14:19

361 Q. You hadn't seen one? 14:20

A. No.

362 Q. Scrolling up the page then, please. Mr. Gibson comes in to correct matters. He explains that:

"Somehow Ronan has managed to completely misinterpret the discussion", and so he sets out the position as he under stands it. "Under MHPS, the period of immediate exclusion can only last for four weeks, at which point a decision needs to be made whether to formally exclude 14:20

an individual or allow them to return. He says this will be decision vested in nominated managers in the Trust, and with regard to Mr. O'Brien's case, this decision needs to be taken by 27th January. To prepare for this decision, Dr. Wright asked that I speak to Michael Young to ask his views as to whether there were duties Mr. O'Brien could undertake either independently or with supervision or administrative support. I have not yet had this discussion with Ronan. This is as far as we've got, no decision has been made. We are doing the preparatory work to allow an informed discussion to lead to a decision. Ronan, I'm sorry if this was somehow unclear, this is the current position." 14:21 14:21

Just scrolling back up to the top then. Mr. Carroll then chimes in and he says: 14:21

"So just that I am able to provide an account of my conversation with Esther, following my conversation with you, Simon, and to make it absolutely clear that I have not managed to misinterpret anything." He takes exception to this. He says he did not tell you, Mrs. Gishkori, that the decision had been taken to allow Mr. O'Brien to return to work. 14:21

"What I did say was that I just had a conversation with you, Simon Gibson, the content of which was the possibility of Mr. O'Brien being permitted to return to work following the exclusion period." 14:22

So, crossed wires here?

A. Every so slightly, yes, but it was the gist of it and we did, yes.

363 Q. The gist of -- 14:22

A. The gist of it is there was a consideration that he was going to come back and the decision had to be made by 27th January et cetera. Maybe I was the one that got the crossed wires, who knows.

364 Q. You seem to take objection, if we scroll on up the page past the apologies. You say to Simon Gibson you have concerns in relation to him, that's Mr. Gibson, speaking to Mr. Young about anything in relation to this case. 14:22

14:23

Why should the Medical Director's office not be speaking to the Clinical Lead in Mr. O'Brien's service area to scope out the potential for him returning to work with or without restrictions?

A. Well, at the last meeting we were told to keep it all very -- just between ourselves; nobody talk about it outside et cetera, you know. I just didn't feel -- I felt it was appropriate for Richard to speak to Mr. Young, to tell you the truth. I didn't really feel it appropriate that Simon would go, but Richard nominated him to do it so that's fair enough. We were told just to keep -- so that the whole thing didn't blow up out of -- it was early stages and nobody wanted the whole Trust to know about it. We had to be 14:23 14:23

discreet. I think he said that himself, Simon, in one of the emails.

365 Q. Your objection was to Mr. Gibson taking the role as opposed to approaching --

A. Yes. I think it should have been consultant to consultant and a little more discreet, just. 14:24

366 Q. Could I ask you about Mr. O'Brien and private work. If we go to TRU-00113. Ronan Carroll, at the bottom of the page, is providing a read out following a meeting which Colin Weir, Martina Corrigan and himself, Mr. Carroll, had with the Urology consultants on the morning of 3rd January. They were updated in relation to events and they had a number of questions. One of the questions at 4 was: 14:25

"What is The Trust's position on Mr. O'Brien undertaking private work and in particular using Trust secretarial staff to type private patient work whilst off?" 14:25

If we scroll up the page, please, you provide an answer in relation to that as regards point 4, the private patient work issue.

"Mr. O'Brien is at liberty do what he wants off Southern Trust premises but he cannot use the services of the Trust in the carrying out of his own private work, not unless the secretarial staff do the work outside core hours and don't use any facilities of the 14:25

Trust."

So although we saw a moment ago you didn't want Mr. O'Brien back at that time because of a patient safety issue and allowing you to scope out the extent of the issue -- 14:26

A. Yes.

367 Q. -- here you seem to be giving a green light to Mr. O'Brien being able to do what he wants essentially outside of the Trust. Do you not see an inconsistency in that? 14:26

A. Yes, I do but there had been a conversation at probably one -- it must have been at the Oversight Committee, in that someone was away off to check because, as far as they knew, because nothing had been, like, served on Mr. O'Brien yet, or be accused of anything yet, we couldn't stop him from doing any work at home, but that he couldn't use any the Trust premises or secretaries or anything else, or notes or put them on to lists or anything like that. But the conversation, as far as I recall it, was that because he hadn't been kind of found guilty - I don't know what other way to put that - of anything yet, that we couldn't impose that on him. That's the conversation that I remember. 14:26 14:27

368 Q. If we just scroll up the page, please. I think Mr. Gibson takes a different view. If you just stop there at No. 4, please. He explains in this email back to you: 14:27

"In line with the MHPS framework, Mr. O'Brien is not completely at liberty to undertake private practice outside the Southern Trust. As his responsible officer, Dr. Wright advised Mr. O'Brien not to undertake private work during the period of this investigation and to inform any private providers that he was currently excluded from his main employment. The exception would be if Mr. O'Brien felt there was a patient safety issue." 14:27 14:28

That was, if you like, the rule or the understanding of Mr. Gibson?

A. Yes.

369 Q. Were you unsighted on that?

A. Yes, I was. I didn't know that Dr. Wright had told him not to. The last conversation that I heard that I was part of, we didn't have the power to not make him do it. That's fair enough. I didn't know that and that was fine. 14:28

370 Q. I want to ask you about a discrete issue concerning Mr. O'Brien's reply to the Patient 10 Serious Adverse Incident Review. He was supplied with a copy of the report and asked for his comments. As we can see at AOB-01384... Maybe down another page, please 1385. Yes, scroll down. He is sending this to you? 14:28 14:29

A. Mhm-mhm.

371 Q. This is Mr. O'Brien writing to you, providing his comments concerning the final draft report of the Review Panel. I don't want to ask you anything about

the substance of his comments, they are plainly clinical, broadly clinical in nature. Could we go to AOB-01394. He says in his very last line, because part of his argument, I suppose, is that triage of routine and urgent cases is not well thought out in his view, 14:30
and he says that he believes that:

"The triage on non-red flag referrals should be revisited with a commitment to accommodate all views, to discuss who, when and how this challenge can be 14:30
satisfactorily resolved."

This is addressed to you. Mr. O'Brien would maintain there is a healthy debate, I suppose, or conversation to be had about the demands on consultants' resources 14:31
in the completion of non-red flag referrals, or the triage of non-red flag referrals.

Did you take this as an opportunity to open this debate or to do anything about it? 14:31

A. Well, the first thing I would have done was share this with the panel. The letter went out from me in the first place because the Chair of the panel, who was Mr. Glackin, didn't feel as though he could send it out to him because he was his colleague and he said he 14:31
wasn't his manager. So, it was down to Tracey or me. So, it left my office so that's why he replied back to me. I in no way wrote the letter or had anything -- you know, it wasn't that way.

So yes, that would have been passed back to the Oversight Committee and discussed, I suppose just to say to you everybody else was able to do their non-red flag referrals; everybody else did them without any bother, and some of them did his at times as well when he had other commitments to other things. So, you know... but if one consultant feels there needs to be some sort of a revisit of any sort of the systems, then of course that should be revisited, yes. 14:32

372 Q. So you received this back?

A. Yes.

373 Q. You said it goes to the Oversight group. Does it go to the Oversight group or does it go to the SAI panel?

A. It goes to the SAI but the Oversight group would also have seen this, yeah. 14:32

374 Q. Did you essentially act as the postbox for it?

A. Yes.

375 Q. As opposed to taking any initiative with regards to what is set out in the last paragraph? 14:33

A. I acted as the postbox but I did read it. At the end of the day, the panel who had made the recommendations were the best people to look at it all and take it forward.

376 Q. Yes. The recommendations, as the Panel will have seen in the SAI report, were directed towards addressing non-compliance with triage, not directed towards opening up the debate about who and when it should be done. Is it fair to say that that debate wasn't taken 14:33

forward, as far as you are aware?

A. As far as I am aware, perhaps it probably maybe would have been revisited if and when Mr. O'Brien returned, asking him what it was, you know, he thought about or what his ideas were. I think it's important to stress that he was one of the people who agreed on the current process, or the process as was at the time. As I said to you before, everybody else managed to do it, and others help him out as well. 14:34

377 Q. You say in your statement -- maybe just bring it up to put it in context for us, WIT-23406. This is the bottom of the page. You've recorded that in relation to Mr. O'Brien's response to the SAI: 14:34

"That his 11 pages of comments and questions sent people in all directions answering and gathering comments. For me, he simply didn't follow a system which had been religiously and ably followed by all the other team members." 14:34

In terms of that first sentence, who are these people you are referring to? And "sent in all directions"; what does that mean? 14:35

A. So, he asked a lot of questions. I just can't remember what they all were now but why did this happen, that should have been this, and every single thing in that would have had to have been addressed. So the governance team were answering some things and so were Complaints. All I am saying is it created a flurry of 14:35

activity, if you like, answering it, you know. I was just sort of saying to myself, look, if he had followed the system himself, we wouldn't have been in this position. It created an awful lot of work is what I'm saying. 14:35

378 Q. So, we saw briefly that Mr. Carroll and others had met with clinicians to ask for their input in reviewing Mr. O'Brien's cases. The untriaged was the first body of work that they had to carry out and then they moved on to the cases that hadn't been dictated. You were 14:36 kept up to date with those developments. For example, we can see at TRU-263809 that you are being told that -- just down the page, please. "Please see attached a further eight patients that have been upgraded to red flag". Then on up the page, 14:37 Mr. Carroll is saying that the running total is now 17?

A. Upgrades.

379 Q. Later, it goes to 19 and so on.

A. Mhm-mhm.

380 Q. I want to ask you, what view did you form of the work 14:37 that was being carried out by clinicians to address Mr. O'Brien's practice? Did you keep yourself in touch with what was happening?

A. Absolutely, yes. Well, most of -- most of the Urology consultants agreed not only to review the red flags but 14:37 to see patients if necessary. They did that with waiting lists initiative times, so they had to be paid extra for the sessions that they did. They all chipped in, because I said to Ronan just get these red flags

seen just as soon as you possibly can, without making a mistake either because you know when you panic, then something goes wrong, but just very, very systematically seen, please. All of the consultants did chip in and do their bit.

381 Q. Leaving aside the cost of it, was there any discernible impact on service delivery given that clinicians were being, if you like, caught up in this recovery process?

A. Well, as I say, they didn't do it in their clinical time per se as in their core hours, they did it outside of their core hours. I suppose the impact would have been that perhaps, you know, they might have got tired and they might been weary overdoing it, so yes in that respect. But then there was also the Working Time Directive and they had to make sure that they -- Human Resources would make sure that they followed the rules in relation to that.

382 Q. Yes.

A. But there was money; there was personal, I suppose, just tired and exhausted because they were redoing a lot of the work that someone else should have done.

383 Q. So, it stretched the clinicians?

A. It stretched them, even though they weren't doing it in core hours, do you understand they would have done it outside of their time. Sometimes they did it in their -- because I know this, they would have had an SPA, they would have had a session every now and again where they had to train; sometimes they forewent that to do some of the things. So that could have impacted as

well a bit.

384 Q. As I say, the issues around undictated clinical encounters was processed after the untriaged cases were looked at. It wasn't until June 2017 -- if we just look at TRU-268814. This is an email from Martina Corrigan, as I say 7 June 2017. She is updating on the findings from the undictated clinics, commenting that: 14:40

"There are 110 patients who have to be added to the review Outpatient waiting lists. There are 35 patients who need to be added to the theatre waiting lists, all of which will be classed as category 4, which is routine." 14:40

She goes on down the page to say: 14:41

"There are three patients whom the consultants have concerns on, and arrangements have been made for urgent appointments." 14:41

Then at the bottom she provides, if you like, a summary snapshot of the kinds of issues that emerged when the non-dictation was looked at.

Could I ask you this: Mrs. Elliott, Mr. O'Brien's secretary, when she gave evidence last week and to some extent in some of what Mr. O'Brien has said to the Inquiry, I suppose are critical of the delay in processing these undictated cases. Mrs. Elliott's 14:41

evidence in some respects was if it had only been left to Mr. O'Brien and Mrs. Elliott, these could have been progressed, these undictated cases could have been progressed more quickly than appears to have been done here because he was, while on sick leave, working through the cases? 14:42

A. Some of them, yes.

385 Q. As Mrs. Elliott said to maximum effect, those were her words in her statement. Your comments on that, please. Do you think the service had any other option -- 14:42

A. No.

386 Q. -- but to put these in the hands of other clinicians?

A. Absolutely not. Mr. O'Brien had had a chance already to do them and he didn't, for whatever reason. Somebody, like me, had given him a chance again to do it. For whatever reason, that didn't happen. So, while it may have been slightly more prolonged and whatever, I don't think he has anybody to blame only himself that they hadn't been done. He did write somewhere, could you please give me the chance to get these done at home. I saw it somewhere, I don't know where that was. But he was on sick leave, you know, so it's hard to... 14:42 14:43

387 Q. There was a further case conference on 26th January. You didn't attend that but you delegated Ann McVey to attend? 14:43

A. Yes.

388 Q. This is covered in an email, if we look at TRU-267445. Your secretary, Emma Stinson, is explaining that

unfortunately you will be unable to attend because of annual leave, and happy that the meeting proceeds in your absence. Vivienne Toal responds to that and explains this is a very important meeting and requires senior representation from Acute Services. "Given Ronan's involvement in the parallel process", that is he was assisting in gathering information around matters that would be the subject of investigation, she didn't think it appropriate for him to attend and she asks you to deputise for Thursday if you couldn't go. 14:44

Mrs. Toal's disappointment signalled in this email at your inability to attend, is that warranted given the nature and gravity perhaps of the issues that were to be under discussion? 14:44

A. To be honest with you, I think it's not warranted and I believe it's very unfair. I've tried very, very hard to get annual leave days pushed in here and there and I was taking days because I was going to lose them. I don't know what that was about. My granddaughter was born very close to that so I'm assuming it could be something to do with that. But that was par for the course with Mrs. Toal; she spoke to me in that tone a lot. You know, I sort of felt as though she was my boss, that sort of a way, that's the way she spoke. I always felt she was the Chief Executive's representative really. 14:45

Clearly, she told me Ronan is not -- I felt Ronan was

the best person to go, he knew it all inside out. But in the event, I think I sent Ann McVey, who was an AD for Medicine who didn't know anything about it really. But I followed the instructions and sent Ann.

389 Q. Given that the issues under discussion were primarily whether the exclusion of Mr. O'Brien should be lifted, and whether there was a case to answer in terms of progressing with the MHPS investigation, would you accept at least that your involvement in a meeting such as this would have been preferable than sending Ann McVey, who knew nothing about it? 14:46 14:46

A. Mr Wolfe, every meeting I attended at that level was something like this. Let me tell you, this wasn't the only meeting. I can give you reams of answers about meetings; they were always like this. But given the pressure that I was under in the Trust, and given the fact that nobody really cared where I was or what I was doing, I was going to take that day's annual leave. I don't really know what the reason was but there must have been a good reason. I would still stand up and say I deserved my annual leave just like everybody else. Would I have thought Ronan would have been excellent to go because he did know everything about it. 14:46 14:47

390 Q. Let's move to the meeting itself. I understand that Ann McVey would have given you a read out from the meeting? 14:47

A. She would definitely have. Yes, she did. She was very thorough.

391 Q. If we go to TRU-00039, we can see that a number of actions were directed to you?

A. Yes.

392 Q. If we scroll down the page, please. As a condition of return to work, Mr. O'Brien was, in the decision of the Oversight Committee, to be subject to a monitoring arrangement? 14:48

A. Mhm-mhm.

393 Q. And that wasn't available for the meeting?

A. Mhm-mhm. 14:48

394 Q. But it would be needed, and it was agreed that the operational team would provide this detail to the case investigator and members -- the case manager and members of the Oversight Committee. You and Mr. Carroll were asked to deal with that? 14:48

A. Yep.

395 Q. Over the page, Mr. Weir was asked to deal with, if you like, a consideration of whether Mr. O'Brien had an unsustainable workload. Thirdly, that necessitated an urgent review of his job plan, Mr. O'Brien's job plan. 14:49 It was directed that there would be a comparable workload activity exercise conducted. Again, that was directed to you and Ronan Carroll.

We'll turn to those matters in a moment. This was to be, as I understand it, the last Oversight meeting until 2019 and maybe after you had left? 14:49

A. Left.

396 Q. This is Mrs. McClements --

A. That's right. She took over.

397 Q. -- attended a meeting. Maybe for a slightly different purpose than this; it was post MHPS. Is that right, that there were no further Oversight meetings certainly no further recorded Oversight meetings that we are aware of? 14:50

A. I certainly wasn't invited to any. I do remember being told, by Simon I think - I just withdraw that because I don't know if it was him or not - that my input really wouldn't be needed any more, they had got it to the point where they were taking over and Tracey and I weren't needed any more, Tracey, the governance, and me. 14:50

398 Q. Although this committee directed actions, important actions perhaps, to be conducted - a monitoring plan, a review, a comparative review of Mr. O'Brien's workload, those kinds of things - to the best of your knowledge there was no supervision of those processes? In other words, you didn't have to seek approval for what was to be produced? 14:50 14:51

A. I do know that there were conversations that went on between -- because I think Martina was the driver in most of this, and her team below her. There were conversations went on in relation to Martina linking up with the consultants and trying to draw up some sort of -- as has been asked, their plan; how many PAs did they have; how many SPAs did they have et cetera. So I do know it happened. It happened between Martina, Ronan and the team. 14:51

399 Q. Staying with some of these actions. The job plan.
A. Yeah.
400 Q. We know that Mr. Weir, by September 2018, had produced a job plan and left it with Mr. O'Brien --
A. Yeah. 14:52
401 Q. -- to agree or disagree?
A. Yeah.
402 Q. It was never, ever finalised, it was never, ever signed off. Did you take any interest as Director of Acute Services in trying to drive that towards a conclusion? 14:52
A. With the job plan, no, I didn't, to tell you the truth. The job plans were very much the medical side of the house, the professional side. For some reason, though, I always had to sign them off at the end. I always felt uncomfortable because I didn't know what I was 14:52 signing but the Director had to do it. But these were very much led by the Medical Directorate and not me.
403 Q. The issue of developing a monitoring plan. Let me ask you about this, you wrote to Mrs. Hynds in relation to that. Let's look at the email that you sent, 14:53 TRU-267575. Ann McVey has briefed you, as I suggested to you earlier, following the meeting that took place on the 26th. You have a few questions. "Is there a time scale for developing the monitoring process". Secondly: "Is it okay for us to involve the other 14:53 clinicians in developing the plan?"

You set out some difficulties around that. Weir is part of the investigative team. Mark Haynes is the

other CD for surgery but also works as a urologist. Did you get any clarity around that?

A. I really can't remember. I really don't remember even that email, to tell you the truth. Siobhán Hynds is likely to have either phoned me, because she was very thorough so she wouldn't not answer an email. 14:54

404 Q. I think if we go to this email, it might give us something of an answer to my own question. TRU-00732. This is the plan?

A. Yep. 14:54

405 Q. Just scroll down. No, I don't think... You can't remember. What role did you have in the formulation of the plan?

A. Really just making sure it happened, you know.

406 Q. You didn't draft it but just made sure it was drafted? 14:55

A. It would have been drafted and then probably -- yeah, made sure it was drafted and then I would have commented obviously on it, or changed or whatever or made comments for discussion. Just the way you would when something comes through to you that someone else has done. 14:55

407 Q. You perhaps have had an opportunity to look at the four issues that were to be addressed in the plan, were addressed in the plan. Were you satisfied with the work ability of the plan and its comprehensiveness? 14:55

A. I was satisfied that the four biggest areas were there and that they were to be addressed. I suppose nobody really knew how it was going to go when you started to practice it, but I was more than happy that we were

going to go and make an attempt at it and obviously come back with the results, or report them as we went. No, I was happy enough.

408 Q. It provided that the work was to be monitored by the Head of Service, Mrs Corrigan? 14:56

A. Corrigan, yeah.

409 Q. Reported to the Assistant Director?

A. Ronan.

410 Q. Ronan Carroll. Any deviation referred to the case manager, Dr. Khan? 14:56

A. Khan, yeah.

411 Q. Was there no role for local medical management, and by that I mean his clinical lead or the associate medical director or a clinical director?

A. I mean, that's, I suppose, what I was asking in that email. 14:56

412 Q. So, was there to be further monitoring of it, and did you consider that that was perhaps not helpful?

A. Well, considering I suppose that Mr. Weir, who was his clinical lead, the CD for that area, was on the group, then I suppose, you know, he was there. 14:57

413 Q. Well, obviously Mr. Weir's role as the investigator was to move into the hands of Dr. Chada. I suppose in terms of a plan that is designed to focus on Mr. O'Brien's compliance -- 14:57

A. Right.

414 Q. -- with certain targets --

A. Yes.

415 Q. -- and to enable an understanding of the ability to

achieve those targets, and to better understand if things broke down, would it have been better to have local clinical management input?

A. Yes, although -- yes, although Martina was really very versed in everything that was happening and going on. She would have known. She was the best person really to do it because she knew exactly what they did when, how many SPAs they had, how many PAs they had et cetera. She would have been -- but yes, of course the answer to your question is yes. 14:58

416 Q. What was your sense of compliance with the plan over the remainder of the time that you stayed in employment with the Trust?

A. You mean whose compliance?

417 Q. Was it well complied with by Mr. O'Brien, to the best of your understanding? 14:58

A. Well, I always asked. I think there was once perhaps that Martina had went off and Ronan had said himself that he forgot. I mean, we are all human, people forget things. It was brought back on to line the systems very quickly. So as far as I made out, yes, more or less he was complying with. There was once or twice whenever I think the triage numbers went up. But it was more or less complied with at that point. 14:59

418 Q. We have seen that in the summer of 2017, there were concerns around triage, concerns around retaining charts in his office, and this led to a meeting between Mr. O'Brien with Mrs Corrigan, Ronan Carroll, and Mr. Weir on 25th July 2017. Is that something that 14:59

should have been drawn to your attention, or perhaps it was?

A. No, it was. I remember that happening. I remember Ronan telling me that they met with him. Did they do it remotely, I think? 15:00

419 Q. I don't know. It was not a minuted meeting.

A. No.

420 Q. Although Mr. O'Brien surreptitiously recorded it?

A. Recorded it. I think there was an email in and around it as well; I remember seeing it somewhere. I knew 15:00 they met with him and sort of tried to ask him what are you doing about this; just tried to bring him onto the track as best they could. I remember that.

421 Q. Were you not concerned that so early into the monitoring arrangements, summer of 2017, they had on 15:00 one view fallen into deviation quite quickly, albeit remedied --

A. Yes.

422 Q. -- quite quickly? Was that not a concern that you might done something about such as bringing it to the 15:01 Oversight Committee for comment?

A. Well, I remember whenever I heard about it and read about it, thinking, you know, it is so easy to go off track. It is so, so easy. It seems to take an army of people to keep this man online and on track. I do 15:01 remember discussing this with Richard, maybe informally but I do remember saying it's very easy to go off, it's very, very easy for him to go off if two or three people aren't on his case, you know, as it were.

423 Q. But was it regarded as something to keep monitoring but not something to raise the alarm bell with too heavily?
A. Yes, I think that's fair to say. I think they were keeping him on track doing what he should do, doing what was in his job plan, doing what the others did. I think that's what they were trying to do. I suppose if he was doing that with -- you know, there comes a point yes, well, I had an issue with how many people it took to keep him right. You asked earlier about the impact on the service. When so many people were trying to keep this man online with his triage and dictation et cetera, you know, what about their job because people like Martina and the clerical team didn't have the option of WLIs. They had a job and that was that. 15:02
424 Q. On the other side of the line, Mrs. Gishkori, if Mr. O'Brien is struggling or falling off the line, does that not warrant query as to how well supported he is for doing the work that's expected of him? 15:02
A. Well, you see --
425 Q. If the answer to the question is yes, have you anything to tell the Inquiry about what help or assistance was given to him? 15:03
A. I am being honest with you, I think he was getting quite a lot of help and assistance. You know, he knew these people are all helping to keep him online. He knew. You know, I think Mr. O'Brien knew and just deliberately just was trying do his own thing. You know, there was a condescending sort of attitude of him, I am in charge, I am untouchable, and I think he 15:03

just did it as he did it. Now, his secretaries and everybody else would have said he had his own way of doing it and it would have been far better, but it wasn't far better. I think my answer to your question is I think he was supported enough.

426 Q. In fairness to Mr. O'Brien in terms of falling off the line over the period of the monitoring, as you have accepted yourself, were relatively few occasions. One occasion that was drawn to your attention was during the summer/autumn of 2018, the following year. You had been absent from work between 14th June --

A. That's right.

427 Q. -- and 14th September --

A. Mhm-mhm.

428 Q. -- 2018?

A. Mhm-mhm.

429 Q. You returned to work. Part of your absence was coincident with Mrs Corrigan being off work.

A. Okay.

430 Q. During that period, there was some deviation from the monitoring arrangements. That was drawn to your attention; isn't that right?

A. I don't remember if it was, I'm sorry. I really don't. I wasn't in great form when I came back. I don't remember. But I would like to think that the systems were there for it to be drawn. I just don't remember anybody giving me a hand-over. I think Anita Carroll covered for me whenever I was off. But I don't really --

431 Q. Let me just see if I can assist your recollection in the following way. On 4th October 2018 it was reported that Mr. O'Brien had 74 sets of charts tracked to his office, and 91 letters undictated dated from 15th June 2018. Clearly, three months had passed and these letters hadn't been dictated. The explanation for the failure to monitoring Mr. O'Brien during that period was that Mr. Carroll had neglected to instruct somebody to cover it during Mrs Corrigan's absence. Now, when this was drawn to Dr. Khan's attention, he described it as unacceptable practice by both clinician and management. You were advised of the issue almost as it was repairing itself. 15:06 15:06

If we look at TRU-251523. This is 23rd October, and there has clearly been a meeting about Mr. O'Brien's notes and dictation. Ronan Carroll is asking: "Are we to continue monitoring Mr. O'Brien against the four elements of the action plan?" 15:07

Just scroll on up, please. Simon Gibson says he assumes that would be a question for the case manager or the Oversight Committee, with you again copied in. And then Dr. Khan, again with you copied in, says: 15:08

"The action plan must be closely monitored with weekly report effected as per action plan. You also clarified yesterday there were 91 outstanding dictations and today only 16".

I think that portrays a misreading of the figures; there were only 16?

A. Yes, yes.

432 Q. And that had reduced over a period of time. At the top of the page then, please, Mr. Carroll suggests that the Oversight Committee would write to Mr. O'Brien reminding him of his obligations and responsibilities to comply with the action plan and that it would be monitored. 15:08

A couple of questions arising out of all of that. You suggest that your memory around this may not be fresh?

A. No.

433 Q. Given that, see if you can help me with this. Dr. Khan, critical of the failure to monitor during Mrs. Corrigan's absence. Was that drawn to your attention and did you take any steps to speak to your management about that failure? 15:09

A. I suppose I only had what was in those emails. I also would have spoken to Ronan to see who is going to do it when Martina is not here; how will we manage it. Clearly, Dr. Khan is not happy with the way we do it. So I spoke to Ronan continuously about it but I don't think anybody ever wrote to Mr. O'Brien. I certainly didn't see anything reminding him of his obligations. Maybe Dr. Khan did or somebody did but it wasn't me. 15:09

434 Q. Certainly Dr. Khan has shown us correspondence where --

A. Right.

435 Q. -- in relation to other matters he is commenting upon arising from the MHPS reporting at that time, and if there was a grievance he dealt with it. A footnote to a letter: "May I remind you of your obligations regarding the action plan." 15:10

A. Okay.

436 Q. It didn't, it would appear, register with or be sent across to the Oversight Committee there being at one point such a significant shortfall, 91 cases, in terms of dictation. For whatever reason, it wasn't drawn to 15:10 the attention of the Oversight Committee. Can you help us with that, being a member of the Oversight Committee?

A. I can't. I had been off for nearly a year at that point. 15:11

437 Q. You had been off for three months?

A. Sorry, sorry, I beg your pardon. That was the last time. I had been off for three months. Probably -- I don't know how many Oversight meetings. Maybe there were none, were there? 15:11

438 Q. That's the point I made to you earlier, that there didn't appear to be any after the meeting in January of that year?

A. I really don't know. I know that when Dr. Khan took over managing the case, he kind of dealt with a lot of 15:11 the things. But I don't remember honestly, I'm sorry, what happened there. I really don't.

439 Q. Perhaps, Mrs. Gishkori, it comes to this, and I have to allow for the frailty of your memory around this, but

it does appear, whether by word of mouth and certainly by email towards the end of the piece --

A. Yes. Yes. Yes.

440 Q. -- when it appears Mr. O'Brien has regathered his thoughts and dealt with the dictation and reduced it to 16 cases, or whatever the figure was, of a high of 91, could it be the case that the seriousness of this -- put it another way, it wasn't regarded seriously. My question I suppose to you should it have been regarded seriously? 15:12

A. Of course it should. Situations like this should always be regarded with utmost seriousness. I suppose in my mind, having been off, someone else having been in my place, with Dr. Khan now in charge, it was almost I felt as though he was calling the shots and dictating what had to be done, sort of, really.

I remember very, very little of this from there on, I'll tell you the truth. From that to 2019 is nearly a blank for me. But you can continue and I'll do my best. 15:13

441 Q. Can I continue with this point. Mrs. O'Kane, when giving evidence, she stated that when it became obvious to her in July of 2020 --

A. Right. 15:13

442 Q. -- that there had been nonadherence in 2018 -- sorry, I'll put this another way. She is saying, and the reference is TRA-01432, what became obvious in July 2020 was that there had been nonadherence in 2018 and

that this hadn't been robustly communicated within the system.

She goes on to say that when she spoke to you in February 2019 in connection with whether to refer to the GMC, that was her thinking at that point in time, she contacted you and you didn't identify any ongoing concerns with Mr. O'Brien and expressed the view that he was a well-respected surgeon. I suppose tying all of that together, she is bemoaning the fact that she was left in the dark in relation to what happened in October 2018, the deviation from the action plan, whereas you, as Director of Acute, should have been informing her that there had been a recent difficulty? 15:14 15:14

A. I don't remember having any telephone call or spoke to her or anything with Dr. O'Kane. That would be very clear to me. I just don't remember that. I think she said she spoke to me after Trust Board, I think it was she said, and I do not recall that at all. 15:15

443 Q. Regardless of whether she contacted you or whether there was any discussion, do you agree with the apparent criticism from her that how deviation in October 2018 was dealt with wasn't optimal; it could have been more robustly handled and better communicated? 15:15

A. Yes, of course. I agree with that.

444 Q. At that time, Dr. Khan was obviously wearing two hats. He was case manager for the MHPS process; he was also Interim Medical Director in Dr. Wright's absence.

A. That's right.

445 Q. Do you think that there was more that he should have been doing around this deviation, particularly given his role as Medical Director?

A. I wouldn't really like to criticise Dr. Khan at all because, I mean, I know that I probably failed at many points in time. I can't really say. I never spoke to Dr. Khan about it, that's for sure. I think we all could have done more, just let's put it that way, including him. Everybody. 15:16

446 Q. The MHPS investigation concluded in or around June of 2018?

A. Mhm-mhm.

447 Q. It went to Dr. Khan, the case manager, for consideration? 15:17

A. Yep.

448 Q. He produced a report. If we go to AOB-01914, that's the first page of the report. You were privy to the report, Mrs. Gishkori?

A. Yes. 15:17

449 Q. You didn't share it with Mr. Carroll, your assistant director?

A. Did I not? I would have thought he would have --

450 Q. The question is ought you to have shared with him?

A. Yes, of course. 15:18

451 Q. I think he has said he didn't see it until it was copied to him by Mrs. O'Kane in early 2020.

Pull up the email in respect of that. TRU-252712.

A. May I ask you, Mr. Wolfe, do you have proof that that was sent to me? I know I read it but I don't know if I read it at that time, you know. I don't know when I read it. It could even have been in this pack.

452 Q. I don't believe I have seen an email copying it to you or sending it to you. What I can say is that here is an email from Maria O'Kane, 10th February 2020. Just scroll down the page and take it in this order. She is writing to Mr. Carroll, 10th February. 15:18

"As you're aware in the case management report," I think she means the MHPS report, "it was recommended that an organisational review of systems and processes be undertaken on progress of this, please." Sorry, I think there are words left out. 15:19

She is looking for an update essentially as the RQIA and GMC are seeking information.

Ronan replies: "Yes, I am now aware of same. Prior to the email attached, I was unaware." 15:19

So I derive from that, and indeed from his evidence I think, that he hadn't received a copy of the report from you now. As regards whether you had seen it -- 15:20

A. Got it, yeah.

453 Q. Dr. O'Kane says: "As you know, it" that's the report, "predated me. I had discussed it with Esther on a number of occasions, on the first occasion at her

request, and she was in possession of it as she showed it to me. I wrongly assumed that you would have had automatic access. As you might know, it hadn't been the shared with Mark Haynes either by the Medical Director's office or Esther. Could I ask, given it is a highly confidential report, could the relevant recommendations be circulated rather than the entire report."

Doing your best, do you think Dr. O'Kane is right, first of all, that you did have access to the report and that you discussed it with her? 15:20

A. I certainly didn't discuss it with her, I know that for sure. I definitely didn't. I would like to see evidence of where it was sent to me because I don't remember it being sent. I remember reading it, whether it was a year ago at the very beginning of this, or where. Because I wasn't part of it, do you know what I mean, and Dr. Khan never interviewed me. You know, whether he didn't send it, I don't know. I really -- and if it was sent to me, then why wasn't it sent to Ronan as well. I don't know. 15:21

454 Q. I'm sure the Trust representatives are listening to your evidence, and if it was sent to you, formally --

A. Yes. 15:21

455 Q. -- whether in late November, late 2018 when it was published --

A. Yes.

456 Q. -- we will be provided with --

A. That will do.

457 Q. -- the email chain.

A. That will do.

458 Q. Whether you received it at the time or subsequently, at the time of the publication or subsequently, I suppose is at the heart of the questions I wanted to ask you. 15:22

A. Yes.

459 Q. The report provides criticisms of the Acute managerial team. If I could just see if this assists your memory at all and if it doesn't, we can move on. If we go to AOB-01923, in the final conclusions or recommendations. I invite you just to read through that, particularly the second paragraph and subsequently. 15:22

Scrolling down, it reaches the point of saying: 15:23

"In order for the Trust to understand fully the failings in this case, he", that is Dr. Khan, "recommends the Trust to carry out an independent review of the relevant administrative process with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes." 15:23

Doing your best, Mrs. Gishkori, can you help us in terms of when you might have first appreciated that such criticisms were being made of the Acute Directorate? 15:24

A. Well, I think it was almost a given. Everybody knew

there had been opportunities missed. Everybody knew that maybe we had slipped this way, that way or the other way. Communication was wrong. So I wouldn't have considered it to be a surprise, to tell you the truth. You want to know when I -- 15:24

460 Q. Let me go come to that second part of it in a moment. Do you accept the fairness of the criticisms that are advanced there?

A. Yes, I do.

461 Q. They didn't come as any surprise to you? 15:25

A. No.

462 Q. That there were systemic failings at all levels of management?

A. Yes.

463 Q. There were opportunities to fix this or address it 15:25 before MHPS?

A. Yes. Yep.

464 Q. The question was what was to be done following that. Dr. Khan says "an independent review". Can you remember being tasked with the responsibility of 15:25 thinking about commencing such a review?

A. No, it wasn't. I presume it was the corporate team somewhere did that. I know Dr. Julian -- I'm not sure if Julian Johnston came along. Maybe that's away back, but I don't remember -- 15:25

465 Q. This review wasn't pursued until the summer of 2020 after you had --

A. Had gone.

466 Q. -- left the building, as such. Mrs. O'Kane has said,

as I showed you from her email, that she discussed with you, first at your instigation, the need to pursue this recommendation. You would accept, would you, that given the gaps and failings in the system which had been exposed by MHPS, there was an urgent need to look at that?

A. Yes, absolutely. Yeah. I mean, it was one thing dealing with the doctor himself but also then looking at the systematic processes around that. Absolutely, it was. 15:26

467 Q. The report said as much about the system as it did about the doctor?

A. Mhm-mhm.

468 Q. So, thinking about it in light of the questions I'd asked you, can you assist me in terms of whether you received this report and its recommendation in the time in which you were in service of the Trust? If so, did you give any thought to the need for an independent review? 15:27

A. Definitely not. I don't remember ever even talking about an independent review with anyone, or thinking about where we would get that. That would always have been from corporately, who would have arranged the independent review anyway; it would never have been me. 15:27

So I'm sorry, I am going to have to tell you I don't remember. My mind is just a block at that particular time. I wish I could remember. I am going to look through emails when I go home myself, because I've got

all the emails, and see did it come through to me, you know. I would really like to know myself.

469 Q. What was your sense or understanding of how matters were left by the autumn of 2018? You must have been familiar with the fact that the investigated completed and something had happened? 15:28

A. Well, I knew then that it moved on a bit further and that -- you see, I wasn't part of the Oversight group from then on. I had nothing to do with it from then on really. 15:28

470 Q. Did you know, for example, that the report of Dr. Khan had charged the organisation with a need to pursue a conduct hearing with Mr. O'Brien, but that had been blocked or the progress of that had been blocked because Mr. O'Brien raised a grievance? 15:28

A. I remember his grievance and I remember the people who went to it, but I wasn't there. I remember his grievance being heard. Yes, I remember that.

471 Q. That was after you had left?

A. I remember the grievance. 15:29

472 Q. That was after you had left?

A. Well then, there maybe was another one, was there?

473 Q. I'm not sure.

A. There was definitely a meeting with him and his wife. You see, do you know what, I'm maybe getting mixed up in all I have read over this past year and few months, to tell you the truth, and what I was still there. 15:29

474 Q. That's quite all right, Mrs. Gishkori.

Let me bring you to some reflections that you have offered the Inquiry in respect of MHPS. These are set out in your witness statement and I suppose they are the product of you thinking about all of the issues in the round for the purposes of the Inquiry.

If we go, first of all, to WIT-23411. If we go to paragraph 24, please. What you say here is, the question - if we were to go to the question but I think I have memorised it - is asking you about how fair and comprehensive and fit for purpose were the MHPS framework --

A. Guidelines.

475 Q. -- and the Trust guidelines that sat as a companion piece to the framework. What you say is you do believe they are fit for purpose.

"I believe the guidelines could be better implemented by staff. For example, I believe the issues with Dr. O'Brien when they came to light could have been practically resolved at a lower level."

Can you help us to understand that? At what point in time do you think they could have been practically resolved at a lower level?

A. Well, knowing what we know now, people knew about this way back in 2012, '13, '14, even before that. The longer something goes on, the more entrenched the problem gets. So, not just the guidelines but I just

feel that if he had been managed way back when, you know, with people knowing what they did, it would have been better than letting it drag on and then having terrible SAIs and people come to harm, you know.

476 Q. You know, as you say, that issues such as triage, for example, retaining patient charts at home, which was a symptom as we now know of delayed dictation -- 15:31

A. Yes.

477 Q. -- they were known long before MHPS was instigated?

A. Oh way -- that's right. 15:32

478 Q. What does it say about the systems within the Trust, the culture of the Trust, the personnel retained by the Trust, that these things weren't addressed at a lower level, as you describe it, at an earlier point in time?

A. I don't know that I am in any position to comment on the personnel that were in post at the time, what their issues were, why they couldn't do it. I know some people tried. The culture of the Southern Trust when I joined was performance, very much performance driven. There wasn't an awful lot of governance. I'm sure you are going to ask me that later anyway. So it was performance nearly or nothing. Perhaps individually wee pockets of people tried to deal with it and the culture was, well, you know, we've tried and you know, somebody moves on. 15:32 15:32 15:33

There was an awful lot of movement and fluidity in terms of staff in the Southern Trust. I mean, I was one of I don't know how many directors. Eamon Mackle

told me they were drawing bets of how long I would last. There was a culture of people moving a lot. That's really all I have to say.

Roles and responsibilities is also, for me, massively important. As I have already told you as well, you know, the communication between me, up and down through my line and vertically and horizontally too, that was never adhered to really. If someone of my staff wanted to go to see the Chief Executive, they did. I mightn't have known, Ronan mightn't have known. There was that culture of just go and talk to whoever you like. That left people out of the loop and out of the -- didn't know then, and there was a lot of misunderstanding. That type of culture existed, very much so. 15:33 15:33 15:34

479 Q. Can I unpack that a little. Is that suggesting that while processes might have been in place to tackle issues such as this, they were in a sense ignored, not in any malevolent way but the culture was such that people didn't follow through with things in accordance with the processes that were in place? Is that what you are getting at? 15:34

A. It is probably fair, although as I say I don't want to comment on what outcomes happened but I just can comment on what the processes were. People didn't follow their line of communication, went -- talked to anybody about it. If they didn't get the answer they wanted out of me, they went to somebody higher than me, whereas that was not a culture I was used to. I felt 15:34

like a fish out of water in it, to be honest.

480 Q. If we go down to paragraph 25 of the next page WIT-23412. There we are. What you say in the concluding paragraph here is that you believe that a meaningful, nonjudgmental meeting with Mr. O'Brien in March 2016 would have been beneficial. 15:35

"This would have allowed attempts to give him the help that was ultimately provided through the formal action plan which was developed months later. The suggestion from Charlie McAllister would again have been a more efficient method to resolve this issue. Operationally, therefore, those patients who had not had their referral actioned may have been reviewed at an earlier stage." 15:35 15:36

The suggestion from Mr. McAllister was what?

A. To take Mr. O'Brien out of the theatres.

481 Q. Yes.

A. And make him catch up with his admin. 15:36

482 Q. Your primary point here, as I interpret it, is that the March 2016 meeting attended by Mrs. Corrigan and Mr. Mackle was not well handled, or not as well handled as it could have been, and that was a missed opportunity? 15:36

A. Yes, I think so. I think, you know, in my opinion Mr. Mackle was just about to leave, he knew there were issues with Mr. O'Brien and I suppose he felt he needed to commit it to paper. I can really understand that.

That's what happened. Then it wasn't Heather that went, you're right, it was him. I don't think there was anything really meaningful. You know, Mr. O'Brien quotes that Mr. Mackle just shrugged his shoulders and went "well, I don't know what". I've read that somewhere. 15:37

483 Q. If that's correct, and I know that that's perhaps controversial --

A. Exactly. Exactly.

484 Q. What were the key ingredients so far as you are concerned that appear to have been missing from the process commencing March taking us up to September? What should have been done? 15:37

A. Having a real meaningful action plan for him at that point; making him part of the solution; asking him what it was he needed to be helped. Setting, you know, the good old fashioned smart objectives. They are still applicable, specific measured, and that they are achievable and realistically in time. Those are still... If they had that and got him on board with it. 15:37 15:38

At the same time now I would probably add a few bits to the bottom of that, and say, you know, Mr. O'Brien, I believe, was perfectly, perfectly able to do what they asked him do but he chose not to. I don't know why he just chose not do it and that's for him to answer. I think he still could have done it. But then really, you know. Or maybe at the meeting, who knows; maybe at 15:38

the meeting he palmed them off. Him and Mr. Mackle didn't have a good relationship anyway, I think.

485 Q. Reflecting on your own role, you were plainly sighted on the fact that a meeting was to take place in March 2016, as you explained to us on the last occasion? 15:39

A. Yes.

486 Q. You probably didn't look out for the outcome for that meeting or too studiously followed it. It then went into the hands -- the issue of Mr. O'Brien went into the hands of Mr. McAllister and Mr. Weir. We saw that 15:39 they were having discussions in August. Then we get to the Oversight Committee meeting in September and things develop along that route.

Was there an opportunity for you to lead on a 15:39 meaningful, nonjudgmental meeting at any point, or is that what your aim was after the 13th September meeting?

A. With Mr. O'Brien, you mean?

487 Q. Yes. 15:40

A. I suppose in retrospect, yes. It wouldn't be something that I would normally do, just pull a consultant out of nowhere in because he did have a line of command, as we talk about, professionally and operationally. So, knowing what I knew in March 2016, we have to keep 15:40 remembering that, I didn't believe there was - now I do - I didn't believe there was any major issue, apart from, as I said before, him being slow, him being not a team member, causing a real rumpus in the whole time by

spending too much time in theatre et cetera.

What I do know as well, even before March '16 letter, Heather had already met the Medical Director, Richard Wright, with others, I'm not quite sure. Simon I think as well. So they knew -- 15:41

488 Q. Of course.

A. -- the magnitude of it, but I didn't.

489 Q. Yes. A further reflection is set out at WIT-23384, if we scroll down to paragraph 71, where you say: 15:41

"The process in relation to the specific concerns relating to Mr. O'Brien was more prolonged than it should have been. The health Service was on its knees. Mr. O'Brien was a really good practical surgeon who had been excluded from work at a time when we really needed his skills. There were no concerns about the clinical side of his practice. The Oversight Committee resolved the backlog and he was essentially returned back to baseline but I think it could have been done faster had the suggestion by Charlie been implemented at first instance." 15:42 15:42

I'm struggling a little bit to understand the various bits and pieces of this. We know that Mr. O'Brien was excluded for a period of four weeks approximately? 15:42

A. Yes.

490 Q. The month of January. Then a decision was taken at Oversight on 26th January to permit his return. He

returned, albeit on a phased basis, shortly thereafter.

What are you getting at there? Did you think that four week period was excessively long with the Health Service on its knees? 15:43

A. The Health Service was on its knees full stop. From the minute I walked into the place, the Health Service -- and it is on its back now, or on its mouth and nose. What I am trying to say there is at a point when Urology was at breaking point, at a point when Urology would have needed maybe double the surgeons they had and double the space to operate in, this was a surgeon who at that time we thought his practical skills were excellent; worked with patients all his life; there were no complaints, we thought, about his practice. 15:43 Therefore, I had just wanted at that point to try and make it right with the suggestion that Charlie made, again, as I say, based on the information I had at the time.

15:44

I did ask Richard, you know, I did phone him up and say is it okay to do this. He knew more than I did but nobody shared that with me. Nobody.

491 Q. It's your belief, coming back to the heart of this, that the McAllister approach would have been a panacea for resolution of this? 15:44

A. I don't know if it was a panacea. I think it would have been difficult. I do think, had all been equal, Charlie had stayed, Colin had stayed and Mr. O'Brien

had stayed, I think between them they could have sorted it. You know, see at the end of the day, consultants do stick together and they normally find a way through the thing. I've noticed that. Nurses hang each other out to dry but consultants stick together when times are tough, and that's my opinion. 15:45

492 Q. You make a point that Mr. O'Brien was a really good practical surgeon; there were no concerns about the clinical side of his practice?

A. Yep. 15:45

493 Q. Could I ask you about that because it is a theme that emerges from the evidence of a number of witnesses. Does that categorisation of the shortcoming suggest a misunderstanding of the patient risk implications --

A. No. 15:45

494 Q. -- of the practice that the Trust believed he was maintaining? We've seen, for example, with triage what happens if that admin/clinical process isn't followed. It's not strictly admin, there is a clinical dimension of it as well. 15:46

A. Mhm-mhm.

495 Q. Are you not falling into the trap here, and perhaps it was a trap that caused others to delay pressing the right buttons opening the right processes to deal with this? 15:46

A. I'm not saying that because he was a good surgeon, we had to ignore everything else. I am not saying that at all. What I was saying was I understood from others, given that I was new, had no induction or anything

else, given that others had told me he was excellent, I'm thinking right, well, since he is excellent, let him do his dictations on all his patients, let him do his triage, let him do the backlog in terms of Outpatients and let this man work as part of the team.

I am not saying because he was a good practical surgeon, let him away with it. No, not at all, not in the slightest. I suppose the bonus was when he got into theatre, he did a good job; far worse if he had been incompetent there, you know. It wasn't a cop out. He needed to deal with it. I just still felt that he was best placed to do it. I honestly believed he if he knew the gravity of the situation, as told to Charlie by me, he would -- anybody wise would start toeing the line and getting it right, I would have thought.

496 Q. When you think about MHPS and the investigation that was conducted, and knowing what we know now about what the Trust says was discovered in 2020 - after you had left, of course - but the Trust say that there were significant concerns of a clinical and a governance nature, do you think the Trust, indeed any of the people including yourself associated with these issues --

A. Yes.

497 Q. -- in 2016, 2017, is there anything that could have been done before 2020 to try to discover, uncover, these other shortcomings which were to be discovered in 2020?

A. I think the minute anybody noticed that he wasn't following -- you see, there is this thing about systems, Mr. Wolfe. It is that - and I was always taught and I think I have said this before - let the system take the pressure, not you. You follow the system because if something goes wrong and you are following a system, nothing happens. If you just decide to be a maverick and go off on a tangent, you're on your own when something goes wrong. I cannot believe that this individual didn't understand that. For me, way back when Dr. Gillian Rankin or whoever was before her decided to deal with it, he decided for his own reasons not to follow it. To me, this is a one-off. I can't understand the man's thinking. 15:49 15:49

498 Q. Yes, but what about the Trust's thinking? 15:49

A. The Trust's thinking?

499 Q. Could the Trust and people like you who were in a position of influence have done any more to bring forward the discovery of what was to be discovered in 2020? Can I put it in these terms? 15:49

A. Yes.

500 Q. You talk about the importance of systems, and you talk about - and these are your words - maverick behaviour. If there is evidence of that, and it's obviously a matter for the Panel -- 15:50

A. Sure. Sure.

501 Q. -- who weigh your evidence and see if your description is apt, but if it is apt, is there anything that the Trust and people like you could have been doing by way

of inquiry, investigation, to get to the bottom of what was to be discovered two years, three years later?

A. Yes, I think there is always more we could have done and there were lots of missed opportunities. There is absolutely no doubt about that. But when you're in the moment, when there is so many other things. I told you about firefighting, missing lots of meetings, having to cancel things, having to have a report ready for tomorrow lunchtime, this becomes just one other thing, that's just the truth. It shows the level of risk that people who work in the Health Service have to have; it shows the level of risk. It is so high because you cannot -- nobody will ever eliminate risk but it is really hard to minimise it given the volume of work that everybody has. Of course there were missed opportunities. 15:50 15:50 15:51

Of course we could sit down now and write a gold standard plan of what we could have done, of course. But 20/20 vision is -- hindsight is 20/20. I look at it too thinking, gosh, where did I -- whenever I have been reading these pages, thinking what did I do about that or that. Your mind just goes mad. This past year that's been. 15:51

502 Q. Do you think it's only with hindsight that you are able to realise what should have been done, or was it perhaps more a complacency on the part of those who were charged with dealing with this that led to a failure to dig below the surface? 15:51

A. Well, I can only speak for myself, Mr. Wolfe, and I was anything but complacent. I feel as though, as I said, put my neck on the line to try and sort it out quickly. I can't speak for everyone else, nor would I try to judge them because I don't believe that's fair. I can just say for myself I was anything but complacent, really. It may not come across like that, but there you go. 15:52

503 Q. Chair, I probably have an hour and a half or so going into the governance aspect. There are a range of questions and things that arise out of that. I am not going to get finished today, adding in your questions. 15:52

CHAIR: Mrs. Gishkori, I am rally sorry about this, I am going to have to ask you to come back tomorrow morning. 15:53

MR. WOLFE: Sorry to cut across you. We started early and therefore I would be reluctant to push it on to 4:45 and still not be finished. Is this a convenient time?

CHAIR: We'll rise today and start again tomorrow morning. 15:53

MR. WOLFE: I was speaking to Mrs. Gishkori's solicitor and 10:30 would be suitable in the morning?

A. Yes. I'm supposed to looking after the grandchildren tomorrow, so I will have to take one of them to school, try and get the other to my mother's or something, and then come. 15:53

CHAIR: Well, okay. Can I just confirm with Mr. Wolfe, you intend we will finish by lunchtime tomorrow,

including your questioning and ours?

MR. WOLFE: 100%.

CHAIR: If that helps you make arrangements, Mrs. Gishkori.

A. Lunchtime is 1:00, is it? 15:53

CHAIR: Yes.

A. If could be home for two o'clock to get him out of school, that will more or less work.

CHAIR: If we start tomorrow a little bit later at 10:30. Thank you. 15:54

THE INQUIRY ADJOURNED TO 10:30 A.M. ON THURSDAY, 15TH JUNE 2023