Urology Services Inquiry

Oral Hearing

Day 54 – Thursday, 15th 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.

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Mrs. Esther Gishkori

Examined by Mr. Wolfe KC (cont'd) 3

Questioned by the Inquiry Panel 54

1 THE INQUIRY RESUMED AT 10:30 A.M. ON THURSDAY, 15TH
2 JUNE 2023 AS FOLLOWS:
3
4 ESTHER GISHKORI, HAVING PREVIOUSLY BEEN SWORN,
5 CONTINUED TO BE EXAMINED BY MR. WOLFE KC AS FOLLOWS: 10:03
6
7
8 CHAIR: Good morning, everyone. Mr. Wolfe.
9 MR. WOLFE: Good morning Mrs. Gishkori. Thank you for
10 coming back. I understand all the grandchildren have 10:29
11 been safely deposited at school.
12 A. They have.
13 1 Q. Just a couple of what might be described as fact checks
14 around governance arrangements to commence with. Let's
15 then just look at the evidence you gave the last time. 10:29
16 You were asked by me back in February to describe the
17 governance team that you had around you when you
18 started. If we just bring up TRA-03069, and at the
19 bottom of it. Pause a minute.
20 10:30
21 I was asking you about your governance team and you
22 explained that when you started, there was no
23 governance team in place when you joined. You said,
24 well, there was one person and she was an 8B, and you
25 gave her name as Margaret Marshall. I am going to ask 10:30
26 you whether you have misremembered that perhaps, and I
27 want to bring you to what Mrs. Marshall has said in her
28 statement. If we go to WIT-87129. Just from 1.4
29 onwards, if we just scroll down. What she is

1 describing here, if you just take a moment to look at
2 it, is that from 1st March 2013 until October 2014, she
3 held two posts simultaneously, the first of which was a
4 corporate post. She was Interim Assistant Director of
5 Clinical and Social Care Governance, and with a role to 10:31
6 progress the Trust-wide governance agenda. She had a
7 second post, a Clinical and Social Care Governance
8 Coordinator aligned to the Acute Directorate.
9
10 If you just scroll on down, please. She says, if we go 10:32
11 towards the end of it, her role in Acute Directorate
12 lasted until October 2014. Going over the page: "My
13 secondment to the role of Clinical and Social Care
14 Governance", as I say, ended in October '14 when the
15 Interim Director, Mrs. Burns, restructured her 10:32
16 governance team. In 2014, she solely held the post in
17 corporate.
18
19 So, when you came into post as Acute Director in,
20 remind me, June 2015? 10:32
21 A. September.
22 2 Q. Mrs. Marshall is at pains to explain that she wasn't
23 your 8B, she was in the corporate role and had no role
24 within Acute?
25 A. Margaret -- I wasn't sure of the dates, to tell you the 10:33
26 truth, but Margaret Marshall was around to sort of give
27 me a bit of a heads-up about what she did and what she
28 didn't do. I was aware of the fact that she was
29 corporate now, and I suppose really what I should have

1 said to you there was there was an 8B role, as far as I
2 was concerned. But actually when I looked into it
3 more, the 8B role had been given up for savings.
4 3 Q. Yes.
5 A. But Margaret Marshall was around, and she told me about 10:33
6 what she did and what she didn't do et cetera. So, she
7 was the nearest person to that 8B before I went. I
8 didn't realise that there was a year had gone between,
9 because it was October to September, you may as well
10 say. Yes, I have no doubt that her recollection of the 10:33
11 dates is true.
12 4 Q. Yes.
13 A. Yeah.
14 5 Q. If I can summarise, Margaret Marshall was around?
15 A. Oh yes. 10:34
16 6 Q. She was there to give you steer or advice, but you
17 accept that she was in a corporate role and wasn't in
18 Acute Directorate?
19 A. That's right. She had moved to the corporate team but
20 she did -- I knew her from the past so she sort of just 10:34
21 gave me a little bit of a heads-up of what she did and
22 didn't do, what she could and couldn't do given the
23 magnitude of the role et cetera. It was one of the
24 reasons why she didn't really want to stay any longer,
25 because she didn't feel as though she could do two jobs 10:34
26 at once. Nobody can.
27 7 Q. I think you're right to say that there was an 8B role
28 within Acute?
29 A. Yes, yes.

1 8 Q. But at that time, it wasn't filled?
2 A. No.
3 9 Q. In fact, there was no budget for it at that point in
4 time?
5 A. At that point in time, no. 10:34
6 10 Q. At the point of your appointment, I should say?
7 A. That's right. That role had been, I understand, given
8 up for savings. It was really one of the only roles
9 that was there in terms of senior management, you know.
10 11 Q. Yes. I want to look at how that 8B role was filled. 10:35
11 It was filled, Trudy Reid was appointed to it; isn't
12 that right?
13 A. That's correct.
14 12 Q. Let's just look at that because I want to look at it
15 through the lens of what you had said about Tracey 10:35
16 Boyce's role and how that came into being, because her
17 evidence conflicts with yours --
18 A. Certainly, yes.
19 13 Q. -- in terms of how all that came about.
20 A. Okay. 10:35
21 14 Q. Let's approach it in this way. If we look again at
22 your evidence in February, TRA-03070. Just at line 18,
23 two thirds of the way down. There we go. You are
24 explaining when you came into the post of Director of
25 Acute: 10:36
26
27 "Governance was the only thing I didn't have an
28 assistance director to report to me on, and I felt that
29 was very important because I wanted to keep all of my

1 service the same, so actually Kieran Donaghy, who was
2 the previous Director of Human Resources told me -- he
3 was very helpful in the beginning, and he told me that
4 Tracey Boyce, who was the Director of Pharmacy, had
5 just done a Diploma in Governance, a post grad diploma 10:36
6 I think..." skipping through that.
7
8 "Mr. Donaghy said, 'you know, you should use that as a
9 starting point'. So I spoke to Tracey and she was
10 happy enough to do it based on the fact that her's was 10:36
11 a very busy job as well, but she was then able to
12 appoint an 8B and then, more importantly, three Band 7s
13 who did the leg work, if you like, of the Governance
14 Team."
15 10:37
16 I will just stop it there. There are two issues, broad
17 issues I want to explore with you: Whether she was in
18 post, if you like, at the time of your appointment or
19 whether you managed to get her appointed, and this
20 issue about whether there were three Band 7s. Let me 10:37
21 explore that.
22
23 If we go to WIT-87633, and this is what Dr. Boyce says.
24 If we go to para 4.4. Here she is explaining, if you
25 like, the history of her role in the Acute Directorate 10:38
26 on the governance side. She explains that a year
27 before you were appointed in October 2014, she was
28 asked by Mrs. Burns to manage the Acute Governance team
29 for a few weeks while the Acute Governance lead post

1 was being recruited. This was because the previous
2 post holder, Margaret Marshall, had moved into the
3 Corporate Governance Lead role, as we've just explained
4 and you've just accepted?
5 A. Yes. 10:38
6 15 Q. "I was asked to take this on as, out of the six
7 assistant directors in the Acute Directorate, I had the
8 most governance experience."
9
10 She explains that she had set up the Northern Ireland 10:38
11 Medicines Governance Pharmacist team in a previous
12 post, and completed a postgraduate Doctor of Pharmacy
13 Practice on the subject of medication related to
14 patient safety.
15 10:39
16 Then at 4.5 she explains that shortly after this, she
17 was told that the Acute Governance Lead role was not
18 going to be replaced as the salary had been given up as
19 a cost efficiency saving, and that's something again
20 you have recognised this morning? 10:39
21 A. Mhm-mhm.
22 16 Q. She wasn't happy at this decision as she had been told
23 that she would be managing the team on a temporary
24 basis until the posted been filled. She explains about
25 her extremely large workload in pharmacy. 10:39
26
27 So, in February 2016, after you had come into post, you
28 agreed to the replacement of the Band 8B post and Trudy
29 Reid was recruited into that?

1 A. Mhm-mhm.
2 17 Q. What she is saying is that she was already acting in an
3 oversight role or a management role in the Acute
4 Directorate --
5 A. Yep. 10:40
6 18 Q. -- covering the gap because the Directorate didn't have
7 the money to replace the governance lead. So, when you
8 came into post, it's Dr. Boyce's recollection that she
9 was already in the governance role and it wasn't a case
10 of you coming to her and, if you like, appointing her 10:40
11 for the first time, she had already agreed to act into
12 that role in addition to her Director of Pharmacy role?
13 A. Yes.
14 19 Q. Do you accept that?
15 A. Yes, I suppose I do. I suppose I need to maybe make 10:41
16 things just a little clearer as maybe I didn't the last
17 time. One of the first things that I did when I was
18 appointed was just see what teams were around, who was
19 working where and what the structure was like. I
20 didn't seem to see much of a governance structure in 10:41
21 Acute, to tell you the truth. So that was one of the
22 first things that I said to Mr. Donaghy, because he was
23 my link, if you like, he was my go-to person. He had
24 been around a long time and he knew the place. In my
25 naivety, I wanted one full whole-time equivalent 8C, 10:41
26 which is assistant director level, for governance. As
27 I said to you before, that was based on experience I
28 had in another Trust were there were 8Cs -- I mean, I
29 can count at least three assistant director level

1 people who were looking after governance as a whole;
2 all the different departments of it.
3
4 I thought Acute, because of the size of it and because
5 of the quantum of the work there was, that we needed to 10:42
6 have one whole-time equivalent and one 8B whole-time
7 equivalent. That was my starting point because, as you
8 would know, after that you start to employ the team
9 below.
10 10:42
11 Kieran told me that there was no -- given the current
12 circumstances with money and the financial restraints
13 and we had to save a lot of money in each year, he said
14 you'll not get a full-time whole-time equivalent Band
15 C, but he said Tracey -- now, Tracey had made it very 10:42
16 clear that she was, if you like, minding the shop.
17 20 Q. Exactly.
18 A. In other words. He said to me if I were you, I would
19 make that permanent, you know, as one of the ADs that
20 report to you, and give her a team. So that was a kind 10:43
21 of a lever for me to at least get an 8B in, do you know
22 what I mean. I said, well, if I can't have an 8C,
23 we'll now need an 8B, clearly we need the money back
24 for that, and we need to appoint an 8B and a
25 substantial team to support. By the way, that for me 10:43
26 was only a starting point. I suppose naive that I was
27 then too, I did put, as I have said before, governance
28 safety -- governance was patient safety. It was one of
29 my priorities because performance only tells you what

1 you are doing and what you are lacking in doing, but
2 governance has so much more to it. That was the point
3 that I was at.
4
5 I knew I couldn't have a whole-time equivalent 8C but I 10:43
6 knew if I wrote the paper, sold the story, begged, I
7 would get an 8B. So I went back to Acute then and said
8 this to Tracey. I called her in and said, look Tracey,
9 I suppose I've got -- I understood the magnitude of her
10 role; I mean she was the lead pharmacist and in my 10:44
11 opinion it should never have been given to her. But
12 based on Kieran's advice, and based on the fact that
13 probably all the other ADs maybe didn't have a lot of
14 governance experience, I asked her to fill that role
15 but did say, look, we're going to get an 8B as well. 10:44
16 It would have been my thoughts that she would have been
17 able to, you know, give that 8B an awful lot more work
18 that she was doing at the moment. So, that's the way
19 it happened.
20 21 Q. Yes. So you appear to accept that, to use the 10:44
21 expression, she was minding the shop and was in that
22 role of minding the shop in the absence of an 8B when
23 you came into post?
24 A. That's right.
25 22 Q. I think that's the distinction that certainly I would 10:45
26 like to draw out, bearing in mind your evidence on the
27 last occasion.
28 A. Sorry.
29 23 Q. She was already in a role. What you seem to be saying

1 additionally was that when you came into post, you
2 spoke to Kieran Donaghy and almost, am I picking you up
3 right, you wanted to upgrade or make slightly more
4 formal Tracey Boyce's role in governance?
5 A. Well, it was sort of his advice for me to do so,because 10:45
6 I didn't have another choice. It was an AD somewhere,
7 I had seven of them.
8 24 Q. Yes.
9 A. And because of Tracey's experience in governance,
10 medicines governance -- governance is governance, as 10:45
11 you know, the principles are all the same. So I
12 knew -- and Tracey was excellent, I would have to say.
13 Hands down, she was an excellent Director or AD for
14 Governance for me. No doubt about it.
15 25 Q. That's exactly the point. Was she ever made AD for 10:46
16 Governance within Acute, because certainly it was her
17 evidence that at no time would she accept that as her
18 job title because that would put her into difficulty
19 with her professional responsibilities in pharmacy.
20 The sense of her evidence certainly - I hope I am 10:46
21 accurate in describing it in this way - she hoped or
22 expected to step away from this minding the shop role
23 upon the appointment of the Governance Lead in the
24 spring of 2016, but that never happened?
25 A. No, and that was never -- I always wanted an Assistant 10:47
26 Director of Governance.
27 26 Q. Yes.
28 A. I was very clear about that. Tracey did it, maybe
29 reluctantly. But it was never added to her job

1 description, I don't think. So if you're talking about
2 it being formal, you know, it was never added on. It
3 was nearly like one of those other any other activities
4 that we would see necessary. So no, it wasn't made
5 formal in terms of a job description. It wasn't, no. 10:47
6 27 Q. But so far as you're concerned, if I understand your
7 evidence, she was fulfilling some of the key aspects of
8 an assistant director's role even if she didn't have
9 the formality of the title and the pay packet?
10 A. She wasn't -- yes, that's right. I mean, it's not the 10:47
11 way pay packets worked, unfortunately. People were
12 asked to assume, you know, other roles, take them on,
13 and as far as I am concerned, nobody was ever paid
14 extra for them. Tracey was a Band 9 anyway.
15 28 Q. The chief distinction, of course, is her job is 10:48
16 Director of Pharmacy --
17 A. Yes.
18 29 Q. You had assistant directors across your directorate
19 carrying specific roles. Whatever her governance
20 activities were in Acute, they were add-ons to her 10:48
21 pharmacy roles; isn't that right?
22 A. That would be right.
23 30 Q. As I've said, upon the appointment of Trudy Reid and
24 the reinstatement of the lead governance role, it was
25 Dr. Boyce's expectation that she would be able to step 10:48
26 away. Was that never your understanding?
27 A. No, not ever. I made it clear to everyone in the
28 beginning that I believed there should be an AD for
29 Governance. Unfortunately for Tracey, she was my

1 choice. She displayed the most knowledge in the area.
2 So, while I would have loved to have let Tracey go back
3 to her pharmacy role, I didn't really have a big choice
4 as to what I would do else.
5 10:49
6 But what -- you know, the thing is whenever Tracey was
7 minding the shop, let's just put it that way, she was
8 nearly a one-man band, let's face it, with probably
9 maybe the clerical people, albeit that they were
10 excellent, helping her. I was going to be very 10:49
11 proactive in getting the 8B role reinstated but for me
12 again, with my structures, having them the way I wanted
13 to have them, Tracey could have delegated as much
14 worked as she liked to the 8B but really report to me
15 overall as the assistant director. It is just the way 10:50
16 I worked. I wanted to have an assistant director in
17 charge of everything in my directorate, because
18 otherwise I might have been pulled into stuff that
19 wasn't for the director and forgetting.
20 10:50
21 I had hoped that her role would decrease a little bit
22 with the appointment of the 8B but I didn't want Tracey
23 not to be involved at all.
24 31 Q. Yes. If we scroll down the statement in front of us to
25 bring us to the next point. Dr. Boyce, as you can see 10:50
26 at 4.7, is explaining that following upon the
27 appointment of Trudy Reid, you were not prepared to
28 take back direct responsibility for interfacing with
29 the Acute Governance Lead, despite it being part of

1 your remit. Tracey Boyce was told of this verbally at
2 a one-to-one meeting with the director, obviously you?
3 A. Yeah.
4 32 Q. "Therefore [she] continued to mentor and support the
5 governance lead as they needed someone to facilitate 10:51
6 their work. This involved meeting Trudy Reid every
7 Tuesday morning to discuss any issues the team were
8 having in accompanying her to brief Mrs. Gishkori on
9 governance issues once per week."
10 A. Yep. 10:52
11 33 Q. By contrast, and just to lead to the question, when
12 Mrs. McClements replaced you in mid to late 2019 --
13 A. Yes.
14 34 Q. -- she, according to Dr. Boyce's evidence, reassumed
15 this interface role with the Governance Lead, and at 10:52
16 that point Dr. Boyce was able to step back. The way it
17 has been framed by Dr. Boyce is the kinds of duties
18 that she was performing alongside or interfacing with
19 the Governance Lead were the kinds of duties that you
20 should have been taking on but you did not, by contrast 10:52
21 with Mrs. McClements. Do you understand that and
22 accept that?
23 A. No, I don't accept that. I understand it but I don't
24 accept it. Well, first of all, I am not here to answer
25 for whatever way Melanie decided to run the 10:53
26 directorate; that was her business. I suppose the cat
27 was out of the bag in terms of governance at this point
28 in time and maybe she felt that she needed to be closer
29 to what was going on.

1
2 But in terms of Trudy Reid every Tuesday morning, yes,
3 that's true, that happened. I would have been more
4 than happy, Mr. Wolfe, I need to make that very clear,
5 to meet Trudy Reid on my own every Tuesday morning for 10:53
6 her to brief me on governance, but it is my belief that
7 Trudy needed the support of Tracey in doing so, and
8 that's why I think Tracey came. Trudy had worked in
9 Surgery before, I think, and she had worked in patient
10 flow and things - I'm just not sure so I won't say 10:54
11 that - but Trudy herself was a little bit anxious in
12 relation to the role and I believe it was more her that
13 needed Tracey to come with her. I would have been more
14 than happy for Trudy to come alone, more than happy.
15 35 Q. Yes. Is it the case then, just so that we understand 10:54
16 you properly, you felt that governance in Acute was
17 such a significant issue that you needed an AD?
18 A. Yes.
19 36 Q. In the absence of a formal AD, you felt the need to
20 retain the input of Tracey Boyce? 10:54
21 A. Yes.
22 37 Q. Because your role was so significant, you couldn't be
23 that interface with Trudy Reid as much as you would
24 have liked, it needed someone of Dr. Boyce's standing
25 to carry some of those responsibilities? 10:55
26 A. It needed an assistant director, in my opinion.
27 38 Q. Yes. Dr. Boyce has suggested that -- if we just pull
28 up her statement, TRA-05849. If we just go to line 4,
29 please. I'm asking her why you wouldn't take on this

1 direct interfacing role with Trudy Reid, and you have
2 given me an account this morning of why. Dr. Boyce's
3 perspective on it was that you were overwhelmed with
4 the post, it was a massive post, "and also there was
5 maybe a level of inexperience in terms of governance, 10:56
6 leading governance in a very big, very vast ranging
7 Directorate." She says, "I think the fact that I was
8 there and had already been doing it sort of allowed
9 [you] not to maybe take it back fully."
10 10:56
11 The downside of it, she explains, is that it made her
12 nervous on your behalf because obviously:
13
14 "Then Esther was going into Senior Management Team, the
15 Corporate Governance meeting and so on, without that 10:56
16 interface so I was always nervous about how she could
17 then represent and talk about her risks and so on."
18
19 Do you recognise that there was this risk of a gap if
20 you weren't as fully committed to the governance 10:57
21 aspects as Tracey Boyce says you ought to have been?
22 A. I think there is a bit of a mixture there, so if you
23 would let me sort of take it apart and explain it as we
24 go.
25 10:57
26 The first thing is "Esther was overwhelmed with the
27 post". Of course she was; that was a given. Just, you
28 know, for one moment here I am from another Trust, from
29 another culture, from almost a different world, turning

1 up with absolutely nobody to give me any sort of an
2 induction or hand-over; anything. Into the bargain,
3 the post is too big for one person; we know that.
4 Then, someone who was actually looking forward to
5 taking governance forward finds out there is not really 10:58
6 a governance team at all in Acute.
7
8 So yes, I was uncomfortable and I felt extremely just
9 unsupported in terms of -- you know, if you feel
10 supported when you are in a swimming pool with rubber 10:58
11 rings and everything and everybody takes that away, you
12 feel a little bit adrift.
13
14 In terms of feeding to corporate governance, I was
15 always briefed by my AD before I went to any corporate 10:58
16 governance meeting if I was to present at it. Because
17 the AD through the team knew exactly what was
18 happening, going on, I was briefed, I asked questions
19 of them, they answered, and I went to corporate
20 governance with my brief and reported, and came back 10:58
21 and did the same thing the other way around whatever
22 they said. I don't know why she was nervous about that
23 because that's how I worked.
24
25 Tracey was an excellent person, a very quiet 10:59
26 individual, got on with her pharmacy a lot, apart from
27 her coming on a Tuesday morning to brief me about the
28 things with Trudy, because I think Trudy in the end did
29 start with her team to do most of the work, if you

1 like. So, the interface -- I mean, I am going back to
2 my point, I can only tell you the truth, I needed an
3 assistant director just the way I managed every other
4 division in my directorate. I can only give you that
5 answer to that question, Mr. Wolfe. 10:59
6 39 Q. Yes. The Tuesday meeting to brief you --
7 A. Yes.
8 40 Q. -- on governance developments, in relation to that
9 Tracey Boyce reports that she put those meetings into
10 your diary and it was sometimes the case that those 11:00
11 meetings were cancelled. She explained to the
12 Inquiry - I just give the reference, TRA-05852 - that
13 those briefings would often be the first thing to be
14 cancelled if your diary was under pressure?
15 A. If it was under pressure on a Tuesday, yes. I mean, 11:00
16 the thing is, and the way I worked and the way I worked
17 with my secretary, was most of the internal meetings
18 that I had with people, a lot of those people worked on
19 my floor, my admin -- our admin floor, it was a circle
20 sort of. Tracey, at the most, had to walk from 11:00
21 pharmacy, which was at the back of the hospital
22 forward. Now, if I was asked to go to the meetings say
23 at the Board or the Department of health or just
24 somewhere representing, maybe a regional meeting, it
25 wouldn't have, I believe -- the Tuesday governance 11:01
26 meeting would have to be the one that took the back
27 burner because when I came back from that meeting, I
28 could always catch up five or 10 minutes if there was
29 any top-line things.

1
2 Was it ideal? No, of course it wasn't ideal but I was
3 in a job that I always had to prioritise on the day.
4 So yes, those governance meetings... But I would have
5 always have said to Emma, my secretary, if there is 11:01
6 anything, ask Trudy, ask Tracey; if there is anything I
7 really need to know this week, anything to be concerned
8 about, will they run round after I come back. It was
9 made informal like that.
10 41 Q. Yes. You used an expression yesterday in relation to 11:01
11 governance, you said it was the "bottom of the pile"?
12 A. No doubt about it. Not the bottom of my pile, not for
13 sure, but the bottom of the pile in terms of, you know,
14 that was a time, thinking back, where there had to be
15 massive cuts or we had to save in the budget. 11:02
16 42 Q. Yes.
17 A. You know, people were being displaced. What I found a
18 lot as well was if a job, say, had been not got rid of
19 been replaced in some other way and there were members
20 of staff displaced, sometimes those members of staff 11:02
21 would have been put into governance. Those members of
22 staff perhaps didn't want to be there, perhaps they
23 didn't have a lot of experience, so Tracey and the team
24 would have had to train them up, whatever. Then they
25 maybe left because they didn't like it. It wasn't 11:02
26 given in, my mind any way, the importance that
27 performance was given.
28 43 Q. Yes, and we'll come to look at some of the finer points
29 of that. I'm not sure that there is too much

1 disagreement then between you and Tracey Boyce --
2 A. No, I don't think so.
3 44 Q. -- now that we've fleshed it out?
4 A. Yes.
5 45 Q. Would you accept that often times that she would have 11:03
6 been Chairing the twice monthly Standards and
7 Guidelines meeting, the monthly Acute Clinical
8 Governance meeting in your absence?
9 A. No. There were -- there was the Friday morning
10 Clinical Governance meeting, if you just allow me to 11:03
11 tell what you these all were and then it might be
12 clear. The Friday Clinical Governance meeting was
13 the AMDs, the CDs, my ADs, Tracey, Trudy and me. That
14 was the meeting that we presented all the SAIs, or
15 someone presented them, normally the Chair of the 11:03
16 panel, which was a consultant. They presented,
17 everybody discussed it, we all read them in advance;
18 they were discussed there. If it was agreed, then it
19 was signed off at that meeting.
20 11:04
21 Trudy normally sort of presented everything, Tracey was
22 there; as was I. Then there would have been -- you
23 know, you've heard there was no lessons learned
24 committee but at the end, you know, I would have said,
25 look, folks, is there anything that we need to do or 11:04
26 change in terms of our practice that will mitigate this
27 happening again? Mostly the consultants would say,
28 look, we've already done A, B, C, D and E, it was
29 signed off and that happened. There was the Friday

1 morning Clinical Governance meeting.
2
3 Then there was the Corporate Governance meeting. That
4 was chaired by one of the nonexecutive directors. This
5 is the one that Tracey talks about being nervous at not 11:04
6 having my information. But Tracey also was there with
7 her pharmacy hat on. So while I had the papers, while
8 I was there presenting that, very often Tracey had some
9 deeper detail which she would have shared. But neither
10 of us chaired that meeting; that was a nonexecutive 11:05
11 director.
12
13 Then there was my own SMT, we called it. Senior
14 Management Team. That was the Acute Senior Management
15 Team which I chaired probably 99% of the time. Now, we 11:05
16 rotated the agenda on that meeting. One week it was
17 performance, one week it was finance, the next week it
18 was human resources and then it was governance. People
19 were invited into that meeting. Like, for example,
20 when it was performance, the room was coming down with 11:05
21 people talking about performance. When it was
22 governance, there weren't too many people coming in
23 corporately to tell us anything, but I chaired it. It
24 was a very full -- you know, I have to tell you I think
25 that was a very, very fruitful meeting because all the 11:06
26 ADs were there, everybody leant in. There was no other
27 agenda really in that meeting apart from getting the
28 work done and getting it right.
29

1 Those were the meetings that I think you are alluding
2 to. So, I have explained them.
3 46 Q. Let's just look at what Dr. Boyce says, WIT-87635. At
4 4.9 she says during your time as director, she was
5 often asked to chair the monthly Acute Governance 11:06
6 meeting, the Acute Clinical Governance meeting and the
7 twice monthly Standards and Guideline meeting in place
8 of you. I wonder is that correct and, secondly, what
9 is that a reflection of? Is it a reflection of you
10 being torn in other directions or is it a reflection of 11:07
11 something else?
12 A. That is not my understanding, to be fair. I think
13 Tracey -- I mean, she is very thorough. The twice
14 monthly Standards and Guidelines, Caroline Beattie came
15 to my governance week, do you know what I mean. When 11:07
16 we were looking at governance, Caroline Beattie came
17 and presented standards and guidelines. She came
18 with -- in fact, you showed us in some of the papers
19 you sent to me latterly, there was a standards and
20 guidelines template. So, Caroline Beattie dealt with 11:07
21 everything she could in terms of standards and
22 guidelines. What she wasn't sure where to go when, she
23 brought to our...
24 47 Q. Yes.
25 A. So she definitely didn't Chair that. The monthly Acute 11:07
26 Clinical Governance is the one I told you. The doctors
27 were there; Tracey recorded all of that. I mean, I had
28 said to Trudy, look Trudy, would I expect you to chair
29 this because Trudy knew the most about it. Tracey did

1 have a lot of input there, an awful lot, but I felt we
2 all had input. Certainly, let me tell you, that was my
3 meeting, and when I came, it had sort of died a death
4 and we got it resurrected again. It was another very
5 useful meeting but it was set up by Dr. Rankin. 11:08
6 48 Q. To summarise, Dr. Boyce has used the expression in her
7 evidence that governance always operated, during her
8 time and during the period of relationship with you, as
9 a shoestring team. She disagrees with you, for
10 example, when you say that she was able to appoint 11:09
11 three Band 7s to do the leg work, as you said the last
12 time?
13 A. Yes.
14 49 Q. I'll maybe come back to that as an example --
15 A. Okay. 11:09
16 50 Q. -- of how she was trying to explain to this inquiry
17 that really it was a shoestring operation to deal with
18 governance issues. You've said it was the bottom of
19 the pile. So, is there agreement between you and
20 her -- 11:09
21 A. Oh, totally.
22 51 Q. -- in terms of the environment in which governance
23 operated?
24 A. I mean, Tracey and I quite often had that conversation.
25 It doesn't really look like it but we did have a good 11:09
26 relationship, and she would have came in my door all
27 the time and said there's been another SAI in relation
28 to -- ED was a big area, you know, an awful lot of
29 comings and goings and patients et cetera. Both of us

1 are totally 100% agreed on that.
2 52 Q. Yes. Just another factual issue which emerges between
3 your evidence and hers. If we put up on the screen
4 your evidence from February again in relation to what
5 you were describing as backlog of serious adverse 11:10
6 incidents?
7 A. Yes.
8 53 Q. TRA-03071. Just from line 14, please. I am asking you
9 to illustrate by way of example governance shortcomings
10 that existed when you came into post. You explained 11:10
11 that there were a few that you didn't manage to crack.
12
13 "For example, when I came in to my position, there were
14 more than 200 serious adverse incidents that had been
15 reported on. More than 200. So, this team began very 11:11
16 quickly to look at those serious adverse incidents, get
17 teams together."
18
19 You go on to explain that by the time you pulled the
20 team together and then they sat, they looked into it 11:11
21 and they followed the SAI procedure.
22
23 "And by the time I left, those SAIs had been reported
24 on or were being dealt with."
25 11:11
26 So the point of difference between you and Dr. Boyce
27 comes to this: She says that there were not more than
28 200 SAIs when you came into post, there was a backlog
29 of approximately 20 or so. She explains that back in

1 October 2014, it had been realised that there were
2 between 200 and 300 unopened incident reports?
3 A. Yes.
4 54 Q. Not SAIs, incident reports, of which approximately 10%
5 were to be recognised after screening as SAIs. Is that 11:12
6 right, that it wasn't 200 SAIs, it was 200 to 300
7 incident reports?
8 A. Incidents. I think, of course, that's true. Again,
9 when I reflected on this and thought even the language
10 that I used, believe it or not, when I joined the 11:12
11 Southern Trust was very different to what I had been
12 used to. You might think that is, you know, not very
13 serious but actually it was. They talked about Datix
14 all the time and I didn't even know what a Datix
15 honestly was. I was embarrassed to ask what is a 11:13
16 Datix, but it was the system in which an incident
17 report went on.
18
19 When I said 200, I did mean 200 incidents, of which
20 nobody knew how many SAIs were in it, but there were 11:13
21 200 unopened incidents. Some of them became SAIs and
22 some of them were just maybe near-misses; IR1s, as I
23 would call them; Datix as they called them. So yes,
24 no, I stand corrected and I'm sorry; that's exactly the
25 way it was. 11:13
26 55 Q. Okay. I want to look now at efforts that were made to
27 try to boost governance and the structures and staffing
28 around governance during your time in post.
29 A. Yes. Mr. Wolfe, sorry, can I interrupt? Do you mind

1 if I answer the last bit of your question because to me
2 it's important as well because I made a mistake in what
3 I said there about the SAIs and the process in relation
4 to the SAI. What I meant there was I didn't go looking
5 for the consultant myself, it was the royal "we" there, 11:14
6 as Tracey and Trudy. If there was an SAI in relation
7 to the Emergency Department, they went there, tried to
8 find a chair of the p, somebody to present it, which
9 would have been a doctor. That all took an awful lot
10 of time and effort, because they were busy enough. So 11:14
11 sorry, that was the bit --
12 56 Q. If we want to develop that point just to its
13 conclusion, let me put up what Dr. Boyce said about
14 that. If we go to TRA-05581. I think what you've said
15 may coalesce with what Dr. Boyce has said. Just scroll 11:15
16 down the page, please. Sorry, if we go back to 05876,
17 I beg your pardon. Just scroll down for me. This is
18 Dr. Boyce explaining to the Inquiry that once these
19 incidents reports were opened, 10%, maybe around mid
20 20, became SAIs? 11:16
21 A. Yes. Yep.
22 57 Q. Just scroll down slowly so I can find the point. She
23 said it probably took a number of years, perhaps two
24 years, to get back to how this -- to get back to
25 managing the SAIs? 11:16
26 A. Mhm-mhm.
27 58 Q. Just scroll down again, please, for me. Keep going,
28 please. I set out for her your evidence where you use
29 the royal "I", "so I pulled the team together". This

1 is where she answers this point. This is it at line 8.
2 She is explaining how the team was pulled together to
3 deal with those incidents?
4 A. Yes.
5 59 Q. She said: 11:18
6
7 "The way we did it at the screening meeting, when the
8 screening team decided that it was an SAI, they decided
9 on the level of the SAI, whether it was going to be 1,
10 2 or needed to be referred corporately -- 11:18
11 A. Yep.
12 60 Q. -- "if it was going to be a Level 3, which is the most
13 serious. They would have decided the level but also
14 they would have proposed the team"; that's the
15 screening unit? 11:18
16 A. That's right.
17 61 Q. The screening committee would have proposed the team at
18 that point, "who needed to be on. With the AMD
19 present, they would have allocated the Chair from one
20 of the consultant body, obviously taking into account 11:18
21 conflicts of interests et cetera". Sorry for the long
22 time to get there --
23 A. Yeah.
24 62 Q. -- is that an accurate account?
25 A. That is an accurate account. All I'm saying, the point 11:19
26 that I was trying to make was that I should have said
27 "we" got that together, but it was the team, the
28 governance team. It was absolutely filled with
29 problems because consultants couldn't do it, it took

1 them ages to get a team together, somebody was doing
2 something else. There was a point that Tracey - Tracey
3 came up with it and I thought it was excellent - to
4 actually have a few consultants have PAs, have their
5 team protected to be able to sit and do these, so they 11:19
6 couldn't say no because they had protected time to do
7 them. We tried to take that forward as well.
8 63 Q. Yes. We're going to look at that as part of what I am
9 now going to explore with you, which is initiatives
10 that were proposed and how you got on with them in 11:20
11 terms of trying to improve governance structures and
12 staffing.
13
14 Could I bring you right away to WIT-88277. Tracey
15 Boyce is writing on 4th April 2016. Clearly there have 11:20
16 been discussions going on in relation to governance and
17 she has been thinking about an alternative option for
18 governance structure, which she is attaching. It
19 incorporates a lead nurse role into the structure,
20 which is something she knows some of the people 11:20
21 interested were worried about. She has left what she
22 describes as the Band 7's role in as an option, as she
23 says:
24
25 "I personally don't think the lead nurses would be able 11:21
26 to cope with the amount of governance work that needs
27 to be done on top of their other roles. We have an SAI
28 investigation backlog", which we have just discussed,
29 "and we still haven't made a start on the implementing

1 Lessons Learned piece. Can we discuss this at team
2 talk tomorrow."
3
4 If we just scroll down, we can see her structure. Can
5 you assist us, Mrs. Gishkori, what was being talked 11:21
6 about at that time, and what was it symptomatic of in
7 terms of the governance environment in which you
8 worked? What were the problems and what was being
9 discussed here as being a potential solution?
10 A. The problems were basically that there was far too much 11:22
11 work for the team that existed, and that's the bottom
12 line. As Tracey said, you know, there were SAIs
13 overdue; some incidents hadn't been opened again; all
14 of the things that we have already discussed. Tracey
15 had discussed this with me on several occasions, and I 11:22
16 was more than happy to look at and consider what she
17 was suggesting, as well as my assistant directors.
18 When she talks about taking it to team talk, I think
19 it's fair enough to say that there was a meeting of --
20 no, a mixture of thoughts in relation to how this 11:23
21 should go forward. Some people felt that the
22 governance leads...
23 64 Q. Just scroll down.
24 A. Sorry, go on ahead.
25 65 Q. I'm not sure if we can put this all on the one screen. 11:23
26 There is an issue here; there is an option suggested
27 for Divisional Governance Leads?
28 A. Yes.
29 66 Q. Two for MUSC at Band 7, one for Surgery and Elective

1 Care, which is where obviously Urology sits.
2 A. Yes.
3 67 Q. And one for Integrated Women's Health?
4 A. Maternity.
5 68 Q. And maternity. Help us with that because that is to 11:23
6 become an issue, isn't it, in terms of the ability to
7 fill those posts?
8 A. Yeah. So, the medicine and unscheduled care bit, there
9 was going to be two just because of the size of
10 medicine. Medicine was humongous; medicine takes over 11:24
11 the hospital in the winter time; medicine is why people
12 have to wait so long on their operations, et cetera;
13 medicine is just everything. That was the reason why
14 those two Band 7s were proposed. One for surgery and
15 accident -- that was fine, and maternity Band 7, yes, 11:24
16 that was fine too. That was, of course, in addition to
17 the Divisional Governance Leads. May I say that that
18 is starting to look much more like what I would have
19 been used to previously.
20 69 Q. Yes. 11:24
21 A. So I did say this to Tracey. I mean, she was wise
22 enough to go to other Trusts and see how it worked.
23 You know, that's what we all did when we were looking
24 at structure to see. I mean, I don't know what else
25 you want me to say about it. 11:25
26 70 Q. You respond to this proposal.
27 A. Yeah.
28 71 Q. If we can see at WIT-88283, a further few pages on.
29 You are coming back to her, it is 12th April, a week

1 later?
2 A. Yes.
3 72 Q. This issue about the governance leads --
4 A. Yep.
5 73 Q. -- you accept that this is a good option to bring 11:25
6 forward?
7 A. Mhm-mhm.
8 74 Q. There will be an integral part of both teams. I am
9 anxious to understand, this is a proposal brought
10 forward by Tracey Boyce? 11:25
11 A. Mhm-mhm.
12 75 Q. You've said it's in recognition of the fact that the
13 environment in which you were working, there was too
14 much on the agenda and not enough staff to get it done?
15 A. Mhm-mhm, yep. 11:26
16 76 Q. Is this proposal from her designed to restructure
17 governance, bring more bodies --
18 A. In.
19 77 Q. -- into the team and start to address both backlog
20 issues -- 11:26
21 A. Yes, and proactive stuff.
22 78 Q. -- and be proactive?
23 A. Absolutely.
24 79 Q. And proactively, because it was Tracey Boyce's evidence
25 again that we were always very reactive. We'll maybe 11:26
26 look at what that means. But what did you have in mind
27 for this new team if you could get the resources to
28 fill it?
29 A. Again, there would have been, of course, the reacting

1 and very quickly acting to incidents, accidents,
2 complaints, anything that had just happened. Even
3 there were so much learning out of near-misses even but
4 we didn't even get to do that. But the proactive part
5 of governance, which was the bit that I was just so 11:27
6 waiting to do, and that was things like, you know, the
7 junior doctors in other Trusts had an audit facilitator
8 to go to. Audit is very important in medicine, so the
9 junior doctor would have had, as part of his or her
10 portfolio, had to do an audit. The juniors didn't 11:27
11 really know how to or where to start, but would I have
12 loved a team that were there and had a pack ready - I
13 mean, this is not out of my head, I am just comparing
14 to where I came from before - had a pack ready,
15 discussed the audit they wanted to do, make sure it 11:27
16 wasn't a bit of research, because a lot of people
17 sometimes don't know the difference between research
18 and gathering information and audit and they are all
19 very different.
20 11:28
21 So, also a Lessons Learned committee. Now, they can
22 turn into just going through templates by death of, you
23 know, but I wanted to look at things like trends and
24 patterns, for example. You know, what are all of these
25 SAIs about; is there a big trend here; do we need to do 11:28
26 training; do we need to develop the people on the
27 ground to do more training in relation to this, maybe
28 it is just that they don't know.
29

1 I would have loved to have things like audit meetings
2 where everybody came on, say, one day a month and
3 presented an audit. Now, they did this in their
4 individual -- some of them did it in their individual
5 directorate, say Acute Medicine and maybe Maternity 11:28
6 were good at it. But this was where everybody; came,
7 the morning was, you know, blanked out and everybody
8 looked -- somebody presented their audit. The learning
9 that came out of those was massive. People started to
10 get to know each other and talk about the issues, 11:29
11 people started to realise that it wasn't only them that
12 had their issues.
13
14 Then there was training and development as well. I
15 know Human Resources was a very big part of that but, 11:29
16 to me, it was fundamental in governance. So you know,
17 people were having -- and I'm sure this is the same
18 really in other Trusts, people were having real, real
19 problems just getting mandatory training done, just the
20 mandatory stuff. If somebody was booked to go on a 11:29
21 course and the ward was short, that course was
22 cancelled, all the time. In my time, courses that
23 required you going on an airplane or a boat or
24 something, they were all cancelled; you don't go, you
25 can't go, we don't have the money for ticket or a boat 11:29
26 ticket or what.
27 I just wanted to get started. The biggest thing that
28 was maybe just pie in the sky for me was changing the
29 culture in relation to governance. Culture eats

1 strategy for breakfast. If you are going to ask me
2 what I learnt, that's the biggest thing.
3 80 Q. Just picking up on some of that and maybe reflecting it
4 through the eyes of Dr. Boyce as well. If we go to
5 TRA-05857. At line 22, I think she echos something of 11:30
6 what you have just said. I am asking her what she
7 means when she said in her statement that governance
8 wasn't fit for purpose. She is saying, "I suppose
9 everything we were doing at the time was reactive." She
10 goes on to illustrate that by reference to how SAIs 11:31
11 were handled.
12 A. Yes.
13 81 Q. If we go forward three pages, please, to 5680 in the
14 series, and just at the top of the page. She is saying
15 that really they hadn't the resource to engage with 11:31
16 families. This is again this reactive piece.
17
18 "We should have been much more proactive, theming our
19 incidents or complaints as well because quite often
20 complaints were a good way to spot an emerging issue 11:31
21 before real harm happens."
22 A. Yes.
23 82 Q. "And then developing proactively as a result".
24
25 Is that again something familiar to you, that that's an 11:32
26 area of work that simply wasn't being done or not being
27 done consistently?
28 A. Not at all, no, and that's only the tip of the iceberg.
29 As an example, simulation suites. The Trust that I

1 worked on had a massive big department of every single
2 illness that could strike a body, and they simulated it
3 and let the people come in and deal with it, do you
4 know what I mean? If there had been an incident or an
5 accident in relation to, I don't know, inserting a 11:32
6 urinary catheter - I am only saying that - then they
7 could come and simulate it, and learn and be part of a
8 learning supported environment.
9
10 One doctor in Daisy Hill in Paediatrics had a 11:32
11 simulation. He had set it up himself, a wee small
12 room. But there was so much we could have done, you
13 know.
14 83 Q. Yes.
15 A. I probably was very ambitious thinking. Well, if I had 11:33
16 still been there, who knows?
17 84 Q. She goes on to make the point that under governance at
18 that time, clinical audited completely collapsed?
19 A. That's true. The only audit that I remember - and I
20 was sitting in my first governance meeting waiting for 11:33
21 all these people tripping in with audit - and the only
22 audit that was reported to us was one, pressure area
23 care. There was bundles, they talk about these
24 bundles; I don't know if it comes across. The best way
25 to deal with this condition is to do five things, and 11:33
26 it was a bundle. You got zero marks even if you left
27 only one of those out of the bundle. That gentleman
28 came and reported on the care of pressure areas. But
29 that was a regional, we had to do that.

1
2 Then there was another one in relation to - and it was
3 regional as well - ventilator acquired pneumonia, but
4 it was a bundle too. Do you know what the thing was,
5 the doctors did do audit in their own small way because 11:34
6 they have to, but it just didn't ever come up through -
7 like, she mentions Gail Brown there, that's right - the
8 governance team as a whole. So, there was bits and
9 pieces of it happening because practitioners wanted to
10 deliver evidence-based practice but we had no idea of 11:34
11 what was going on and how much of it. As she says, it
12 had collapsed, and that's very sad because audit is one
13 of the best tools you have in governance, for sure.
14 85 Q. And standards and guidelines --
15 A. Yes. 11:34
16 86 Q. -- that was another area that was under significant
17 pressures; isn't that right?
18 A. That is right. Standards and guidelines, I am assuming
19 everybody knows what those are, but the standards and
20 guidelines came from NICE, the National Institute For 11:35
21 Clinical Excellence. They normally came down from the
22 Department and the lead doctor or the lead nurse of the
23 province. They were all to do with like, you know,
24 this is the first line in dealing with glaucomas, is
25 everybody doing this. Or we need you to tell us how 11:35
26 you are dealing with fractured neck and femurs, what's
27 your rate. All of those things because there was a
28 standard in relation to all of those. We were duty
29 bound to make sure we were delivering that standard.

1 87 Q. Yes. If we look, for example, at the Acute Risk
2 Register - just bring it up on the screen quickly,
3 please, WIT-94611 - we can see. I think the figure
4 that I pulled out of it - I can't quite see it on the
5 page - is that as of April 2018, this is the risk 11:36
6 register of July 2019 but it indicates that as of April
7 2018, 34% of standards and guidelines relevant to Acute
8 remain partially compliant or not compliant?
9 A. Yes.
10 88 Q. Yes. Thank you very much indeed. 11:36
11
12 Is that again illustrative of the capacity of your
13 governance resources to adequately implement?
14 A. To be fair, this is a regional problem. To be fair to
15 Caroline Beattie -- I mean if Caroline couldn't do it, 11:37
16 let me tell you now, nobody could, because she was
17 so -- I wanted her in my team but I wasn't allowed to
18 bring her up. She was brilliant at standards and
19 guidelines, absolutely fabulous.
20 11:37
21 What happens with standards and guidelines, so
22 sometimes there is a delay, just as it says there, in
23 it coming to our Department of Health from wherever
24 down, and by the time it gets on the ground to us,
25 sometimes it's out of date, believe it or not. 11:37
26 Probably this is where your 34% is coming. Sometimes
27 the consultants would say look, wait a wee minute, we
28 don't do this any more because X, Y and Z; regionally
29 we have agreed do this, this, this. So, it took quite

1 a long time then to write that all up and get it back
2 up to where it came from. I think that's probably --
3 and it is a regional problem. There is a problem with
4 how quickly the standards and guidelines get to us, and
5 therefore sometimes they are not implemented because 11:38
6 some of them have gone out of date, or consultants
7 query their efficacy really.
8 89 Q. Yes. Taking you back then to the spring of 2016,
9 Dr. Boyce has proposed this new structure with
10 additional staffing input? 11:38
11 A. Yes.
12 90 Q. And you, from your email appear to recognise the good
13 sense of that?
14 A. Yes. We had chatted about it, you know, before it.
15 91 Q. Just picking up then later the next year and asking you 11:39
16 to reflect on why progress wasn't made around this. We
17 have one of your senior team members, Mr. Carroll --
18 A. Yes.
19 92 Q. -- writing. If we go to WIT-14751. The heading or the
20 subject is "Governance Structure Within Acute 11:39
21 Services". It's 28 August 2017, more than a year, a
22 year and a half since governance structures were being
23 discussed.
24
25 "Please find attached three, there are possibly more, 11:39
26 SAIs where there is no evidence that the
27 recommendations have been actioned. We agreed to have
28 three governance managers working to each, two for
29 MUSC, one for Surgery and Elective Care. Can I ask for

1 an update on the above subject?"
2
3 Just scroll on up, please, and we'll work through a
4 number of emails. It's now September; he says that he
5 hasn't received an update. He is, I suppose, asking 11:40
6 for permission to bring in a sister, Cathie Rocks, from
7 a career break to fill a gap. Then up the page again,
8 Tracey Boyce is thinking that's a good idea; wondering
9 how it's going to be funded. Up the page again. He
10 says: 11:41
11
12 "We're 18 months into the restructuring. It would be
13 great to get this finally bottomed out. Helen, Esther,
14 please come back to me if this is not in order."
15 11:41
16 Scrolling up the page again. He says we are now a
17 further three months since he sent the email.
18
19 "The structure we all signed up to has not materialised
20 and in fact I am unsure what the actual structure is." 11:41
21
22 Maybe that's a convenient point to pause. Plainly, and
23 we can see it through other members of your staff at
24 various times; Patricia Kingsnorth subsequently --
25 A. Yes, managed to get them, I think. Sorry. 11:41
26 93 Q. Various members of your staff at various times, we can
27 see through the material, are asking about resources
28 because they can't get things done. Here, very
29 prominently, Mr. Carroll, over a period of several

1 months, is saying what's going on here.
2
3 You have received a proposal for restructuring?
4 A. Yes.
5 94 Q. What is done with that? 11:42
6 A. The proposal. So whenever you took anything that
7 wasn't funded, which would be my SMT, the Directors,
8 the Chief Executive SMT, you had to write a paper, you
9 had to give your reasons why. You had to involve
10 members of that team, the performance team, but they 11:42
11 helped us write up a proposal in the proper format,
12 what you wanted, et cetera. I tried to do it a wee bit
13 informally too, you know, when I was down to see the
14 Chief Executive, we really need more governance staff,
15 here are the stats now in relation to incidents, 11:43
16 accidents; we haven't even started doing anything
17 proactive yet.
18
19 Most of the people -- like Connie and Adele that you
20 see there, both of those, Connie was a lead nurse 11:43
21 seconded in because there was a change in the lead
22 nurses. We didn't ever have - this is what I am
23 telling the Chief Executive - we didn't have a fully
24 functioning governance team that was fit for purpose
25 that was made to fit our needs. I suppose this is 11:43
26 where I really felt like the punch ball, to tell you
27 the truth. Helen that they talk about there, was my AD
28 for Human Resources, HR. She was trying her best, with
29 me, to get finance because Vivienne Toal, who was her

1 boss, was very integral in the decision-making at
2 headquarters. We were always sent back, 'we want you
3 to check that or that'; 'well actually, we have
4 restructured a lot of things and there are people who
5 are displaced, you have got to go and check that 11:44
6 first'. That was one of the things. Or 'bring it back
7 next month because we need you to check points 2, 3,
8 and 4'. It was one of the most soul destroying
9 processes that I have ever had. It was always me, of
10 course. 11:44
11
12 Then I had to come back and tell my staff, well
13 actually, we have to do this and that and the other
14 thing. Ronan, very clearly, I remember that because he
15 got very, very exercised in relation to the fact that 11:44
16 these people hadn't come along yet.
17 95 Q. Yes.
18 A. Even though before that, before originally there were
19 very few of them about at all. But they did manage,
20 just before I left, I think Patricia Kingsnorth, we 11:44
21 managed to push it over the line, and I think the
22 people --
23 96 Q. Let me ask you about that, and I am not sure about
24 that, we maybe need to ask the Trust some further
25 questions. In terms of the proposal that Tracey Boyce 11:45
26 developed in April 2016 and sent to you, and I am going
27 to show you in a moment another structure that she
28 drafted in 2018.
29 A. Yes.

1 97 Q. Did either of those proposals for restructuring and
2 extra resources for the governance team ever make it
3 to, I assume, the Chief Executive's office as a formal
4 paper, a formal proposal for revamping governance
5 within Acute? 11:45
6 A. I think it would have gone to not the Chief Executive's
7 office but his SMT meeting.
8 98 Q. That's what I am asking you to say. Can you be
9 clear --
10 A. I am more than -- 11:46
11 99 Q. Sorry. Can you be clear with me, and we can ask the
12 Trust for the papers if necessary --
13 A. Yes.
14 100 Q. -- did a proposal for restructuring governance and
15 gaining extra resources, did that make it to the Chief 11:46
16 Executive's SMT?
17 A. I am fairly sure it did. That's my best guess, I'm
18 sorry. I remember discussing it with the Chief
19 Executive. There were papers like this every day in
20 SMT, to be honest. I know I am not allowed to assume 11:46
21 but that's my best guess. But I certainly remember
22 discussing it through with the Chief Executive, yeah.
23 101 Q. Just scrolling up the page while we're here for
24 completeness. Mr. Carroll, I suppose, illustrates
25 somewhat neatly, he started -- we started this chain by 11:46
26 highlighting how the absence of adequate governance
27 resources impacting on following up on the action plan
28 through SAIs. Here, he is saying he had been at a
29 discussion with one of the Northern Ireland Coroner's,

1 Mr McGurgan, who had outlined in the talk some
2 continuous failings on the parts of Trusts. In that
3 context, it is illustrating Mr. Carroll's point:
4
5 "Which again brings me to my concern with regard to 11:47
6 governance structures within Acute Services. We are
7 approximately 19 months into restructuring and no
8 further forward with respect to having the agreed
9 structure in place?"
10 11:47
11 This, it seems goes on and on, and your staff are
12 obviously aware of the gaps in governance and are
13 frustrated by it; is that fair?
14 A. Everybody was frustrated, including me. There is no
15 doubt about it. If I am allowed to comment on that 11:48
16 email?
17 102 Q. Of course.
18 A. Is it okay? Sometimes I felt -- and I know everybody
19 was frustrated, Ronan too, everybody was frustrated.
20 But now we knew what a governance team would do. They 11:48
21 had coped without this for years but now everybody knew
22 - which to me was good - everybody knew that we needed
23 some more facilitators. However, to document
24 comprehensively is a single person's -- those three
25 things there, everybody is on a register, a nurse, a 11:48
26 doctor, an allied health professional, they are duty
27 bound to document comprehensively; they are duty bound
28 to communicate openly and with understanding to
29 patients and relatives; and training and updating, we

1 know we have to do that; sometimes at least we did the
2 mandatory. Sometimes I think excuses were given in the
3 absence of this governance team which we were trying
4 very hard to put in but, as far as I was concerned, and
5 I have said it before, governance is everybody's 11:49
6 business, every member of staff should understand that
7 it is their duty as a practitioner to do those things
8 as well. I am not taking away from the fact --
9 103 Q. I think you make that point, if we scroll up above this
10 email. Yes. This is the point you have just 11:49
11 articulated:
12
13 "Governance is everyone's business, especially
14 documentation, communication, etc."
15 11:50
16 But Mr. Carroll and the team around him, they can only
17 do so much with the resources they have?
18 A. Of course.
19 104 Q. Isn't that right?
20 A. Yes. Yes. 100%. 11:50
21 105 Q. What they need is to be adequately resourced for
22 governance purposes?
23 A. They pull it together, yes.
24 106 Q. Just in this sequence again, if we can go to WIT-14752,
25 and scroll down a little. Down on to the next page, I 11:50
26 think. Just here, this is 5th June 2018. It is more
27 than two years since Dr. Boyce had sent you an earlier
28 edition of a restructuring arrangement?
29 A. Yes.

1 107 Q. On 5th June 2018 she is attaching a further paper for
2 your consideration?
3 A. Yes.
4 108 Q. Just down the page. We can see - the Inquiry saw this
5 last week when hearing from Dr. Boyce -- 11:51
6 A. That's a new one.
7 109 Q. -- this is a new one. We can see along the left-hand
8 margin the proposal which you alluded to earlier, which
9 is to find protected time for Chairs of serious adverse
10 incidents, for example. Then below that again - just 11:51
11 scroll down slightly - is Tracey Boyce's short paper
12 for an enhanced structure.
13
14 If we go up the page to 14751 or up the document,
15 please. Just there. The question arises - just scroll 11:52
16 down slightly - you go off in the month of June, and
17 Tracey is asking:
18
19 "I don't think Esther got a chance to share this with
20 you before she went off", and she is not sure if it has 11:52
21 been shared with Shane Devlin either; he was then Chief
22 Executive.
23
24 Are you confident that you put your shoulder to the
25 wheel in terms of trying to get additional resources 11:52
26 for governance?
27 A. There is no doubt about it. There is no doubt about
28 it. As well as additional, I was always made to feel
29 that I was there with my begging bowl, there she comes

1 again. You know, it was nurses, allied health
2 professionals, it was consultants, it was everything,
3 but the governance team is an absolutely integral part
4 of everything we do. You know, there was a man -- just
5 I used to say this in my papers but it didn't really go 11:53
6 down very well, I think there was a man in 1990 called
7 Crosby, and he said that governance is free. Actually
8 if you have the proper team in place and if that team
9 are working towards your evidence-based or your utopia,
10 as it were it will cost you nothing because you will 11:53
11 not have any SAIs, you will not have anybody
12 complaining with claims for things and whatever. He
13 said governance is free. I still, through Atul Gawande
14 and all those people who wrote on quality, that comes
15 through very, very forcefully. That was the culture I 11:54
16 lived in, you know.
17 110 Q. Yes.
18 A. I went off, by the way -- sorry, Mr. Wolfe.
19 111 Q. It is, of course, Utopian when you're working in an
20 environment where clinical performance is so under 11:54
21 strain for reasons we'll maybe look at before we
22 finish; there is always going to be significant
23 governance issues; isn't that right?
24 A. Of course, but if you have all the consultants in place
25 that you need. Like I mean, like I said to you, that's 11:54
26 Utopian. I wouldn't want to blame the Southern Trust
27 on this because the region is short of consultants, the
28 region is short of staff. Even though the Southern
29 Trust, places like Daisy Hill, for example, found it

1 very hard to recruit, we were in an uphill battle.
2 People that live in Belfast, tend to work there.
3 That's all -- those are all other things that were
4 added into the mix. But just to say to you that in
5 June I went off very unexpectedly, very quickly one 11:55
6 afternoon, so it wasn't planned.
7 112 Q. Yes.
8 A. Sorry.
9 113 Q. Can I bring this area to a close by putting two further
10 points to you. Mr. Carroll said in his statement, and 11:55
11 I don't think I need to bring it up - it's WIT-13171 -
12 that he explains, and we can see it illustrated in
13 those emails, that he had long pushed for more
14 resources but at the date of his statement, he was
15 saying that adequate resource still wasn't in place. 11:55
16
17 If I set alongside that something Dr. Boyce said in her
18 evidence when she came before the Panel. TRA-05866.
19 Scrolling down, please. She is explaining that she had
20 put a proposal to you, as we've seen, in 2016. Then 11:56
21 Ronan, 18 months later, as we've seen, still pushing,
22 and then we have the new proposal. Scrolling down and
23 over the page, please. She is reflecting on the sense
24 of frustration. This is your email about governance
25 being everyone's business. 11:56
26
27 One point she made in response to your evidence on the
28 last occasion that she was able to recruit two new Band
29 7s. She makes the point here that those Band 7s had

1 always been in place but there was a displacement
2 situation where there was turnover of staff, and what
3 she got in place was inexperienced people coming into
4 post, and she had to counsel them and essentially bring
5 them up to speed on governance. 11:57
6 A. That's right but in my -- you see, those two governance
7 people were nursing governance posts that we're talking
8 about. It was lead out fairly clearly in Margaret
9 Marshall's, whenever she had said what small team she
10 had, there were two nursing governance facilitators who 11:58
11 were -- the money came from the Director of Nursing and
12 they were answerable to the Assistant Director of
13 Nursing. Now, they helped - they were Band 7s - but
14 they could only follow the nursing agenda because they
15 were made -- they weren't even the governance 11:58
16 facilitators that we needed, do you know what I mean?
17
18 Then there were lead nurses who did the nursing, sort
19 of -- the lead nurses helped with that as all. But the
20 Band 7 ones that I am talking about are people who were 11:58
21 going to follow Tracey and Trudy's agenda 100%, and
22 that's where we got the backfill of people coming in.
23 114 Q. Right.
24 A. So people would have said, you know, that one is
25 displaced, that one is displaced and that one is 11:58
26 displaced, sure, they'll do in governance.
27 115 Q. Can I ask you this: Was it your sense that by the end
28 of your time in the Acute Directorate, governance, in
29 terms of its capacity and resourcing, was in a better

1 place than what you found at the beginning, or was it
2 treading water?
3 A. Ever so slightly. Every so -- well, we treaded water
4 for a long time. It was ever so slightly better but,
5 to be honest, whenever I left, anything was the last 11:59
6 thing from my mind so I didn't even think about
7 governance when I was going away. I was looking
8 forward very much to working with Patricia Kingsnorth
9 because she, to me, had exactly the same idea and I
10 knew I could -- we could have -- and she was very 11:59
11 proactive in Maternity.
12
13 So, it was slightly better. Certainly the language
14 that I used in my meetings about governance being
15 important, and trying to bring on board. But, as I 11:59
16 said to you before, you know, the culture was
17 performance, performance, performance, and I don't know
18 that I did very much to change that as an individual.
19 116 Q. Let's just deal with that culture, as you describe it.
20 You've said in your witness statement, if we can just 12:00
21 bring it up, WIT-23378. Just scroll down, please. At
22 paragraph 35, you are explaining that:
23
24 "Through the lines of management and the help of the
25 clerical teams, the metrics were presented to me and I 12:01
26 in turn presented those to the HSCB personnel as
27 appropriate."
28
29 When you refer to metrics in this context, is that the

1 performance data?
2 A. Yeah.
3 117 Q. Were you responsible then for interacting with the
4 HSCB, the Commissioner, in relation to those issues?
5 A. Ultimately, because there was an SBA service budget 12:01
6 agreement so we had to, obviously, give an account of
7 ourselves; I completely understand that. But we had,
8 interestingly enough there was a performance team in
9 Acute. They gathered all the data and the statistics
10 and sent it to the performance team in headquarters, 12:02
11 and I know they were corporate. But, for me, you know,
12 I thought in my mind there was an awful lot of
13 repetitiveness going on there. Very often I thought if
14 I could take my team in Acute and put them all into
15 governance, you know, because the statistics were going 12:02
16 to go down to them anyway. It was just how it was set
17 out. I was never in a position to change that
18 performance. It stayed the way it was and that was
19 made very clear to me. I mean, it was a well-oiled
20 wheel. 12:02
21 118 Q. Yes.
22 A. Yes.
23 119 Q. Your repetition there a few moments ago, it was all
24 about performance, performance, performance?
25 A. Yes. In my view that's how I found it. 12:02
26 120 Q. Yes --
27 A. And finance too, sorry.
28 121 Q. If we go back in your statement to WIT-23376. Just
29 from paragraph 14 downwards, you talk about the risk

1 register which was utilised by Urology. You explain
2 that Urology Department was on every agenda due to the
3 number of patients and long waiting times. "The Trust
4 Board had continual access to the risk register." You
5 go on at paragraph 15 to talk about the main issues 12:03
6 were demand outstripping capacity and the factors that
7 play into that.
8
9 You say at 16 that Urology was not adequately staffed,
10 in your view. You explain that one of the problems 12:04
11 here was the difficulty in recruitment.
12
13 Down the page, you talk about attempts to try to solve
14 that problem with recruitment drives. You explain at
15 19 "management posts were never vacant". You go on 12:04
16 into the Datix area.
17
18 Is there a sense, Mrs. Gishkori, that during your time
19 as Director of Acute, focusing on Urology now, that
20 this was a service under stress, and the emphasis in 12:05
21 terms of your work, and perhaps other services within
22 Acute, was about driving performance, ensuring that
23 your staff were driving performance because that's what
24 the Commissioner was wanting to see, and that
25 governance issues and the management and 12:05
26 superintendence of governance issues played second
27 fiddle to that?
28 A. Yes, I would 100% agree with you. Just to comment on
29 the first part of your statement there in relation to

1 Urology, I mean nobody has any idea how short. One of
2 my consultants had to go to Belfast on a Friday to do a
3 certain procedure, otherwise the people in Northern
4 Ireland had to go to England. So, how was I going to
5 keep him back from that, from patients who then had to 12:06
6 travel to England and home again in a very poor state
7 of health? It was regional but it was still very real
8 for us, and it was very, very under resourced.
9
10 I mean, they did everything they could, you know. They 12:06
11 got lithotripsy going on and they tried to do extended
12 days through theatre. It wasn't that they said to
13 themselves -- and they always fighting me for more
14 theatre space. Not fighting but bartering for it. But
15 then I had to think of all the other services that 12:06
16 would fall down if they got more space. You know, it
17 was all of that, it was all of that.
18
19 But performance was always top of the twig, and
20 finance. We were reminded you will not appoint any 12:06
21 more staff; you will not -- people are displaced, they
22 have to move into this. We had to come up with savings
23 plans all the time.
24 122 Q. Yes.
25 A. And it was a soul-destroying period. 12:07
26 MR. WOLFE: Thank you. I have no further questions
27 for you.
28 CHAIR: Would you like to have a short break before you
29 answer some questions from the team.

1 A. No, if you don't mind.
2 CHAIR: Or just get it over with?
3 A. Please.
4 CHAIR: Mr. Hanbury, do you have some questions?
5 12:07
6 THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS
7 FOLLOWS:
8
9 MR. HANBURY: Thank you very much for your evidence. I
10 have just a few clinical ones. 12:07
11
12 As a urologist, I am well aware of theatre limitations
13 and capacity issues, and you just mentioned that.
14 A. Yes.
15 123 Q. Mr. Haynes and Mr. O'Brien wrote to you about 12:07
16 differential waiting times on one or two occasions.
17 Did you have a way of looking at reallocation of
18 theatre space according to those in most need?
19 A. Absolutely. Well, so every -- there was a meeting, a
20 theatre meeting, as it were, and theatre lists were 12:08
21 discussed, maybe taking a theatre list off someone
22 else, may be taking -- but there was very, very little
23 wriggle room, Mr. Hanbury, for any of it. Of course it
24 was discussed. They did try to extend a working day,
25 but if the staff extended work tonight, then there was 12:08
26 nobody for tomorrow. That was the other thing, theatre
27 nurses were very. Very limited.
28
29 But Mr. Haynes was part of a regional group looking at

1 all of that. I think there was a bit of a jiggling
2 about of that level. I was aware of it but not part of
3 the decision-making because they knew much more
4 clinically than me. There would have been a bit of
5 jiggling about, as it were, at a regional level to try 12:08
6 and -- for example, there were clinics set up in Daisy
7 Hill that didn't need Intensive Care for Urology,
8 because they didn't have an Intensive Care Department.
9 People from the region would have come and tried to do
10 that with them to try and get rid of that. There were 12:09
11 so many initiatives to try.
12
13 Ultimately, the demand just outstripped the risk. It
14 was amazing to watch how much. Regionally, I mean, I
15 think we weren't as bad as some of the other Urology 12:09
16 Departments in the region, yeah.
17 124 Q. There was one initiative, must be slightly before your
18 time, from an Australian group who came in in the
19 independent sector, which did seem to impact
20 considerably. 12:09
21 A. Absolutely.
22 125 Q. Were those alternatives thought about at your level?
23 A. Those were. It was like pop-up theatres where they had
24 the whole theatre team, just a wee bit like the one we
25 used in cardiology. Was it Aspen? I just don't 12:09
26 remember the name of it. Yes, it was before my time
27 but I was told about it and I thought great, brilliant,
28 let's get it, but then it was the money, it was very,
29 very expensive.

1 126 Q. It was the money.
2 A. It was, absolutely. I would have had them all over the
3 place in every corner because they worked, those
4 worked. But there was just no money to pay for them.
5 127 Q. Thank you. Also in theatres, you mentioned, going on 12:10
6 to Mr. O'Brien, a couple of comments, one that he was
7 slow working. What do you actually mean by that? Do
8 you mean his productivity?
9 A. Mr. O'Brien was notorious. When he went into theatre,
10 he just could have been there at nine o'clock at night. 12:10
11 He just took his time, which seems to be just right
12 across the board really; it was his type. He took his
13 time doing operations. He might have slipped an odd
14 wee one in between that nobody knew. All of this. I
15 was told he was generally slow. As you know, there was 12:10
16 a theatre management system. They recorded the time
17 there was knife to skin and the time that the operation
18 went over. His times went way out longer than anyone
19 else's for a particular procedure.
20 128 Q. Thank you. You also made another comment about his 12:11
21 practice causing havoc. Again, what do you mean by
22 that? Is that an organisational thing or what? Why
23 did you choose those words?
24 A. I chose those words because he wasn't a team member.
25 He would have, as you saw in one of the complaints, 12:11
26 told somebody to come in the night before but nobody
27 else knew about that. So, the gentleman turned up at
28 the ward 'I am here for my operation', 'well, what
29 operation'. That's the sort of havoc I am talking

1 about. And because he went on so late, then others had
2 to go off the list that were due to be done that day
3 and then there had to be found time for them again.
4 Things like that.
5 129 Q. So it was more a scheduling thing and perhaps overruns? 12:11
6 A. Just scheduling and him, I suppose, not toeing the
7 line, as everybody else, did that caused havoc.
8 130 Q. Thank you. Going back to the end of 2016 when
9 Mr. O'Brien had some scheduled surgical sick leave, you
10 seemed to be quite happy about his plan to do lots of 12:12
11 administration when he was on sick leave. Was that
12 unusual?
13 A. It is very unusual because, you know, there are so many
14 HR rules in and around being on sick leave. I suppose
15 there wasn't much anybody could do about it because he 12:12
16 had the charts at home, so he did it and sent them in.
17 I think someone had told him that's acceptable.
18
19 So yes, it is very strange to do. Had I made the
20 decision initially, I wouldn't have let him. That 12:12
21 shouldn't have happened really.
22 131 Q. Did he volunteer to do that?
23 A. Oh yes, yes absolutely. He wanted to do it. He
24 actually wrote somewhere, there is evidence somewhere
25 that he said if you would allow me to do it this way. 12:13
26 So, when he was off sick, he was doing his work and
27 sending them in in dribs and drabs.
28 132 Q. You mentioned following the system and obviously its
29 one of your themes. The Inquiry are aware of a couple

1 of post-op deaths maybe related to checking mechanisms
2 at the time of surgery and the WHO checklist. Did that
3 come before you as clinical --
4 A. No, that would probably have been discussed at the
5 AM&M meetings. The doctors always discussed all the 12:13
6 deaths. But no, I am not aware of the deaths that were
7 possibly to do with the WHO checklist. Thats a system
8 again.
9 133 Q. One certainly was an SAI so that could have come to
10 you. 12:14
11 A. If I see it, I might remember it. I just can't off the
12 top of my head say. It does tell you why you should
13 follow systems, doesn't it?
14 134 Q. Generally speaking, were you happy with the surgeons
15 complying with theatre procedures? 12:14
16 A. Absolutely. The girls that managed theatres made them
17 tow the -- they were well policed. But they had a good
18 relationship and, yes, in general the surgeons were
19 excellent. I mean, I have had surgery myself there and
20 no qualms. 12:14
21 135 Q. Just lastly, Mr. O'Brien being generally regarded as a
22 good surgeon. Do you think in retrospect, looking
23 back, that was referring to his technical skill, and
24 would you agree that a good surgeon should be assiduous
25 with administration and assiduous with keeping up to 12:14
26 standards and guidelines --
27 A. Yes.
28 136 Q. -- and that sort of thing.
29 A. I would agree a good surgeon should be an all-rounder

1 and you can't leave one thing. It's like your bundle.
2 You can't leave one thing off because if you leave one
3 thing off, the other things will suffer. It just shows
4 you what the general word around the place is because
5 that's what I got, everybody said -- I mean, there were 12:15
6 a lot of patients wrote in who complimented him.
7 That's the thing. Whenever you are looking at trends
8 and patterns, you look at the compliments as well.
9 There were very many patients who complimented
10 Mr. O'Brien. One said he even knew the name of his 12:15
11 cat. So he got into detail with -- that is the
12 patient's cat, not Mr. O'Brien's.
13 137 Q. One more question. Waiting lists; there are a couple
14 of SAIs which refer to waiting list management, which
15 we've discovered was quite variable around the Urology 12:15
16 Department. Were you content that the waiting list
17 management across the surgical division was well
18 organised? Did that theme come up in other --
19 A. No, it was -- no, across the surgical division, they
20 did run a tight ship. At any point I could ask, you 12:16
21 know, who is where with what. I always got a print-out
22 through Ronan, because he was the AD, who had done what
23 and how many were waiting, et cetera. No, I wouldn't
24 say that the system there -- I'm sure it wasn't perfect
25 but I didn't have any major issues with it at all. 12:16
26 138 Q. It was mainly a demand and capacity problem?
27 A. Yes, massively.
28 MR. HANBURY: Thank you very much.
29 DR. SWART: Just briefly on the surgical checklist, was

1 there 100% compliance with the surgery checklist? The
2 WHO checklist is the one usually used?
3 A. That was very much -- I was an operational director,
4 that was very much down the professional line.
5 139 Q. But you would expect metrics on that as part of 12:17
6 governance?
7 A. Yes. I can't answer your question.
8 140 Q. Do you know, because I can't see those figures
9 anywhere.
10 A. There would be through -- oh no, you know would 12:17
11 definitely. They did them, you know, knife to skin,
12 what temperature was the patient, I heard all of that.
13 So those would be --
14 141 Q. Compliance with the checklist is a specific thing that
15 was introduced and it's mandatory. 12:17
16 A. Yes, of course. I would imagine if you check through
17 the surgical -- through Ronan, you would be able to get
18 that. I'm nearly sure you would.
19 142 Q. You wouldn't have sight of any of that?
20 A. Not now, no. 12:17
21 143 Q. I mean at the time. Would you have known?
22 A. At the time, yes, but there was never any --
23 144 Q. Would you have known if there was a particular theatre
24 --
25 A. I would have know if there was a deviation or if they 12:17
26 really fell down. If they stayed within, give or take
27 a few... but I would have been told if there hadn't
28 been. I'm sure your question could be answered fully.
29 145 Q. It's really what you know. I mean, if nothing is ever

1 escalated, then you won't know?
2 A. That's right. Sometimes I only ever got to know the
3 bad bits. When the good bits were all right, sure
4 that's all right, we are doing it type of thing,
5 unfortunately. But yes, but I never got to hear of any 12:18
6 deviation.
7 146 Q. Just going to complaints, I think you recognise the
8 defensive nature of some of the letters. You talked
9 about that. I don't see much evidence in the letters
10 of action, in other words telling the patient and their 12:18
11 family that certain staff are going to be informed,
12 they are going do things differently in the letters I
13 have seen. Would you accept that?
14 A. Sorry, go over that again.
15 147 Q. If someone writes in and says all of these things 12:18
16 happened, we had a complaint letter we discussed as
17 part of this evidence.
18 A. Yes.
19 148 Q. I don't see much in the letter saying as a result of
20 your complaint, we are going to talk to the secretaries 12:18
21 about how they answer the phone, we are going to do
22 these things. I don't see much of that in the letter.
23 My question to you is did you have discussions about
24 that, because that's not something that requires a huge
25 infrastructure to implement; it doesn't require a 12:19
26 change in government resource but it does require a
27 change in attitude?
28 A. Yes, you're right. I do remember as we went along, you
29 know, and discussing what we put in complaints,

1 responses, yes, there would have been that. There
2 would have been I will make sure that team knows in
3 future; I will speak to X and make sure they
4 understand; apologies that you have had to experience
5 that. So yes, there would have been that. 12:19
6 149 Q. You had that discussion?
7 A. Yes.
8 150 Q. Did it go to if I went onto one of your wards at the
9 time and said to the ward sister what was the latest
10 complaint on this ward and what have you done as a 12:19
11 result, would they be able to answer that question?
12 A. Yes, they would. They had a dashboard up of what --
13 yes, they did.
14 151 Q. So, you were able to make some changes on that during
15 your time? 12:19
16 A. If you went in, you would have heard when the last --
17 when they last fell down in terms of whatever audit
18 they were doing. It was just the pressure.
19 152 Q. (Off microphone) complaints?
20 A. Yes, it was part of it. It was part of it. 12:20
21 153 Q. Secretaries, in particular. Would the secretary see
22 the complaint about the way they answered the phone and
23 be --
24 A. If someone complained about them and the patient had an
25 issue with it, then they would have been spoken to, 12:20
26 absolutely.
27 154 Q. Not a waiting list complaint, I am thinking about the
28 waiting list issue. Patients are waiting a long time
29 so they write in and then they are told you are waiting

1 a long time because there is a lot of cancer patients
2 and they take priority. That's quite a common
3 response. In that would be quite a number of attempts
4 to ring secretaries and so on quite often. Was that
5 brought back down to the secretaries? 12:20
6 A. It was because it was very common. It came through --
7 that particular point came through the patient
8 experience group. They would have said, you know,
9 we're told this, this and this, just tell us what we're
10 asking in a nice way. The secretaries would have been 12:20
11 talked to a lot. Yes, absolutely.
12 155 Q. Did that result in a change in the way they answered
13 the phone?
14 A. Yes, I do, I do. I do believe that.
15 156 Q. Bearing in mind the waiting lists are longer and 12:21
16 longer, as an Acute Director, what discussions did you
17 have at a governance meeting about how you assess the
18 harm to patients on those waiting lists? Again, I have
19 asked other people about this, I have not been able to
20 ascertain any methodology that was discussed. Was this 12:21
21 discussed is my question?
22 A. Waiting lists were always discussed both in performance
23 and in governance.
24 157 Q. This is a specific thing. Not did you discuss them;
25 not did you discuss them. Did you discuss how you 12:21
26 would go about working out who might be coming to harm
27 on that list?
28 A. Yes.
29 158 Q. What was the flavour of that?

1 A. The flavour of that was making sure that - and this had
2 happened already - making sure that the surgeon who was
3 in charge of the list had looked through it and said
4 that's a red flag, that's urgent and that one is
5 routine. In my time, and I made sure apart from maybe 12:22
6 once, that all cancers were down in time. That was a
7 golden rule. I discussed that within my group and they
8 knew that.
9
10 They always brought into my group quite late in the 12:22
11 afternoon, whatever meeting I was at, it was brought
12 into the room what we were going to have to cancel
13 tomorrow. I always asked for a narrative what is going
14 to be cancelled tomorrow, and I always said whenever
15 you're phoning this patient, give them time to air 12:22
16 their views but don't -- I didn't like to say
17 cancelled, I liked to say postponed because cancelled
18 to a person means that's it, it's over, whereas...
19 Then I also -- I monitored this very carefully because,
20 you know, if it had have been me, I would have been 12:23
21 distraught, how quickly then they were done after that.
22 159 Q. In the news this morning, the Ombudsman has reported on
23 waiting lists and lack of communication with patients.
24 I can't understand how you could possibly have managed
25 with awaiting list of four years to actually get 12:23
26 underneath which patients were coming in. This is a
27 general question, and the question is more around the
28 level of discussion. It's a very difficult thing to
29 answer, there is no perfect way of doing it. Did

1 people realise the risk in this?
2 A. Oh, of course, every day, absolutely, and who was on
3 that list. I know your question is about something
4 else but there were cleansed very often because very
5 often -- 12:23
6 160 Q. That's one thing you can do, make sure they need to be
7 on it?
8 A. Make sure they need to be on it, phone them up, this is
9 the hospital. I know, yes. I know what happens in
10 other areas but, yes, there are people on the waiting 12:23
11 list who -- and that's the risk.
12 161 Q. Did you have some mechanism of getting in touch with
13 them?
14 A. Oh, yes, absolutely. There was always -- there was
15 always the patient's contact details. They were always 12:24
16 brought in for a pre-assessment as well.
17 162 Q. If there is a very long waiting list and people are not
18 ringing up and complaining, how do you know they are
19 not getting worse?
20 A. You don't. 12:24
21 163 Q. Right. Did you have discussions about how they might
22 be contacted to assess that deterioration?
23 A. Waiting lists were always looked at and cleansed on a
24 regular basis. Patients were asked. Sometimes letters
25 went out. I said this, you know, just to say to 12:24
26 patients we understand your operation has now been
27 delayed X amount of months, we are predicting it's
28 this; if you have any trouble patients were always
29 asked to contact their GP because in the community that

1 was the only link they had. In the hospital we didn't
2 really have any link with them apart from contacting
3 them about their surgery. GPs were fundamental.
4 164 Q. Okay. You made quite a lot of comments about culture.
5 We have had from a variety of people that there have 12:25
6 been problems with the silos of management and
7 leadership. We have heard about hierarchy and problems
8 that might cause. We have heard that everybody was
9 working very hard to do their best throughout many
10 parts of the Trust. What, in your view, was -- apart 12:25
11 from just focusing on performance, I am not really
12 talking about that, was there anything about the
13 culture that you felt was detrimental to taking all
14 these things forward?
15 A. Apart from what you've just said? 12:25
16 165 Q. Those are the things we have heard about but was there
17 anything else missing? What was missing from your
18 perspective, because clearly you have strong feelings
19 about this? Everybody talks a lot of talk about
20 strategy and culture and all these things but when 12:25
21 you've worked in a system, sometimes you can identify
22 some specific things that need development to go
23 forward. What would they be?
24 A. I believe in terms of communication, there were silos.
25 In terms of management that would have been above me, 12:26
26 people didn't necessarily follow their roles and
27 responsibilities. That was actually a trend right
28 across, and I would say that to you. Roles and
29 responsibilities, for me, is every bit as important as

1 following up a procedure. I need to know what my role
2 is but I also need to know what your role is so that we
3 don't overlap or I don't do your job, causing conflict
4 and concern.
5 12:26
6 There was an awful lot of dissatisfaction in that. I
7 believe it's because people didn't know what their
8 roles and responsibilities were and they just did
9 whatever they thought on the day.
10 166 Q. Where do you see the responsibility for fixing that as 12:27
11 lying?
12 A. Well, whenever it's a culture, it's very, very, very
13 difficult to fix. It would needed to have come
14 corporately from the top on down. It would needed to
15 have been -- you see, you can't make somebody do 12:27
16 something unless they believe it's right to do. You
17 know, me making people believe, from my very, very
18 small part I discussed it, discussed the importance of
19 -- and it's not even hierarchy, it is just
20 communication lines. I didn't mind talking to whoever 12:27
21 in the canteen or whatever, but as long as the
22 information that needed to be passed up and down went
23 through the proper lines. That was massively not
24 there. So, somebody in --
25 167 Q. How much of that do you see as related to a huge span 12:27
26 of control that you had, that the Trust as a whole had?
27 How much of it was related to that and how much --
28 A. Quite a lot of it.
29 168 Q. Okay.

1 A. I couldn't give you a percentage but I struggled
2 massively with that. Now, I wasn't the person who went
3 along with the status quo so I was the thorn on
4 everybody's flesh trying to change it, you know.
5 169 Q. One last thing. Quite a discrete issue was the issue 12:28
6 of hundreds of notes at home?
7 A. Mhm-mhm.
8 170 Q. Now, that went against any sort of information
9 governance guidance. It's a fairly obvious thing.
10 Yet, the senior information risk officer at the Trust 12:28
11 was not aware of that until quite late in the day and
12 yet people on the ground were very aware of it and I
13 think perhaps didn't even complain too much about it.
14 Why is that; why did that happen?
15 A. You see to be perfectly honest with you, taking charts 12:28
16 home was an historical thing to do. It's wrong,
17 completely 100%, I'm not saying -- but people had sort
18 of got used to doctors taking charts. Sometimes there
19 wasn't... It didn't come in -- it didn't strike an
20 alarm bell in people's minds because of actually it had 12:29
21 been something that happened. You know, there was
22 doctors took them home to write them up. This is years
23 ago.
24 171 Q. I know years ago.
25 A. And people still sort of -- and because, there is 12:29
26 another thing as well and I'm not going to speak on
27 behalf of the records people, but I know there was a
28 massive issue in trying to store them, trying to keep
29 them safe, trying to keep a record of where all of them

1 were. That's a regional problem too. But in terms of
2 your question of why was that officer not told at that
3 point in time when we understood, I just have to say
4 I'm sorry, I don't know.
5 172 Q. Did you know that there were hundreds of notes at home? 12:30
6 A. No. No, I didn't.
7 173 Q. Never mind the silo, it was not brought up in --
8 A. No. No. No.
9 DR. SWART: Thank you very much.
10 A. You are more than welcome. 12:30
11 CHAIR: Mrs. Gishkori, you will be really relieved to
12 know that I have no questions for you.
13 A. You haven't any?
14 CHAIR: No, I am not going to ask any more. I think we
15 have covered quite a lot over the past couple of days 12:30
16 and the last time you came to speak to us. Thank you
17 for your evidence. I hope you are home in time now to
18 collect your grandchildren.
19 A. Thank you very much.
20 CHAIR: Ladies and gentlemen, we are back again the 12:30
21 week after next, the Tuesday. Tuesday the 27th.
22 MR. WOLFE: With Mrs. Burns.
23 CHAIR: Yes, at ten o'clock. Thank you, everyone.
24
25 THE INQUIRY ADJOURNED TO 10:00 A.M. ON TUESDAY, 27TH 12:31
26 JUNE 2023
27
28
29