



Urology Services Inquiry

Oral Hearing

Day 71 – Wednesday, 15th November 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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1 CHAIR: Good morning, everyone. Mr. Wolfe.

2 MR. WOLFE KC: Good morning, Panel. Your witness this
3 morning is Dr. John Simpson. I quite forget whether he
4 wishes to affirm or take the oath.

5 09:59

6 JOHN SIMPSON, HAVING BEEN AFFIRMED, WAS EXAMINED BY

7 MR. WOLFE KC AS FOLLOWS:

8

9 1 Q. MR. WOLFE KC: Good morning, Dr. Simpson.

10 A. Good morning. 09:59

11 2 Q. My first task is to take you to the three statements
12 that you prepared for the Inquiry to date and to have
13 you adopt them, if you wish, as part of your evidence
14 to the Inquiry. So, starting with your primary
15 Section 21 response which we received last year. It's 09:59
16 WIT-25695, and you'll recognise that.

17 A. Yes.

18 3 Q. It is your primary response to the Inquiry. You put a
19 little note on it to indicate that you've amended it
20 and I'll bring you to those amendments shortly. 10:00

21

22 If we go to the last page of this. It is 25732,
23 WIT-25732. That's your signature, is it, Dr. Simpson?

24 A. Yes, that is.

25 4 Q. The question, which I will repeat against all three of 10:00
26 your statements is do you wish to adopt this statement
27 as part of your evidence to the Inquiry?

28 A. I do, yes. Thank you.

29 5 Q. Then the second -- or the addendum to this is

1 WIT-103283. I think it primarily deals with the
2 monopolar and bipolar resection issue which emerged for
3 the Inquiry after your primary statement?
4 A. Yes.
5 6 Q. Going to the last page of that, 103290, you see it is 10:01
6 signed off on 27 October last, and that's your
7 signature?
8 A. Yes.
9 7 Q. Again, do you wish to adopt that as part of your
10 evidence to the Inquiry? 10:01
11 A. I do, yes.
12 8 Q. Thank you.
13
14 Then, finally, a very recent further addendum received
15 on 9th November from you, WIT-105748. It deals with 10:01
16 a number of typographical errors and focuses
17 substantively on an issue to do with actioning results
18 of investigations, an issue that arose in 2011. You
19 had some input or knowledge on that and you wish to
20 clarify points about that. We'll look at that in the 10:02
21 course of your evidence this morning.
22
23 Just going to the last page of this, WIT-105751, as I
24 say received from you 9th November. Again, do you wish
25 to adopt that statement as part of your evidence? 10:02
26 A. I do, yes.
27 9 Q. Dr. Simpson, you were the Medical Director for the
28 Southern Trust between August 2011 and July 2015; isn't
29 that right?

1 A. Yes.

2 10 Q. That's primarily the reason why we have asked you along
3 to give evidence. I will wish to explore with you the
4 state of clinical and professional governance at the
5 point at which you took up that post and how you 10:03
6 developed it. The Panel may consider that this is
7 a fairly significant period, having regards to the
8 issues that it is examining. We'll want to explore
9 with you this morning your ambition or goals for
10 governance, what governance initiatives you oversaw, 10:03
11 and with what success. Finally, we'll look at some of
12 the specific issues that relate to urology and their
13 association with Mr. O'Brien.

14

15 If we could have up on the screen, please, WIT-25704. 10:03
16 This is the section of your statement where you set out
17 your various roles, qualifications, and occupational
18 history. You are a psychiatrist by profession?

19 A. Yes.

20 11 Q. You took up a consultancy in psychiatry in what was 10:04
21 the -- I think it was -- was it the Newry and Mourne
22 Trust in 1992?

23 A. It was actually the old area mental health unit which
24 then the Trusts, the 17 Trusts were then shortly after
25 that. My contract was transferred to the new Newry and 10:04
26 Mourne Trust.

27 12 Q. So just scroll down. There's the answer. So you were
28 a psychiatrist -- a consultant psychiatrist during that
29 time.

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You made an entry into what might be called medical management or professional management at, I think, a relative early point in your career. You became a clinical director of Mental Health. Just scrolling down, I think that was 1994?

10:05

A. Yes.

13 Q. From there -- scrolling down -- I think in 2007 Associate Medical Director. Then, as we know, 2011 into the Medical Director's role.

10:05

Help me with this: Your involvement in medical leadership posts from 1994, what was the interest in that; what drew you into that field? Obviously, it was supplementing or complementing your work as a psychiatrist during many of those years?

10:06

A. Yes, that's it, really. I could go back to the '80s when there was a massive change in psychiatry. The Royal College of Psychiatrists had a very definite move into multi-disciplinary work and a multi-disciplinary leadership. So, training as a senior registrar in psychiatry, there would have been management training, leadership. That was for all psychiatrists. So it wasn't a big jump really to move into medical leadership, but the opportunity arose. There were four clinical directors in Newry and Mourne - medicine, surgery, obstetrics & gynaecology, and psychiatry. I went for that post, interviewed and got the post.

10:06

10:06

1 It didn't make my job any more difficult. I probably
2 haven't known very much else apart from being
3 a clinical director and a frontline psychiatrist
4 through my entire career. They do complement each
5 other. The delivery of psychiatric care is about 10:07
6 delivering in teams. The set-up in Newry and Mourne,
7 I thought, was a very healthy teamwork-type atmosphere
8 that I was very comfortable with, coming from
9 psychiatry. And I found that the Newry and Mourne
10 approach, being a hospital, was quite a comfortable one 10:07
11 and a very forward-looking leadership from Paddy
12 Loughran Medical Director, and Eric Bowyer, Chief
13 Executive. It was in addition to my full-time
14 psychiatry post but the two things merged, really.
15 I had a very good support from a senior manager at well 10:07
16 at that point.

17 14 Q. One of the things that we'll maybe touch upon as we go
18 on this morning is that a number of witnesses who have
19 held medical leadership roles in surgery in the
20 Southern Trust, and I can think off the top of my head 10:08
21 of Mr. Mackle, Mr. Brown gave evidence yesterday,
22 Mr. Haynes, to name but a few who have given evidence
23 to the Inquiry -- Mr. Weir as well -- they pointed to,
24 if you like, a strain or a pressure felt by them in
25 taking on a leadership or a management role alongside 10:08
26 a busy clinical practice in the sense that they weren't
27 as well supported, or didn't perhaps have enough time
28 on their hands to adequately manage those roles.
29 That's not what you found in psychiatry?

1 A. No. In the Newry and Mourne Trust for more than ten
2 years, there was a lot of support. It was a small
3 hospital and a community as well, and a very good
4 manager that I work with. It was different because at
5 that stage I was also the budget holder as well as the 10:09
6 Clinical Director for a team of about 60 people but it
7 wasn't that difficult, I thought. However, when the
8 new Trust formed in 2007, the original proposal was
9 I should be a clinical director for Mental Health.
10 I said no because I knew there was a massive job ahead 10:09
11 in terms of integrating the various parts of Mental
12 Health across the new Trust area. So I said, yes, I'll
13 do it but I want to be the Associate Medical Director
14 and I want two Clinical Directors and I want a Band 5
15 secretary to support me, and I want the kind of, if you 10:09
16 like, partnership that I had had with the new Director
17 of Mental Health that I had in Daisy Hill. Now,
18 I wasn't the budget holder, which was the new Director
19 of Mental Health, but we forged a partnership really.
20 10:10
21 So I'm not sure if the other guys realised what was
22 ahead of them. I had a rough idea that it would be
23 pretty busy, and I was experienced in those matters.
24 The other thing that I got was backfill. I did get an
25 extra payment, but the extra sessions were passed to 10:10
26 a staff grade, a very experienced staff grade, who then
27 freed me up. Well, I actually argued for two full days
28 a week; I got one and a half.
29 15 Q. Yes.

1 A. So I was in a different -- coming from a different
2 angle completely to the surgeons who were moving into
3 this field de novo, really.

4 16 Q. Yes.

5
6 Then 2011, I suppose the big job, the Medical
7 Director's role. How well did you feel in terms of
8 experience and equipment to take on that role at that
9 time? What were you bringing to the post and why did
10 you want it?

11 A. Well, I had four years working under Paddy who, in
12 fact, previously had been like a mentor to me -- Paddy
13 Loughran, that is -- and sitting around the table with
14 the other Associate Medical Director every quarter.
15 I had a good idea what was ahead of me. I was quite
16 interested because I thought there's a lot I could do
17 to bring a multi-disciplinary approach to both the
18 clinical world and the leadership world. Well, just
19 looking for a new challenge really at the age of
20 whatever I was; early 50s, whatever.

21
22 Interestingly, and I think it should be on the record
23 here, I had come from a position, as we all had in the
24 health service, where there had been expansion. We had
25 been given development monies to restructure St Luke's,
26 the old hospital, build a new one, investment in
27 a community team. There was a dramatic change around
28 2011/'12 in terms of austerity, efficiency aims and so
29 on. I didn't calculate on that having such an effect.

1 So, I was doing the job with optimism as a medical
2 director.

3 17 Q. We'll, in a few moments, come to look at some of the
4 initiatives that you undertook as Medical Director.
5 You stayed in the post for four years. Why did
6 you leave it in 2015? 10:12

7 A. At the time I was able to take early retirement.
8 Looking back I would call it early burnout, because
9 after about a year of, you know, going back to family
10 and doing things, catching up, I noticed that I got my
11 enthusiasm back, so I must have lost it. I think 10:13
12 that's what the health service does to people.
13 Particularly those were very, very good years but very
14 busy years; everything was stretched. I was trying to
15 push one way, the health service was being pulled, 10:13
16 maybe, in a different direction. It wasn't all
17 difficult but it was pretty exhausting.

18 18 Q. Yes. You say early retirement or early burnout. You
19 had maintained employment within the Public Health
20 Service in a number of governance roles. Just briefly 10:13
21 to tidy that up and finish where you are, if you just
22 scroll down we can see that I think you hold three
23 roles. Let me see, are they there? If we go down.
24 Yes. The first is from 2015 to present, you're
25 employed at the Leadership Centre. You describe the 10:14
26 kind of work you engage in there, including in
27 association with Level 3 Serious Adverse Incidents.
28 You have roles in MHPS investigations, and also you've
29 had a role in the Hyponatraemia Inquiry or

1 post-Hyponatraemia Inquiry work stream. You then
2 second had a role with the RQIA, including undertaking
3 site inspections. You describe that there. Then, just
4 over the page --

5 A. I would do less of those two jobs at the moment. I'm 10:15
6 more of an adviser now in RQIA rather than inspections.
7 I haven't done any consultancy work probably for about
8 two years, well, two years really, since becoming more
9 involved in the Southern Trust again.

10 19 Q. Yes. Your involvement in the Southern Trust, I think 10:15
11 it is described at the end. Yes. From 2020 you have
12 been chairing Serious Adverse Incidents reviews,
13 primarily in the Mental Health Directorate. So that's
14 your current lot.

15 10:15
16 Let me bring you back to Medical Director. We have the
17 job description for that role at WIT-25757. If
18 we scroll down, we can see that your key result areas
19 are spread across a number of subdisciplines including
20 governance, which is what we primarily want to focus on 10:16
21 today. But just to show the breadth of the job, we'll
22 come back to some of these governance features. Keep
23 scrolling. Maybe just in the interests of time, I'll
24 say them. You had responsibilities for service,
25 medical education and training, research and 10:16
26 development, quality, financial and resource
27 management, corporate management, HR, and management
28 responsibilities. So, it was a wide package of duties
29 that you held.

1 A. Including infection control, which was again quite a
2 big -- prevention of infection; IPC.

3 20 Q. You explain in your witness statement you had
4 responsibility for 11 Associate Medical Directors and
5 20 Clinical Directors, give or take.

10:17

6

7 where were you based? were you based in Daisy Hill or
8 based in Craigavon?

9 A. Both. Mainly in Craigavon in the headquarters. So,
10 the main corridor, Chief Executive opposite, HR
11 Director next door.

10:17

12 21 Q. You explain again in your statement -- this is
13 WIT-25706 -- that you reported to Mrs. McAlinden, who
14 was the Chief Executive at that time. If we go to
15 WIT-25713, you explain that for the first two years,
16 you were required to have regular 1-to-1 meetings with
17 the Chief Executive as an informal performance review.
18 These became less frequent thereafter. why was that?
19 was that because they were unnecessary or was there
20 a difficulty there in the relationship?

10:18

10:19

21 A. There were strains but whether they were any more
22 severe than the strains between any Medical Director or
23 Chief Executive, I'm not sure. Having said that, her
24 office is directly opposite mine so there's plenty of
25 communication. The strains would be the obvious ones.
26 The Chief Executive is obviously the chief accounting
27 officer and has that responsibility to make sure we
28 have break-even. My responsibility, I think, is more
29 towards, if you like, patient safety, the doctors, the

10:19

1 GMC, and so there's that lively tension. So there were
2 some lively debates at times, surely, yes. As the
3 years, I think -- and I have to mention the austerity
4 issue, it became more and more a preoccupation. The
5 phrase that sticks in my mind most is "3% efficiency 10:19
6 savings year on year". That obviously was mandated of
7 the senior management team. I didn't agree with it.

8 22 Q. I'm going to take you to that just in a moment and see
9 how that debate worked out. But in terms of the
10 support that you felt from above and in terms of the 10:20
11 support that you had to do the job, you mention that
12 you were supported by one Band 8 manager, Mrs. Brennan.
13 How well supported did you feel in the role?

14 A. It started off very well. Anne Brennan had worked
15 there for all of those years with Paddy Loughran, so 10:20
16 that was really important. Another person, Stephen
17 Wallace, likewise. So that continuity was very useful.
18 It was a very small department and it was very tight,
19 but we were a good team and well organised.

20
21 what I didn't realise and what I look back on now and
22 see is that from the professional point of view, I'm
23 the only doctor at the senior management team and I'm
24 the only doctor on the Trust Board. There were times
25 I would have thought not so much supported, I would 10:21
26 have liked actually more challenge, questions.
27 Sometimes I would give an opinion to Trust Board and
28 I would be hoping that someone would push me and ask me
29 questions and get me to think, you know.

1
2 Another weakness, I think, looking back on the
3 structure in terms of support was that from
4 a professional point of view, the Director of Nursing,
5 Francis Rice, was also the Director of Mental Health 10:21
6 and learning Disability which in itself is a full-time
7 job. The Director of Professional Social Work was also
8 the Director of CYP, Children and Young Person's
9 Directorate. At that senior management table, although
10 they are the professional heads, their preoccupation is 10:22
11 with the operational delivery and, increasingly, with
12 efficiency savings and so on and so forth, and
13 performance targets. That dominates the structure.
14 Looking back, I think other Trusts were probably the
15 same, but looking back I think that was a weakness. 10:22
16 where I'm making arguments, counter-arguments, as
17 always, against the stringencies that we were under,
18 those two people, who would be very sympathetic
19 obviously, and very professional, but their main
20 preoccupation is to go with the flow and maintain 10:22
21 financial, if you like, balancing the books and also
22 pushing through on performance targets.

23
24 It became increasingly problematic, I think, as the
25 years went by. I could see the point from the Chief 10:23
26 Executive and so on, the Southern Trust was held up as
27 an example of, you know, financial regularity and so on
28 and so forth. But it became quite intense in 2014
29 because more was being asked of a Trust that was

1 already very lean. I could understand the pressure on
2 the senior management team, the Chief Executive.

3 23 Q. You mentioned just a moment or two ago, I think it was
4 in the context of a review of director
5 responsibilities, that you thought it appropriate to 10:23
6 suggest that your responsibility for infection
7 prevention and control should sit elsewhere. You set
8 this out in your statement at WIT-25726,
9 paragraph 57.2.

10 A. That's a different one, I think. 10:24

11 24 Q. I should bring you to WIT-25701, sorry.

12 A. Yes.

13 25 Q. Your purpose in suggesting that was to free up more
14 time for clinical governance, generally. That
15 suggestion was received sympathetically but was 10:24
16 refused. We can see Mrs. McAlinden dealing with that
17 in response to you at TRU-250689.

18

19 Just while we're waiting on that, if we scroll down.
20 Mrs. McAlinden really sets out her view that it's not a 10:25
21 straightforward matter of shifting responsibilities.
22 In raising this point in your statement, is the
23 significance of it that you felt that the focus of your
24 role should be on clinical governance, professional
25 governance and Patient Safety in getting the structures 10:26
26 and the systems around that right, and that this area
27 of infection control, while important, was an
28 unnecessary distraction for you? Is that the point
29 you're making?

1 A. It was a big distraction. There was a Pseudomonas
2 issue with neonatal deaths. There was a C-Diff
3 problem. There was a problem with infections -- sorry,
4 IV line sites. There was loads of activity. I also
5 mentioned in the dispatches the issue with indwelling 10:26
6 catheters and so on. It was a big area. I think the
7 problem I had was that prior to my arrival, the
8 responsibility for governance, I think, had been pushed
9 down into the frontline, shall we say. I thought after
10 a year or two it had become actually submerged, because 10:26
11 it sounded like a good idea at the time. It became the
12 responsibility of the Chief Executive working with an
13 Assistant Director For Clinical Governance and I was
14 side on to that, which was okay for a while. In fact,
15 the AD for Clinical Governance was in the office next 10:27
16 door to me. But I felt that as time went by, clinical
17 governance was being submerged and not surprisingly
18 because of the emphasis on productivity, performance,
19 and so on and so forth.

20
21 what was also happening was I would be getting phone
22 calls from the Board saying what about this SAI, John;
23 what about that SAI, and I would say I haven't been
24 consulted yet about those, because I would only be
25 consulted about an SAI review when things weren't 10:27
26 working very well. So, I didn't have that overview
27 although what I did do was kind of insert myself into
28 it. So there was a meeting every month of the Clinical
29 Governance Coordinators from the four different parts

1 of the Trust and I would join that, with Debbie Burns
2 who was the AD.

3 26 Q. Let's look at that issue you've raised and just try to
4 understand it structurally within the Trust.

5
6 If I could bring up on the screen, please, from your
7 statement, WIT-25730. At paragraph 71.1 you're saying
8 you're concerned that as far as you were aware:

9
10 "I was the only Medical Director of a Trust in Northern 10:28
11 Ireland who was not also the Director of Clinical
12 Governance, therefore I did not have an overall view of
13 Patient Safety and did not have the resource at my
14 disposal to improve and develop clinical governance.
15 Matters of concern would be escalated to me by the 10:28
16 Assistant Director for Clinical Governance on an ad hoc
17 basis."

18
19 Just help us better understand that. The
20 responsibility for clinical governance, did it rest 10:29
21 with the Chief Executive?

22 A. In name, but in practice it rested with me, you know,
23 and that was how it worked out. It might have been
24 a good idea at the start to sort of divulge and divest
25 clinical governance down into the frontline but, from 10:29
26 my perspective, I think I lost something from that and
27 it took me a while to figure all of that out. In my
28 job description it says I'm responsible for clinical
29 governance as part of the senior management team, which

1 could have been fine, as I said, but there was
2 weaknesses in the structure outside of clinical
3 governance. I felt a little bit disenfranchised, if
4 you like; responsibility without power.

10:30

5
6 But also, from a positive point of view, I wanted to
7 reform -- and we'll come to that -- mortality,
8 morbidity meetings into a Patient Safety system.
9 I also wanted the resource, which a big thing in Health
10 Care Trusts, the budget. I didn't have the budget for
11 clinical governance. I couldn't say let's move here,
12 let's move there, I want more to do this and so on. So
13 I was always -- it was okay at first. I was always
14 bargaining, if you like, chipping in saying could we do
15 this, and relying very heavily on powers of persuasion,
16 and so on and so forth. No one really disagreed with
17 me but anything I would say, the managers would say,
18 well, yes, John, but what about these waiting list
19 targets? The doctors would say yes but I've got to,
20 you know, keep up the performance, there's so many
21 clinics to be done and so on and so forth.

10:30

10:30

10:30

22
23 So the ideas that I would have had weren't strange and
24 weren't -- I didn't think so any way. I mean,
25 I distributed a paper one time from the King's Fund
26 called Distributive Leadership to try to explain to
27 people where I was coming from. I didn't think that
28 I was really coming from left field but I think my
29 perception was that they thought I was. I think the

10:31

1 structure that was there didn't stop me but it did slow
2 me down, I think, and make things more difficult.

3 27 Q. Let's just pull this back to your job description again
4 and maybe help to enhance our understanding of what you
5 just said. WIT-25758. Scrolling back a little bit. 10:31
6 This is the governance heading in some of the things
7 we'll look at this morning, Professional Leadership and
8 Guidance to Support the AMDs, CDs, and the Clinicians.
9 We'll look at how you tried to exercise that role in
10 a moment. 10:32
11

12 Scrolling down to number 3, we'll just take a snapshot
13 of some of these. I think this is the point you just
14 made to the Panel, that you're a member of a senior
15 management team and you have corporate responsibility 10:32
16 as opposed to specific or individual responsibility for
17 ensuring a specific system of integrated governance
18 within the Trust. It goes on, a further snapshot,
19 picking up at number 4 your responsibilities as
20 a responsible officer are set out. We'll look at how 10:33
21 you dealt with that.
22

23 But just going back to number 3 for a moment. In terms
24 of the set-up around governance that you think --
25 judged by your answer -- was a regrettable or 10:33
26 retrograde set-up or framework, you talk about budget
27 and having to try to persuade people that your course
28 was a sensible one and it should be funded; were there
29 communication issues as well? You know, were you

1 getting to hear about serious incidents that were
2 perhaps happening around the hospital? How did you get
3 to know about those? Was the system receptive to you
4 being adequately informed?

5 A. I was dependent on being informed. I wouldn't have had 10:34
6 the information to, if you like, know what questions to
7 ask. As I mentioned earlier, I think a DRO person from
8 the Board would say, you know, about a particular SAI,
9 how's that going, what's the delays, and I wouldn't
10 know about it. I was consulted where they -- that 10:34
11 would have been the Assistant Director and the Clinical
12 Governance Coordinators -- if they thought they had
13 a difficulty with an SAI review, but I had no regular
14 oversight of it.

15 10:34
16 You know, thinking back -- I don't want to blame
17 austerity for everything but this system might have
18 worked well had there been not such a pressure to
19 deliver targets. I think I could have been -- I can't
20 say more persuasive, but my persuasions might have been 10:35
21 more successful in allowing me to develop what I wanted
22 to develop had it not been for that. You know, even
23 getting the budget and being the responsible officer
24 and set up a new appraisal system, enhanced appraisal,
25 you know, I had to argue for the money for that, 10:35
26 something like £150,000 out of a budget of 500 million.
27 That's how tight things were. That's the stress. It
28 was achieved but everything was pressured and
29 contingent upon financial break-even.

1 28 Q. Let me bring you to, I suppose, one vignette to
2 illustrate the financial culture, what you refer to in
3 your statement as the prevailing culture at that time.
4
5 In 2014 there was a particular pressure, I think it was 10:36
6 to make £28 million worth of savings within the Trust.
7 You explain that in your witness statement at
8 WIT-25701. At paragraph 0 just there, I'll not read it
9 all out but you say:
10
11 "To illustrate the prevailing culture at the time 10:36
12 across the NHS and the emphasis in the Trust placed on
13 financial break-even and year on year efficiency
14 savings, I would draw your attention to the following."
15
16 This was a particular series of events in 2014 where 10:36
17 you were asked, as with others, other directors, to
18 make proposals that would contribute to the overall
19 package of savings being required by the Commissioner
20 and the Department. 10:37
21
22 If we go to TRU-25055 and just scrolling down a little.
23 You're writing to Stephen McNally. Is he an accountant
24 within the Trust?
25 A. Director of Finance. 10:37
26 29 Q. You're explaining to Mr. McNally what, in your view, is
27 not possible in terms of delivering savings within your
28 directorate. One suggestion appears to have been made
29 around pausing medical revalidation for six months.

1 You set out, I suppose in no uncertain terms here, your
2 view of that.

3
4 Could you just help us understand what was being
5 suggested to you? Was it being made as, I suppose, 10:38
6 a serious point to you that this is something that
7 could be surrendered for six months?

8 A. Looking back, I can understand the Trust and the Trust
9 Board's view, which was the previous number of years of
10 which I had witnessed, the Trust had been very, you 10:39
11 know, obedient, shall we say, very successful in
12 financial management, improving performance, and so on
13 and so forth. Anecdotally, probably the best in
14 Northern Ireland. So I think the Trust leadership at
15 that point thought asking us for 26 million in-year 10:39
16 savings was just ridiculous. I think it was not well
17 received. The contingency plan, dare I say it, was
18 almost like a game of poker, who is going to blink
19 first. So the suggestions were -- I couldn't have
20 taken them very seriously, really. In fact, the budget 10:39
21 in the medical directorate as such was tiny. When
22 they're talking about those things, it's really
23 scraping barrel bottom, etcetera, etcetera. So, they
24 were unrealistic.

25
26 I suppose what the Director of Finance was trying to
27 show to his -- you know, I answer to the GMC, he
28 answers to the Directors of Finance in the Department,
29 you know, that we are actually trying; you've pushed us

1 so far, this is how far, we can't go any further.
2 I presume that was the thinking. I didn't appreciate
3 it.

4 30 Q. Just to scroll down to show some. You say on
5 revalidation, your advice is it would be unworkable and 10:40
6 unsafe to pause this process. The Panel can look at
7 the fine detail of that.

8

9 The second suggestion that you have to deal with is
10 that litigation could be paused. Is that one that you 10:40
11 were able to take seriously?

12 A. With all due respect to Stephen McNally, you know, he's
13 an accountant, he's looking at balance sheets. I don't
14 think he really understood. I tried my best to explain
15 that these things were unrealistic. 10:41

16 31 Q. It's an indicator of --

17 A. Litigation didn't cost. I did the litigation. You
18 know, I met with the Board, the DLS person, every
19 month. Nowadays there's three deputy medical
20 directors, one of which -- I did everything. So, how 10:41
21 could there be savings? I didn't understand that.

22 32 Q. I think there's a third one on this sheet, something to
23 do with water testing. There you go, perhaps
24 illustrative.

25 A. We had just been through, as the whole of the North had 10:41
26 been through, you know, baby deaths because of
27 Pseudomonas, contamination of water supply in the
28 neonatal units. Dr. Damani was the infection control
29 lead and would have been scrupulous in his advice to

1 me. I took most of it. He did push the boat out
2 certainly but with good reason. So the water testing
3 might have been reduced slightly but really I don't
4 think that would have looked very good.

5 33 Q. Just scrolling back up, we see Mrs. McAlinden's 10:42
6 response to you. You can see that there. So, she is
7 coming back on that and saying that really radical
8 options have been put forward by others and you are
9 being asked to step down; somebody has referred to Colm
10 Robinson and his work. What was his work? 10:42

11 A. Colm managed, if you like, the routine audits.
12 "Manage" is the best word because he relied very
13 heavily on the nurses in the wards, the falls audits
14 and wound audits and such like, which happened in every
15 hospital. That was a very lean programme to start 10:43
16 with. He was asking nurses to use their own spare time
17 to work with him on these audits. So it was one post,
18 a Band 3/4 post. I was concerned about the message
19 that would send out. I knew probably we wouldn't have
20 to implement these contingency plans but I was worried 10:43
21 about the message that it would send out to frontline
22 staff, that somehow or other Patient Safety measures
23 could be paused. I didn't think that was a good idea.

24 34 Q. Yes. I think, just scrolling up further, you come back
25 again and say you have: 10:43

26
27 "No option but to advise against any reduction or pause
28 in our capability to measure and improve Patient
29 Safety."

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Is that a reference to Colm's role?

A. Yes, because I think they had accepted by that stage that the other possible financial reductions were not realistic. So that was probably the only thing that we disagreed on.

10:44

35 Q. Likewise, you would.

"... caution against any reduction in our capability to continue with Professional and Operational Governance."

10:44

Pointing to the serious financial difficulties, you go on to say:

"If the minister decides that there will be a reduction in the overall level of care provision, in that context it surely becomes more important that we continue to monitor quality and safety. In addition we must continue to improve the quality of whatever level of care we are permitted to deliver. Without continuous measurement, this becomes extremely difficult."

10:44

10:45

Is that a kind of description of your thinking, of your approach to governance in general?

A. Yes. My approach has always been Quality Improvement. You can never be perfect, you can't be safe, but you can safer. You can be criticised for not getting this right or getting that right by the public, the Coroner, whatever, but if you can show you are constantly trying

10:45

1 to improve, I think that goes down well with the
2 public, the public understand that. Even where Quality
3 Improvement doesn't necessarily improve quality, you
4 were trying. That was my view.

5
6 I think by that stage I was getting pretty exhausted by
7 the whole business. I think I handed my resignation in
8 about five or six months later.

9 36 Q. Tell me, you've talked about the Trust's obedience,
10 I think was the word, in terms of this break-even or
11 three percent strategy and how it was regarded, at
12 least anecdotally, one of the Trusts that routinely
13 came into line in that respect. Are you suggesting in
14 your evidence that the culture of senior management or
15 the attitude of senior management was more favourable
16 towards delivering the efficiencies, and less
17 favourable or less interested in the Quality/Patient
18 Safety agenda that you outline as being your interest?

19 A. Well, as I said earlier, no one really disagreed with
20 me. They would agree. They're all good health service
21 people, I have to say. Agree in one moment but in the
22 next moment "but we have to do this". So I don't doubt
23 their commitment to Patient Safety and the lessons from
24 the Francis Inquiry and to Mid Staffs. That was all
25 very current. But it's hard to describe the
26 relentless -- it is probably still happening, I don't
27 really know because I'm not up there any more -- but
28 the relentless pressure to produce so-called, I think,
29 efficiency savings. I had the understanding that --

1 well, if I got the sack as Medical Director, I'm still
2 a doctor, I can still earn a living. These people, on
3 pain of dismissal really, had to do what they had to
4 do; I understood that. But it was very stressful, for
5 them as well. I am particularly sympathetic to those 10:48
6 people in middle management, the heads of service, the
7 assistant directors, because they are the people that
8 are asked to square the circle. I think a lot of
9 the -- I appreciated the strain I was under but I think
10 those people are under even greater strain. 10:48

11 37 Q. If we go to -- these emails were, if you like, in the
12 build-up to a Board meeting that had to consider the
13 contingency savings. If we turn to that briefly,
14 WIT-25735. It is a meeting of 15th August. We can see
15 your name as being present, and those in attendance are 10:49
16 outlined.

17
18 If we move on to the next page, please, just scrolling
19 down. The financial position is set out by
20 Mrs. McAlinden. As said earlier, there is a need to 10:49
21 produce 28 million to arrive at break-even, as it's
22 described here. She goes on to outline a number of
23 pieces of correspondence. There's a letter from the
24 Chief Executive of the HSCB. In this letter, assurance
25 is sought that none of the proposed contingencies will 10:49
26 impact on Patient Safety and that all the proposed
27 contingencies are supported by all Trust Directors,
28 including professional leads. Mrs. McAlinden's
29 response to that is that the commitment to safe care is

1 impossible to guarantee, as is the securement of
2 clinical commitment due to the short term and
3 counter-strategic nature of the necessary measures to
4 achieve break-even. The Trust Board members agreed
5 that the Chief Executive should include this point in
6 her covering letter for the draft contingency plan.

10:50

7
8 Does that echo the point that you made a moment or two
9 ago, that senior management, indeed middle management
10 as well, was sympathetic to the notion that the
11 continuing relentless drive for cost saving was going
12 to impact on Patient Safety or potentially impact on
13 Patient safety? There could be no guarantee, as it
14 suggests here?

10:50

15 A. That's a fair point. I think the potential risk was
16 there; they recognised it. The letter from the Chief
17 Executive at HSCB, it is a bit of a bind, really, isn't
18 it, you know; we pushed you so far. The Southern Trust
19 position was we have really done very well to work
20 within your limits and so on, you shouldn't be asking
21 us to do the same as every other Trust since
22 we've already performed better. That was the position.

10:51

10:51

23 38 Q. I think if we scroll down to WIT-25739, just a couple
24 of pages down. We can see, I think after a discussion
25 around the table -- I'll come back to your contribution
26 to that discussion in a moment -- there were a number
27 of key concerns agreed and they're set out there in the
28 document in front of you. I think the last one is,
29 perhaps, another echo of what you have just said:

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"While the Trust Board is prepared to deliver on its responsibility" -- assumedly a legal responsibility -- "as set out in the Permanent Secretary's letter by enacting the approved elements of the draft plan, it would not be supportive of doing so given the detrimental impact of such actions on service users and staff". 10:52

A. That's a fair point. As I say, it was almost like a game of who is going to blink first between the Trust and the Board. At this point really I'm thinking, well, that's all very well, people, but my responsibility is to the GMC and therefore to the public and to the medical staff and professional staff; I can't go along with this. So I wanted that included in the minutes. 10:53

39 Q. If we just go back, I think you do make an intervention at this meeting. If we scroll back. Yes, it is just there, in fact. A number of the nonexecutive directors made contributions to the meeting. I think I'm right in saying that it was only yourself and Mrs. Burns among the staff as such who have made recorded interventions. You said or you raised your concerns about the potential adverse impact on quality by the proposals in the draft plan to temporarily redeploy resources to critical frontline services from areas such as Patient Safety, audit and evaluation. That's it, that's your concern in a nutshell? 10:54

A. Yes. And although it didn't happen, I was worried that

1 the very notion of it would filter down to frontline
2 staff. You know, that after a number of years of
3 financial pressure and so on, that we just have to
4 knuckle down and get on with the throughput. That was
5 a worry.

10:54

6 40 Q. Yes.

7
8 In terms of your role, you wear several hats or you
9 hold several responsibilities. One is to the GMC.
10 You're an employee, you're also a Board member or
11 a director who attends the Board.

10:55

12 A. I would be an Executive director of the Board.

13 41 Q. Did you have a sense of any conflict of interest when
14 it came to matters such as this?

15 A. Yes, I think so. As I say, the weight of the Trust and
16 the personnel at the top was towards fulfilling these
17 targets. So the Medical Director -- it was me --
18 you're, shall I say, relatively isolated in these
19 discussions, and it's important to make your presence
20 felt.

10:55

10:55

21
22 With regard to the GMC, you see, it is not just
23 a matter of me as a doctor, there's a responsibility of
24 me as a Medical Director to ensure that the Trust --
25 the organisation within which doctors are employed --
26 is a safe organisation. I think this is one of the
27 issues that arose in maybe the Bristol Babies Inquiry
28 and also the Mid Staffs Inquiry. If you like, I had to
29 protect myself, if you like. I had to speak up.

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As I say, I knew the likelihood of the contingency plan being put into place was unlikely but the thought of it was enough to worry me.

42 Q. Ultimately, as I understand it from your evidence, it wasn't implemented? 10:56

A. It wasn't.

43 Q. Yes.

A. And what happened about the 26 million, I can't remember precisely. 10:56

44 Q. In terms of you talk about the three percent and that still echoes in your ear today, had you a sense of what was going on on the frontline in terms of the delivery of the services and how it was impacting on clinicians in terms of their delivery, or what was expected of them in relation to delivery? 10:57

A. Yes. That would have dominated the discussion at my quarterly meeting with the Associate Medical Directors. It came up a lot in the discussions around job plans where, you know, job planning was a new thing, measuring what doctors do, a demand capacity assessment. So, it was a very live issue for all the clinical staff, not just the medics. My perception of it was -- again from a Quality Improvement point of view -- any systems engineer will tell you that a safe system needs to run at around 85 percent capacity. 100 percent capacity, it is going to fail at some point. 65 percent is not good either. You need that room to manoeuvre to run, running repairs, 10:58

1 developments, reflection, deal with peak demand. By
2 that stage we were accepting as normal winter pressures
3 as if that was acceptable; it's not. You know, the
4 system should be built around capacity and demand to
5 measure the two up.

10:58

6
7 So what was happening with the efficiency savings was,
8 in fact, they weren't efficiency savings. They were
9 making us less efficient in the long run.

10 45 Q. Obviously how the services are delivered are
11 operational matters for each directorate and obviously
12 cascading down into the services themselves. But were
13 you receiving information/intelligence that the medical
14 frontline staff were, if you like, because of these
15 austerity measures, frequently having to, I suppose,
16 resolve dilemmas in how they approached, for example
17 the heavy waiting lists that they would have? Just to
18 work this example through, the suggestion might be that
19 if they're taking on an extra load to deliver on
20 a waiting list initiative, that that's going to impact
21 on their ability to be as efficient and productive in
22 other areas of their work.

10:58

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10:59

23 A. I think -- I don't think there was any evidence of
24 people cutting corners in order to, you know, get the
25 job done. Where that did arise would be -- I think
26 it's in the evidence -- issues such as introducing new
27 clinical guidelines. That takes time, it takes effort,
28 it takes doctors out of their everyday work to do
29 things differently. It requires training, changes of

11:00

1 organisation. There's always that tension between
2 a clinical guideline and what a frontline practitioner
3 says this works for me, and the old-fashioned idea of
4 consultants saying to the health service, "This is my
5 practice". That was disappearing but, still, they had 11:00
6 their way of doing things.

7
8 whenever you were trying to introduce changes like
9 that, or the changes that I was suggesting about
10 morbidity/mortality meetings, there was no suggestion 11:01
11 that we can't do this, you know, it was just this is
12 going to be difficult. You're asking us to do things
13 which are difficult. Good ideas, John, but difficult
14 to implement. I think I was worried but there was no
15 direct evidence that things were falling apart, but 11:01
16 I was concerned about how things might pan out in the
17 years ahead. So my four years or so, I think the
18 organisation survived quite well, frontline clinical
19 staff, middle managers, senior managers, but it was at
20 full stretch. 11:01

21 46 Q. If we, just to extend this debate a little, think about
22 urology. Urology had skyrocketing waiting lists in
23 virtually all domains, both outpatients, day cases,
24 inpatients, and review. The Inquiry certainly hasn't
25 received any particular evidence to suggest that the 11:02
26 Trust was itself auditing morbidity of patients while
27 they languished on waiting lists. The clinicians
28 themselves would have had a good idea of what was
29 needed for patients on the waiting lists. The argument

1 might be that they had an obligation, where they could,
2 to try to mitigate risk for their patients to the
3 extent that resource allowed them to do so. would you
4 view that as -- I use the word "obligation", you can
5 choose another word if it is more comfortable -- would 11:03
6 you see that as being an obligation on the clinician to
7 mitigate where they can?

8 A. More than likely but I can't think of any simple
9 examples to illustrate the point.

10 47 Q. I suppose one illustration might be Mr. O'Brien has 11:03
11 given evidence to the Inquiry through a Section 21 that
12 he took on an extra load of theatre work, more sessions
13 than would have been part of his work plan, whether
14 pursuant to working waiting list initiatives or what
15 have you. In doing that, that obviously expands -- 11:03
16 there's a need to expand his time in theatre to deal
17 with that, but that might impact on other parts of his
18 work?

19 A. Yes.

20 48 Q. That's the kind of dilemma that he certainly points out 11:04
21 as being one that was impacting him.

22 A. That's not unreasonable. I didn't hear about that in
23 particular but it was widespread, those kind of issues,
24 for, if you like, the type of focus on waiting lists
25 which was for, you know, procedures, that you can do 11:04
26 more of these but this has a knock-on effect on other
27 parts of the system. You know, opening the doors to do
28 procedures, then other things happen. I think,
29 possibly... My perception of healthcare, you see, is

1 that it is lifelong and it is mostly about managing
2 chronic conditions. There's acute chronic episodes and
3 there's acute care, but that's only a snapshot of what
4 goes on in the bigger system. Possibly where to look
5 on that would have been in the general practice because 11:05
6 it is the GPs who are maintaining the patients as they
7 wait for whatever pain relief operations or so on and
8 so forth. It's difficult from the hospital Trust point
9 of view -- well, the Trust point of view, to see what's
10 going on out there. 11:05

11
12 We did have an Associate Medical Director for Primary
13 Care, which was an excellent idea, Peter Beckett, to
14 bring those to us. We organised meetings whereby
15 clinicians from the various parts would go out to meet 11:05
16 the three sectors of GPs to improve that communication.
17 But all I can think back is the ethos of the time -
18 we've got to keep active. Running to standstill,
19 I think I saw in someone's deposition. That was not
20 just urology. You know, my first year was heavily 11:06
21 preoccupied by paediatrics, for example. I can mention
22 three or four major problems that I had to work with.
23 It probably should have been in my job description
24 "firefighting" because that's where most of your time
25 was spent. 11:06

26 49 Q. Yes.

27
28 Let me move then to some particular initiatives that
29 you undertook. One of the issues that you took forward

1 was in respect of morbidity and mortality under that
2 broad Patient Safety aspect of your description. Can
3 you help us by summarising where you saw the state of
4 Patient Safety in that domain when you entered your
5 role, and what was your ambition or objective in terms 11:07
6 of improvement?

7 A. Yes. I had come from a reform of the Mental Health
8 Service and a new Psychiatric Inpatient in Craigavon.
9 It wasn't that difficult to set up a multi disciplinary
10 Patient Safety meeting. We didn't call it 11:07
11 morbidity/mortality. In that area we had patient input
12 from the patient advocate; we had input from the
13 auditors of, you know, falls of various things.
14 We reviewed serious incidents, we reviewed minor
15 incidents. That was a monthly multidisciplinary look 11:07
16 at quality that we established, and I thought it worked
17 quite well.

18
19 When I looked at the M&M system in Craigavon and
20 Daisy Hill, it hasn't changed since I was a houseman. 11:08
21 You know, it was very much a lecture theatre-type
22 approach. Very useful, educational, but no outputs as
23 I could see. It was uni-disciplinary. Why should
24 mortality be only for medics is the phrase I used.
25 Because no matter how focused, say, a surgical team is 11:08
26 on the lead surgeon, it is the whole team. So what
27 I wanted was a multidisciplinary review, one that
28 focused on learning and outputs as opposed to
29 interesting cases or big scary cases, shall we say.

1 The surgical one and the medical one were too big so
2 I wanted them subdivided and then to come together.
3 I wanted them all to be in the same afternoon so that
4 radiology, paediatrics and so on could stagger their
5 attendance at the various meetings. But it is a bit 11:08
6 like rewiring an old house, it is much easier to build
7 a new one.

8
9 The greatest success I had in that was in ED because we
10 just created a new AMD post for ED. It had been under 11:09
11 medicine, which was too big. So, a new AMD and a new
12 CD in the Emergency Departments in both hospitals. So
13 I set up a brand new M&M meeting there, which
14 I checked, it's still going. It was easy because
15 we started from scratch. There was a good team ethos 11:09
16 in ED. So a team ethos into quality and safety was
17 quite easy. I sat in a few of those meetings and
18 I thought this is the model. They were
19 multidisciplinary right from the start; there's a team
20 ethos; there's an ethos of getting things done. There 11:09
21 was no problem about bringing head of service and AD
22 into the meeting, which would have been unknown in
23 M&Ms. where there were outputs, then the head of
24 service would know exactly why the outputs were being
25 demanded of the service and so on and so forth. It is 11:09
26 very difficult to manage culture change, but you have
27 to start.

28 50 Q. Let's just hold that thought and look at a couple of
29 specifics around culture change and what you maybe saw

1 as being less than adequate. Let's start. You're only
2 a few months into the role and you wrote on
3 25th November 2011 an e-mail about morality reports to
4 Mrs. McA Linden. TRU-250591. You are talking about
5 mortality reports, a work in progress. You're saying: 11:11

6
7 "These are one of but a number of windows on the
8 quality of clinical activity. They seem to me to be
9 useful but need to be more fully embedded into our
10 governance systems. I don't think they should be seen 11:11
11 as something that only belongs to the Medical
12 Directorate, it is a much bigger and broader issue".

13
14 You say:

15 11:11
16 "The more I think about it, I see a need to integrate
17 all of our reporting on clinical and social care
18 governance both upwards to the Trust Board and downward
19 to the clinical teams, not just the medics. I believe
20 some Trusts in England produce an annual or bi annual 11:11
21 quality report which brings together all of
22 intelligence on clinical and social" -- I think that
23 should say "care governance. I think we should be
24 aiming to do that in 2012."

25 11:12
26 So, a number of issues going on there. Maybe if you
27 could just unpack it for us. You're suggesting, maybe
28 as a statement of intent early in your posting, that
29 the Trust needs to do better on these issues?

1 A. Yeah, modernise, I suppose, is a better word for it.
2 We may have been the only Trust using those reports;
3 I think maybe one other. I think it started under
4 Paddy Loughran, the previous Medical Director. They're
5 sort an eye in the sky look at the larger things about 11:12
6 morality. They produce some interesting points.
7 I mean, if there was a divergence between expected
8 morality and real morality, we would look into it.
9 A few times there was a divergence and we would have
10 asked -- I remember asking Eamon Mackle to pull the 11:12
11 charts in a few cases. In fact, they had already been
12 looked at at the M&M meeting, which was fine. It was
13 really just a taster: CHKS was the name of the firm
14 that we'd employed. It wasn't the most decisive thing,
15 it was a useful thing. I did look through the urology 11:13
16 one because it is not a specialty where there's many
17 deaths in theatre and so on and so forth. It is really
18 more trauma, surgery, ED, medicine and so on and so
19 forth.

20
21 It was really just the start; I wouldn't put too much
22 weight on that. The point I was making really at the
23 end was we needed to come up with a quality report. I
24 mean, that was agreed. I think I was a bit ambitious
25 thinking we could do it pronto, but that's the way 11:14
26 I am.

27 51 Q. We'll go on just now to look at how you relaunched and
28 rebadged M&M. There were two stages, really.

29

1 Does this e-mail suggest that in terms of the Trust at
2 that time and its approach to looking at the quality of
3 its activity, that really it did need to modernise?
4 Was that primarily what you were saying?

5 A. Yes. Again, there was no disagreement on that but it's 11:14
6 maybe not the number one priority, as we've said, with
7 regard to activity and so on. I mean, yes, everyone
8 agreed with it and we would present the result to the
9 governance committee and so on, they were of interest.
10 But it was only one of -- one of a number of windows 11:15
11 that you could have to look at quality and performance
12 in terms of safety, that is.

13 52 Q. Yes.

14
15 I suppose we've received evidence -- and this is 2011, 11:15
16 so the Inquiry is looking at, obviously, a broader
17 period than that -- but we received evidence that might
18 suggest on one view that the measurement of quality,
19 a sense of inquisitiveness around quality wasn't
20 necessarily there; wasn't party of the operations and 11:15
21 culture of the Trust maybe as the years go on. Did
22 you get support for what you were trying to push? If
23 you did get support, how was that manifested in
24 activity terms?

25 A. Yes, I got support. I remember being with Gillian 11:16
26 Rankin, talking about these things in the Acute
27 Directorate. The response of the Associate Medical
28 Directors was yes, but again, that's very interesting
29 but do you realise what we're asked to do.

1 53 Q. Just to be specific, what were they being asked to do?
2 A. When I told them that I was going to change the M&M
3 system into a Patient Safety system, and that there
4 would be eventually patients working with me in the
5 oversight of it, but in the first instance we would 11:16
6 invite a nonexecutive director to, you know, gently
7 introduce the idea that that should be the case, my
8 argument was, well, it's better to have that debate in
9 the Trust and being, if you like, questioned by Trust
10 Board, rather than, if you like, a more embarrassing 11:17
11 intervention by the Coroner much later or an. So that
12 was the argument, really that we should really focus on
13 these things. I'm not sure if it was much different
14 than any other Trust.

15 54 Q. If we look just, there was this relaunch, as you call 11:17
16 it, of M&M, 1st July 2013, so two years into your post,
17 WIT-26041. Here, you're writing to the Associate
18 Medical Directors. I suppose is this the first step of
19 this relaunch? If I talk it in terms of steps, the
20 second step in terms of creating subspecialty. Patient 11:18
21 Safety meetings came two years later, is that right,
22 with the creation of urology-specific --

23 A. Probably before that. I can't remember the timing of
24 it but we were making steady progress from 2012 right
25 through to 2014/'15. 11:18

26 55 Q. Just help us with this relaunch then. Just maybe see
27 the whole e-mail or the whole memo. Why was it
28 a relaunch? Why was recalibration, if you like,
29 necessary?

1 A. As I say, the M&M meetings to date were largely
2 educational, based in lecture theatres, exclusively
3 medical. I really wanted to not so much relaunch it as
4 call it a new Patient Safety system, but we hasn't
5 quite got agreement on that terminology. I think by 11:19
6 that stage I'd won the support of the Associate Medical
7 Director and others. I mean, they were clearly with
8 me. What I wanted to get through with that memo was to
9 the frontline, to every clinician. I may have said it
10 somewhere but the point I was making was I'm the 11:19
11 responsible officer, which was a new thing for
12 a Medical Director to be, it is my responsibility to
13 make sure when I revalidate you, that you're part of
14 a governanced system, a Patient Safety system, that you
15 engage in it. I wanted to make it clear, because I had 11:19
16 this opportunity with enhanced appraisal, to say to the
17 doctors I want you to actually engage and provide
18 reflection and evidence of that in your appraisal
19 statement. Appraisal was a very new thing. It is not
20 really performance management but I wanted to introduce 11:20
21 that requirement.

22
23 So that e-mail really was I was quite sure of my ground
24 in that I had the support of the Trust and the senior
25 medical leaders. I wanted to get it right down to the 11:20
26 frontline medics and the other clinicians, obviously.

27 56 Q. The three bullet points in the middle of the page,
28 could you help us with those? They seem significant.

29 A. Yes. Well, you see, previously there were -- there may

1 have been a culture of an M&M meeting beforehand on the
2 initiative of a doctor or group of doctors, and that
3 was great. I think I got asked about this in the
4 Hyponatraemia Inquiry as well. Just because one group
5 of doctors somewhere produces an improvement, it 11:20
6 doesn't necessarily go anywhere. Even when there are
7 outputs from an M&M meeting, they are not necessarily
8 recorded, formalised or followed through. The learning
9 point should be directly linked to our educational
10 systems. In other words, if it was just learning, then 11:21
11 we had educational systems where the learning would be,
12 you know, the first priority on that agenda as opposed
13 to I want to learn about this because I'm interested in
14 it.

15
16 The second issue was that where things weren't clear,
17 we should actually mandate the Trust audit programme,
18 which was quite threadbare and, you know, not
19 a priority, that has to be said. That should determine
20 audit activity rather than again individual registrars 11:21
21 or doctors saying I would like to audit this, that or
22 the other. Then at action points, try system-wide
23 improvements. That is where it goes in to management,
24 to the heads of service and to the directors. So it is
25 very -- I'm being very hopeful there, you know. It's 11:21
26 a start.

27 57 Q. Yes. Just to make two points perhaps to you. In terms
28 of, for example, audit, we've heard from Mr. Glackin,
29 who was for a long time, I think six or seven years

1 maybe, clinical lead on the urology Patient Safety.
2 That would have been perhaps after your tenure as
3 Medical Director concluded. He was bemoaning the
4 absence of both administrative support and the absence
5 of support for targeted audit. 11:22

6
7 The second point you could maybe deal with at the same
8 time is on the evidence before the Inquiry, there might
9 be seen to be a disconnect between learning points; for
10 example, learning points around the management of stent 11:22
11 replacement. How do they get into service-wide
12 improvements? How do they become actioned? An
13 ambitious programme, but have you any sense of your
14 hopes for Patient Safety, how well were they
15 implemented thereafter? 11:23

16 A. It's hard to say. I think I didn't stay long enough,
17 really, to find that out. Again, it's just about
18 changing culture because previous to that, not just in
19 the Southern Trust, a lot would have depended on
20 champions, a lead nurse, lead doctor, a lead manager 11:23
21 saying I want to push this through. What I was trying
22 to say there was where we develop learning, important
23 learning from episodes of -- it could be near-misses as
24 well as untoward events, that should be the drive, not
25 whether or not some individual should come up with 11:24
26 a good idea. That's a problem.

27
28 I think what Mr. Glackin's pointing to is correct. The
29 previous idea was that a doctor, if you like, would bid

1 for a resource to get part of the audit department to
2 work for them, and that depends on how important the
3 doctor was, how good an argument they put forward.
4 I was trying to make the point that case should come
5 directly from the experience of the Trust as a whole as 11:24
6 opposed to what one or the other person might argue
7 for. Obviously the next point after that would be to
8 expand the resource. What I was hoping for was if
9 we had this real, if you like evidence-based, hard
10 evidence-based opportunities for learning, then audit 11:25
11 would have to be followed through on. But there wasn't
12 the resource in the audit department to do that.
13 That's how it was.

14 58 Q. Yes.

15 11:25
16 Then in 2015, in May 2015, I suppose a few months
17 before you closed the door behind you and moved off to
18 pastures new, there was a reform project presentation
19 around M&M. If we just look at that briefly.
20 WIT-26047. Is it right to look at these various steps 11:25
21 as a project that you were working through the system
22 over a period of years? If we look just at the next
23 page, I think the goals are set out there.

24 A. Yes. I said earlier that it was very nice to be able
25 to get straight into ED and start from scratch because 11:26
26 ED, I attended the first two or three of them and was
27 happy to leave them to it. So we got there
28 straightaway.
29

1 The overarching goal, I think we were halfway there.
2 I mean, I think we might have made that preparation to
3 the other medical leaders. There was an informal
4 Medical Directors' meeting of the five Medical
5 Directors. At the same time, Julian Johnson was 11:26
6 working within the Belfast Trust, coming from
7 a different angle looking at how deaths are reported to
8 the coroner and whether or not the department needed to
9 have a second look at those as exist in Scotland. He
10 was coming at it from a different angle, so we were 11:27
11 both working together on this point. In other words,
12 whenever the -- I forget the term -- the person who
13 would be employed to take a second look at cases --
14 death certificates, not so much cases referred to the
15 Coroner -- that they would be able to go into the M&M 11:27
16 systems and look for evidence of what actually
17 happened.

18
19 we have a thing called the IMEXHS system, which is an
20 electronic recording system that we piloted in 11:27
21 Daisy Hill. The case would be presented, projected
22 onto the wall, the minute of the discussion would be
23 minuted live, everyone would have an input into it.
24 M&M medicine in Daisy Hill is quite a small operation,
25 so it was very easy to get that started. That was the 11:27
26 general gist of things. You could make a recording of
27 what your thoughts were, what you were able to do, what
28 you weren't able to do. As I say to provide assurance,
29 really. It's to show that we're doing our very best to

1 learn from experiences but we're not perfect. But you
2 need evidence of that, I think, on an ongoing basis.

3 59 Q. If we just go over the page, there's a list of proposed
4 interventions. This is explaining to those coming to
5 this meeting how, I think, at this meeting there was 11:28
6 a proposal that we would now call it Patient Safety
7 meeting, just to move on. But this was laying down the
8 law in terms of how we, as a Trust moving forward, are
9 going to bring greater professionalism, greater focus
10 to our Patient Safety meetings; is that right? 11:28

11 A. Yes. We didn't hit all 15 targets at once but we were
12 getting there at this stage. For example, in obs &
13 gynae, they already had a specially-driven trigger list
14 before my time. I wanted everyone to have that.
15 Rather than just putting information in the IR1 system, 11:29
16 you know, I'm worried about this or this happened, for
17 the Trust and the frontline clinicians to say these are
18 the areas that we want you to fill in IR1s about
19 because we want intelligence back from them. It has to
20 be said, though, the IR1 system, the paper-based system 11:29
21 we inherited, it wasn't being used as intelligence
22 gathering for Patient Safety, it was being used for all
23 sorts of reasons. Doctors generally ignored it, it has
24 to be said.
25 11:29

26 But there had been really good progress made in obs &
27 gynae, away before my time, that they had already a
28 trigger list -- probably driven by litigation, I have
29 to say -- that they had to look at, you know; certain

1 things in obstetrics that regularly go wrong, and look
2 at them. They also had the benefit of a risk midwife
3 who, if you like, was to me the perfect example of
4 where governance and clinical teams get together to
5 make things happen. The risk midwife would be looking 11:30
6 at that trigger list and deciding what actions to be
7 taken. There was quite a good, I think,
8 multidisciplinary approach between midwives and
9 obstetricians in that.

10 60 Q. Can I just pick up on one intervention or one 11:30
11 initiative set out here. If we move to WIT-26055, just
12 five or six pages on down, there's a reference to
13 a lessons learned letter. Is that new thinking or is
14 that something that you were bringing in from
15 elsewhere? 11:30

16 A. Well, there already was a lessons learned letter coming
17 down to us from the Board, which they had extracted, if
18 you like, from common SAIs across the five Trust.
19 I thought we needed something local. I am not sure if
20 we got that started, I think we did, but I can't 11:31
21 remember a lot about it.

22 61 Q. So the idea was, for example, an SAI would produce some
23 learning, it would be discussed at the Patient Safety
24 meeting between the clinical lead of the Patient Safety
25 meeting and interested others. A letter, if that's the 11:31
26 right expression for it, would be developed for broader
27 circulation?

28 A. It was to bring, if you like, the issues and the very
29 good and healthy discussions that had previously

1 existed in M&M out into the wider clinical field for
2 all professions.

3
4 One of the things we did achieve is to regularise the
5 M&M Chair position into an appointed position, 11:32
6 interviewed for competitively, appointed and given half
7 a PA a week, a small amount of time but, nevertheless,
8 previous to that the M&M Chair had been a volunteer.
9 I also thought that was a very good idea as a way of
10 introducing newer and younger consultants to medical 11:32
11 leadership. Because my idea of that medical
12 leadership, which I tried to explain many times, is not
13 about being the most senior doctor, it's about making
14 things happen, making good things happen. So we did
15 that and I was very pleased with that. 11:32

16 MR. WOLFE KC: I wonder if now would be a useful time
17 to take a short break.

18 CHAIR: Yes, 15 minutes. We'll come back at 11.50,
19 ladies and gentlemen.

20
21 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

22
23 CHAIR: Thank you, everyone. Mr. wolfe.

24 MR. WOLFE KC:

25 62 Q. Hello again, Dr. Simpson. 11:50

26
27 Could we bring you to the issue of your role as
28 responsible officer in the context of appraisal and
29 revalidation. You explain in your statement how your

1 role as responsible officer strengthened your position
2 as Medical Director in the Trust, but you also
3 highlight the general lack of resources for leadership
4 and management at that time, as you explained this
5 morning. Nevertheless, despite these resource issues, 11:50
6 you say you oversaw the introduction of a revalidation
7 programme for doctors and enhanced appraisal. Can
8 I ask you about that?

9
10 If we turn to WIT-25871. It's useful. This is an 11:51
11 email explaining that there is to be training for
12 appraisees and an appraiser clinic. Just scroll down
13 to the next page. It's perhaps a helpful illustration
14 of the messages that were being sent out to those who
15 were engaged in this programme. 11:51

16
17 Could you help me with this? I think you said earlier
18 that appraisal wasn't intended or wasn't designed as a
19 performance management initiative. But was it in any
20 way shaped or directed towards, at least in part, 11:52
21 helping to identify concerns in association with
22 a doctor's practice, if they existed?

23 A. Yes. Some of the -- all of the appraisers were
24 volunteers, if you like, other than the Clinical
25 Directors, so we needed extra people; so that was the 11:52
26 training, what if I'm not happy with this doctor's
27 performance? The instruction was they should
28 immediately stop the appraisal and alert the Clinical
29 Director that they were not happy with the doctor's

1 presentation, if you like, and the evidence thereof.
2 I don't think that happened -- it might have happened
3 one or two occasions but not very often. What did
4 happen was there were a number of doctors, a small
5 number, who really struggled to engage in appraisal, 11:53
6 full stop. Because appraisal previously had been
7 almost if you like this, you can do it, if not, we're
8 not really going to get at you. There were three or
9 four occasions it did highlight doctors' problems, more
10 in terms of health, if I remember clearly. That was 11:53
11 useful.

12
13 But appraisal really was meant to be informative to
14 help the doctors put their best foot forward. So there
15 was a requirement to be involved -- my requirement, 11:53
16 I don't think anyone else did that -- that they should
17 be involved actively in M&M and Patient Safety,
18 wherever that might be in the Trust. And they should
19 also discuss complaints. That was not nevertheless
20 received very well at first because the idea would 11:54
21 be -- I think as the BMA and others had said, appraisal
22 is about the doctors coming forward, but we made it
23 clear, or I made it clear, that any complaints against
24 the doctor would be given to the appraiser and the
25 appraisee, not in any sort of punitive way. But the 11:54
26 idea really was, because quite a few people had
27 mentioned it, they wanted something, they needed some
28 meat and drink to discuss at an appraisal meeting, not
29 just okay, that's very good, thank you. So when we did

1 an audit of the appraisals, we found that possibly only
2 60-odd percent where there had been a really good
3 record of discussion feeding into the PDP plan. I was
4 okay with that.

5
6 The most important point in the first instance was to
7 get engagement. Because appraisal engagement prior to
8 the Medical Act, prior to the introduction of
9 revalidation, was around about 40-60 percent here and
10 there. We got it up to near enough 100 percent. Not
11 always of a great quality but at least that was the
12 starting point.

13
14 There were other things which were good and bad about
15 it. We allowed doctors to choose their own appraiser.
16 That has since changed, they have a designated
17 appraiser. The thrust was really to get engagement in
18 the appraisal system as a necessary precursor to
19 revalidation because the GMC requirement was at least
20 one enhanced appraisal, which would include 360
21 feedback from patients, staff and colleagues, and
22 reflection. We gave them a website. We created
23 a website called Southern Docs where there was
24 reflective templates to be used, and we expected
25 doctors to present at least three or four. It wasn't
26 hard and fast, but at least three or four of these
27 reflective templates on their practice, say a major
28 incident or a complaint or a learning point; we left it
29 quite open. But the general idea was to get

1 a discussion going and to look at the doctor's practice
2 with the support of an appraiser, and then for there to
3 be a clear line from that to the PDP, the personal
4 development plan. Of course that is what appraisal is
5 about, it is about personal development for the doctor. 11:56

6
7 From the Trust point of view, it is important to know
8 that we have evidence from the doctors that they are
9 putting their best foot forward and showing what they
10 can do and how they're going to improve. 11:56

11
12 The other thing that emerged over time was that where
13 we did have criticisms of doctors, sort of at a low
14 level or whatever, we could put that into their PDP and
15 insist that it be there so that it is checked by the 11:56
16 appraiser at the next level. So there was an element
17 of performance into it, but it was largely informative.

18 63 Q. Let me pick up on some of that. This was in part about
19 changing culture, it was getting the system of
20 appraisal in the mainstream. As you say, 40 to 11:57
21 60 percent, you got it up to close to 100 percent. At
22 that level it was a success. I suppose if this Inquiry
23 is looking at, I suppose, methodologies or instruments
24 by which a Trust can pick up on doctors in difficulty,
25 doctors not performing as they are expected to, if 11:57
26 that's one of the Inquiry's interests, the Inquiry, at
27 least going back to the early days of appraisal, the
28 Inquiry would be wrong to think that appraisal was
29 focusing robustly or rigorously down on that kind of

1 issue. It wasn't about that, really?

2 A. No, and there's been criticism from the BMA and others
3 since then where appraisals have been in some Trusts
4 used more for performance. That, I think, isn't the
5 right way forward. There has to be, if you like, 11:58
6 a back-up to say, well, we're also going to look at
7 your performance and adherence to guidelines and, you
8 know, what we want you to do as an employee. This is
9 about you telling us how you want to get better and can
10 we help you. 11:58

11 64 Q. Right.

12 A. So it couldn't really -- I think there's a gap there in
13 terms of performance management.

14 65 Q. Yes.

15 A. I tried to introduce it at the AMD level. what I said 11:58
16 to all the AMDs was I want you guys to come up with
17 your own performance targets for every year.

18 66 Q. We'll come to the AMD. Let's just step into this
19 training document as a source to help us understand
20 aspects of the appraisal process. If we go to 11:59
21 WIT-25882. I think you've said in your evidence
22 earlier the doctor's role includes identifying an
23 appraiser for him or herself so they, in a sense, at
24 that time got to select. It's for the doctor, at least
25 in part, to identify factors that may inhibit 11:59
26 performance. Of course, you say it was intended as
27 informative as opposed to performance management.
28
29 We see in Mr. O'Brien's case that he was appraised by

1 his peer, Mr. Young, who was also clinical lead for
2 five continuous years. Whether the purpose of the
3 scheme is formative as opposed to management
4 performance, that's not good governance, is it?

5 A. No, but it's a start because previously there would 12:00
6 have been no requirement, really, to engage in
7 appraisals. It was a start. There was a debate at the
8 time as to whether or not a doctor should be appraised
9 by someone from the same specialty. But what we tried
10 to do as we moved on was to train professional, if you 12:00
11 like, appraisers who could do that. I was in favour of
12 that because my appraiser as an Associate Medical
13 Director was Paddy Loughran, who was an anaesthetist,
14 so I had to explain to him what I was doing in
15 psychiatry, which is no bad thing. I believe the Trust 12:01
16 now allocates appraisers, and I think it is changed
17 every so often to keep things fresh. So, that wasn't
18 ideal.

19 67 Q. As it says there, they have to identify factors that
20 may inhibit performance. 12:01

21
22 We know, if we go to WIT-25905, that in terms of
23 a review of practice during the appraisal process,
24 there's an expectation that significant events will be
25 examined. A report will be extracted from the Trust 12:02
26 Datix. Is that the same thing as saying that an
27 incident report should form part of the portfolio of
28 evidence going into the appraisal process?

29 A. Yes, but it's still up to the judgment of the

1 individual doctor which significant event to focus on.
2 Again, this is proceeding in baby steps; we want you to
3 focus on something; we're leaving it up to you; it is
4 better than focusing on nothing, which was the
5 previous. The Trust Datix incident management system 12:02
6 was no more than a prompt. I think it did frighten
7 some people.

8
9 Datix, as it had been, was more like almost pejorative,
10 "I've been IR1'ed. Somebody's reported me". It wasn't 12:03
11 really being used properly as I thought it should be
12 and I think it is now more likely to be an
13 intelligence-gathering system for quality agreement.
14 So, these were all very new. I'm not sure, in fact,
15 that what I was doing was the same in other Trusts. 12:03
16 I think doctors might have felt a bit uncomfortable.
17 On the other hand, the website we put up, Southern
18 Docs, was actually received very well in other Trusts
19 who used it. But this was all very new, I think.

20 68 Q. When you say "baby steps "and it gave some leeway, 12:03
21 perhaps substantial leeway, to the doctor to select
22 what examples to use, does that suggest -- and just
23 help us understand the process -- that say there was
24 a series of incident reports relating to a doctor,
25 perhaps not portraying him or her in a good light, 12:04
26 under the process at that time, or during your time,
27 could that doctor have kept those to one side so that
28 the appraiser didn't see them, or did the appraiser
29 receive what was on the system?

1 A. I think significant events was a very broad brush. It
2 was up to the doctor to choose which to bring to the
3 appraiser, the appraisal discussion. So yes, as
4 I said, it was a first cut in these things, it's not
5 the finished article. But, on the other hand, it 12:04
6 raises the question should there be a separate process
7 of performance management to look at those things in
8 detail, which I think we had the beginnings of with the
9 medical leadership structure, but the medical
10 leadership structure was very thin on the ground. 12:05

11 69 Q. In terms of -- I'm trying to think about this as well
12 from the appraiser's perspective, the appraiser -- I
13 think about Mr. Young as clinical lead -- he may have
14 access to all sorts of, if you like, soft intelligence.
15 You know, Mr. O'Brien's case, I'm not going to do DARO 12:05
16 or I have disagreements with DARO; I'm not going to
17 action results as soon as they're available; you know,
18 I find triage impossible to do. Those kinds of things
19 may not at any particular point in time find their way
20 into an incident report but the clinical lead, just 12:06
21 happens to be the clinical lead in this example, he is
22 appraising the doctor and it is supposed to be
23 informative. Is it your expectation and was it
24 a well-communicated expectation that appraisers should
25 be using that kind of material, that soft intelligence? 12:06

26 A. We wouldn't have communicated that down to them, no.
27 I don't think we would have got any volunteers to do
28 the appraisals if that was the case, if they were being
29 asked. That was something that we heard from the

1 ground up, you know, what exactly do you want me to do?
2 If it is to help a doctor get better and improve and so
3 on, yes, we'll do that but we're not going to be, if
4 you like, policing them. That current was also coming
5 from the BMA, the doctor's union, and rightly so, 12:07
6 I suppose, that if you want to police a doctor's
7 activity, for want of a better word, you need to use
8 a different system.

9
10 with regard to all of those things you mentioned in 12:07
11 urology, it would strike me that -- as I think we did
12 try to explain to doctors -- the appraisal system is
13 a way of advocating that you need help, that you need
14 help to develop. The personal development plan is --
15 what we've, I think, instructed the appraisers is to 12:07
16 bring those issues together into a plan that can be
17 actually enacted, reasonably so. If not, then, you
18 know, the appraiser should be approaching whoever the
19 Clinical Director was, because the appraiser might not
20 be the medical manager. But these were early days. 12:07
21 I don't know if... We were possibly pushing the boat
22 out a bit with regard to the other Trusts. I can't be
23 sure about that, it's my opinion that we were expecting
24 quite a bit, I thought, of the doctors in the
25 Southern Trust and it was how far can you bring them in 12:08
26 one or two years. I thought I had a certain amount of
27 leverage because, you know, I think I might have said
28 quite specifically if you don't engage with what I'm
29 suggesting you should engage with, I'm not revalidating

1 you and you're not going to be a doctor. Whether that
2 was the right approach or not, but carrot and stick
3 sort of thing. But I was aware that we had a very
4 large audience.

12:08

5
6 For example, if you had been in your first year as
7 a consultant, you would have been doing this regularly
8 through your training; ARCP, annual review, something,
9 something. So the younger consultants who had recently
10 been through, if you like, the senior registrar
11 training, appraisal was just the next step, it was no
12 problem whatsoever. Doctors of, you know, 30/40 years
13 vintage in this system would look askance at this and
14 say what's all this about?

12:09

15 70 Q. Let's just glance back at your job description again to
16 remind us of your role vis-à-vis other medical leaders.
17 It is WIT-5757. It was expected of you that you would
18 provide professional leadership and guidance to support
19 AMD, Clinical Directors and lead clinicians throughout
20 the Trust in relation to governance of the medical
21 workforce including clinical practice and service
22 change. Could we focus on that?

12:09

12:10

23
24 You've said in your witness statement, this is
25 paragraph 26.1, you initiated an informal performance
26 review process with your AMDs, involving biannual more
27 frequent meetings with each AMD to review their
28 performance objectives, although these, in the nature
29 of the informality of these meetings, weren't minuted.

12:10

1 You go on to explain that you approached this project
2 in a testing of the water fashion to introduce the
3 concept to medical leadership in the Trust. You saw
4 your role in this process as one of leadership
5 coaching. That's paragraph 26.1 of your statement. 12:11

6
7 Could you help to set that in context for us, those
8 initiatives? Were you dissatisfied in any way with the
9 quality of the AMD cadre or was it about helping them
10 to get better? 12:11

11 A. What I had found and what I witnessed when Paddy
12 Loughran was the Medical Director, so I'm sitting
13 around the table with these ten -- actually we
14 increased the post by two, so maybe 11 or 12 it was
15 then -- to one degree or another, they would have seen 12:11
16 themselves as conduits, you know, relating to
17 management the views of their colleagues almost as, you
18 know, an equal among equals in reviewing their --
19 presenting their colleagues' views to management and
20 then presenting management's views to their colleagues. 12:12
21 That was the ethos generally in the health service for
22 a long time, and it was still there when I took over
23 the Medical Director's post. Really it was an attempt
24 to modernise and change that.

25 12:12
26 So I did a number of things. One of those things was
27 to say to the medical leaders, look, medical leadership
28 is about making things happen, more disciplinary wise
29 with the managers with the different clinical groups;

1 making changes; making good things happen. It's not
2 about maintaining the status quo, which was
3 understandable, I thought. I wouldn't be overcritical
4 that I thought they should be carrying out. What
5 I said to them was, look, you identify for me what your 12:12
6 objectives are and let's see how you get on with them
7 and I'll hold you to account for that, in a friendly
8 and informal manner just to kick things off. And also
9 for them to take that view down through their system to
10 the CDs and also to their consultants. I had 12:13
11 experienced that as the AMD for Mental Health, if you
12 like. So the Director of Mental Health would be saying
13 to me, John, what are we doing here? What are you
14 supposed to be doing, what's your plan? We would agree
15 on something, I would go and do my bit, he would go and 12:13
16 do his bit. More of an equals thing but still the
17 whole business of making things happen. So yes, the
18 culture that I arrived to find was one of let's keep
19 the ship afloat, let's keep moving, let's maintain the
20 status quo. 12:13

21 71 Q. It was about changing or adjusting their outlook?

22 A. Yes.

23 72 Q. In terms of --

24 A. These were, I think -- not every one of them, but to be
25 fair to them, these were very senior practitioners, 12:14
26 excellent in their fields. We mentioned Eamon Mackle,
27 an extremely skillful surgeon; maybe medical management
28 not his strongest point, but he is there, like the
29 others, because of his seniority. I got as far as

1 I could with that. By the by, what I was able to do
2 was increase the complement by, I think, two new MDs;
3 one for infection control, that became Dr. Damani, one
4 for ED, that was Seamus O'Reilly. Two new CD posts.
5 I made a rule those should be competitive interviews 12:14
6 and they should be interviewed on the basis of a
7 leadership, which is a competency-based interview
8 process, in other words can you give me examples of
9 things you have done in this modality or that modality
10 of leadership. So, it was that. 12:15

11
12 Then the other change -- it's related to this -- that
13 I made was instead of sitting in on interminable
14 consultant interviews, many of whom we appointed then
15 didn't turn up, took jobs elsewhere, that I interviewed 12:15
16 or inducted every new appointee, should it be
17 a consultant or staff grade, and explained the same
18 process to them, that they were now leaders; whether
19 they liked it or not, that's how the system viewed
20 them; that there was a medical leadership structure; 12:15
21 that you didn't have to be in it to contribute to it;
22 that I expected all consultants and staff grades to
23 contribute to medical leadership. The final thing
24 I said to them was if you find that the current medical
25 leadership structure isn't working for you, come 12:15
26 straight to me.

27 73 Q. Thank you.

28 A. And I think the other arm to this process was I created
29 an educational programme for that level of Clinical

1 Directors, lead clinicians, and consultants who wanted
2 to come on board into medical leadership.

3 74 Q. Could I draw your attention to something Mr. Mackle
4 said in his evidence in terms of, I suppose, the
5 support he had from you. If we go to TRA-02098, just 12:16
6 go to line 9. I'm asking him about his AMD role and
7 whether he felt, at least on a personal level,
8 generally supported by each of the medical directors he
9 worked under. He goes through each of them. Just
10 scrolling down. Most of the time then in terms of time 12:16
11 spent with a Medical Director would have been with you.
12 He says "I was moderately supported". I said that
13 suggests a lot more could have been done to help you.
14 I'm not sure the stenography picks this up precisely or
15 whether he did express himself in these terms: 12:17
16

17 "Well, shall we say, I expected more of an
18 interpersonal relationship. I thought I was alone but
19 then I recognised other AMDs had the same".
20 12:17

21 "I felt there was an interpersonal relationship";
22 I wonder whether that should say "poor personal
23 relationship". That was certainly the memory I had in
24 my head. Then in preparation I saw that the word
25 "interpersonal relationship" had been recorded. No 12:17
26 matter, it appears to suggest some kind of negativity
27 in terms of his perception of his relationship with you
28 in the context of whether he was well supported. He
29 expands that into other AMDs and said he understood

1 that they felt the same.

2
3 Can you comment on that for us, if you can?

4 A. well, I was there to do a job, I wasn't there to make
5 friends. You know, I did try very hard to help Eamon. 12:18
6 I did put pressure on him. He was particularly behind
7 with the job plans compared to the other AMDs, and that
8 was something I would have pushed him on. I had no
9 choice to do that. So, it was a working relationship.
10 As you can see, I probably met him, I think, more than 12:18
11 any other AMD to provide that support and
12 encouragement. But I wasn't supportive of the status
13 quo and that's the truth. I thought that, say, in
14 contrast to where I had been, because my job plans had
15 all been completed before 2011 -- I don't know what 12:19
16 year that was -- so he was a couple of years behind.
17 I did understand the difficulty. In contradistinction
18 to, say, anaesthetics, where it's easier to come up
19 with a team job plan and a demand capacity match, and
20 then fit each doctor, each anaesthetist, into the job 12:19
21 plan team and therefore individual job plan.
22 Understandably much more difficult to create that kind
23 of approach or result, actually, that existed in
24 anaesthetics compared to surgery. But again, with all
25 due respect, I think Eamon had that view that he was 12:19
26 there to represent his colleagues' view. My view was
27 I expect things to happen.

28 75 Q. You touched upon what you said to him about job plans.
29 Let's just bring that up for completeness. TRU-250634.

1 This is 2012. Just at the bottom of the page, you are
2 writing to Eamon with a number of points. You say, as
3 regards job plans:

4
5 "All of the other AMDs have made significant progress 12:20
6 in this regard. Your performance in this area is
7 a matter of concern."

8
9 He writes back to say he is on sick leave. Let me see.
10 Yes, sorry, I just spoiled the redaction. Not 12:21
11 a significant matter, I think.

12
13 That's an example of you having, I suppose, to chase
14 his performance.

15 12:21
16 In terms of the evidence, as I say, I brought you to
17 the transcript and it uses the word "interpersonal",
18 whatever that might mean. If I can interpret that as
19 him saying that there were poor personal relationships
20 between you and the other AMDs, is that fair, in your 12:21
21 view?

22 A. No.

23 76 Q. How did you routinely meet with them to support them or
24 guide them?

25 A. So, every year I would do each one of their appraisals. 12:22
26 That would have been a bit of concentrated activity
27 around, say, March/April to the summer. Then I had
28 possibly bimonthly performance meetings. Then there
29 were the team -- sorry, what I tried to do is create an

1 AMD team, so there was that quarterly team meeting.
2 Possibly the two AMDs I would have been most critical
3 of were medicine and surgery, but I was fully
4 appreciative of the difficulties they had. I think
5 they were overstretched. I could see the massive 12:22
6 responsibility in general medicine in terms of numbers
7 of doctors, and the more specific problems with
8 surgeons are probably more difficult to manage than
9 others. There is that self-selecting personality type
10 that you get among surgeons, and I think Eamon had 12:23
11 difficulty in bringing his group into being a team, and
12 therefore no progress on a team job plan and really
13 hard-nosed, if you like, discussions with each one of
14 them about job plans.

15
16 what I tried to explain was my view, which was that the 12:23
17 initial job plan is not the be-all-and-end-all of
18 things. It is an initial job plan, it is a yearly
19 negotiation. That's how I managed things in Mental
20 Health, maybe erring on the side of being easy on the 12:23
21 doctor first off but then year on year, you are looking
22 at metrics to see exactly what's happening, is there
23 fair distribution of work between the team members.
24 That would be how I would have used it, you know,
25 I can't tell you all and give orders, but really 12:24
26 consultant A is doing a lot more than consultant B, can
27 we even this out a bit. That would be an annual
28 discussion. That's what I thought should have
29 happened, and did happen in other specialties. But you

1 obviously have to take account of the fact that Eamon
2 did have some health problems which were quite serious.
3 This is where he asks Robin Brown to come up and help
4 him with urology.

5 77 Q. We'll come to that in a moment but just finally on AMDS 12:24
6 and indeed Clinical Directors as well, what was your
7 expectation of them? I'm thinking in particular,
8 obviously they have a range of activities that they
9 might be expected to engage in, but where they have an
10 awareness that clinicians for whom they are responsible 12:25
11 in managerial terms are in difficulty, maybe providing
12 less than optimal service, maybe placing aspects of the
13 service at some risk, was there a clear understanding
14 that at some point along the line, you would need to
15 hear about it? 12:25

16 A. Certainly. An example, I mentioned earlier about
17 paediatrics. Within a few weeks of starting, Gillian
18 Rankin had brought me up to her office because there
19 needed to be a bringing together of minds with regards
20 to children in casualty with potential surgical 12:25
21 problems, appendicectomies, and also trauma. The ED
22 consultants were basically being left holding the baby,
23 who do we get to come and see this child? The surgeon
24 saying I'm not a paediatric surgeon, the paediatrician
25 saying I'm not a surgeon; then the Central Surgical 12:26
26 Unit for children wanting a referral from ED that would
27 have, if you like, the imprimatur of possibly both
28 surgery and paediatrics. Long negotiations went on
29 with that, which we made a lot of progress with. After

1 a period of time, I just decided that the AMD for
2 Paediatrics was not performing and I asked him to stand
3 down. That would have been well known to everyone.
4 Coincidentally, the Clinical Director for Paediatrics
5 resigned for personal reasons, so I had to step into 12:26
6 that role. This is all 2011/2012, to, if you like,
7 encourage a new leadership to come forward, which
8 we did do. But everyone would have been aware. The
9 basic issue that I had with the AMD for CYP, children
10 and paediatrics, was that very issue that you 12:27
11 mentioned, taking responsibility for clinical
12 governance in a very real way to solve the problem, and
13 the problem wasn't being solved and I wasn't happy
14 about that.

15
16 So I can imagine that the other AMDs would have thought 12:27
17 this is quite serious. What I was trying to explain to
18 them was, well, look, it's better that we take this
19 seriously now rather than be criticised later for not
20 taking action. 12:27

21 78 Q. Yes.

22 A. What happened, as I say, that first year, by
23 December/January 2012, the Pseudomonas problem had
24 arisen with the neonatal deaths. We had a
25 non-accidental -- a potential, suspected non-accidental 12:27
26 injury in paediatrics which resulted in a baby death.
27 I had to refer three of the consultant paediatricians
28 to the GMC. There was a whole host of issues in that
29 area. So this is business, this is what happens.

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when you ask that question, I mean at our quarterly AMD meetings, I would be bringing these discussions, these points, to the other AMDs that this is where you guys are sitting on, you're sitting on an responsibility.

12:28

79 Q. You can see that. You explain in your witness statement paragraph 65.1 that the opportunity to formally raise concerns to you -- and here you cite Mr. O'Brien or urology -- were at the clinical governance sections of the quarterly AMD meetings, or for professional governance at the HR and Medical Directorate meeting. Let's just briefly look at perhaps the structure of the quarterly AMD meetings. If we go to a sample of minutes for June 2014, WIT-25821. If we just scroll through, you can see towards the end of the meeting, Section 5 of the meeting, it's called Governance Reports. It records that you asked your AMDs to report governance issues by exception. Is that a standing item on the agenda?

12:28

12:29

A. Yes, and it had been before my time under Paddy Loughran. What I wanted to do with that was really to bring it into like a team arena where all of the AMDs could learn from each other about governance issues. I would have expected their governance escalation to be happening anyway, but that was an opportunity for, if you like, me to do a bit of team building, to get the discussion going, and to ask -- although they were very reticent to do this -- but to try to ask maybe Dr. McAllister to challenge Dr. Chada, what is that

12:30

12:30

1 about, to get that kind of discussion going. Because
2 I remember when Paddy Loughran was doing it, he would
3 often use me to ask questions and get a discussion and
4 a debate going about governance.

12:30

5
6 It was about raising the awareness of the
7 responsibility of these people of what they had. What
8 they brought to me was up to themselves, I couldn't
9 determine that. It wasn't necessarily that this was
10 the main thrust; they would be expected to bring that
11 to their operational director or directly to me as
12 Medical Director and to the HR Medical Director
13 meeting.

12:31

14 80 Q. Obviously within your job description, you are the
15 designated officer for fitness to practise issues, for
16 referrals to the GMC. So while you say it's up to them
17 what they brought to these meetings, was there also an
18 expectation and understanding that where issues were
19 crossing a particular line, that you would need to
20 know, that there was a duty to inform you?

12:31

12:31

21 A. Yes, but more so directly to the medical HR meeting
22 through their meetings with me or through their
23 Clinical Director -- sorry, Director of Service, or
24 through HR. Each directorate would have an HR person
25 embedded in it as well as what I had at the Medical
26 Director HR meeting. That's where the main -- they
27 would know that's where doctors should be sent to,
28 whether it's performance, MHD, maintaining high
29 potential standards, potential referral to GMC, that's

12:32

1 where that would go for individual doctors. This was
2 more about system problems, if you like.

3 81 Q. Let me move to urology specifically. There's a range
4 of somewhat disparate issues I want to raise with you.
5 Can I raise a staffing issue with you? If we go to 12:32
6 TRU-25059. Sorry, let me go back to your statement,
7 WIT-25696. At paragraph (d), you're explaining that
8 you're involved in a series of emails on
9 17 February 2012 regarding negotiations with
10 Mr. Patrick Keane, the Specialty Adviser For Urology, 12:33
11 on the job plans for the upcoming new consultancy post,
12 the consultant urology posts, specifically the
13 proportion of SPAs, Supporting Professional Activities,
14 which were to be allowed. It seems that the Trust
15 wanted to advertise the post with 1.5 SPAs rather than 12:34
16 2.5 and Mr. Keane indicated that would not attract
17 colleague support. Do you remember this issue?

18 A. Yes.

19 82 Q. The internal emails, if we go to TRU-250955. I think
20 there was a suggestion that the post could be 12:34
21 advertised as 2.5 for a fixed period and that the job
22 plan could be adjusted down afterwards to 1.5?

23 A. Yes, I agreed to that.

24 83 Q. That's the wrong reference. 250595.

25 12:35
26 what was happening here, it would appear, is that on
27 one view publicly the Trust was putting out an
28 advertisement suggesting 2.5 SPAs for the job but there
29 was a recognition internally that this couldn't be

1 maintained for the longer term?

2 A. My view, and I think what we agreed, and I think it was
3 agreed regionally if not nationally, is there's a split
4 in that 2.5. So it is a standard consultant contract,
5 2.5 Supporting Professional Activities. But I think 12:36
6 what we were insisting on, and why we agreed 2.5 to be
7 reduced -- not to be reduced but that 1.5 was for
8 doctor's own professional development and the other one
9 is for what we, the Trust, ask the doctors to do in
10 terms of being involved in, you know, improvement 12:36
11 activities, service development, so on and so forth.
12 In other words, you were guaranteed your 1.5 Supporting
13 Professional Activities, but the other one was
14 contingent upon doing things which were of benefit to
15 both doctor And Trust. It probably wasn't -- I don't 12:36
16 know where that came from initially but I don't think
17 there would have been any point advertising a point
18 with 1.5 SPA's. Nowhere else was doing that. I think
19 we did want to get the point across that it was 1.5, if
20 you like, for yourself and one for us, as in the 12:37
21 employer.

22 84 Q. So in the approach, taken there was no
23 misrepresentation of the remuneration that a doctor
24 would enjoy?

25 A. I don't think so, no. I think we'd already established 12:37
26 that, you know. I can't remember the detail but I know
27 we'd already established that split in the 2.5.
28 I think that was agreed nationally as well, I'm pretty
29 sure. Yes, because I think we also agreed that, say

1 you had four consultants in a team, so they had these
2 four sessions that belonged to The Trust, if you like,
3 that three of the doctors could give their Trust PA,
4 SPA if you like, to a doctor to do a specific piece of
5 work. It was really about fair play and taking account 12:38
6 and making note of what was happening.

7
8 Prior to that there was a bit of unfairness amongst
9 doctors, you know, that a certain doctor might go off
10 and do all sorts of esoteric things and visits all over 12:38
11 the place and other doctors would have to cover for it.
12 I didn't like that idea.

13 85 Q. So it was giving an element of control to the Trust?

14 A. Fair play as well, yes.

15 86 Q. Let me then turn to an initial view you appear to form 12:38
16 in relation to the approach to clinical governance
17 within urology. It concerned a trainee doctor called
18 Dr. Aminu.

19 A. Aminu, yes.

20 87 Q. And you were copied into an email on 2 March 2012. If 12:39
21 we can bring that up on the screen, please. It is
22 TRU-250598. This is being written to Dr. Weir, who
23 was -- was he a director for --

24 A. Medical education.

25 88 Q. So, Mrs. Roberts is writing to him to inform Dr. Weir 12:39
26 about a doctor.

27
28 "... who is currently under investigation by the GMC.
29 She understands that the Training Programme Director

1 For Urology has spoken with Michael Young and Aidan
2 O'Brien and there have been no complaints about Patient
3 Safety or probity. We will be responding accordingly".
4

5 If we can pick up the issue with reference to your 12:40
6 statement. It is at WIT-25697. Yes, just to take up
7 at the Director of Acute had -- sorry, maybe we'll
8 start at the top. You explained the inquiry that had
9 come in and the Director of Acute, Dr. Gillian Rankin,
10 had received a similar inquiry from the GMC on 12:41
11 29 February, which she brought to your attention. The
12 issue, as you explained, just to cut to the chase, was
13 that an inquiry was raised in terms of whether concerns
14 had been raised about the competency of this doctor.
15 Scrolling down. You say that Mr. Brown, in his role as 12:41
16 Clinical Director at that time, discovered that
17 a senior nurse, Shirley Tedford, had already raised
18 concerns about the competency of this doctor to the
19 Lead Clinician For Urology, Mr. Young, "but that this
20 had not been escalated to either of us", that's to you 12:42
21 or Dr. Tedford.

22 A. No, Robin Brown.

23 89 Q. Robin Brown.

24
25 You're explaining -- just so that we fully understand 12:42
26 the picture -- Mr. Young was aware of the concern,
27 having heard about it from the nurse, but hadn't drawn
28 it to your attention and hadn't drawn it to Mr. Brown's
29 attention; is that it?

1 A. Yes, nor Mr. Weir as the Assistant Director of Medical
2 Education.

3 90 Q. You go on to say:

4
5 "Although this was a matter of concern, the swift and 12:42
6 appropriate response by Mr. O'Brien did compensate,"

7
8 because, as I'll demonstrate now, after you raised
9 a concern about how the matter had been dealt with,
10 Mr. O'Brien went and spoke to the doctor and then 12:43
11 forwarded a report to you.

12
13 If we go to TRU-250599.

14 A. Yes, I think Mr. O'Brien must have been the educational
15 supervisor for that doctor. In other words, he was in 12:43
16 Mr. O'Brien's team. I think that's why he replied.

17 91 Q. TRU-250599. You are speaking to the Director of
18 Nursing, presumably because it was a nurse who had
19 raised the concern about this doctor, Dr. Aminu, with
20 Mr. Young. What you're saying to Francis Rice, you're 12:44
21 explaining the background.

22
23 "This kicked off by a letter that you had received from
24 the GMC. Our urology consultants thought he was just
25 about okay. It seems the nurses have a totally 12:44
26 different view. My guess is that there is something
27 amiss in urology regarding multidisciplinary working,
28 never mind professional governance".

29

1 Then, just before I ask you some questions about that,
2 if we go to AOB-819723. On the same day, 13th March,
3 you write to Robin Brown and Aidan O'Brien asking for
4 something in writing regarding the concerns about
5 performance of this doctor. Then you go on at the end 12:45
6 to say to both Gillian Rankin and Francis Rice:

7
8 "It is a matter for concern that a senior nurse would
9 have significant concerns about the performance of
10 a doctor that don't seem to have been followed through. 12:45
11 I think that there must be some learning here regarding
12 clinical governance."

13
14 This is, I suppose, just under two years into your role
15 as Medical Director. Your concern, it appears to be, 12:45
16 is that...

17 A. One year.

18 92 Q. One year, sorry, yes. Just coming up on just under one
19 year.

20 12:46
21 Your concern is that there's a live concern on the
22 ground about the competence of a doctor or the actions
23 of a doctor. The nurses had this concern, rightly or
24 wrongly; the doctors don't seem to have that concern,
25 rightly or wrongly, but the problem is the person who 12:46
26 knows about it and who has responsibility to do
27 something about it, that is Mr. Young, hasn't raised
28 it. Is that the point?

29 A. Yes. I mean, as I said in the email, it's my guess

1 there's something amiss. I wouldn't have thought very
2 much different of any area in the Acute Directorate --
3 and that's why I brought Francis into it -- whereby
4 I thought nurses were very reticent to criticise
5 doctors in any shape or form. So, there was that lack 12:47
6 of action in terms of Michael Young but there was also
7 this block that Gillian certainly -- sorry, Shirley
8 Tedford did report it to Robin Brown. Robin is only
9 coming up once a week from Daisy Hill to look at things
10 and doesn't see everything, so fair enough. 12:47
11 But Shirley then also has her professional lines to say
12 this doctor may be putting the whole system at risk.
13 It wasn't that bad as it turns out. I'm quite removed
14 from the frontline, so to speak, and I can only guess
15 what's going on there, and I'm expecting people to 12:48
16 raise issues up through the system, first to Robin,
17 then to Eamon and then to me. It indicated to me that
18 there was a general cultural problem, I didn't think
19 necessarily particularly in urology, but generally.
20 I was pretty aware of it throughout the Trust and it 12:48
21 was a real contrast to my experience of mental health.
22 Mental health nurses, mental health social workers
23 would have no computation whatsoever about putting
24 a doctor in his place and, if that didn't work, coming
25 to me as the Clinical Director or Associate Medical 12:48
26 Director. I was a bit concerned about that.

27
28 I discussed it with Francis and Gillian, what we did,
29 and Francis as I described to you has a full-time job

1 in Mental Health never mind being Director of Nursing.
2 what we did was a series of walk rounds. There was
3 a whiteboard initiative being brought into all the
4 wards with the new technology and we used that as an
5 opportunity to go and visit all the wards. But the 12:49
6 subliminal message, which is a very gentle message, is
7 look, any concerns at all, it is not just a matter of
8 going to the doctor, you can go to your lead nurse, the
9 lead nurse can go to Francis, Francis can speak to me.
10 It was trying to open that up. It was very limited, it 12:49
11 was a limited intervention. How far we got with that,
12 I don't know.

13 93 Q. The Panel may consider it prescient that early in your
14 role in the Medical Director's office, you are pointing
15 to -- and saying that it was your sense that it was 12:49
16 more widespread than urology -- but you're pointing to
17 a sense that professional governance, clinical
18 governance, are potentially weak. Ultimately,
19 I suppose, it comes down to ensuring that those who
20 have a responsibility, whether that's the clinical 12:50
21 lead, the clinical director or the Associate Medical
22 Director, that they are doing their jobs to escalate
23 matters or to challenge matters at source.

24 A. Yes.

25 94 Q. Did you, appreciating that was the culture that you 12:50
26 were working within, take any particular initiatives in
27 that respect, or was it part and parcel of building the
28 change that we've looked at already through M&M and
29 that kind of thing?

1 A. I'm pretty clear on the memory at the time that what
2 concerned me was the deference to seniority, to
3 hierarchy. That, to me, was the problem. It spills
4 over into clinical governance and so on and so forth,
5 but the block is because of undue deference to 12:51
6 hierarchy. That was my view. I had seen evidence of
7 that right across the Acute Directorate; more so in
8 Craigavon than in Daisy Hill. Daisy Hill is a smaller
9 hospital and less in the way of those blockages, shall
10 we say. I saw it more as a cultural problem throughout 12:51
11 that had to be tackled. I thought my best way was to
12 tackle that systematically as opposed to individually.
13 I'm pretty sure similar problems existed elsewhere.

14 95 Q. Yes. Clearly there can be no quick fix to those kinds
15 of things. We'll probably go on this afternoon to look 12:51
16 at some of the specific issues that didn't come up to
17 you and were left improperly addressed, some might
18 argue, in association to Mr. O'Brien's practice. But
19 when you look back from that position at the things
20 that didn't arrive on your desk, nobody told you about 12:52
21 them, I think, will be your evidence, if I can
22 anticipate. What does that say to you, given that you
23 had a sense of that at the very beginning through this
24 incident.

25 A. I had a sense of it everywhere; that was my problem. 12:52
26 As I say, there were firefighting issues arising all
27 over the place. One of the positives in that was
28 I knew Robin Brown quite well from working together in
29 Craigavon -- sorry, in Daisy Hill. We were both

1 Clinical Directors. I'm pretty sure he would have made
2 it clear to Shirley Tedford that it's very easy to
3 approach me if you have any concerns about anything
4 clinical governance wise. But then Robin is at
5 a disadvantage because he is coming up from Daisy Hill 12:53
6 maybe half day a week and so on and isn't fully
7 cognisant of all these things. But I was confident
8 leaving things with him, he's a very approachable,
9 sensible manager.

10 96 Q. Can I just finish and we'll take an hour this afternoon 12:53
11 just to go through some of the other issues.

12 A particular issue around Mr. Mackle. He was the AMD
13 for surgery; one of his areas of responsibility was
14 urology; one of the clinicians who he had to deal with
15 across a number of issues, including job plan, chasing 12:54
16 triage as an issue, an issue around benign
17 cystectomies, an issue around intravenous fluid in
18 antibiotic management, a number of incidents leading in
19 late 2011 to a facilitation in relation to a job plan
20 dispute. He has recalled in his evidence that at some 12:54
21 point in 2012, he can't recall a specific date, that he
22 was advised that there was a concern abroad that he was
23 bullying or harassing Mr. O'Brien. The upshot of that,
24 just to put it in simplistic terms, was that he was
25 invited to stand back from having a director input in 12:55
26 the management of Mr. O'Brien, and Mr. Brown, as the
27 CD, was to become more prominently involved if issues
28 were to arise.

1 He said, just to be clear -- if we can just bring this
2 up on the screen, please. WIT-11679 at paragraph 92.
3 Just scrolling down.

4
5 "At my next meeting with John Simpson, I advised him of 12:56
6 the issue and the change in governance structure in
7 Urology. There was no formal investigation of the
8 complaint and I've checked with Zoë Parks, etcetera,
9 and she says there's no record on my file of the
10 accusation of bullying." 12:56

11
12 So he is saying there, without going into specifics,
13 that he told you about the issue and the change in the
14 structure. Is that something you remember?

15 A. Not in the same way, no. He may have said something to 12:56
16 me about that. My perception was that he was
17 struggling with job plans, one of them was urology, and
18 that he proposed he needed help from Robin Brown to
19 come up from Daisy Hill to help him manage. That was
20 the general agreement. 12:57

21
22 If he had been accused of bullying, I would have taken
23 that very seriously because in another case, another
24 doctor accused another AMD of bullying and to me that
25 calls into question the whole validity of medical 12:57
26 management, including pipeline. So, that would have
27 been investigated had it been raised. I would have
28 said, I imagine, to Eamon, look, write that down, bring
29 it up to HR, put something on record, we will have to

1 look at that, because that's what I did in other cases.

2

3

But I did read his transcript and I think he makes the point that he was a bit -- quite upset by the whole thing and maybe not thinking very clearly. He may have thought that he said that to me but I don't remember any comment about bullying. 12:58

6

7

8

97 Q. It wasn't discussed with you by any other person in senior management?

9

10 A. No. I probably would have informed the Chief Executive 12:58

11

that there was a change -- maybe she already knew -- that Robin Brown was come up to help Eamon. That was the general view which seemed a reasonable thing to do.

12

13

14

As I said earlier on, it was putting Robin in a difficult position but he was up for it, so I agreed to it. 12:58

15

16

17

MR. WOLFE KC: It is one o'clock. Back at 2.00?

18

CHAIR: Yes. Two o'clock, everyone.

19

20

THE INQUIRY THEN ADJOURNED FOR LUNCH AND RESUMED AS 12:58

21

FOLLOWS:

22

23

CHAIR: Thank you, everyone.

24

MR. WOLFE KC: Good afternoon, Dr. Simpson.

25

98 Q. Could I have up on the screen, please, WIT-16551. 13:57

26

27

Drawing your attention, Dr. Simpson, to a record of this meeting, it obviously predated your time in the Medical Director's hot seat. 1st December 2009,

28

29

1 attended by Mrs. McAlinden, then Acting Chief
2 Executive, and Dr. Loughran, Mr. Mackle, Mrs. Burns
3 notably, Mrs. Trouton notably; Mrs. Rankin. I didn't
4 read out Mrs. Clarke deliberately. I've named the
5 people you would have had some interactions with in 13:57
6 terms of -- primary interactions with that might have
7 related to urology when you took up post.

8
9 The reason for bringing you to this document is that
10 all of those significant, important people are in 13:58
11 attendance. If we scroll down, please, to the next
12 page. It is a meeting concerning urology. Just scroll
13 back up, sorry. A number of quality and safety issues
14 are addressed at the meeting. One of them is an issue
15 in relation to the use of IV antibiotics, which was 13:58
16 then the subject of a review or informal consideration
17 or investigation as to the appropriateness of the
18 practice. Just scrolling down, the action is set out
19 there. It was a practice which certainly concerned
20 Mr. O'Brien and perhaps Mr. Young, although Mr. Young's 13:59
21 evidence in relation to that is yet to be given to the
22 Inquiry and he takes some issues.

23
24 Then there's a second issue in relation to quality
25 discussed, the triage of referrals. One consultant's 13:59
26 triage is three weeks and he appears to refuse to
27 change to meet the standard of 72 hours. When
28 Mr. Mackle gave evidence, he believed that that was
29 a reference to Mr. O'Brien. Red flag requirements for

1 cancer patients:
2
3 "One consultant refuses to adopt the regional standards
4 that all potential cancers require a red flag and are
5 tracked separately". 14:00
6
7 Then, fourthly, the chronological management of lists
8 for theatre. Those are issues on the agenda concerning
9 urology and clinicians within urology at that time
10 before you take up post; a year and a half before you 14:00
11 take up post.
12
13 By the time that you do take up post, Dr. Simpson, the
14 behaviours of Mr. O'Brien around triage are said to be
15 continuing, according to the evidence. There had been 14:00
16 an issue which was investigated around benign
17 cystectomy. In the middle of 2011, just before you
18 took up post, there was an investigation conducted by
19 Mr. Brown in relation to the disposal by Mr. O'Brien of
20 some patient notes in a bin, fluid management or fluid 14:01
21 balance notes. There had been a lively dispute between
22 Mr. O'Brien and managers in relation to his job plan
23 that went to facilitation.
24
25 were any of those issues drawn to your attention by way 14:01
26 of hand-over?
27 A. No. Only the letter that Eamon Mackle sent to I think
28 Gillian, copied to me, about the benign cystectomies,
29 the conclusion of that report which seemed to me to

1 close the matter. This minute is completely new to me.
2 I've never seen anything or heard anything about it.

3 99 Q. Yes. If we go back to what you've just said, you
4 refer to being told about the benign cystectomy issue.
5 TRU-281958. It's 28th July and Patrick Loughran, 14:02
6 Medical Director at that time. This must have been
7 just a week or two before you took up the position and
8 he was to vacate the position. You're copied into this
9 under the heading "Urology Review", along with
10 Mr. Mackle and Ms. Brennan. Were you doing some kind 14:03
11 of hand-over or dummy run before taking up the
12 position?

13 A. Yes. We had a couple of weeks in July where I shadowed
14 Paddy, and I was confident enough that most things
15 could be handed over in terms of continuity with 14:03
16 regards to the same managers being in place,
17 particularly Anne Brennan. I did suggest to The Trust
18 that Paddy should be kept on for a session or two per
19 week for a few -- maybe six months, but that wasn't
20 agreed to. I thought that would have been helpful. 14:04

21 100 Q. I mean there are other emails that the Panel are aware
22 of and you have referred us to around this issue. But
23 in short, they seem to be saying to you the review has
24 been conducted -- to use the language of this -- the
25 final report produced by Marcus Drake, who was 14:04
26 a urologist who came over to do a desktop review of the
27 patient charts, seems to be the words here supportive
28 or indeterminant. They're not his words but that's the
29 description given to you.

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As you explain in your section 21, this was really a matter for Mr. Mackle to follow up and put to bed, and if there were any issues requiring your involvement, they would be drawn to your attention. That was your expectation?

14:05

A. Certainly, yes.

101 Q. Is it fair to say then that when you started the Medical Director's role, you didn't understand there to be any issues or concerns regarding Mr. O'Brien or the practices within urology service in general?

14:05

A. Definitely not. No, there wasn't. I have a vague memory, it wasn't straightaway but it was maybe at some stage, but it's a vague memory of me in a meeting or an informal meeting with Debbie Burns as Director of Acute, so it must have been actually 2013, perhaps. Possibly Eamon Mackle was in the room and I must have asked a question because the answer was "That's just Eamon, he's very slow". I can't remember what the discussion was about. It might have been about a number of things.

14:05

14:06

102 Q. Sorry, did you say that's just Eamon or is that's just Aidan?

A. Sorry, Aidan. Yes.

103 Q. Is that what you meant to say, Aidan?

14:06

A. Yes. That's just Aidan, that's just him, he 's very slow.

1 That's the only memory I have of any concerns being
2 raised. I can't remember the discussion, in particular
3 what was the subject matter, but there was nothing to
4 alert me. That puzzles me, but there was nothing to
5 alert me of any concerns.

14:06

6 104 Q. I'll raise some issues with you this afternoon in
7 relation to triage and in relation to patient charts,
8 dictation and what have you, and take your views on
9 each one briefly.

10
11 Can I start with the issue of actioning results. The
12 scenario is the clinician has referred a patient to
13 diagnostics, whether that's histopathology or whether
14 it is radiology, to get a scan done. The report comes
15 back. The question, I suppose, is who's going to read
16 it, when's it going to be read and when is action going
17 to be taken. It's that context we're looking at.

14:06

14:07

18
19 Can I ask you to look at an email, 2nd September 2011.
20 It's TRU-250590. It's, as I say, 2nd September.
21 You're just not three or four weeks, perhaps, and it is
22 from Gillian Rankin to a number of people. The issue
23 is meeting regarding a consultant urologist. It says:

14:07

24
25 "I think there would be merit discussing current issues
26 around one of our senior staff. Is there any chance we
27 could meet 2.00 to 3.00 p.m. Monday next."

14:08

28
29 Then there's a specific message for Eamon.

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Do you know what, at first blush on reading that, what that was about or who it concerned?

A. No. I mean, I've looked at that last year. I've no memory of it, to be quite frank. Why it wasn't followed up... I was up in Gillian's office for other reasons, as I mentioned earlier, with the paediatric interface with ED. I have just drawn a blank on that. I have no idea what that is about.

14:08

105 Q. I'm going to seek your views on whether my efforts to fill in the blanks could be right, and you can comment accordingly.

14:09

If I can draw your attention to an email chain about a week prior to this email. It starts at TRU-276808. Just scroll down. This is Heather Trouton, and she's writing to a number of people, including Eamon Mackle. It's, as I say, 25th July 2011, a week before the email calling a meeting about a particular urologist. What she's saying here is:

14:09

14:09

"I was going to address this verbally with you a few months ago but just to be sure, can you please check with your consultants that investigations which are requested, that the results are reviewed as soon as the result is available and that one does not wait until the review appointment to look at them."

14:10

Going on up then, and we can see Martina Corrigan

1 copies that email in to a range of people, including
2 Mr. O'Brien and other of the consultants in urology.
3 The date on that is 27th July. Then Mr. O'Brien
4 responds to that. In essence, there's a lot of
5 questions set out but he's saying that he is writing in 14:10
6 response to the email "informing us that there's an
7 expectation that investigative results and reports
8 should be reviewed as soon as they become available",
9 and he's concerned about that for several reasons.

10
11 Just going on up the page, there is then an email on
12 25th August suggesting that Martina will need some
13 assistance in replying to that.

14
15 On up the page I think there might be further... 14:11

16
17 "I have been forwarded this email by Martina and
18 I think it raises a governance issue as to what happens
19 to the results of tests performed on Aidan's patients.
20 It appears that at present he does not review the 14:12
21 results until the patient appears back in Outpatients
22 Department."

23
24 Clearly, management are concerned that results could go
25 unread while a patient waits for a review appointment, 14:12
26 which at that time and subsequently was not necessarily
27 easy to get, that is a review appointment, because of
28 waiting list background.
29

1 I wonder can you help us. When you look at that, do
2 you think the meeting called for 2nd September could
3 have been to address that issue, or do you simply not
4 know?

5 A. I don't know but it sounds like a possibility, 14:13
6 certainly. But then I had no sight of any of these
7 emails or no discussion about them.

8 106 Q. Nobody came separately to you --

9 A. No.

10 107 Q. -- to say this is the issue we need to discuss? 14:13

11 A. No.

12 108 Q. The original email that I brought to your attention
13 mentioned "issues", plural. Just to go back to it,
14 TRU-250590. So it's issues, plural. "Current issues
15 around one of our senior staff". 14:14

16
17 What happens next around this issue is drawn to your
18 attention, at least the broader issue of actioning
19 results. Diane Corrigan from the Commissioner's Office
20 wrote to the Trust on 14th November. If we could have 14:14
21 up on the screen, please, WIT-105752.

22
23 Just to fill you in with a bit more background, the
24 issue around actioning results was a development or
25 a spin-off of a root cause analysis case where the 14:14
26 patient concerned ran into difficulty because a swab
27 was retained in her cavity during surgery. A scan
28 after four months picked up an abnormality, but
29 Mr. O'Brien didn't read the scan report so that the

1 patient came in as an emergency patient at about
2 12 months post theatre, post surgery, and it was then
3 detected that there was a foreign body in her cavity.
4

5 That issue about reading the report or the 14:15
6 investigation report as soon as it might be available
7 had not been picked up on within the SAI review, and
8 this is Mrs. Corrigan's reason for writing.

9
10 If we go down to the last page, the second page of this 14:15
11 letter in the final paragraph, where she picks up on
12 the point:

13
14 "It is the practice of the patient's consultant 14:16
15 urologist not to review lab or radiology reports until
16 patients attended their outpatient appointment. There
17 was no further comment on this practice nor any
18 recommendation relating to this in the SAI. I believe
19 that this highlights an area where the Trust would have
20 considered action to be appropriate". 14:16
21

22 From that letter coming in, it's drawn to your
23 attention; isn't that right?

24 A. Yes.

25 109 Q. Gillian Rankin copies you into an email in relation to 14:16
26 this. If we can go to WIT-10574. Sorry, wrong one.
27 If we go to WIT-105754. Just scrolling down. The
28 letter from Diane Corrigan is being copied around this
29 level of management. Then moving up, there's

1 discussion about who should draft a response. Then in
2 the next email at the top from Gillian Rankin, there's
3 an agreement that Deborah Burns would take care of the
4 drafting and Gillian Rankin explains that would be
5 great.

14:18

6
7 "This was discussed with all AMDs on two occasions in
8 the past year and I think our only specific issue is
9 with one urologist and Heather" -- that is heather
10 Trouton, I think -- "has been working on this in
11 detail".

14:18

12
13 I think this is identifying the fact that it is one
14 urologist and we believe that to be Mr. O'Brien. Did
15 you ask any questions around this to see whether the
16 actions or conduct of this clinician were being
17 effectively addressed?

14:19

18 A. Yes. I believe I sent an email to Debbie and Gillian
19 on 9th December. Scroll up slightly. It was something
20 along the lines of, "Dear Debbie, what's the progress
21 on this".

14:19

22 110 Q. Yes.

23 A. And she replied, that afternoon in fact, that a letter
24 had been drafted and an action plan was in train.

25 111 Q. Certainly the follow-up from Mrs. Corrigan was to write
26 a letter, I think. The letter is below that, I think.

14:19

27 A. This would have been -- every Friday I would sit down
28 with Anne Brennan and try to tidy up loose ends.

29 112 Q. The letter is at 56 is it? 58. There we are. The

1 upshot was that this was a letter going back to
2 Mrs. Corrigan. You can see what was being proposed in
3 the last paragraph. The Trust was going to consider
4 whether it would be appropriate to devise a protocol
5 around this. But I'm just wondering -- well, that's 14:21
6 a general response to a problem. It was being flagged
7 to you that there was a problem with a particular
8 urologist. We obviously had the proposed September
9 meeting which, according to Mr. Mackle, the
10 meeting didn't take place for whatever reason. He 14:21
11 thought it was an issue to do with this. He thought it
12 was going to be a discussion in relation to actioning
13 results. Then the matters develop and it is now in the
14 eye view of the Commissioner, and the word back to the
15 Commissioner is we're going to look at this and develop 14:22
16 a protocol, perhaps. But I wonder, wearing your hat
17 with the responsibility for the practice of doctors,
18 whether there was enough information there for you to
19 get to grips with the particular doctor concerned, or
20 what was your way of dealing with that? 14:22

21 A. Well, with that issue or any other issue, my view would
22 have been there's all sorts of changes of practice that
23 doctors have to cope with and whatever. Where a doctor
24 should be escalated to me, I don't think it's my
25 business to escalate it to myself. A doctor should be 14:22
26 escalated to me whenever there is a lack of engagement,
27 for whatever reason, or concerns because then that
28 indicates there's a broader problem, possibly each
29 a fitness to practise issue, whatever. What I remember

1 from that is there seems to have been a plan to fix the
2 problem. If it hadn't been fixed, I would have assumed
3 that would have been escalated to me. But it wasn't;
4 I don't know why exactly. But it seemed to me that was
5 a problem being fixed. Appropriately so, because that 14:23
6 was the responsibility of, if you like, the three
7 people involved, the Assistant Director For Clinical
8 Governance, Debbie Burns; the Lead Clinician Associate
9 Medical Director who is responsible for the performance
10 of his doctors, and the Operational Director, all of 14:23
11 whom I would have trusted to escalate to me whenever
12 necessary.

13 113 Q. Does it appear to you somewhat odd that you're being
14 called in to a meeting in September, the meeting
15 doesn't happen but it's a meeting to urologist unnamed, 14:24
16 and then that disappears. The meeting doesn't happen,
17 no discussion, you're not reporting any discussion
18 around a particular urologist, and nothing else emerges
19 from that.

20 A. All I can assume is I assumed they were fixing the 14:24
21 problem. If they hadn't fixed it, they should escalate
22 to me. Why they didn't, I'm not sure. I was
23 available. Other doctors were escalated to me. So,
24 I have to pass on that. I don't really understand.

25 114 Q. Just to focus on, perhaps, what you might have expected 14:25
26 on this singular issue, a doctor declaring that he has
27 great problems or concerns with the notion he should
28 action results promptly or read results and action them
29 promptly. We know that this wasn't the only case of

1 a patient getting into difficulty or potential
2 difficulty because Mr. O'Brien didn't read the results
3 promptly. There was one case in 2020, which is part of
4 the nine SAIs that have led to all of this. There was
5 another case, Patient 92 in 2018. It may be that 14:25
6 Mr. O'Brien continued to take the view that he wasn't
7 resourced for adequate time to read these reports
8 promptly, and it may be that he continued to practise
9 in the way that I described.

10
11 From a governance perspective, there really was a need
12 for somebody to sit down with him at this moment in
13 2011 and say, right, this is the rule, this is what
14 we expect, and you're going to be monitored for
15 compliance. Does that seem reasonable? 14:26

16 A. I would expect that. Where I would expect I would be
17 brought into it is if there was non-compliance over
18 a period of time. That to me then calls into question,
19 you know -- maybe not so much fitness to practise but
20 is there wider issues here that need to be 14:27
21 investigated. It wouldn't have been the slightest
22 problem to me to look at this, really.

23 115 Q. Could I ask you --

24 A. I think the only possible explanation is that, you
25 know, with low-level concerns that, if you like, the 14:27
26 guys in the front are meant to fix and if they are not
27 fixing them, maybe, I don't know, maybe they feel they
28 are failing if they have to refer up to me.

29

1 I know from reading other transcripts that there seems
2 to be this idea that referral to a Medical Director,
3 the medical HR meeting and potentially Maintaining High
4 Professional Standards is some kind of never event.
5 But it wasn't like that, in my view. It would be 14:27
6 better to refer up earlier. In some cases that
7 happened, and in fact we exonerated some doctors where
8 there had been concerns which were unfounded. Others,
9 we went further. That kind of -- those series of
10 issues, I think, should have been what you would call 14:28
11 the preliminary or informal stage to take a broader
12 look at that. I'm not sure why that didn't happen.
13 That would have made everything a lot easier.

14 116 Q. Just to pull up on that point about something of a
15 squeamishness or a never event 14:28

16
17 to use that term, about bringing things to you because
18 they may be regarded as too low-level, there's perhaps
19 an example of that kind of thinking in discussions that
20 were taking place around triage and in relation to 14:28
21 Mr. O'Brien's tendency to retain patient charts at
22 home.

23
24 Let me ask for your comments on this sequence. If
25 we go to TRU-278249. I suppose really the top email 14:29
26 there encapsulates what Mrs. Burns is saying. For
27 a period of perhaps a couple or several years, it had
28 been noticed that Mr. O'Brien had been retaining charts
29 at home, and that was causing difficulties when

1 patients were coming in. Sometimes he could be
2 contacted and he would bring the charts back promptly
3 but sometimes patients might come in as an emergency
4 and there was no chart there. Mrs. Burns is saying, in
5 the context of one particular incident, asking did the 14:30
6 patient get seen:

7
8 "I think if we can't agree with him, John Simpson needs
9 involved."

10 14:30
11 So that goes to Anita Carroll, Heather Trouton and
12 Martina Corrigan. Mrs. Trouton decided that the
13 appropriate course would be to speak to Michael Young
14 and Robin Brown in relation to this. We can see
15 TRU-278249. Sorry, wrong reference. If we go to 14:30
16 WIT-98423 at the bottom of the page. If we work from
17 the bottom up, she's writing to Messrs Brown and Young,
18 and the issues are triage and having charts at home.
19 She is saying:

20 14:31
21 "I really need a response in one week on how this is
22 being addressed for now and the future or I will be
23 forced to escalate to Debbie."

24
25 Debbie Burns already knew about the issues. 14:32

26
27 "It is already being suggested that Dr. Simpson be
28 involved" -- that was the previous email from Debbie
29 Burns which I showed you -- "which I have not

1 progressed to date but it may have to come to that
2 unless a sustainable solution can be found."

3
4 Then if you just go up the page towards Mr. Brown's
5 input, to take his input. Michael Young says I will 14:32
6 speak, and Mr. Brown says "well, Aidan is an excellent
7 surgeon and I would be more than happy to be his
8 patient. That could be sooner than I hope", he jests,
9 "so I would prefer the approach to be "how can
10 we help"."

11
12 I assume, judging by what you said earlier, that you
13 are thinking that these issues, if they are protracted,
14 if they are not getting fixed despite repeated
15 engagement with Mr. O'Brien, they should come to you? 14:33

16 A. Definitely. I know from reading other transcripts this
17 view that Maintaining High Professional Standards is
18 some kind of disciplinary process; it is not. It was
19 more or less designed by the BMA to deal with the
20 process of people being put on gardening leave where 14:33
21 senior doctors couldn't be dealt with, knowing what to
22 do, and so on and so forth. When I came into post, as
23 HR described it to me, this is a comfort zone for
24 doctors compared to the disciplinary processes for
25 other staff. That wouldn't have been a bother to me to 14:33
26 have add it under Maintaining High Professional
27 Standards. After a year, I did agree with Kieran
28 Donaghy that we should be looking for doctors to be
29 escalated to us sooner rather than later, particularly

1 where there's a train of lower level concerns that may
2 or may not indicate a major problem, before a major
3 problem happens.

4 117 Q. You talked earlier -- sorry to cut across you -- about
5 the efforts you put in to try and change the outlook of 14:34
6 your AMDs and to some extent your CDs as well; you were
7 meeting with them and telling them how you wanted to do
8 business. Given that those were the messages you were
9 putting out, can you try to explain, or at least
10 comment on, the thinking that is revealed in these 14:34
11 emails. Mrs. Trouton was obviously operational staff
12 so you had no, I suppose, direct input into her way of
13 working. But we have Mr. Brown here clearly aware of
14 the difficulties being caused, and he's not drawing
15 them to your attention. 14:35

16 A. Yes, and I know Robin's approach. Robin Brown is
17 a very benevolent type leader who likes to see the best
18 in people, and I can understand that approach. It took
19 me a year to get through to everyone that Maintaining
20 High Professional Standards can sometimes exonerate the 14:35
21 doctor. It is not a disciplinary process, it's
22 a discovery process. The fact that NCAS, National
23 Clinical Advisory Service, is involved from the start
24 makes it very clear, it is about remediation, the
25 outcome is to be remediation, it's to fix the problem. 14:35
26 So, when you have ongoing problems like that and they
27 are not being solved, use the Medical Director's
28 Office, the HR advice, the expertise there was between
29 the four of us, Kieran Donaghy, Ian Parks, myself and

1 Anne Brennan, to come up with a resolution.

2
3 The other thing -- and reading through the other
4 transcripts, this seems to be mixing -- is the cases
5 did fix, if you like come up with solutions, it was 14:36
6 normally or usually when the doctor was represented by
7 either the BMA or the Hospital Consultant Specialist
8 Association because those guys are negotiators, they
9 understand the Health Service, what we can do, what we
10 can't do, they advise the doctor appropriately that 14:36
11 this is all about getting things fixed. It's never
12 comfortable to be the subject of an HR procedure but
13 it's also an opportunity for a doctor to clear his
14 name, to say, look, I have my side of the story, and
15 lift it out of the frontline to another view. 14:36

16
17 what we found was that operating MHPS, quite often
18 we needed to get a Clinical Director to be the case
19 investigator from a different part of the hospital
20 because Clinical Directors didn't really like to be 14:37
21 that person. So we came up with that kind of
22 arrangement. Normally it would be Dr. Chada, who
23 volunteered to be the case investigator, and normally
24 Stephen Hall, sadly deceased, as the case manager. It
25 takes it out of the frontline, so to speak, and brings 14:37
26 a bit of a spotlight onto it. We can look at where the
27 risks are, the concerns are; the doctor has an
28 opportunity to put his best foot forwards with regards
29 to his representation, and NCAS advice on remediation.

1 The outcomes are is there a health problem, is there a
2 disciplinary problem, is there a practice problem? But
3 also the outcome is then reviewed by ourselves at that
4 Medical Director's HR meeting. What I'm looking for
5 there is there engagement with the remediation plan 14:37
6 because that's the key to me whether or not this doctor
7 needs to be considered for referral to the GMC. That
8 would have happened.

9
10 what would have happened in those cases is that we 14:38
11 would have discussed something like this amongst
12 ourselves. The Employment Liaison Adviser from the GMC
13 would come in afterwards and we would discuss cases
14 like that with her, either potential referrals or
15 referrals. Even then, you know, the doctor is then -- 14:38
16 there's another investigation separately by the GMC.
17 The doctor again has an opportunity to seek
18 remediation, sort the problem out. I don't know why
19 that wasn't escalated. I just don't know.

20 118 Q. Dealing specifically with the issue of triage, you'll 14:38
21 know that Dr. Chada, in her report, referred to 783
22 untriaged referrals dating back to your time as Medical
23 Director. The Inquiry has received some evidence that
24 the issue of triage was drawn to your attention. Just
25 I'll go through the three items and then you can 14:39
26 comment.

27
28 Mr. Mackle, at WIT-11784. Just scrolling down, he says
29 as regards the issue of triage being an ongoing

1 problem, he was first aware of it in 1996. This is the
2 last four lines of the paragraph.

3
4 "I did inform Paddy Loughran and John Simpson of the
5 issue but I admit I didn't raise it as a serious 14:39
6 governance concern and neither did they question it as
7 being one. On reflection due to the repeated failure
8 to perform timely triage, a thorough investigation
9 should have been undertaken."

10
11 Mrs. Corrigan, at AOB-60406, she says that you were
12 aware of the difficulties. This is paragraph 6, four
13 or five lines down:

14
15 "I am aware that in the past Dr. Gillian Rankin would 14:40
16 have addressed the problem with Dr. Simpson in his role
17 as Medical Director."

18
19 She goes on to say on the next page, I think it is
20 paragraph 6 -- No. She says at one point... Sorry, if 14:40
21 we go to the next page, sorry, at paragraph 12. She
22 says:

23
24 "I know the issue would have been addressed with
25 Mr. O'Brien verbally but I suspect it was never in 14:41
26 writing to him. I know it was verbally addressed by
27 Eamon Mackle, Paddy Loughran, John Simpson and more
28 recently Dr. Wright."
29

1 There's two witnesses to the Inquiry suggesting the
2 triage issue was raised with you. Just in fairness,
3 Mr. O'Brien makes it clear that you didn't speak to him
4 verbally, didn't speak to him about the issue, but
5 Mrs. Corrigan evidently thinks you did and Mr. Mackle 14:42
6 thinks he raised it with you, albeit not as a serious
7 governance concern.

8 A. I have no memory of that, none at all. So...

9

10 It is a serious matter of concern. 14:42

11 119 Q. Yes. At one point, as you know, Mrs. Burns, it's
12 alleged, although she has a different view of it --
13 maybe I'll just rephrase that to be absolutely clear,
14 keep it neutral -- at one point a so-called default
15 arrangement was put in place so if that triage wasn't 14:42
16 performed, the patient was placed on the waiting list
17 in accordance with the classification of the referral.
18 So a routine case, if it needed upgraded, wouldn't be
19 upgraded because it wouldn't be triaged but it at least
20 found its way on to the waiting list. Was that issue 14:43
21 discussed with you?

22 A. No. The evidence by Eamon and Martina and Debbie --
23 the Inquiry is the first time I've heard of any of
24 this.

25 120 Q. Yes. 14:43

26

27 Mrs. Burns, to be clear -- bring this up on the screen
28 please, WIT-98934. Just in the middle of the page.
29 The question is "what is the evidence that the problem

1 was referred to higher authority"? I think the proper
2 way to understand that is if you look to five lines
3 down, DB, that's Deborah Burns, "cannot remember if she
4 made John Simpson aware of the problem".

14:44

6 within that note, as you can see a bit of a shorthand
7 note, she went on to give evidence in relation to this,
8 suggesting that you didn't have a good relationship
9 with Acute sector consultants. I think that's --

10 A. 200 of them? I mean, that's nonsense. I have no
11 idea --

14:45

12 121 Q. I suppose it is difficult for you to deal with the
13 perception, but plainly issues were not raised with
14 you, on your account. We've seen how Mr. Brown
15 hesitated and then didn't ultimately bring the charts
16 or triage issue to you. You've been at pains to
17 explain that you took a very balanced view of MHPS; it
18 wasn't a disciplinary weapon, as such.

14:45

19 A. Yes.

20 122 Q. But do you think you could have sent out the message
21 that, you know, difficult doctors or doctors with
22 shortcomings would have something to fear if the issues
23 were brought to your attention?

14:45

24 A. I sent out those messages numerous times. For example,
25 there was another consultant where there was low-level
26 concerns, bullying. I had to put the message out,
27 really, people, you need to give me evidence of it.
28 Even though the HR Director was telling me, well, that
29 bit of evidence isn't much. What I decided to do was

14:46

1 to launch MHPS because it needed to be dealt with.
2 Although there was very little beyond the informal
3 phase, it actually produced a result and the bullying
4 stopped. So, I can't understand this.

5
6 Possibly, maybe, I'm the first Medical Director whose
7 also Responsible Officer and a direct line to the GMC.
8 As I've described to you, and perhaps it didn't get
9 through everywhere, it's not just -- it's that
10 old-fashioned idea, you know, that these doctors are 14:46
11 wonderful, until something terrible happens and then
12 you have to escalate to the GMC. It wasn't like that.
13 I mean, there were plenty of cases that were escalated
14 and dealt with fairly firmly, and compassionately at
15 times. Probably when there has been a bigger issue. 14:47
16 You know, there has been some criminal cases, for
17 example, that were straight up to me. But lower-level
18 concerns, that seems to have been missed somewhere.

19
20 I never took the view that doctors were special people; 14:47
21 they're people who do a special job. Had that -- well,
22 who knows. If that was escalated to me, my approach
23 would be let's fix this for the benefit of the Trust
24 and for the benefit of the doctor and for the benefits
25 of the patients. What would guide me in that would be 14:47
26 not so much did he comply with this or did he comply
27 with that, it would be really I would be looking at the
28 doctor's insight and serious engagement with
29 remediation and getting the problem fixed.

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So, even after MHPS is finished, there will be, say in cases where there's remediation, we don't walk away from it, we review it every month and get reports as to how well that's going. The big issue for me as a Medical Director is if I think that there isn't proper engagement or there's evasiveness or there's something else going on, to me that indicates a problem with fitness to practise, the more global fitness to practise. But as I said earlier on, that would be then discussed with the Employment Liaison Adviser. If it was that I did refer someone to the General Medical Council, they would do their own investigation, make their own judgment.

14:48

14:48

14:48

This is unknown. I don't know why. It is not just me, this is unknown to everyone, really, I thought.

123 Q.

You did some work around the administration of the transition from being a private patient into the NHS. You did some work in 2014, including what was described as a paying patient's roadshow. I don't need to bring this up onto the screen but the work was described as introducing a formalised process necessary for the Trust to meet with the Department 's audit requirement. Is it fair to say you were trying to tighten up the procedures around that?

14:49

14:49

A.

Yes. I think it actually kicked off under Paddy Loughran's time and we finished it, myself and Anne Brennan, just to bring clarity to, you know, we're

1 not a private hospital but private patients can be
2 treated if they're transferred appropriately to an NHS
3 system.

4 124 Q. In that context, I want to ask you about this. Bring
5 up on the screen TRU-27504. Sorry, try 27508. Scroll 14:50
6 down four pages, please.

7
8 There's a message sent by Mr. Haynes, if we scroll down
9 the page, to Mr. Young and Mrs. Corrigan, in May 2015.
10 He is saying: 14:51

11
12 "I feel increasingly uncomfortable discussing the
13 urgent waiting list problem while we turn a blind eye
14 to a colleague listing patients for surgery out of date
15 order, usually having been reviewed in a Saturday 14:51
16 non-NHS clinic."

17
18 He sets out further detail around that. That's the
19 issue. He's asking Mr. Young -- if we just scroll down
20 the page -- "This needs to be challenged to put a stop 14:51
21 to it".

22
23 Up the page then, we see Mr. Young's response. "Point
24 taken. Agreed. Play a straight honest game." The
25 suggestion might be that he's going to address it. 14:52
26 I think the evidence around whether it was addressed is
27 still to be fully revealed to the Inquiry, but this is
28 a year after you've re-emphasised, perhaps, the need
29 for probity around the transfer of private patients

1 into the NHS.

2

3 would you have expected an issue like this to be
4 addressed locally by the clinical lead or the clinical
5 director, or would you have expected to have heard
6 about it yourself? 14:52

7 A. If it wasn't fixed, I should have heard about it. It
8 was, you know, it was my policy, if you like. If the
9 medical leadership structure couldn't handle it, then
10 they should have said to me, look, this isn't working; 14:53
11 we understand what the policy is. In general, I think
12 the vast majority of doctors thought it was a very
13 sensible policy; this is clarity. At the same time we
14 were doing job plans and if doctors wanted to do
15 private lists, they could go to the Ulster Independent 14:53
16 Clinic or whatever. All of this was in the job plans.
17 All of this was above board Board and very clear.

18

19 If that hadn't have been sorted out, I would have
20 expected to hear about it because, as you say, a 14:53
21 question mark over probity.

22 125 Q. And nobody drew it to your attention?

23 A. No.

24 126 Q. A couple of final issues, Dr. Simpson. You were aware
25 of an issue, or an issue was drawn to your attention, 14:54
26 concerning antibiotics for patients who had indwelling
27 catheters. If we go to TRU-250625, I think we can see
28 Dr. Damani. He was a microbiologist; is that right?

29 A. Yes. He was the lead clinician, and we made him, in

1 fact, Associate Medical Director at some point then for
2 infection control. He might have been that at that
3 stage. So I would have been in touch with -- and I was
4 the director responsible for infection prevention and
5 control, so I would have been in regular contacted with 14:54
6 Nizam.

7 127 Q. Yes. He is attaching a letter about antibiotic
8 prescribing in urology. This, just for the avoidance
9 of doubt, is distinct from the issue in 2009/2010 about
10 intravenous fluid management and antibiotic. This is 14:55
11 a separate issue. He's saying:

12
13 "I attach a letter which was sent to urology.
14 Discussed this with urologists and received no reply."

15 14:55
16 The letter is a letter from 2010. Just scrolling down.
17 It was addressed to Mr. Young. You can see at the
18 bottom of the page, copied to Mr. Akhtar and
19 Mr. O'Brien. Really it was addressing a concern about
20 empty microbial negativity and the overuse or 14:55
21 inappropriate use of antibiotics.

22
23 If we go to your witness statement in this respect,
24 WIT-25726. At 57.1, you say:

25 14:56
26 "The only concern raised regarding Mr. O'Brien which
27 had the potential to impact on Patient Safety was
28 this", the antimicrobial prescribing for indwelling
29 catheters by urologists.

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You go on to explain why that might be a problem.

Could I ask you this, doctor, the letter or the email from the microbiologist, Dr. Damani, it was a general letter. It doesn't appear to have been making any allegation about any specific consultant, let alone Mr. O'Brien. Where you've said the only concern raised concerning Mr. O'Brien which had the potential to impact on Patient Safety, had you some information that Mr. O'Brien had a shortcoming in his practice in this respect, or why did you phrase it that way? 14:56

- A. No. I think I was trying to answer the question. It says "Please explain why and identify the person", and I knew that the Inquiry was interested in Mr. O'Brien. 14:57
- But the letter from Nizam Damani was about both consultants and junior staff. He had picked it up from Raj, Dr. Raj who was doing the antimicrobial ward rounds, and also the GPs that there was a problem. I think the specific problem in urology was there was always a debate about guidelines, particularly with microbiologists and frontline clinicians. I think what Nizam was complaining about was there was no discussions. He wanted a debate. That's okay, that's what we hoped for. As I think I mentioned, an antimicrobial ward round was quite a new thing, introduced by Dr. Damani. So it is a staff grade, quite brave, going into, if you like, second-guess prescribing habits of doctors, not just in urology but 14:58

1 right across the Trust, to challenge. Our view was,
2 well, that's okay, we don't have to get absolute
3 adherence to guidelines but we want a discussion at
4 least. So, I think the letter from Nizam came because
5 Raj had felt he wasn't getting feedback or a potential
6 for discussion. 14:59

7
8 I presumed at the end of that that there was then an
9 opening up of discussions because if there hadn't have
10 been, Nizam would have told me because I was meeting
11 him every week. 14:59

12 128 Q. Yes.

13 A. But in a broader sense of guidelines, you know, we were
14 having big problems with venous thromboembolism, VTE,
15 guidelines being different in different parts of the
16 Trust and trying to get everyone to agree on a Trust
17 approach. This was to try to get everyone to agree on
18 a Trust approach for prescriptions for antibiotics.
19 We had similar problems with the respiratory physicians
20 in their antibiotic treatment in community acquired
21 pneumonia. So, it was a general problem. 14:59

22 129 Q. Can I just go back to your answer. Could I ask whether
23 it would be fair to correct what you said at 57.1. If
24 there was no particular -- no evidence at all in
25 relation to Mr. O'Brien's practice, as appears from the
26 email it is a general concern that urologists haven't
27 responded to correspondence and hadn't engaged in the
28 discussion that Mr. Damani wanted. But it wasn't, as
29 you suggest here, it wasn't a concern regarding Patient 15:00

1 Safety and Mr. O'Brien?

2 A. Strictly speaking, that's true. That should be
3 adjusted regarding -- I suppose any concern regarding
4 urology consultants and -- you know, urology
5 consultants, because their practice was obviously 15:00
6 determining what the juniors were doing on the ward and
7 what was in the letters going out to the GPs. So, yes.

8 130 Q. One final issue of perhaps low-level concern that
9 crossed your desk in relation to Mr. O'Brien concerned
10 his responsiveness to litigation requests. If I could 15:01
11 refer you to TRU-250703. Obviously litigation is one
12 of the concerns that comes under your job description.
13 Karen Wasson is the staff member with specific interest
14 in that area. She is chasing this with Eamon Mackle.
15 15:01

16 "A number of medical negligence cases where we have
17 requested information involvement reports from
18 Mr. O'Brien and have yet to receive a response."
19

20 Then I think up the page, you're copied in. 15:02

21

22 If we go to 250705, just two pages down. Just scroll
23 down, please. We can see that one of the points she's
24 making is that Mr. O'Brien had been asked for a report
25 on 30th August 2012 and the report wasn't received 15:02
26 until 20th January 2014. In isolation, that looks like
27 a long time; maybe there were complexities around it.
28 You wrote to Mr. O'Brien, and he wrote back saying that
29 he was unaware of repeated reminders. This is

1 TRU-250706. Did that tardiness in relation to
2 responding to litigation requests cause you concern, or
3 was that not untypical of practitioners?

4 A. It wasn't. I'm not sure that even Mr. O'Brien would
5 have been an outlier. That was a common enough 15:03
6 chase-up that we would have had to do to get responses
7 from consultants with regard to litigation. I think,
8 I suppose, it was an understanding on that; there's
9 a lot of other things going on clinically. It's quite
10 a big job probably to respond to that, to go back and 15:04
11 look at notes and make that response. So I'm not sure
12 if he was that much of an outlier compared to others.

13 131 Q. In that respect.

14
15 As we observed this morning, Dr. Simpson, towards the 15:04
16 start of your tenure as Medical Director, you were,
17 I suppose in the context of Dr. Aminu's case that
18 we looked at, you're furrowing your brow and saying,
19 looks like there's a professional clinical governance
20 issuing within urology, and, as you explained this 15:04
21 morning, you were seeing that in other places as well.
22 That was an issue in 2011. Fast forward to 2015 and
23 issues that you think you should have known about,
24 should have been brought to your attention because they
25 were unresolved, weren't making it to you. Does that 15:05
26 suggest perhaps that, at least within urology, the
27 culture of not disseminating, not communicating, not
28 escalating hadn't really changed that much?

29 A. That's quite possible. It's difficult to change

1 culture. I would have seen that, I think, in the
2 context of Craigavon Hospital generally going right
3 back to 1992, when Craigavon was its own Trust of the
4 17 Trusts, which was never a good idea, separate from
5 the community, separate from Daisy Hill. My instinct, 15:06
6 both as a consultant starting in 1992 and then Medical
7 Director 2011, was there was that sense of elitism that
8 really might have been partially justified but is not
9 best -- it's not well disposed to, you know, proper
10 clinical governance. 15:06

11
12 For by MHPS, GMC and so forth, the way to deal with
13 these things at the coal face. Healthy teams keep each
14 other right and they set the right culture. It's not
15 reasonable, you know, to expect any clinician of any 15:06
16 stripe to be at their best for 30 years. You know,
17 performance will wax and wane, the team should
18 compensate for that. Where they can't compensate,
19 that's the time to escalate. Teams can't compensate
20 whenever the clinician is not working with them. If 15:07
21 that keeps going up the chain, then it is clear that by
22 the time it reaches any medical director, then you know
23 there's a much larger problem.

24 132 Q. I think you maybe say it best -- not to criticises how
25 you are saying it now -- but within your statement in 15:07
26 terms of the learning, if we just pull up WIT-25731.
27 You're saying the specific difficulty was and still is
28 to embed clinical governance into everyday clinical
29 practice. This is at 72.5. The objective being is to

1 get a multidisciplinary rather than uni-disciplinary
2 working fashion. By creating that, it's more likely
3 that issues of concern can be addressed at the earliest
4 possibly opportunity?

5 A. Yes, I think I said it better there, certainly. I've 15:08
6 experienced that. An outlier in a healthy team can be
7 brought back into line, and that's what you'd expect.
8 If that can't happen, then the team has to say, well,
9 we have to do something about this because that poor
10 performance reflects on all of us. That's where the 15:08
11 problem should be, you know, solved or not solved. If
12 it's not solved, then it should be escalated.

13 133 Q. If I take you to just an earlier part in your
14 statement. WIT-25729, 67.2. You're saying that:

15 15:08
16 "Medical oversight and clinical governance has improved
17 over recent decades. There's now a greater
18 understanding of its importance by doctors, managers
19 and healthcare leaders. There has been investment in
20 medical leadership." 15:09

21
22 where do you observe that best? where have you seen
23 that? You're out of Craigavon, you're out of the Trust
24 as a Medical Director for eight years. where's this
25 expression of, I suppose optimism or confidence, come 15:09
26 from?

27 A. Well, I did some site visits with RQIA. Not just
28 mental health, we visited, inspected, the private
29 hospitals, the hospices, the Children's Hospital, and

1 others. You could see that there was a change.

2
3 I think the big change probably, as I mentioned earlier
4 on, the younger consultants back then coming through to
5 new appointments, late 2000-2010, had been trained in 15:10
6 this, that they're part of a team, that they're going
7 to be assessed every year to see can they be
8 a consultant and finish the training. Then that
9 carries on. So, that culture has changed. I think it
10 has been slower in some specialities than others. 15:10

11
12 In terms of understanding and improvement, you know,
13 the current Medical Director has three Deputy Medical
14 Directors in his own Trust. There have been extra
15 posts created. I think there's a view now about what 15:11
16 is the optimum management span of control for
17 a Clinical Director, should it be 20 consultants rather
18 than 100. So there's a much more clear view. I think
19 there's a clearer view that, you know, doctors are
20 responsible for Quality Improvement and not just the 15:11
21 patient in front of them.

22
23 There will always be this tension between the needs of
24 the Trust which is we have to serve the population, and
25 the doctor who just sees the patient in front of him. 15:11
26 That tension will always be there.

27 134 Q. You make a point in this paragraph about there will
28 always be a difficulty, particularly at an early stage,
29 to identify and manage concerns about a senior doctor

1 who is deliberately evasive. Is that intended as
2 a general remark or are you suggesting that Mr. O'Brien
3 was deliberately evasive?

4 A. It's difficult for me to say because I've only been
5 reading the transcript since; I haven't had any 15:12
6 experience of any of the problems that were raised at
7 the time. But I've had other experience with doctors
8 who have been deliberately evasive. Again, certainly
9 within psychiatry, but it's much easier. You know,
10 a consultant is part of a team, a part of a consulting 15:12
11 team, part of a multidisciplinary team. There's no
12 hiding place, really. Using the calling card of
13 seniority or the hierarchical thing, it's just not
14 there. But, you know, it has to be tackled.

15
16 I think what I'm trying to say there really is what
17 I said earlier on, doctors are not special people, they
18 are people who do a special job. They have all the
19 problems that ordinary and everyday people have, white
20 coat or not. 15:13

21 135 Q. Yes. We know that, I suppose, within four or five
22 months of you vacating the Medical Director's post that
23 Mr. Mackle and Mrs. Trouton approached the new Medical
24 Director, Dr. Wright, and told him about their concerns
25 about Mr. O'Brien's practice. The trigger for that, at 15:13
26 least from Mrs. Trouton, would appear to be, well,
27 a further concern has come to light about Mr. O'Brien's
28 failure to dictate clinical encounters. But they, for
29 whatever reason, felt it was an appropriate time to

1 approach the Medical Director but ironically you had
2 never been approached in that way, and one could
3 probably draw a line between that approach and
4 eventually the MHPS process commencing in the early
5 months of 2017.

15:14

6
7 when you think, knowing all that you know about this
8 now, do you reproach yourself in any way for the fact
9 that these issues didn't come your way to be dealt
10 with, or do you think that in terms of trying to build
11 culture and build support for the medical leadership
12 that you did all you could to expose these issues?

15:14

13 A. I can't think of anything else I could have done except
14 being available, which was -- I was available and
15 approachable. I was approached and I was available for
16 other issues that were escalated. Now I think it's
17 more of a judgment call of what the threshold is and
18 I think it was too high, whereas in other cases I made
19 it very clear it should be lower. I find it hard to
20 understand what happened. I just...

15:15

15:15

21 136 Q. Okay. Thank you very much for your evidence. The
22 Panel may have some questions for you.

23 CHAIR: Thank you, Dr. Simpson. I'm going to hand you
24 over, first of all, to Mr. Hanbury, who will have some
25 questions.

15:15

26
27 THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS
28 FOLLOWS:
29

1 MR. HANBURY: Thank you for your evidence, Dr. Simpson,
2 very clear. I just have a few random, diverse
3 questions for you in no particular order.

4 137 Q. Job planning. You mentioned surgeons may be more
5 something than physicians; maybe I am misquoting you. 15:16
6 Do you have a theory for that? We usually quite like
7 a regular job plan.

8 A. Well, I made a contrast really with -- we had issues
9 with physicians as well -- no, I made a contrast with
10 the anaesthetists because I thought the best way to 15:16
11 approach this is let's get fair play in the team; this
12 isn't just the Trust wanting to keep tabs on you. The
13 anaesthetists were able to create a team job plan
14 first. It's easier because they are bite-sized chunks.
15 They knew what their demand was, they knew what their 15:16
16 capacity was and they could then redivide the team plan
17 job plan into individual job plans.

18
19 what could I say about surgeons. You're a surgeon,
20 I presume? 15:16

21 138 Q. Okay, I'll let that go. But just to go on from your
22 comments about team job plans, that's not something, I
23 think, the urologists ever who were asked to deal with
24 did. Do you think that was a missed opportunity?

25 A. Yes. I think, you know, the surgeons work alongside 15:17
26 the anaesthetists, they would have been well aware of
27 the progress that that particular MD, Charlie
28 McAllister, had made. I think, like any change, if you
29 are working with a team of people, it is easier than if

1 you are working with each individual as you go along.
2 I think maybe that's where things fell down. Trying to
3 deal with a one-to-one job plan with 25, 30 people,
4 that's going to take time.

5 139 Q. Okay.

15:17

6 A. You can get into the trenches -- I mean, one of the
7 things, and we discussed this quite regularly with the
8 Chief Executive, we had a round table meeting quite
9 regularly -- the general view was don't be getting into
10 the trenches with a doctor. If they say 13 PAs and you 15:18
11 say 12.5, you know, go with that but it's going to be
12 reviewed next year. So I think that would have been my
13 advice. And my approach is get the baseline done even
14 if you don't completely agree with it, and review year
15 on year on, year on, year on. What I would have done, 15:18
16 certainly in psychiatry, is that I would have made it
17 clear that everyone knew what everyone else's PAs were.
18 Whether that was legal or not, I don't know. My idea
19 was, look, we all have to work together on this and
20 I want to ensure fair play to all of you. There were 15:18
21 individual job plans created in psychiatry but there
22 was that team approach. If you've got a healthy team
23 to work with to start with, you know, you're going to
24 make progress. If the surgeons don't see themselves as
25 a team, which I don't think they did, fair enough, then 15:18
26 you're going to make slow progress dealing with them
27 individually.

28 140 Q. Thank you.

29

1 Moving on, I wanted to ask you about your observation
2 about waiting list initiative activity being done
3 during the working week. What was your implication
4 there because most of the surgeons were on 12 or so PAs
5 at least, presumably they were being paid for every 15:19
6 session anyway? What was the implication to your
7 observation?

8 A. If they justified they were doing something at weekends
9 or whatever, but the problem is I didn't know, we
10 didn't have a record. The auditors were quite within 15:19
11 their rights to say if you don't know exactly where
12 these sessions are, day, evenings, weekends, how can
13 you know when the waiting list initiatives are done out
14 of hours or not.

15 141 Q. Another question going on from that. If you have 15:19
16 a clinician who is struggling with admin in other parts
17 of their activities but also doing a lot of waiting
18 list initiatives, should that raise a red flag?

19 A. It would certainly raise a question as to why.

20 142 Q. Yes, okay. 15:20

21 A. The basics have to be done first.

22 143 Q. Okay.

23 A. At the same time, I witnessed a lot of pressure from
24 senior management to get these extra sessions done and
25 get the waiting list down. That was a big priority. 15:20

26 144 Q. So there may have been pressure for performance?

27 A. Oh, undoubtedly. Undoubtedly, yes.

28 145 Q. You're relaunch of the old-fashioned
29 morbidity/mortality to a patient's safety was

1 interesting. Was there really a half-day type idea
2 where clinicians are freed up? We're very familiar in
3 England. Here, was there a big pushback for loss of
4 activity from either the Board or --

5 A. Not really. The pushback was getting everyone's 15:21
6 diaries to coincide. I think there was a rolling audit
7 day, I think, in surgery already. We just thought we'd
8 use that. So there was some huffing and puffing in
9 certain areas but everyone came along to it eventually.

10 146 Q. So it wasn't a big problem? 15:21

11 A. We got over it.

12 147 Q. The standards and guidelines are interesting. There
13 are so many, aren't there, and I think every hospital
14 struggles with that. But if something important comes
15 along, for example prostate state cancer management for 15:21
16 urologists, was there a mechanism that the AMDs or
17 someone you appointed would chase up, do a sort of gap
18 analysis or some other mechanism to see how
19 a department was doing compared to a standard?

20 A. When we got standards in, we would appoint a change 15:21
21 lead, but that was very much a volunteer and we needed
22 someone with that particular expertise who would be the
23 champion for the change and lead it through. So there
24 was a process to implement standards and guidelines.
25 I don't think we were sophisticated enough to follow up 15:22
26 the adherence, that I can remember. I know that
27 process of tracking standards and guidelines was new in
28 my time. I can't claim total credit for it. There was
29 Margaret Marshall and Anne Brennan, they were a lot of

1 people involved in that, but we didn't have any
2 tracking mechanism in 2011. That was my main concern
3 first of all. Standards and guidelines were coming in
4 from the CMO's Office, from NICE, from all sorts of
5 different directions and not through one single point. 15:22
6 All the Trusts then agreed it should come through the
7 Chief Executive's office and disseminate down and then
8 track. I don't think we were sophisticated enough to
9 audit the adherence.

10 148 Q. Thank you for your honesty there. 15:23

11
12 Recruitment, we heard from a lot of witnesses, has been
13 a big problem; certainly urologists. Are there any
14 magic fixes there? What are your comments in general
15 terms? 15:23

16 A. The smaller specialties in Northern Ireland are always
17 difficult because there's a smaller pool. Literally
18 you could probably be a direct correlation to
19 difficulties in recruitment to distance from Belfast,
20 as simple as that. So we had problems but the 15:23
21 Western Trust had bigger problems. The
22 Southeastern Trust, being part of Belfast almost, you
23 know, Dundonald, easily commuting distance, would have
24 less problems. We had difficulties but we knew
25 we weren't in as much difficulty as the Western Trust. 15:24

26 149 Q. Thank you. Two more short ones.

27
28 One about the saline TURP and, in general terms, the
29 equipment of new equipment when new, safer techniques

1 come along. In general it seems to have taken some
2 Trusts a long time to adopt something that the rest of
3 departments across Northern Ireland adopted fairly
4 soon. There may be a few reasons for that. Purchase
5 of the equipment seemed to be a big problem. Do
6 you have any comments there?

15:24

7 A. I think that was after my time. I'm not really sure
8 what happened about that. But as I said in my witness
9 statement, you know, we were early adopters for other
10 guidelines. The Belfast Trust, I saw that witnessed.
11 But where the other three Trusts -- if we're going to
12 be compared to anyone we should be compared to
13 Southeastern, Western Or Northern, with a smaller
14 complement of staff. When you look at that case, and
15 it was a big case that the Coroner drew attention to,
16 largely I think because if the Coroner hadn't dealt
17 with it, we may never have heard about it if it hadn't
18 been a death. So he made a big splash with it, as
19 he should have done.

15:24

15:25

20
21 The issue, on my reading of it, was more about
22 adherence to WHO guidelines with regards to Patient
23 Safety huddle, and WHO checklist, team working, and
24 measurement of fluid in/fluid out, and intraoperative
25 sodium measurement. Charlie McAllister, Lead for
26 Anaesthetics, was very sharply on to that and was able
27 to given assurance of safety until the switch was made
28 from glycine to saline.

15:25

15:26

29 150 Q. Just one more, if I may. The Urology Department had

1 a lot of problems with quoracy of their
2 multidisciplinary meetings, particularly with radiology
3 and oncology. Did they ever come to you for help to
4 try to negotiate?

5 A. No. I only heard about that through reading the 15:26
6 transcripts.

7 151 Q. So that never filtered up to you, that particular
8 problem?

9 A. No.

10 CHAIR: Thank you. 15:26
11

12 Dr. Swart.

13 DR. SWART: Thank you for your evidence. I recognise
14 many of your struggles as a previous Medical Director
15 myself, so my comments are in that light, really. 15:26

16 152 Q. I'm interested in where the directives from on high, so
17 from the DH, came in terms of quality. Most
18 specifically, in 2011 there was a document called
19 Quality 2020 produced by the Public Health Authority
20 and it has lots of objectives in it. One of the 15:27
21 objectives was that every service should have,
22 essentially, a quality score card and that quality and
23 safety should be the top of every Board and management
24 meeting's agenda. Was that brought to your attention
25 frequently? Did you succeed in any of that? Because 15:27
26 I can't see quality score card certainly, and I can't
27 see quality and safety at the top of the Board either.
28 I might be wrong. What was your perspective?

29 A. Yes, I remember that initiative from the Public Health

1 Agency. That would have been -- I've forgotten the
2 doctor's name. All the Medical Directors would have
3 been brought to that. What they tried to do, not
4 unreasonably, was to get Quality Improvement projects
5 together and sort of change leaders, whatever. 15:28
6 I criticised it at the time. A very good initiative
7 but my view was it was very much a top-down approach
8 rather than getting out amongst the frontline teams.
9

10 At the same time, the Board did have a Patient Safety 15:28
11 agency -- I forgot the actual title -- who did do that
12 and tried to build from the ground up. But the sort of
13 global let's have Quality as our priority, it never
14 really --

15 153 Q. In England, for example every Board meeting generally 15:28
16 would start, for example, with a report from the
17 Medical Director with a quality score card. Did
18 you ever talk about that at Board level?

19 A. No.

20 154 Q. No. 15:28

21 A. I mean, I did suggest early on, 2011, that we should
22 have, as Trusts in England had, an overarching quality
23 report taking into account all of that. I know again
24 people agreed with me, and there was an attempt to get
25 that off the ground from Paula Clark, Director of 15:29
26 Planning, but it didn't really happen.

27 155 Q. It's not that easy to do, of course, for a variety of
28 reasons. But in your role on the Board as Medical
29 Director, were you given the job of educating the Board

1 in terms of how to look at data with respect to
2 Quality, or ensuring that the Finance Director
3 understood the Quality agenda? Did you have that remit
4 or did you feel you were fighting with the other
5 directors about that?

15:29

6 A. The problem I had with the Board was just the amount of
7 information that was delivered to the Board. I think
8 they struggled to interrogate all of the information.
9 What I tried to do -- I mean, you know, Board papers
10 before IT were at least a foot high. You have
11 non-executives, myself and others. Most of those
12 papers were about activity levels and financial, you
13 know, management as such. There was no coherent
14 approach to that.

15:30

15
16 As I said earlier on, I think I would really have liked
17 a medic to be one of the nonexecutive directors, to, if
18 you like -- not just me, put the Trust on the spot and
19 say what are you did about Quality; where is this
20 report; I want to see that. But I think the
21 non-executives were overwhelmed with the detail of
22 process.

15:30

23 156 Q. One example I would say would be with respect to
24 cancer, where there's a lot of information about
25 ministerial targets, even in the latterly constructed
26 performance meetings, but no information on precise
27 compliance with peer-reviewed standards, which is quite
28 a simple thing. Do you think the Board had any
29 awareness of that or were they just overwhelmed because

15:30

15:30

1 of the breadth and depth of the --

2 A. The Trust Board?

3 157 Q. Yes.

4 A. No. I think -- yes, I mean, I think they went with the
5 flow, understandably, which was about activity and 15:31
6 financial management. There were maybe discussions
7 but, you know, a typical Board meeting, at least a half
8 day, if not a whole day, and the professional directors
9 brought in at the end, any comments.

10 158 Q. Did you ever have the really barn door discussion of 15:31
11 are we going to be shot for the money or shot for
12 Patient Safety; what matters more to the Board?

13 A. Well, that Board meeting --

14 159 Q. Was that the closest you got to it, that one?

15 A. Yes. Well, there was another big argument over closing 15:31
16 an infection control overspill ward. That was hot and
17 heavy. It actually came to a vote at the Trust Board
18 because I completely disagreed with its closure.
19 Again, it was closed because they wanted to open extra
20 beds for winter pressures. I was saying yes, but if we 15:32
21 have to close a ward because of C Diff or more
22 likely Norovirus, you're losing capacity anyway. That
23 was a hot and heavy debate.

24 160 Q. But Mid Staffs, for example, those lessons are
25 well-publicised and the key thing was money over 15:32
26 quality. How aware was the Board of that?

27 A. I'm not sure.

28 161 Q. Okay. I'll move on from that.

29 A. Probably the best place for those discussions were the

1 Board development days and so on, where we would have
2 had more of a discussion. I think it would have been
3 better if we had had three executive professional
4 directors, social work, medicine, nursing, as opposed
5 to just me because everyone else is focused on
6 activity.

15:33

7 162 Q. It is a big remit for one person.

8 A. I think the balance of power, shall we say, might have
9 been tipped differently. I think the Trust, if I'm
10 right, because I didn't know but I was looking through
11 the evidence, after I left, at some point or other they
12 did create an Executive Director of Nursing, which
13 I think is a big step forward.

15:33

14 163 Q. On a slightly different tack, there's quite a lot about
15 job planning in our various bits of evidence; it's
16 a big issue for most Trusts. My experience of job
17 planning is that there is an opportunity to put
18 objectives into job plans and team job plans in terms
19 of standards to be achieved, but I can't see that
20 featuring in the job plans we've seen here. Why is
21 that? Why was there no inclusion, or was it simply
22 thought that it would be added later? Do you have any
23 perspective?

15:33

24 A. Yes, I think it was that that would be a name. Just
25 getting the basics done in terms of the baseline job
26 planning was a massive effort and very, very slow.
27 Using job planning in a more proactive sense like that,
28 perhaps it did come to that after I left but we hadn't
29 got that far in 2014/'15.

15:34

1 164 Q. We also heard evidence from people in various roles,
2 I'm thinking particularly of the clinical lead role now
3 where there was a statement there was no job
4 description, no formal development for clinician leads;
5 there seemed to be a rather confused understanding of 15:34
6 the role of clinical governance of any such role. Does
7 that surprise you?

8 A. No, I think I would be very sympathetic to lead
9 clinician. In a medical management structure, medical
10 leadership structure, that's quite thin on the ground; 15:35
11 well meant when it was first developed. But when
12 that's thin on the ground, I think there's an awful lot
13 expected of the lead clinician when they are trying to
14 help. My view of the lead clinicians was that they're
15 trying to help us. I wouldn't have been expecting too 15:35
16 much of them. I also thought that we should be going
17 easy on the lead clinicians because I wanted them to
18 apply for clinical director posts; I wanted them as a
19 sort of introduction to medical leadership.

20 15:35
21 Again with the whole pressure of activity and so forth,
22 I had great sympathy for anyone who was a lead
23 clinician.

24 165 Q. How should that be fixed because they need time, they
25 need development, they need guidance? It's a hard job. 15:35

26 A. I wonder should we have them really, because I think
27 you are better off as a clinical director. When I was
28 doing the psychiatry job MD, I had two clinical
29 directors. They had sessions to work with me, they

1 knew what they were doing, they had the responsibility,
2 they had paid responsibility.

3
4 I suppose you're thinking about urology. Perhaps in
5 a subspecialty where the Clinical Director has a number 15:36
6 of subspecialties, they may want a lead clinician in
7 that subspecialty, but I would have thought of that
8 more in terms of advice about specifics of that
9 specialist as opposed to taking a lot of
10 responsibility. I don't think there was a job 15:36
11 description.

12 166 Q. Would you accept that maybe there was a little lack of
13 clarity as to whose job it was to raise issues,
14 clinical issues on the ground in that scenario where
15 we all have a responsibility as doctors to raise issues 15:36
16 anyway? There does appear to have been a lack of
17 clarity.

18 A. I think that's fair enough.

19 167 Q. Is any of that responsible for the fact that things
20 weren't escalated? We've heard things about hierarchy, 15:36
21 deference, blinded by people's seniority. We've heard
22 the operational management saying that's a medical
23 manager's job and the medical manager saying that's an
24 operational manager's job. How much of that confusion
25 was evident to you at the time you were in post? 15:37

26 A. Not within urology, I didn't pick up on that.

27 168 Q. Just generally, I mean.

28 A. Generally, as I say there were a significant number --
29 a significant stream of doctors were escalated to me.

1 169 Q. So you wouldn't have described that as an issue?
2 A. Yes. I remember one particular issue, without going
3 into too much detail, of a consultant who was --
4 I think I mentioned it earlier, actually -- there was
5 concerns about him bullying, or her, let's say, 15:37
6 juniors. There was a reluctance to bring that forward;
7 does this meet the threshold. I was being told that
8 informally, and I remember it. In fact it was one of
9 the things that Paddy Loughran passed on to me, that
10 you need to deal with this, John. It did need a bit of 15:38
11 encouragement into the system to say, look, you need to
12 bring this forward. All I can think of is that
13 everyone seems to think it is the nuclear option; from
14 in my perspective, I was thinking can I fix this.

15 170 Q. You seem to be a fan of MHPS; would that be correct? 15:38
16 Most people seem to complain about it.

17 A. Well, I had heard about it. As it was described to me
18 by Kieran Donaghy, HR Director, and Zoë Parks, Malcolm
19 Clegg, very experienced people, were saying no other
20 profession has this luxury, was their view. It was 15:38
21 written by the BMA, and it was to solve that problem of
22 doctors being put on gardening leave. We had to work
23 out how to use it, which we did. I think we had a good
24 team, was the point really, to know how to use it.

25 171 Q. If you had to change it, what would you change in MHPS? 15:39
26 A. It only occurred to me recently, just looking through
27 all the -- what's the word? -- the transcripts, that
28 where it worked well, and I think where it didn't work
29 well reading through the one led by Dr. Chada, was it

1 became very confrontational very early on. What
2 doctors need to know is that that's the wrong approach.
3 What I experienced with the BMA and with the Hospital
4 Consultants Association was a negotiating type
5 approach. You can't really tell a doctor, by the way, 15:39
6 the person you bring into an MHPS has to be an
7 experienced negotiator from the union, but it should be
8 someone who has those skills. I think we should be
9 saying that to them; not just anyone. To get the pest
10 out of the system, you need someone who is prepared to 15:39
11 negotiate on your behalf, who can liaise with the
12 Trust, who can liaise with NCAS and come to
13 a negotiated solution. Because we did do that.

14 172 Q. Going back to the directors that you got as medical
15 director about Quality, where did that come from? As 15:40
16 Medical Director, you are the guardian of quality
17 safety generally on the Board. Who in the Department
18 of Health contacted you with key matters that you
19 needed to bring to the Board's attention, or key
20 matters that needed to be brought into commissioning 15:40
21 frameworks or anything of that nature?

22 A. Well, a letter from the CMO is the one that you look at
23 very --

24 173 Q. Did you get many of those?

25 A. Not many but there were -- there could have been five 15:40
26 or 10 a year. So, I mean one of the big ones was
27 December, Christmas Eve 2011, that there had been baby
28 deaths unaccounted for, potentially contamination of
29 water supplies. I couldn't remember the actual letter

1 but that was the CMO. When the CMO sends you a letter,
2 you pay attention.

3 174 Q. Was it your experience that a letter like that goes to
4 you for action as Medical Director, and that it is also
5 brought into the commissioning discussions? 15:41

6 A. Yes. A letter such as that goes to the PHA, goes to
7 the Board, goes to all the chief executives as well as
8 the medical directors, yes.

9 175 Q. And to the Health and Social Care Board, or now the
10 SPPG. 15:41

11 A. Yes. That would be Karen Harper would have been the --

12 176 Q. So they would have all been aware of that?

13 A. Oh, yes.

14 DR. SWART: That's all from me.

15 CHAIR: Just a couple of things from me. 15:41

16 177 Q. We've heard from, I can't remember now which witness,
17 but basically with the drive to meet targets, that was
18 where the focus was, and you've sort of confirmed that
19 today. Is it fair to say that Quality got lost and the
20 Quality metrics and the need for Quality got lost in 15:41
21 the need to meet targets?

22 A. In general, I would say to me it felt it was submerged.
23 It was meant to be there, everyone agreed it was the
24 right thing to do but it was always 'but we've got this
25 other thing to do first'. I mean, the reform of M&M 15:42
26 into a Patient Safety system, I would consider that
27 a big achievement. That was exhausting. No one told
28 me to do it, no one particularly helped me with it
29 except, you know, Anne Brennan, Stephen Wallace and

1 a few others.

2 178 Q. I'm thinking more now at Board level. Because the
3 focus was so constantly on performance, do you think
4 that the whole issue of quality of service was lost?
5 The consideration of it was lost at Board level? 15:42

6 A. It was put on the long finger, I suppose, is the better
7 term. That's good when we get round to it. I mean the
8 simple things were infection control, because that was
9 the one area where I had a lot of control over. So,
10 you know, introducing bare below the elbows, the proper 15:43
11 isolation of patients, changing behaviours, doctors not
12 have dangly things hanging over patients and so on,
13 proper insertion and checking of IV lines, we did get
14 good engagement with that. We had a team of infection
15 control nurses, they had the imprimatur of the Medical 15:43
16 Director behind them
17 and we also had the ability to audit compliance. In
18 small ways in very obvious things like that, because if
19 you don't do that, you're going to get a C. diff
20 outbreak or a Norovirus outbreak, or you're going to 15:43
21 get wound infections -- sorry, not wound infections but
22 IV line infections. So, there were certain wins.

23
24 We were, and I say we, we had infection control nurses
25 doing audits. At one stage we actually brought in PPI, 15:44
26 Personal and Public Involvement. I don't know if
27 we got round to it but we had two people from the
28 community offering to help us with the audits. To me,
29 that was a good success, where you can actually make

1 changes but it takes quite a bit of an effort.

2 179 Q. It took effort but perhaps not money?

3 A. You do need resource. As I said earlier on, there was
4 an awful lot of arguments about money. You can get
5 into the trenches over this. The arguments should be 15:44
6 about capacity and demand. As I say, capacity should
7 be never running at 100 percent and then you can do
8 things. So, the argument augers back from central
9 government is we're putting money in, but you have to
10 measure demand which was increasing. Our capacity was 15:45
11 being squeezed in terms of efficiency saving, so the
12 mismatch. You had great sympathy for frontline staff
13 on a ward, a ward sister, and the pressures they were
14 under.

15 15:45
16 Even small things like, you know, cutting back on the
17 hours of a ward clerk who should be taking, you know,
18 administrative tasks off the ward sister was a false
19 economy. There were pressures coming from everywhere.
20 I was very aware of that more in infection control than 15:45
21 anywhere, more than any other things, because it is
22 a very direct, obvious thing that you can measure and
23 look at. People did work with us. In fact, at one
24 point we were the highest performing Trust in the UK
25 both with regards to C. diff infections regarding 15:45
26 peripheral lines. So, I can't be too hard about them,
27 they did work with us when they could.

28 180 Q. You talked about trying to change the culture and how
29 that is slow to happen. I just wondered whether there

1 was any correlation between attempting to change the
2 culture and the budget constraints?

3 A. Yes. I mean, looking back, the progress that we did
4 make, the things that needed to be done with investing
5 in management, clinical management being 15:46
6 multidisciplinary, all the papers that I had
7 disseminated from the King's Fund, if austerity had not
8 hit us in 2012/'13, I think we would have solved those
9 problems because we were starting to solve them. As
10 I said earlier on, no one really disagreed with me. 15:46

11 181 Q. But they just didn't have the budget to meet it?

12 A. The budget and the stress. I mean, people were
13 stressed to keep up with the demand at all levels. As
14 I said earlier on, particular sympathy for middle
15 managers because they were asked to do the impossible. 15:47

16 182 Q. Just one final point. Mr. Wolfe drew your attention to
17 some emails about the Urology Department and the
18 problems that there were. There was a urology meeting
19 and a minute of a meeting about the Urology Department.
20 15:47

21 Your predecessor, he was at that meeting, he appeared
22 to know about those issues; yet you followed him around
23 but you didn't, might I suggest, get a full hand-over
24 from him. would that be fair?

25 A. No. He didn't mention urology but there were plenty of 15:47
26 other things he mentioned to me. It would have been
27 good if he had been able to -- had been allowed to stay
28 on. My suggestion was about six months, maybe a half
29 day a week.

1 183 Q. I suppose the corollary of that is when you left and
2 Mr. Wright came in, I think, as your replacement, what
3 kind of hand-over did you give to him about the issues?
4 A. We met quite a few times. I think he was quite happy
5 with what -- I can't remember any specifics but there 15:48
6 was a few meetings possibly could have been done better
7 but, as I alluded to earlier on, I was burnt out at
8 that stage, I needed to get away. I stepped out of the
9 Health Service and the Southern Trust totally.
10 CHAIR: Thank you very much, Dr. Simpson. That 15:48
11 concludes your evidence.
12
13 I think we're going to take a short break, Mr. Wolfe.
14 I know you wanted to try and start the next witness
15 this afternoon. Is that still in hand? 15:48
16 MR. WOLFE KC: I wonder could we just step through the
17 preliminaries with him, get him sworn, prove a few
18 things, check the tech is working okay.
19 CHAIR: That's fair enough. We'll take a break now
20 until 4.05 and then have a short session after that. 15:49
21
22 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:
23
24 CHAIR: Thank you, everyone.
25 MR. WOLFE KC: Good afternoon, Panel. Your witness 16:02
26 this afternoon, at least for a short period of time,
27 Chair, is Prof. Roger Kirby. I understand he proposes
28 to be affirmed.
29

1 ROGER KIRBY, HAVING BEEN AFFIRMED, WAS EXAMINED BY
2 MR. WOLFE KC AS FOLLOWS:
3

4 184 Q. MR. WOLFE KC: Good afternoon, Prof. Kirby. Martin
5 wolfe speaking. We consulted last Friday, if you
6 recall. 16:03

7 A. I do. Thank you.

8 185 Q. Apologies for keeping you waiting. It has been a long
9 day already for you, no doubt. I understand you have
10 an important engagement tonight so we don't propose to 16:03
11 sit for much longer than 15 or 20 minutes, and
12 hopefully shorter than that, so that you can be on your
13 way. Just simply to introduce ourselves and maybe deal
14 with some preliminaries.

15
16 You can hear me okay? 16:04

17 A. Loud and clear, yes. Thank you.

18 186 Q. Let me just check that you have in front of you a hard
19 copy, a paper copy, of the witness disclosure bundle.

20 A. I do, yes. Right in front of me here, yes. 16:04

21 187 Q. When I refer to bundle number page 457, let's see if
22 I can bring you to that.

23 A. I have to get it on my other computer here so give me a
24 little minute.

25 188 Q. We'll have that up on the screen here. It's AOB-42537. 16:04

26 A. I need a little minute to get back to that.

27 189 Q. An easier way of saying that is it's your medical
28 report concerning Patient Or Service User A?

29 A. Yes, I've got that. I've got a paper copy of it and

1 I'll get it on my screen as well. I have that.

2 190 Q. When we get going tomorrow, we'll try and move through
3 this kind of transaction as efficiently as possible.
4 Maybe what I will do is call out what we call the Bates
5 reference number for the purposes of getting the 16:05
6 document up on the screen in the chamber here, and
7 I will also give you the standard page number.

8 A. Right.

9 191 Q. You may be able to follow that.

10 16:05

11 You, Prof. Kirby, have produced nine medical reports --

12 A. Yes.

13 192 Q. -- in respect of the nine series Serious Adverse
14 Incident review reports which were produced for or on
15 behalf of the Southern Trust in respect of cases in 16:06
16 which Mr. Aidan O'Brien had some involvement. Isn't
17 that correct?

18 A. That is correct.

19 193 Q. What I'm going to ask you to do is -- this is obviously
20 the first of those reports. As I've said, there are 16:06
21 nine. Do you wish to adopt those reports as part of
22 your evidence to the Inquiry?

23 A. Yes, I do.

24 194 Q. We've received no indication that you wish to amend any
25 of them so are you content that they stand as an 16:06
26 accurate account of the opinions that you hold in
27 respect of those cases?

28 A. Yes.

29 195 Q. I won't, as I say, bring you through all nine of them

1 but the answers you supply applies to all nine of them;
2 is that correct?

3 A. That is correct.

4 196 Q. We can see, just by way of illustration on the first
5 page of this report, a list of the documents provided 16:07
6 to you and which you have relied upon in formulating
7 this report. Obviously there's sometimes a different
8 and overlapping set of reports attached to each of the
9 reports?

10 A. Yes. 16:07

11 197 Q. Is it fair to say this is a comprehensive statement of
12 the material that you took into account?

13 A. Yes, it is. Although I have had some additional
14 material since, I don't think it materially changes my
15 view on any of these nine cases. 16:08

16 198 Q. Yes.

17

18 Just to explain how you came into the position of
19 drafting these reports and becoming involved in this
20 exercise, you received instructions from Tughans 16:08
21 Solicitors of Belfast; is that right?

22 A. That is right, yes. About a year ago; something like
23 that.

24 199 Q. Do you consider that you are offering expert opinion in
25 respect of those matters having regard to your 16:08
26 experience and qualifications?

27 A. Yes, I do.

28 200 Q. Just something about your expertise. Kindly, I think
29 yesterday, you provided us with a curriculum vitae. We

1 can bring that up on the screen. It's AOB-42642. I am
2 not sure if you have a paper copy alongside you. I
3 have never before read a CV amounting to 39 pages; I'm
4 sure it reflects a very busy life.

5 A. I apologise for that.

16:09

6 201 Q. No apology required.

7

8 I suppose just to pick up on some of the highlights,
9 you are currently President of the Royal Society of
10 Medicine; is that correct?

16:10

11 A. That is correct.

12 202 Q. Your professional life. If we could scroll up, please.

13 The format of this is personal details and education.

14 You won't see this unless you have a paper copy,

15 professor. We can see your professional qualifications

16:10

16 and then your appointments. It is the case, is it not,

17 that your first consultant urologist post was at

18 St Bartholomew's Hospital in April '97?

19 A. Correct.

20 203 Q. Then you moved from there to St George's from

16:10

21 April 1995 to April 2004?

22 A. Correct.

23 204 Q. With that post, you were also Director of Postgraduate

24 Medical Education?

25 A. Correct.

16:11

26 205 Q. Then Professor of Urology at St George's

27 from November 2001?

28 A. Correct.

29 206 Q. Moving then to establish the Prostate Centre --

1 A. Correct.

2 207 Q. -- in London in July 2005?

3 A. Yes.

4 208 Q. Is that a private facility or an independent sector
5 facility focusing on prostate disease? 16:11

6 A. It was.

7 209 Q. Is that a concern that you established?

8 A. Yes.

9 210 Q. And you were Medical Director?

10 A. Correct. 16:12

11 211 Q. You stayed in that role until November 2019. Was it at
12 that point that you retired from medical practice?

13 A. Yes.

14 212 Q. We can see from your CV that you have deployed your
15 energies in a range of writing initiatives, both books 16:12
16 and peer-reviewed articles. I think I counted more
17 than 300 peer-reviewed articles or books; is that
18 right?

19 A. Yes.

20 213 Q. Your primary interest is in prostatic disease; is that 16:12
21 correct?

22 A. Yes.

23 214 Q. In terms of the instructions that you received in order
24 to prepare medical reports, are you familiar with the
25 standard expert's declaration which is typically signed 16:13
26 off when an expert provides a report into our domestic
27 courts?

28 A. Yes, I'm aware of that.

29 215 Q. Are you broadly familiar with the Ikarian Reefer Rules?

1 These are rules that emerged from an English High Court
2 decision or judgment which form the bedrock for
3 experts' declarations.

4 A. Yes, I'm aware of that. I have a copy in front of me
5 here.

16:14

6 216 Q. Good.

7
8 Having regard to those rules and the standard expert
9 declaration, and in the absence of a declaration from
10 your report, can you confirm the following for me:

16:14

11 That the evidence that you have provided, both in the
12 form of a report and the evidence that you will provide
13 to the Inquiry over the next day or so, is that and
14 will that be the independent product of you as an
15 expert uninfluenced by the issues or the exigencies of
16 these proceedings and those who have instructed you?

16:14

17 A. Yes, I can confirm that. That is the case.

18 217 Q. Do you, in turn, recognise that your obligations in
19 giving evidence are primarily to assist the court, and
20 that this duty overrides any obligation to the party or
21 parties who have retained you?

16:15

22 A. I understand that, yes.

23 218 Q. Thank you.

24
25 The opinions you've expressed in the nine cases
26 you have considered, I think it's fair to say, is it
27 not, that the conclusions that you have reached within
28 those reports do not raise any significant criticism,
29 and perhaps no criticism at all, of Mr. O'Brien's

16:15

1 clinical practice?

2 A. I understand where he's coming from, yes. It wasn't my
3 intention to criticise but to understand why he'd done
4 the things he did in regard to those nine patients,
5 yes. 16:16

6 219 Q. Just to be clear, the reports that you provided are for
7 the purposes, primarily, of these proceedings, the
8 proceedings of this Inquiry. They have not been
9 provided for the purposes, for example, of a General
10 Medical Council proceedings or, indeed, for any civil 16:17
11 proceedings?

12 A. No, they have not. I'm aware that we may need to
13 prepare those reports later but at the moment those are
14 not -- these reports that you have are not geared
15 towards the GMC. 16:17

16 220 Q. In terms of your foreknowledge of Mr. O'Brien, before
17 being instructed to provide expert medical opinion in
18 respect of these nine matters, did you know
19 Mr. O'Brien?

20 A. No, I didn't, no. I've never met him personally. 16:17
21 I have liaised with him on one Zoom meeting organised
22 through Tughans. That's all.

23 221 Q. Was that for the purposes of finalising your opinions?

24 A. Yes.

25 MR. WOLFE KC: Okay. I think for the purposes of this 16:18
26 afternoon, we can park the bus there and let you board
27 a bus.

28 A. Thank you.

29 222 Q. We'll tune in again at 10 o'clock in the morning and

1 hopefully get your evidence completed tomorrow.

2 A. Thank you very much.

3 CHAIR: Thank you, Professor. We'll see you again
4 tomorrow. Thank you.

5
6 10 o'clock, ladies and gentlemen.

7
8 THE INQUIRY ADJOURNED TO 10:00 A.M. ON THURSDAY 16TH
9 NOVEMBER 2023

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