Urology Services Inquiry

Oral Hearing

Day 77– Tuesday, 9th January 2024

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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	DIRECTLY EXAMINED BY MS. McMAHON	3

1 THE INQUIRY RESUMED ON TUESDAY, 9TH JANUARY 2024, AS
2 FOLLOWS:
3
4 CHAIR: Morning everyone, happy new year and welcome
5 back for another session. 10:02
6 MS. MCMAHON: Good morning. The witness this morning
7 is Eileen Mullan and she is going to affirm.
8
9 MS. EILEEN MULLAN, HAVING BEEN AFFIRMED, WAS DIRECTLY
10 EXAMINED BY MS. McMAHON AS FOLLOWS: 10:02
11
12 MS. MCMAHON: Good morning, Ms. Mullan. My name is
13 Laura McMahon and I am junior counsel for the Inquiry,
14 I'll be taking you through your evidence today. I know
15 we have time tomorrow, if we need to move into tomorrow 10:03
16 we will do so. But we'll see how we get on today.
17 1 Q. You have been called to give evidence as you are the
18 Non-Executive Chair of the Southern Health and Social
19 Care Trust and have been on the Board for a period of
20 time as a member -- a director of the Board. You were 10:03
21 sent a Section 21 notice dated 5th July 2023 and your
22 reply to that can be found at WIT-100434. We'll see
23 your name at the top of that, notice No. 15 of 2023,
24 and, if we go to WIT-100568, you will see a signature
25 there dated 25th September 2023 and do you recognise 10:03
26 that as your signature?
27 A. I do.
28 2 Q. And do you wish to adopt that response to the
29 Section 21 notice as your evidence?

1 A. I do.
2 3 Q. Thank you. Just at this point, is there anything you'd
3 like to add or amend or indeed anything you'd like to
4 say at this point before we move into the detail of
5 your evidence? 10:04
6 A. There is nothing I would like to add or amend, but
7 there is something I would like to say at this point.
8 I would like to reiterate the apology that was given to
9 the Inquiry on 10th November by our counsel, Donal
10 Lunny KC. That apology was given on behalf of the 10:04
11 Trust. It was given on behalf of our Chief Executive,
12 Dr. Maria O'Kane, and it was given on behalf of me as
13 Chair of the Trust Board. The fullness of that apology
14 is in the Inquiry dated 11th or 10th November for your
15 records. Thank you. 10:04
16 4 Q. Thank you, Ms. Mullan. So just by way of general
17 context as to the information you can bring to the
18 Inquiry, you were a Non-Executive Director of the
19 Southern Health and Social Care Trust from
20 15th February 2016 to 30th November 2020, and then you 10:05
21 became Chair of the Trust Board from 1st December 2020
22 and you're currently Chair?
23 A. That's correct.
24 5 Q. You've provided us with an extensive statement and
25 exhibits attached to that. The Inquiry has received 10:05
26 all of that and it's in evidence now and they have your
27 statement to consider within the context of other
28 evidence they've heard and will hear. So the purpose
29 of today, really, is for us to look at some of the key

1 aspects of your statement, for me to highlight some
2 issues that may be of interest to the panel in looking
3 at the evidence in the round and also informing their
4 recommendations. So we'll dip in and out of your
5 statement and I'll ask you to explain or give us a 10:05
6 bigger context of some of the issues that the Panel
7 have heard about and may yet hear about.
8
9 So the general outline of your evidence will be on
10 three broad headings: First of all, your role and the 10:06
11 general Board structure within that role; the functions
12 of the Board, the way in which the Board received and
13 processed information and gathered it and shared it up,
14 the communication generally and decision making.
15 We then look at Board knowledge of and involvement in 10:06
16 issues generally and specifically within urology and
17 also in relation to Mr. O'Brien; then, thirdly, the
18 broad topic of the current position and the Board, the
19 learning that has occurred, the reflections that you
20 have included in your statement and any response to the 10:06
21 learning and really what the position is now. The
22 Panel will be keen to hear your views on what the
23 current structures are and how they may be improved to
24 inform any recommendations they may have.
25 10:06
26 So I'll just start with you generally, your background
27 and role. If you go to your statement at WIT-100436,
28 just paragraph 4.4 there, we'll see your
29 qualifications, we'll start with those. You have a BA

1 Honours degree in Business Studies, a Postgraduate
2 Certificate in Management and a Diploma in Management
3 Practice. You also have a Masters in Management and
4 Corporate Governance; the IOD - is that the Institute
5 of Directors? 10:07
6 A. It is.
7 6 Q. Certification in Company Direction and, also from the
8 IOD, a Diploma in Company Directions.
9
10 Then if we go back up to the previous page we'll see 10:07
11 your employed roles. You've worked in Training
12 Consortium, Training for Women Network, the Belfast
13 Metropolitan College. Then I think currently you're
14 the director of a company, Strictly Boardroom Limited.
15 Could you give us just an outline of what that company 10:08
16 does and the services provided by it?
17 A. Yep. In the early days, Strictly Boardroom is a
18 website that I provide pro bono to offer information in
19 relation to vacant board roles within the public and
20 third sector primarily here in Northern Ireland. 10:08
21 I have run that for a number of years, just to share
22 information. Later, from 2020, I mobilised the company
23 into a live company, it was shelf previously, and I use
24 that as a mechanism for me in my self-employed work.
25 So through that then it will be either me undertaking 10:08
26 work with boards within the public or third sector,
27 going in as a governance consultant, and also the work
28 that I do in relation to Boardroom Apprentice, which is
29 an initiative I founded in 2017, which provides

1 opportunities for people to prepare for board roles.
2 I do that here in Northern Ireland and also in Great
3 Britain.
4 7 Q. I think probably between us today we will be told off
5 at some stage about the speed at which we deliver my 10:09
6 questions and your answers, so if I promise to try and
7 slow down would you do the same?
8 A. I will.
9 8 Q. People are taking a note as well, but I am forever
10 being told off, so you won't be on your own. 10:09
11 So if we just go to the previous page, you have
12 outlined your expertise in relation to boards. At
13 paragraph 4.2 we'll have a look at some of the boards
14 you have been on. You started in 2009 in the Northern
15 Ireland Environment Agency and you were a Non-Executive 10:09
16 Director there; then Age NI, you were a Trustee, then
17 you were the Chair of Age NI from December 2013 to
18 March 2018. You were the Chair and Trustee of
19 Audiences NI and then, in January 2015 to
20 December 2020, you were Senior Council Member on the 10:10
21 Health and Care Professions Council.
22
23 Then, as we've said, in 2016 to 2020 you were in the
24 Southern Health and Social Care Trust; 2014 to 2021 you
25 were Committee Member in Northern Ireland for the 10:10
26 National Lottery Community Fund and then your current
27 role is as Chair in the Southern Trust. So the
28 Southern Trust role and perhaps the Health and Care
29 Professions Council jump out slightly as being two

1 perhaps potentially related in some way in relation to
2 health care provision, and they would be boards you
3 have been on for quite a number of years.
4
5 Now we will go on to look at this later on in more 10:10
6 detail about the level of expertise needed or would be
7 helpful to be on the Board. But in relation to your
8 particular experience on boards, what is your view or
9 your experience of coming on to a Health Care Board and
10 whether that particular expertise is helpful or is 10:11
11 there a new skill set required and perhaps a new
12 mindset?
13 A. Okay. Certainly there is a thread of health and social
14 care through the Board roles, particularly Age NI
15 through to the Health and Care Professions Council and 10:11
16 then the Southern Trust. So for the mechanics of
17 governance and being a Board Member then yes, but when
18 you step into the realms of a Non-Executive Director
19 role within the Health and Social Care Trust it's at a
20 completely different level. So my view on it is that 10:11
21 I had a set of skills that I was bringing to the table,
22 a desire and a willingness to serve, but when I got to
23 the table for the Health and Social Care Trust I was on
24 a steep learning curve to understand the complexity and
25 the vastness of the work within health and social care 10:12
26 at that level.
27 9 Q. The difference, I suppose, as well is in the business
28 of a trust where it is patient safety, issues about
29 risk that have outcomes that you wouldn't expect from

1 other Board decision making, was that something that
2 was new to you at that point?
3 A. It was at that scale. Age NI had a domiciliary care
4 provision. It also had a care home dimension, focused
5 care homes. So there was a patient safety and care 10:12
6 aspect there but not at this level in relation to
7 Health and Social Care Trust.
8 10 Q. You have provided some detail in your statement but
9 just as a general proposition: Did you feel that the
10 training or information provided to you at the start of 10:12
11 your tenure as an NED, Non-Executive Director, in the
12 Trust prepared you properly for the role?
13 A. No, and if I may give some context to that.
14 11 Q. Yes, please do.
15 A. The induction process, when I stepped in in 2016 there 10:13
16 was a period of six to 12 months where you had an
17 opportunity to meet with all the directors, to
18 understand the nature of the work that goes on in their
19 Directorate. That was very helpful: One, you got to
20 meet the team that were leading the directors, you got 10:13
21 to understand in part what they were there to do. In
22 Northern Ireland, particularly for health and social
23 care trusts, you are sent on a half day course called
24 "On Board" to prepare you for the roles and
25 responsibilities. That course was never going to -- 10:13
26 that half day session was never going to prepare me for
27 health and social care in a governance way.
28
29 Sitting here now looking back to 2016, that learning

1 curve was so steep that I say that it has taken quite a
2 number of years to get to the knowledge base that
3 I have today. I would be advising - and you may want
4 to come on to this at another point - but I would be
5 advising that certainly what is needed for 10:14
6 Non-Executive Directors needs to be different. I have
7 been having conversations with the Department of Health
8 and with the Health and Social Care Leadership Centre
9 to bring about a different focus of induction, training
10 and development opportunities for Health and Social 10:14
11 Care Non-Executives here. That needs to be bespoke for
12 health and social care and not that it is grouped into
13 a training session for Non-Execs, whether you're on the
14 Housing Executive or you're on an infrastructure body
15 or you're on a health trust. I think we need to 10:14
16 contextualise the health trusts, we need to
17 contextualise health and social care, and we need to
18 equip Non-Executive Directors to understand the kind of
19 business that comes before you as a Non-Executive
20 Director. These reports are vast, they are 10:15
21 complicated, they are not something that we would ever
22 have experienced. So whilst I have had Board
23 experience in the past, nothing would prepare me for
24 the information that was going to flow my direction as
25 a Non-Executive Director. So my advice to colleagues 10:15
26 in the Department of Health and Leadership Centre is to
27 develop a suite, and that's the work that is undergoing
28 at the minute.
29 12 Q. Thank you for that context. We will come on to look at

1 some of the information that is contained in Board
2 packs to give the Panel and others an idea of the
3 complexity of the information and the volume. But just
4 as a general point, you mentioned there about the
5 knowledge base that was required was something that was 10:15
6 outside your remit at that stage and perhaps the remit
7 of other board members, would you agree that in order
8 for a board member to be sufficiently curious about
9 information that either they need or they are provided
10 with, that they have to have a knowledge base and the 10:16
11 confidence to ask the right questions so the
12 information and the training would be essential?
13 A. Absolutely.
14 13 Q. If we look your role as a Non-Executive Director first
15 of all, WIT-100437, your Section 21. At 5.1, you say: 10:16
16
17 "I commenced my tenure as a member of the Southern
18 Trust Board on 15th February 2016, was reappointed from
19 15th February 2020 and completed my tenure on
20 30th November 2020." 10:16
21
22 Just in relation to that, while we're on that
23 particular point, the appointment and the reappointment
24 of board members, is that something that has to be
25 applied for or is the reappointment automatically if 10:17
26 the Board Member wishes it to be so?
27 A. It's both. It depends on the department, but there is
28 an approach in Northern Ireland from the Commissioner
29 of Public Appointments Office that reappointments

1 should not be automatic. The Department did bring in a
2 piece of work, going back to 2019 possibly, where
3 current Non-Executive Directors would have to re-apply
4 if they wanted a second term. That has happened
5 sometimes but it hasn't been consistent. 10:17
6 14 Q. And the previous Chair, you took over from
7 Mrs. Brownlee, do you have a recollection of her
8 tenure, the length of time she was on the Board or as
9 Chair, do you have an idea of that?
10 A. Chair for nine years with the Southern Health and 10:18
11 Social Care Trust. I understand she was a
12 Non-Executive Director previously on the Southern
13 Health and Social Care Trust, she might have been there
14 eight years. Then the legacy organisation, she was a
15 Non-Executive Director in the legacy organisation as 10:18
16 well.
17 15 Q. Are you currently appointed on a four year term?
18 A. At the moment, yes, and my term concludes in November.
19 16 Q. Do you have any view as to the appropriateness of
20 reappointing individuals or people applying when you're 10:18
21 looking perhaps to identify skill mix or skill set, do
22 you have any view on whether it should be encouraged
23 that people stay on Boards for long periods of time or
24 do you feel that there should be a way of refreshing
25 both the individuals the skill mix? 10:18
26 A. I would agree with you on that. Positions on Boards
27 should always be based on what skills are needed at
28 that point in time. If you think of any organisation,
29 you have a strategy for a period of three years, there

1 is work to be done on that and then the lens may
2 change. Your Non-Executive Directors and the skills
3 that are required will change too. So longevity should
4 not be about because you have been there, it should be
5 about the skills that you have or the skills that are 10:19
6 required at that point in time.
7 17 Q. Now if we look at the roles and responsibilities of the
8 Non-Executive Director, just paragraph 5.2, we are just
9 at that page, and you say:
10 10:19
11 "The main duties of the role and responsibilities of
12 the Non-Executive Director, as detailed in my letter of
13 appointment of 8th March 2016 and my letter of
14 reappointment of 22nd October 2019 were as follows:
15 Share in the independent Non-Executive oversight, 10:19
16 scrutiny and stewardship of the HSC Trust work; hold
17 executive directors to account, including assessing the
18 performance of and appointing senior management; sit on
19 Board Committees, such as the Governance and Audit
20 Committee; participate in professional conduct and 10:20
21 competency inquiries as well as staff disciplinary
22 appeals; scrutinise decision making on major
23 procurement issues and scrutinise the handling of
24 complaints."
25 10:20
26 So the first, point (a) there mentions about oversight,
27 scrutiny and stewardship, and I suppose that
28 encompasses the entirety of governance generally as the
29 role of the NED. Then if we look at your tenure and

1 role and responsibilities as Chair of the Governance
2 Committee. Just can I ask you, you ended up on the
3 Governance Committee, was that something that you
4 volunteered for or was your appointment as Chair of the
5 Governance Committee something that was given to you, 10:20
6 if I can put it that way?
7 A. Yeah, I was appointed as Chair of the Governance
8 Committee by our previous Chair Roberta Brownlee.
9 18 Q. And what year did you take that up?
10 A. That was 2016, later in 2016, later in the first year 10:21
11 of appointment.
12 19 Q. If we go to WIT-100438, paragraph 6.1, you've given us
13 the date:
14
15 "I commenced my tenure as Chair of the Governance 10:21
16 Committee on 8th September 2016."
17
18 And you completed it on 30th November 2022. Do you
19 know who the current Chair is?
20 A. Mr. Martin McDonald. 10:21
21 20 Q. Thank you.
22 A. Sorry, can I caveat that?
23 21 Q. Yes, of course.
24 A. Mr. Martin McDonald but is now moving to Pauline
25 Leeson. 10:21
26 22 Q. When is that? Is that something that is imminent?
27 A. It's imminent, yes.
28 23 Q. If we look at paragraph 6.2, and you explain:
29

1 "There was to the best of my knowledge no specific role
2 specification for the Chair of the Committee. The
3 Committee is delegated its authority by the Trust Board
4 through its terms of reference. My role, as I carried
5 it out, was to ensure that the Committee fulfilled its 10:22
6 remit as outlined in the terms of reference."
7
8 Now there was no role specification in relation to
9 chair, was there any training in relation to that
10 particular post given perhaps the significance of the 10:22
11 Governance Committee when one considers patient safety
12 and risk, was there anything specific to your induction
13 to allow you to take up that role?
14 A. No, there was no training.
15 24 Q. Do you feel that if you had have had training it may 10:22
16 have benefitted you taking up specifically in relation
17 to governance, there might have been some assistance
18 given to you at that time?
19 A. I would, but I would also say - and a thread runs
20 through all of this in relation to the role of the 10:23
21 Non-Exec within health and social care - there is
22 something about creating a space for overlap between
23 Non-Execs, that period of being able to shadow somebody
24 so that you can transfer your skills, you can hand
25 skills to the person that is coming behind you so that 10:23
26 there is no gap and you are not asking somebody to
27 start from afresh with nothing, there is no stabiliser
28 sitting there. So, in my view, and it is what is
29 happening currently, certainly with me to Martin

1 McDonald to take on that Chair's role and Pauline
2 Leeson then taking on the Chair from Martin, there is a
3 natural succession plan in there that has allowed each
4 of us, well apart from myself, but allowed for Martin
5 and Pauline to be able to have that support in stepping 10:23
6 into that role.
7 25 Q. If we look at the terms of reference at 6.3 of the
8 Governance Committee:
9
10 "The terms of reference detailed that the remit of the 10:24
11 Committee is to ensure that:
12 (a) there are effective and regularly reviewed
13 structures in place to support the effective
14 implementation and continued development of integrated
15 governance across the Trust; 10:24
16 (b) assessment of assurance systems for effective risk
17 management which provide a planned and systematic
18 approach to identifying, evaluating and responding to
19 risks and providing assurance that responses are
20 effective; 10:24
21 (c) principal risks and significant gaps in controls
22 and assurances are considered by the Committee and
23 appropriately escalated to the Trust Board;
24 (d) timely reports are made to the Trust Board,
25 including recommendations and remedial action taken or 10:24
26 proposed if there is an internal failing in systems or
27 services;
28 (e) There is sufficient independent and objective
29 assurance as to the robustness of key processes across

1 all areas of governance;
2 (f) recommendations considered appropriate by the
3 Committee are made to the Trust Board, recognising that
4 financial governance is primarily dealt with by the
5 Audit Committee." 10:25
6
7 So if we just go back up and look at a couple of these.
8 So point (a), that there are "effective and regularly
9 reviewed structures in place to support the effective
10 implementation and continued development of integrated 10:25
11 governance across the Trust"; and then (c), for
12 example, "principal risks and significant gaps in
13 controls and assurances are considered by the Committee
14 and appropriately escalated to the Trust Board".
15 10:25
16 They are quite broad terms of reference, and keeping in
17 mind that the Governance Committee deals with
18 governance as does the Board and director level deals
19 with operational aspects; sitting here today and
20 knowing what you now know about the Inquiry and the 10:26
21 evidence, which I'm sure you've had the opportunity to
22 listen to some of or read some of it, do you feel that
23 the terms of reference were able to be fulfilled by the
24 Governance Committee based on the information they were
25 provided with or perhaps not? 10:26
26 A. I think the "perhaps not". The Governance Committee
27 was not provided with the information in light of what
28 we know now has come through the Inquiry.
29 26 Q. Now you said in your statement later on you can't know

1 what you don't know, and we'll look at some of the
2 information that was coming to the Governance Committee
3 and the Board and the confidential meetings. But it
4 does seem as if there was perhaps inadequate
5 information brought up, and I will come on and ask you 10:27
6 later on about the position now --
7 A. Okay.
8 27 Q. -- and the way in which information makes its way, but
9 if the terms of reference are the same for the
10 Governance Committee now when Mrs. Leeson takes over, 10:27
11 would you be content that those terms of reference are
12 able to be satisfied by the way in which information is
13 now brought to the Governance Committee?
14 A. I am. I suppose we're at a changeover in relation to
15 what comes to the Governance Committee and how it is 10:27
16 coming to the Governance Committee. I would say a lot
17 of it is as a result of what's come through this
18 Inquiry in terms of the approaches that are being
19 deployed at an operational governance level then to
20 feed through to our Governance Committee. So I'm not 10:28
21 sure whether you want me to speak to that now or maybe
22 we talk about it later. Because I can see it starting
23 to happen in a more fruitful and meaningful way in
24 respect to previously. If you even go back, the
25 escalation piece to Trust Board, you can't escalate 10:28
26 something unless you know there is something to
27 escalate. What I put in place now is a requirement of
28 Committee Chairs in their report to the Trust Board,
29 there is a section there, they need to detail

1 escalation to Trust Board. So the Committee Chair
2 needs to take ownership of what the committee are
3 escalating up or not and be confident in that.
4 28 Q. So even the presence of that is a trigger --
5 A. Yes. 10:28
6 29 Q. -- that people then know that escalation is required?
7 A. Yeah.
8 30 Q. At paragraph 6.4, which we have on the screen - and for
9 the transcript it's WIT-100439 - you set out what you
10 attempted to do during your tenure as Chair of the 10:29
11 Governance Committee. You say:
12
13 "I endeavoured to ensure that the Committee fulfilled
14 its remit by working with the Board Assurance Manager
15 in preparation on agreeing the Committee agenda, annual 10:29
16 work plan and the contributors and attendees at the
17 Committees' meetings. My role at the meetings was to
18 ensure all agenda items were discussed and outcome
19 actions reached and then to provide assurance on behalf
20 of the Committee to the Trust Board. In practice this 10:29
21 was about providing structure to the meetings, ensuring
22 appropriate time was allocated and being able to manage
23 the flow of the meeting on the day and create the
24 environment for those attending to be open and honest
25 in their contributions." 10:29
26
27 Just by way of practicalities, were the Governance
28 Committee meetings before or after Board meetings?
29 What was the timetabling of those meetings?

1 A. Governance Committee meetings happen quarterly, but
2 they won't sit naturally either before or after. There
3 is a calendar of events for both the Board meetings and
4 all the committees. So it isn't that it happens the
5 day before or the morning of, it just happens in a 10:30
6 cycle.
7 31 Q. What about the confidential meetings?
8 A. Confidential governance meetings happen just before the
9 Governance Committee meetings. So it would start at
10 8.30 or quarter to nine in the morning with the 10:30
11 Governance Committee meeting then starting at 9.30,
12 depending on the agenda items.
13 32 Q. And so, if we look at your tenure as Chair of the Trust
14 Board at WIT-100441, we will look at some of these
15 issues in more detail, but I just want to set out the 10:30
16 landscape of your involvement so far. At 7.1, you say:
17
18 "I commenced my tenure as Chair of the Board of the
19 Southern Health and Social Care Trust on 1st December
20 2020 and I continue to hold this role currently. My 10:31
21 tenure is due to complete on 30th November 2024."
22
23 Then, at 7.2, you set out the main duties. You say:
24
25 "The main duties and responsibilities of the role of 10:31
26 the Non-Executive Chair, as detailed in the letter of
27 appointment dated 18th November 2020 are: The
28 Non-Executive Chair is responsible for leading the
29 Board and for ensuring that it successfully discharges

1 its overall responsibility for the organisation as a
2 whole."
3
4 At point (b):
5 10:31
6 "The Non-Executive Chair shall ensure that the SHSCT
7 policies and actions support the wider strategic
8 policies of the Minister and that the SHSCT affairs are
9 conducted with probity."
10 10:32
11 Then, at 7.3:
12
13 "The Non-Executive Chair has particular leadership
14 responsibility on:
15 (a) formulating the Board's strategy for discharging 10:32
16 its duties;
17 (b) ensuring that the Board in reaching decisions takes
18 proper account of guidance provided by the Minister,
19 the sponsor department, the HSCB and/or the PHA;.
20 (c) ensuring that risk management is regularly and 10:32
21 formally considered at Board meetings;.
22 (d) promoting the efficient, economic and effective use
23 of staff and other resources;.
24 (e) encouraging and delivering high standards of
25 regularity and propriety;. 10:32
26 (f) representing the views of the Board to the general
27 public;
28 (g) ensuring that the Board meets at regular intervals
29 throughout the year and that the minutes of meetings

1 accurately record the decisions taken and, where
2 appropriate, the views of individual board members;(h)
3 ensuring that all members of the Board, when taking up
4 office, are fully briefed on the terms of their
5 appointment and on their duties, rights and 10:33
6 responsibilities and receive appropriate induction
7 training;.
8 (i) advising the Department of the needs of the SHSCT
9 when Board vacancies arise with a view to ensuring a
10 proper balance of professional, financial or other 10:33
11 expertise;.
12 (J) annually assessing the performance of individual
13 board members;
14 (K) ensuring the completion of the Board governance
15 self assessment tool on an annual basis; 10:33
16 (l) ensuring that board members are made aware of the
17 code of conduct for board members of HSC bodies 2012,
18 including the Nolan Seven Principles of Public Life, and
19 the requirement for a comprehensive and publically
20 available register of board members' interests; 10:33
21 (m) communications between the Board, Ministers and the
22 Department shall normally be through the Non-Executive
23 Chair who shall ensure that the other board members are
24 kept informed of such communications on a timely basis;
25 (n) operating the Board and chairing all Board meetings 10:34
26 when present, the Non-Executive Chair has certain
27 delegated executive powers and must comply with the
28 terms of appointment and with the SHSCT standing orders;
29 and

1 (o) working closely with the Chief Executive and
2 ensuring that key and appropriate issues are discussed
3 by the Board in a timely manner with all the necessary
4 information and advice being made available to the
5 Board to inform the debate and ultimate resolutions." 10:34
6
7 It's quite a list, when you read it out like that you
8 wonder what attracted you to that particular position.
9 But just in relation to that, just for the Panel's
10 information, is the Chair of the Board remunerated, is 10:34
11 it a remunerated position?
12 A. It is indeed.
13 33 Q. What about the Non-Executive Directors?
14 A. They are remunerated also.
15 34 Q. Just give us a flavour of life as the Chair, I can't 10:35
16 imagine you have much spare time if you are going to
17 meet all of those requirements, but what is it like
18 being the Chair and what are the demands on your time?
19 A. It's an absolute honour to be the Chair of the Southern
20 Health and Social Care Trust. I didn't step into this 10:35
21 role lightly. Whilst it is an extensive list, that is
22 what is required. They say in the information booklet
23 that goes with the application form that it's a three
24 day per week post. It's not, it's seven days. You're
25 thinking about it, you are responding to it or you're 10:35
26 in it and that's what is required. We are in the
27 business of health and social care that operates 24/7.
28 My view is that at the senior leadership level then we
29 need to be available and working at the same level we

1 are asking of our staff teams.
2 35 Q. In relation to your Board at the moment, give us a run
3 down of the numbers and the areas of particular
4 expertise or professionalism that those members bring
5 to the Board? 10:36
6 A. Okay. So the Board of the Trust is made up of 13
7 individuals, eight of them are Non-Executive. So you
8 have your Non-Executive Chair and then you have a
9 financial Non-Executive and that's the person who is
10 either qualified or highly experienced in financial 10:36
11 aspects. Then you have six further Non-Executive
12 Directors who are all lay members. Five additional
13 members are the executive directors, you have the Chief
14 Executive Medical Director, the Nursing Midwifery and
15 Allied Professions Director, the Executive Director of 10:36
16 Social Work and the Director of Finance Procurement and
17 Estates. So those professional governance roles sit as
18 part of the Board. So the Board is made up of 13
19 individuals.
20 10:37
21 In terms of the skills that are on our Board currently
22 from our Non-Executive Directors, they range from
23 social work to public sector leadership, management,
24 financial, governance, community and voluntary sector
25 work as well. Then the professional side is our 10:37
26 executive directors who are bringing to the table their
27 extensive professional experience obviously in
28 medicine, social work, nursing, allied professional,
29 midwifery, financial, procurement and our Chief

1 Executive then across the piece.
2 36 Q. Now the service provision expertise comes from the
3 executive directors, the senior leadership team --
4 A. Correct.
5 37 Q. -- and, as you have mentioned, the medics and other 10:38
6 staff. We'll look later on at the potential for there
7 to be more curiosity, perhaps, about the information
8 that was brought and maybe the absence of curiosity and
9 the working out of that, do you have any view as to
10 whether it would be beneficial or useful to have 10:38
11 previous service providers on the Board who perhaps
12 know a bit more about the nuts and bolts and their
13 experience might trigger particular questions from them
14 that might allow the Board to be better informed on
15 some issues that are brought to them? 10:38
16 A. I don't, I don't have that view. I currently sit with
17 a Board where I have two doctors and one nurse who are
18 executive directors. My expectation is they bring
19 their professional role to the table. We have
20 Operational Directors that attend our Board meetings 10:38
21 and are part of our committee meetings. I have two
22 further nurses in there. If I look back to 2016-2020,
23 our former Chair was a nurse; Siobhán Rooney, another
24 Non-Executive who is longer serving than ourselves
25 there at that time was a nurse. So we had those, if 10:39
26 you want to put it, that knowledge and skills sitting
27 at the table than we do have now. My expectation is
28 that they bring their curiosity too. The curiosity is
29 not just down to the lay Non-Executive Directors, it

1 has to be across the piece of the Board. I invite our
2 Operational Directors to be a part of the conversation
3 as well, and I see that coming through over the last
4 couple of years.
5 38 Q. We are going to look at Board training in a moment, but 10:39
6 just on that point that you have mentioned about, you
7 felt that the skill mix was sufficiently robust for
8 curiosity to be generated, just as a broad point: Do
9 you have any view as to why people perhaps weren't more
10 curious about information that was brought then, if the 10:40
11 skill mix would have allowed that, why perhaps more
12 questions weren't asked when certain information was
13 brought to the Board and it doesn't seem that there was
14 any desire to interrogate it in any robust way, do you
15 have any view on that? 10:40
16 A. I do. My observations, both as a Non-Exec and now in
17 the position of Chair, there appears to be this view
18 that when you get into the boardroom the questions only
19 come from Non-Executive Directors, that the Board is
20 Non-Executive Directors. That is not the case. The 10:40
21 Board is made up of 13 individuals with other
22 Operational Directors being a part of that discussion.
23 So there's a long held way of working where the people
24 responded to questions and didn't think they had a
25 place to ask a question. What I have attempted to do 10:41
26 in the time that I have been in post as Chair is to
27 create that environment and allow our executive
28 directors and Operational Directors to know that they
29 have a voice at that table too and to use it. I'm

1 seeing that happening more and more over the recent
2 years. So I think it boils down to a way of working
3 that has been ingrained for a long period of time and
4 the thought process that we are there to respond. Some
5 of the language that was used, that is used actually in 10:41
6 the terms of reference, you know we talk about
7 scrutiny, we talk about challenge, that is interpreted
8 as we sit and wait till we are asked a question rather
9 than thinking I have a role to do that too.
10 39 Q. So can I take from your answer that it's two-fold 10:42
11 really: Promoting and encouraging confidence and
12 confidence building and also fostering the correct
13 cultural environment that people feel able to ask and
14 be curious without thinking that they are either
15 inappropriately asking or asking a question that they 10:42
16 shouldn't?
17 A. And if I may add a third one: Reminding executive
18 directors that they are executive directors of the
19 Board. So when we make a decision as a Board, it's
20 making a decision, 13 people are saying this is the 10:42
21 path, so they have to be involved in that discussion.
22 40 Q. Now, when we look at Board training and we go to your
23 statement at WIT-100443, at paragraph 8.1 you say:
24
25 "The Non-Executive Chair is responsible for 10:43
26 identifying and organising training for board members.
27 Non-Executive Directors also have a personal
28 responsibility to identify training needs at least
29 annually through the appraisal process."

1 Now, before you became Chair was it your experience on
2 the Board that training needs for NEDs were
3 appropriately identified and met?
4 A. Not at the level it could have been. When I look at
5 that period 2016 to 2020, I think we could have been 10:43
6 doing so much more to enhance our knowledge and
7 understanding than what we did. I certainly look from
8 2020 onwards and see the amount of opportunities we
9 have taken to enhance our knowledge and understanding
10 to help us do our jobs. As a Board this isn't just 10:44
11 purely just about the Non-Executive Directors but as a
12 Board collectively together. I think we could have
13 done much more. There is an onus on us individually as
14 Non-Execs to raise the flag and say 'I would like'.
15 There are few opportunities each year within the world 10:44
16 of health and social care in Northern Ireland to attend
17 conferences and events. But they are not training
18 opportunities, they are not about enhancing our skill
19 set. I think we should get better at that.
20 10:44
21 I come back to the work with the Health and Social Care
22 Leadership Centre, my vision of that is a very clear
23 and robust induction process and then an offering of a
24 suite of learning opportunities that all Non-Execs can
25 select and access on a regular basis. And it shouldn't 10:45
26 just be a once off. We shouldn't just be training
27 people when they come into the role, we should be
28 continuing their training every year to enhance so as
29 long as they are with us then we are enhancing their

1 skills and knowledge across the piece.
2 41 Q. We'll look at some of the training that was provided so
3 the Panel can get a flavour of the specific Board
4 expertise and some of the issues that are relevant to
5 the Inquiry, for example MHPS. Just before we do that, 10:45
6 if we look at some of the ways in which training is
7 provided, you say at paragraph 8.2:
8
9 "Organisation of training for board members would be
10 carried out through the office of the Chair and CEO. 10:45
11 This can be arranged as a result of discussions at
12 Trust Board and Committees through discussions with
13 Chair/CEO and/or all Board and Operational Directors.
14 Currently as Chair, I discuss with the Board Assurance
15 Manager training and how best to provide it. Training 10:46
16 can be provided in a number of ways. A provision of a
17 training course such as "On Board", as was prescribed
18 by the Department of Health for newly appointed
19 members; (b) through Board workshops in developing the
20 Board's understanding of a given area; and (c) 10:46
21 mandatory training provided by the Trust for all staff
22 and board members."
23
24 Then if we go to WIT-100444, you have provided some
25 examples of the Non-Executive Director Board Member 10:46
26 training and I just wanted to highlight a couple of
27 those. If we move down we'll see dates on the left.
28 21st March, for example, 2016 there was a Trust Board
29 induction, induction into Trust Board, committee

1 structure, what is expected of a Board Member.
2
3
4 Then if we move down to 19th September 2016, we'll see
5 there was training in performance and reform induction, 10:47
6 information session on the performance and reform
7 directorate. 27th March, again performance and reform
8 induction, information session on performance and
9 reform directorate.
10 10:47
11 If we could just pause there for a moment. We've
12 looked with other witnesses at performance and reform
13 and the information that is provided to the Board
14 setting that out and there's been a bit of a tension
15 between quantitative data and qualitative data and the 10:47
16 way in which the Board might be perhaps better informed
17 on one argument of the information underlying the data.
18 So, for example, why waiting lists are the way they are
19 and actually looking down at the layers underneath and
20 was the focus too much on numbers and meeting targets 10:48
21 and not on quality.
22
23 I'm just wondering, when we are looking at the
24 induction, which presumably allows people to understand
25 the information that is presented to them as an NED, 10:48
26 did you have any view on whether the data you received
27 in relation to performance and target indicators was
28 more numbers driven than quality driven?
29 A. I'll take the last part first. Yes, certainly target

1 driven about meeting targets. When I even recall the
2 performance report which came to the Trust Board before
3 we had a dedicated committee, it was, obviously, RAG
4 rated, red, amber, green, so the reds got the focus.
5 It was about what we were not doing and what we were 10:49
6 not meeting. The conversation around patient safety
7 and quality of care was not as prominent as it was
8 about meeting the target.
9
10 But when you talk about the performance and reform 10:49
11 induction, like with any of these inductions this is
12 about an introduction into the department. If I was
13 crafting it again, which I am just about to do with
14 newly appointed Non-Executive Directors, one of the
15 first things that needs to be done is take people 10:49
16 through the papers that are prepared for the Trust
17 Board and its committees to help them understand the
18 thinking behind it, and not just a welcome and
19 introduction into the Directorate. Then you build on
20 that over a period of time is my view. 10:49
21 42 Q. We'll look at that and you can comment perhaps on the
22 volume and appropriateness of your review of what's
23 provided. If we go back to the table and we look at
24 30th August 2017. 30th August 2017, we can see MHPS
25 training was provided by DLS. Then if we look at 10:50
26 24th May 2018, there is a workshop for Non-Executive
27 Directors on understanding medical data; 1st December
28 2021, regional training on MHPS procedure for NEDs
29 again, and you were at those training. Now they are

1 four years apart, but in relation to what you
2 subsequently were to discover about the application of
3 the MHPS procedure in relation to Mr. O'Brien, I know
4 you didn't know about it at the time, the information
5 was provided to the Board on an anonymous basis in 10:51
6 2017; but do you feel that the training that was
7 provided in 2017 on MHPS was sufficient for you or any
8 of the other NEDs at that time to understand the
9 significance of that process and to properly perform an
10 oversight role? 10:51
11 A. No, it wasn't. Certainly in 2017, that was the first
12 exposé to it. My takeaway was you have a role there to
13 keep momentum. We get to 2021 and there is a
14 further -- what I would add to that is that
15 Non-Executive Directors kept raising this for the need 10:51
16 to have a deeper understanding into our role when
17 assigned an MHPS case. I'd say that, whilst the
18 training wasn't - and this isn't a reflection of June
19 Turkington, okay - I think the MHPS process is just
20 difficult and it was hard to really pin down and 10:52
21 clarify what the Non-Executive Director was there to do
22 and not.
23
24 We've had a further session, I'm not sure if it is on
25 that list, it might be in 2023? 10:52
26 43 Q. It's not on that particular list.
27 A. Okay. There was a further session earlier this year
28 which is far more detailed, and I suspect, as a result
29 of this Inquiry, has helped informed the thinking of

1 both Department and DLS to that. Then we were able to
2 have time with the trainer as Non-Execs so we could
3 have that, I suppose, in camera conversation about the
4 application of our role with reflections from our
5 colleague John Wilkinson in relation to the Inquiry. 10:53
6 44 Q. We'll look at Mr. Wilkinson's role and I'll ask you to
7 comment on that later on. There was a gap in the
8 training, we can see there, 12th March 2019, and then
9 1st December 2021, I presume the Covid period probably
10 interfered with some of the training. 10:53
11
12 If we look now at some of the all Board Member
13 training, not just the NED. If we go to WIT-100447 for
14 the transcript at paragraph 9.4, I just want to point
15 out a couple of examples for the Panel to see the 10:53
16 flavour of the training that was provided. We'll see
17 the first one there on 25th February 2016,
18 Non-Executive Director Induction Program, Chief
19 Executive's Business, overview of SH and SCT,
20 Introduction and Overview of Directorates; Finance 10:54
21 Report and Financial Plan 2016/17, update; Performance
22 Report, Quality Improvement Framework update.
23
24 Then, on 28th April 2016, there is an update on the
25 whistleblowing survey, including training standards and 10:54
26 guidelines, presentation; then Board Governance Self
27 Assessment Projected Outrun 2015/16 and performance
28 report. The Board governance self assessment is
29 something you were involved in?

1 A. Yes.
2 45 Q. What does that involve just for the purposes of
3 learning?
4 A. Okay. It's an annual self assessment tool devised by
5 the Department of Health for health and social care 10:55
6 trusts and, I suspect, all their Arms Length Bodies
7 within health and social care to complete. What
8 happened was the Non-Executive Directors would meet
9 with the Chair and discuss and complete. The executive
10 and Operational Directors would meet with the Chief 10:55
11 Executive and do that. Then the two pieces would come
12 together and then that is submitted to the Department.
13 Part of that process is about identifying areas of
14 concern and risk, so not having a stable management
15 team, having gaps, and Non-Execs would be part of that, 10:55
16 and also identifying a case for learning and where
17 there has been growth and development.
18
19 I suppose, there is two points I would like to make on
20 it. Firstly, it's very much a tick-box exercise, not 10:55
21 something - and I have not been an advocate of it since
22 I first came across it - but it's a mandatory tool that
23 must be completed and submitted to the Department.
24 What I have attempted to do in my current role as Chair
25 is have that as a unified conversation and a unified 10:56
26 outcome that goes to the Department, so we work on it
27 together as a Trust Board, which is what we did in
28 August 2021, which was the first time we were able to
29 physically come together post Covid.

1 46 Q. That's something that is still used by the Department,
2 the Board governance self assessment, that is still in
3 use, that tool?
4 A. It is. It goes to the Department and nothing comes
5 back. 10:56
6 47 Q. That was my next question. What is the outcome of it?
7 A. Nothing comes back, so actually what is the purpose of
8 it is my view. The Chief Executive and I have agreed
9 that this year we will undertake as a trust what's
10 called a well-led review. I think those are quite 10:57
11 familiar in England, if I'm right. We planned that to
12 begin in April 2024. For me, even looking at the scope
13 of it, the fact that it looks at leadership and
14 governance throughout the entire organisation, this
15 here is where we all sit in the room and say how good 10:57
16 we've been. It's not really a decent reflection and
17 meaningful reflection of our governance as a Board.
18 I would like our organisation to be able to say whether
19 or not they felt the Board were carrying out their
20 functions appropriately. So I look forward to the 10:57
21 well-led review. This is still required by the
22 Department. I don't see a value and a purpose in it.
23 We carry it out and I have attempted in the last few
24 years to ensure there is a degree of meaning for us
25 within the Trust that something positively comes from 10:58
26 it. That's it.
27 48 Q. The well-led review you think is perhaps a better fit
28 for outcomes and learning that you would want to derive
29 from the communications with other members of the

1 Board, does it sound like something that is the better
2 tool to use?
3 A. Absolutely, that's what I view it as at the moment,
4 yes.
5 49 Q. If we just look at another couple of examples of the 10:58
6 training for all board members, 27th April 2017:
7 Sharing the SHSCT pledge with our young people, Board
8 governance is mentioned there; Board Effectiveness - A
9 Good Practice Guide, 26th April 2018. There is mention
10 of the corporate risk register; quality improvement, 10:58
11 what does it mean for Trust Board? Board governance
12 self assessment.
13
14 We have had witnesses that you may have been able to
15 listen in or are aware of their evidence, we have asked 10:59
16 people about the risk register. I know that mentions
17 the corporate risk register, and you have touched upon
18 it in your statement, but it doesn't seem that the
19 particular issues that are of concern to the Inquiry
20 found their way on to any risk register in order to 10:59
21 move up to the Board and to allow them to be identified
22 as a patient safety or risk issue; does that surprise
23 you now that you know the extent of the issues of
24 concern, would you have expected those to be on,
25 perhaps not on the corporate risk register, but any 10:59
26 risk register?
27 A. Yes, I would have.
28 50 Q. Would that, if they had have been included on the risk
29 register in a sufficiently clear or detailed way, was

1 that a means by which the Board may have been alerted
2 to the issues that are now subject to the Inquiry?
3 A. Yeah, you could see how it could escalate up to
4 committee and then the Trust Board and then you would
5 have that level of oversight and questioning and 11:00
6 probing around it, yep.
7 51 Q. If we go to 17th October 2019, just skip down. This
8 one includes training on reflection and learning from
9 SAI in correspondence from the family to the Chair -
10 just for the note the personal information has been 11:00
11 redacted - and also roles and responsibilities of board
12 members. Then if we go to 27th February 2020, the
13 Clinical and Social Care Governance Review was on the
14 agenda for the workshop and then a qualitative analysis
15 of how learning from serious adverse incident reviews 11:00
16 can contribute to reducing deaths by suicide of young
17 people in the care of mental health services.
18
19 Now those two examples specifically mention SAIs and
20 outcomes, what was your experience both as an NED and 11:01
21 now as the Chair in relation to being informed about
22 SAIs and then informed about learning and
23 implementation of any recommendations or requirements
24 after the SAI has been completed?
25 A. From the SAI perspective then, we would get an overview 11:01
26 at the Governance Committee of the number of SAIs.
27 There has been a journey travelled on this one with the
28 committee to ask for themes to come through, maybe for
29 some examples so we could get a sense of what these

1 SAIs were about and if there is anything in essence
2 connecting the dots, rather we have 54, we have
3 completed 22, there is 33 outside the realms. So it
4 was moving it more into is there intelligence within
5 this information that we need to be considering. That 11:02
6 is a journey we travelled 2016-2020 and 2020 through to
7 now, we are seeing that evolve more so in relation to
8 the reporting.
9
10 Specific and serious SAIs and the learning from it, in 11:02
11 the early part of my tenure we wouldn't necessarily
12 have seen that coming through. But certainly as time
13 has moved on then it's an opportunity to review and the
14 seriousness of it has come through either committee or
15 to Trust Board and we need to take stock and reflect 11:02
16 and ensure, and certainly from our perspective as a
17 Trust Board is there anything we needed to do
18 differently as well as what's happening within the
19 Trust itself.
20 52 Q. Does the Board or the Governance Committee have any 11:02
21 involvement in the outworking of SAI recommendations or
22 ensuring that themes of governance that might emerge
23 are dealt with operationally by executive directors and
24 the SLT generally?
25 A. When they have come to the Board or through the 11:03
26 Committee, the serious ones that have come to us, then
27 an action plan would be expected, that action plan and
28 then a follow up to the Board or the Committee in due
29 course as to the progress that is being made on that.

1 53 Q. That layer of oversight that wasn't previously there is
2 now there?
3 A. Yeah.
4 54 Q. If we go to 15th October 2020, Mortality and Patient
5 Safety Data - A Training Session. Now, in relation to 11:03
6 that specific stream of intelligence or information or
7 data for the Board, is it your view that the way it is
8 presented from mortality and patient safety, is that
9 something that assists you in trying to understand
10 governance concerns or is that more of a specific 11:04
11 clinical issue that the Board don't really get involved
12 in?
13 A. I would -- there is yes and no, I'll explain why.
14 I would say my reflection of 2016-2018 is that I was
15 not fully aware or understood the information that was 11:04
16 coming before us. If I think about mortality and
17 morbidity, it was the previous Chief Executive Shane
18 Devlin that really helped unlock that in terms of
19 understanding what that report meant to us as a
20 Committee, a Governance Committee at that time, and 11:04
21 then, obviously, the piece there for that report is
22 about how safe our service is. I never really got that
23 until Shane Devlin had taken the time to explain that.
24
25 Patient safety data as well, incredibly important and 11:05
26 it was about how the new scores that were coming
27 through, the pressure ulcers, how that all impacts on
28 patient care. It gives us, as lay observers, an
29 indication of where care is not where it needs to be

1 and the patient safety element of that. So, the two
2 parts is no in the early days but yes in a better state
3 now.
4 55 Q. You've mentioned about patient safety and you've talked
5 about risk a moment ago, is that language frequently 11:05
6 used at Board meetings, is there a general culture
7 around that that is the fundamental core by which all
8 decisions should be assessed against, is that the
9 culture of the Board, that there is a requirement to be
10 constantly alert to those potential issues and 11:06
11 detriment to patients?
12 A. Yes, it is, it is now.
13 56 Q. When you say "now", is that a difference from -- are we
14 drawing the line at when you became Chair or is the
15 line drawn before that, where would you say "now" 11:06
16 begins?
17 A. I would say I draw the line when Dr. Maria O'Kane
18 became the Medical Director for the Southern Health and
19 Social Care Trust, she brought a different focus.
20 57 Q. Did that focus permeate with the Board and the SLT? 11:06
21 A. It did.
22 58 Q. In terms of a practical outworking of that cultural
23 change, if I can use that term, you can correct me if
24 you don't agree with that, but in terms of the
25 practical outworkings of that, did that allow for more 11:07
26 robust and honest conversations around patient safety
27 and risk?
28 A. It has done so, yes.
29 59 Q. We will look at the chronology of some of the issues

1 around urology later on, but one of the things that
2 other witnesses have been asked, and I'll ask you now
3 just in relation to that, is that there does seem to
4 have been perhaps individual or general lack of
5 recognition that some of the issues that may be classed 11:07
6 as administrative or not directly clinical didn't seem
7 to alert people to the potential for patient risk or
8 the impact on patient safety. Because, for example,
9 charts or issues that seem to be carved off as not
10 directly patient facing, if I can put it like that, do 11:07
11 you think that that was an issue for the Board as well,
12 that if things weren't directly clinical then there may
13 have been a lack of focus on the potential risks?
14 A. My observations on that is that the interpretation by
15 some of the role of the Board and the interpretation 11:08
16 then of the role of senior leadership and senior
17 management team, the operational stage in operational
18 and the Board needs to stay where the Board is. But
19 actually it is the Board's responsibility, it is all
20 the Board's responsibility. So whilst our job as board 11:08
21 members is not to go in and do the doing, our job is to
22 ensure that the doing is being done and is being done
23 in the right way. So you can't separate them like
24 that.
25 11:08
26 I do recall language being used 'that's operational',
27 'don't go there, that's operational.' So we have,
28 certainly in the last few years the language that we're
29 using, Dr. O'Kane talks about safe high quality care,

1 talks about patient safety, what about the patient in
2 this, what about the patient, that comes through more
3 and more. That has just refocused all our tenets [sic]
4 in that regard.
5 60 Q. It's an example of perhaps a reluctance or a failure, 11:09
6 whichever way you might want to characterise it, of not
7 recognising risk or asking questions around risk when
8 the Board was told in 2017 about the MHPS process, it
9 doesn't seem to have triggered any concern. I'll
10 rephrase that: It doesn't seem to have triggered any 11:09
11 action or curiosity on the part of the Board to ask
12 about patient safety or to ask if there had been any
13 investigation carried out, whether people were safe or
14 was there a concern or a risk, it doesn't seem to have
15 triggered any of that, not just from the Board but from 11:10
16 others as well. But I am asking you as a Board member
17 at the time, I know you weren't Chair, but you were on
18 the Board; do you think that that was an opportunity
19 when patient safety and risk may have been raised or
20 explored at that point so that a wider look could have 11:10
21 been considered as to what those issues were?
22 A. Absolutely. We should have been asking is there a
23 patient safety risk here. Not one question is my
24 recollection from any board member, and that includes
25 the executive board members too. 11:10
26 61 Q. Again then would your answer be the same, if we fast
27 forward to August 2020 when the Board was told and
28 there was an absence again of any, I'll use the term
29 curiosity because I have used it before, but any

1 interrogation of the information the Board was told to
2 see if there was a patient safety or risk issue?
3 A. In August 2020?
4 62 Q. It was slightly different because of the alert.
5 A. It came up under "Any Other Business", it was a 11:11
6 statement. Then we came to it in the September where
7 the questioning came in. But, yes, patient safety,
8 even in 2017, knowing the SAI as I do now, the patient
9 safety was there, only these two pieces of information
10 weren't being joined together. 11:11
11 63 Q. Do you see those as opportunities lost?
12 A. Absolutely.
13 64 Q. I just want to ask you about, just in front of us there
14 there is reference, on 29th April 2021, the Muckamore
15 Abbey Hospital, report of the independent leadership 11:12
16 and governance review and structures review. Then if
17 we just move down slightly, 9th December 2021,
18 Muckamore Abbey Hospital, independent leadership and
19 governance review update.
20 11:12
21 Just in relation to that particular review, was the
22 purpose of that workshop to take the learning from that
23 review and implement it more broadly, is that your
24 recollection of it?
25 A. Yeah. We had asked Barney McNeany, who was our 11:12
26 Director for Mental Health and Learning Disability, to
27 look at the review. Then we as a Trust Board and as a
28 Trust needed to look at what are the lessons for us and
29 is there learnings there that we could deploy to ensure

1 that we wouldn't fall through the same challenges that
2 they did at that time. So that was about identifying
3 the lessons, it was about focussing in on the Southern
4 Trust and saying what is it that we need to do
5 differently or is there anything that -- have we got 11:13
6 everything that we need, do we need to do things
7 differently and do we need to shape something to ensure
8 that we don't have the same challenges as Muckamore.
9 65 Q. Some of those reviews bring up issues or potential
10 lacunas or training that might be required or services 11:13
11 that might be required, is that a matter for the Trust
12 and the Department to agree funding or the provision of
13 that or is the Trust expected to meet the needs of
14 review recommendations out of its existing budget?
15 A. Yes, it is. Any actions that come out, the expectation 11:13
16 is that we need to meet them.
17 66 Q. If we could just go to 18th May 2023. Just on reading
18 this, the language in this box seems slightly
19 different, it just seemed aimed at more culturally
20 significant language. When you talk about: 11:14
21
22 "What is the Trust doing to improve communication?
23 Improving communication with patients, organisational
24 development perspective, what more can we do? Setting
25 the Trust Board's risk appetite." 11:14
26
27 Without being seen to look for any compliments for the
28 Inquiry, it does seem as if some of those themes are
29 matters that we have touched upon here, and I am just

1 wondering if there has been any learning already
2 permeating through in May 2023 to inform some of the
3 workshops?
4 A. I would say absolutely. It would be remiss of us not
5 to take the learning so far. I invited the Ombudsman 11:15
6 to a Board workshop. The Ombudsman was about to
7 release a report particularly in relation to Health and
8 Social Care Trust engagement with patients. I had
9 known from our experience at the Trust that we get
10 reported to at Governance Committee in relation to the 11:15
11 number of cases, referrals, what is proceeded or not.
12 So this was a great time to bring the Ombudsman in to
13 hear from their perspective and for us then to reflect
14 on what we heard and is there stuff we need to
15 consider. Communication is one of our key complaints 11:15
16 and remains so for the population that we serve. So,
17 through this, it was about what do we need, what can or
18 should we do differently.
19 67 Q. Now if we look at some of the ways in which some of the
20 governance issues may make their way to the Board, I'll 11:16
21 just touch on this topic briefly. If we look at
22 WIT-100476 at paragraph 19.2. The reason to look at
23 this is that later on we'll look at the way in which
24 information was provided to the Board and you can maybe
25 perhaps comment on where you think communication lines 11:16
26 may have arisen or in fact fell down and didn't work.
27 At 19.2, you say:
28
29 "The lines of management for providing information to

1 the Board on governance issues include the following:
2 (A) from committees to Trust Board via Chair's report
3 and copy minutes; (b) from Chief Executive and/or their
4 senior management team to the committees and the Trust
5 Board via reports and papers; and (c) from 11:17
6 Non-Executive Directors through to the Board Chair
7 and/or raised with the Chief Executive at the Chair/CEO
8 Non-Executive Director meetings or through the Chair
9 Non-Executive Director meetings."
10 11:17
11 19.3:
12
13 "The information would be received either by email or
14 verbally depending on the situation and the timing.
15 Where meetings were being arranged to discuss the 11:17
16 issues, any papers would be uploaded on to Decision
17 Time, which is the on-line portal for all Trust Board
18 papers in advance or provided on the day for all
19 members to review; what was in place to bring urgent
20 issues to the Trust Board was through the Committee 11:17
21 structure, directors' workshops, confidential Trust
22 Board and Trust Board itself."
23
24 Then you say at 19.5:
25 11:17
26 "In my capacity as Chair the following communication
27 lines currently exist in tandem with the formal touch
28 points outlined in my response to question 13 above:
29 (A) confidential Trust Board meetings allowing for the

1 CEO and directors to alert the Trust Board to any
2 issues;
3 (b) Chief Executive briefings with Non-Executive
4 Directors which happen every two months, providing the
5 CEO with the opportunity to bring urgent matters to the 11:18
6 Non-Executive Directors;
7 (c) as Chair I can alert the Board on an urgent issue
8 through email or through arranging a meeting of the
9 Board, if required; and
10 (d) any Board Member or Operational Director can bring 11:18
11 to the attention of the Chair or CEO any concern on an
12 urgent basis."
13
14 So there is a broad range of ways in which information
15 can flow back and forth. Obviously that depends on the 11:18
16 confidence of the people providing the information, the
17 integrity of the information that is provided and the
18 detail that you are given, so it is very much
19 personality led in some ways, would you agree with
20 that? 11:19
21 A. I would.
22 68 Q. I know we mentioned about culture before, but I'm just
23 wondering, in practical terms, I know there is a lot of
24 training and a lot of attempts to enhance people's
25 confidence and attract the right people on to Boards, 11:19
26 I am just wondering, with your broad experience and
27 your expertise around Boards, is there anything in
28 particular that you have found enhances the culture of
29 a Board sufficiently to allow people to speak openly

1 and to bring problems without there being a sense of a
2 blame culture or that someone is going to get in
3 trouble, is there anything that you have come across
4 and you think, well that actually works, that is
5 beneficial or is it really something that is an ongoing 11:19
6 challenge?
7 A. It is down to the individuals. Everybody in the room
8 has got to want the same thing and got to come to the
9 meeting with the same willingness to be open and honest
10 all the time. So when you have that mix then it's 11:20
11 great, you bottle it, you keep it, then you duplicate
12 it and send it on its way. So you're always trying to
13 achieve that. So when you get new members on your
14 Board, the culture and the platform that you set, there
15 is a role there for me as Chair to help new members 11:20
16 understand this is how we work as a Trust Board, that
17 it is open and it is honest and that it's a safe space
18 for people to contribute, no matter what level they
19 work at within the organisation.
20 69 Q. Does the existence of confidential meetings, does that 11:20
21 enhance that? Does it allow that to be explored more
22 fully or does it make little difference to getting the
23 proper information that you need to make good
24 decisions?
25 A. The confidential meetings primarily are, when they are 11:21
26 about patients or about staff and about a service area
27 that is not ready for the public domain because there
28 is complexities around it, they shouldn't get to the
29 public domain and is certainly a journey that we have

1 taken over the last number of years. So the
2 confidential meetings are not a space that you can be
3 honest in and you don't be honest here in a public
4 meeting, you have got to be honest in them both. It is
5 not an either/or situation. 11:21
6 70 Q. When we looked at the training we saw mention of
7 whistleblowing, I just wonder what your views are on
8 that as a means of identifying relevant information to
9 allow you to look at governance through that lens?
10 A. It is, and I'll give you a short example of it, would 11:22
11 that be helpful? In maternity we had as a Governance
12 Committee noticed a level of increasing litigation,
13 particularly child birth, and I hadn't realised just
14 how difficult that process is, how dangerous it is.
15 But what happened was we were noticing these increases 11:22
16 in litigation, we were asking questions and being
17 curious around it. Then a whistleblowing case came in
18 and that really just pinpointed and alerted the need
19 for a focused effort and the Executive Director
20 responsible then took a lead on that, so yes. 11:22
21 71 Q. It can be effective?
22 A. Very effective.
23 72 Q. In your experience?
24 A. Yes.
25 73 Q. Escalation of governance issues you have dealt with at 11:22
26 WIT-100480 at paragraph 22.1. And, at 22.2, you
27 mention a list of methods for escalation, and we will
28 just highlight them briefly. The first one are Early
29 Alerts, point (a), which we will go on to discuss

1 briefly later on; (b) confidential Trust Board meetings
2 that we have just looked at; (c) the Governance
3 Committee then, which we have already looked at; point
4 (d) Chief Executive briefings with the NEDs which
5 happen on a monthly or bimonthly rota. Then there are 11:23
6 internal audit reports, you have mentioned at point
7 (e); then the executive and Operational Directors also
8 attend the Audit Committee. I think that goes back to
9 the point you made earlier on where there is a
10 collective responsibility for people to bring matters 11:23
11 to the appropriate Board and Committee.
12
13 Then, at (g), the Trust Board workshops, which we've
14 looked at as well. Then, at (h), at the end of each
15 Trust Board meeting, Executive Directors of Medicine, 11:24
16 Social Work, Nursing and Finance are asked if there are
17 any other issues relating to their professional roles
18 they wish to bring to the Board's attention. So that's
19 an opportunity for anyone to raise anything at that
20 particular point. 11:24
21 A. Yep.
22 74 Q. Just before, Chair, with your indulgence, just before
23 we break, if I can just go to WIT-100479. Again for
24 the Panel's note, looking at your attitude to risk and
25 risk management, and I just want to read this in, 21.1: 11:24
26
27 "The Governance Committee has been the committee that
28 receives and discusses the corporate risk register at
29 its quarterly meetings. During my tenure as Chair of

1 the Governance Committee, 'deep dives' on corporate
2 risks were instigated from 2019. These allow for risks
3 and mitigations to be further explored to ensure that
4 the right measures are in place in relation to a risk.
5 The senior management team review the risk register on 11:25
6 a regular basis and update it accordingly. Each
7 directorate carries its own risk register and where
8 risks can no longer be managed at Directorate level,
9 they are escalated to the senior management team."
10 11:25
11
12 21.2:
13
14 "The Board receives the Chair's report from the
15 Governance Committee and yearly receives the corporate 11:25
16 risk register in full. The Chief Executive and
17 Accounting Officer is the accountable director and
18 holder of the risk register."
19
20 At 21.4: 11:25
21
22 "The risk register should be a fluid document which
23 should and does change as risks are mitigated and
24 removed and as new risks come into existence."
25 11:26
26 Just pausing there, we did see some risks just repeat
27 on risk registers as though they were standing items
28 almost?
29 A. Yes.

1 75 Q. Is that something now that isn't the case, is there
2 more of a proactive oversight than management of risk
3 registers?
4 A. There is some that still stay and that is because the
5 environment we are in within health and social care, 11:26
6 they are not going away any time soon. But certainly
7 there is more fluidity to the risk register. You are
8 see the risks being de-escalated and others being
9 escalated and coming to the committee by way of Chief
10 Executive. 11:26
11 76 Q. Then at 21.5, you say:
12
13 "The Trust has not in my time had a risk appetite
14 statement. However, work has begun on this with a
15 dedicated workshop in November 2021 externally 11:26
16 facilitated. This has been further developed through a
17 Trust Board workshops on 18th May 2023 and 18th
18 September 2023. The current work on establishing an
19 appropriate level of risk appetite will further support
20 the Board." 11:27
21
22 Just 21.6:
23
24 "Although there is as yet no risk appetite statement,
25 my experience on the Board has been that it takes the 11:27
26 question of risk generally very seriously and that it
27 has no appetite for any risks that relate to clinical
28 concerns and patient safety."
29

1 Thank you. Just, we've talked about the risk and the
2 cultural change you say has come about with Mrs. O'Kane
3 taking up post, but just for purposes of the Inquiry, a
4 risk appetite statement, you couldn't just explain what
5 that is and what purpose it serves? 11:27
6 A. Okay. The risk appetite statement is a statement of
7 the Trust to say this is the risk we are willing to
8 accept. What we have done as a Trust Board through the
9 two workshops is created a statement that we are all
10 agreed on and a level of tolerance of risk. So we can 11:28
11 have a risk to say this is our risk but we know there
12 is a bit of flexibility and we know how we can mitigate
13 that in relation to the individual risk. So the risk
14 appetite statement gives us the framework within which
15 we will adopt our risks or, sorry, deploy across our 11:28
16 risk areas as a Trust Board from here on in, and that's
17 coming to our Trust Board meeting at the end of this
18 month.
19 77 Q. Is that something that has been around for a while or
20 is that a relatively new approach? 11:28
21 A. The concept has been around for a long time. We used
22 the Good Governance Institute through Dr. John
23 Bullivant to start our thinking on it. A risk appetite
24 statement at Trust Board level is something that hasn't
25 been in place. 11:28
26 78 Q. And is there any -- do you understand why it hasn't
27 been in place, is there any reason why it didn't exist
28 before?
29 A. I honestly don't know why.

1 79 Q. Do you think it might have been something that would
2 have been of assistance in both assessing and
3 monitoring and overseeing risk?
4 A. I do. It sharpens your antennae, you are thinking
5 about it. Certainly for me I can see how we deploy -- 11:29
6 the outworkings of this risk appetite statement would
7 translate over to the reports, cover sheets for all
8 Trust Board papers and that the executive directors
9 would be minded of the risk when they are presenting
10 their papers. 11:29
11 MS. McMAHON: Chair, I wonder if that's a convenient
12 time to take a break?
13 CHAIR: I think it's just after half past, so we will
14 come back at 11:45.
15 11:29
16 THE HEARING ADJOURNED FOR A SHORT PERIOD
17
18 THE HEARING RESUMED AS FOLLOWS:
19
20 CHAIR: Thank you everyone. 11:46
21 80 Q. MS. MCMAHON: If I can take you back to paragraph 21.1
22 of your statement, WIT-100479. Just, I've read this
23 out already, but there is mention there, the second
24 sentence in that paragraph:
25 11:47
26 "During my tenure as Chair of the Governance Committee
27 deep dives on corporate risks were instigated from
28 2019."
29

1 Just if you could explain what deep dives entails,
2 please?
3 A. Happy to. On the corporate risk register, our
4 corporate risk listed good mitigations and all of that,
5 and we can sit and look at that as a Governance 11:47
6 Committee for a 15 minute window and have a brief
7 conversation. The idea about the deep dives is to
8 allow us to get in underneath the skin of some of these
9 very significant risks and to allow a broader
10 conversation with the Governance Committee to test the 11:48
11 controls and the mitigations that were narrated in the
12 document. That is the purpose of the deep dives.
13 There was one, at least one. We tried, we were very
14 ambitious, we thought we could do two, but at least one
15 at each committee where we were able to get into a deep 11:48
16 dive situation.
17 81 Q. Does a deep dive involve any consultation with
18 clinicians or other frontline staff who are providing
19 the service that is being looked at?
20 A. No, the deep dive would be the Governance Committee 11:48
21 with the Operational Director or the Executive Director
22 that was there, the holder of that risk and the Chief
23 Executive as well.
24 82 Q. Might there be some benefit of including frontline
25 personnel in that review in order to, if there was, for 11:48
26 example, any clinical concern or major concern that had
27 resulted in the corporate risk being identified, that
28 that would be properly understood, would that be
29 something that you would feel would be useful or do you

1 feel that is not necessary?
2 A. Without a doubt having our frontline staff involved in
3 the identification of risks is incredibly important.
4 As to whether that can be pragmatically delivered and
5 practically delivered within the realms of a deep dive 11:49
6 within a Governance Committee I'm not sure. But my
7 expectation would be that the directors responsible
8 will have gone across this with their teams, they
9 should be coming to the table having had the
10 conversation and knowing how it works in practice for 11:49
11 their staff teams.
12 83 Q. I think by your answer just before that one that there
13 hasn't been a deep dive into anything involving the
14 urology service?
15 A. No. 11:49
16 84 Q. Just in relation to the statement at 21.6 at WIT-100479
17 where you say that the Board takes the question of risk
18 generally very seriously and that it has no appetite
19 for any risks that relate to clinical concerns and
20 patient safety. The Inquiry has heard evidence of long 11:50
21 waits for review and admission for treatment, just
22 general waiting list issues and delays in the provision
23 of health care, do you see those as risks to patient
24 safety?
25 A. I do. 11:50
26 85 Q. Given that statement and your answer, is there anything
27 specifically that the Board is doing or has done or
28 plans to do to try and reduce any risk to patient
29 safety that exists because of waiting lists or to

1 negate them in any way?
2 A. There is in some part within the realms of what we as a
3 Trust Board and Trust can do in relation to --
4 certainly if I was to use the example of elective care.
5 Elective care, yeah, so the overnight centre which is 11:51
6 now based at Daisy Hill Hospital, which is our second
7 Acute site. The increasing numbers of lists being
8 carried out there is to help reduce the waiting lists,
9 the use of virtual clinics to help with waiting lists
10 as well across the piece of the Trust. But in the 11:51
11 whole gambit of all of this then there is the
12 significant challenges faced with workforce and access
13 to consultants and specialists in order to carry out
14 these lists as well as the nursing and specialist
15 nursing staff to support that function; then being 11:52
16 commissioned to carry out work, so that work needs to
17 be paid for, you need to be commissioned to carry it
18 out in order then to be able to carry it out and have
19 the staff team to do it. Those latter two, as much as
20 we can try there is other elements that need to come in 11:52
21 to support that.
22 86 Q. Now I want to move on to the Board Member Handbook
23 which we have in the Inquiry papers which was issued by
24 the Department of Health after the Hyponatraemia
25 Inquiry and it can be found at WIT-101127. Now just 11:52
26 for the Panel's note, and I'm sure the Panel know that
27 the independent review -- sorry, the Inquiry into
28 Hyponatraemia related deaths reported in 2018 and this
29 report is dated May 2021. It is a resource to support

1 the delivery of safe and effective care. It is quite a
2 large handbook, very detailed, and you will be relieved
3 to hear that I don't intend to go through a lot of it,
4 but I would like to jump through some of the main --
5 well some of the points that may have particular 11:53
6 resonance with the issues for the Panel, if we go to
7 WIT-101128. I should just ask you, this is a document
8 that you are familiar with?
9 A. It is.
10 87 Q. Is it a document that you use with your board members, 11:53
11 is it something that is used as a working document?
12 A. I wouldn't use it as a go-to document. Our terms of
13 reference, our appointments, letters, all have similar
14 threads going out and the standing orders then for
15 Trust Board. But I am familiar, with it in terms of 11:54
16 its content and its focus. I'm not sure did I say it
17 has been shared, it was shared with all Non-Executive
18 Directors at its release point by me.
19 88 Q. Just the middle paragraph, I am just going to read this
20 paragraph which just sets the context: 11:54
21
22 "Mr. Justice O'Hara made 96 recommendations in his
23 report, including 16 specifically in relation to
24 leadership and governance. In response, the Department
25 of Health set up an extensive programme involving over
26 200 individuals from a range of backgrounds, including
27 service users and carers, health and social care staff
28 and board members, and representatives from the third
29 sector to take these recommendations forward.

1 I acknowledge that it has taken some time for
2 implementation of the recommendations to start. This is
3 regrettable, but sadly inevitable owing to the need to
4 deal with the Covid-19 crisis. This handbook is the
5 first product to emerge from the IHRD report and I
6 intend, now that the worst of the pandemic is hopefully
7 behind us, that the pace of implementation will
8 increase."
9
10 I had asked you a question earlier about 11:55
11 recommendations and whether they potentially or
12 actually put a burden on the Board to implement what is
13 suggested in some of the outworkings of either the
14 Inquiry and indeed this handbook and whether the
15 funding for that came from existing Trust funds; is 11:56
16 this another example perhaps where the handbook
17 indicates an expectation and the Trust has to finance
18 or provide training or meet that expectation from its
19 own funds?
20 A. Can I just clarify with you in relation to the 11:56
21 implementation in the handbook or the implementation of
22 the recommendations?
23 89 Q. Well both in some respects. Because obviously the
24 implementation of the Inquiry recommendations are not
25 complete and very wide ranging, but in relation to the 11:56
26 handbook there is some expectation around training and
27 a standard of service provision that may require the
28 Trust to bring about some training and to focus some
29 funds, so is it a separate answer for each or is it the

1 case that the burden falls with the Trust?
2 A. There is a separate answer for each, okay. So for the
3 recommendations and the process that was involved to
4 get to the point of the over 200 individuals, all
5 trusts played their part in that. That was done within 11:57
6 the realms of your business as usual. So that support
7 -- and you were releasing staff to carry out those
8 functions and to go to those meetings, that was done as
9 part of that.
10 11:57
11 In relation to the training that is mentioned in
12 relation to Non-Execs, when Non-Executive Directors are
13 appointed, I mentioned earlier in my statement about
14 the "On Board" programme. There is two programmes that
15 are offered in the appointment letter, one is the On 11:57
16 Board programme, the other is a programme offered by
17 CIPFA, which is the Chartered Institute of Public
18 Finance and Accounting, I could be wrong on that. For
19 Non-Execs that is paid for by the Department, but for
20 the executive directors it is paid for by the Trust. 11:58
21 90 Q. In relation to implementation of the expectations from
22 either the recommendations from the Inquiry or from the
23 outworkings of a handbook like this, do you find that
24 the conversations with the Department are mutually
25 beneficial, that there is an appetite to improve things 11:58
26 and to try and provide funding that will allow that to
27 happen?
28 A. The funding landscape for the Trust, whilst the
29 Department would be supportive, obviously, for the

1 implementation to take place, as we would, as well, not
2 always does that support follow with finance in order
3 to be able to resource it. So the expectation is you
4 do it within the gift of what you have, the envelope
5 you are working within. The financial envelope within 11:58
6 which the Trust operates has been one that has been
7 challenging for many, many, many years. It is referred
8 to as a capitation gap. So our population increases,
9 the health needs of our population increases but the
10 funding doesn't follow that increase to enable us to 11:59
11 meet the demand that is in place. So that's an ongoing
12 conversation with the Department. That is heard, that
13 is understood but obviously in the current financial
14 brackets they are not in a position to be able to
15 address it in any shape or form. 11:59
16 91 Q. The handbook also serves as a reminder of where
17 accountability stops, I know you have included the
18 diagram in your statement, but if we look at
19 WIT-101147. And just in the box, it says, and ALBs are
20 Arm's Length Bodies. I think you mentioned earlier in 12:00
21 your evidence that this incorporates many Boards, it is
22 not just health. It says:
23
24 "While ALBs should operate with a level of autonomy to
25 deliver their services, the Minister is answerable to 12:00
26 the Assembly for the overall performance and delivery
27 of its ALBs and, therefore, ultimate accountability for
28 the exercise of proper control of financial, corporate,
29 clinical and social care governance in the HSC system

1 rests with the Minister."
2
3 Just giving the specific wording of that in the
4 structure of accountability, the current absence of a
5 minister and the absence of an assembly in Northern 12:00
6 Ireland, as the Chair of a Trust Board faced with -
7 I know you will explain the significant and competing
8 demands on the service provision in all the trusts, but
9 in your expertise in the Southern - what impact, if
10 any, does it have on your day to day operations, your 12:01
11 ability to make decisions, that there is in fact no
12 minister in place?
13 A. It has an impact on some of the changes that are needed
14 to be made. If I can come back to that in a second, if
15 you don't mind, but on a day to day, in terms of 12:01
16 running the business of delivering health and social
17 care, it doesn't make any difference. But if we are to
18 change, and I am coming back to the beginning piece, if
19 we are to effect the changes that are needed in light
20 of Bengoa 2016, so here we are eight years later into a 12:01
21 10 year plan that didn't get started. So there is
22 significant changes that need ministerial approval for.
23 The absence of those and the absence of that change and
24 reconfiguration and what health and social care in
25 Northern Ireland needs to look like and needs to 12:02
26 operate like in the future, that is a huge gap and a
27 void.
28
29 In the meantime, though, there is work being done

1 between the Chairs, between the Chief Executives,
2 working with the Department to try and shape and -
3 I can't think of a word, I can't remember the word,
4 sorry - to shape and basically create the pathway for
5 some of that change to take place. So an example for 12:02
6 us in the Southern Health and Social Care Trust would
7 be, yesterday the Permanent Secretary announced the
8 consolidation of emergency general surgery into
9 Craigavon Area Hospital and it will no longer now be
10 provided in Daisy Hill Hospital. We have gone through 12:02
11 a programme of work over the last two years to put in
12 temporary measures, to go out and consult, to engage
13 locally with political reps and the community to get us
14 to the point that that is the safest way to deliver
15 that service. So that decision by the Permanent 12:03
16 Secretary yesterday is to be very welcomed. It is
17 those kind of decisions that are needed to help effect
18 the change for the delivery of health and social care.
19 92 Q. The Panel have heard reference to Bengoa from other
20 witnesses as well, you mentioned yourself it is eight 12:03
21 years ago, and arguably the landscape has changed
22 considerably both with Covid and post-Covid, do you
23 think there is the potential for Bengoa to perhaps be
24 slightly out of date and the need then for fresh eyes
25 on a way of approaching health care services should a 12:03
26 minister come into post?
27 A. The premise within Bengoa doesn't change. There is
28 need for significant change in how we deliver health
29 and social care without a doubt. As to what that might

1 look like now needs to be shaped by our staff,
2 particularly our nursing staff and our clinicians
3 across the piece of how best to deliver that in
4 whatever shape or form that may look like. So at a
5 regional level at the moment there is a piece of work 12:04
6 ongoing in relation to hospital blue print; what will
7 the hospital that is near you, what will it deliver,
8 what will it be known for. We can't have everything on
9 every site, so we have to rationalise as best we can to
10 ensure that our expertise and our very limited resource 12:04
11 of specialist staff are placed in the best location to
12 provide the best service and care for our patients so
13 there is a need for that change.
14
15 The premise of Bengoa stands, change is needed. There 12:04
16 is work being done at a regional level with the
17 leadership of health and social care to try and -
18 navigate is the word that I was looking for - to
19 navigate that process.
20 93 Q. I mentioned the diagram just a moment ago, and we will 12:05
21 look at it just in passing, the Panel will be familiar
22 with the set up, it is WIT-10119. It is just a
23 familiar diagram, again emphasis on accountability and
24 lines of accountability. Then if we go to the next
25 page, at paragraph 1.5.3 "Accountability of Individual 12:05
26 HSC Board Members". The report states the following:
27
28 "To what extent can a board member be held liable at
29 law for their actions? Basically if an individual

1 Board member incurs a civil liability in the course of
2 carrying out their responsibilities for the Board they
3 will not have to pay anything out of their own pocket
4 provided they have acted honestly and in good faith.
5 12:06
6 However, it should be noted that this indemnity does
7 not protect any Board member who has acted recklessly,
8 criminally or in bad faith. The issue of Board member
9 indemnity cover should be covered in the letter of
10 appointment and the ALB's code of conduct for board 12:06
11 members."
12
13 Then if we move to WIT-101180. There is comment on
14 what is required for a board member to be effective.
15 The Nolan principles are mentioned, you mentioned those 12:06
16 in your statement as well. At 3.2.4, "being an
17 effective board member", I'll start at the third
18 paragraph:
19
20 "In order to be effective in their role, board members 12:07
21 should."
22
23 Then just the first one: "Actively participate in
24 collective decision making and chair or participate in,
25 where required, one or more of the Committees of the 12:07
26 Board."
27
28 Then just move down to the third point, it says:
29

1 "Question intelligently, challenge rigorously, debate
2 constructively and decide dispassionately."
3
4 That is a very eloquent but burdensome sentence
5 perhaps, but it does encompass in a much more elegant 12:07
6 way what I have been probably trying to say all morning
7 which is that there is a requirement that the Board
8 really focus their attention so that they can be the
9 eyes and ears of the Minister effectively so that
10 accountability can properly flow backwards and 12:08
11 forwards. The reason why I'll stop on that point with
12 the handbook and move on to the reality of Board
13 membership is I want to look at the Board packs, I want
14 to look at some of the information the Board are
15 expected to look at. 12:08
16
17 Just by way of context can I ask you, what is the lead-
18 in time for the board members to receive their packs
19 before the Board meeting? Then and now if it is
20 different but you can give us the full answer. 12:08
21 A. It is a constant challenge, it can be anything from one
22 to five to six to seven days, depending. Not all the
23 papers, a good majority of the papers will be arriving
24 on time, but there will always be late comers. There
25 will always be last minutes, there will be changes, 12:08
26 just the nature of the work, those papers. It could
27 only have just arisen and we have asked for a briefing
28 on it or there is significant pressures within the
29 system and the lead director is just pressed, so it can

1 come late and that's been an ongoing occurrence. That
2 isn't about 2016 to 2020 or 2020 onwards, it is just a
3 difficult timeline to meet.
4 94 Q. I just missed the start of your answer, how many days
5 did you say? 12:09
6 A. Between one and five or it could go to seven. Ideally,
7 the requirement is that, if our meeting is on a
8 Thursday, we will get them the previous Thursday, we
9 tend to get them on the Friday. Sometimes late ones
10 will come through Monday/Tuesday. There has been 12:09
11 occasions where something doesn't come through till
12 Wednesday evening.
13 95 Q. So sometimes operationally or even from the Board's own
14 governance processes, there is a late addition to the
15 pack that may result in people getting papers a bit 12:09
16 later?
17 A. Yes.
18 96 Q. We have obviously been provided with quite a volume of
19 Board packs. I just want to take you through what a
20 typical pack may contain. I know you're familiar but, 12:10
21 being a Public Inquiry, people online and also the
22 Panel not being familiar with that, I just want to give
23 them a flavour of the type of documents, the detail of
24 those documents and also I will be calling out
25 references so the Panel will know where these documents 12:10
26 could be found if they need to, but we don't need to go
27 to any of them. It is just really to set the scene for
28 the reality of Board membership when the Panel are
29 considering the actions of the Board in their

1 deliberations?
2 A. Sorry, just before you go on, you had stopped at this
3 statement, questioning intelligence and
4 dispassionately, can I offer you a reflection on that?
5 97 Q. Please do, yes. Sorry, I should have given you the 12:10
6 opportunity?
7 A. Apologies. This is the piece for me where the
8 impression and interpretation of what a Board does gets
9 lost. Because a Board should be about having an
10 engaged, informed, intelligent conversation. We are 12:11
11 all working for the same outcome, to get the best
12 decision that will impact on those that we are here to
13 serve. So it is really important that we do the
14 rigorous piece, that we do the constructive piece and
15 there is a support and challenge function in there for 12:11
16 each other, not just that it is a support for the
17 executives or the challenge for the execs and support
18 for the Non-Execs, it has got to be a support and
19 challenge function for both.
20 98 Q. Thank you for that. That does provide a better context 12:11
21 then for some of the information we are going to look
22 at. As I say I will just give the headlines of some of
23 these, a typical pack. So obviously an agenda. So,
24 Chair, if you don't mind, I'll just read out the
25 references and if anything needs to come of any of this 12:12
26 we'll know where the documents are. So when I read out
27 a reference, it is just an example of one such agenda,
28 an example can be found at TRU-122076. They also
29 usually contain the minutes of previous meetings of the

1 Trust Board for approval, an example of that is at
2 TRU-122113. The pack will contain minutes, annual
3 reports of committee meetings for approval, and one
4 such example from a Patient and Client Experience
5 Committee is TRU-122756. It will also contain a Chief 12:12
6 Executive's business report as relevant, an example of
7 that is at TRU-122098.
8 CHAIR: I hesitate to interrupt, Ms. McMahon, but it
9 might be helpful to know just what volume of material
10 one of these is. 12:13
11 MS. MCMAHON: I'll divide it up in content and volume,
12 it was just easier for me to do it, or Ms. Smyth
13 I should say, I am not taking any credit. The Chief
14 Executive's business report can be found at TRU-122098;
15 the good news stories for the Trust, TRU-112033. It 12:13
16 will contain the Chair and NED business which usually
17 details the events that the Chair and NEDs have
18 attended, an example is at TRU-112036. Then it will
19 contain financial performance reports at various times,
20 TRU-112011. 12:14
21
22 There is also potential for other financial reports,
23 for example a summary report of capital and revenue
24 proposals greater than £300,000, TRU-122390.
25 Monthly corporate dashboard, an example of that is at 12:14
26 TRU-112116. That's a monthly performance report
27 assessing performance against objectives and goals for
28 improvement. Some of the packs also contained a
29 document heading "Matters arising from previous

1 meetings", an example is at TRU-122132.
2
3 It also could contain a medical appraisal and
4 revalidation annual report summarising the work
5 undertaken by the revalidation team to ensure that 12:15
6 doctors continue to meet GMC requirements, at
7 TRU-121926. Medical director reports of various
8 natures including, for example, research and
9 development, TRU-115506. Health care associated
10 infection was another example at TRU-122572. 12:15
11
12 It could contain human resources reports. These tend
13 to contain very high level reporting of workforce
14 issues, for example, HORD Trust Board report providing
15 data on workforce productivity, sickness, movement and 12:16
16 recruitment, an example is at TRU-122709. An estates
17 services annual report, there is an example at
18 TRU-115768. There was an example in one of the packs
19 of a document which was a proposal to apply the Trust
20 seal to documents, where the Trust Board is asked to 12:16
21 formally endorse contract documents for the Trust
22 framework, TRU-117683. It might also contain reports
23 about children in need and looked after children, an
24 example at TRU-123616. Also it may contain progress
25 reports on statutory equality and good relations 12:17
26 duties, an example at TRU-122424. There will be a
27 report of the Executive Director of Nursing, Midwifery
28 and AHPS setting out updates on activity and
29 development within the professions, an example of that

1 can be found at TRU-122591. It might also contain at
2 times a Trust delivery plan which sets out the actions
3 the Trust will take in response to the Department of
4 Health commissioning plan direction, an example of that
5 is at TRU-122134. 12:18
6
7 Sometimes there are Powerpoint presentations on issues
8 of interest. So, for example, organ donations or
9 presentation on volunteer service, examples at
10 TRU-122079. 12:18
11
12 Sometimes one of the packs had a Board governance self
13 assessment tool - we talked about that earlier - it can
14 be found at TRU-115100.
15 12:18
16 In later years there are various reports produced to
17 discuss the Inquiry report into hyponatraemia-related
18 deaths that we have talked about and accompanying
19 recommendations and the Trust's work to take forward
20 actions on that, an example of that is TRU-118807. 12:19
21
22 Just picking up on the Chair's question around the
23 volume and the issue of the timing and the lead-in and
24 the ability to actually read, absorb and develop a
25 critical analysis that would allow people to ask, to 12:19
26 question intelligently, challenge rigorously, debate
27 constructively and decide dispassionately. The Trust
28 Board pack for 24/11/2016 contained 530 pages, that can
29 be found at TRU-112538. For 25th May 2017 the pack

1 contained 809 pages, TRU-113942. For 26th October
2 2017, the pack contained 896 pages and that's found at
3 TRU-116788. Those dates are chosen because of what was
4 going on at the time on the operational side and the
5 potential for governance issues to be highlighted, just 12:20
6 to give an idea of the volume.
7
8 As well as the volume of detail and the volume of
9 papers, also information is provided in relation to the
10 time allocated for discussion of some of the issues 12:20
11 which might give us a bit of a flavour of the level of
12 detail that perhaps could have been achieved within
13 that timeframe. If I can say from the outset, and you
14 can push back on this if your experience is different,
15 but the general impression given by the agendas is that 12:21
16 the time set aside during the Trust Board meetings for
17 consideration of minutes of the Trust Board committees
18 was not extensive. So by way of example to back that
19 up, at TRU-124356, the agenda for the meeting on
20 28th March 2019, 20 minutes is allocated for the Trust 12:21
21 Board to consider the minutes and key issues of the
22 Endowments and Gifts Committee, the minutes, key
23 issues, terms of reference and committee schedule of
24 reporting of the Governance Committee; the minutes, key
25 issues, terms of reference and committee work program 12:21
26 of the Audit Committee and the minutes and key issues
27 of the Patient and Client Experience Committee.
28
29 Now there are other times but that is just a snapshot

1 of one, and I know that that was in 2019. I mean,
2 you've sat in the meetings, you have received these
3 Board packs, it would be an unfair question to ask
4 someone with such extensive Board experience as you
5 because your ability to review and analyse information 12:22
6 may be somewhat more highly developed than others on
7 the Board, but did you ever feel that the paperwork and
8 the Board packs were - I don't want to use the word
9 overwhelming - but certainly challenging to get on top
10 of and to understand in advance of the meeting, just in 12:22
11 relation to the variety of documents and the volume
12 first of all before we look at the time?
13 A. I would agree with you, it is a huge volume to get
14 through at whatever point you get it. The important -
15 and this comes back to the directors being really clear 12:23
16 and articulate in their cover sheet as to the key
17 threads that they are presenting, the challenges and
18 the risks and indeed what the ask is, either of the
19 committee or the Trust Board, and then the detail is
20 there for anybody who wants to delve into it. So you 12:23
21 can only go so far. There is not one Non-Executive
22 Director - I'll speak for myself - not one of us could
23 sit here and say that we can thoroughly review 890
24 pages in a five day window, bearing in mind that, if we
25 are getting it on Thursday and Friday, then you have 12:23
26 the weekend. Obviously, we are not full time, so there
27 is other activities going on during the week. So you
28 are trying to pull this information into your sphere as
29 best you can in the time you got it, so the cover sheet

1 for me is the critical component.
2 99 Q. Now the Trust Board meeting minutes of 24th October
3 2019, we can look at that, TRU-128380. We are going to
4 these minutes because they reveal that a decision was
5 made to change the manner in which the Committee Board 12:24
6 minutes were presented to the Trust Board. So that's
7 TRU-128380. So, just at number 14 there, where it says
8 "Board Committees". So this was in Mrs. Brownlee's
9 time:
10 12:24
11 "By way of introduction, the Chair advised of the
12 implementation of a new standardised format for how
13 each Subcommittee Chair communicates the work of their
14 committee to the Trust Board. She stated each report
15 will be taken as read unless there is an urgent issue 12:25
16 the Committee considers the Board should be taking
17 action on."
18
19 Now, just the wording of that, if you can help me
20 understand the process by which a decision like that is 12:25
21 made because it is not immediately clear, at least to
22 me, on reading that. "The Chair advised of the
23 implementation of a new standardised format", if we
24 stop there and I ask: Does that mean there has been a
25 discussion about this and there's been a unanimous 12:25
26 decision that this should be the way in which something
27 is implemented or is it the case that the first time
28 the other members of the Board hear about this is by
29 the inclusion of this paragraph on this, or do you have

1 any recollection around this being brought about or
2 talked about or decided?
3 A. I have no recollection exactly on this front, but I
4 would surmise, because Non-Executive Directors would
5 repeatedly raise concerns in terms of the agenda, the 12:26
6 length of time given to items and the challenge,
7 obviously, in completing the business of the Board
8 agenda within the start time and the end time that is
9 given. I'm surmising that there was a conversation
10 between the Chair and the Non-Executive Directors on 12:26
11 this. I am surmising, I cannot recall. Because we
12 would, as chairs of committees, we would need to have
13 had a discussion on how this was going to be in terms
14 of a new way of working.
15 100 Q. Is it the case that the Board, any Board Member, if 12:26
16 they get a report from a committee, that they can
17 unilaterally ask to talk about some of the issue on
18 that so they can say can I just ask a little bit about
19 what this says here?
20 A. Absolutely. 12:27
21 101 Q. Is there any sense that going to a default position of
22 the report having been read unless somebody wants to
23 raise it, and in fact the onus seems to be in this
24 paragraph on the committee, "unless the Committee
25 considers the Board should be taking action on it the 12:27
26 reports will be deemed to have been read", is there any
27 sense that that default position removes a layer of
28 oversight from the Board in that the necessary
29 interrogation or the possibility of there being a

1 conversation or a more detailed look at these things is
2 not to be assumed to take place, the default is that it
3 won't happen, do you think that is a possibility?
4 A. Yes, I do, I agree with you on that. The impression
5 would be that we just take it as read and move on. But 12:28
6 that does not stop any member raising their hand and
7 raising a question.
8 102 Q. Is that still the position now, that you're Chair, is
9 it still that each report will be taken as read unless
10 there is an urgent issue? I know lawyers look at 12:28
11 things slightly differently, but - I can't help myself
12 - it does seem as if there is a criteria of urgency
13 motivated by the Committee that are the two triggers
14 before the report will be opened more formally?
15 I mean, I will accept I'm probably looking at that a 12:28
16 wee bit through a different lens, but what's the
17 position now, is it the same?
18 A. No, it's not. The Committee Chair Report, the revised
19 version means a revised approach for committees, there
20 is a Committee Chair Report plus the minutes of the 12:28
21 meeting. Those are presented by each Committee Chair
22 and there is an allocation, I think, of 10 minutes
23 within each agenda for each committee. It is up to the
24 Chair then to raise, to give an overview, to raise the
25 issues or say 'everything is fine, I present this for 12:29
26 information' and any work plans or any areas of work
27 that they are presenting to the Trust Board for
28 approval. So there is the allocation of time for each
29 committee, there is the onus on the Chair to present

1 the paper and the reports and the minutes are there of
2 the meeting as well so that everybody has had the
3 opportunity and sighted on what has been covered.
4 103 Q. So the Chair of the Committees and the Directors, the
5 executive directors of the SLT for example, they are 12:29
6 responsible for highlighting on the cover sheet or the
7 first bit of information what the Board should focus on
8 given the volume, the volume of information that is put
9 before them?
10 A. Yeah. 12:29
11 104 Q. You really do depend on that?
12 A. Just for my clarity, if you are talking about the cover
13 sheet, there is one from the Chair of the Committee and
14 there is one -- yes, okay. So the responsibility lies
15 with all those individuals to make sure that that cover 12:30
16 sheet is telling the story, the real story, and what is
17 needed then from the Trust Board in that regard.
18 105 Q. I just want to ask you something about what Mr. Devlin
19 said in his witness statement. We don't have to go to
20 it, but for the Panel's note it is at WIT-00046. It is 12:30
21 just a comment that he made and he says this:
22
23 "The Trust Board agenda is regularly 60% discussion of
24 clinical governance issues."
25 12:30
26 Would that be your recollection?
27 A. It wouldn't. 60% of the Governance Committee would
28 be -- if not more. The Trust Board covers a vast
29 arrange of the goings on in the Trust. Even from the

1 list that you read out a short time ago, you have got
2 estates, you have got finance, you have got Human
3 Resources as well as the delivery of the professional
4 governance reports. I wouldn't see it as 60%, but I
5 wouldn't be saying that on the basis that it's less. 12:31
6 It can change depending on the meeting, it can change
7 in relation to the areas and the topics that we're
8 looking at, that clinical governance could be popping
9 up at 80% at one meeting depending on what we are
10 focusing our attention on. 12:31
11 106 Q. Were there enough clinical governance issues arising
12 over your period as an NED and now as Chair for you to
13 think, yeah, the pathways exist and are functioning
14 properly for clinical governance concerns to come
15 before us? 12:31
16 A. Could you repeat that please.
17 107 Q. I wish I could, it is such a good question! We'll have
18 to read the transcript. Really the essence of it is,
19 did you hear enough about clinical governance problems
20 or issues or concerns for you to be satisfied that yes 12:32
21 the pathways exist for us to get those concerns brought
22 to our attention, if that was close enough?
23 A. I would say I don't think so, not in the earlier part,
24 it is not coming to the fore as much as it is now.
25 108 Q. You've given us an example of you emailing questions in 12:32
26 advance from another NED at WIT-04222 and WIT-04223,
27 and this was an email trail where one of the other NEDs
28 had sought some clarity about a private patient issue,
29 it is just really as an example of interrogation and

1 curiosity by one of the NEDs and you trying to resolve
2 it. If we just move down, I don't need to read this,
3 but Geraldine Donaghy. She draws attention to the fact
4 that 15 minutes have been allocated to discuss a paper
5 in relation to the internal audit report on 12:33
6 Mr. O'Brien's urology private patients and compliance
7 with relevant guidance. What Mrs. Donaghy has done is
8 to identify that she needs to have more information
9 before she can properly take part in the discussions at
10 the Board, and she sends that to you. So you can see 12:33
11 the last line there, the paragraph in her email:
12
13 "I would appreciate if sufficient time were provided at
14 the meeting to hear and discuss the responses."
15 12:34
16 Just go up to the email before this, thank you. You
17 then send this on to Shane Devlin explaining the
18 context. You say in paragraph three:
19
20 "Geraldine has noted she had a number of questions and 12:34
21 I encouraged her to send them in advance. Geraldine
22 has raised a series of questions from the report."
23
24 Then you said, last sentence of paragraph 4:
25 12:34
26 "To manage time tomorrow, if these could be
27 answered/reflected on in advance."
28
29 The reason why I am bringing that example, is that an

1 example of the change in culture that you referred to
2 earlier on in your evidence where you said there seems
3 to be more openness, more willingness for people to
4 reach out and say 'I need a bit more information on
5 this' and perhaps be more value adding when it comes to 12:35
6 the actual meeting?
7 A. Yes.
8 109 Q. I just want to briefly, you mentioned it in your
9 statement, the impact on staff turnover potentially on
10 Board efficacy, most particularly with the Chief 12:35
11 Executive, if we go to your statement at WIT-100468.
12 You just mention this in two paragraphs, paragraph
13 16.6, and you say:
14
15 "The 2021/2022 Board governance self assessment 12:35
16 recognised the risk to the stability and effectiveness
17 of Trust Board as a direct consequence of vacancies at
18 Senior Executive and Non-Executive Director level.
19 Actions to address this included all senior executive
20 positions to be advertised and appointed by 12:36
21 December 2022 and Non-Executive Director positions
22 competition programme, including SH and SCT vacancies,
23 to be advertised by public appointments unit in
24 October 2022."
25 12:36
26 Then you say at paragraph 16.7:
27
28 "In my experience, having instability in the Board and
29 Senior Executive Team directly impacts on the

1 effectiveness of the governance structures. During the
2 period 2016-2018 there were interim Chief Executives
3 and Interim Executive Directors who were members of the
4 Trust Board. In addition, six out of eight
5 Non-Executive Directors were newly appointed during the 12:37
6 2016/2017 year. The appointment of Mr. Shane Devlin as
7 Chief Executive in 2018 allowed for the beginning of a
8 process to make substantive appointments to the senior
9 team. August and November 2020 saw the end of tenures
10 for two long standing Non-Executive Directors. This 12:37
11 created two vacant positions which, as I write, remain
12 vacant. The appointment of Dr. Maria O'Kane as Chief
13 Executive in 2022 has seen the follow through on
14 completing the restructure and recruitment of permanent
15 and substantive posts across the senior leadership 12:37
16 team."
17
18 So you've started that paragraph by saying "having
19 instability in the Board and senior executive team
20 directly impacts on the effectiveness of the governance 12:37
21 structures"; given the change of staff and the quite
22 high volume of turnover of personnel for Chief
23 Executive, what was your experience of the impact on
24 the effectiveness of the governance structures when you
25 were NED and latterly as Chair, what was the actual 12:38
26 impact of that?
27 A. You want me to look then and now?
28 110 Q. Yes, that would be helpful.
29 A. Okay. So this for me was without a doubt a moment in

1 time for the Southern Trust that it is still reaping
2 and hurting from, not having that stability at senior,
3 exec and Board level. At that time - obviously I'm
4 only one/two, well one year in in 2016, well I start in
5 2016, so my observations for the instability absolutely 12:38
6 rippled throughout the leadership team. You could see
7 from their need to have leadership, to have a vision,
8 to know where they were going and who was taking them
9 there and what was going to happen when they got there
10 and that they were doing it together as a body 12:39
11 corporate.
12
13 So I would pinpoint this as one of the most pivotal
14 times for the Southern Trust. Looking back and sitting
15 where I am now, I am in the position, as I sit here 12:39
16 today, viewing down the lens of having seven new
17 Non-Executive Directors within a 12 month period. So
18 we are back at this place again where you have such a
19 change at that level. I'm sitting as Chair comfortably
20 in that the senior leadership team bar the Executive 12:39
21 Director of Social Work, which will be advertised later
22 this month - and that has only been delayed as a result
23 of the external review by Ray Jones - that that team is
24 in place, there is a leadership there from the Chief
25 Executive, that there is plans afoot for the vision and 12:40
26 the strategy of the Trust that our team so desired.
27
28 But from the Non-Executive Director position, this
29 organisation will see a massive change within the next

1 12 months, a loss of experience, skill and continuity,
2 but that should not be a reason to extend. But I think
3 if I asked them all to extend they may say no anyway.
4 But you should not -- the tenure time for our Non-Execs
5 is two tenures of four years and that comes to an end 12:40
6 for the majority of them this year.
7 111 Q. Is there a difficulty in trying to address those
8 particular issues arising, is there any solution to
9 that?
10 A. There is two things: There was a delay in the 12:41
11 recruitment process and there was 16 Non-Executive
12 Director vacant posts across the Health and Social Care
13 Trust alone in Northern Ireland. So we were all
14 carrying vacancies for the last two, three or four
15 years for some. That recruitment process has only just 12:41
16 concluded there end of November, beginning of December
17 for those 16 vacant posts. There is a waiting list
18 that has been created as a result of that recruitment
19 exercise to fill the upcoming vacancies in the next 12
20 months. So that's a helpful addition and one that 12:41
21 should always be available in any recruitment process
22 for this, because the recruitment process can take up
23 to 12 months.
24
25 In this case, I think, you talked about what I had said 12:41
26 around 2022 to be advertised for, that didn't happen
27 and that's just pressures of the system. So we have
28 got there. Two Non-Executive Directors have been
29 allocated to the Southern Trust at this point. I have

1 two Non-Execs that are about to leave within the next
2 30 days and they will need to be replaced too.
3 112 Q. In your experience is this a particularly unique time
4 for recruitment, is there anything that's feeding into
5 that or has it always been historically challenging to 12:42
6 get recruitment sufficiently, well done in sufficient
7 time so that there is no gap, has it always been like
8 that?
9 A. In my experience in health and social care, yes. But
10 my experience other than that is succession planning. 12:42
11 When you appoint somebody you know when their end date
12 is going to be so you start your succession planning at
13 that point; you know three years into a four year
14 appointment, if you are going to be losing one or two
15 members, you will be running a competition, you plan 12:43
16 for that competition. You don't wait till you get to a
17 couple of weeks before the end point and then run the
18 competition, because then you have an extension to put
19 in place, then the length of time of the competition to
20 roll out, to give you an outcome. And you may not get 12:43
21 an outcome is the other risk on that, you may not get
22 the skills that you require for your Board at that
23 point. So succession planning for both Non-Exec and
24 executive directors in health and social care hasn't
25 been particularly good and that is something that would 12:43
26 need to significantly change. Because these are
27 important leadership roles, they need to be planned for
28 and recruited for in the most appropriate way to ensure
29 we get the right skills at the right time for the

1 organisations.
2 113 Q. And who is responsible for that?
3 A. For the Non-Executive Directors, that sits with the
4 Department of Health.
5 114 Q. Why has there been no succession planning if 12:43
6 self-evidently time periods of tenure are going to
7 expire and it is foreseeable that there will be
8 difficulties, why do you think there has been a failure
9 to bring about succession planning?
10 A. I honestly, I would only be giving you my thoughts, 12:44
11 I don't know why it hasn't been. But I suspect that,
12 in the scheme of what the department does, it is not up
13 there in the top 10 things to keep an eye on. But from
14 where I sit as a Non-Executive Chair of the Health and
15 Social Care Trust the leadership of the Trust certainly 12:44
16 is in my top three every day of the week. So I would
17 be encouraging the Department to ensure succession
18 planning was appropriately planned for from here on in.
19 115 Q. On one view, when one looks at that handbook, the
20 detail and the expectation, the legal responsibilities, 12:44
21 the statutory responsibilities and the governance
22 responsibilities, it could be argued that it is
23 difficult to see why keeping Boards fit and healthy and
24 filled would not be something that would be in the
25 Department's best interests? 12:45
26 A. These are not attractive roles. You've got to want to
27 do this. You don't step into a Health and Social Care
28 Trust as a Non-Exec because you have some time on your
29 hands. You do it because you want to bring your

1 skills, your experience and your absolute commitment to
2 health and social care to the table. I firmly believe,
3 and it is with my Boardroom Apprentice and other hats
4 on, people want to serve, they want to learn to do
5 that, so let's create the space for people to be able 12:45
6 to serve on our Health and Social Care Boards and get
7 that right at the beginning. Succession planning needs
8 to be thought about the moment you appoint somebody.
9 The senior executive team succession planning, I know
10 from talking with our current Permanent Secretary Peter 12:45
11 May, this is something he has focused on, something he
12 has focused on in relation to the training and
13 development of Non-Executive Directors and that
14 induction piece, that is on his agenda and he is
15 watching it and he wants that to happen. We need to 12:46
16 think of how we make these roles, not just Non-Exec,
17 but the senior executive roles attractive to encourage
18 people to apply, because they are incredibly rewarding.
19 116 Q. When you have a turnover at Chief Executive level to
20 the extent that was apparent in the Southern Trust, is 12:46
21 there a danger or possibility that the Chair, whether
22 it be you or the former Chair Mrs. Brownlee, who will
23 come and give evidence and answer questions herself,
24 but is there a possibility that either advertently or
25 inadvertently they become more involved in operational 12:46
26 decisions because they have corporate memory or because
27 they need to fill a gap that may exist at any time?
28 A. Absolutely. We talked earlier about Roberta Brownlee's
29 tenure with the Southern Trust and within the Southern

1 Trust area and the legacy trust. She is constant, she
2 was a constant individual for the Southern Trust. When
3 you look at the flux of the senior executive and the
4 Board, Roberta Brownlee was the constant person that
5 was there. So either rightly or wrongly the stepping 12:47
6 from the Chair to the Chief Executive role, you can see
7 how easily that was for Roberta Brownlee to do and that
8 she felt, I would suspect she probably felt that she
9 needed to step in at that flux period. But that flux
10 created that space that allowed Mrs. Brownlee then to 12:47
11 become in essence what I have referred to in my
12 statement as a de facto Chief Executive when we didn't
13 have a substantive Chief Executive in post.
14 117 Q. We will look at Mrs. Brownlee later on in relation to
15 her involvement on the Board. I just want to briefly 12:48
16 touch on the urology departments being flagged up or
17 being raised at Board level. A couple of these are
18 before your time so I won't take you to them because
19 you can't speak to them, but I am going to give those
20 examples just for the Panel's note? 12:48
21 A. Okay.
22 118 Q. The first one is 2009 when the Trust Board was made
23 aware of the ongoing capacity issues in urology and the
24 related impact on patient waiting time, an example of
25 that Trust Board is at TRU-105665 which is 12:49
26 24th September 2009. The minutes state that the Trust
27 Board was advised that the trusted had undertaken a
28 review of urology services and this had highlighted a
29 capacity gap.

1 Then on 25th August 2011 the Trust Board was advised
2 that the Trust is continuously aiming to improve
3 urology services and the longer waits are, at that
4 point, decreasing in numbers. However, again there is
5 a capacity issue in terms of prioritisation of 12:49
6 referrals, and that can be found at TRU-106429.
7
8 And then, 30th August 2012:
9
10 "The Trust Board members were advised by way of a 12:50
11 monthly performance management report that the
12 performance risks identified that in-patient day cases
13 and urodynamics result from an established capacity gap
14 in urology for which recurrent investment has been
15 committed. The Trust Board is advised that current 12:50
16 in-house capacity is entirely absorbed in managing red
17 flag referrals and urgent cases."
18
19 The note of that can be found at TRU-106600.
20 12:50
21 Then in 2013, on 26th September, the Trust Board is
22 advised that:
23
24 "Urology continues to present an ongoing risk which is
25 the subject of regular discussion with the Health and 12:51
26 Social Care Board. The Health and Social Care Board is
27 said to have accepted the workforce constraints
28 affecting this area of performance."
29

1 And that's at TRU-107138.
2
3 Then coming into your time, you started in
4 February 2016, I don't expect you to remember this, but
5 just to let the Panel know that we are moving into a 12:51
6 more relevant period for you. Similar issues were
7 raised in March 2016 the Trust Board is advised that
8 the longest Trust waits are in urology. When you look
9 at the numbers now, I suppose the example then with 34
10 patients at that point were waiting from 2012/2013, and 12:51
11 that's found at TRU-109040.
12
13 In January 2017, the Trust Board are told that the
14 majority of breaches of the 62 day waiting target are
15 within urology, and that is at TRU-112949. 12:52
16
17 In January 2019 the Trust Board are advised that the
18 longest wait in terms of in-patient and day case waits
19 are within urology, and that's at TRU-123905.
20 12:52
21 There is an example of when the Trust Board discuss the
22 issues and seek information from the directors and
23 senior staff on their plans to resolve the issue. An
24 example of that can be found in the minute of the Trust
25 Board meeting of 24th January 2019, and that's at 12:53
26 TRU-123905. That is an example when Aldrina Magwood
27 presented the performance report for approval, the
28 members considered it:
29

1 "One of the Board, Mrs. McCartan, referred to the
2 longest wait in terms of in-patient and day case waits
3 within urology at that point at 257 weeks.
4
5 The members recognised challenges within urology 12:53
6 regionally and Ms. Magwood assured members controls are
7 in place to review and manage lengthening access
8 times."
9
10 When you're told something like that at the Board do 12:53
11 you consider 'well operationally they are on top of it,
12 so we have been reassured from a governance
13 perspective.' I mean, hindsight is a wonderful thing,
14 but is there a level of scrutiny and say 'well what are
15 you doing and what are your timeframes for trying to 12:54
16 turn this around', was there active conversations like
17 that at any point?
18 A. I wouldn't recall specifically, but certainly there
19 would be conversations around seeking assurance and
20 getting it from the director responsible. I would also 12:54
21 say that urology, as with other services under pressure
22 and demand, so it wasn't the only one. If it was
23 sitting as an outlier it would certainly raise a flag,
24 but it wasn't sitting as an outlier in relation to us
25 having pressure in our services in the Trust. And 12:54
26 2019, also 2016/2017 through, I know certainly our
27 emergency department at Daisy Hill occupied a huge
28 amount of the Board time but also other specialisms in
29 the Trust.

1 So, back to your question, we would question, seek
2 assurance from it. But, for me, certainly sitting
3 listening to the minutes or the pointers that you gave
4 from before 2016, I think you have four, if not five,
5 were urology, pressures and demand capacity was raised. 12:55
6 And now we step into 2016 and 2019, I think 2019. So
7 you have quite a number there where that would be
8 saying to me as a Non-Executive Director 'this keeps
9 raising its head', but at that point certainly
10 assurance would have been sought from Aldrina Magwood 12:55
11 and the director responsible as well.
12 119 Q. Again there is another example in 2019, 24th October
13 2019:
14
15 "A report was prepared by the Chair of the Patient and 12:56
16 Client Experience Committee for the Board meeting."
17
18 We don't need to go to this, but this can be found at
19 TRU-128158. The Committee had at that meeting
20 considered a presentation highlighting the work in 12:56
21 urology. The presentation was by Kate O'Neill who
22 we've heard from:
23
24 "The presentation by Kate O'Neill highlighting work in
25 urology revealed the impact of the service on the 12:56
26 clients. In addition, the presentation revealed the
27 real impact behind the performance figures on service
28 users. The significant impact of service development
29 was highlighted including the use of specialist nurses.

1 Challenges to the service were noted. Workforce
2 planning, quality of life issues for the service user,
3 inability to reach cancer targets, waiting lists,
4 multiple attendances at ED due to urology-related
5 issues; equipment needs, service improvement issues." 12:57
6
7 And then "innovation overload".
8
9 Just one of the sentences that jumps out slightly is:
10 12:57
11 "The presentation revealed the real impact behind the
12 performance figures on service users."
13
14 I suppose that highlights the value adding of a service
15 provider coming to the Board and giving the context 12:57
16 that may have just been a one dimensional performance
17 figure, and Kate O'Neill is actually giving you the
18 real life examples.
19
20 The subsequent minutes of that meeting for which the 12:57
21 report was prepared don't appear to reflect any
22 substantive discussion about urology after that
23 presentation, that can be found at TRU-128380. I am
24 just wondering, by this stage was there a sense that
25 'well these are just the problems in urology' and 12:58
26 perhaps, I know we're focused on urology but obviously
27 wider governance and perhaps in other departments as
28 well, was there a bit of 'we know about this and it
29 doesn't seem to be improving'?

1 A. At the minute I can't recall the full conversation at
2 the committee meeting, but I do recall we did discuss
3 the impact on the patients and that hit home for quite
4 a number of us. I also recall that that conversation
5 was continued with the Chief Executive I think as part 12:58
6 of one of the meetings between the NEDs and the Chief
7 Executive. So whilst the minute does not reflect
8 certainly the impact on the patient, and that's what
9 the Patient Client Experience Committee is there for,
10 it was certainly heard. Having our service providers 12:59
11 and our staff come and tell us as it is as well as our
12 patients is something that is incredibly important to
13 inform us both at committee and at Trust Board. So
14 I am very taken by what we heard at that meeting in
15 relation to the impact. 12:59
16 MS. McMAHON: And I fully accept the minute can't cover
17 everything, but it was just as an example of specific
18 issues in urology being raised. I am going on to a
19 separate topic, Chair, and I wonder if that's a
20 convenient time? 12:59
21 CHAIR: Yes, we'll come back, ladies and gentlemen, at
22 2.05.
23
24 LUNCH ADJOURNMENT
25 13:57
26
27
28
29

1 THE HEARING RESUMED AS FOLLOWS:
2
3 CHAIR: Thank you everyone.
4 120 Q. MS. MCMAHON: Ms. Mullan, I just want to move on now to
5 a new topic, it's the chronology and the way in which 14:01
6 you discovered the concerns around urology and
7 Mr. O'Brien, and we will look at your witness statement
8 at WIT-100503. I'll just read out the question that
9 you've answered. We asked you at paragraph 31:
10 14:02
11 "Please provide full details of when, how and by whom
12 you and the Board were first made aware of issues and
13 concerns regarding the practice of Mr. O'Brien, to
14 include all information about what was said and/or
15 documentation provided." 14:02
16
17 You say at 31.1:
18
19 "At a confidential Trust Board meeting on 27th January
20 2017, Mrs. Vivienne Toal raised, under agenda item 6, 14:02
21 Maintaining High Professional Standards, the
22 following."
23
24 And you quote this:
25 14:02
26 "Mrs. Toal advised that, under the MHPS Framework,
27 there was a requirement to report to Trust Board any
28 medical staff who have been excluded from practice.
29 She reported that one consultant urologist was

1 immediately excluded from practice from 30th December
2 2016 for a four week period. Mrs. Toal reported that
3 the immediate exclusion has now been lifted and the
4 consultant is now able to return to work with a number
5 of controls in place. Dr. Wright explained the 14:03
6 investigation process. He stated that Dr. Khan has
7 been appointed as the case manager and Mr. C. Weir as
8 case investigator. Mr. J. Wilkinson is the nominated
9 Non-Executive Director. Dr. Wright confirmed that an
10 Early Alert had been forwarded to the Department and 14:03
11 the GMC and NICAS have also been advised."
12
13 At 31.2, you say: "The consultant's name was not
14 disclosed to us at that time."
15 14:03
16 At 31.3: "There were no documents provided to us
17 either. Information was provided verbally by Mrs. Toal
18 and Dr. Wright."
19
20 At 31.4: "I now know that the consultant being 14:03
21 referred to at this meeting was Mr. O'Brien. I believe
22 that I only became aware of this in or about
23 August/September 2020."
24
25 And you say at 31.5: "Up until that point, 27th 14:04
26 January 2017, I was not aware of any issues or concerns
27 regarding the practice of Mr. O'Brien."
28
29 Now the meeting on 27th January 2017 when you were

1 informed, the trigger for you being informed or the
2 Board being informed was the requirement under MHPS
3 that the Board is told, and we've read out what you had
4 been told, was that the totality of the information
5 that was provided at that time at the meeting, what 14:04
6 you've quoted in 31.1?
7 A. As I recall, yep.
8 121 Q. Was there any discussion about this item after
9 Mrs. Toal gave her information to the Board, do you
10 remember anything? 14:04
11 A. No, I don't. I don't remember any discussion and
12 actually I don't believe there was any discussion.
13 122 Q. Did anyone ask why he had been excluded?
14 A. I don't believe anybody asked.
15 123 Q. Do you think that that might be a natural question for 14:05
16 someone to ask 'well, if a consultant has been
17 excluded, what's behind it', would that have been --
18 there was no reason or there was no bar to anyone
19 asking that question?
20 A. No. There is two questions should have been asked that 14:05
21 day: First, what was the reason and, second, do we
22 have a patient safety concern.
23 124 Q. Do you recall at all if the Chair made any comment or
24 said anything or raised any queries like that?
25 A. No, I don't. My reflection, this is the minute from 14:05
26 that meeting, it is, isn't it? This is the actual
27 minute from the meeting?
28 125 Q. Yes, this is in your statement, and it is taken up from
29 it.

1 A. Yeah. So, going on my experience, that would be the
2 totality of what was discussed at that point in time.
3 126 Q. Do you recall if there had ever been an MHPS process or
4 outcome or investigation brought to the Board at any
5 other meeting that you had been at? 14:06
6 A. Since?
7 127 Q. No, before.
8 A. Before, no.
9 128 Q. No. At this point in 2017, given the training that we
10 looked at earlier, were you familiar with what MHPS 14:06
11 was, can you remember?
12 A. I don't recall, but the training for MHPS followed a
13 few months after this. It was quite possibly that
14 would be the first time I would have heard the term
15 MHPS. That could be quite possibly the first time 14:06
16 I heard it.
17 129 Q. Is it possible then that the Board weren't even aware
18 what the framework was whenever they received this
19 information?
20 A. It would be possible for some of the Board but not all 14:06
21 of the Board.
22 130 Q. If we take it that it wasn't all the Board and some of
23 the Board were familiar with what MHPS was, does that
24 surprise you even more that they didn't ask 'well,
25 what's behind this'? 14:07
26 A. Yeah, it does. Because you have three Non-Execs who
27 are in less than a month, another three in less than a
28 year. You have two further Non-Execs and you have an
29 executive director sitting there who had longer term,

1 longer experience and knowledge and understanding,
2 where MHPS I would like to think has come up in the
3 lifetime before I was a member of this Board, that they
4 would be familiar. So you look to them for, I suppose,
5 their insight into this. 14:07
6 131 Q. Did it surprise you or even on reflection do you have
7 any views that you were only told this after the
8 consultant actually had been -- the exclusion had been
9 lifted given that the requirement to report to the
10 Trust Board was that someone had been excluded, but the 14:07
11 Board is being told at the point at which the exclusion
12 has been lifted four weeks later?
13 A. Yeah. The first part of your question?
14 132 Q. You are being told on 27th January 2017, the point at
15 which you are being told is that the consultant is now 14:08
16 back to work; the requirement under MHPS is to report
17 an exclusion from practice, not a return from
18 exclusion?
19 A. Yeah.
20 133 Q. Do you think you should have been told when the 14:08
21 consultant was first excluded rather than when he was
22 brought back?
23 A. Yeah, we should have been. Then there is the SAI that
24 took place in 2016 as well which didn't come before.
25 Those two pieces of information would have made a great 14:08
26 deal of a connection. I have thought about this in
27 terms of what I thought at the time at this meeting, it
28 was in essence a sense that you are being told this,
29 this is happening over here, don't need to worry about

1 it. They just felt that this thing called MHPS is
2 happening here, we'll come back to you. That was just
3 my reflections from that meeting. But, yes, the
4 framework says we should be told of exclusion and this
5 is the point of being returned from exclusion. 14:09
6 134 Q. So there was a sense that we are looking after this,
7 we'll update you if there is anything else?
8 A. Yep.
9 135 Q. The reason why I'm just asking slightly about the
10 detail of it is, if you are looking for fracture lines 14:09
11 in the chronology, opportunities for perhaps something
12 to have been done and for perhaps people to look at
13 things a bit more deeply, was this an opportunity in
14 2017, had people questioned that something might have
15 arisen and there might have been, as you say, a patient 14:10
16 safety review or at least a risk assessment?
17 A. This is certainly a point of fracture, no questions
18 asked, no exploration. Even following through from the
19 Minister in that meeting to others, there is no follow
20 up. So, absolutely, we did not question, we did not 14:10
21 explore properly, we were not curious enough. We did
22 not engage in a conversation, we did not ask, we did
23 not ask any questions at that point.
24 136 Q. I was just going to say, then the next time it came up
25 was 27th August 2020, the confidential meeting, and it 14:10
26 was brought up under "Any Other Business". If we just
27 move down. Then you've helpfully provided a table in
28 your reply. The first item on that is 27th August
29 2020. There was an Executive Director update at the

1 Trust Board workshop by Maria O'Kane. The notes from
2 the Trust Board workshop held on 27th August say:
3
4 "Dr. O'Kane brought to the Board's attention SAI
5 investigations into clinical concerns involving a 14:11
6 recently retired urologist. Members asked that this
7 matter be discussed at the confidential Trust Board
8 meeting following the workshop."
9
10 The next item, the minute from that is -- the last 14:11
11 sentence of that box, the second box:
12
13 "Members request a written update for the next
14 confidential Trust Board meeting."
15 14:11
16 Now were you at that meeting as well?
17 A. Yes, the August and the September.
18 137 Q. And did you know the name of the consultant at that
19 point?
20 A. I don't, not into August. 14:12
21 138 Q. There had been no connection, because you didn't know
22 the name in 2017 and you didn't know the name in 2020,
23 there was no way you could have connected?
24 A. There is no automatic flag for me on that front, no.
25 139 Q. So in August '20, I just want to ask you about 14:12
26 27th August 2020, the meeting, can you remember the
27 context in which Dr. O'Kane brought this information to
28 the Board? I know it was under, "any other business",
29 but was there any sense of a linkage, was there any

1 sense of urgency, was there any expectation that the
2 Board would take decisions or was it really just
3 providing you with information at that point?
4 A. Yep. So my observations on it is that the Early Alert
5 was - I expect we will talk about it - but the Early 14:13
6 Alert came earlier in the summer. This was the first
7 meeting of the Trust Board. This was a workshop that
8 we were doing other items on, so under "Any Other
9 Business" in the workshop then that would be the first
10 point in time for Dr. Maria O'Kane to raise this with 14:13
11 the Trust Board in its entirety. That was done at the
12 workshop piece.
13
14 And then there was - could you scroll back, can you go
15 back, please, to the table with the two parts? Thank 14:13
16 you. Yep. Then there was a confidential Trust Board
17 meeting just following, immediately following that
18 workshop and, as it wasn't on the agenda that was
19 given, then Dr. O'Kane raised it under "Any Other
20 Business" at that point. 14:13
21 140 Q. Again, it's the same question around patient safety and
22 risk assessment, was there any consideration given to
23 carrying out any - I'll use the phrase deeper dive -
24 but any other further analysis of the information to
25 find out if there was a risk at that point? 14:14
26 A. At that point there was no information other than the
27 verbal update being given by Dr. Maria O'Kane. Then
28 our discussions was that a fuller update to be provided
29 at our next confidential meeting in September.

1 141 Q. Given that was a month away, would you have anticipated
2 or expected or even assumed, not just you, the Board
3 generally and the collective responsibility, that
4 Dr. O'Kane would have been, had one eye on patient
5 safety or risk or at least had that to the forefront of 14:14
6 her mind whenever she is dealing with this issue?
7 A. Oh, I have no doubt.
8 142 Q. What would you have anticipated that she would have
9 done to assure herself that patients were safe and the
10 risk had been minimised or eliminated, if there was one 14:15
11 at that point?
12 A. I suppose at this point the consultant in question was
13 no longer an employee of the Trust, that's the first
14 thing; secondly then, going on the information we got
15 in September, looking back, the amount of work that was 14:15
16 done to identify where patients were at risk and were
17 not safe, that work was being done at pace in the
18 background. So certainly from the September meeting
19 and the document provided by Dr. O'Kane through her
20 assistant Medical Director, it certainly showed the 14:15
21 work and the efforts being -- I suppose the timeline
22 and the chronology of all the events and the work that
23 was being done.
24 143 Q. In tandem, at that time you mean, later on after this,
25 the 2020/2021 timeline? 14:15
26 A. Yes.
27 144 Q. You mentioned the Early Alert, if we just look at that,
28 it is at WIT-101965. Now this is the Early Alert dated
29 31st July 2020. The Panel has looked at this before

1 and, subject to the views of the Chair and the Panel,
2 I don't intend to read it in. But it sets out in quite
3 a bit of detail about the lookback review and the
4 issues that had arisen and gives data on the number of
5 patients, the time period and mentions the Royal 14:16
6 College of Surgeons preliminary discussions and the GMC
7 involvement. So it's quite a detailed Early Alert that
8 indicates that, from 7th June, on 7th June 2020 the
9 Trust became aware and they are sending this Early
10 Alert to the Department on 31st July, so seven weeks 14:16
11 after they became aware. They have obviously evidence
12 gathered, got it together and put this in.
13
14 Now, that was an Early Alert. At the time as a member
15 of the Board did you receive Early Alerts that were 14:17
16 issued?
17 A. At that time it wouldn't have been a constant
18 occurrence.
19 145 Q. But there would have been some that you might have got?
20 A. Some we would have received, yep. 14:17
21 146 Q. Was there ever any reason why you got some and not
22 others, was there some understanding with the Board
23 that only certain Early Alerts would make their way to
24 the members?
25 A. I have no understanding as to why some would come and 14:17
26 some would not, whether it was about the nature of it,
27 because they were different. So it wasn't like it was
28 only the ones with the media interest came our way or
29 the ones with patient safety came our way. There was a

1 difference between them all, so I don't know why there
2 wasn't a consistent issue out to Non-Executive
3 Directors.
4 147 Q. Can I ask how you would know there was an alert if you
5 didn't get it, how would you know you didn't get some, 14:18
6 I suppose?
7 A. Exactly.
8 148 Q. You just assume you didn't get some or did you
9 subsequently learn that they had been issued and you
10 hadn't been told? 14:18
11 A. In the process of doing my Section 21 then I was able
12 to go back and look at Early Alerts that had been
13 shared. I think I have a schedule in there of some
14 that we got. And, as an Non-Executive Director, I know
15 that I would have got some coming through and from 14:18
16 conversations we would have had as Non-Executive
17 Directors with the Chair and Chief in the past, we
18 would have been asking about Early Alerts and having
19 that shared. So we knew this Early Alert process was
20 there, it would come our way sometimes but not all the 14:18
21 time.
22 149 Q. We'll look at some of the ones you received and your
23 comments on that in a moment, but just while we are at
24 this particular one which sort of sets the ground work
25 for future actions of the Board. It was sent by 14:19
26 Stephen Wallace on 3rd August 2020 and the subject is:
27
28 "Confidential, Early Alert, Urology, July 2020."
29

1 It's addressed to "Dear Roberta". There is no
2 recipient, but it says:
3
4 "Dear Roberta, please find attached an Early Alert
5 regarding urology for your information. As per 14:19
6 regional Early Alert processes, the Board and
7 Department have been provided with the attached
8 information. Dr. O'Kane has spoken to the CMO office
9 to advise of the content. The CX..."
10 14:19
11 Which we know to be the Chief Executive:
12
13 "...has also been made aware. Please note, given the
14 sensitivities and ongoing processes surrounding this
15 issue, the internal circulation list has been limited 14:19
16 and we ask that this is not shared wider at this stage.
17 Regards, Stephen."
18
19 And Stephen Wallace was the Interim Assistant Director
20 of Clinical and Social Care Governance. Does he still 14:20
21 hold that post, Mr. Wallace?
22 A. No, he doesn't.
23 150 Q. Now there is no circulation list on this email so we
24 don't know -- but it wasn't sent to you?
25 A. No, this wasn't sent to me. 14:20
26 151 Q. Do you know who else received it? I know Mrs. Brownlee
27 received it, but do you know who else would have
28 received this email and the Early Alert at that point?
29 A. I would suspect the Chief Executive got a copy.

1 Certainly all of them that's coming from the Medical
2 Director, it would have went to -- the Board they are
3 referring to there is the Health and Social Care Board,
4 not the Board of the Trust or the Department. So I'm
5 not sure if it went any further than that, I don't 14:20
6 know.
7 152 Q. Did you see this email just for the first time because
8 of the Inquiry disclosure?
9 A. Correct.
10 153 Q. Do you understand what the second paragraph means 14:21
11 "given the sensitivities and ongoing processes
12 surrounding this issue", do you have any understanding
13 of what that refers to? Given Early Alerts usually do
14 contain sensitive and ongoing issues, do you take that
15 to indicate that there was something in particular 14:21
16 about this Early Alert that made it different from
17 others?
18 A. Yeah, because Early Alerts that we get now say "please
19 find Early Alert attached", the reference and who it
20 has come from. This one, you can check, or we can 14:21
21 check certainly, I'm nearly sure that this email,
22 because I would have included a copy within my
23 statement, is only to our former Chair Roberta
24 Brownlee. That second paragraph for me, I suppose I'm
25 taking it is in relation to Mr. O'Brien and 14:21
26 Mrs. Brownlee.
27 154 Q. Do you take that to be the case because of information
28 that you have learnt from the Inquiry or because you
29 know something else?

1 A. Oh, no, from the Inquiry and the process of the
2 Inquiry.
3 155 Q. Now, Mrs. Brownlee didn't bring this to the Board,
4 didn't raise this, didn't address any of the issues in
5 this with you at that point? 14:22
6 A. At that point, no.
7 156 Q. Given that you have had a look at it now, you were
8 provided with a copy of it, do you think it is
9 something that should have been shared with the Board?
10 A. Oh, yes. 14:22
11 157 Q. And had it been shared with the Board, just based on
12 your experience, your tenure at that time, your
13 knowledge of the Trust, what do you think would have
14 been the actions of the Board or what do you think the
15 process would have been once the Board, if they had 14:23
16 have seen this Early Alert?
17 A. Yeah. Could you just remind me, the date of the Early
18 Alert was 31st July?
19 158 Q. Yes.
20 A. Yes. If that Early Alert had have been shared with all 14:23
21 Trust Board members at the same time as it went to the
22 Department, that certainly would have triggered a
23 response particularly from Non-Executive Directors in
24 terms of the seriousness of it and the patient safety
25 issues that were contained within. For me that would 14:23
26 have warranted an urgent meeting of the Trust Board.
27 159 Q. In fact the meeting that did take place the next time
28 was 27th August meeting that we just looked at?
29 A. Yeah, but that wasn't a Trust Board meeting, that was a

1 workshop. So our next formal meeting was in September,
2 which was way too far out. If you are looking at the
3 timeline, from 31st July towards the end of September,
4 there is eight weeks of time where the Trust Board
5 could have had a deeper understanding of what was going 14:24
6 on, and certainly issues which I suspect you will come
7 on to, being able to manage some of the issues that
8 evolved around this process.
9 160 Q. I just want to ask you about an email that you sent on
10 the same date, 27th August 2020, WIT-101126, I just see 14:24
11 the timing of this email, it is from you and it is sent
12 on 27th August 2020 at 12:17, would that have been
13 after the workshop or?
14 A. At lunchtime, quite possibly after, yeah. I know we
15 started in the morning. 14:25
16 161 Q. There are no times on the workshop, I wasn't sure. So
17 to Roberta Brownlee, Shane Devlin, then Sandra Judt,
18 Jennifer Comac, Elaine Wright. The subject is "blind
19 spots". You say:
20 14:25
21 "Both the Muckamore report provides a great opportunity
22 for the Trust Board to take a look at its blind spots.
23 If a workshop could be planned, I think that would be a
24 great use of time for all. We don't know what we don't
25 know, and it is good to hear if anything is keeping our 14:25
26 directors awake, or is bubbling up for them.
27
28 Regarding the Board composition and the pending loss of
29 yourself, Siobhán, Martin's time out and first terms

1 ending for some, this needs to be flagged and I know
2 you do. Last year the Commissioner for Public
3 Appointments initiated a process where Non-Executive
4 Directors would not be offered a reappointment without
5 running a recruitment competition. That then brings 14:26
6 its own challenges as we are not sitting at the end of
7 August and a typical process can take six to nine
8 months."
9
10 So some of the points that you have mentioned already 14:26
11 in your evidence, the time to recruit. I think I was
12 the one who said that you had mentioned we don't know
13 what we don't know, I thought it was in your statement
14 but it was in this email. Just wondering about the
15 timing of the email on the same day, there may be 14:26
16 absolutely nothing in it, but given that it is entitled
17 "blind spots", I know you have mentioned the Muckamore
18 report, but I was just wondering if there was anything
19 that triggered in you a concern that perhaps there was
20 a need to look at information that was being provided 14:26
21 just a little bit more deeply and if it could have been
22 the content of the meeting on the workshop on
23 27th August, I know it's asking you to cast your mind
24 back, but is it entirely coincidental?
25 A. I think it is. But then, as you ask me, that meeting 14:27
26 where it was raised, certainly there will be a sense of
27 tension at that point in time which it would be hard
28 not to feel, you being a part of that meeting. So did
29 that trigger for me? I honestly, I can't say that it

1 did. But certainly this is the kind of thing that
2 I would think about in relation to how we ensure that
3 we are allowing our directors and enabling them the
4 opportunity to state out loud any concerns that they
5 have, outside of the realms of a formal meeting as 14:28
6 well.
7 162 Q. So it was another way of trying to get to the
8 information that you needed. Is it possible you were
9 triggered by the revelation at the meeting?
10 A. It could be, it could be possible. 14:28
11 163 Q. Just for completion I just want to read in what you
12 have said about the Early Alerts in your statement, if
13 we go to WIT -- sorry, was there any reply to this
14 email?
15 A. What email? This one? 14:28
16 164 Q. Yes.
17 A. I don't think so. I don't think so, it would have been
18 in my statement, I don't think so, or it should have
19 been.
20 165 Q. We will go to the Early Alerts, your comments on that, 14:28
21 WIT-100464. We had asked you about "how do you ensure
22 that the Board is appraised of concerns against
23 applicable standards" and you've used the Early Alert
24 as an example. But you start off by staying, at 15.1:
25 14:29
26 "As Chair of the Trust Board I ensure that the Board is
27 appraised of both serious concerns as well as current
28 Trust performance against applicable standards of
29 clinical care and safety through the mechanisms

1 outlined in my response to question 13 above. As Chair
2 I have adopted a firm position on the need for the
3 Trust Board to be notified first of any significant
4 issues arising outside of the scheduled Board meetings.
5 I understand fully that a balance needs to be struck in 14:29
6 that a certain level of validated information is
7 required before escalation of a concern to Board.
8 Nevertheless, I have operated a no-surprises approach
9 with the current and previous Chief Executives. Chair
10 and CEO meetings provide for a formal and informal 14:30
11 space for CEO to raise concerns or issues. I am
12 content with this approach."
13
14 And you say at 15.3:
15 14:30
16 "Prior to 18th September 2020, Early Alerts were only
17 shared with the former Chair. These alerts are issued
18 through the Corporate Governance team by email. Since
19 18th September 2020, Early Alerts are now shared with
20 all board members. I have set out below some examples 14:30
21 of Early Alerts received by the former Chair which were
22 shared with the Non-Executive Directors, along with the
23 date of such sharing."
24
25 Then you set them out below that. 18th September 2020, 14:30
26 that was before you took up post as Chair?
27 A. That's correct.
28 166 Q. What was it about that date that there was a decision
29 made that all Early Alerts are shared with Board

1 Members, how did that come about during Mrs. Brownlee's
2 tenure?
3 A. I don't know. But, if you don't mind, I think it would
4 be important, because of what we talked about
5 previously in relation to sharing of Early Alerts and 14:31
6 I said as Non-Execs we would have got some. The
7 inference there is that the Early Alerts, what it says
8 there is Early Alerts were only shared with the former
9 Chair. Some of them would have been forwarded on to us
10 as Non-Execs, so it wasn't that they came to us 14:31
11 directly. They didn't come to us directly - previously
12 - they now come to us directly.
13 167 Q. Okay. They came through the Chair previously then?
14 A. Came through the Chair previously.
15 168 Q. That is where there was the ability for some to reach 14:31
16 you and some not?
17 A. Yes.
18 169 Q. Okay. Just so I don't forget to mention, Mr. Lunny has
19 helpfully suggested that the time of the workshop was
20 at 9:15, relying on WIT-101541. Just to put the 14:32
21 timeline then, that your email was probably at
22 lunchtime, as you said, and the workshop was in the
23 morning?
24 A. Yeah.
25 170 Q. It may well have lasted all day, I don't know? 14:32
26 A. Yeah, and it's virtual.
27 171 Q. It's virtual.
28 A. Because I was wondering, like was I sitting in the
29 middle of a meeting writing an email which would have

1 been wrong.
2 172 Q. So you were multitasking?
3 A. Yes.
4 173 Q. Okay. You've given the Panel the Early Alert
5 references, the ones that were sent to Roberta Brownlee 14:32
6 and then when they were forwarded on. So all of those
7 seem to have been provided?
8 A. Yes.
9 174 Q. So again you have just emphasised that it was
10 inappropriate in your view, it wasn't adequate is what 14:33
11 you have said for it not to be shared?
12 A. Yes.
13 175 Q. If we go to WIT-100482. You refer to the Early Alert
14 again at this point and you say, at 22.7:
15 14:33
16 "In relation to urology specifically and, as mentioned
17 at question 15 above, an Early Alert was issued on
18 31st July 2020. I have no record of receiving this
19 Early Alert during July or August. However, I received
20 confirmation that the former Chair, Roberta Brownlee, 14:33
21 was notified with a copy of the Early Alert on
22 3rd August 2020. As also mentioned above at question
23 15 at a Trust Board workshop on 27th August 2020 under
24 agenda item 6, 'Update from executive directors,
25 verbal', the then Medical Director, Dr. Maria O'Kane, 14:34
26 brought a governance issue to the Board's attention,
27 namely an SAI investigation into clinical concerns
28 involving a recently retired consultant urologist.
29 Members asked that this matter be discussed at the

1 confidential Trust Board meeting immediately following
2 the workshop.
3
4 At the ensuing confidential Trust Board meeting on
5 27th August, Dr. O'Kane brought to the Board's 14:34
6 attention the SAI investigation into concerns involving
7 the urologist in question. Members requested a written
8 update for the next Trust Board meeting."
9
10 Then you say: 14:34
11
12 "This item was then brought to the next confidential
13 Trust Board meeting on 24th September 2020 with a
14 detailed paper provided by Dr. O'Kane and presented by
15 Dr. Damien Gormley. This is also when board members 14:34
16 other than the Chair were first notified that an Early
17 Alert had been submitted, although the date of its
18 submission was not clarified until the meeting of
19 22nd October. Further updates were provided to the
20 Board on 12th November 2020 and 10th December 2020 and 14:35
21 the issue has subsequent remained on the confidential
22 Trust Board agenda."
23
24 Just the earlier paragraph, you mentioned the SAI and
25 the information that was provided, what's the position 14:35
26 now when SAI information is provided to the Board, is
27 there more of an interrogation of the governance themes
28 even while the investigation is ongoing or do you find
29 out about it at the end, what's the current process?

1 A. What has happened is in relation to serious adverse
2 incidents, a serious SAI that has come to us, they are
3 all serious, but a significant one has come to the
4 Board, it will come with an action plan, an update on
5 an action plan from the appropriate directors. That 14:35
6 will be quizzed then by the board members, then with
7 either an update to come back at three or six months,
8 depending on the nature of that. In some cases it
9 maybe delegated down to a committee for closer
10 observation. 14:36
11 176 Q. We talked earlier about the box or the escalation table
12 that had to be filled in and that was a way of
13 triggering people to remember about that, is there
14 anything similar at Board level that prompts
15 consideration of patient safety issues or risk in SAIs 14:36
16 or any other governance, does anyone automatically say
17 'okay, that sounds like we need to do a risk assessment
18 or look at patient safety', is that an ad hoc thing or
19 is it more formal?
20 A. It's not formal, it just happens. It will either come 14:36
21 from a Member of the Board or indeed the director
22 reporting may highlight that there is a patient safety
23 issue. If you want I can give you a short example?
24 177 Q. Yes, please.
25 A. Okay. So, our Director of Nursing, Allied Health 14:36
26 Professional and Midwifery reported to a Governance
27 Committee meeting, at the end of the meeting, only some
28 months ago about concerns that she had in relation to
29 one of our wards within Craigavon Area Hospital. It's

1 staffed predominantly - it's an uncommissioned ward
2 which means we are not funded for the beds or the staff
3 - but the ward is full of patients. It is staffed by
4 agency and locums which brings higher levels of risk
5 and there had been a number of incidents. She raised 14:37
6 this at the Governance Committee to say that she had
7 serious concerns about this, that she wanted governance
8 to know. As a result of that then there was a
9 commitment to come back with an update and an action
10 plan on what was taking place. That happened, but also 14:37
11 in between that then that was noted up to Trust Board
12 and the actions that were being taken.
13 178 Q. If we go back to the statement that you have made about
14 the Early Alert. When you say that the item was
15 brought to the next confidential Trust Board meeting on 14:38
16 24th September and board members were first notified of
17 the Early Alert had been submitted. Then you say:
18
19 "Although the date of its submission was not clarified
20 until the meeting of 22nd October." 14:38
21
22 Can you give us a bit of context for that?
23 A. I can. I think it was Shane Devlin had said that the
24 earlier it was sent up, the question was raised when
25 was that sent, and that couldn't be answered at that 14:38
26 meeting. So the answer was given at our next meeting
27 in October.
28 179 Q. So it was more just a follow up of the administrative
29 date rather than any difficulty getting information?

1 A. Yeah.
2 180 Q. If we go to WIT-100486. I just want to go through this
3 just to make sure that we have covered what information
4 you were given. You've reflected on this in your
5 statement, you have said this in your evidence as well, 14:39
6 at 25.2:
7
8 "The Trust Board were made aware of a consultant being
9 excluded from practice at its meeting on 27th January
10 2017. I now know the consultant was Mr. O'Brien but 14:39
11 did not know that in January 2017. This was I believe
12 an appropriate point at which to raise an issue of
13 potential concern with the Board. The issue having been
14 raised, the Trust Board members including me did not
15 question or dig deeper into the situation and on 14:39
16 reflection perhaps we ought to have been more curious,
17 if not on 27th January then perhaps in the months that
18 followed when no further updates were provided."
19
20 Now you mentioned the meeting then in August and in 14:39
21 September and there were no further updates. Just from
22 your own perspective is there any reason now why nobody
23 followed any of that up? I mean, even on reflection do
24 you think it was an assumption that it was being dealt
25 with, was it simply that? 14:40
26 A. In August or January? In January 2017 or in August?
27 181 Q. August, August 2020.
28 A. My view on it is that we were given the headline of the
29 issue, it was being raised at Trust Board and a

1 detailed paper was going to come to us. This was being
2 raised -- this wasn't a Trust Board meeting. If it had
3 have been, then the expectation would have been that it
4 would have been an agenda item under confidential.
5 This wasn't an agenda item in August for either the 14:40
6 workshop or the confidential meeting. If you go
7 through the timeline of 7th June through to the Early
8 Alert on 31st July through to the workshop and the
9 confidential meeting, then if that information had have
10 come out sooner it could have been an agenda item and 14:41
11 it could have had the paper that came, it could have
12 had, depending on, obviously, the team would have had
13 to have concluded their work ensuring that they had all
14 the information correct before they come. But it could
15 have happened that it would be an agenda item in August 14:41
16 with the papers to discuss. We had no agenda item, no
17 papers to discuss, that came in September, which, in my
18 view, is why there was limited discussions or
19 questions.
20 182 Q. At what point do you think you were adequately informed 14:41
21 about the issues? When did you start to think we are
22 getting a handle on this or this is more concerning,
23 what was the stage for you in the chronology?
24 A. The September meeting.
25 183 Q. Did that meeting then, did that involve more questions 14:41
26 from you or anyone else?
27 A. Oh, it certainly did, it certainly involved a lot of
28 questions and commentary from board members. It
29 certainly raised a significant red flag in terms of the

1 seriousness of what had happened.
2 184 Q. The Panel has heard evidence then of the steps that
3 were taken up to and including the establishment of the
4 Public Inquiry, the different aspects, the look back
5 review and the Royal College of Surgeons and the 14:42
6 ongoing review; when you look at that now, do you feel
7 that from that point on in September that the steps
8 taken by the Board were sufficient?
9 A. From September? Sufficient in part but not in full.
10 185 Q. Okay. What might have been done differently, now 14:42
11 looking back at events as they unfolded with the
12 benefit of hindsight?
13 A. I think the Board should have -- we should have had
14 dedicated meetings in relation to this from September
15 onwards and not as part of other confidential meetings. 14:43
16 I think we should have been meeting and getting updates
17 in terms of the progress, mindful, obviously, that all
18 these processes need to go on and us, as Non-Executive
19 Directors and board members, need to get assurance that
20 these are happening in the right way and the right 14:43
21 timelines, but to give it the appropriateness of its
22 place in terms of the importance of what has been
23 presented to us.
24 186 Q. So apart from regular meetings or perhaps more focused
25 meetings on the subject matters arising, could there 14:43
26 have been any more proactive actions the Board might
27 have taken around patient safety risk in order to
28 ensure that going forward things were -- you had
29 received enough assurance that everything was being

1 done operationally that was necessary?
2 A. I think we did. The SAI reviews, the lookback reviews,
3 we had the external reference group that was
4 established. We had the oversight assurance group from
5 the Department that was established. There was regular 14:44
6 updates coming to the confidential Trust Board meeting
7 on progress that was being made. So certainly the work
8 that is being done to assure, to be clear on what
9 happened, to provide assurance on the steps that were
10 being taken to build in improvements has certainly all 14:44
11 been coming since then, I'm comfortable with that.
12 I think as a Trust Board, we could have handled our
13 meetings better in terms of our question and our
14 exploration in the early parts.
15 187 Q. Now there were concerns and Mr. O'Brien has raised 14:45
16 concerns about the adequacy of the service, the
17 staffing and historical concerns and other current
18 concerns. You mention that in your statement at
19 WIT-100515, paragraph 34.1, and you say:
20 14:45
21 "I received an email from Sandra Judt, Board Assurance
22 Manager, on instruction from Mrs. Roberta Brownlee on
23 11th June 2020 with other Non-Executive Directors a
24 copy of a letter sent by Mr. O'Brien to the former
25 Chair, Mrs. Roberta Brownlee, on 10th June 2020. This 14:45
26 letter raised concerns in relation to the ongoing HR
27 process, Mr. O'Brien's request for retirement and his
28 request to return on a part-time basis post retirement.
29 This was an operational HR issue which was being dealt

1 with through the director of HROD, Mrs. Vivienne Toal,
2 in conjunction with the Medical Director, Dr. Maria
3 O'Kane."
4
5 You say at 34.2: "The former Chair, Mrs. Roberta 14:46
6 Brownlee, raised receiving the letter at the
7 confidential meeting dated 22nd October 2020."
8
9 So this was a letter sent but the Board or you took the
10 view that this was a staffing issue, a human resources 14:46
11 issue and therefore operational in nature?
12 A. Yeah.
13 188 Q. Would it be usual for the Board to receive any
14 documentation in relation to employment matters within
15 the Trust or would that normally be carved out as being 14:47
16 operational?
17 A. It wouldn't be. It wouldn't be unusual because people
18 can email and communicate with the leadership of the
19 Trust quite easily. So people can write in, send an
20 email or put a call in to the Chair or Chief 14:47
21 Executive's offices, so that wouldn't be unusual. And
22 it's not unusual for staff to raise concerns at Board
23 level either, that has happened in the past too.
24 189 Q. So who makes the decision then if letters are sent in
25 about employment issues or HR issues, who makes the 14:47
26 decision whether those correspondences make their way
27 to the Board, would that be Vivienne Toal?
28 A. No, they can actually just write to the Chair directly.
29 190 Q. Such as this example?

1 A. Yeah.
2 191 Q. But the outcome of that was that it didn't find its way
3 for consideration by the Board because it was deemed to
4 be a HR/operational issue, if I am reading that
5 paragraph correct? 14:48
6 A. I deemed it -- I deemed it to be operational. On
7 receipt of that I deemed it to be operational because
8 it was about his employment.
9 192 Q. And so it didn't find its way to the Board?
10 A. It did find its way -- 14:48
11 193 Q. Apart from Mrs. Brownlee, but it wasn't discussed?
12 A. No.
13 194 Q. No, that's the point?
14 A. It did find its way, sorry.
15 195 Q. That is the point. It didn't find its way to the 14:48
16 agenda, I suppose, I should have said?
17 A. No, it did not.
18 196 Q. Would that be the decision? So, for example, if there
19 was correspondence between Mr. O'Brien and the Chief
20 Executive about HR issues, issues around employment, 14:48
21 you would expect that to be dealt with by the Chief
22 Executive and for him to exercise his judgment whether
23 it should ever come to the Board?
24 A. Yes.
25 197 Q. Now, when you found out in the September that it was 14:49
26 Mr. O'Brien was the consultant and you say that that
27 was really the start of their being a bit more
28 investigation or questions asked or perhaps more
29 focused attention given to the issue, would you expect

1 to be provided with documentation in relation to, for
2 example, the MHPS procedure that would have informed
3 you of Mr. O'Brien's view on what was alleged against
4 him or his response to the investigation, would they be
5 documents that should have or might have informed the 14:50
6 Board's view of risk or patient safety if you had seen
7 what the response was to the allegations, would that be
8 something that normally would find its way?
9 A. No, it's not something that would find its way, nor
10 would I expect it to find its way to the Board. But 14:50
11 what I would expect is that there is an escalation
12 then, when the director responsible, which would be the
13 Medical Director, knows this information, then it is
14 shared, escalated.
15 198 Q. So rather than see the actual originating documents you 14:50
16 would expect to be given the context of 'well the
17 consultant says this', reported secondhand but given
18 the information nonetheless?
19 A. Yep.
20 199 Q. Does that also apply for the case manager's 14:51
21 determination in the case, Dr. Khan, you didn't ever
22 see that?
23 A. No, and I wouldn't expect to see that either.
24 200 Q. Again is that something that you would expect to be
25 reported on rather than be provided? 14:51
26 A. Yeah, that's reported on and, if helpful, I can talk
27 about the process now in terms of reporting from MHPS
28 to the Governance Committee, but if not I can...
29 201 Q. Oh, yes, please do, that would be helpful.

1 A. Okay. So a new process has been put in place. Up
2 until obviously the Inquiry, MHPS was just something
3 that was mentioned or noted in terms of exclusion. The
4 process that's now in place at a confidential
5 Governance Committee includes the MHS process for 14:51
6 doctors and dentists. We also have a nurses in
7 difficulty report from our Executive Director of
8 Nursing and there is the building of one for social
9 works through our Executive Director of Social Work,
10 MA2S process; details when the case started, who the 14:52
11 case manager is, case investigator is, who is the named
12 Non-Executive Director. It gives you a small synopsis
13 of what the issue are, and it details then any
14 outworkings and updates that comes to us at a
15 confidential Governance Committee every quarter. So 14:52
16 you can see very clearly, four, five, six cases. At
17 the next meeting you will see that cases have
18 concluded, there is a new one there. There is that
19 visibility for everybody in terms of the MHPS processes
20 that are under way within the Trust. 14:52
21 202 Q. So it's like a dashboard that gives you an immediate
22 overview?
23 A. Correct.
24 203 Q. With a bit more detail perhaps. So along the same
25 lines as what you might expect to see or not, would you 14:52
26 ever expect to see a formal grievance from a consultant
27 as a result of him being exposed to a procedure that he
28 is not content with, again is that something that would
29 be reported, the content of it but not provided?

1 A. No, I wouldn't expect to see the grievance within the
2 HR discipline and then process then through the Chief
3 Executive unless it needs escalated.
4 204 Q. What about a referral to the GMC or a deferral of
5 re-validation, would they be matters that you might 14:53
6 expect to see?
7 A. Yeah. That comes through on the confidential
8 governance for MHPS, but it also would come through on
9 the medical director's report on re-validation and
10 appraisals. 14:53
11 205 Q. So any addendum to a formal grievance would fall into
12 the same category as the original grievance, it
13 wouldn't come up?
14 A. Yep.
15 206 Q. I wonder if we could go to your statement at 14:53
16 WIT-100553, we'll move on to these in full in a moment,
17 but I just want to ask you about one issue. Just move
18 down to the second bullet point. So, at WIT-100554,
19 you identify one of the issues as "the doctor was
20 unwilling to be managed." You say: 14:55
21
22 "It appears to me that Mr. O'Brien did not want to be
23 managed and was resistant to changing any of his
24 problematic practices. I believe he attempted to
25 thwart processes that were begun to address some of his 14:55
26 issues, including threatening legal action. I also
27 believe that he used his close relationship with the
28 Chair of the Board as a tool to directly/indirectly
29 warn people off."

1 I just want to ask you about that. Do you recall just
2 a couple of moments ago when I was asking you about did
3 you see Mr. O'Brien's answer to the MHPS, did you see
4 his grievance, you would have expected summaries or
5 overviews of those to be provided but not the actual 14:55
6 documents; do you recall seeing any of those summaries
7 of documents or anyone saying he has put a grievance in
8 or he says this about the MHPS or he has added this
9 addendum in where he has set out his reply to all of
10 the allegations, do you remember getting that sort of 14:56
11 information?
12 A. No. And, just for clarity, I wouldn't expect a
13 summary. What I would expect is the director
14 responsible to be able to escalate to the Board and the
15 committee where it is needed. I wouldn't expect the 14:56
16 Board to get summaries of grievances from doctors,
17 nurses or social workers across the piece. But
18 certainly the director responsible needs to be showing
19 where there is concerns and what they are doing about
20 it and if there is, obviously, trends there in relation 14:56
21 to individuals or more.
22 207 Q. I suppose that's what I meant by a summary, basically
23 giving you the bullet points of what the position is.
24 And the reason I am asking you that is, I want to
25 understand, when you say "I believe he attempted to 14:57
26 thwart processes", what you mean by that and where you
27 got the information from about his attempt to thwart
28 processes?
29 A. Okay. So in preparing my Section 21 then I have an

1 array of information that I can glean from as well as
2 the transcripts and the work of the Inquiry to date.
3 So what I am saying there is, from my observations,
4 that there was pauses, delays, challenges, all of those
5 put a huge delay in the process of MHPS. That for me, 14:57
6 it certainly came across to me that there was an
7 attempt to thwart the process, to delay it, to stop it,
8 to pause it, to slow it down, whatever the case may be.
9 Certainly from the evidence that I have read in
10 relation to his approach around stating his legal 14:58
11 links, for the want of a better word.
12 208 Q. So it's mostly your information around that comes from
13 the Inquiry rather than anything at the time that you
14 knew or were made aware of?
15 A. No, that's right. 14:58
16 209 Q. And of course Mr. O'Brien would say that putting in a
17 grievance or seeking legal advice or having recourse to
18 legal action against an employer that in his view he
19 has acted unlawfully are just proper recourses for him
20 that are available should he wish to follow that route 14:58
21 rather than representing any threat for legal action,
22 they are simply avenues of redress for him, would you
23 accept that, that there are legitimate avenues for him
24 to pursue?
25 A. Oh, absolutely, yes. 14:59
26 210 Q. Again when you make reference to his close relationship
27 with the Chair of the Board as a tool to directly,
28 indirectly warn people off, again that's information
29 you received as a result of the Inquiry's data?

1 A. Yes.
2 211 Q. Rather than anything that you know personally?
3 A. No.
4 212 Q. Thank you. Sorry for that detour but I just wanted to
5 make sure I had given you the opportunity to comment on 14:59
6 issues that have arisen or may arise.
7
8 I just want to ask you some questions about
9 Mrs. Brownlee. It's clear from the statement, and I'm
10 sure evidence that you have heard, that you now know 15:00
11 that she had a friendship with Mr. O'Brien, can you
12 just give us the context of when you found out about
13 that, what your understanding was before you found out
14 about that, if you had any idea that she had a close
15 friendship with him. 15:00
16 A. I had no idea to the depth and the extent of their
17 friendship, which obviously has come out as a result of
18 the Inquiry. But even just at that September meeting,
19 and I think I put it in my statement, a quick Google
20 search told me that they were both on the Board of a 15:00
21 charity for a number of years and their relationship
22 went back sometime. So my observations on that,
23 I wouldn't necessarily know who is friends with who
24 within the Trust, but as a result of this and the
25 interactions and observations I had from the period of 15:01
26 August through to November was certainly clear to the
27 extent of that relationship for our former Chair
28 Mrs. Brownlee.
29 213 Q. If we just put in context what may have been

1 complicating about that when you look at the role of
2 the Chair and the expectations around the revelation
3 about conflicts of interest or potential conflicts of
4 interest. The meetings and agendas always give the
5 opportunity for anyone to declare potential conflicts 15:01
6 of interest, I am sure you are familiar with that, it
7 is just a general caveat for everyone at the start of a
8 meeting, if any matter is on the agenda just declare
9 them. And in fact there is an example of you having
10 done so, if we just go to that, a meeting on 26th May 15:02
11 2016 at TRU-109276.
12
13 I'm just simply going to read out what the minute says
14 just to indicate that you properly made a declaration.
15 You'll see there at paragraph 2: 15:02
16
17 "Declaration of interest. The Chair requested members
18 to declare any potential conflicts of interest to any
19 matters on the agenda. Ms. Eileen Mullan declared an
20 interest in Unison." 15:02
21
22 And the Chair at this point was Mrs. Brownlee?
23 A. Correct.
24 214 Q. There are also examples earlier than that, just before
25 your time, but when Mrs. Brownlee was Chair and for the 15:02
26 Board's note, evidence of members of the Trust Board
27 being reminded of their codes of conduct during the
28 relevant period. An example of that is found within
29 the minutes of the public Trust Board meeting of

1 30th August 2012 at TRU-106646. You'll see at
2 paragraph 2: "There were no declarations of interest
3 in relation to any of that."
4
5 Then it goes on to note, at paragraph 3.1: "Revised 15:03
6 codes of conduct and accountability. The revised codes
7 of conduct and accountability have been issued to board
8 members on 19th July 2012 together with a covering
9 letter from the Chairman. The Chairman reminded board
10 members of the importance of subscribing to these codes 15:03
11 and demonstrating high standards of corporate and
12 personal conduct."
13
14 Was Mrs. Brownlee the Chair in 2012, do you recall?
15 A. I believe so. 15:04
16 215 Q. And then, under point 2:
17
18 "Board meeting etiquette. The Chairman had written to
19 board members on 9th August 2012 outlining good
20 practice principles for Board and Committee meetings." 15:04
21
22 Then we have another example in 2017, again you were an
23 NED at this point, a letter dated 24th March 2017, at
24 TRU-113435. Now, this is a letter from the Department
25 of Health to the Chairs of the health and social care 15:04
26 Arm's Length Bodies and NIFRS.
27 A. Northern Ireland Fire and Rescue Service.
28 216 Q. The Department say:
29

1 "Dear Chairs, conflicts of interest. In response to a
2 query raised at the Departmental Board, I wish to take
3 the opportunity to remind Non-Executive Directors of
4 the requirement for board members of public bodies to
5 act appropriately when a conflict of interest situation 15:05
6 arises. All NEDs must discharge their duties in line
7 with the Seven Principles of Public Life and any
8 conflict of interest must be identified and managed in
9 a way that safeguards the integrity of board members
10 and maximises public confidence in the organisation's 15:05
11 delivery of public services.
12
13 I would draw your attention to the attached codes of
14 conduct on accountability that all NEDs will have
15 received on appointment. In particular I draw your 15:05
16 attention to paragraph 8 on public business and private
17 gain. I ask that all your Non-Executive Directors take
18 the opportunity to refamiliarise themselves with the
19 contents of the codes."
20 15:06
21 And then gives a website for more detailed guidance on
22 that. Then the code of accountability sets out the
23 requirement that Chairs and all board members declare
24 any conflict of interest, and that code can be found at
25 TRU-113448. 15:06
26
27 At paragraph 20, it says:
28
29 "Declaration of interests: It is a basic requirement

1 that Chairs and all board members should declare any
2 conflict of interest that arises in the course of
3 conducting HSC business. Chairs and board members must
4 declare on appointment any business interests, position
5 of authority in a charity or voluntary body in the 15:06
6 field of health and social care, and any connection
7 with a voluntary or other body contracting for HSC
8 services. These should be formally recorded in the
9 minutes of the Board. Directorships and other
10 significant interests held by members of HSC Boards 15:07
11 must be declared on appointment, kept up-to-date and
12 set out in the annual report.
13
14 In addition the HSC Boards must keep a register of
15 interests appropriate to the body's activities. The 15:07
16 register should, as a minimum, list direct or indirect
17 pecuniary interests which members of the public might
18 reasonably think could influence board members'
19 judgment. Board members are urged to register
20 non-pecuniary interests which relate closely to the 15:07
21 body's activities and interest of close family members
22 and persons living in the same household as the Board
23 Member."
24
25 Paragraph 22: 15:07
26
27 "Registers of interests must be open to the public.
28 Details of how access can be obtained should be made
29 widely available and included in annual reports.

1 Registers of interests should be published annually."
2
3 So that's the groundwork for the expectation around
4 conflict of interest. I don't imagine any of that is
5 news to you given that you triggered your own conflict 15:08
6 whenever you thought it was appropriate.
7
8 If we go back to your statement at WIT-100547, just at
9 the very bottom. I just want to look at the start of
10 the table to see the heading that you have given to 15:08
11 this. This is paragraph 47.1 where you say:
12
13 "I am now aware of governance concerns arising out of
14 the provision of Urology Services as follows."
15 15:09
16 And we will look at those in a moment, but I want to go
17 back down to WIT-100547 just at the bottom, the heading
18 is:
19
20 "Declaration of conflict and interest and management of 15:09
21 it. I was unaware of the extent and depth of the
22 relationship between Mrs. Brownlee and Mr. O'Brien.
23 When I now consider the confidential Trust Board
24 meetings and the meetings between Chair, CEO and NEDs
25 between August and the end of November 2020 I see an 15:09
26 inconsistent approach by the former Chair from making
27 no declaration of interest at one meeting to declaring
28 an interest and leaving another meeting, to denying an
29 interest yet still leaving another meeting.

1 As a result of evidence now before the Inquiry it
2 appears to me that there was a clear conflict of
3 interest for the former Chair. The Trust Board should
4 have been made aware of the extent and fullness of the
5 relationship between her and Mr. O'Brien. At the 15:10
6 October 2020 meeting when I realised there was more to
7 this issue, a very simple Google search revealed to me
8 that the former Chair and Mr. O'Brien had governance
9 roles in a charity. At this point the Chief Executive
10 Shane Devlin raised the conflict with the former 15:10
11 Chair."
12
13 And you quote: "The Northern Ireland Audit Office
14 defines a conflict of interest as: 'A conflict of
15 interest involves a conflict between the public duty 15:10
16 and the private interest of a public official in which
17 the official's private capacity interest could
18 improperly influence the performance of his/her
19 official duties and responsibilities'."
20 15:10
21 It further explains: "The interest in question need
22 not be that of the public official or Board Member
23 themselves. It can also include the interests of close
24 relatives or friends and associates who have the
25 potential to influence the public official or Board 15:10
26 Member's behaviour."
27
28 (b): "As a benchmark, a close relative would usually
29 refer to the individual's spouse or partner, children,

1 adult and minor, parent, brother, sister, inlaws and
2 the personal partners of any of these. For other
3 relatives it is dependent upon the closeness of the
4 relationship and degree to which the decisions or
5 activity of the public entity could directly or 15:11
6 significantly affect them."
7
8 (c): "Where an individual has to declare interests of
9 this nature, they may wish to seek advice from a senior
10 public official or the Board Chairman to ensure all 15:11
11 potential conflicts are identified."
12
13 (d): "A friend or associate should be considered as
14 someone with whom the individual has a long standing
15 and/or close relationship, socialises with regularly or 15:11
16 has had dealings with which may create a conflict of
17 interest.
18
19 The NIAO provides a checklist in their good practice
20 guide as shown below." 15:11
21
22 Then there is an actual tick box that one has to fill
23 in if you want to recognise a conflict of interest.
24 Then you give a declaration or a summary of the Chair's
25 declaration or non-declaration of interests. 15:12
26 You say:
27
28 "At the confidential Board meeting on 27th August the
29 minutes of that do not indicate that Mrs. Brownlee

1 declared any interest nor that she left the room for
2 any part of the meeting."
3
4 And that was the meeting where Dr. O'Kane brought the
5 SAI investigation through, you will remember. There 15:12
6 was also the meeting on 24th September 2020, the
7 minutes of that can be found at TRU-130822, if we just
8 go to that, please, for a moment. Sorry, just in
9 advance of paragraph 7:
10 15:13
11 "The Chair left the meeting for the discussion on the
12 next item. Mrs. Leeson took over as Chair at this
13 point."
14
15 And item 7 is Urology. I'll just read the first 15:14
16 sentence:
17
18 "The Chief Executive set the context to this item by
19 advising that there is likely to be significant media
20 interest and reputational issues with this case." 15:14
21
22 So on 24th September Mrs. Brownlee left the meeting.
23 Is it the case that when you declare a conflict of
24 interest that you simply have to declare the conflict
25 without giving any context, is it normal just to say 'I 15:14
26 have a conflict and I'm leaving the meeting', as you
27 did in the example we gave, you say you had a conflict
28 with Unison and you identified that?
29 A. Well your duty is to raise it. The decision then rests

1 with the Chair of the Board as to the management of
2 that. So you should know when you get the agenda
3 what's on the agenda. You should then, before the
4 meeting, at least raise it with the Chair and let them
5 know that you have a conflict, and you might want to 15:15
6 give some background information to that at that point.
7 But the register of interest, which we complete
8 annually, should detail all. So there should be a
9 natural alignment, unless something else comes up
10 during the year which is not part of your register. 15:15
11 But you would be raising it at the meeting, but you may
12 have had a conversation with the Chair in advance.
13 217 Q. If we just move down to paragraph 7 we will see that
14 there was a fair bit of detail provided and subsequent
15 actions arising, so during this particular part 15:15
16 Mrs. Brownlee wasn't there. Then the meeting on
17 22nd October 2020, which can be found at TRU-131853,
18 this was a meeting after this meeting. At this meeting
19 Mrs. Brownlee didn't declare a conflict of interest.
20 You will see the update on clinical concerns within 15:16
21 Urology at item 7. So we'll see there is a discussion
22 around Bicalutamide, other issues in advance.
23
24 And then, at TRU-131854, we have a paragraph that says,
25 the second paragraph on that page said: 15:16
26
27 "The Chair advised that Consultant A had written to
28 herself in June 2020, the contents of which she shared
29 with the Non-Executive Directors in which Consultant A

1 raised concerns at how the HR processes were being
2 managed and requesting that his formal grievance and
3 its included appeal are addressed. The Chair was
4 advised this matter was being progressed through HR
5 processes. The Chair also raised the fact that a 15:17
6 number of different urology consultants had been in
7 place over the years and asked why they had not raised
8 concern about Consultant A's practice and similarly why
9 had his PA not raised concerns regarding some delays in
10 dictation of patient discharges. The Chair also asked 15:17
11 should a GP not have recognised the prescribing of
12 Bicalutamide as an issue?"
13
14 And that is in as a question:
15 15:17
16 "Dr. Gormley stated that patients remained under this
17 one consultant's care and this will be examined under
18 the SAI process. The Chair then asked about
19 Consultant A's appraisal and asked if performance
20 issues had been identified through this process and, if 15:17
21 so, were professional development and training needs
22 then identified. Dr. Gormley advised that
23 Consultant A's appraisals were also part of the review
24 process.
25 15:18
26 In terms of systems and processes, Mrs. McClements
27 spoke of the SAI process since 2016 when a robust
28 action plan was put in place at that time to address
29 such issues as triaging communication et cetera and the

work since June 2020 to scope and review the patient records of Consultant A's cases. Mr. McAnuff noted that when performance issues were identified, additional measures were put in place and asked if these additional measures had not effected positive change, what further controls would need to be put in place should there be concerns raised about other consultants. Mrs. McClements referred to the query as to whether such clinical concerns could happen elsewhere and she advised that the Trust required more time to conduct its review and scoping exercises.

In response to a question from the Chair as to whether one consultant urologist reviewing the patient files was sufficient, Mrs. McClements provided assurance that, in addition to Mr. Mark Haynes' involvement, there is some clinical nurse specialist input and the Head of Service is involved in reviewing systems and pathways. She referred to the multi-disciplinary aspect of this work as detailed in the paper.

In addition there has been independent sector consultant sessions reviewing oncology patients and subject matter experts engaged as part of SAI process. Mr. Wilkins stated that this was a complex case with various strands. He advised that whilst he supported the Trust's request for delay in a ministerial announcement, it was important that this was not a prevaricated delay. Ms. Donaghy referred to this case

1 coming into the public arena and asked about natural
2 justice and Consultant A's right of reply. She raised
3 her concern at the issues Consultant A had raised in
4 his grievance around his appraisals, pressure of work
5 et cetera and she asked that these are addressed as 15:20
6 part of any review. Mrs. McCartan restated the
7 importance of the Trust releasing information only when
8 it is assured it is accurate. Mrs. Leeson highlighted
9 the importance of due process being followed with SAIs
10 completed as a priority to ensure learning from this 15:20
11 case for the benefit of patients.
12
13 Following discussion, the consensus view of Trust Board
14 was to approve the Trust's request to seek a delay in
15 the ministerial announcement. Members emphasised the 15:20
16 importance of a robust timeline to conclude the review
17 processes. It was agreed that following the Trust
18 Board meeting the Chief Executive would informally
19 advise the Department of Health of the Trust Board's
20 decision followed by a formal letter." 15:20
21
22 I read all of that to put on the record the extent of
23 the discussions in October during which Mrs. Brownlee
24 stayed and was present for. There was discussion of
25 SAI, discussions of the grievance. Who is 15:21
26 Mrs. Donaghy?
27 A. Non-Executive Director Geraldine Donaghy.
28 218 Q. She mentioned "raised concern at the issues
29 Consultant A had raised in his grievance around his

1 appraisals". I don't think you were given the
2 grievance, we have established, you weren't given those
3 documents?
4 A. No.
5 219 Q. So how would she have got that information, would that 15:21
6 have been something that would have been reported to
7 the Board?
8 A. She got it from the email from Roberta Brownlee
9 attached with a copy of the letter from Aidan O'Brien.
10 220 Q. From the complaints that Mr. O'Brien was making? 15:21
11 A. Yep.
12 221 Q. So it is from that email --
13 A. Yeah.
14 222 Q. -- rather than from any of the original documents. So
15 there is mention of the subject matter experts at that 15:21
16 point. So as I read through it seems that
17 Mrs. Brownlee has -- do you remember this meeting, were
18 you at this meeting?
19 A. Yes.
20 223 Q. And do you remember the meeting itself? I know there 15:22
21 is a lot of meetings, but do you remember this
22 particular one given the nature of the discussions?
23 A. Yeah, I do. Not verbatim, I do remember the meeting,
24 but I wouldn't remember every single word and detail,
25 but I do remember the meeting. 15:22
26 224 Q. You remember the generality of it?
27 A. Yes.
28 225 Q. Were you surprised that Mrs. Brownlee remained in the
29 meeting having excused herself from the previous one?

1 A. I was. I was also surprised that the precursor to this
2 was an email to Non-Executive Directors to advise that
3 she would be remaining in the meeting.
4 226 Q. The email that said she would be saying in for this.
5 But we will look at the detail of the actual 15:23
6 interactions with the Chair, this is obviously a step
7 removed and a bit of distance in between. But what was
8 your view at the time of the Chair's interactions about
9 the issues in relation to Mr. O'Brien at this
10 particular meeting? 15:23
11 A. Yeah, this didn't feel right at the time. I just felt
12 this was -- the focus and the attention from the Chair
13 did not feel as it should be from a Non-Exec
14 collectively looking at the issues.
15 227 Q. When you say it didn't feel right, do you consider that 15:23
16 it was, first of all, inappropriate for Mrs. Brownlee
17 to be at this meeting given her conflict?
18 A. Absolutely.
19 228 Q. Do you think her interventions at the meeting or
20 contributions to the meeting, do you consider those 15:23
21 also to have been inappropriate?
22 A. I do.
23 229 Q. And why is that?
24 A. I have racked my brains on this one, No. 1 why was it
25 accepted by me and the rest of the Board that it was 15:24
26 okay for a former Chair to stay in for this item at
27 this meeting and, No. 2, why did I or the rest of the
28 Board not stop the Chair at this point and ask her to
29 leave the meeting so the conversation could continue.

1 So I don't know why we didn't do that.
2 230 Q. What about the substance of what Mrs. Brownlee is
3 raising at the meeting, where she is effectively -- she
4 is raising concerns, she is saying that the consultant
5 is raising concerns at the processes, she advises about 15:24
6 the HR processes. She also raised the fact that a
7 number of different urology consultants had been in
8 place over the years and asked why they had not raised
9 concerns about Consultant A's practice and similarly
10 why his PA had not raised concerns regarding some 15:25
11 delays in dictation of patient discharges. I mean,
12 that's a level of detail around operational matters and
13 the consultant's daily duties, did you get any sense at
14 all that she was advocating on his behalf?
15 A. That's what it felt like. 15:25
16 231 Q. Do you know if it felt like that to other members of
17 the Board?
18 A. I do. Certainly for our Chief Executive Shane Devlin
19 at the time, I spoke to him after the meeting.
20 232 Q. We'll look at that in a second, he refers to that in 15:25
21 his evidence to the Inquiry?
22 A. Okay.
23 233 Q. The last sentence in that second paragraph:
24
25 "The Chair also asked should a GP not have recognised 15:25
26 the prescribing of Bicalutamide as an issue."
27
28 That level of detail around, an expectation around a
29 GP, the prescription of Bicalutamide and the

1 identification of that, is that particular detail that
2 you might expect a Chair of the Board to have awareness
3 of?
4 A. Well certainly I don't.
5 234 Q. Again, do you think this is an example of Mrs. Brownlee 15:26
6 advocating on behalf of Mr. O'Brien?
7 A. That's how it came across.
8 235 Q. Would you have had information that would have informed
9 you to ask a question like that at that point in
10 October? 15:26
11 A. Absolutely not.
12 236 Q. Obviously that information could have come from any
13 source, and Mrs. Brownlee will come along and give
14 evidence. But one of the possibilities, of course, is
15 that the information came from Mr. O'Brien, at this 15:26
16 point you weren't aware of the extent of their
17 friendship?
18 A. No.
19 237 Q. You had googled after this meeting?
20 A. Yes. 15:27
21 238 Q. And was it Mrs. Brownlee's interaction and contribution
22 to this meeting that made you think there was more to
23 this as regards depth of friendship?
24 A. Absolutely, this for me triggered so many alarm bells.
25 239 Q. So just to be clear now that you are Chair of the 15:27
26 Trust, it is your view that Mrs. Brownlee should have
27 excused herself from this meeting and the sense at the
28 time from you and now in evidence is that you got the
29 feeling that she was advocating on behalf of

1 Mr. O'Brien at this meeting?
2 A. Yes.
3 240 Q. You mentioned about Mr. Devlin, about his concerns, the
4 Inquiry has heard from Mr. Devlin and I am going to
5 give a reference of his comments in relation to that 15:28
6 before going to his transcript. He refers to this
7 issue at WIT-00095. I am just going to read two
8 extracts from that, we don't need to go to it, we have
9 gone through it before. But Mr. Devlin states:
10 15:28
11 "Specifically with regards to urology during my tenure
12 when items were brought to Trust Board I did not feel
13 that the conversation was quite as open as with other
14 topics. On reflection I would question the total
15 commitment of the Chair of the Trust to be totally open 15:28
16 with regards to her willingness to criticise urology
17 and specifically Mr. O'Brien. At the confidential
18 meeting of the Trust Board on 22nd October, we tabled
19 the details of the case so far and strongly debated the
20 concerns with regards to Mr. O'Brien." 15:29
21
22 Then he puts in some of the extracts from that note
23 that we have just looked at. He then says in his
24 statement:
25 15:29
26 "I was left with the strong impression during the
27 meeting that the Chair was advocating on behalf of
28 Mr. O'Brien, a feeling which was shared and relayed to
29 me by a number of SMT colleagues."

1
2 Did anyone from the SMT mention this to you?
3 A. No.
4 241 Q. Did any other Board Member mention to you that they
5 shared your concerns? 15:29
6 A. I don't recall. This meeting was virtual, so unlike
7 other meetings where you would have everybody
8 physically in the room, when the meeting ends the
9 meeting ends, so I don't recall any conversation at
10 that juncture. 15:29
11 242 Q. It was a couple of days after that meeting that
12 Mr. Pengelly telephoned Shane Devlin, is that something
13 -- to inform him of the care [sic] relationship and the
14 closeness in friendship. That was something you found
15 out by Googling rather than by being told by anybody in 15:30
16 the Board or the SMT?
17 A. That's correct.
18 MS. McMAHON: When he gave evidence Mr. Devlin was
19 asked about this issue and he mentioned you, so I just
20 want to read out the extract in case you have any 15:30
21 comment to make. That's at TRA-01809. Sorry, Chair,
22 I have just realised time, do you want me to stop and
23 I can come to this extract when we come back?
24 CHAIR: Yes, I think we'll take a short break. Just to
25 let everyone be aware, I certainly have to be away by 15:31
26 five o'clock, so I don't know if we'll get you finished
27 today, Mrs. Mullan, but I understand you are available
28 tomorrow morning, if that's the case.
29

1 THE HEARING ADJOURNED FOR A SHORT TIME
2
3 CHAIR: Thank you everyone.
4 243 Q. MS. MCMAHON: Thank you. Mrs. Mullan, I had just gone
5 to the extract from the meeting that we were looking at 15:49
6 and I then asked just to go to the transcript of
7 Mr. Devlin's evidence at TRA-01809. This is where
8 Mr. Wolfe Senior Counsel asked Mr. Devlin some
9 questions about that meeting and the note that we have
10 just looked at. So you'll see at the top of the page 15:50
11 he reads out the last extract from his Section 21, his
12 view of that meeting. Then Mr. Wolfe starts his
13 questions at line 8, he says:
14
15 "Q. Some questions arising out of all of that. First 15:50
16 of all, you've alluded to the fact that after this
17 meeting the concerns that you had about her
18 attendance..."
19
20 And the reference here is to Mrs. Brownlee: 15:50
21
22 "...about her attendance and participation were shared
23 with you by members of the SMT and that was then the
24 subject of conversation before speaking to
25 Mr. Pengelly, who specifically within the SMT did you 15:50
26 speak to?"
27
28 And Mr. Devlin replies: "It would have been generally
29 SMT. So I can remember talking to the Director of HR,

1 the Medical Director et cetera. There was also a
2 conversation with one of the Non-Execs as well, with
3 Eileen Mullan, who is one of the Non-Execs who also
4 felt as I felt in the meeting. I am very conscious
5 that I was aware that the Chair was not going to 15:51
6 declare a conflict of interest."
7
8 If I just stop there. That's reference to the email
9 exchange with Mr. Devlin and the Chair that the Panel
10 have seen when Mr. Devlin gave evidence when he 15:51
11 identifies the conflict. Then back to the transcript:
12
13 "Because she had emailed me to say so, and I am very
14 conscious that I thought that that would be okay.
15 I suppose the frustration I had at the end of the 15:51
16 meeting was I think that was the wrong decision because
17 actually in the meeting I felt that it was not as
18 balanced as it should have been. Certainly after the
19 meeting, initially after the meeting there would have
20 been conversations across all of SMT. Then explicitly 15:51
21 I had a conversation with Eileen Mullan as a
22 Non-Executive about the meeting. She expressed her
23 apologies to me, actually, for the way the meeting had
24 progressed."
25 15:52
26 Now I just want to stop there. Do you recall speaking
27 to Mr. Devlin about this meeting after it?
28 A. I do.
29 244 Q. And was it something that took place immediately after

1 the meeting or was it sometime after?
2 A. It was probably -- my recollection was that it was me
3 and the Non-Execs and Shane still on a call, that would
4 have been maybe a call either that day or shortly
5 afterwards, but it was in close proximity. 15:52
6 245 Q. Do you remember if he brought up the meeting or did
7 someone else or did you bring it up, do you recall
8 that?
9 A. I brought it up.
10 246 Q. What was the context of you -- can you remember why you 15:52
11 brought it up and what was said?
12 A. Yeah, I brought it up because, firstly, I was annoyed
13 at myself and I was annoyed with my Board colleagues
14 collectively, not individually, that that meeting had
15 been allowed to go ahead in the way it did particularly 15:53
16 for that item. The rest of that meeting was fine, but
17 particularly for that item; that Shane Devlin as the
18 Chief Executive should not have had to make a decision
19 to say the Chair could be in attendance for urology,
20 that the Chair of the Trust Board felt that it was okay 15:53
21 to say that she could be at that meeting and just tell
22 everybody she would be there and how the meeting
23 unfolded. So for me the decision as to whether the
24 Chair of the Trust Board can attend a section of a
25 meeting where there is a conflict of interest is not 15:53
26 for the Chair of the Trust Board to make.
27 247 Q. And is it for the Chief Executive to make?
28 A. No.
29 248 Q. Whose responsibility is that? Who is the gatekeeper

1 for that if the Chair is the one that is potentially
2 making what could be reviewed as the wrong decision?
3 A. Yeah. Then that brings me to the Board. The Board
4 should have met, the Board should have - without
5 Roberta Brownlee being in attendance - the Board should 15:54
6 have met, discussed it and agreed, agreed that Roberta
7 Brownlee should not be in attendance for that section
8 of the meeting. When you raise the conflict of
9 interest and the management of it, sometimes the Chair
10 will involve members, depending on the nature of it. 15:54
11 Here we have the Chair who is usually the arbitrator of
12 what happens in relation to conflicts of interest being
13 the one that has the conflict of interest, hasn't
14 raised the conflict of interest, is at the meeting.
15 I believe the Board should have made it, I apologised 15:54
16 to Shane, he should not have been put in that position
17 nor should that agenda item progressed as it did. That
18 should have been dealt with, if not by the Non-Execs,
19 but definitely by the collective Board.
20 249 Q. When you were having this conversation with Mr. Devlin, 15:54
21 were there other people on the link from the Board or
22 the SMT?
23 A. My memory is other Non-Execs were there, but I have not
24 asked them if that was their memory or not. I'm nearly
25 sure that this was Non-Execs and Shane on that call. 15:55
26 250 Q. Do you remember the feeling that you expressed,
27 Mr. Devlin expressed, if that was shared by those other
28 Non-Execs?
29 A. Certainly there was an alarm for the Non-Execs as well

1 as a result of that meeting.
2 251 Q. You mention additional contact with Mrs. Brownlee in
3 your statement, if we go back to that at WIT-100563 at
4 paragraph 52.1. So, you are asked at paragraph 52:
5 15:55
6 "Given the Inquiry's Terms of Reference is there
7 anything else you would like to add to assist the
8 Inquiry in ensuring it has all the information relevant
9 to those terms."
10 15:56
11 At 52.1, you say:
12
13 "I am including below details of an exchange of emails
14 communication between Mrs. Roberta Brownlee and myself
15 on 8th and 9th September. I do not recall the content 15:56
16 of the voice message left on my phone that is referred
17 to in the below email trail. Urology and Mr. O'Brien
18 are not mentioned in these emails. However, this
19 happened between the Trust Board workshop on
20 27th August and the next scheduled Trust Board meeting 15:56
21 on 24th September 2020."
22
23 Then you set out: "On 7th September 2020, 09:05, you
24 got an email from Roberta Brownlee indicating that she
25 plans to attend governance meeting on most of Thursday 15:56
26 morning and she hopes this is acceptable."
27
28 I presume, when we look at the third column across,
29 this emails to you because you are the Chair of the

1 Governance Committee, or was that an email to everyone?
2 A. No, that was to me as Chair of the Governance
3 Committee.
4 252 Q. Then on 8th September, 08:55, email sent from Roberta
5 Brownlee Trust Board Chair asking: 15:57
6
7 "At the beginning of the confidential section when all
8 members present may I speak to the Board on a few areas
9 as Chair and after you do the welcome I need to speak."
10 15:57
11 Again the email was sent to you as Chair of the
12 Governance Committee and Sandra Judt as the Board
13 Assurance Manager that the Panel have heard from.
14 Then, at 15:51 on the same date, email from you to
15 Roberta Brownlee. You advised that there was not going 15:57
16 to be a confidential section of the Governance
17 Committee:
18
19 "I offered the Chair five minutes at the start of the
20 meeting before moving on the agenda items." 15:57
21
22 And you say, on the right-hand side column: "Busy
23 agenda. Happy to give a few minutes but must move on
24 to Covid 19 outbreak and other substantial items."
25 15:58
26 Given the contents of 27th August meeting that we have
27 looked at at length, was the only reason you weren't
28 facilitating a confidential section of the governance
29 meeting because of Covid and because of issues that

1 needed to be discussed?
2 A. No, the Chair didn't give me an indication as to the
3 item she wanted to discuss but was asking for time at
4 the meeting. We already had a very substantive agenda.
5 The 27th August meeting, the outcome from that or the 15:58
6 action from that was a paper to come to the
7 confidential September Trust Board meeting and that's
8 where I expected it to be. So the agenda for the
9 Governance Committee and particularly the issues around
10 the Covid 19 outbreaks was on our workload that day. 15:58
11 253 Q. Did you ask her what she wanted the time for? I know
12 she hadn't told you, but did you ask her?
13 A. I don't believe I specifically asked her for it, no.
14 254 Q. Then on that date, at 18:41, email from Roberta
15 Brownlee to you. And she says: 15:59
16
17 "Eileen, message noted. I could not address my
18 comments in five minutes as Chair of the Board.
19 Several serious matters. Will ensure my point is
20 highlighted and asked to be addressed/actioned in the 15:59
21 full agenda. Roberta."
22
23 What did you understand her to mean by this or was that
24 all you got?
25 A. That's all I got. 15:59
26 255 Q. And you didn't reply to that email?
27 A. No, I don't believe so and I can't scroll up to show
28 you. Yeah, that's okay.
29 256 Q. Back down again.

1 A. No, I don't believe so. I think what happened was a
2 phone call after that from Roberta.
3 257 Q. If you put it in chronology order, so the next thing is
4 9th September phone call. Did you find out what she
5 meant by that email on the 8th when she talks about 16:00
6 several serious matters?
7 A. No, I didn't find out.
8 258 Q. You didn't get any other email about that. So
9 9th September 2020, you got a missed telephone call
10 from her, there was a message left. You returned the 16:00
11 call and there was no answer. Then you used the follow
12 up email, which we will look at now as a guide for the
13 message:
14
15 "The Chair indicated significant issues she wanted to 16:00
16 bring to the Board's attention."
17
18 Then we go to 9th September, 15:23. This is the email
19 from you to Roberta Brownlee:
20 16:00
21 "I advised the Board Chair Roberta Brownlee that if she
22 had several serious matters she wished to share as
23 Chair of the Board then it might be prudent for her to
24 hold an emergency Trust Board meeting. That would mean
25 all Non-Executive and Executive members would be in 16:00
26 attendance. The Governance Committee has other staff
27 attending and two absent executive members."
28
29 So in that email you are saying the pathway for her to

1 raise serious matters is not through the Governance
2 Committee, it's to hold an emergency Trust Board
3 meeting so that everyone could attend?
4 A. Yeah. And, if I recall back, this was about, she
5 wanted to speak to the Trust Board. This was a 16:01
6 Governance Committee meeting and not all Trust Board
7 members would be present. So I was very clearly
8 setting down the delineation, if this was serious
9 matters for Trust Board attention then call an
10 emergency Trust Board meeting and bring Trust Board 16:01
11 members together.
12 259 Q. Then Mrs. Brownlee replies that night at 20:25, that
13 was the previous email from the morning and copied in
14 the Chief Executive and Board Assurance Manager:
15 16:01
16 "She noted that the Chief Executive and she would be
17 updating the following day's meeting on issues that
18 were all well known to the Trust Board members at that
19 time. Further she went on to say that she did not wish
20 to delay the start of the meeting. She stated that she 16:02
21 did not see the need for an emergency Trust meeting as
22 all Trust Board members would be present for the
23 confidential section, excluding those on holidays and
24 the absence of one NED."
25 16:02
26 So she has come back and said I don't need an emergency
27 meeting, I thought in a previous email you had said
28 there wasn't going to be a confidential section?
29 A. No.

1 260 Q. She is working on the presumption that there still was
2 going to be one?
3 A. Yes.
4 261 Q. And that as everyone would be at that then that was
5 still a proper vehicle for her to utilise to raise her 16:02
6 concerns?
7 A. Yeah, but we weren't having a confidential meeting.
8 The people attending confidential -- the only
9 difference between confidential in terms of the
10 attendance would be the likes of Dr. Tracey Boyce, 16:02
11 Director of Pharmacy.
12 262 Q. Thank you. I just need to look at this. Now, did you
13 reply to this email?
14 A. I don't believe so.
15 263 Q. If you don't mind me saying, there does seem to be a 16:03
16 little bit of tension in the back and forth between you
17 and Mrs. Brownlee, is that an unfair characterisation?
18 A. No, it's not. The Chair of the Board was looking,
19 without giving the details as to what she wanted
20 covered, was looking for time at a Governance Committee 16:03
21 meeting that wasn't confidential to discuss serious
22 matters, for all the Trust Board members. I was
23 pushing back to say, if it was serious enough, then
24 bring the Trust Board together for an emergency
25 meeting. I am also very mindful of the timeline of 16:03
26 this from the workshop in August and the pending Trust
27 Board meeting at the end of September.
28 264 Q. The later September meeting. It does seem as if there
29 is a bit of a dance going on, that Mrs. Brownlee is not

1 telling you what she needs to say and you're not
2 asking. The back and forward is in relation to the
3 opportunity to say something, that you don't know what
4 she is going to say and she is not telling you what she
5 is going to say, that's how it reads? 16:04
6 A. Yeah, that's a fair point.
7 265 Q. Was there anything happened between 27th August meeting
8 and these emails that resulted in a deterioration or a
9 difficulty between the two of you, was there any
10 interaction that resulted in this sort of reluctant 16:04
11 email exchanges?
12 A. I don't recall, I don't recall. That's like within 10
13 days, I don't recall.
14 266 Q. Did you ever find out what it was that she wanted to
15 say? 16:04
16 A. No. When I looked at the minutes of the Governance
17 Committee meeting, there was nothing substantive that
18 came through in her commentary at that meeting.
19 267 Q. She uses the phrase "serious matters", as a member of a
20 Board, I presume if you as a Chair would have used that 16:05
21 phrase to your NEDs or to your Board generally, you
22 wouldn't use it just casually?
23 A. No, you wouldn't.
24 268 Q. You would want it to indicate that there was something
25 of particular import that you wanted to draw to their 16:05
26 attention. Now, Mrs. Brownlee can give her own
27 evidence about her use of language, but if you were to
28 use that or you were to read that, would that indicate
29 to you that there was indeed something that she needed

1 brought to your attention given the issues around
2 liability that we looked at earlier on, that you have
3 collective responsibility as well as an individual duty
4 to act appropriately, did you think what is this, this
5 must be serious, we need to know about this, was there 16:05
6 any sense of that?
7 A. Well there is -- and you're right, I didn't ask her
8 what it was about. But what I will say is that if it
9 is serious enough then bring together the Trust Board
10 and share your serious matters with them. 16:06
11 269 Q. Do you know if she spoke to anyone else about this
12 matter or raised it with Mr. Devlin or any other NED?
13 A. I don't know.
14 270 Q. And as you say there was nothing then on the subsequent
15 minutes of the Governance Committee that might have 16:06
16 been reflective of this indication of seriousness?
17 A. No, not on my review.
18 271 Q. I know we have also provided you with Mr. Wilkinson, he
19 was the NED for the MHPS process from the Board. As we
20 understand it, Mrs. Brownlee appointed him or asked him 16:06
21 would he take that role on, is that a decision for a
22 Chair, is that something that you have had to do as a
23 result of an MHPS where you have had to appoint an NED?
24 A. It is.
25 272 Q. And is that the role of the Chair as an individual or 16:07
26 is it usually the Trust Board to make that decision
27 collectively?
28 A. It is the role of the Chair.
29 273 Q. When you make that decision what are the factors that

1 you take into consideration when you are deciding who
2 is most appropriate?
3 A. Who is available.
4 274 Q. So it just goes down to availability?
5 A. Yes. 16:07
6 275 Q. There is no matching of skill set or personality types
7 given the nature of the NED role in the MHPS process?
8 A. No.
9 276 Q. You don't consider who might be best suited to support
10 or facilitate that role with someone else, it is just 16:07
11 who can do this?
12 A. Yep, who is available and in essence who doesn't have
13 one right now, that would be point one, and then, point
14 two, who is available.
15 277 Q. If we look at Mr. Wilkinson's Section 21 at WIT-26092, 16:07
16 at paragraph 2 Mr. Wilkinson says:
17
18 "On 19th January 2017 I was appointed as the designated
19 Non-Executive Director by the Chair of SHSCT, Mrs. R.
20 Brownlee. The primary purpose of my role was to liaise 16:08
21 with Mr. Aidan O'Brien and ensure the momentum of the
22 Maintaining High Professional Standards process in
23 respect of Mr. O'Brien was maintained by ensuring
24 timely responses to requests made by him. I met with
25 Vivienne Toal, Director of Human Resources, and 16:08
26 Organisational Development to review the role of
27 designated NED.
28
29 On 24th January 2017 a meeting was held with

1 Mr. O'Brien, Mr. Weir and Mrs. Siobhán Hinds. Mr. Weir
2 was the case investigator and Siobhán Hinds is the Head
3 of Employee Relations who was assisting Mr. Weir with
4 the investigation.
5 16:09
6 On 25th January 2017 I sent a letter to Mr. O'Brien
7 introducing myself as the designated NED. I made him
8 aware that I was informed about his immediate exclusion
9 which became effective on 30th December 2016. At this
10 time the case manager was Dr. Khan and the case 16:09
11 investigator was Mr. Weir. The relevant documents can
12 be located."
13
14 And he gives a reference of where they are:
15 16:09
16 "On 25th January 2017 I received an email from Vivienne
17 Toal outlining the next steps in the process. I
18 received another email from Vivienne Toal providing me
19 with an update prior to the Trust Board meeting."
20 16:09
21 Then at paragraph 6, he says -- so you can see that
22 that's the context in which Mr. Wilkinson had been
23 secured for that position, just in the preceding days
24 leading up to this contact with Mrs. Brownlee.
25 16:10
26 Paragraph 6: "On 26th January 2017 I met with
27 Mrs. Brownlee and we discussed the case. Mrs. Brownlee
28 expressed her opinion about the case. She explained
29 that she had known Mr. O'Brien for a number of years

1 and that he had been her consultant, that he was an
2 excellent surgeon and that he had helped many people,
3 that he had built up the Urology Department in the
4 Southern Health and Social Care Trust and had worked
5 hard to meet patients' needs as they awaited surgery or 16:10
6 a diagnosis. She asked me to make contact with
7 Mr. O'Brien."
8
9 Then he talks about receiving an email and goes on
10 explaining the rest of the chronology. So that's 16:10
11 paragraph 6, contact with Mrs. Brownlee. If we go to
12 WIT-26095 and look at paragraph 19, this is on
13 2nd March 2017 he says at paragraph 19:
14
15 "On 2nd March 2017 Roberta Brownlee telephoned me and 16:11
16 expressed her concerns about case progression and time
17 scales. She stated that Mr. O'Brien was a highly
18 skilled surgeon who had built up the Urology Department
19 and was well respected by service users. She further
20 expressed concern about the handling of the case by 16:11
21 Human Resources. Mrs. Brownlee pointed out that the
22 case was having an adverse effect on Mr. O'Brien and
23 his wife. She asked me to contact Mr. O'Brien."
24
25 And if we go to paragraph 35 at WIT-26099, on the 15th, 16:11
26 Mr. Wilkinson says:
27
28 "On 15th February 2018 Mrs. Brownlee made an informal
29 oral inquiry to me regarding Mr. O'Brien's case."

1 So can we just go back to paragraph 6, please, it's at
2 WIT-26092. We can see that the first contact was on
3 26th January 2017 and I've highlighted other contacts
4 with Mrs. Brownlee. What's your view on the
5 appropriateness of those contacts between Mrs. Brownlee 16:12
6 and Mr. Wilkinson?
7 A. Well certainly when I was given my MHPS case I didn't
8 have this level of interaction with the Chair in regard
9 to the case. The place for testing whether there is
10 momentum and progress and challenges should be within 16:12
11 the confidential section of the Governance Committee.
12 This feels for me that the Chair is carrying out her
13 own oversight and scrutiny of one case.
14 278 Q. Is there perhaps a little bit more than that, that
15 there is some advocacy on behalf of Mr. O'Brien taking 16:13
16 place in paragraph 6?
17 A. Absolutely.
18 279 Q. "Excellent surgeon, helped many people, built up the
19 Urology Department", what's your view on that?
20 A. That should never have been discussed. If I may, if I 16:13
21 allocate a case, a case goes to the Non-Exec, the
22 Non-Exec is given it, then their engagement then is
23 between the case manager and case investigator and HR.
24 I don't phone them up and ask them how things are going
25 and tell them about the individual in question, that is 16:13
26 not appropriate. That certainly just makes it a case
27 for advocating on behalf of the doctor in question by
28 the Chair of the Board.
29 280 Q. It is one interpretation of that, advocating for the

1 doctor or potential for that, trying to influence the
2 outcome?
3 A. Yeah, you could see that too.
4 281 Q. Now, that paragraph 6 was on 26th January 2017. When
5 we went through the chronology of meetings that 16:14
6 Mrs. Brownlee either did or didn't declare a conflict
7 of interest, we started off in the August one. But
8 there was, of course, the meeting on 27th January, just
9 the day after Mrs. Brownlee contacted Mr. Wilkinson,
10 when Mrs. Brownlee actually left the meeting. Now it 16:14
11 is not recorded in the notes that it was because of a
12 conflict, but she left the room for the discussion of
13 the item involving Mr. O'Brien. It was the day
14 immediately after this.
15 A. Yes. 16:14
16 282 Q. Then when we come to 27th August she is back at the
17 meeting again following this particular process. So
18 that is just for the note of the Panel, that meeting on
19 27th January 2017 is at TRU-112985.
20 16:15
21 Just for completion for you, I don't know if you heard
22 Mr. Devlin's evidence or you are aware of his view,
23 even though his observations about Mrs. Brownlee have
24 been put before the Inquiry Panel. He states in his
25 Section 21 the following, we don't need to go to it, 16:15
26 but for the note of the Panel is at WIT-0096. And he
27 says the following:
28
29 "It is important to note that even though our working

1 relationship was less than optimal, I do not believe
2 that this had any impact on the path that was followed
3 with the Mr. O'Brien case and/or Urology. All
4 appropriate regard to Mrs. Brownlee as Trust Chair was
5 given from me. Out relationship did not alter my 16:16
6 behaviours with regards to sharing information with the
7 Chair and Board and I am of the view that the actions
8 Mrs. Brownlee chose to take were not affected by our
9 relationship."
10 16:16
11 Now we have spoken earlier about when there were
12 fracture times of potential interventions and I think
13 you agreed that 2017 was an opportunity when things
14 might have been handled differently. So just on that
15 discrete issue would you slightly part company with 16:16
16 Mr. Devlin's view that Mrs. Brownlee's position as
17 Trust Chair perhaps didn't lend itself to issues rising
18 to the surface as soon as they might have?
19 A. Well I wouldn't disagree with Shane Devlin's comments
20 on that. We have evidence before us that on the - and 16:16
21 forgive me, it is late in the day - 27th January was
22 the Trust Board meeting in 2017. Very clearly
23 Mrs. Brownlee knew who the doctor was that was going to
24 be referenced at the meeting, and she knew that before
25 that meeting. Mrs. Brownlee at the meetings then in 16:17
26 August, whilst nobody, none of us know what the
27 directors are going to say when they are asked is there
28 anything else, she may or may not have known at that
29 point, but she certainly knew in September, October and

1 November.
2 MS. McMAHON: Just a comment - again for the Panel's
3 note - Martina Corrigan around Mrs. Brownlee's
4 relationship and friendship with Mr. O'Brien and the
5 way in which she considers he used his connections. 16:18
6 Just for the note that is WIT-26300.
7
8 I am just conscious that you have said it is late in
9 the day, you have been answering the questions all day,
10 I just have a discrete section that I can move on to in 16:18
11 the morning and then the Panel will have some
12 questions. We are going to move into the learning and
13 it may well be that you want to give us more detail
14 around that. So tomorrow it will be the learning and
15 update on where we are, just to give you a heads up of 16:18
16 where we will start, and, if the Chair is content then,
17 would that be an appropriate time to rise?
18 CHAIR: Yes, I think it has been a long day for
19 everyone, not least of which the witness, and the first
20 day back after the holiday break is always difficult 16:18
21 for us all. So we will see you all again at 10 o'clock
22 in the morning then. Thank you.
23
24 THE HEARING STANDS ADJOURNED TO WEDNESDAY, 10TH JANUARY
25 2024 AT 10 AM
26
27
28
29