Urology Services Inquiry

Oral Hearing

Day 79– Thursday, 11th 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.

Gwen Malone Stenography Services

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THE INQUIRY RESUMED ON THURSDAY, 11TH JANUARY 2024 AS FOLLOWS:

CHAIR: Good morning everyone, Mr. Wolfe.

MS. PAULINE LEESON, HAVING PREVIOUSLY AFFIRMED, CONTINUED TO BE DIRECTLY EXAMINED BY MR. WOLFE AS FOLLOWS:

1 Q. MR. WOLFE: Good morning, Mrs. Leeson. Just to recap, we finished yesterday having looked at issues around the Early Alert. I suppose your evidence sits as follows: By the end of August, 27th August 2020, you had a meeting with your fellow Non-Executive Directors with Dr. O'Kane which then moved into a Board meeting and it was at that point you were told in relation to a consultant that there were a series of SAIs that were being examined and it was the view of you and your fellow NEDs that this should be committed to writing and brought formally to the next Board meeting scheduled for September. The issue was introduced to you under "Any Other Business", and really not in writing, as I think you would have preferred looking back on it. And at that point you hadn't been told about the Early Alert. At that point you didn't know that this was the same practitioner, Mr. O'Brien, whose MHPS case had been introduced to you in January 2017. Furthermore, you did not know the outcome of the MHPS process and nor did you know that he had been referred

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10:01
10:01

to the General Medical Council in 2019, is that all an accurate recap?

A. Yes, that's correct.

2 Q. Yes. It would appear that shortly after that meeting, and certainly in advance of the next Board of Governors, I should say, mixing roles up here, in advance of the next Trust Board meeting which took place on 24th September, you were contacted by Mrs. Brownlee, the Chair of the Board, to discuss whether you would step in and chair the meeting, at the next Board meeting if the issue of this doctor's performance and the issues arising from the doctor's performance came onto the agenda again, is that right? 10:02 10:02

A. Yes, I was asked to chair the item on the serious concerns. 10:03

3 Q. Yes. And as we sort of saw yesterday the name of the doctor wasn't mentioned in the August records of the Board or the workshop?

A. No.

4 Q. But was the name, did the name become known to you at some point? 10:03

A. When Mrs. Brownlee rang me she named the consultant. She stated that she had or felt herself that she had a conflict of interest because she had been a patient of his and I think that she said that he had saved her life. 10:03

5 Q. Yes.

A. And asked me to chair the item in the next Confidential Board meeting on the serious concerns that were going

to be brought to the Board.

6 Q. Right. So she had, perhaps you all had a view of the road ahead, that this wasn't going to be the end of the matter, it was going to be the subject of further discussion in September? 10:04

A. Well, we had asked, as you correctly said, for a paper to be brought to us, to supplement the verbal report, we really needed to see the facts and we needed to have the timeline.

7 Q. Yes, and we'll spend some time now this morning looking at that. Could I just start by putting in front of you Mrs. Brownlee's perspective on her communications with you, and if we start with that. It's her Section 21 statement at WIT-90873. So she records, if I could just read it aloud: 10:04 10:05

"Because of what could have been perceived a conflict of interest, I spoke around July/August 2020 in a conversation with Pauline Leeson to explain that I did not wish to attend Board meetings where Mr. O'Brien was going to be discussed. I asked Pauline Leeson, as a NED, would she chair the Board meeting when this topic arose about Mr. O'Brien. I reminded Pauline of the importance of following due process in a timely manner and asked her to check when Mr. O'Brien had his appraisal completed and about his revalidation. 10:05 10:06

I also asked Pauline to check whether his personal assistant had any comments on lack of administration and if there were any concerns raised by medical

colleagues who worked alongside Mr. O'Brien. I questioned what the GPs had prescribed for the same conditions because I knew there was an issue about what medicines Mr. O'Brien had been prescribing.

The conversation with Pauline was not for the purposes of advocating on behalf of Mr. O'Brien but to protect the Trust and to ensure that due process was being followed in procedures and governance adhered to.

I was alerting Pauline regarding the systems in place. I never asked the outcome, only if these questions had been asked. Pauline was merely asking for advice and I was helping her prepare for the Board meeting in August 2020."

10:06 10:07

And that should probably refer to the Board meeting in September 2020, isn't that right?

10:07

A. Yes, because it was a workshop in August.

8 Q. Yes. And just to be clear in terms of your recollection, we saw yesterday the workshop and it moving into a Board meeting yesterday; the conversation with Mrs. Brownlee that you remember, did it occur before that, those August events, or did it occur in advance of the September meeting?

10:08

A. My recollection was that it was in advance of the September Board meeting.

10:08

9 Q. Yes.

A. And she was quite specific about chairing the item in the September meeting.

10 Q. Yes. Now, you've indicated, I have read that out in

full, and you've indicated in your witness statement that you disagree with elements of what Mrs. Brownlee has said there. Could you outline your points of disagreement?

A. Okay, could I ask you to scroll. 10:08

11 Q. Of course, and I can bring you to your witness statement.

A. Scroll up.

12 Q. Yes, if we scroll up to the start of where I started.

A. Okay. Certainly when Mrs. Brownlee spoke to me she 10:08
didn't perceive it as a conflict of interest, she said it was a conflict of interest. She named Mr. O'Brien. My recollection of it was that she said there were serious concerns that would be brought to the Board meeting and asked me if I would chair the item at that 10:09
Board meeting. I mean, this was quite a normal practice. Mrs. Brownlee would have rung people, you know, either to chair consultant panels or to maybe chair parts of the Board meeting, so I didn't think there was anything unusual about that. And she had 10:09
clearly stated her conflict of interest so, as far as I was concerned, that was the end of the conversation.

13 Q. Yes. You made a note, or you've said you have made a note in respect of that conversation. If we just can bring that up, it's a very short note, WIT-99862. And 10:10
it's written on what appears to be notepaper relating to another organisation, Relate NI, is that just something you had handy?

A. Yes, it was on my desk at home. I just made a quick

note of what she had asked me to do, what she had said, just to remind myself.

14 Q. What does the note say?

A. It says: "Take the Chair. Conflict of interest. Urology. If there were concerns that was the issue that she wanted me to raise in the Board meeting, if there were concerns why weren't they raised before, why weren't they flagged before." 10:10

15 Q. Flagged before, okay. And just going back to Mrs. Brownlee's statement, you were working through it at WIT-90873. And she, as you've heard read by me, she sets out in her statement a range of issues that she says she was telling you to raise at the Board meeting or suggesting that you might think about and raise, including issues relating to prescribing, about re-validation, about the role of his personal assistant. Were those issues raised with you? 10:11 10:11

A. My recollection was that they weren't. I know these issues came up in the email that Mrs. Brownlee sent the day before the Board meeting so maybe she has got confused there. 10:12

16 Q. Yes, we will certainly ask her about that. I think the email you refer to is to be found at WIT-98812, if we just take a brief look at that. No, I've got the wrong reference there. See if I can come back to that in due course. Yes, thank you. Michael was about to tell me that as well so thank you. So, what you were saying is Mrs. Brownlee in her witness statement has recounted a range of things she believes she may have raised with 10:12

you or did raise with you for the purposes of chairing this item on the next Board meeting. You say you think she is mistaken and you point to this email that she sent to, as we understand it, her fellow Board members on the eve of the Board meeting and we can see she is speaking to a paper that was circulated in advance of the Board meeting. It says: 10:13

"This paper references many HR areas." 10:14

She has read the paper and she's asking a series of questions including why hasn't an alert paper on this area never come to the board before. She is asking about performance with comparison with other consultant urologists. "Have we any concerns raised by GPs." 10:14 She's asking about appraisal process. Scrolling down, just to the end of it, please. So she is essentially asking colleagues to take these matters on board and think about them in advance of the meeting on the 24th. 10:15

Just in terms of your engagement with Mrs. Brownlee, was this the first time that she had, to the best of your memory, declared a conflict to you and explained the basis for it?

A. The first time was when she phoned me and asked me to chair the item in the Board meeting, that was the first time that I was aware that she had a conflict of interest. 10:16

17 Q. Yes. In terms of the basis for that conflict it was

explained to you as arising from her patient relationship with the clinician, Mr. O'Brien?

A. Yeah, it was, yeah, purely that she had been his patient.

18 Q. We know through evidence to this Inquiry that there are potentially other sources to the conflict including a friendship and a quasi business relationship through an organisation called "CURE", and we'll ask Mrs. Brownlee about that when she gives evidence. Were those potential sources for conflict ever raised with you by her? 10:16 10:17

A. I only knew about those by reading through the transcripts for this Public Inquiry, they were never raised with me.

19 Q. Mrs. Brownlee, as we have observed from her statement, has explained that in speaking with you, it wasn't for the purposes of advocating on behalf of Mr. O'Brien, it was simply with a view to protecting the Trust and ensuring that due process was being followed. In her dealings with you, the conversation that you've referred to, did you regard it as advocacy on behalf of Mr. O'Brien or, in the alternative, was it simply in your view a straightforward and appropriate transaction asking you to take over the Chairmanship because of her conflict? 10:17 10:18 10:18

A. I thought that it was an appropriate conversation, that she had rung me to tell me that she had a conflict of interest. She explained what it was. Whether or not her asking me why these serious concerns had not been

flagged before was appropriate or not, I'm not sure but...

MR. WOLFE: I've received an objection to how I framed the question in relation to the "CURE" relationship where I described it as quasi business. 10:19

CHAIR: Well, they were both directors of a charity.

MR. WOLFE: Yes, it was a company which was set up for charitable purposes, that's why I used --

CHAIR: Yes, but they were both directors, so quasi business was reasonable. 10:19

MR. WOLFE: Well I agree, Chair, so I thought I would draw that to your attention in case the record required correction in your view, I don't believe it does.

20 Q. In terms of the meeting then which you were being asked to chair on 24th September, we are aware that a report was furnished to members of the Board in advance of that meeting, you clearly received that report, isn't that right? 10:19

A. Yes, that's right. 10:20

21 Q. And we can take a look at that. The report is to be found at WIT-99831, and it's apparently authored by Dr. O'Kane, although no doubt, given the range of issues covered in it, it's the product of a number of contributors no doubt. This was no doubt a helpful report for the Trust Board in that it comprehensively brought the Trust Board into, I suppose, contact with the whole background to events that had transpired and brought you - that is the organisation - to the place 10:20

it was in in September 2020. How did you regard the report?

A. Well I have to say when I read the report I was stunned. I had to sit down and read it about three or four times. I suppose for me there was, you know the report was well written, it's what we asked for, it was factual, there was a timeline. But I suppose in my role as NED I had, you know, two major concerns and a range of emotions I have to say. My first concern was for the families involved. Sometimes when you see these reports, and you will see it a lot, I have seen it a lot in child protection investigations that I have been involved in, they are listed as cases and behind these cases are people. They are fathers and mothers and sons and daughters. So for the families involved I think this was very distressing and traumatic. 10:21 10:21 10:22

But my second concern was also for our staff. Our caring, dedicated, committed staff who had worked so hard through Covid now had a separate challenge. They had to go out and contact all these families. In the report it said there was over 700 cases where there was potential for causing harm. So I think that was quite distressing for the staff as well. So for us, obviously the report was helpful as you say, Mr. Wolfe, in terms of giving us the full range of information, but I think it also had quite a huge emotional impact on NEDs as well. You know, I think when I look through the timeline and looked at the length of the time that 10:22 10:23

these problems were going on and the staff who had very little support from us as NEDs, apart from John Wilkinson, and I felt that certainly we had not provided safe enough systems to keep these patients safe and obviously to support our staff. 10:23

22 Q. Yes, we'll look at some aspects of the report just now. You pointed out that your initial response to it was concern for the patients, concern for the staff, did it also jar with you that you are now getting this information, and we'll see the kinds of information 10:24 that you were now being given, but did it not jar with you that you're getting information in September 2020 that perhaps ought to have been provided to you at appropriate stages several years earlier?

A. Well, I mean I've thought about this a lot, if we had 10:24 had these systems in place that we have now we would have seen this report earlier. You know, obviously I don't know why we weren't told earlier, why did the staff not feel that they could approach us earlier with these concerns, was it around confidentiality, was it 10:25 around gathering the information? I don't know.

23 Q. Well, we'll maybe come to some specific aspects of that in a moment. I've described the report as comprehensive, there is at least one area where perhaps isn't wholly comprehensive and I want to raise that 10:25 with you. But if we scroll down the initial page, and just on to the next page please, we're provided with an introduction. And just looking at the first paragraph it sets as its context the events of June 2020, three

months earlier, and it's observing that on the Associate Medical Director's initial review of a list of patients which had been sent into the system by Mr. O'Brien, he noted that two of the patients were stated to have been listed on 11th September and 11th February 2020 but it appeared, on his review, you're being told that there was no, essentially no record for those patients on the Trust's systems. 10:26

Now just to point away from this document, that issue has been the subject of some controversy before this Inquiry. Mr. O'Brien has given evidence that that is quite wrong, that there were records for these patients on the system. Has that issue been reviewed by the Board in light of that evidence, do you know? 10:26 10:27

A. I don't know, I would presume that some of these cases were part of the SAI.

24 Q. I think it's a slightly different issue, it's about record keeping and it's about, if you like, the triggering for this process, Mr. O'Brien's point being that the premise for getting into all of this is wrong, that there were records, he had made appropriate records for these two patients and that they were to be found on the lists? 10:27

A. Well if Mr. O'Brien has provided that evidence, I certainly haven't seen it. 10:27

25 Q. Okay. It hasn't -- what I'm asking you is has it been discussed on the Board?

A. No.

26 Q. No. And getting back to what you were being told then at the time, if we just scroll down, the initial pages are taken up with the Trust, that is Mrs. O'Kane explaining to you the preliminary investigative steps being undertaken by her team to get to grips with the problem, essentially an initial fact-finding stage. We then, if we scroll forward to WIT-99841, a few pages further on, she sets out, if we scroll down the page, she sets out the findings of the MHPS investigation and she explains that there were 783 untriaged referrals by Consultant A, of which 24 were subsequently deemed to be needed to be upgraded, a further four with confirmed diagnosis of cancer. She then gets into the findings that there were charts being kept at home. And, just scrolling down, she documents the findings of the MHPS, which are not uncontroversial in light of Mr. O'Brien's evidence, but she has pointed out that there were a substantial number of clinics, 66, affecting over 600 patients where there had been no dictation done. And, finally, she points out problems in relation to the management of private patients into the NHS with unfair priority is the sense of it. So that's the information that the Trust Board is being given more than two years after Dr. Chada has made these findings in her MHPS investigation report. 10:28 10:29 10:29 10:30 10:31

Now, you say you thought about whether there were perhaps good reasons for not bringing such information to the attention of the Board before now, do you think

there are any good reasons, can you conceive of good reasons why the Non-Executive Directors were not given this information?

A. Having read the report, and obviously the transcripts of the Inquiry to date, it seemed that alongside this there was a long running grievance where, you know, particularly HR staff were asked to provide a lot of information. I think that maybe slowed that process down quite a bit. The consultant concerned was also ill for part of the time so he was in work and out of work, but it seemed to me that he was reluctant to engage with the process. And, as I said before, Managing High Professional Standards, I was unsure, is it a clinical process or is it a HR process. The clinical process probably needed just to go ahead in terms of looking after our patients and ensuring that patient safety was the priority and the HR process, in my view, and the grievance, could have been handled in priority. But, obviously, the Medical Director and the Chief Executive didn't feel that they had a complete enough suite of evidence to bring to our attention. Having looked at a lot of the evidence given to the inquiry, I suppose the conflict of interest of the Chair is something that stands out to me. Because normally you would go from Medical Director to Chief Executive to the Chair, but if the Chair had such a conflict of interest, I only knew it as a patient conflict, but if there was also a personal friendship and some sort of involvement with a charity, then that

10:32 10:32 10:32 10:33 10:33

was a much bigger conflict of interest than I certainly would have imagined and I would imagine that that would make it very difficult for the senior leadership team to take this sort of issue to the Chair.

27 Q. Now I wonder in all fairness to the various perspectives that you have just outlined whether you are overcomplicating it, my question to you is was there any good reason, underscoring the word good reason, why this kind of information would not be brought to the attention of the Non-Executive Directors? 10:34 10:34

A. Well it should have been brought to our attention and it wasn't.

28 Q. Thank you. If we scroll back up the page, you're told in this timeline that on 1st October 2018, again a little shy of two years beforehand, that Dr. AK, who we know to be Dr. Khan, met with the consultant to outline the outcome of his determination, that the case should be forwarded to a conduct panel under MHPS. Now, you now know that Dr. Khan produced a written determination setting out his view in light of the investigation report produced by Dr. Chada. That written determination, was that ever provided to the Trust Board? 10:35 10:35

A. No. 10:36

29 Q. Did you know about its existence before the Inquiry provided it to you?

A. No, and I suppose under the present system that determination would have come in the quarterly report

to Governance Committee.

30 Q. Let's leave that aside for the moment. We need to focus on what the Executive Directors of the Trust did and didn't do in realtime and whether their performance in this respect is of concern to you. So if we focus on what Dr. Khan said. If we can open up his determination at AOB-01923, and I know that you will have had an opportunity to read the report. I want to draw your attention to his final conclusions and recommendations. You are familiar with this now, is that fair? 10:37 10:37

A. Yes, yes.

31 Q. What he is saying, if I can paraphrase, is that the MHPS investigation has raised concerns that don't just rest with Mr. O'Brien, they also affect and relate to a management system within Acute Services that has gone, in his view, badly wrong. And if I can read he says: 10:38

"The investigation report highlights issues regarding systemic failures by managers at all levels, both clinical and operational within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr. O'Brien. No one formally assessed the extent of the issues or properly identified the potential risks to patients." 10:38 10:39

He goes on to say:

"The default processes were put in place rather than addressing the deficiencies."

The findings of the report, he says, should not solely focus on one individual, Mr. O'Brien. And in his final paragraph he recommends the conduct of an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. 10:39 10:40

Now, is it fair to say that you have only been able to read that report in the last three to four weeks?

A. Yes.

32 Q. And that's because it was given to you by the Inquiry? 10:40

A. Mhm-mhm, yes.

33 Q. And if we go back to the report that you received from Mrs. O'Kane in preparation for 24th September meeting and we'll find it at WIT-99841 where she talks about - just scrolling down - where she talks about the Case Manager's determination. She solely refers to that part of his decision that discusses the need for a Conduct Panel in association with Mr. O'Brien's practice. What is hidden from the view of the Trust Board is all of those concerns expressed by both Dr. Chada and then Dr. Khan about the performance of management within Acute at all levels and the need for an independent review of this. As you say none of this was brought to your attention? 10:41 10:41

A. No, and I wouldn't use the word "hidden".

34 Q. Okay.

A. I think in the general scheme of things these reports would not be brought to Governance or Trust Board. You wouldn't see the full determination or the full reports under Maintaining High Professional Standards, you would see the outworkings of it, what the determination was and then what we were going to do about it. 10:42

35 Q. Okay. So you are being told within this timeline one aspect of the determination, open and above board, transparent, that there is to be a Conduct Panel or that there ought to be a Conduct Panel. If "hidden" isn't the right word to describe not telling you about the criticisms of the performance of management, what is the appropriate word? 10:42 10:43

A. Well, when we look at these sorts of reports and incidents, in my view it is never about one individual, it should be about the systems that we have or have not got in place. So the discussion, as we went through after this report in Trust Board, was about the systems as well as what had happened with this particular individual and we were very clear that the systems that we had were not keeping the staff supported and the patients safe enough. 10:43

36 Q. So, is it satisfactory that you were not told the views of Dr. Khan in respect of the failures of management back in 2018 given that it was the same management, largely, which remained in place through 2020 when these other difficulties associated with Mr. O'Brien's 10:43

practice were revealed?

A. I think we should have been told about them. I mean, we should have been told what Dr. Khan had found in his determination. Something that was so serious should have been brought to Confidential Governance or Confidential Trust Board meeting. 10:44

37 Q. And why do you consider that to have been important?

A. Sorry, ask again?

38 Q. It may appear obvious, but could you spell out to us, in light of that answer, why would it have been important that you would know this? 10:44

A. Because then we could look at the events in the round. I mean, it's our job to look at the systems, it's our job to improve them, it's our job as a Trust Board, both Executive and Non-Executive, to improve the services. Patient safety is the No. 1 priority. But alongside that, and it's something that Dr. O'Kane has really emphasised, is psychological safety, that staff feel empowered and feel safe enough to bring those issues to us to discuss and obviously they didn't. 10:45

39 Q. Yes. By the end of 2018 and the commencement of 2019 Mrs. O'Kane was Medical Director?

A. Yes.

40 Q. And in some respects, perhaps with others, had ownership of aspects of this together with the relevant management within Acute. Have you ever asked her why this information, obviously you couldn't have asked her about the Dr. Khan report only knowing about it recently, but have you ever asked her to explain why 10:46

the MHPS findings in the round didn't come to the Trust Board prior to September 2020?

A. No, I don't think we have had that discussion.

41 Q. Now that you know about Dr. Khan's report in all its glory, including his recommendation that there should be an independent review, is this something that Dr. O'Kane should now be asked about? 10:46

A. Well I think that as a Trust Board we should take some time out to talk about what's happened here. Certainly that's one of the issues that we should be talking about, to explore with Dr. O'Kane why the reports weren't deemed serious enough to be brought to us. 10:47

42 Q. Put it this way: If Dr. Khan's opinions had been put before you towards the end of 2018, maybe the early months of 2019, you as a Board would be saying 'right, we need to do an independent review here, we need answers to the questions which Dr. Khan has posed and we need a remedy, we need a solution so that things can be done better moving forward,' does that sound sensible and appropriate? 10:47 10:48

A. We should have taken some time out.

43 Q. You weren't told about it?

A. Yeah.

44 Q. My point is, if you had been told about it, does it sound sensible that that is the kind of steps that a governance savvy Board would have responded with? 10:48

A. Yes, I think we would have discussed it and taken some action on it given that there was also an ongoing grievance.

45 Q. I used the word "hidden" from you, is there a better word to describe a failure on the part of the Executives to tell the Non-Executives about the criticisms that they had received?

A. Well, I mean that's the call of the Medical Director and the Chief Executive, what's appropriate information to be brought to Governance and a Trust Board. Certainly having read Dr. Chada and Dr. Khan's reports I think the determination should certainly have been brought to us for discussion in terms of the failings of these systems around governance. 10:49 10:49

46 Q. If we could just scroll through the remainder of this report just so that the Panel can remind itself. So the findings of the MHPS are set out, just scrolling down. Then you're told, again for the first time, as I understand, that this consultant had been the subject of a referral to the General Medical Council. Again is that something you should have been told previously, even on a confidential basis? 10:50

A. I would have thought so. Under the present system we're told. 10:50

47 Q. Yes. Then we're into a timeline for a grievance process. You will recall yesterday that was the subject of the expression of concern by Mr. O'Brien in his June correspondence, but you took the view that this wasn't something that bore further inquiry from you as a NED? 10:51

A. I think, as I said yesterday, Mr. O'Brien's letter, I considered it to be a HR matter, where he was

aggrieved and he said in the letter that he was aggrieved that he was not being asked back to undertake part-time employment.

48 Q. And I'm curious, the fact that you received that letter and your colleagues received that letter, did that not even arouse your interest to ask of Mrs. Brownlee why are we getting this, does Mr. O'Brien deserve a response, what is behind all of this? 10:51

A. From my point of view I thought it was inappropriate for Mr. O'Brien to send it to the NEDs. I thought it was entirely appropriate for him to send that letter to Vivienne Toal, the Director of HR. I also thought it was unwise and inappropriate of Mrs. Brownlee to send the letter or ask for the letter to be sent on to the NEDs. For me it was clearly a HR matter. I have been a senior manager for 25 years, I've dealt a lot with HR. In the letter, in my opinion, it was about Mr. O'Brien's employment. He didn't, there was no whistleblowing issues and certainly he didn't raise any patient safety issues. So it was entirely appropriate that he sent it to HR, but I thought it was inappropriate for him to send it to Mrs. Brownlee. 10:51 10:52 10:52

49 Q. And did you tell her that?

A. Did I tell?

50 Q. Her that? 10:52

A. No, I just ignored it.

51 Q. And then, if we continue scrolling down to the next page, 44 in the series. You're told about the serious adverse incidents starting with the index incident of

Patient 10, and then you're told about further incidents or SAIs that had materialised at a much earlier point. I don't think anywhere in the document is it spelt out to you that the omissions giving rise to these SAIs occurred in 2016 and were only the subject of a finalised SAI report in May 2020. You are now aware of that, is that fair?

A. Yes, I am, yes, yep.

52 Q. Again does that add to your sense that this issue in the round hadn't been well managed if an SAI investigation on the subject of failure to triage had been allowed to drift for three years or so?

A. Yeah. I mean, I've read the SAI from 2016, the root cause analysis, and I have also read the root cause analysis of these SAIs. I would say that really we should have been appraised of the seriousness. I mean, SAIs are serious any way, but in 2016 my understanding now, that it wasn't just one patient, there were more patients. Also these issues had gone back a longer time, which we certainly weren't told about in 2017.

53 Q. Yes. We'll come to your preparation for 24th September meeting in just a moment because I think some of those points emerge in your thinking at that time and I just want to work through them with you. But just one point that you could maybe help us with, if we go to WIT-90874, it concerns whether Mrs. Brownlee was privy to the report that we've just been looking at and she has said, just about... yes, so she says, just in the middle of the page:

"Pauline Leeson took the Chair in my absence. Prior to receiving Inquiry discovery documents I had never seen the paper prepared for agenda item in September 2020. I knew none of this detail of the allegations regarding Mr. O'Brien." 10:57

I think you're quite clear that Mrs. Brownlee had seen the paper in advance of 24th September meeting?

A. Well my reading of Mrs. Brownlee's email the day before the meeting was, I thought that was the paper that she was referring to and she was quite clear in that email that she had seen it. I think she had also asked the Chief Executive to make some changes in it in regards to Mr. O'Brien's name. 10:57

54 Q. Well, I think we'll just go back to that email and perhaps Mrs. Brownlee, in fairness, will be able to clarify it for us, but it is WIT-99812 and we touched on this earlier. And she's saying "You're aware I'm removing myself from this agenda item" and she still, she says, has a very serious responsibility for this. She has discussed it with the Chief Executive yesterday: 10:57 10:58

"I have read this paper and have noted many areas that need explained. This paper references many HR areas." 10:58

So it may be that there is some confusion there, but the only paper that you are aware of that was prepared in advance for this 24th September meeting is the one

we have been discussing?

A. Yes, yes, that's right.

55 Q. You have, as part of your disclosure to the Inquiry, sent us some notes that appear to be your preparation for chairing the item on 24th September. If we can pull those up, they are found at WIT-99863. You appear, I suppose diligently, to have worked your way through the report that Dr. O'Kane had provided for the meeting. You're summarising, as we can see from these notes, what you're picking up from the paper itself. 10:58 10:59

Just scrolling down, so you're starting with what had occurred in June 2020 or at least what the AMD, that is Dr. Haynes, Mr. Haynes had reported, as occurring, patients assessed in September 2019 and February 2020 but not added to the in-patient list. You regard that as or you're describing that, picking up on the paper, as potentially very serious clinical risks. You've noted earlier that Mr. O'Brien vehemently disputes that. But then you're into describing, summarising - if we scroll down - the various other aspects of the paper. 11:00 11:00

If we could bring you, I suppose, to rather laboriously go through it. If we could bring you to the list of queries that you arrived at and they are at 6-7 in this series, four pages through. Just that bottom half of the page, yes, just from there, thank you. I suppose, the first thing on the list is "This is the first time 11:00

this is being brought to the Trust Board." That has echoes of what Mrs. Brownlee, I think, on your handwritten note had been saying to you, that was a concern to her, why is this only coming to the Board now? 11:01

A. Yeah.

56 Q. You shared that concern?

A. Well it was the first time that it had been formally brought in writing to the Trust Board. We had had a verbal report of concerns about a number of SAIs in 11:02 August, but this was the first formal written paper.

57 Q. Yes. Then there is a question for John, is that John Wilkinson?

A. John Wilkinson.

58 Q. And you've said: "How long you have been involved." 11:02 Just translate that for us?

A. "And when did it terminate."

59 Q. Right. Thirdly, "what level is this SAI at", comparing the outset, that's 2016, and "what level of SAI is it now", in 2020. Is this a focus on the SAI that started 11:02 life in 2016/2017?

A. Yes, yes.

60 Q. And does that say, "what determined the level of the SAI"?

A. Yes. 11:03

61 Q. And then you asked, "why no formal action in 2016"?

A. Yes.

62 Q. Scrolling down, can you help us with that one?

A. "After identified in 2016, why did it take until 2020".

63 Q. Yes, quite. 7: "Was there any evidence to state that patients suffered harm." And if you could help us with 8.

A. Yes: "Look at decision making, who made the decisions. What evidence -- how was he allowed to continue to practice?" 11:03

64 Q. Yes. I suppose aspects of that have echoes in Dr. Khan's determination around decision making, who made the decisions?

A. Hmm. 11:04

65 Q. That's directed at the failure of decision making, is it?

A. Yes, and also where good decisions were made.

66 Q. And if we could look at the minutes of the Trust Board, we can find those, so far as is relevant to urology, it's item 7 on the agenda at TRU-130826. And just at the bottom of the page: 11:04

"The Chief Executive set the context of this item by advising of the likelihood of significant media interest." 11:05

Scrolling down. Then Dr. Gormley intervened and took the matter forward. Dr. Gormley was the?

A. Deputy Medical Director. 11:05

67 Q. Deputy Medical Director. She attended that September meeting in lieu of Dr. O'Kane?

A. He, Damien.

68 Q. He, sorry?

A. Yes.

69 Q. And Dr. O'Kane was absent from the September meeting. She was also absent from the October meeting, which we will come to. Did you think that unusual? I'm not sure if you ever received an explanation for her absence, but it's hard to think of anything more significant in terms of the life of a Trust as something like this which was bubbling up towards what was to become a Public Inquiry territory? 11:06

A. Yes, I wasn't aware of why she wasn't present. 11:06

70 Q. For two meetings in a row?

A. Yes. Well, I suppose to give some context, during this time, obviously we were just coming out of Covid, there were huge challenges, particularly in the acute hospitals. Dr. O'Kane in my opinion was trying to 11:06 manage a lot of very different pressures. And it's not just in hospitals, it is also in the community services. She has -- I mean, Dr. Damien Gormley is a very able Deputy Medical Director. He gave a good summary of the clinical concerns, he went through the 11:07 paper in great detail and laid it all out for us.

71 Q. Yes. So he lays it all out for you, you intervene asking about previous SAIs, sorry asking about new SAIs given that there had been previous SAIs and you're told that an External Chair has been appointed. You ask how 11:07 far back the process would go and you're told that the focus has to be on immediate concerns. You had, as we saw, a list of questions or concerns prepared as part of your homework or your preparatory work for this

meeting, notably:

"Why hasn't this come to us before now? What was the decision making that has led up to all of this?"

11:08

Again, we're vulnerable to whether the minute is a full account of what transpired at the meeting, did you get an opportunity to ask the kinds of difficult questions that you had in mind?

A. Yeah, I mean those questions are usually part of my prep, what I'm thinking through, you don't always ask all those questions. Dr. Gormley gave a really very detailed report on the paper that he had presented. Certainly I thought that they were the most important questions to ask. I would have been concerned that there were previous SAIs that we didn't know about in 2016 and also how many more were there given that we have been told that there were over 700 untriaged cases where there might be potential for harm. 11:09 11:09

72 Q. So you got the facts from him that you, as a Board, were now fully in the picture, there was nothing else? 11:09

A. Well, I think he gave a very full account of what was in the paper. I was certainly reassured, particularly when an External Chair has been appointed to take forward those SAIs, that would have assured me that this matter was being treated very, very seriously and once that happens that then goes into a different process. 11:10

73 Q. So your priority, I suppose, was to seek assurance that

we're now getting to grips with this, that the appropriate investigative processes are in train?

A. Well the pragmatic side of me said that we've got this situation now, so we have to look at how we're going to deal with it and what systems, what kind of processes were going to be put in place to, No. 1, deal with the SAIs that we had but also to look back and see was there anything else that we had missed.

74 Q. Yes. To the extent that your instinct was to ask questions and to probe about the failures, if they were failures, or the omissions that led to this situation, have you ever asked those questions? 11:11

A. I think that we should have taken time out, particularly as a group of Non-Executive Directors, to discuss this paper and what had happened and where the failures had been and we haven't done that. But - and it's not in terms of any excuse - the process then went into a completely different direction. Obviously we've got, we had the External Chair, then in November we had the announcement, initially I think in October where they were talking about a review, and now in November they announced, the Department announced, the Minister actually announced that it would be going to Public Inquiry. So that's where the learning will come from and that was then our focus in terms of the opportunity to explore what had happened and where we had failed as a system and what recommendations and learning could come out of this process to strengthen our governance going forward. But having said that, we had already 11:11 11:12 11:12 11:12

started to strengthen the governance from the June Champion report in terms of putting in those reports into the Clinical and Social Governance part of the Governance Committee.

75 Q. Is that to imply that the deficit of information sharing with the Board, which you have already alluded to in response to my questions, is not now the picture, it shouldn't have been the picture at the time but the position has now changed? 11:13

A. I think there's been a considerable cultural shift in the Board. We're working together much more as a collaborative Board. It doesn't mean that you don't ask hard questions, you don't scrutinise. I mean, some of the meetings are quite robust in terms of the many challenges and pressures that come up in the Trust Board. But I think that the culture has really encouraged I think particularly through the current Chair and the Chief Executive, encouraged an environment where staff feel much more psychologically safe, where they can come to us and tell us if they have concerns, where there are risks and together we look at how we can minimise those and put in mitigations. 11:13 11:14 11:14

76 Q. Just looking at minute in front of us, we see that Ms. Donaghy has picked up on a point which I was addressing yesterday, which is the Early Alert. She is asking when was this Early Alert submitted, that seems to indicate a view that perhaps there was a degree of unhappiness on the part of NEDs that you had been kept 11:14

in the dark about this for more weeks than was healthy. The Chief Executive undertook to clarify and we know that this was clarified. Was there a sense amongst the NEDs that you had been kept in the dark for more time than was healthy, not just over the summer months of 2020 but stretching it back further to the MHPS and all of that? 11:16

A. I think, you know, Ms. Donaghy asked a really good question. The context to that was that Early Alerts were only shared with us on an occasional basis and only in the last year. Now, we would see all the Early Alerts. The situation then was that you wouldn't necessarily see all of the Early Alerts, certainly this Early Alert in my opinion should have been shared with us. 11:16

77 Q. You were explaining to us how there has been something of a cultural change and I just wanted to help you illustrate that, if we go to WIT-90675. This is an example of a report which, as I understand it, is brought to Governance Committee, I'm not sure if the report has changed in form over time. But if we just open it up, essentially - and bring that up, yes, thank you, that's very kind of you. We've received evidence already, the Panel will remember, explaining that the cases that are triggered or are potentially going to be screened into the MHPS Framework are now routinely brought to the Governance Committee's attention and you have full visibility on the processes as they wind through the system, is that right? 11:17 11:18

A. Yes, that's correct.

78 Q. We can see the relevant date the case being opened, the name -- well, you get a summary of, I suppose, the issues at stake. We've taken the liberty of redacting that for obvious reasons and then you get to know who is involved, whether the PPS are involved, whether the GMC has been informed, whether there is impact on patients, that is a patient safety issue, and whether there is an SAI. I think - just scrolling down - there is other elements of the data. So this is indicating new cases coming into the system as well as, up above that, cases that are further down the track. 11:19 11:19

So are there any aspects of this information flow to the Non-Executive Directors that you think are healthy or, on the other hand, do you see room for even further improvement along the lines of this model? 11:20

A. Well, I mean, there is always room for improvement. Yesterday I did give you my opinion on the role of the NED in this process. I think that this is such a helpful document in terms of a Clinical and Social Governance report to Governance Committee. It's one of the suites of, what we call the triangulation of data, that will show us what issues are coming through, what sort of -- the reasons why some doctors, you know we have it for nurses and social workers as well in difficulty, so that we're getting a good idea of what's going on in those professional areas. It sits alongside the reports from SAIs which sits alongside 11:20 11:21

the complaints, litigation, clinical audit. So you get a much rounder view of trends and patterns over a period of time rather than just separate reports that give you snapshots of what the challenges are in certain areas. So for me I think that this provides a much fuller, more comprehensive data for us to really get an understanding of what's going on in the Trust.

79 Q. Yes. It is perhaps something of a solution, and it will be for others to judge whether it's a wholly adequate solution, to the lacuna that I have been exploring with you at some length this morning. And just to revisit it in conclusion: The events of 2020, in the summer of 2020, happened against a background where the Non-Executive Directors of the Board were deprived of an opportunity to scrutinise the patient safety issues that had arisen and been revealed by the findings of the MHPS investigation as well as the management failings that had been revealed by the MHPS investigation. Can I assume that you would agree with the proposition that, if the Non-Executive Director members of the Board had been allowed to challenge, had been given the information to permit scrutiny, that action could have been taken to improve matters long before you got to 2020?

A. Well, as I said yesterday, I mean governance is a dynamic process, it's always improving, you're always looking to make the systems better. So it would have been more helpful if we had have got timely reports about some of the incidents to help us provide better

oversight.

80 Q. But, I appreciate the sentiment that governance is a dynamic thing, but what we're talking about here is basic behaviours, are we not, the sharing of and the legitimate sharing of information with the very people who are employed by the Department to exercise scrutiny and to provide challenge. This should have been a basic response on the part of the executive employees of the Trust to a real live problem? 11:24

A. I think on reflection the decisions to share information have improved greatly and that's been through a number of discussions and conversations around Trust Board where we recognise that all of the Directors, Non-Executive and Executive Directors, have a responsibility for patient safety and for governance and they feel, I would say, more safer to come forward and give us that information. I mean, certainly since 2020 the systems have improved. I think the Directors have greater trust in us in terms of sharing information. I don't know why the -- in the grand scheme of things those sorts of reports from Dr. Khan and Dr. Chada wouldn't be shared in their entirety, but certainly the determinations and the outworkings of them would now be shared under this sort of framework. 11:25 11:25

81 Q. I suppose the question, Mrs. Leeson, is do you have trust in them, if they have failed to share the findings of Dr. Khan, even in a confidential forum, particularly where those findings highlight managerial failings? 11:26

A. Well I suppose, Mr. Wolfe, for me, do they trust us, that's my question. Trust is a two-way process. Did they not trust us to share the information with us? I don't know.

82 Q. Okay. Please answer it by reference to the proposition that I put: If you're not getting information from the Executives, information that you believe you should have received, where is the basis for trust in those Executives? Have you thought about that? 11:27

A. Yeah, I have thought about it quite a lot. I mean, I'll go back to what I said, you know, did they trust us enough to hold that information, to give it to us. I think for me a lot of it is about systems, what systems were there to support them to share information, to be assured that we would treat it in a way that would be helpful and supportive to practice. 11:27

83 Q. The difficulty, of course, is that you're answering this question in something of a vacuum in that you haven't yet and nor have your colleagues asked the likes of Dr. O'Kane why didn't you share this with us? 11:28

A. And I think that's a discussion going forward, having seen a lot of the transcripts and obviously the evidence in the Inquiry that we will need to address.

MR. WOLFE: It's 11.30, should we take a short break and conclude? 11:28

CHAIR: We'll take a 10 minute break, if that suits everyone, come back at twenty to.

THE HEARING ADJOURNED FOR A SHORT PERIOD

THE HEARING RESUMED AS FOLLOWS:

CHAIR: Thank you, Mr. Wolfe.

84 Q. MR. WOLFE: I want to bring you finally to the Board meeting that took place on 22nd October 2020. As we recall, you had been asked to asked to chair the, let's call it an urology item in the September meeting because of Mrs. Brownlee's actual conflict of interest in terms of how you believe it was described to you or, as she puts it, her perceived or possible conflict of interest. But on 22nd October she did not leave the meeting for the urology item but stayed in the Chair and participated in the meeting, isn't that correct? 11:40 11:40

A. That's correct.

85 Q. And we'll just look briefly at that meeting. In advance of the meeting you were shared a report that Dr. Gormley spoke to in Dr. O'Kane's absence at the meeting. The report, if we just briefly open it, I don't wish to examine it in any detail, but it's to be found at WIT-99846. It, in essence, if we just scroll down, it is explaining to you that there is likely to be considerable interest, media interest in this matter. It updates you on the first substantive pages - just scrolling down - in terms of, it's a duplication here, keep going, sorry. So that's something of the background to the events that were unfolding. 11:41 11:41 11:42

Then, if we scroll down, I think it's the next page,

they set out a summary table of the serious adverse incidents, of which I think there were ultimately nine, I think there is nine set out in this summary table for which an external, who we now know to be Dr. Hughes, and what is described as a subject area expert, Mr. Gilbert, were appointed to take through. So that information, by way of update, is given to you ahead of the October meeting. 11:43

Then if we go to the meeting itself, we can find the minutes at TRU-131853. So Dr. Gormley spoke to that report and we can see, just scrolling down, that the Chair, that is Mrs. Brownlee, intervened to make some remarks. She recalled that she had written -- Consultant A had written to herself in June, she had shared that with Non-Executive Directors. She raised concerns at how the HR processes were being managed and requested that - sorry, I've got that wrong - Consultant A is raising these concerns and Mrs. Brownlee is bringing them onto the table at this meeting and she was told that this matter would be progressed through HR channels. She also raised the fact that a number of different Urology Consultants had been in place over the years and asked why they had not raised concerns about Consultant A's practice. Similarly, why had his PA not raised concerns regarding delays in dictation of patient discharges and she asked: "Should a GP not have recognised the prescribing issue in association with Bicalutamide." 11:43 11:45 11:45 11:46

Just scrolling down. Dr. Gormley responded to aspects of that and then the Chair asked about Consultant A's appraisals and asked if performance issues had been identified through this and again Dr. Gormley responded. Just in terms of Mrs. Brownlee's presence at the meeting were you alerted in advance of the meeting that your role as Chair, or temporary Chair for the urology item, would no longer be required?

A. I can't remember if she had maybe indicated through an email that she would be attending this meeting, I can't recall. 11:47

86 Q. But what I'm asking you specifically, I suppose is, did Mrs. Brownlee ever approach you --

A. No, no.

87 Q. -- to discuss the fact that she would attend the meeting? 11:47

A. Not me directly, no.

88 Q. No. In terms of her attendance at the meeting for this item first of all, what is your view of that or what was your view of that in terms of its appropriateness? 11:48

A. Well, I mean, in my view, once she had declared a conflict of interest to me in her phone call, she should have taken herself out of all the processes. She should not have participated in meetings, she shouldn't have sent that email before the Trust Board meeting in September, as much as to keep herself right as well as the Trust Board. But, you know, she had declared a conflict of interest, very clear about that, and I was surprised that she was coming to the meeting. 11:48

89 Q. Yes. We can see from some email correspondence that Mrs. Brownlee's proposed attendance at the meeting had been the subject of discussion, not with the Non-Executive Directors it would appear, but with Mr. Devlin and, through Mr. Devlin, with Dr. O'Kane. 11:49
If we could just briefly look at that. If we could go to TRU-253705. She's telling Mr. Devlin: "I wish to confirm that I will be staying in for this item". This is an email of 20th October, two days before the meeting: 11:49

"It is an extremely serious matter - she says - for the Board and I need to be present. I have no conflict with this particular matter. My past personal illness, I will try to overcome the emotions." 11:49

Then she sets out in the body of the email some of the issues that she is concerned about.

Just scrolling back up, please, so Mr. Devlin raises 11:50
this with some of his executives. We can see just above that on 20th October at 23:54 Mrs. O'Kane, or Dr. O'Kane is writing:

"Shane, my understanding from what the Chair has 11:50
disclosed openly is that she has been a patient of this doctor in recent years. Given that we will be discussing the impact on patients potentially, I am concerned."

Then just further up Mr. Devlin goes back to Dr. O'Kane and says:

"Happy to discuss. Although the Chair has not been a patient in recent years, she was a patient nearly 20 years ago. I think as Chair she needs to be part of the conversation and the whole Board need to be in the middle of this." 11:51

Can we assume that this kind of conversation was not something that you were privy to in October 2020? 11:51

A. That's correct.

CHAIR: Mr. Wolfe, I think Ms. Leeson was copied in to the email from Mrs. Brownlee, if we can just scroll down. 11:51

MR. WOLFE: Yes.

A. Apologies, Chair, I was copied in to the decision for her to come.

90 Q. MR. WOLFE: Yes. Her presence then two days later at the meeting wouldn't have come as a surprise in that sense, it had been heralded in this email. I am wondering in light of her open disclosure, certainly with you and for the record in respect of the September meeting, that there was a conflict, whether that should have triggered an objection, or at least a debate, at the commencement of the meeting on 22nd October? 11:52 11:52

A. Well, I have to say I was surprised at the decision being made. I think in his evidence Shane Devlin said in retrospect that it was a mistake for Mrs. Brownlee,

for her sake as well as the need for the discussion to be open and frank. I had presumed, and this was normal practice, that the Chair and the Chief Executive looked at the agenda in advance of Trust Board meetings and decided what the agenda items were going to be and who was going to attend. So, yeah, in retrospect I should have made an objection and I didn't.

91 Q. Was this development ever the subject of a conversation between you and your fellow NEDs with or without the input of Mrs. Brownlee even after this meeting? 11:53

A. No. I think, it's not to excuse it, but during this time a lot of the meetings were virtual. So if they had have been in person, usually we would meet afterwards and might have made some comments. But a lot of these meetings were virtual and you just came off the call and that was it. But I personally was surprised at the decision and I thought it was unwise and inappropriate that she attended. 11:54

92 Q. And I think you now are accepting that it should have been challenged -- 11:54

A. It should have been challenged.

93 Q. -- in some way and at least an explanation sought?

A. Yes, yeah, yep. But obviously it was a decision that she had discussed with the Chief Executive and he had agreed. 11:54

94 Q. You've described in your witness statement at paragraph 30.24, we needn't bring it up, that you found this to be an uncomfortable meeting and I have drawn attention to some aspects, the majority of aspects of

Mrs. Brownlee's input and the issues that she raised, drawing comparison with other practitioners, asking about the performance of general practitioners and the PA, asking about the fitness for purpose of the appraisal arrangements and what have you. Is it those issues and the raising of those issues that caused it to be an uncomfortable meeting or what are you alluding to?

A. I think that I found Mrs. Brownlee's behaviour to be, what's the word, defensive of the consultant concerned. A lot of the questions were not about what we had found in the report, they were more about other consultants, his PA, prescribing of medicine, I just thought it was really inappropriate.

11:55

11:55

95 Q. And in terms of her input, in your view did it have any practical impact or effect on how the Trust and the Trust Board was intending to pursue matters?

11:56

A. No, I don't think so. I mean, I think, you know Shane Devlin managed the meeting very professionally, very well. I think certainly I try to keep a focus on SAIs and the process rather than looking at other areas. So, you know, in retrospect I think that we were able to have the discussion that we needed to have and then move on. But I felt, and I've said it in my evidence, that I didn't feel that Mrs. Brownlee could be objective in that meeting because she had been a patient of Mr. O'Brien.

11:56

11:57

96 Q. Again your discomfort with the approach adopted, did you feel that she was placing the emphasis in the wrong

place as opposed to a focus on the risk of patient harm, the focus was in defence of Mr. O'Brien and criticism of others or how were you viewing it as you heard it?

A. Well the discussion should have been on patient safety, that's what the purpose of the meeting was. I felt that Mrs. Brownlee was defensive of Mr. O'Brien. She raised the issues that she had outlined in her email in September and brought those into the meeting, whereas the processed had actually moved on in terms of, we now had a process around SAIs, the Department was talking about a review. Ultimately in November it was, quite rightly in my opinion, a Public Inquiry. 11:58 11:58

97 Q. Yes. We can go back to the minute of the meeting itself, TRU-131854. And we have the Chair, as we have noted her intervention, Dr. Gormley responding to it. Scrolling down, Mrs. McClements' intervention. Scrolling down again, a question from the Chair about the process of using one Consultant Urologist and whether that was sufficient. Scrolling on down. One notes from the record that, although a number of the respondents to Mrs. Brownlee's interventions indicate that certain matters would be taken on board, it's a matter for the process going forward, there is no direct or indirect criticism or effort to stop her or to challenge her in circumstances where everyone round the table knew that there was a conflict. Was this just a matter that you put up with whereas with the benefit of hindsight you think she should have been 11:58 11:59 12:00

stopped?

A. I think the context for this was that Shane Devlin had agreed that she should come to the meeting. So in my opinion we just had to manage the meeting and get through the business as best as possible, keep the 12:00
focus on patient safety and address any other concerns.

98 Q. Do you think it's unfair to suggest that a Chair with this acknowledged conflict coming in and being given free rein to raise issues like this, do you think it is unfair to suggest that this says something adverse or 12:01
negative about the quality of governance and the quality of the culture of this particular board at that time?

A. I think that it was unwise to agree to let Mrs. Brownlee attend the meeting. It was unwise of her 12:01
to say that she was coming to the meeting. It's difficult when it's a Chair, it's been agreed with the Chief Executive. As I've said, my view was that we just had to try and keep it on to patient safety and any of the issues that we needed to discuss. And, to 12:02
be fair, I think Shane handled it very well. We did get the information from Dr. Gormley that we needed and we got an update on what was happening and the way forward.

99 Q. Thinking back on these matters now and the approach of 12:02
yourself as a member of this Board and your Non-Executive colleagues, do you consider that there was perhaps an unhealthy degree of deference to both the Chief Executive and the Chair and perhaps to the

other Directors in not standing up and not asking the kinds of hard questions and opposing the kinds of interventions that we see from Mrs. Brownlee?

A. Well in retrospect we should have challenged it and stopped the meeting and ask her to leave but we didn't. 12:03

100 Q. Was there an unhealthy degree of deference?

A. I think, you know, there was a lot of respect for Mrs. Brownlee. She worked long hours, she was a very caring, she is a very caring and kind person. But I think she made a very unwise decision, once she 12:03 declared that she had a conflict of interest, to send emails and to come to meetings when this matter was being discussed.

101 Q. If we look at what was, I suppose, the end point of this meeting, there was, I suppose, an emphasis placed 12:04 on trying to slow up the process of any public announcement in respect of the difficulties faced by the Trust and the consensus of the meeting was to approve the Trust's request to seek a delay in the ministerial announcement. Just scrolling up the page, 12:04 I think Mr. Wilkinson made the point that, whilst he supported the Trust's request for a delay, it was important that this was not, what he described as a "prevaricated delay."

12:04

What was at the root of that in your view, was it simply a case of the Trust trying to get certainty or get increased precision around the extent of this bad news story before the announcement was made or what was

it?

A. Yeah, I mean, my recollection was that we were not asking for a long delay. I think it was around perhaps making sure that staff, relevant staff would be told about it in advance. So there was no desire to, as John Wilkinson said, to have a long delay or prevaricated delay. It was just a very simple matter of -- my understanding was making sure that staff knew that we were clear about what the Terms of Reference were. 12:05 12:06

102 Q. Yes. Obviously shortly after that meeting then matters moved into the sphere of a Public Inquiry announcement and here we are today. Obviously the Trust has engaged with the Department and various reform processes have been examined and no doubt put into effect and some of your evidence this morning touches upon aspects of that. Your reflections within your statement, if we could bring up WIT-99802. You were asked, or you say: 12:06

"The governance arrangements were fit for purpose but they were not robust enough to deal with the practice of Mr. O'Brien." 12:07

Just that one sentence seems to reveal an inconsistency and I just want to give you the opportunity to deal with it. We've heard from you this morning about the kinds of information that wasn't shared with you. You have observed from Dr. Khan's report his view that there were managerial failings, since writing this 12:07

you've heard more evidence through the Inquiry about the problems faced by the Trust in dealing with this. Do you still think that the governance arrangements were fit for purpose?

A. I would say the governance arrangements were fit for purpose at that time, but, as I've said before, governance always needs to be improved, it needs to be reviewed, it needs to be made better. I think the governance arrangements that we have in now are much better and potentially would deal in a better way with what has happened with this case. 12:08 12:08

103 Q. I'm struggling a little bit with that. In what way do you think they were fit for purpose at any point between 2016 and 2018 or even before that if the kinds of problems that have been identified by this Inquiry were not being scrutinised, challenged and remedied? 12:09

A. Well, we did have the reports. I think the difficulty with the reports, that they were separate reports so we weren't able to see patterns and trends, but we still had reports. I think, as I've said there, the big failing was that, in this particular case, that we didn't have an overview of Maintaining High Professional Standards. I think that alongside the SAIs would have shown us more clearly about both the performance of urology and the practice of Mr. O'Brien. 12:09 12:09

104 Q. Does that not suggest that they weren't fit for purpose?

A. Well, they were fit for purpose at that time but...

105 Q. But how were they?

A. Well, we did have reports. We did have -- they weren't fit for purpose. They were fit for purpose at that time in terms of having governance meetings, having reports. The difficulty was that they didn't come together as a composite report to tell us what was happening in terms of these cases and performance in more general terms.

106 Q. With the effect that patient safety was jeopardised?

A. Well obviously patient safety was jeopardised here.

107 Q. And the heart of governance is protecting patients, maintaining their safety? 12:11

A. Yes. I have said before it's a deep matter of regret that the governance systems weren't safer enough to make our patients safe and support our staff.

108 Q. In 2022 the Southern Trust suffered another difficulty in that it was reported that the laboratory screening system in association with cervical smears were reporting results which other centres wouldn't have regarded as negative but would have prompted further inquiry as a potential abnormality. Now, I understand that as a Board you have had an involvement in dealing with this issue? 12:11 12:12

A. Yes, that's correct.

109 Q. Have you observed any change, any improvement by comparison with the urology situation in terms of information coming to the Board, in terms of you and your colleagues in the Non-Executive role having opportunity to scrutinise and challenge what has occurred in cytology or have things not improved? 12:10 12:12

A. Well I think they have improved considerably. The context for this is that this is not just limited to the Southern Trust. You have also got other Trusts who have faced similar challenges and also the PHA is a major partner in the roll out of this programme. But as soon as those matters were brought to our attention, we met about them, there was an action plan produced. There was arrangements for some capacity in other Trusts to do some extra screening and lookback. So I think our reaction to that has been much swifter. You know, all the information I think has come to us and we have had several really in-depth discussions about this. 12:13 12:13

110 Q. Yes. So, I'm more interested in the role of the Board and particularly the Non-Executives on the Board as opposed to the substance of the issue itself which obviously may have sensitivities at this point in time. What you're saying to us is, by contrast with your experience through the urology issue, the information coming to you as a board member is both quicker, it is coming to you more swiftly and in turn does that enable you as a Board to challenge more effectively and attempt to shape the agenda? 12:13 12:14

A. Yes, absolutely. The swiftness of the response has been much better than obviously this situation. All the reports, everything we've asked for has come to us. We have had a number of meetings, I think one on a Friday night. So we have been very engaged with that issue and, yeah, with very, very little delay. 12:14

111 Q. What would you put that down to? Would you say that that's improved leadership, would you say it's improved culture as a result perhaps of learning from urology or what is it?

A. Yeah, I think there is a number of factors. I think certainly the current Chair and the Chief Executive are very mindful that our priority is patient safety. Alongside that, particularly Dr. O'Kane would emphasise psychological safety. So staff are encouraged to come to us with any risks, any concerns as quickly as possible. So there has been a big cultural change there in terms of the swiftness of issues being raised and the information being given to us very quickly and comprehensively. 12:15 12:15

MR. WOLFE: Okay. Thank you for answering my questions, I apprehend that the Panel might have some further questions for you. Thank you. 12:16

CHAIR: Thank you, Mr. Wolfe. I am afraid we can't let you go just yet, Ms. Leeson, Mr. Hanbury has a couple of questions. 12:16

THE WITNESS WAS THEN QUESTIONED BY MR. HANBURY, AS FOLLOWS:

MR. HANBURY: Just a couple of questions for you. Thank you very much for your information statements. 12:16

112 Q. You managed to, as a Board, make a difference when the issues of the cardiology department and stroke problems came through, obviously on the medical as opposed to

the surgical side. But we've had evidence that the waiting times both for surgeries, assessment, outpatient, new and follow-up appointments, had been a problem, not just in urology, but in about nine surgical departments, so over quite a period. I guess my question is, on reflection do you think that you should and could have done more as a Board to address that as a separate issue?

A. To address urology?

113 Q. Not just urology, just the whole thing about waiting times? 12:17

A. Waiting lists. I mean, I think, you know that's a constant theme in the Board, both waiting lists and delayed discharge. It's not something that is just particular to the Southern Trust. I mean, it's an issue for Northern Ireland in particular and we are continually exercised about the waiting lists. I think Covid really, really made things much more difficult for us in terms of tackling that. And also, and it's not by way of excuse, I mean we as a more rural Trust face enormous challenges in terms of workforce, attracting staff, specialist staff in particular to the Southern Trust. Most consultants, surgeons, doctors, want to work in Belfast. You know, they feel safer there, they probably get better terms and conditions in terms of weekends off. But it is certainly something that we are continually mindful of. We are always looking at ways that we can -- you know, sometimes you can make applications to the Department for specific

monies to come in and clear some of the backlogs. But, I think to be honest going forward it's going to be something that's going to be challenging us for some time.

114 Q. Okay. But I mean, this had been going back right to 2009, so it is not just a recent thing. But was it discussed in detail at the Board? I just have a feeling it was continually reported and 'oh, it is just the waiting list again', no one grabbed this nettle and made particular issue of it? 12:19

A. Yeah, yeah. I mean --

115 Q. Whereas you did get more resources for other problems?

A. Yeah.

116 Q. And it wasn't just urology?

A. Yeah. 12:19

117 Q. Okay, we'll move on. In a similar view, looking at cancer care, the peer review picked up from a gap analysis that there were problems, again not just in urology, but breast, colorectal, lung as well. It is like reading a Datix, there is a lot there, but just picking out a couple of things: Radiology and clinical oncology and availability of clinicians and this thing of quorum of multi-disciplinary meetings, which obviously can affect the quality of opinion, of care; so did you discuss that at the Board, the sort of specific cancer problems and whether there anything that you could improve there? 12:20

A. Yeah. I mean, a lot of these services in my opinion were impacted by our failure to recruit specialist

staff. You know, urology was down, the Chair I think said yesterday that we lost nine consultants in one go through retirement and obviously wanting to move on out of Daisy Hill. It is such a high pressured service. I mean, and I'm sure you know yourself as a consultant, there are so many services, particularly under Acute, that were coming up with longer waiting lists, more challenging issues. I know certainly that the Director of Performance, who I would have worked with quite closely, in Performance Committee was always putting in bids for extra money to try and bring some of those resources in. 12:21 12:21

MR. HANBURY: Okay. Thank you very much, that's all I have.

CHAIR: Dr. Swart? 12:21

THE WITNESS WAS THEN QUESTIONED BY DR. SWART, AS FOLLOWS:

118 Q. DR. SWART: I think the evidence we've heard throughout the Inquiry, and I think it's quite obvious, was that there was a blind spot with respect, on the Board of the Board, with respect to the totality of the issues in urology, and the impact on safety, quality and all the other things we have talked about. This is generally a combination of issues, to do with governance, culture, management processes, organisational development focus and all of this is the responsibility of the Board. Now, I agree this is a 12:21 12:22

dynamic process, you never get it right and I know that myself from my work in health care and you have to put a lot of emphasis. I absolutely agree that one of the ways to get round it is to start with a clear statement of what the most important thing is. You have articulated the desire to put patient safety first on behalf of the Board and we have heard that also from your Chair. 12:22

Now, I have just got a number of questions as to how that is playing through. So the first question is, how many board development days did you have solely on helping the Board to understand what patient safety is, how to measure it, how to develop it, how many days overall? 12:22 12:23

A. Well every other month would be a workshop, so some of those workshops, like understanding medical data.

119 Q. No, but how many, just on the whole safety focus, specifically to say what does my board need to know about patient safety? 12:23

A. I couldn't honestly tell you that.

120 Q. So you haven't looked at it in that way maybe?

A. No.

121 Q. Okay. When you say we care about patient safety, we've got a situation here where your staff have said pretty much across the board 'well the Trust cared about targets', your Chair and others have said 'well now we are starting to move towards patient safety', that's pretty easy to say, it's quite difficult to do. So, 12:23

the first question around that is, how is that manifested in the Board discussions? Can you give an example of how the Board sets out that it lives and breathes patient safety over everything else? How is that manifested in the discussions in the Board or the agenda or do you have a view about that?

A. Well I think, you know, at the beginning of each Board meeting we invite a particular area, sometimes the focus is patient safety and that's really to look at from the staff's point of view what the issues and concerns are. I think that's a really helpful way to look at patient safety because sometimes as a Board, as you know, you can be quite remote and you can talk about strategy a lot. 12:24

122 Q. What's the first item on your agenda, though? 12:24

A. Sorry?

123 Q. What is your first formal agenda item on the Board?

A. Well usually we have a presentation.

124 Q. After that, a formal agenda item?

A. It would be minutes. 12:25

125 Q. And after that?

A. Then you would have reports.

126 Q. Okay. Now, one of the things you can also do as a Board, and I know you've mentioned, your Chair has mentioned this, you go round and talk to different areas and you ask them about things; what questions, how do you do appreciative listening with the staff that let them know that you care about safety more than the target, how do you do that? 12:25

A. Yeah. Well typically I would spend maybe about one and a half to two hours on a leadership walk. We do have a guide about what sort of questions you would ask. For me, given my background, I would be very interested in safeguarding and part of that is patient safety, 12:25
safeguarding vulnerable adults in particular. So I try and get a sense, I mean I did a recent walk in one of the wards in Craigavon and talked, asked the sister from the patient journey, when they come in, how is everything, how are they treated when they come in as a 12:26
person, but also how all that is recorded and how the patient perceives their experience. So on that leadership walk what was really helpful was they had an uncluttered ward, they had their white boards which are for both staff and for patients to look at, where they 12:26
were on their patient journey. Also what was really helpful there that I thought was that they had pre and post-op on the same ward, I mean obviously a divide, so that they could look at how patients were received, treated and how they were looked after in recovery 12:26
afterwards.

127 Q. So if you went to the emergency department on a leadership walk, have you done any of those?

A. Some of the other NEDs have done that, I haven't done.

128 Q. So you don't know what questions they routinely ask in 12:27
that department?

A. Well, you know, the general questions are very open questions.

129 Q. Yep.

A. About their workload, how they feel about their job, how they communicate with patients, what sort of issues would come up to them, particularly I imagine in an emergency department, obviously overcrowding, all those sorts of things. 12:27

130 Q. How much emphasis do you think has been made in terms of you as a team, the whole Board understanding what will send the right message to staff about what you care about, have you specifically talked about that?

A. Yeah, we have. We have talked quite a lot about what the purpose of leadership walks, doing joint walks, the value of them. Obviously we write reports which are, you know there isn't a tick box any more. There used to be a tick box, now it is more an open conversation, open discussion. Staff can raise any issue. Of course I would prompt staff to raise issues as well around risks and concerns and that's reported on and brought back into governance. 12:27 12:28

131 Q. You don't specifically ask, for example, 'do you feel your department is safe today?' Is that a general question or not? 12:28

A. If I was going into a surgical ward I would ask that.

132 Q. Good. Then at the Governance meeting you have got some safety indicators, but there are not very many of them and they are quite basic really. I can't see a suite of safety metrics coming to Governance or to the Board, most organisations I have worked in there is quite a big suite of safety metrics at the Board and a bigger suite at Governance and a bigger suite in the 12:28

Directorates. It is about trying to say how are we doing. You will be familiar with stroke, there is 10 indicators in the national stroke audit which most places use as a sort of 'how are we doing.' It is a mixture of performance, practical things that make a better service and so on, and that generally would come to committees regularly as would, for example, overall compliance with cancer standards, which are part of performance really, because they are basic, 'have you done this, have you done that', they are not individual quality of care. So what discussions has the Board had about what the Board would like to see about safety throughout the Trust and has that discussion happened in terms of what do we need to know, how do we need to know more, how has that been informed by your Medical and Nursing Directors and others? 12:29 12:29 12:29

A. Yeah. I mean, I think that's a conversation that Dr. O'Kane has started with us. I would have a concern that standards and guidelines, that part of governance is under resourced, that has come to the Board. 12:30

133 Q. I mean, that's a huge piece of work. But even before fixing all of that, there is an indicator in almost every service that relates to a national audit, there is at least one, probably four or five indicators that can be tracked. Then you don't need people to come and tell you there is a problem because you know there is a problem, you can see it changing over time. If you are now waiting three days to have your fracture, like a femur operated on and you were waiting 12 hours, you 12:30

know there is a problem; if your stroke patients aren't on a stroke ward most of the time, you know there is a problem. So how far has that discussion got and, if it hasn't got very far, is there a recognition that it is needed in some detail? 12:30

A. Yeah, I don't think it has got very far. And to be fair to Dr. O'Kane, I mean that's something that I think that she would like to progress and it is certainly something -- I mean, I think she has had so many challenges since she has come into post. 12:31

134 Q. Yes, I mean this requires ongoing work, investment, buddying, all kinds of things. You don't do it just like this?

A. No.

135 Q. It is not a sprint, it's a marathon over many years. 12:31 However, what I am familiar with is this focus on safety comes first and then you start to understand what it means and it gets broadened out. So I just wondered what the understanding of the Board was really, it is not something you can fix straight away? 12:31

A. No, I don't think it is that developed.

136 Q. Okay. Then going back to -- so those are objective things you can measure. Then you say the Governance Committee is much better, and we can see that in the papers. Can you give me an example of something that 12:31 came to Governance and, because of the triangulation, the Governance Committee were saying well actually 'we are not satisfied with this, we need a further report on it, we're worried about it' and

that's resulted in a change?

A. Yeah. I mean the example that springs to my mind is maternity, litigation, SAIs.

137 Q. Okay. Is there any other area where that has happened where you have thought 'oh, hang on a minute'? 12:32

A. I am trying to think.

138 Q. Because maternity is right up there?

A. Yes, I know it is. I'm trying to think. I suppose a lot of the deep dives for me have been in performance.

139 Q. Again in performance there is a lot more to it than waiting times? 12:32

A. Yes, yes.

140 Q. I don't think we have seen evidence that that breadth of performance is considered together. I mean, it is very difficult because it does overlap with governance and other things, but it is very hard to consider that on its own, isn't it? 12:32

A. Yes, it is indeed.

141 Q. Just another thing, and I am afraid it goes back to the Board culture. We've heard that now there is a more united collaborative atmosphere in terms of Executives and Non-Executives, and maybe that wasn't always the case before, there is work ongoing to improve that, and again that's something that always needs constant attention. When you were sent that letter from Mr. O'Brien to the Chair and it was just forwarded on to you, my experience of any Non-Exec receiving such a letter would be, what is this about, speaking to the Chair, they probably pop into the office of the Chief 12:32 12:33

Executive or the Medical Director and say 'what is all this about, do we have a policy on retirement, what's all this, it doesn't sound very good, senior consultants don't write letters like this all the time'. It appears that didn't happen. Was that because you didn't feel comfortable talking to the Chair about it? I mean, you think it's an HR issue, I'm not discussing that, it's really what was your curiosity? Did you not feel comfortable to drop into the Medical Director and say 'what's this doctor, is this a problem?' Why do you think that was? Why did you just sort of want to ignore it which seems to be what happened? 12:33 12:34

A. Yes, I didn't feel comfortable talking to the Chair about it. I think if that letter came in now I would talk to the Chair. 12:34

142 Q. Did you thinkthere was a general issue in the Board of the Chair versus everyone else or was it a personal thing with you and the Chair, what was the atmosphere?

A. No, I mean the Chair, the ex-Chair was a very approachable, kind person. I think that the present Chair is probably a lot more approachable in terms of those sorts of issues. 12:34

143 Q. Okay. The Early Alerts were not circulated, who pressed for that change? Was it from that September on that people said 'hang on, we need to have these', how did that change? 12:34

A. Well I think it was a culmination of factors. Certainly we had begun to get occasional Early Alerts,

but, no, I think that...

144 Q. Did somebody stamp their foot and say 'this is enough and it must change'?

A. Well I think the current Chair did.

DR. SWART: Okay, thank you. 12:35

THE WITNESS WAS THEN QUESTIONED BY THE CHAIRPERSON, AS FOLLOWS:

145 Q. CHAIR: If I can just come back to the letter that you got that was forwarded by Mrs. Brownlee to you all, I know you've said you ignored it, are you aware of what the other NEDs did, did they all ignore it? 12:35

A. I don't know if anybody went back to Mrs. Brownlee on it or not. 12:35

146 Q. CHAIR: And certainly, I mean I'm subject to correction from anybody who can point it out to me, but Mr. O'Brien writes to the Chair of the Board, there doesn't seem to have been a reply from her to him?

A. I haven't seen a reply. 12:35

147 Q. CHAIR: No, I don't think any of us have. But again if the Trust can identify a reply then we would be glad to see it. But, in any event, she may have spoken to him verbally about it, we don't know and we can ask her that. But would you accept that it is not particularly 12:36 good governance not to reply to such a letter?

A. Yes, as I have said before anyone can write to the Board, particularly if they are concerned about whistleblowing or patient safety, we would welcome

anyone raising concerns. I would have presumed that, you know, certainly Vivienne Toal would have replied, the direct letters.

148 Q. CHAIR: Well there were three letters?

A. Three letters. 12:36

149 Q. CHAIR: There were three letters to Shane Devlin, to Vivienne Toal and to Roberta Brownlee. The very least Mr. O'Brien was entitled to was a reply from each of them or a reply saying 'I have left this to be dealt with by HR' or whatever the case may be, but there were 12:37 no letters that we have seen from Mr. Devlin or Mrs. Brownlee?

A. No, I haven't seen those.

150 Q. CHAIR: The other thing you said, you ignored it, you thought it to be an HR issue but you didn't recognise 12:37 there to be any element of whistleblowing in it, but this is a letter that is complaining about the Trust not following its policies and procedures, is that not effectively whistleblowing?

A. Well I interpreted that: is there policies and 12:37 procedures about his return to employment.

151 Q. CHAIR: But you didn't ask anything more about that or say 'well were the procedures followed'?

A. Well I didn't think it was a whistleblowing enquiry. The letter had already gone to Vivienne Toal, so 12:37 I presumed as the Director of HR that she would be replying to that.

152 Q. CHAIR: No, I think you are missing my point. My point is that the complaint is about HR processes and

procedures, so as a board member did you not recognise that when you read it?

A. Yes, but I suppose the overriding theme of the letter was about his own employment and his wish to return to employment, that would be my interpretation. 12:38

CHAIR: Okay, well thank you very much.

MR. WOLFE: Just on that, Mr. Beech has kindly referred me to AOB-04361 which shows that Mrs. Brownlee at least sent something of a reply, it's not substantive as such, you can see it there: 12:38

"Confirming receipt of your email, copied to the NEDs. I have also spoken to the Chief Executive on your correspondence and he too has received a copy."

12:38

Whether there is anything more from...

CHAIR: We can ask Mrs. Brownlee.

MR. WOLFE: Certainly the Trust will point out to us if the Chief Executive and Mrs. Toal provided substantive responses. 12:39

CHAIR: Thank you. I think you are certainly free to go, Ms. Leeson. I think that concludes our evidence for this week, Mr. Wolfe, isn't that correct?

MR. WOLFE: It does, thank you.

CHAIR: Okay. So thank you everyone, we will see you again next Tuesday at 10 o'clock. 12:39

THE HEARING ADJOURNED UNTIL TUESDAY, 16TH JANUARY 2024