



Urology Services Inquiry

Oral Hearing

Day 81– Wednesday, 17th 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

I N D E X

P A G E

Mrs. Roberta Brownlee,
Examined by Mr. Wolfe KC

3

Lunch adjournment

85

1 THE INQUIRY RESUMED AT 10:00 A.M. ON WEDNESDAY, 17TH
2 JANUARY 2024 AS FOLLOWS:

3
4 CHAIR: Good morning, everyone. Mr. wolfe.

5 MR. WOLFE KC: Good morning, Chair. Your witness this 10:05
6 morning is Mrs. Brownlee.

7
8 ROBERTA BROWNLEE, HAVING BEEN SWORN, WAS QUESTIONED BY
9 MR. WOLFE KC AS FOLLOWS:

10
11 1 Q. MR. WOLFE KC: Good morning, Mrs. Brownlee. 10:05

12 A. Good morning, Mr. wolfe.

13 2 Q. Thank you for coming to the Urology Inquiry. I want to
14 begin by bringing up on the screen your witness
15 statement, followed by a couple of addendum witness 10:06
16 statements which we've received in the course of the
17 last 48 hours or so, and I'll ask you whether you wish
18 to adopt those statements as part of your evidence to
19 the Inquiry.

20
21 So, commencing with your primary response to the 10:06
22 Inquiry's Section 21 notice. We received it on
23 29th November 2022. If we go to WIT-90846, and that's
24 the first page. If we go to the last page at
25 WIT-90911, and that's your signature? 10:07

26 A. Yes.

27 3 Q. And you recognise that statement or that response as
28 yours. Subject to the corrections contained in your
29 addendum statements, do you wish to adopt this document

1 as part of your evidence to the Inquiry?

2 A. Yes, I do.

3 4 Q. Thank you. Then on Monday of this week, we received an
4 addendum from you. It's to be found at WIT-105947. As
5 you can see at the bottom of the page, it's a one-page 10:07
6 document, it's unsigned and undated. That is a
7 document endorsed by you; is that right?

8 A. Yes, that's correct.

9 5 Q. It deals with some corrections to the timeline in
10 respect of your dealings with Mr. Pengelly? 10:08

11 A. Yes.

12 6 Q. We'll look at those in some detail later in your
13 evidence. Can I ask you this: There's a second
14 supplementary or addendum statement, which I'll put up
15 on the screen now. WIT-106615, and this is signed by 10:08
16 you. Over the page it contains an attachment, which is
17 a phone record concerning a telephone call with
18 Mr. Pengelly on 26th October 2020. Taken together,
19 both of those documents, the first addendum and the
20 second addendum, do you wish to adopt those as part of 10:09
21 your evidence to the Inquiry?

22 A. Yes. Yes, I do.

23 7 Q. Thank you. Now, the importance of your evidence,
24 Mrs. Brownlee, is or arises out of the fact that you
25 were Chair of the Southern Trust from 2011 through to 10:09
26 November 2020, which was obviously a pivotal period in
27 terms of the issues which this Inquiry has to consider.
28 Do you understand that?

29 A. Yes.

1 8 Q. If we could just bring up on the screen something of
2 your background. If we go, first of all, to WIT-90848,
3 we can see your academic and professional
4 qualifications. You are a nurse and a midwife by
5 profession? 10:10

6 A. Yes.

7 9 Q. We can see that you have post graduate qualifications
8 in nursing as well as in management or leadership. You
9 have a Masters in Executive Leadership, which was
10 gained in the period 1996 to 1998 before you took up 10:11
11 your role, 10 years before you took up your role on the
12 Southern Trust Board; isn't that right?

13 A. Yes. Yes.

14 10 Q. Taken together, do those qualifications or did those 10:11
15 qualifications assist you in your role as Chair of the
16 Southern Trust Board?

17 A. Absolutely. As a registered nurse, they assisted me to
18 understand a lot of the clinical and nursing
19 background. All of my years that I had worked in
20 health and social care in the independent sector, I had 10:11
21 held senior positions in the largest privately owned
22 health care organisation in the UK. We had a private
23 hospital and we had 42 nursing homes, both in England,
24 Scotland and in Northern Ireland, so I had a vast
25 experience. Of course then my academic Masters in 10:11
26 Executive Leadership added to that by giving me
27 additional tools to be equipped. So yes, absolutely.

28 11 Q. Just if we go up the page to WIT-90846. Just go to the
29 top of that page. We can see your professional roles

1 set out. Back in the mists of time, registered nurse
2 was your first occupation; various employers;
3 midwifery, ward manager. Then just scrolling down,
4 moving into the private nursing home sector. You've
5 described your role with -- was it Tamaris or Sandown 10:13
6 you are describing as the largest nursing home
7 provider?

8 A. I started my career in the Sandown Group and then it
9 was bought over, and then I was joined into the Tamaris
10 Healthcare UK but it had a subsidiary in Northern 10:13
11 Ireland, so it became the largest because we brought
12 together quite a number of the groups there. We had
13 the 42 homes across a range of services. We also, in
14 my previous employment, had the private hospital as
15 well. 10:13

16 12 Q. Yes. We can then see in or about 1998, your first
17 steps into, I suppose we could describe it as public
18 service, as a Non-Executive Director for the then
19 Armagh and Dungannon Health and Social Care Trust. As
20 we scroll down, we see that that public service has 10:14
21 continued in a significant number of roles since that
22 time and continues to this date; isn't that right?

23 A. Yes, that's correct.

24 13 Q. So just looking at that, you became a Non-Executive
25 Director in the Southern Trust for the first time in 10:14
26 2007, moving on to become Chair of that organisation,
27 as I've said already, from 2011 through to 2020.
28 Setting aside those roles, you were also occupying
29 other Board memberships in other public bodies.

1 Southern Education and Library Board; you are still a
2 member a lay panel member of the Care tribunal?

3 A. Yes.

4 14 Q. Over the page, Chair of Macmillan Cancer. Described
5 yourself as a cofounder of CURE, the Craigavon 10:15
6 Urological Research and Education charity. I want to
7 come later in your evidence to ask you about the
8 background to the formation of that charitable company.
9 You were a cofounder with whom; who were the other
10 cofounders? 10:15

11 A. We'll probably come to it later on but I had been very
12 sick and I was a patient in Craigavon in the Urology
13 Department, and the ward sister then was a lady called
14 Eileen O'Hagan, who was the ward manager but an
15 absolutely amazing person. Because of some of the 10:16
16 deficits that I found as the need for my care, I mean,
17 Eileen and I, along with many others, but Eileen and
18 others were the cofounders of this CURE charity.

19 15 Q. As I say, we'll come in more detail to that later in
20 your evidence. Membership of a number of Board of 10:16
21 Governors. You are a board member of AFBI, the
22 Agri-Food and Biosciences Institute. That is an Arms
23 Length Body from the Department of Agriculture; isn't
24 that right?

25 A. Yes. Yes. 10:16

26 16 Q. I think, just scrolling down, a Board member of the
27 Prison Service Pay Review Board, and external assessor
28 for performance on the Education Authority. As well as
29 all of that, a director and owner of a nursing home, as

1 we can see there. It's, I suppose, worth pointing out
2 that at the same time as serving as Chair of the
3 Southern Trust, you had the Prison Service Pay Review
4 Board role; you had the AFBI role, as well as managing
5 or owning your own nursing home; that's a significant 10:17
6 set of responsibilities. Was it?

7 A. Sorry, just the AFBI Board member was towards the end
8 of my term as the Southern Trust Chair. But yes, it
9 was.

10 17 Q. Yes, we can see it there -- 10:17

11 A. Yes.

12 18 Q. -- your Southern Trust role ended in 2020. You appear
13 to have had four years as a Board member at AFBI when
14 you were still with the Southern Trust; is that right?

15 A. Yes, yes. I mean, it was a busy life, I would be a 10:18
16 busy person. I enjoy my work. I am totally committed
17 to health and social care and I believe I had a lot of
18 experience that I could bring to assist. I loved
19 education. I was very committed to the voluntary
20 sector as well. So yes, it was busy but I had 10:18
21 excellent support at home and I managed it, I believe
22 well. If one was to look at my record of attendance
23 both in the Southern Trust at meetings and indeed in
24 other Board appointments, I think I rarely missed a
25 meeting, but it takes organisational skills and good 10:18
26 support. But I enjoyed it and I loved everywhere that
27 I have worked and assisted to improve any additionality
28 to services.

29 19 Q. I think Mr. Pengelly yesterday reflected on the

1 importance of people coming forward to give of their
2 time in public service in these kinds of roles. What
3 was your motivation for not only coming into such a
4 role way back in the early part of 2000s, but then
5 taking on additional roles and staying in those roles
6 over a lengthy period of time? 10:19

7 A. Well, just like you refer, the public appointments
8 attracting younger people who have an interest and can
9 give of their time is jolly hard work. At the time I
10 was doing my executive leadership, there was a part of 10:19
11 that programme about public service, so I was very
12 interested. I was much younger then. So in that year,
13 despite holding a Senior Chief Executive's position in
14 the independent sector, my boss and Board were very
15 supportive of me taking on a role in then the Armagh 10:20
16 and Dungannon Health and Social Care Trust. So it was
17 probably that I believe I had a lot of skills and I
18 could contribute much to the Board. I also was very
19 committed to community and voluntary work, and I
20 believed if there was anything I could do to enhance 10:20
21 that, I would. It was something I did then and to
22 date, I've loved it. That's why.

23 20 Q. Very good. In terms of the Southern Trust role, I
24 spent some time focusing on that, your initial
25 impressions of it, how you did the job and the kinds of 10:20
26 challenges you faced and, if you overcame them, how
27 they were overcome. You succeeded Mrs. Balmer as
28 Chair?

29 A. Yes.

1 21 Q. And that was 2011?

2 A. Yes.

3 22 Q. As I've noted already, you served two terms but with an
4 extension towards the end when ultimately Mrs. Mullan,
5 or Ms. Mullan, succeeded you? 10:21

6 A. Yes.

7 23 Q. What was the difficulty, if any, as you understood it,
8 in delaying your successor's appointment, or what was
9 the reason for the delay?

10 A. I completed my two terms and I was ready to go, and 10:21
11 Mr. Pengelly had phoned me to discuss just -- I mean,
12 you would have been constantly in touch with them about
13 the replacement. It was always quite a long drawn-out
14 process to recruit Non-Executive Directors and indeed
15 chairs. I understand the complexity around that all. 10:22
16 But at that time, my post, when my term was up after
17 the eight years, hadn't even been advertised.

18

19 Also at that time, there was a lot going on within the
20 Trust, and a lot of, you know, changes. I suppose for 10:22
21 stability, I was asked to stay on for a short period,
22 for less than a year, and for the continuity of that.
23 Also, to be able to do that, you would have to have had
24 a successful track record and successful appraisals,
25 and I did say I would stay on until someone was 10:23
26 appointed, with the intention hoping that it would go
27 to press and there would be a successful applicant. So
28 it was just due to instability probably at chief
29 executive level, the appointment process hadn't taken

1 place. There was many other chairs' posts coming up at
2 the same time to be vacant. No other reason than that,
3 I believe.

4 24 Q. I suppose Covid became a factor, perhaps, in early
5 2020?

10:23

6 A. Yes. Yes.

7 25 Q. And undoubtedly, as you reflect in your witness
8 statement, that may have had some impact?

9 A. Yes.

10 26 Q. Interestingly you make the point that your second term,
11 the clock on it would have stopped at some point in
12 2019. You make the point that even as the clock
13 stopped on that period, they hadn't yet gone to press
14 to advertise for your replacement.

10:23

15 10:24

16 Can I ask you this: Mrs. Mullan, in her evidence last
17 week, I suppose bemoaned what she saw as a lack of
18 attention to succession planning, both on the Executive
19 Director side as well as with regard to Non-Executive
20 Directors. Focusing on that latter part, is that
21 something you would share a concern about, that the
22 Department wasn't as focused on succession planning as
23 it ought to have been?

10:24

24 A. Well, certainly it would have been something I would
25 have brought up at my annual appraisal. I also had
26 been selected by the Commissioner of Public
27 Appointments as a reflection for all of my years of
28 service how to attract other younger people into this.
29 So, I would have been bringing up to the Department,

10:24

1 and indeed I remember speaking at that time for the
2 same reason. I'm not sure there was a lack of focus.
3 I mean, they knew it needed to be done but other
4 departments or other areas became a priority. So it
5 could have been another Trust or the Northern Ireland 10:25
6 Ambulance Service, there was always somewhere else got
7 the Chair first. So yes, it could have been better
8 organised, but I suppose I always say the pressures
9 that everyone was under. But most of the
10 Non-Executives that I have worked with in my years all 10:25
11 had extensions. Mrs. Balmer that you referred to was
12 an excellent Chair, an excellent role model in every
13 aspect, and trained her Non-Executives to the highest
14 standard in preparedness for all that a Board requires.
15 She went off quite quickly towards the end due to 10:26
16 illness, so another Non-Executive Director stepped in
17 to act up in that role before the appointment was made
18 to myself. So, there was no planning for Mrs. Balmer
19 going, to be fair, because of illness.

20 27 Q. Could I draw your attention to something you've said 10:26
21 about the renewal of your first term in office. If we
22 go to WIT-90848. Towards the end of that first
23 paragraph - sorry, it's the second paragraph - you say:

24
25 "It's important to note that I was asked to stay on as 10:27
26 there was no permanent Chief Executive in post from
27 early March 2015 until Shane Devlin was appointed in
28 March 2018".
29

1 In the way that you've expressed that, you're seeming
2 to suggest that you were asked to enter a second term,
3 a second four years as Chair because there was no
4 permanent Chief Executive; is that correct,
5 Mrs. Brownlee?

10:27

6 A. It was one of the contributory factors, yes, for
7 stability. At the time when Mrs. McAlinden left in
8 March 2015, we knew she was going and had her three
9 months' notice and we talked quite a lot. I can
10 remember the meeting in the Department because it was
11 just Christmas Eve of the previous year when we were
12 talking to Mr. Pengelly about that appointment. At
13 that time, to be fair to Mr. Pengelly, there was other
14 Chief Executive posts vacant. I remember the Belfast
15 Trust was vacant and the Western Health and Social Care
16 Trust was vacant. I mean, he asked if I didn't mind
17 that the Southern Trust waited in the pecking order for
18 advertisement for the Chief Executive posts until those
19 posts were filled.

10:28

10:28

20
21 Chief Executive posts in the health and social care
22 family are not very attractive, for whatever reason.
23 You wouldn't have many applicants, and sometimes none.
24 I mean, these other two Trusts, he believed, were more
25 of a priority. I remember him saying we had a very
26 stable senior management team, an excellent senior
27 management team, very competent, well-experienced and
28 many in post for years, and also my track record was
29 pretty good. It was a Trust that really hadn't much

10:28

10:29

1 trouble. The Southern Trust was renowned during my
2 tenure as a Trust that had outstanding performance and
3 had achieved many rewards under the leadership of
4 Mrs. McAlinden. I mean, it was very stable. I
5 remember other Trusts had some difficulties at that
6 time. So, that would have been a contributing factor
7 to it, my reappointment. But I also said I was willing
8 to. You're asked at your appraisal are you willing to
9 be considered for another term, which I was.

10:29

10 28 Q. Yes.

10:29

11 A. And I hadn't to be interviewed. Apart from my
12 appraisal, you didn't have to reapply for a second
13 term.

14 29 Q. To summarise on that, you were very keen to stay on for
15 a second term --

10:30

16 A. Yes.

17 30 Q. -- but from a Departmental perspective, losing the
18 stability provided by Mrs. McAlinden rendered it, I
19 suppose, even more important that continuity, in the
20 form as you as the Chair, was realised during that
21 period?

10:30

22 A. Yes.

23 31 Q. Thank you. We have noted from your evidence, I'm not
24 sure if it is - yes, it's just as you've said it
25 there - during the three-year period following
26 Mrs. McAlinden's stepping down until the appointment of
27 Mr. Devlin in the spring of 2018, that was a period of,
28 I suppose, some instability given the lack of
29 leadership at executive level; is that fair?

10:30

1 A. I wouldn't like to say it was unstable. Mrs. McAlinden
2 in her time left an excellent Trust. I mean, it was in
3 very good arrangements in relation to governance and
4 lots of other performance and outcomes; it was very
5 good. So the people that acted up into those interim 10:31
6 role, the first one was the lady, Mrs. Paula Clarke,
7 who came in '15/'16. She had been the Director of
8 Performance for some time; a very capable, competent
9 person, so I didn't see any instability at that time.
10 To me, I describe it as a vehicle that the tank was 10:31
11 well-filled and we were in very good position, and I
12 was proud, and rightly so, to be proud of that Trust.

13
14 So when Mrs. Clarke came in, it was very stable. The
15 person acting up into her role as an assistant director 10:32
16 again had been at that level for some time.

17 Mrs. Clarke then was appointed to a position, a senior
18 position, in England and moved, and then we had another
19 interim. Remember, during this time I would have been
20 keeping very good contact with Mr. Pengelly. I mean, I 10:32
21 had an excellent working relationship with him. I had
22 his phone number, I could have phoned him at any time.
23 I still understood the priorities of the other two
24 Trusts and we all worked very collectively together.

25 10:32
26 In came then Mr. Francis Rice. Again, he was a highly
27 experienced Director, having been in Mental Health. He
28 was a former Acting Chief Nurse of the Department.
29 Again, the Trust was in a very safe position. He had a

1 lot of very good deputies at his level that acted up.
2 Regrettably, Mr. Rice, during the time he was there
3 from '16 to 2018, [REDACTED] and he
4 was back and in and out. But again we had Mr. Stephen
5 McNally, who was the Director of Finance and had been 10:33
6 for many years, and a very competent, capable person
7 who took over. So no, I would disagree that it was
8 unstable.

9
10 I mean, it was the same in the Acute Directorate which 10:33
11 I have heard before the Inquiry. The Acute Directorate
12 in the Southern Trust had Assistant Directors who were
13 there a very long time, had moved around within the
14 Trust. I think there was five or six of them, and they
15 have been before the Inquiry. I mean, very experienced 10:33
16 people. So I wouldn't agree that it was a time of
17 instability. I provided a stability but I had a superb
18 Board of senior managers at that level. My
19 Non-Executive Directors that I had, yes, some may have
20 changed but those that left, we missed them of course, 10:33
21 their skills and expertise, but those that came in were
22 equally very skilled, and I was privileged to have the
23 Board I had during my tenure. All of my Non-Executive
24 Directors and Board of Directors were very competent,
25 capable. I mean, it was a really good Board. 10:34
26

27 I have heard also - we'll come back, no doubt, about
28 the culture - but during my time, the culture was one
29 we had invested in heavily through Mrs. Balmer when the

1 Trust was formed; we spent many times in workshops
2 looking at culture, duty of candour, how could we
3 improve ourselves, how do we perform together, we were
4 very reflective practitioners in our own right. whilst
5 I have heard other comments, I can just tell you, 10:34
6 Mr. wolfe, during my time the Trust was very stable.
7 We would, of course, have liked a Chief Executive of a
8 permanent post and we did advertise. I think we had
9 maybe one applicant, or two, but an appointment wasn't
10 made until Mr. Devlin came in 2018. 10:34

11 32 Q. Others might consider that having such a turnover of
12 interims at the Chief Executive level before you had a
13 permanent isn't ideal, and perhaps you would accept
14 that?

15 A. Yes. 10:35

16 33 Q. It wasn't ideal. Did you not detect any adverse
17 implications of such a turnover?

18 A. Mr. wolfe, I didn't, no.

19 34 Q. You didn't?

20 A. I mean, I would agree with you, you would have liked a 10:35
21 permanent but I had to respect -- I don't think the
22 Belfast Trust appointment was too quick either because
23 of succession and getting the right person, and the
24 same in the Western Trust. My post didn't go to press
25 until they were filled. So absolutely, everyone would 10:35
26 want their own permanent Chief Executive, the
27 accounting officer, but I wasn't in a position to push
28 that any greater than with Mr. Pengelly who was looking
29 at the totality of the region.

1 35 Q. In terms of your role during that period of flux, do
2 you consider that you had to involve yourselves in
3 activities, perhaps on operational side to some extent,
4 that wouldn't normally come with the role of the Chair?

5 A. No. No. Paula Clarke, when she came in, hit the 10:36
6 ground running and fulfilled that role to a very high
7 standard, and the same with those that came after. My
8 style of leadership and my performance as a Chair never
9 changed from Mrs. McAlinden until Mr. Devlin arrived.
10 I didn't do anything different. I was a well-known 10:36
11 Chair. I believe a Chair should be visible and I was
12 out in the Trust a lot, both in the primary community
13 settings as well as the secondary care, so I would have
14 been well-known. It might be perceived by others that
15 I was meddling or getting into whatever, but I never 10:37
16 was involved in the engine room in any aspect. I never
17 attended any operational meetings of any kind but I
18 certainly would have been out a lot in the canteen; I
19 was very involved in the leadership walks. It was
20 Mrs. McAlinden and I who initiated those, no doubt we 10:37
21 will come to talk about those later, but I never seen
22 myself as a Chief Executive.

23
24 Of course, you provide continuity and the conduit when
25 there's people in and out because Mr Rice went off 10:37
26 quite suddenly. I remember the time he came in [REDACTED]
27 [REDACTED], and he needed to go that day.
28 Then you were bringing in, say, Mr. McNally, who you
29 knew well but you had to use the knowledge that you had

1 for a hand over, so that could be perceived. But I
2 certainly was never out and operationally involved in
3 any Chief Executive role.

4 36 Q. You have reflected a short time ago on the success, as
5 I think you view it, of the Board during your tenure. 10:37
6 It's right to reflect that, as set out in your
7 statement, you had been commended with an MBE for your
8 services to the Trust and your commitment to charity
9 work in Northern Ireland; isn't that right?

10 A. Yes. 10:38

11 37 Q. That came your way in the 2019 New Year Honour's List?

12 A. Yes.

13 38 Q. Additionally, you've achieved a lifetime achievement
14 award from the Royal College of Nursing for, I think
15 the citation was "Outstanding Contribution to Health 10:38
16 and Social Care". Isn't that correct?

17 A. Yes. I think one of the reasons for that probably was
18 I was the first nurse, I understand, in the United
19 Kingdom to be ever to bring in models of excellence
20 that could be measured in relation to quality outcomes 10:39
21 for patients. We used a recognised company in the UK,
22 Goldsmith it was at that time. But the forward
23 thinking to know to do that in the independent sector,
24 many of that started some of the quality standards
25 within the health and social care families. 10:39

26 39 Q. Let me talk a little more about your role as Chair of
27 the Southern Trust Board. You describe in your witness
28 statement - if we can bring it up on the screen,
29 please, WIT-90849 - your responsibilities, you say,

1 were substantial, and you explain that you were
2 accountable for the performance management of the Trust
3 in its broadest sense, and you further explain that in
4 that paragraph.

10:40

5
6 As you took up the role and at various points along the
7 way, the Department would issue reminders in relation
8 to what is expected of a Trust Chair. For example, in
9 2017 it reminded Chairs of the importance of practising
10 with integrity and taking steps to avoid conflicts of
11 interest; isn't that right?

10:40

12 A. Yes.

13 40 Q. One of the documents that would have been sent your
14 way, I hope I'm right in saying, is the Code of
15 Accountability. If we could look at that, it's
16 TRU-113442. This is, I suppose, a standard explanation
17 that went to Non-Executive Directors, including Trust
18 Chairs, to set out the basic values of the role, and
19 the responsibilities. Could I bring you to paragraph
20 6, if we could scroll down, please. It explains the
21 role of the Chief Executive Officer as compared with
22 that of Chair. Middle of the paragraph:

10:40

10:41

23
24 "There is a clear division of responsibility between
25 the Chair and the Chief Executive". The Chair's role
26 and the Board functions are set out below. "The Chief
27 Executive is directly accountable to the Chair and
28 Non-Executive members of the Board for the operation of
29 the organisation and for implementing the Board's

10:42

1 decisions". It explains that: "Boards are required to
2 meet regularly and to retain full and effective control
3 over the organisation".
4

5 Does that adequately, I suppose, explain the difference 10:42
6 between the two senior roles? On the one hand you have
7 the Chief Executive and, on the other hand, the Chair
8 of the Board. You are, as Mr. Pengelly memorably put
9 it yesterday, in addition to your Non-Executive
10 Directors, responsible for holding the Executive's feet 10:43
11 to the fire is how he put it, maybe a little
12 inelegantly, but it is about constructive challenge in
13 holding to account; isn't that right?

14 A. Yes. Yes, that's correct.

15 41 Q. The role of the Chair is further explained in more 10:43
16 detail, just if we scroll down to paragraphs 9 and 10.
17 The role of the Chair, almost by way of a job
18 description. You didn't have a separate job
19 description, did you?

20 A. Whenever you made an application for the public 10:43
21 appointment, you got a pack.

22 42 Q. Yes.

23 A. And it was an application and of course then two/three
24 documents, one of which you've referred to, and
25 definitely a document similar to this explaining your 10:43
26 role.

27 43 Q. Yes.

28 A. And the remuneration and all that was expected of you.
29 So, you got a broadened example of a job description.

1 44 Q. Yes. Paragraphs 9 and 10 very much casts the Chair's
2 position into the mould of a leadership role. You were
3 expected to be, I suppose, very much the leader of the
4 Board and to be, I suppose, the public-facing
5 representative of the Board. It is set out and 10:44
6 explained at paragraph 10 across a number of particular
7 tasks or duties. Just scrolling down, I think it
8 continues onto the top of the next page. Just briefly,
9 does that appear to adequately reflect the kinds of
10 responsibilities that you held? 10:45

11 A. Yes. Yes.

12 45 Q. At paragraph 11, it speaks to the importance of a
13 complementary relationship between the Chair and the
14 Chief Executive as being important. I mean, I suppose
15 that's self-evident, you needed to work closely with 10:45
16 your Chief Executive and you needed to function in a
17 complementary fashion.

18

19 we'll come on and talk about some tensions which
20 Mr. Devlin believed punctuated your relationship with 10:45
21 him or his relationship with you. I know that you have
22 a particular view to express on that; that comes as
23 some surprise to you in the round. We'll come to that
24 in a moment. In general, do you feel that over the
25 course of your tenure that your relationships with the 10:46
26 various Chief Executives worked well and were, in fact,
27 complementary?

28 A. Absolutely. I always remember when the Trust was
29 formed in 2007 with Mrs. Balmer then as the Chair, I

1 mean we had time away, and it will always last in my
2 memory how she described the relationship between a
3 Chair and a Chief Executive: It should be a good,
4 working relationship, good communications and good
5 relationships but there should always be the blue 10:46
6 water. There should be a clear knowledge of how you
7 are separate to it. So I mean, all of the Chief
8 Executives I worked with from Mr. Donaghy to
9 Mrs. McAlinden, right through those in the interim
10 posts, Mrs. Clarke, Mr. Rice and Mr. McNally, were 10:47
11 excellent, and I should say they were excellent with
12 Mr. Devlin. I was not aware Mr. Devlin had any
13 concerns about me in any aspects of my work
14 interprofessionally or personally until I read much of
15 the Inquiry. So I had no problem with any of my Chief 10:47
16 Executives, not none ever brought any to my attention
17 of that. We had a very good working relationship,
18 which you had to have. We were dealing with some of
19 the most complex issues on a day-to-day basis and the
20 fast pace of change. So I have never had any problem 10:47
21 with anyone in the Trust that I am aware of, or indeed
22 in anywhere I have worked.

23 46 Q. We're obviously sitting in a Public Inquiry which will
24 consider through your evidence, and obviously through
25 the evidence of others, some alleged shortcomings in 10:48
26 how the Trust has functioned in a particular sphere.
27 viewed from that perspective and what you know of the
28 Inquiry, its reasons for being and its work, have you
29 any reason or cause to reflect that things with Chief

1 Executives over a period of time might have been better
2 approached or better handled so that we are not here
3 scrutinising these issues?

4 A. Well, a lot that is before the Inquiry I have been
5 reading and been informed for the very first time. I 10:49
6 can assure you many times to Trust Board, under all of
7 those different Chief Executives that I have referred
8 to, we dealt with information that came to us in a very
9 structured, in a very challenging, and indeed we were
10 very clear on governance and reporting lines through a 10:49
11 variety of subcommittees. Yes, I'm not disagreeing
12 with you what has come before the Inquiry now is
13 shocking to me, but I can assure you much of it I
14 didn't know. I believe if Mrs. McAlinden and those
15 that followed her had known any of this, and had come 10:49
16 to Trust Board, we would have taken immediate
17 corrective action. I am disappointed about that, but
18 the flow of information or what we needed to know did
19 not come.

20 47 Q. Yes. We'll have an opportunity obviously to explore 10:49
21 that in greater detail but thank you for that for now.

22
23 Your witness statement and the evidence of others has
24 looked at the training needs of the Non-Executive
25 Directors. Can I just open your statement in this 10:50
26 respect? WIT-90852. You explain that in terms of
27 training, you attended numerous training sessions
28 during your tenure:
29

1 "As an experienced Non-Executive Director across a
2 variety of sectors, both in the private, public and
3 voluntary sectors, I gained a broad breadth of skills,
4 knowledge and experience".

10:51

5
6 You also had senior executive positions spanning 25
7 years. You also refer to the training that you
8 received in the academic sphere of Queens' University
9 and elsewhere.

10:51

10
11 Do you consider that in terms of the training and
12 support more generally that was available to you,
13 whether through the Trust or through the Department or
14 through other HSC bodies and supporting mechanisms, was
15 it adequate? Did you feel well-supported and equipped
16 to do your job?

10:51

- 17 A. Yes. Yes, I believed I was well-trained, very
18 well-supported and it was adequate. During the time of
19 the formation the Trust from 2007 with Mrs. Balmer, we
20 had a lot of training because it was the formation of
21 different Trusts coming together, so we had a lot of
22 ground work done then. I couldn't tell you how many
23 times I have attended the onboard training, which I'm
24 sure others have referred to, which is really a
25 department training that you go on. I have attended
26 that on numerous occasions with different public bodies
27 I've sat on. So we were well prepared to be a
28 Non-Executive Director during the early years.
29 When Mrs. Balmer left and then Mrs. Mahood acted up for

10:52

10:52

1 a period of time, I took over from her. No, I didn't
2 have any formal training to move into the role.
3 Mrs. Mahood gave me a very good hand over. I myself
4 believe my breadth of experience at Chief Executive
5 level, I worked to banks in London and I was held very 10:52
6 accountable to boards there. Be assured, Mr. Wolfe,
7 you were very accountable so you knew what that was.
8 We had a lot of governance training in relation to
9 finance and other performance, which you transfer your
10 skills from your practical work into these roles. At 10:53
11 that time, it was Mr. Andrew McCormick when I took over
12 was the Permanent Secretary. I mean, he would have
13 talked to me, he was very available at the end of a
14 phone. He then moved, I think, departments, and
15 Mr. Pengelly; I had him for the rest of my time. 10:53

16
17 To be fair to Mr. Pengelly and all of his deputies,
18 there was never none of them I couldn't have approached
19 at any time. Through my own appraisal, and if there
20 was anything you weren't sure of with your own 10:53
21 self-reflection and reviews, if you were weak in an
22 area or something you didn't know, the onus was also on
23 you to be trained up for that. To be fair to
24 colleagues before and who I worked with in the
25 Department and others, I believe I was well-supported. 10:53

26
27 I didn't have any induction but I'm not just sure what
28 induction you would give to someone coming into a
29 Health and Social Care Board, at whatever level. Yes,

1 I think you can have more, maybe on governance and risk
2 management, but it is doing the job. It is when you
3 get in and see the volume of work and what's coming
4 across your path every day, it is where you have to
5 actually reflect and take cognisance of where you may 10:54
6 have come across this before. You have to be very
7 shrewd, you've to be very detached, you're very
8 accountable, you've to hold others to account, and you
9 have to challenge. So, if you didn't know something
10 that I was dealing with, it would be very remiss of me 10:54
11 not to have made inquiries through senior colleagues or
12 indeed other Chairs. We had a Chairs forum, and that
13 network and all was important. I don't believe I could
14 have been any better trained. I trained a lot myself
15 and a lot of my past experiences, wherever I worked, I 10:54
16 mean I brought those with me. So I wouldn't be
17 critical of that. I learnt a lot on the job.

18 48 Q. Yes. You make the point that you probably have lost
19 count of the number of training for boards that you
20 have attended with the Department. I'm sure it wasn't 10:55
21 like a broken record, that training. What new material
22 was offered to you through such training? I'm thinking
23 in particular that the Health Service in Northern
24 Ireland is clearly an organisation, a large
25 organisation that is subject to expressions of concern 10:55
26 and criticism from time to time. We've had major
27 public inquiries before this one, notably, for example,
28 the Hyponatraemia Inquiry.

29 A. Yes.

1 49 Q. The training that was being offered by the Department,
2 was it cognisant of lessons learned, whether through
3 that inquiry or otherwise, or did the training more or
4 less stay the same?

5 A. No, the training was variable to meet the needs. For 10:56
6 example, if I can use, stepping out of health, when you
7 went to education to the Board, you know you had a
8 different type of onboard training. A lot of it was
9 around governance, accountability, risk management. It
10 was the same in health; the onboard training was 10:56
11 tailored to what was happening at that particular time.
12 We would have used -- I mean, it was a one day. So,
13 you would have used the afternoon on examples of
14 lessons learned, bring it in the Boardroom to actually
15 other specifics. 10:56

16
17 I came into Hyponatraemia and the outcome of the public
18 inquiry. I can remember that well. We tried, despite
19 the number of recommendations, we tried at local level
20 in our workshops to look at specific strands because, 10:57
21 from memory if I go back, I think that was to do with
22 the standard and guideline that came out and came
23 across the desk of, say, a Chief Executive and how did
24 it filter through the organisation so that effective
25 management of fluids took place. I mean, therefore if 10:57
26 you were going to learn any lessons, you wanted to make
27 sure any new standards and guidelines came out, any new
28 alerts from the Department or from RQIA or any other
29 regional -- a lot came from the region like Mid

1 Staffordshire. I mean, a lot of those came. It was
2 one thing I was paramount in reading those, even
3 executive summary, and I always asked the question -
4 and I'm sure there are records and minutes to see -
5 could that have happened here, could it happen again,
6 and what was the immediate learning.

10:57

7
8 Yes, the training may not have gone into a lot of
9 detail in an eight-hour day, but the morning would have
10 been about the theoretical and the afternoon was always
11 practical. It was changed regularly. It was the same
12 company did it, from memory, in health. You know, it
13 changed to meet the needs of a resolving health and
14 social care environment.

10:58

15 50 Q. Could I ask you about the training that was provided to
16 new or incoming Non-Executive Directors. You pick-up
17 on this in your witness statement at WIT-90851. Under
18 question 4 or just below that, you've said that, four
19 lines down:

10:58

20
21 "All new NEDs had an induction which included a buddy
22 system, manual of information on Board assurance
23 documents, visits to every directorate for on site
24 learning with each Director, ongoing meetings with
25 myself, the Board Assurance Manager and the Chief
26 Executive as needs arose".

10:58

10:59

27
28 You were responsible for the NEDs' training needs, you
29 explained, and the senior management team which flowed

1 from their appraisal system and their monthly
2 performance meetings with the Chief Executive. I
3 should have read the first couple of lines as well.
4

5 "The Board Assurance Manager would have notes of the 10:59
6 training records but there was training for risk
7 management and appetite for risk".
8

9 I want to ask you some questions about the training for
10 NEDs. Just on the last point I have raised, risk 11:00
11 management, what was the angle taken there, if you can
12 remember? What were your Non-Executive Directors,
13 through their training, encouraged to think about in
14 terms of risk?

15 A. Well, would you allow me just to go back to explain 11:00
16 about the Board Assurance Manager and the induction.
17 So, the Non-Executive --

18 51 Q. I will come to that.

19 A. Sorry.

20 52 Q. Because there is a particular concern that has been 11:00
21 raised about that which I want to deal with.

22 A. Okay.

23 53 Q. Can I deal with that specific point in terms of risk.

24 A. You mean the risk management and how they were inducted
25 to that; is that what you're asking me? 11:00

26 54 Q. What was the angle? How was that training around risk
27 directed at? What was it directed to?

28 A. Well, if we were training Non-Executive Directors, they
29 would have been told about a risk register. I mean,

1 again all the Non-Executive Directors who came under my
2 watch were experienced, very competent people in their
3 own particular field so they would have known about
4 risks wherever they worked. We would have been
5 explaining to them when you come into health and social 11:01
6 care, honestly the risks are enormous every hour of the
7 day. So we would have been talking to them about
8 risks, how we manage risks, the reporting mechanism
9 through, in my time, corporate governance, and the risk
10 register was held in each directorate and fed up into 11:01
11 the corporate risk register. I mean, we would have
12 possibly shown them -- and I know Sandra Judt, the
13 Board Assurance Manager, the folder of evidence that
14 she would have given a Non-Executive Director was
15 comprehensive. We would have been showing them what a 11:01
16 risk register was and maybe some examples. You know,
17 you would maybe have picked one out of what a risk was
18 and how you managed the risk. The risk could have been
19 as great as not filling a consultant's position to
20 actually a suicide in the hospital. You know, lots of 11:02
21 risks. So, you would have maybe taken one. I do
22 remember workshops that we would have used, risk
23 management and how do you manage risk. The ability to
24 take a risk and to manage risk, and what were the
25 structures you put in place and the framework around 11:02
26 risks to allow you to take the risks because many days
27 would you have been taking risks.

28
29 It would have been quite a light touch, to be fair. I

1 don't want to be unfair to the Inquiry. I'm sorry, I'm
2 coming back to the induction. You would have been
3 explaining to them that at the centre of all that we do
4 in health and social care, it is about people; it's
5 about where patients enter the service, whether it be 11:02
6 in primary care right through to their end delivery
7 whether they come into secondary care. So, the
8 greatest thing we do every day was to look after
9 people. Therefore, you were explaining to them the
10 risks that come with that, and the importance of 11:03
11 quality outcomes and patients' experience. So, it
12 would have been quite a light touch, yes.

13
14 Non-Executive Directors are very busy people in their
15 own field. They are employed to do possibly a day or 11:03
16 two per month, or whatever. So their induction, you
17 were trying to get a day to suit them all. That didn't
18 work. You never got the six or seven people together
19 in the one day. I mean, you were also looking to see
20 the amount of information you gave them, was it 11:03
21 overwhelming? I introduced the buddy system because
22 when I and my former colleagues were Non-Executive
23 Directors, we didn't have that so we thought it was
24 good that when you came in, you got a buddy system to
25 one who was maybe more experienced. Then we also 11:03
26 introduced that going out to the directorate, to meet
27 the Director and see what was going on. That was very
28 beneficial and we had a programme for that. That also
29 showed them the risk when they were out for them to ask

1 questions.

2 55 Q. Just put a marker down, we'll come on later in your
3 evidence to consider issues around the risk to
4 patients, particularly in the urology sphere associated
5 with the lengthy waiting lists which the Trust 11:04
6 experienced, which may have been a factor of resources
7 issues and the ability to bring appropriate staffing
8 resources into place at the appropriate time. We'll
9 look at that in a little detail later.

10

11:04

11 Listening to what you're saying about risk and what
12 your Non-Executive Directors were, I suppose, told or
13 counselled about during their training, training was
14 light touch in order not to overwhelm - there was a lot
15 of information to take on Board - but you appear 11:05
16 confident that at least in their training, there was
17 enough information being given out, enough signals
18 about the importance of taking risk issues on Board and
19 equipping yourself with the knowledge so that you can
20 raise challenging questions? 11:05

21 A. Absolutely. A Non-Executive Director, when they are
22 appointed, just like a Chair, you start the next day.
23 So once you get your letter, you're in. You could just
24 be arriving on the day of the Board meeting or it could
25 be a few days later. It certainly would have been my 11:05
26 job, which I did, I would have given them a brief
27 overview of the Board and the agendas and what was on,
28 but be assured I would have talked a lot about the
29 patients' experience, the quality outcomes and the

1 importance of safety. Absolutely.

2 56 Q. Mrs. Leeson, if I could bring up what she has said
3 about induction training. WIT-99776. You will recall
4 that she was appointed as a Non-Executive Director from
5 in and about January 2017, and she still serves on the 11:06
6 Board. She describes her experience here of the
7 induction training. She describes it as being basic.
8 I don't know if that word aligns with your description
9 or your understanding of it. She goes on to talk
10 specifically about MHPS training, saying that it did 11:07
11 not sufficiently inform or support her to fulfil the
12 role as a non-medical person, just by way of example, I
13 think. Your sense of the training - and we do have the
14 programme, it rolled over a period of months perhaps so
15 as not to overfeed a new Non-Executive Director with 11:07
16 too much information too quickly - you wouldn't appear
17 to describe it as basic?

18 A. No, and with respect to Mrs. Leeson, who was an
19 excellent Non-Executive Director and one I held in the
20 highest regard, I wouldn't say it was basic. I believe 11:08
21 that Sandra Judt was the Board Assurance Manager, and
22 along with my personal assistant, Jennifer Comac, they
23 were my ears and eyes, and they were excellent and I
24 couldn't have done my job without them. Sandra Judt
25 would have put together a very comprehensive pack all 11:08
26 around Board etiquette, Board performance, Board
27 accountability and governance, along with all of the
28 other packs that was necessary around Board assurance
29 and risk, I mean, and you took that to read.

1 Absolutely it would have been overwhelming. Then we
2 sent you out on these visits. I'll come back to the
3 Maintaining Higher Professional Standards, if you don't
4 mind, in a minute. I wouldn't have called it basic. I
5 would respect what Mrs. Leeson says, and I believe 11:09
6 having heard from Mrs. Mullan it is going to be much
7 better. One of the problems you have with a
8 Non-Executive Director, they are still working possibly
9 in other jobs; their commitment and time to do more
10 training - I can remember that vividly from them all at 11:09
11 their annual appraisal and maybe when we would have
12 been talking about training needs analysis - they
13 couldn't have committed much more but I'm always
14 looking to see improvement. So if the Department and
15 someone else can make a better induction for a 11:09
16 Non-Executive Director, then that's healthy.

17
18 In relation to Maintaining Higher Professional
19 Standards, in all of my years as a Non-Executive
20 Director and as a Chair, I never remember any 11:09
21 Non-Executive Director liking this process. We rarely
22 had one in my time, whether it was in a former Trust or
23 not. You may have had only one Maintaining Higher
24 Professional Standards in a year or every 18 months, so
25 you weren't seeing one every month. It is like 11:10
26 anything, if you are not familiar doing it, you don't
27 become as competent. I had probably the training at
28 least four times, and it wouldn't have been a
29 maintaining higher professional standard training we

1 would have put in your induction because you may not
2 have been doing all of those for some time. But when
3 we did have the training, and I have listened to the
4 Inquiry about this, my understanding and interpretation
5 of that is somewhat different. I have in my time, when 11:10
6 I was a non-exec, completed two. I was always told at
7 the training, which was always done by DLS, my role was
8 a supportive role to begin with. It was a role of one
9 to support the clinician in question, to make sure you
10 were like a conduit to them, that if there was anything 11:10
11 that they need or help. It was like a pastoral role,
12 in inverted commas. Plus then the other important part
13 of your role was the timeliness, to make sure that it
14 kept momentum going and that it was meeting its
15 timeframes. 11:11

16
17 I would say most times consultants didn't accept the
18 Non-Executive Director because they saw it quite as a
19 complicated role, you weren't really independent. I
20 can remember one, maybe two, even phoning me because 11:11
21 they couldn't understand if you were the Non-Executive
22 Director, why did you feed back into the Director of HR
23 or Human Resources, and they were the ones wrote you
24 the letter. So, they didn't see you as independent.
25 So whilst I respect -- 11:11

26 57 Q. Was that a trust issue?

27 A. Sorry?

28 58 Q. It was a small "t" trust issue?

29 A. Yes, it was a trust. Certainly the ones that came

1 across, it would have been less in number at the time.
2 So whilst I respect what Mrs. Leeson was saying, it
3 wouldn't have been part of their induction training;
4 maybe again it should. But even if you had had it in
5 your first three or four months, unless you went in to 11:12
6 do one, you wouldn't really have been involved in that,
7 but that is what the training was. I should add that,
8 at that time, we had a Non-Executive Director who was
9 ready to retire in the coming years who was also
10 involved in a very complex case, who would have 11:12
11 discussed it with me, brought it to the Board and even
12 talked to the Chief Executive about it. I know that's
13 not relevant to this but it's in, I'm sure, past
14 minutes. So whilst I maybe criticised for not the
15 training or it, any training I have been on with 11:12
16 respect to DLS, it was good, it was informative. But
17 my understanding of a role, and that never changed
18 during all of my time - however I have heard different
19 from the inquiry --

20 59 Q. Yes. 11:12

21 A. -- but I mean -- and the Non-Executive Directors that
22 are in at that time, and I think most are still there,
23 I would think had training on Maintaining Higher
24 Professional Standards at least four, if not five
25 times. After the one I was speaking of with the other 11:12
26 Non-Executive Director in a complicated process, we had
27 training and we had training again during the time of
28 Mr. Wilkinson. So, we had a lot of training, but did
29 it help you to be effective in what you were doing? I

1 am just explaining to you what my understanding was
2 when I did them and also my understanding of them when
3 I was the Chair.

4 60 Q. You reflect in your statement that there were
5 opportunities for your Non-Executive Directors to 11:13
6 reflect on their training needs and there were other
7 processes through which, I suppose, training needs or
8 training blind spots could be identified and rectified.
9 You refer in particular at page - I'll not bring it up
10 on the screen - WIT-90850, that there was an annual 11:13
11 audit of Board members which permitted self-reflection
12 and then a meeting with you. Then, secondly, the
13 Department of Health had an annual Board effectiveness
14 audit, which addressed how effective the Board was.
15 Again, both of those processes would have allowed 11:14
16 training needs, whether as a group of Non-Executive
17 Directors or as individuals to be identified; is that
18 fair?

19 A. Absolutely. Am I allowed to answer the two parts?

20 61 Q. Yes. 11:14

21 A. Okay.

22 62 Q. In terms of an analysis of training needs, how did that
23 work, in your view? Did it work effectively?

24 A. Absolutely. If I think of the Board effectiveness, we
25 were the first Board that was selected to do that. I 11:14
26 mean, that was a very comprehensive document. You were
27 sent it out in very good notice. The way that I did
28 it -- it wasn't done about with my predecessor, this
29 was a new document. Something tells me it was around

1 '12, '13, '13/'14 year that that came out, and we
2 pioneered that. The way I did it under my watch was I
3 asked each Non-Executive Director on their own to
4 complete that assessment tool. It wasn't a tick box,
5 which I have heard. It was an excellent tool to 11:15
6 reflect how you individually performed, how
7 collectively the Board did, and the learning and the
8 outcomes. You did that individually as a Non-Executive
9 Director. The Chief Executive did the same process
10 with each of his executive team on the senior Board, 11:15
11 and they did it individually. Then the Chief
12 Executive, collectively together with the senior
13 management meeting, brought theirs together. As I did,
14 I then brought the Non-Executive Directors back. We
15 talked about it, what were their scores and what had 11:15
16 they recorded. So we had now, at my desk, my completed
17 draft one and I mean the Chief Executive had theirs.
18 Then we actually had a Board workshop to bring that
19 together to finalise it. I mean, then it came to the
20 Board for approval. It was very comprehensive. 11:16
21 Actually at the end we were asked to give a lessons
22 learnt, an example within the Trust of learning, and I
23 think if I'm right, we always had someone externally to
24 review it.

25 63 Q. Yes. 11:16

26 A. I may be wrong here but I'm fairly sure Ms. Mullan,
27 Eileen Mullan, who wasn't then a Non-Executive
28 Director, was the independent person who came to audit
29 it. We always then had every three years an audit of

1 that. The audit was completed I think in '15/'16 year
2 by the BSO, the Business Service Organisation. So that
3 was that one. If I could come on --

4 64 Q. Could I interpose on that the Board effectiveness 11:17
5 report for 2018-2019, just on the issue of training and
6 what was picked up on that. WIT-101650 under the
7 heading of "Building and Developing the Board."
8 Let me jump to the third paragraph, interesting in
9 light of Mrs. Leeson's evidence. It says:

10 11:17
11 "Whilst NEDs were generally content with Board
12 induction and annual performance assessment processes,
13 it was executive directors who generally did not feel
14 that they had appropriate Board induction and annual
15 assessment of performance on the Board". 11:17

16
17 so that's the results of the survey, if you like, or
18 that analysis across both the executive and
19 Non-Executive teams with regard to induction.

20 A. I remember this. Part of the learning, we accepted 11:18
21 that of course, and then we always had action plans. I
22 mean part of that learning was then that I, as the
23 Chair, would meet the executive directors - I'm not
24 talking about the Chief Executive, they had a different
25 appraisal - I would meet the executive directors who 11:18
26 sat on the Board annually. I think that happened
27 sometime around -- would it have been the summer of
28 '19 - I don't think it was '20 - the summer of '19. My
29 diary will confirm that each one of those executive

1 directors I met on a one-to-one to actually see how are
2 they getting on, what are some of the risks that they
3 are dealing with, what are some of the pressures that
4 they find. I wouldn't disagree with that, that was the
5 BSO independent audit, that they didn't feel an 11:19
6 appropriate induction and annual assessment. But
7 remember the Chief Executive was also appraising his
8 executive team. We didn't get into that but one of the
9 learning points was that I, as the Chair, should have
10 been meeting with them. 11:19

11 65 Q. Let me move on to examining, I suppose in a bit more
12 depth, your approach to your role. If I can bring up
13 WIT-90853. You explain, just scrolling down, that you
14 were in your office approximately four days per week
15 from early morning to late afternoon. You would have 11:19
16 seen the Chief Executive most days. You met with the
17 Chief Executive formally usually once per month, but
18 this was subject to change obviously with busy work
19 schedules.

20
21 "However most days if myself and the Chief Executive
22 were both in the office, we would have had informal
23 chats and indeed had many cups of coffee together
24 informally for updates". 11:20

25
26 Is that intended as a general reflection of your
27 approach throughout your tenure and not particular to
28 one Chief Executive, or is that -- 11:20

29 A. No, that would be them all. I'm sure the Inquiry has

1 been told that the Southern Trust headquarters is
2 located in the old nurses' home building, so it's quite
3 an old building that has been beautifully refurbished
4 but the corridors are still narrow. So if you can
5 imagine my office was in a corridor, a long corridor, I 11:20
6 had an interconnecting door with my personal assistant,
7 and next door to me was the Chief Executive's office
8 who had the same interconnecting. Opposite my door
9 would have been the Medical Director, the Director of
10 HR. As I came down the corridor each day, there was 11:21
11 the Director of Performance. So you had an open door
12 policy for most of my time there to maybe the latter
13 stages.

14
15 I would have been in early every morning; I would have 11:21
16 been in there as the needs of the job required. I
17 would have had very, very regular meetings with the
18 Chief Executives, all of them formally, but if they
19 were in the office and I was there, they would have
20 popped in to me or I would have went into them, I mean 11:21
21 if time allowed; certainly under Mrs. McAlinden's watch
22 and those that followed. I'm sure you are aware,
23 Mr. Wolfe, that every Chief Executive has different
24 styles of leadership. Whilst Mr. Rice was very good
25 with the coffee and had his own coffee machine and the 11:22
26 coffee cups always out, someone coming after him may
27 not have had that same style. That is not a criticism,
28 it is just personalities. Certainly in Mrs.
29 McAlinden's time, we would have walked the walk

1 together to the canteen and around, the same with those
2 that followed, and indeed with Mr. Devlin. But
3 circumstances change in workloads. I mean, Mr. Devlin
4 may not have just been in the office as much but any
5 day he was there, he would have popped in to see me and 11:22
6 vice versa, and if time allowed we would have had that
7 cup of coffee. So there would have been no difference
8 how I worked with chiefs.

9 66 Q. In terms of your own style, we can catch it just at the
10 bottom of the page there - I think you've said it 11:22
11 already in evidence - that your style of management was
12 as a people's persons.

13
14 "If the door were open of a Director office, I would
15 have spoken in to say even a hello; this was well known 11:22
16 as my style. The same to all admin and office support
17 staff who shared the same corridor. I walked the walk
18 as well as talking the talk".

19
20 You were a visible Chair. You liked to meet all grades 11:23
21 of staff and made time to stop and have a brief chat.

22
23 Just before we come to the next bit, your reflection is
24 different Chief Executives have different
25 personalities, different styles. I suppose the sense 11:23
26 of what you're saying there is that you're frequently
27 in the office?

28 A. Absolutely.

29 67 Q. You weren't invisible; you put in long hours?

1 A. Yeah.

2 68 Q. You had your own dedicated office which was situated
3 proximate to other senior members of the team. Are you
4 by implication, I suppose, putting across the point
5 that if there were issues of concern, you were there 11:24
6 and available to discuss them, and indeed you were
7 always keen to ask questions about what was going on
8 within the organisation?

9 A. Absolutely. I would never have passed, as I came in in
10 the morning, an open door. It might have been 11:24
11 7.30/8.00 in the morning, sometimes some of the
12 directors were in at that time; you would never have
13 passed that open door without saying good morning,
14 how's things today, what has happened; much? It wasn't
15 that you were getting involved in the engine room, it 11:24
16 was just actually interpersonal skills to me and how
17 you form relationships and communications are the
18 essence of success and that's how I have built my life
19 so therefore that was just normal to me. Absolutely
20 any Director or any Chief Executive that I have worked 11:24
21 with, all of them including Mr. Devlin, could have
22 approached me at any time. I mean, I had one phone and
23 I was always, because of my other work, 24 hours a day
24 on-call.

25 11:25
26 Just to give you an example. In Mrs. McAlinden's time,
27 I can remember five to twelve at night, she rang me to
28 say we were going to have one 12-hour breach in the
29 Emergency Department. I remember it well. She took

1 her work extremely seriously and would have phoned me
2 and I was always at the end of a phone. One can see
3 from evidence and indeed listening to media that
4 12-hour breaches now, there is maybe 500, 600 per day.
5 But I can tell you that every Chief Executive that I
6 had would have phoned me about any serious concern -
7 and I could list you numerous ones but time doesn't
8 allow - I had no problem with that. Indeed, a Director
9 would have phoned me as well if the chief wasn't there.
10 So I was very approachable, I was very visible and I
11 was always contactable. Always.

11:25

11:26

12 69 Q. You go on as part of your description of your role to
13 reflect, I suppose, in the negative:

14
15 "I never", "I never formally or informally discussed
16 Urology Services or Mr. O'Brien with any member of
17 SMT".

11:26

18
19 Just dealing with the first part of that, I suppose,
20 why is it the case that you never informally or
21 formally discussed Urology Services with any member of
22 SMT?

11:26

23 A. Because I don't recall ever any senior manager - and
24 the only ones that could have been talking about
25 Urology or Mr. O'Brien would have been the Acute
26 Director or maybe the Medical Director or whatever -
27 but I never remember any senior manager, and we're
28 talking about the executive team, talking to me either
29 on the phone or informally to discuss Urology Services

11:27

1 or any concerns about Mr. O'Brien.

2 70 Q. Maybe you had intended to connect the two, I am asking
3 you about Urology Services generally.

4 A. Never. Never.

5 71 Q. We'll come on this morning to look at how the 11:27
6 circumstances and the challenges of Urology Services
7 featured on the corporate risk register from time to
8 time, how it was the subject of performance reports
9 from time to time, and there were obviously serious
10 adverse incidents arising out of Urology. 11:27

11 A. Yes.

12 72 Q. Leaving aside Mr. O'Brien in that sentence, is it
13 really the case that Urology Services in general was
14 never the subject of conversation between you and
15 senior management? 11:28

16 A. Just to correct, I was taking that about me as a
17 one-to-one with. Of course Urology Services, along
18 with many other aspects of service delivery, came to
19 the Trust Board through performance reporting and on
20 the risk register. My apologies. I'm taking that that 11:28
21 I never formally discussed on a one-to-one Urology
22 Services but it definitely came on a performance
23 report. To give you an example as well, until my last
24 maybe 18 months, I chaired every appointment for a
25 consultant; I didn't miss any, I don't think. Then I 11:28
26 introduced Non-Executive Directors to start learning
27 because I knew I was going out in the latter stages. I
28 mean, I would have sat on so many interviews, that's
29 where I collected what I call my soft information. I

1 mean you met so many people normally. The Medical
2 Director I would have chaired them, they would have
3 been on, not all of them attended but in their absence
4 would have been the Associate Director, Clinical
5 Director and then maybe one or two consultants from 11:29
6 that speciality. I mean, you would have talked to
7 those kind of people, not only about be it urology or
8 indeed what other the specialism was. I'm referring
9 there I don't recall individually anybody coming to
10 talk to me about Urology, but definitely it came in the 11:29
11 performance reports and through other means.

12 73 Q. Yes. We'll look in due course at what that looked
13 like. Just to complete the sentence, no discussion
14 regarding Mr. O'Brien with any member of the senior
15 management team. Just on that, I wonder if that is 11:29
16 quite correct. We'll look in due course at whether you
17 had even passing discussion with Dr. Wright, with
18 Mr. Rice, with Mr. Devlin, with Mrs. Toal about
19 Mr. O'Brien and processes that were about to be put in
20 train or were in train in relation to his practice. 11:30
21 We'll come to that in some detail later.

22
23 Isn't it fair to say that you were, from time to time,
24 kept in the picture about developments in respect of
25 Mr. O'Brien, even if those conversations may not have 11:30
26 descended into an awful lot of detail?

27 A. Oh, yes. I mean, when Dr. Wright first came to tell
28 me, I did have that conversation. That was under the
29 watch, I think Mr. Rice was the Interim Chief Executive

1 then. He would briefly have mentioned it. You know,
2 that was informal coming to tell me.

3 74 Q. But that's the point I'm making. That sentence isn't
4 just quite right when you reflect upon it. There were,
5 and we can examine later the extent to which those
6 conversations were sufficiently detailed or whatever
7 the view might be, but some conversations did take
8 place with regards to Mr. O'Brien over the years?

11:31

9 A. Oh yes, with the Medical Director and the appropriate
10 Chief Executive.

11:31

11 75 Q. You have explained that in terms of the work that you
12 did as Chair, you had an annual appraisal every year
13 and at no time did the Chief Executive, senior
14 management team, Non-Executive Directors or indeed
15 Permanent Secretary ever raise any concerns about the
16 performance of your duties; is that fair?

11:32

17 A. Absolutely, never. You know, I did complete a
18 comprehensive process for my appraisal. I mean, you
19 would have been notified by the Department. Over my
20 years I would have changed the -- I introduced for
21 myself a 360 degree asking staff that worked to me what
22 did they think of me basically, and it covered a lot of
23 areas. I mean, I asked them to complete that. Most of
24 them did. I don't remember many whatever didn't have
25 them back. I used that to reply. You complete -- it
26 is quite a comprehensive document, the appraisal for
27 the Chair. Then it was sent into the Department and
28 then you had a formal meeting.

11:32

11:32

29 76 Q. Yes. We'll come on in a moment to look at some of

1 that.

2
3 Mr. Devlin and your relationship with him is perhaps
4 important in terms of the work of the Inquiry because
5 he was the Chief Executive in place and you were the 11:33
6 Chair in place when the issues of concern to the
7 Inquiry flared up. If I could bring you to his witness
8 statement, WIT-00095. Just at the top of the page, he
9 says that in terms of his work with the Board:

10 11:34
11 "One weakness from a personal reflection is that during
12 my early tenure the relationships between me and the
13 Chair, Roberta Brownlee, were not as strong as they
14 could have been. Outside of public Trust Board
15 meetings, we had clashed a small number of times on the 11:34
16 difference between the roles of a Chief Executive and a
17 Chair. In my opinion, given the lack of consistency of
18 personnel in the Chief Executive post prior to my
19 tenure, the Chair had understandably become more
20 involved in the operational delivery of the Trust. As 11:34
21 the new Chief Executive, I found her approach
22 overreaching and in many cases unhelpful. On
23 reflection, I know that this imperfect relationship may
24 have had an impact on the functioning of the Board and
25 I know, through discussion, that some members of the 11:35
26 senior management team found the relationship with the
27 Chair difficult at times".

28
29 Your reflections on hearing that have been set out to

1 some extent in your own witness statement where you
2 described a good relationship, and that you say never
3 clashed to the best of your understanding or
4 recollection?

5 A. I mean, this was a real surprise to me. Shane and I 11:35
6 got on very well. I note what he says. I was not
7 aware, nor never did he make me aware, or indeed any
8 other senior manager mention anything to me about the
9 relationship. I find that actually quite hurtful and
10 stressful that other members of the senior management 11:35
11 team found the relationship with the Chair difficult at
12 times. I never was aware of that and it was never
13 brought to my attention. Certainly I'm sure you've got
14 many copies from all of the executive team their
15 reflection on me, because those would have been held in 11:36
16 my office by my assistant. I don't remember any
17 clashes. It's how you describe "clashes". I don't
18 remember that.

19
20 I think if I've read somewhere - I hope I'm correct - 11:36
21 he named one of those was a visit of the Permanent
22 Secretary to a quality improvement, or something he
23 mentioned. If I would be allowed to explain that. I
24 probably, with my Non-Executive Directors, attended
25 many functions within the Trust on quality improvement 11:36
26 and innovations; excellent, some really excellent
27 stuff. I remember there was one in Dungannon in a
28 venue and myself and two or three others would have
29 attended. We would have attended just to see and

1 learn, we weren't participating. During that time, the
2 Permanent Secretary arrived. Now, Mr. Wolfe, I didn't
3 know he was coming nor did I meet him on that occasion.
4 I did remember saying to Shane afterwards it would have
5 been good to know he was coming. I do think out of 11:37
6 courtesy, if Non-Executive Directors and I have gone to
7 the trouble to go to an event like that, if someone had
8 even said by the way, Richard Pengelly is coming, you
9 have no role to play with him but he will be there, we
10 were learning that both during the event and after. I 11:37
11 do remember saying that to him. I don't think I was
12 very critical of it but I just said I would liked to
13 have known. Going by previous Chief Executives, that
14 would never have happened, never have happened. I
15 think that may have been one that he clashed or that he 11:37
16 refers to. I think the other one, no doubt you are
17 going to come to anyhow, was around governance and the
18 review of clinical and social care governance, so I'll
19 not go into that.

20 77 Q. We will come to that very shortly. Do you accept that 11:38
21 viewed from your perspective, Mr. Devlin's approach to
22 initiating a clinical and social care governance
23 review, which was conducted by Mrs. Champion from the
24 Leadership Centre, his approach to that was a matter of
25 concern to you and in a sense you clashed with him by 11:38
26 telling him about your unhappiness?

27 A. Yeah. Well, probably clash isn't a word that I would
28 often use in my vocabulary, but I would respect it if
29 that's what he called it. Every Chief Executive in a

1 substantive post, Mr. Donnelly and indeed
2 Mrs. McAlinden, Mrs. McAlinden did a major piece of
3 work in relation to clinical and social governance
4 review and governance, corporate governance; a huge
5 piece of work, and a lot of implementation of new 11:38
6 changes and structures that were put in place. But she
7 would have discussed that with me and with the
8 Non-Executive Directors, the terms of reference would
9 have come to the Board and we would have had a
10 discussion of all that involved. I think the Inquiry 11:39
11 has before them lots of emails to'ing and fro'ing
12 regarding this. I mean, I wasn't aware that we were
13 having a clinical and social care governance review. I
14 mean, that's --

15 78 Q. I don't wish to stop you unfairly, we are going to come 11:39
16 to that after the break. Just let me finish this
17 section and we can look at the context in which that
18 CSCG review commenced. Just to elaborate on what
19 Mr. Devlin said in order to explain his experience of
20 working with you, he suggested in his oral evidence - 11:39
21 this is TRA-01094 - that you had, as he described it,
22 huge authority and power in the organisation. He said
23 he couldn't ask a Non-Executive Director - this is line
24 19 - he couldn't ask a Non-Executive Director for
25 help - I'm paraphrasing here - without getting 11:40
26 permission from you, yet you could walk into and speak
27 to an executive Director without issue. Is that the
28 way you organised?

29 A. No, I wouldn't have seen it like that. We're talking

1 about walking into the office. Not all of the
2 directors were in that corridor. For example, the
3 Director of Social Work and Young Peoples' Services as
4 well as the Director for Mental Health weren't on our
5 site so I wouldn't have been able to walk into their 11:41
6 office. I mean, I do think it's good practice if a
7 Chief Executive wants to engage. There was no harm in
8 talking to them, I'm sure he talked to them often and I
9 wouldn't have known. I do think it's good practice,
10 and we would have had that, that if you were going to 11:41
11 use the services of a Non-Executive Director, for
12 whatever it might have been to be part of... I remember
13 Eileen Mullan was involved in a part of a risk
14 management review, and that was discussed and it was
15 nominated that she, because of her experience, would do 11:41
16 that. Of course that happened. But it was good to
17 know if he needed a Non-Executive Director, for
18 whatever role he wanted them, that I should be
19 informed. It wasn't, Mr. Wolfe, that I didn't allow
20 him, as is maybe being perceived, to talk to them. 11:41

21 79 Q. It was a sense that he had to formally request
22 permission of you is how he put it?

23 A. Well, I wouldn't agree with that. Yes, it would have
24 come through an email, or indeed it maybe came up as an
25 action point from a Board meeting or the governance 11:42
26 meeting or one of the other sub-committees if a
27 Non-Executive was to be involved in, say, one of the
28 subcommittees under the Medical Director area, and then
29 you would have formulated which one will do that, I

1 mean through an email, if he calls that formally asked.
2 But, I mean, I don't really understand what that means,
3 to be honest.
4

5 It sounds actually quite harsh that I didn't allow him. 11:42
6 I mean, I know Ms. Mullan and Mr. Devlin, and rightly
7 so, would have had a lot of conversations together
8 around governance and risk when I wouldn't have been
9 there and I didn't know about them, and that's fine, it
10 wasn't that kind of relationship. But what he is 11:42
11 describing there I think isn't just as balanced, I mean
12 about me walking into an office. I would never have
13 asked a Director to do anything without having gone
14 through the Chief's office on any occasion.

15 80 Q. I think within your witness statement you point to the 11:42
16 review of your performance conducted by Mr. Devlin as
17 indicative of a more positive view that he held of you
18 than he has perhaps allowed for in his evidence. If we
19 just look at that specifically, WIT-90934. You can see
20 the period in play here, April '18 to March '19, so 11:43
21 roughly his first year in post as Chief Executive. The
22 scorings are 1 for very effective and 2 for effective.
23 If we scroll down the various indicators or qualities,
24 it's all ones and twos, so effective or very effective.

25 11:44
26 He explains in his evidence, Mrs. Brownlee, that he
27 hoped that this document would be an opportunity for a
28 conversation to improve your relationship with him. He
29 said he found it -- this is TRA-01798. Just look at

1 the detail of that. If you can see what he said. He
2 had hoped that this document would be an opportunity
3 for us to have a conversation about how we could
4 improve the relationship. I put the point to him that
5 most of the assessment of you was very effective or 11:45
6 effective, and he agreed with that. Scrolling just
7 down to the next section, he was seeming to suggest
8 that, as we can see at the last section there, he was
9 regarding a score of two as not being overwhelmingly
10 positive. He says: 11:45

11
12 "I had hoped that by calling out a small number of
13 twos, there would be a point of conversation that we
14 could have had around those to explore why I felt it
15 wasn't the top mark". 11:45

16
17 He went on to say he found it very difficult to give
18 feedback to you because feedback was often not accepted
19 in the way that it was meant. Is that a fair comment,
20 that you were somewhat prickly around any form of 11:46
21 criticism even if that criticism was intended to be
22 constructive?

23 A. Absolutely not. I mean, first of all about this tool,
24 this was a tool I was asking others to complete. I
25 didn't expect to get the top mark in each box. This 11:46
26 was a learning and this was for me to set my objectives
27 with the Department for another year and I would have
28 used that, so I didn't expect that. It wasn't a tool
29 that I also, when I see what Shane writes here of an

1 opportunity to come back -- I'll come back to the
2 criticism that he says in a few minutes. Shane was a
3 very competent, capable, confident Chief Executive who
4 I met very often. I did his setting his objectives. I
5 mean, we had many conversations. So honestly, 11:47
6 Mr. Wolfe, if Shane had a problem with me, I would
7 believe he could have told me and should have told me.
8 I don't recall him ever being critical of me, I mean
9 personally or professionally. I don't remember him
10 ever bringing that to my attention, or indeed anyone. 11:47
11 If he means within the Boardroom and setting agendas,
12 he, along with the Board Assurance Manager and myself,
13 set the agendas, and I believe I afforded him every
14 opportunity at that to talk and to do whatever. So I
15 don't know where he is referring to that he couldn't 11:47
16 approach me or, when he did be critical of me, that I
17 didn't respond well. If he could give me examples
18 of -- maybe it's too late to ask that but I would have
19 liked to have known give me an example of where you are
20 critical of me and I didn't respond well. I have not 11:48
21 read that in any of the documents that has come before
22 me, but I don't recall ever having a criticism.

23
24 Look, we agree to differ, all Chief Executives, that's
25 a healthy environment, but I had the greatest respect 11:48
26 for Shane Devlin and I gave him that respect. Him and
27 I did a lot together and he did a lot of work. I knew
28 a lot about his family, we exchanged gifts. I mean,
29 when I was leaving if this guy didn't think much of me,

1 why did he write and send me this? I can't understand
2 this, Mr. Wolfe.

3
4 It was the same when we come to the senior management
5 team. When I was leaving, I wanted no farewell or any 11:48
6 gifts or anything, but the letters I got via my
7 personal assistant are commendable, from the senior
8 management team at levels, and indeed from Mr. Devlin.
9 So I just want to put on record that I had no
10 recollection of any time Mr. Devlin and I not working 11:48
11 well together.

12 81 Q. I know I am pushing my luck with the break but if I can
13 put one final in this section to you, and, subject to
14 the Chair, we can have a break.

15
16 If we go back to WIT-90881, which is your witness
17 statement again, and the third paragraph. You say:

18
19 "As Shane rightly says, there has been some lack of
20 consistency in personnel in the Chief Executive post 11:49
21 and associated instability. I felt that my position as
22 a longstanding Chair provided much needed stability for
23 the NEDs and I had built a very good professional
24 relationships with them. This is what Shane was
25 unsettled by". 11:50

26
27 Could you help us understand that. Is this your
28 rationalisation thinking back and taking into account
29 what Mr. Devlin has said about your relationship, or

1 had you some sense as you worked with him that he was
2 unsettled and perhaps intimidated by the strong
3 relationships that you say you had built with your
4 fellow NEDs?

5 A. That's probably what I believed whenever he was in for 11:50
6 a while, Mr. Wolfe. Shane would have seen, when I went
7 to the canteen, the number of staff that would have
8 come over to talk to me, or even the ladies serving the
9 tea. I mean the leading cleaning the corridor, et
10 cetera, I had a very good relationship with. He would 11:51
11 have known I had a very good relationship, and I did
12 have until I left, with the Non-Executive Directors,
13 absolutely, and the same with the senior management
14 team. It was the same, when I would have been out for
15 a walk or in the main canteen, I was well known, people 11:51
16 came to talk to me. You know, it was only maybe a
17 sense he probably felt that I knew a lot of people and
18 it will take him time. I had never worked with
19 Mr. Devlin before, he had never worked in my time in
20 the Southern Trust, so it takes time to build. 11:51

21
22 Another point, and it might be soft information, maybe
23 I am fairly wrong, but during all previous Chief
24 Executives, Director's doors would have been open and
25 you could have went in. I mean, then they were closed 11:51
26 of course for when they would have been doing their
27 business. Maybe not relevant at all but I noticed from
28 when Mr. Devlin came, over a period of time, doors were
29 closed and there was a much more closed approach. Now,

1 that's a personal observation. I would have thought my
2 years of experience and how my style was with people -
3 you used the word "intimidating" - it probably may
4 have -- he may have thought it was too much. I mean
5 but sorry, that's my style and I would have known my 11:52
6 staff at every level. I did visits to the laundry. I
7 mean, you just knew your staff well. Remember, that's
8 how you are going to get feedback. When we introduced
9 leadership walks, if you are approachable and you meet
10 people out, they will say to you, you know, something. 11:52
11 That's probably what I meant and I don't think he
12 particularly liked that but, I mean, that's not an
13 unfair criticism of him.

14
15 As far as I am concerned, during all of my time with 11:52
16 Shane we had an excellent working relationship. We
17 worked well together as a Chief. I gave him his place,
18 I kept the blue water between us as best I could.
19 whilst he calls them clashes, that wouldn't be a word I
20 would often use. I can only think of those examples. 11:53
21 I don't call it a clash. It's regrettable but it was
22 regrettable to me as an experienced Chair and someone
23 who is totally committed to their role to read through
24 an inquiry that the Chief Executive had a problem with
25 me, and indeed he refers to others -- 11:53

26 82 Q. Yes.

27 A. -- whenever we did a lot of reflective in-practice. We
28 did a lot -- I mean, if you look at the evidence in
29 2018 and '19, we did a lot of work on the values within

1 the Trust, and the culture. We were really committed
2 to that. Again, I am amazed when people say the
3 culture.

4 83 Q. We'll come to that. Thank you for that answer.
5 Subject to you, Chair?

11:53

6 CHAIR: We are going to come back, ladies and
7 gentlemen, at 12.10. Thank you.

8

9 THE HEARING BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

10

12:18

11 CHAIR: Thank you, everyone. Mr. Wolfe.

12 MR. WOLFE: I want to move on, Mrs. Brownlee, to
13 explore with you how, during your time, you experienced
14 the area or the Trust's approach to the area of
15 clinical and social care governance. Let me start by
16 what you said in your own statement. WIT-90856. You
17 say:

12:18

18

19 "As Chair, I regularly assess the systems through
20 internal audit, external audit, Board assurance,
21 framework, performance reports, Board committee
22 minutes, serious adverse incidents, Medical Director
23 and Director of Nursing reports to the Board, patient
24 safety and quality of care reports to the Board,
25 corporate risk register, and the management statement
26 signed by the accounting officer".

12:19

12:19

27

28 That's governance in general but aspects of that are
29 clinical and social care governance. You go on to say

1 that:

2

3 "Each Chief Executive that I worked with undertook a
4 clinical and social care governance review as well as
5 the high level overarching governance reviews
6 generally".

12:19

7

8 we'll come on to look at some particular aspects of how
9 you looked at governance, or how you used governance
10 tools yourself, later. Help me with this: Various
11 Chief Executives do their own review; by the time
12 Mr. Devlin came into post in April 2018, how would you
13 characterise the state of clinical and social care
14 governance within the Trust?

12:20

15 A. Probably, Mr. Wolfe, what I meant there was each

12:20

16 substantive Chief Executive, it wasn't any interim
17 reviewed, did a formal review. Certainly during
18 Mrs. McAlinden's term, there was an extensive review of
19 clinical and social care governance and corporate
20 governance at the highest level. At that time when

12:21

21 that review took place, she brought the mechanism to
22 the Chief Executive's office, if you know what I mean.
23 She was the lead for that. There was an extensive
24 review then. I may not remember all of the detail but
25 it resulted in each directorate - and that was the same
26 in community care as well - had their own risk register
27 and their own teams of people reporting into that.

12:21

28 Then she would have had regular senior management team
29 meetings with her Executive Directors and would have

1 looked at the governance within each directorate. The
2 Chief Executive also would have met with her Directors
3 very often for formal meetings and one-to-one meetings,
4 and at least half of that time would have been on the
5 individual corporate risk register in that directorate, 12:21
6 so there was time spent on that. There was, I mean, a
7 different emphasis during her time put on governance,
8 overarching we'll call it. I mean, there were
9 structures put in place and different people changed
10 roles. So as far as I am concerned, under her skilled 12:22
11 management and leadership the governance arrangements
12 in the Southern Trust were as good as they could have
13 been with all of the information flow that should have
14 come.

15
16 We had a Board Assurance Manager, Sandra Judt, who was 12:22
17 separate to me and the Board. She had a huge
18 responsibility in relation to Board assurance,
19 standards and guidelines, and was really independent
20 really to the rest of the team, and would have been 12:22
21 very well informed and kept me informed as well. So I
22 would have been very satisfied when Mrs. McAlinden
23 left, I use the analogy, that the engine was
24 well-oiled, it had been very well reviewed, she put in
25 excellent processes around. For example, if I take, 12:23
26 say, nursing and medicine, the Medical Director, what
27 was reporting in on his report all around
28 re-validation; doctor that was failing, or GMC; I mean,
29 health care acquired illnesses, to serious adverse

1 incidents, lots of different feeding into that triage
2 of work. The same in clinical indicators as well, and
3 the same in nursing. I mean, they had their quality
4 nursing standards, and all that came in about workforce
5 and all et cetera was in that. So, Mrs. McAlinden left 12:23
6 a legacy of a very firm, integrated governance system
7 within the Southern Trust, and it was never -- I was
8 never aware we hadn't enough staff, I mean to manage
9 that all. Let's be honest together, we never have
10 enough staff anywhere in health and social care but 12:24
11 nobody, or Mrs. McAlinden, brought it to my attention.
12 The new structures she put in place were very effective
13 and worked well.

14 84 Q. Very well.

15 A. Therefore the Chief Executives followed her followed 12:24
16 that per se. Nothing changed there, there was a lot of
17 fuel and it went. Yes, when Mr. Devlin came in, as I
18 would have expected, his overview with the Medical
19 Director, et cetera, he wanted to do a clinical and
20 social care governance review. 12:24

21
22 Certainly I never had any concerns about the reporting
23 mechanism of clinical and social care governance to any
24 of the Board committees and how it was reported in to
25 us. You are aware of the subcommittees -- 12:24

26 85 Q. Just to be clear, you're characterising the clinical
27 and social care governance structures and environment
28 in fairly positive terms?

29 A. Yes. Yes.

1 86 Q. You appear to have had a high degree of confidence in
2 it?

3 A. Yes.

4 87 Q. Just to be clear, if I can put this in broad terms, the
5 Inquiry has received evidence that because of budgetary 12:25
6 pressures perhaps, perhaps also because of the cultural
7 issues, clinical and social care governance wasn't in a
8 good place by 2018. Take, for example, the area of
9 audit. Audit - perhaps I exaggerate slightly - had
10 collapsed, there wasn't the money to resource posts. 12:25
11 People were moved out of audit into other posts. That
12 had an effect within, for example, within the patient
13 safety environment in that we have heard that the
14 clinicians who led on the Morbidity and Mortality
15 Committee witnessed an environment where audit was not 12:26
16 well pursued, not well organised and not well
17 supported. Did that kind of thing reach your ears?

18 A. You mean clinical audit in the Medical Directorate?

19 88 Q. Yes.

20 A. I am not aware of the Medical Director's report ever 12:26
21 informing us that there was changes in clinical audit
22 because of workforce issues. I mean, that is from
23 memory and in my recollection I don't remember that. I
24 believe that the staffing that was in clinical and
25 social care governance, right people were in the right 12:26
26 place, I mean. Clinical audit or nursing audits are
27 only as good as the tool that you have and the people
28 doing it. So therefore I believe that audit, whatever
29 way you talk about audit, can and should be done

1 regularly, there should be a tool that completes it.
2 when it's not being done, there should be Early Alerts
3 or letting us know through a flow of information. I
4 would have expected that to have come not only through
5 the Medical Directorate but even in an Acute 12:27
6 directorate, if audits weren't being undertaken, say in
7 relation to infection control or tissue viability or
8 whatever some of these things were, I would have
9 expected that to come through the audit and say we are
10 not achieving that. 12:27

11
12 Remember our leadership walks when we went out, and
13 maybe we weren't there enough, but nobody raised any
14 concerns with me that audit wasn't being completed, and
15 certainly I wasn't aware. I knew about the M&M 12:27
16 meetings, sometimes the attendance wasn't as good again
17 due to pressures of work, but I wasn't aware that it
18 was because of clinical audit not being done. It
19 certainly didn't reach my level. I don't recall ever
20 reading that on a medical director's report. 12:28

21 89 Q. Let me put it to you so that I can have your comments
22 on where Mr. Devlin saw it when he came into post. If
23 we go to his statement at WIT-00036, and just at the
24 bottom of the page. He reports that in 2019 he
25 commissioned two reviews to provide assurances around 12:28
26 clinical governance processes. He says:

27
28 "Having worked in other Trusts, I was concerned that
29 the assurance processes were not as robust as I had

1 been used to. In particular, the importance of a
2 completely integrated governance system was not as
3 explicit and, in my experience, felt underresourced".
4

5 Therefore, he progressed with two reviews. First of 12:29
6 all he refers to a Trust Board development workshop
7 and, secondly, he deployed the Health and Social Care
8 Leadership Centre to undertake an independent review of
9 clinical and social care governance within the Trust.

10 If we go over the page, please, he reports that that 12:29
11 review led to 48 recommendations, and we'll come to
12 that in a moment.
13

14 Just on down to the bottom of this page again where he
15 further explains the concerns that he observed and 12:30
16 which led him to initiate this review. He was
17 concerned that the system was disjointed and not
18 operating as he had experienced in other HSC

19 organisations. He makes the following additional
20 points: "The level of expenditure on the governance 12:30
21 functions felt light", and he refers to funding
22 concerns in SAI management, complaints, as well as
23 standards and guidelines. He says there was little
24 evidence of systematic and dynamic flow of clinical and
25 social care information to the senior management team 12:30
26 on a regular basis. His concern, he goes on to say,
27 was that the evidence that was raised was based on a
28 push system, as he called it, from the directorates
29 without a regular systematic review process.

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Thirdly, he says that the level of data and statistical evidence being brought to the SMT in respect of quality and safety was lower than what he was used to in other organisations.

12:31

First of all, that, in light of what you reflected on a moment or two ago, would appear to jar with your experience?

A. Certainly that wasn't what I had found or been reported to me or noted missing. However, I respect what Shane is saying here. He was the New Chief, he is the Accounting Officer, he had a breadth of experience of working in other places. Of course, any new Chief or leader brings with them a breadth of knowledge and experience to introduce new things. So, I mean some of this I would not have known because they are operational, I mean in relation to what comes to the Board. If he was identifying this with the senior management team and the flow not coming, he was absolutely right to do something about it and that's what he was assessing there.

12:31

12:32

12:32

That wouldn't have been what I had found previous to that because all I can say is the reports coming through from, say, the Nursing Directorate or indeed the Medical Directorate covered, you know, serious adverse incidents, complaints, any Early Alerts. I'm just thinking of the medical at this time. Infection

12:32

1 control, shortages of workforce. I mean it would also
2 have identified -- I remember, I think it was
3 Dr. Wright's report of '15/'16 year, where he was
4 reporting then out of the four years of five of free
5 validation and appraisal, we were at 100%. We had all 12:33
6 of that flowing in to that. So I wouldn't, from my
7 experience, have thought there was anything wrong with
8 that, unless someone else.

9
10 I mean in the governance leads in each as they were 12:33
11 feeding in, I would have expected them to identify
12 weaknesses as well. You had the same then in nursing
13 and of course in social work, et cetera. I didn't
14 identify that from my experience. Also, I wouldn't
15 disagree with him when it comes to budgetary 12:33

16 restraints. I mean everywhere in the Trust, you know
17 there was no lucrative money or else anything extra.
18 You know, the budgets were tight, there is no doubt.
19 The delivery of health and social care is extremely
20 expensive and the demand and capacity was enormous. 12:34
21 So, if he had found that it wasn't properly funded to
22 be able to do the SAIs or complaints, or to manage
23 standards and guidelines, we were really strict about
24 those and how those reported in to the Board assurance
25 framework and through the control standards, how many 12:34
26 did it receive; I'm just using it as an example. I
27 mean standards and guidelines, there was huge numbers
28 that came in from both the Department, maybe from RQIA,
29 the Public Health Agency. You know, the assurance of

1 knowing when they came in, how they disseminated and of
2 course appropriately what action was taken.

3 90 Q. But we have also seen in the evidence how the Trust was
4 struggling with those as well. I suppose the point
5 perhaps by way of explanation is this: You didn't
6 appear to realise that there were the kinds of problems
7 that he, perhaps with more of an expert or specific
8 operational eye, was able to identify.

12:34

9
10 We started this morning, I was asking you about whether
11 there were any problems created by the absence of a
12 dedicated Chief Executive for a number of years. Isn't
13 this the kind of thing that can happen when you don't
14 have a permanent Chief Executive taking a comprehensive
15 overview of his organisation. With all due respect to
16 the three or four incumbents who held the reins
17 temporarily, this is the kind of area that requires a
18 degree of dedicated focus; isn't that right?

12:35

12:35

19 A. Oh, yes, yes. A permanent person coming in is looking
20 at all aspects of the business. I would have expected
21 a Chief Executive to look at all areas, and especially
22 governance. I don't remember Shane ever bringing that
23 to my attention but I wouldn't have expected him, those
24 are operational issues. If he, with his team, wanted
25 to make changes on that to improve services and better
26 outcomes, of course.

12:35

12:36

27 91 Q. Before we look at what Mrs. Champion found, could I
28 just look at your response to Mr. Devlin when the
29 report from Mrs. Champion was available. If we go to

1 the Board minutes for 27th February 2020. They are to
2 be found at WIT-00583. Mrs. Champion's draft report
3 was available at the tail end of 2019, and the report
4 was the subject of discussion at this Board meeting.
5 If we just scroll down a little; there we are. Sorry, 12:37
6 just scroll up slightly.

7
8 You're recorded as saying that you felt very offended
9 by the report in how it was written in relation to the
10 Trust Board. You say, for example, you were named as a 12:37
11 contributor when, in fact, you had not been involved
12 and only met the author at the final draft stage. You
13 say whilst you agreed with the Chief Executive that he
14 can undertake a review at any time, you understood that
15 it was a review specific to clinical and social care 12:38
16 governance, yet it went wider than its terms of
17 reference and strayed into corporate governance, which
18 you felt should have involved yourself and the
19 Non-Executive Directors. You made the point that the
20 Trust Board has a responsibility to ensure that the 12:38
21 Trust has effective systems in place for governance and
22 therefore it was important for the Trust Board to have
23 a discussion on the report and agree a way forward.

24
25 It is the case that in the summer of 2019 when the 12:38
26 report was still being developed by Mrs. Champion, she
27 spoke to you and interviewed three of your
28 Non-Executive Directors?

29 A. Yes. Can I go back a little before that, sorry?

1 92 Q. Yes.

2 A. I mean, I had absolutely no problem with the Chief
3 Executive doing a review of clinical and social care
4 governance and its importance to make sure around the
5 quality and safety for patients. I had no problem at 12:39
6 all with that. My point was we didn't know, myself and
7 the Non-Executive Directors. Therefore, I felt that
8 the Chief Executive should have at least sent to me in
9 an email 'I am going to look at clinical and social
10 care governance, I am engaging with lady June 12:39
11 Champion', et cetera, and that would have been fine.
12 But we never saw the terms of reference. So,
13 Mr. Wolfe, at the time the Board Assurance Manager,
14 Sandra Judt, always would have met with me meticulously
15 to have gone through preparation for the Board, what 12:39
16 reports were coming, and a draft agenda. When I met
17 her, this is the first I heard of it. She said there
18 is the draft report, the Champion Report, coming, and I
19 said what's report is that? She is said that's the
20 governance report. I said goodness, you know we hadn't 12:40
21 been involved in it at all.

22

23 We'll move on then quite a bit of time. Then when I
24 spoke to Shane about it, he did say that -- and when I
25 looked at the report, Mrs. Champion's draft report 12:40
26 talked about the Trust Board; it talked about myself.
27 I had never been a contributor to it, none of my
28 Non-Execs. I would have thought, right, Roberta, you
29 might have missed something. I said to Sandra, what

1 was this all about. She explained - she was excellent
2 in her role around governance - what all was happening.
3 I said well, had he met, say, Eileen Mullan -- has the
4 lady met Eileen Mullan, the Chair of Governance, or any
5 of the non-execs, and she hadn't. So I said to Shane I 12:40
6 was concerned that a report was coming to the Board in
7 draft form naming myself and others, and we weren't
8 contributors to it; I hadn't been informed we were
9 looking at the overarching governance, not about
10 clinical governance, and I said would it be possible 12:40
11 for me to meet June Champion. I should also add,
12 Mr. Wolfe, that the Champion Report and outcomes came
13 in at the very latter stages of my tenure so I wasn't
14 involved in the embedding of them.

15
16 Anyhow, I did meet with June and, yes, it was around
17 summer time. I mean, June did tell me have you seen
18 the terms of reference and I said no. She said the
19 terms of reference have now been expanded to look at --
20 and she was apologetic. I said to her I did think it 12:41
21 important if we were going to look at the totality of
22 governance, that she would need to have been meeting
23 possibly with myself but certainly with the Chair of
24 Governance. That's whenever I started a flow of
25 emails, which I think is before the Inquiry -- 12:41

26 93 Q. They are. They are.

27 A. -- about asking. And even Eileen Mullan, who was the
28 Chair and an excellent Chair of Governance, I mean you
29 will see she wasn't aware of it, and indeed expressed

1 concerns about what was written at the end of it, and
2 had asked others. I think Mr. McDonagh was asked. We
3 had an excellent other Non-Executive Director in
4 Governance, Siobhan Rooney, and Siobhan had already
5 brought to my attention that she was concerned about 12:42
6 the content. So that's how that all began, so yes --

7 94 Q. Those emails that you referred to, they are of course
8 before the Inquiry.

9 A. So that was --

10 95 Q. And they date from primarily August 2019. The final 12:42
11 draft of the report wasn't produced until later in the
12 year, so while you have certainly concerns, and we've
13 heard from Mr. Devlin that he, upon reflection, has
14 taken on Board those concerns in terms of the way he
15 handled it, and he said in his evidence that "In 12:42
16 hindsight I could have done a lot more with the Chair
17 and non-executives in advance to warm them up to the
18 report". This is TRA-01653.

19 A. With respect, he didn't involve us at all.

20 96 Q. Is it not fair to say that by the -- and you're 12:42
21 certainly -- your evidence would appear to be correct
22 that until you raised concerns, arrangements weren't
23 made to speak to the non-execs but the non-execs were
24 spoken to in advance of the completion of the process?

25 A. Yes. The report was pulled back then and June agreed 12:43
26 to see three non-execs. It was the summer months,
27 which is extremely difficult to get a sample of
28 non-execs from the Governance Committee. I think we
29 picked Eileen, of course, because she was the Chair, I

1 think Siobhan Rooney was one and I think Martin
2 McDonagh was the other to try and see her.

3 97 Q. That's right.

4 A. And then I had a time with her. That was all good,
5 that is all about collecting evidence from different 12:43
6 areas. Then so that naturally pushed the report back
7 and then the report did come back then at a different
8 time. I suppose what the minute is trying to say, be
9 it clumsy or otherwise, that we were expressing
10 concerns about not the clinical and social care 12:44
11 governance review, it was the overarching review that
12 involved the Board and named the Board and yet the
13 Board as such didn't contribute.

14 98 Q. Now, that's a problem of process and we have your
15 evidence on that. Let me move to the substantive 12:44
16 findings or recommendations of the report, of the
17 review, and let me have your views on that.

18
19 The executive summary of the review is to be found at
20 WIT-00509. If we just go three-quarters of the way 12:44
21 down, the report provides analysis and recommendations
22 throughout Section 4, and we'll look at some of those.
23 Mrs. Champion explains:

24
25 "Good governance is based on robust systems and 12:45
26 processes by which the organisation directs and
27 controls their functions in order to achieve
28 organisational objectives".
29

1 The Trust, she says, has in place the required elements
2 of good governance framework, and she sets some of the
3 key aspects of that framework out. What she then goes
4 on to say is:

5
6 "The Trust Board subcommittee structure is less well
7 defined and requires revision. Senior stakeholders
8 identified a lack of connectivity across the existing
9 governance structure and a lack of a robust assurance
10 and accountability framework which added to the
11 perception that the core elements of integrated
12 governance were being delivered in silos with various
13 reporting lines, corporate, directorate, professional
14 and expert advisory committee. The proposed revised
15 good governance structure will provide the Trust with
16 an assurance and accountability framework which will
17 also address the concerns expressed in respect of
18 existing accountability and reporting lines to the
19 Trust".

20
21 When you read that, Mrs. Brownlee, coming towards I
22 suppose the end of your time as Chair, did that
23 disappoint you, that here was a person experienced in
24 governance arrangements reporting back to the
25 organisation that all was not well?

26 A. Certainly when I read that, it was important to note
27 that and I was delighted that June Champion had
28 identified that. That's what you would have expected
29 in a governance review, someone independent coming in,

1 looking at how we were doing our business and
2 identifying weaknesses. That's healthy. I mean, it
3 was disappointing, and I am assuming the senior
4 stakeholders were, of course, contributors like the
5 Non-Executive Directors. Again, the three people that 12:47
6 would have been contributing from their background
7 would have had a wealth of experience in that. So, it
8 didn't disappoint me or indeed shock me that I was
9 offended, if you know what I mean. It was actually
10 good to know and healthy that the Chief Executive, here 12:47
11 we are now, here's the findings and this is going to
12 get better, you know. So it wasn't that I was offended
13 because I was there and it hadn't been picked up. I
14 mean this is all about teamwork and therefore someone
15 independent identifying the lack of connectivity and 12:48
16 governance processes that could be improved, you know,
17 is just to be encouraged and healthy and let's get on
18 with it. So it didn't -- it caused me, yes, concern
19 that we hadn't identified it sooner; good we'd a Chief
20 Executive in, good June had found this, now let's see 12:48
21 the report and now let's see the action plan and the
22 flow from that.

23 99 Q. You say it was good that it was spotted, we hadn't
24 spotted it sooner. What do you put that down to?

25 A. Well, I just put that down to actually again people not 12:48
26 informing us. Was this not telling us what wasn't as
27 good or was this opinions of others? You know, I think
28 governance and audit is very individual and is very
29 personal and everyone has an interpretation of it in a

1 different way. I mean not unlike when you come to talk
2 about my leadership walks with my Chiefs, those were
3 the pillars of governance I believed and why we had
4 those headings. So therefore, I'm disappointed that
5 the Directors who were the post holder and the 12:49
6 accountable person who we held to account in each
7 directorate through their structures hadn't identified
8 some of these weaknesses. That's what I would have
9 expected, be it in the Medical Directorate, the Acute
10 Directorate or wherever. If your governance processes 12:49
11 are working well and you're doing your audits and
12 you're having the clinical outcomes expected and the
13 quality indicators, I mean if that's all flowing and
14 working well, good. But I wouldn't, or my non-execs,
15 have known if it wasn't informed to us through means of 12:49
16 reporting what was being reported to the Board.

17 100 Q. Let's look at one or two of the specific
18 recommendations that Mrs. Champion made. As I said,
19 there was some 48 or so. I understand that the
20 recommendations regarding the Board were not taken 12:50
21 forward, that's certainly Mr. Devlin's evidence;
22 certainly not taken forward at that time. That may
23 have been a casualty of your concern that the
24 Non-Executive Directors were not properly, in your
25 view, engaged in the process. Is that correct, is that 12:50
26 your understanding?

27 A. Well, I respect what you say but I wasn't aware of that
28 detail of what he is saying that the Trust Board didn't
29 do. I mean, where I see the subcommittee and the

1 governance committee of the Board and the audit
2 committees is where you feed this all into.

3 101 Q. Yes.

4 A. And therefore if any of my Non-Executive Directors,
5 being the Chair or otherwise, hadn't identified these, 12:50
6 or indeed when they were identified, we didn't take
7 action, then of course it's a weakness. But I didn't
8 see it that way.

9 102 Q. The recommendations, let me look at them briefly. If
10 we go to WIT-00560. There's recommendations around 12:51
11 good governance structures, including specifically
12 Board governance. The question I was putting to you -
13 I'm not sure you picked it up correctly - Mr. Devlin's
14 evidence was that it was agreed that these
15 recommendations wouldn't be taken forward at that time, 12:51
16 and I was asking you is that your recollection and was
17 that as a result of your concerns about how the
18 processed been handled?

19 A. No, definitely not, I mean why they wouldn't be taken
20 forward. I do remember this now this is before me. 12:52
21 Like, for example, the Chair of Governance Committee
22 should be involved in the development of the agenda and
23 the cycle of reports. well, with respect to Eileen,
24 she was a very skilled governance person, and Eileen
25 would have been involved in the development of the 12:52
26 agenda with the Board Assurance Manager, I mean before
27 --

28 103 Q. Sorry, I don't wish... It is beyond the scope of your
29 evidence to unpick all of these. I suppose what I'm

1 asking you is, just to repeat, these Board governance
2 recommendations were held back, according to
3 Mr. Devlin?

4 A. Well, I am not aware of them being held back.
5 Definitely not.

12:52

6 104 Q. There were recommendations across 14 other areas. Let
7 me take you to clinical audit. If we go down to
8 WIT-00563. At the bottom of the page, the
9 recommendation is set out as follows:

10
11 "The 2018 clinical audit strategy and action plan
12 should be reviewed and updated. The Clinical Audit
13 Committee should be reinstated and the reporting
14 arrangements considered in the review of the Trust
15 Board committee structure".

12:53

16
17 what lies behind that recommendation would appear, as I
18 put it perhaps earlier, the audit arrangements had to
19 some extent fallen by the wayside. I used the word
20 "collapsed", and maybe that's too strong. If we go
21 into Mrs. Champion's report. WIT-00544. As regards
22 clinical audit, she explains that. This is the second
23 paragraph.

12:53

24
25 "Senior stakeholders advised that internal audit had
26 provided clinical audit with a limited assurance
27 level."

12:54

28
29 She goes on. If we go down to WIT-00554, she says,

1 scrolling down, having set out her findings, "clinical
2 audit is back on the radar" with her recommendations.

3 A. Sorry, I am just trying to find where that is.
4 "Clinical audit including M&M", is that the paragraph
5 you're on? 12:55

6 105 Q. Yes. Before that she goes on to say clinical audit is
7 back on the radar, the implication being that from a
8 position of low assurance with regards to clinical
9 audit, with the recommendations that she is putting
10 forward in place, "clinical audit back on the radar". 12:55
11 The implication is that audit has come from a pretty
12 poor place and it needed the scrutiny of this review
13 and the recommendations that follow to bring it back to
14 health. Did you appreciate that in terms of the
15 information coming to the Board through audit processes 12:56
16 was not as it should have been?

17 A. Well, I certainly remember the limited assurance
18 because that would have come through the audit -- in
19 through the Audit Committee and Governance and also it
20 had been one of the standards. So I do remember the 12:56
21 limited assurance, and the action and the acceptance of
22 the priority ones; I do remember that.

23

24 I mean, I would have to look back. I have no
25 recollection on clinical audit and benchmarking against 12:56
26 clinical standards would have been an agenda point on
27 the Medical Director's reports coming to the Board.
28 Mr. Wolfe, I can't remember specifically anything in
29 any of the Medical Director's report in that recent

1 time there that was indicating they weren't doing them,
2 but that's my recollection. But I don't remember
3 seeing that jumping out at me in the report, that
4 clinical audit wasn't being completed to the highest
5 standard like it was previously. I just can't remember 12:57
6 that.

7 106 Q. Can I bring you to another example. Recommendations
8 were made in relation to Datix; you know the system for
9 recording and reporting upon incidents?

10 A. Yes. 12:57

11 107 Q. If we go to WIT-00564, and scrolling down. As regards
12 the governance information management systems, or
13 Datix, the recommendation at 44.1 is that the Trust
14 consider that the information management systems and
15 administrative support required to support the 12:58
16 implementation of the governance review
17 recommendations, and, secondly:

18
19 "To ensure that the Trust maximises the potential for
20 the use of patient safety software, it is vital that a 12:58
21 dedicated Datix systems administrator is appointed who
22 can ensure the quality of data provided as this has
23 been identified as a gap at present".

24
25 Again, one of these critical tools for good governance, 12:58
26 the need for high quality data to be provided through,
27 for example the Datix system, had fallen into disrepair
28 or wasn't adequate. Again in terms of your
29 understanding, sitting as the Chair over a lengthy

1 period of time, did you not see that kind of deficit in
2 the material that was brought forward to you?

3 A. No. Definitely the Datix system, I wouldn't have been
4 aware that software wasn't meeting the needs and it was
5 inadequate. I definitely wouldn't have noticed that. 12:59

6 108 Q. Sorry, you would or you wouldn't?

7 A. I wouldn't have noticed the software deficit. I would
8 have expected that to come through from informatics and
9 that department. I do remember all of the Datix
10 information that would go on, and that is in relation 12:59
11 to all accidents, incidents, complaints, untoward
12 events, near misses. All of that went onto the Datix
13 system and that would have been fed in. But that
14 system, whether it needed upgraded or not, is only as
15 good as the reporting in. I do remember a whole area i 13:00
16 that around domiciliary care services and indeed
17 independent providers not feeding into that system. So
18 therefore we could have been getting - think of falls
19 as an example - the number of falls; you got it from
20 the hospitals but you didn't get it from the community 13:00
21 settings. Was that a fault? I would see that as a
22 fault of those feeding in the information rather than
23 actually the actual software.

24

25 But I wouldn't have been aware that there was 13:00
26 inadequate information coming through because it hadn't
27 been reported and we hadn't picked it up on the Datix,
28 apart from that example.

29 109 Q. As I say, recommendations across 15 areas in total,

1 Mrs. Brownlee. When you saw that report and reflected
2 upon it, were you broadly in agreement with the need
3 for the kind of structural change that it identified --
4 A. Absolutely.
5 110 Q. -- as well as the need for improvements, if you like, 13:01
6 in the tools that were being used to feed into the
7 structures?
8 A. Oh absolutely, absolutely. I mean if you have engaged
9 an independent person with expertise in governance and
10 they have given you a report like this where there 13:01
11 needs to be improvement, significant improvement and
12 some sooner than others, I mean it would have been
13 remiss of us not to address that, and I would have
14 expected that to start to roll out. I can't remember
15 the actual date this came to the Board; was it late 13:01
16 '19?
17 111 Q. It was February for the first time, 2020.
18 A. Yeah, yeah. February 2020 this was coming to the
19 Board. I do remember it.
20 112 Q. When you saw it and thought about it, Mrs. Brownlee, 13:02
21 did you have any reflections about your own role as a
22 leader in terms of the state that governance had been
23 in and the journey that was going to be required to
24 improve it? Did you reflect in terms of could we have
25 been doing better to spot these problems? 13:02
26 A. Yes. Well, to just answer your first question, I don't
27 remember having sort of a light bulb experience of
28 thinking 'gosh, this has been terrible' and 'you've
29 missed this'. I'm sorry, Mr. Wolfe, I don't remember

1 that.

2

3 But secondly, again I keep bringing this back to those
4 who we hold to account through the Chief Executive and
5 the Directors. Some of this, we would not have been 13:03

6 aware of; we didn't identify it in the information
7 flow. Of course I was very pleased that someone had
8 identified this, and would have supported the

9 implementation of the changes as a matter of urgency,
10 but it didn't come across that oh gosh, your Trust is 13:03
11 not in a good state. Now, I mean I remember February

12 2020, and I think that year that was all the Covid and
13 many other things. But what I must stress is still, in
14 all of wherever this negativity and the learning was,

15 we were having some really good reporting in on 13:03
16 different areas. I think back to during that time, I
17 mean the endoscope, for example, is one example that

18 came to the Trust Board of an alert of picking up
19 through governance. I mean, there is many others
20 around Radiology. 13:04

21

22 whilst I totally respect -- but the report and the need
23 to change, and would have of course supported that, I
24 don't remember anything when I read the report other

25 than it's good to know this and let's start making the 13:04
26 changes. But it came at a very busy time in the Trust
27 with lots of other things ongoing. I would have

28 expected it now at this stage to be well-embedded and
29 has made significant change. But it didn't, to answer

1 your question, come to me that your governance wasn't
2 in a safe place, because we were seeing quite large
3 numbers of serious adverse incidents, Early Alerts, I
4 mean other learning, which would have come up through
5 governance, and I think there is emails to prove that. 13:04
6 what we were picking up was maybe the slowness of
7 reporting serious adverse incidents or Early Alerts,
8 and indeed the learning from it. So that was still
9 working well in the Trust, but I mean it didn't come
10 across to me that you've real concerns here. 13:05

11 113 Q. Thank you. It's 1.05.

12 CHAIR: we'll come back, it's almost 10 past according
13 to that clock, so we'll come back at 2.10.

14

15 THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS: 13:05

16

17 CHAIR: Thank you, everyone. Just before we start,
18 Mr. Wolfe, I just want everyone to know that we are
19 going to sit tomorrow but not before 11 o'clock, so
20 that will hopefully allow people sufficient time to get 14:11
21 in here safely, those who are coming. Anyone who
22 doesn't want to risk it, then certainly follow online.
23 But I think it's better that you know we will be
24 sitting tomorrow.

25 MR. WOLFE: Thank you, Chair. 14:11

26 114 Q. We were discussing just before the lunch break the
27 review of clinical and social care governance. Your
28 evidence was to the effect to some extent you were
29 unsighted on the kinds of concerns that Mrs. Champion

1 identified, but you saw such a review as a positive
2 development in that it shone the lights on difficulties
3 and offered a pathway to progress and move forward.
4

5 Could I come to your witness statement and take your 14:12
6 evidence on the quality of the Board and its work
7 overall, perhaps with a particular eye to its work in
8 the governance field. If we go to WIT-90852. You
9 describe under answer 6, which is down the page, that
10 you considered that you were an effective Board, used 14:13
11 as a role model. Members had a broad range of
12 expertise and experience.
13

14 "We completed yearly individual assessments on our own
15 skills and weaknesses. Training needs were identified 14:13
16 and training was provided. We were a forward-thinking
17 Board and had innovative initiatives in place".
18

19 You go on then to specify a specific initiative, that
20 is leadership walks to improve the governance 14:13
21 arrangements. I want to touch on a couple of the tools
22 of governance which were used or which you had sight
23 of.
24

25 In terms of being a role model, where does that thought 14:14
26 emerge from? Who were you a role model to, and who
27 told you that the Southern Trust Board was identified
28 as a role model?

29 A. Well, I remember - I think I referenced it earlier -

1 when we completed the first Board assessment that was
2 sent through from the Department, we were the first
3 Board, I believe, to do that, because I do remember the
4 Northern Ireland Ambulance Service were much later than
5 us and they sought our advice how to complete it. We 14:14
6 did work through that thoroughly, like I've described
7 earlier without repeating it. That went back to the
8 Department. I remember the Department confirming to us
9 they were very pleased, not only to be completed in
10 time, but the outcomes and what we had recorded. So it 14:15
11 was the Department that self assessment went back to.

12 115 Q. Yes. Can I bring you to the Board effectiveness model
13 which was applied in the period 2018-2019. This was
14 performed by the BSO --

15 A. Yes. 14:15

16 116 Q. -- internal audit section. We can see it at
17 WIT-101640. I'll say that again, 101640. If we go
18 down that two pages to 42, we can get an understanding
19 of the scope of the assignment. If we just move down,
20 it's explained as follows: 14:16
21

22 "The Northern Ireland Audit Office Board Effectiveness
23 Good Practice Guide was used as a basis on which to
24 conduct this assignment".

25 14:16

26 It set out how that assignment was performed, including
27 the use of surveys, the observation of committee
28 meetings, the review of Board minutes and papers, and a
29 review of some of your key strategic and operational

1 papers. The results of the survey were presented to a
2 Board workshop held on 21st February 2019. This piece
3 of work was, I suppose, finishing just as
4 Mrs. Champion's work in relation to clinical and social
5 care governance was commencing, and we can see
6 reference to her work within this assessment.

14:17

7
8 If we go then to the results of this assessment just
9 over the page. It's described under "Level of
10 Assurance".

14:17

11
12 "Overall there is a satisfactory system of governance,
13 risk management and control. While there may be some
14 residual risk identified, this should not significantly
15 impact on the achievement of system objectives".

14:17

16
17 That, in terms of their scorecard, as I understand it,
18 was the top rank. "Satisfactory" is, I suppose, as
19 good as it gets in terms of the language that they use?

20 A. Yeah.

14:18

21 117 Q. Under "Executive Summary", some positive remarks made
22 including, for example, at bullet point 2:

23
24 "From observation of a Trust Board meeting and review
25 of Board minutes, there is evidence of effective
26 challenge by Non-Executive Directors".

14:18

27
28 Nevertheless, there are some remarks within this
29 assessment that perhaps don't paint a wholly positive

1 picture, and again I am anxious to take your views on
2 that.

3
4 If we go to WIT-101646, we can see that with respect to
5 Board minutes - just scrolling down we can see it - in 14:19
6 its entirety, again some positive remarks made about
7 Board participation and levels of scrutiny. One of the
8 problems, I suppose, identified were heavy Trust Board
9 agendas and lengthy Board meetings which could
10 potentially impact on effectiveness; absence of 14:20
11 guidance on how to deal with members of the public;
12 issues at Board meetings creates uncertainty.

13
14 Does that surprise you, or perhaps you were well aware
15 of the heaviness of the Board meeting workload? 14:20

16 A. That didn't surprise me. The agenda at the meetings
17 were heavy. We would have started around 8:30 in a
18 morning, where we would have met the Non-Executive
19 Directors, and I would have met with the Chief
20 Executive to discuss matters of confidentiality, or 14:20
21 serious matters that he may want to bring us up-to-date
22 on or indeed that we had concerns about. So your
23 meeting started 8:30, and then sometime around
24 9:15/9:30 you had a break and then you started the
25 confidential section. We only brought the confidential 14:20
26 which was really confidential, we tried to keep as much
27 as possible to the main meeting. So, your meeting
28 probably was starting around 10:30 and we aimed to
29 finish it at 3:30. I know from feedback from reviews

1 and Board development we tried to bring it back even to
2 before 3:00, and it was difficult. The agendas were
3 heavy because you had a lot of reports. After we did
4 the initial welcome, et cetera, we always started the
5 Board meeting with maybe a lessons learnt model or an 14:21
6 improvement, a quality improvement. We tried to bring
7 frontline staff and middle managers to the Board to be
8 familiar with who we were and also just to test and
9 hear some of the good news stories. So we tried to
10 allow about half an hour for that and then we would 14:21
11 have got into approval of Board minutes. We always had
12 maybe strategic as the first agenda item, or we
13 alternated the next month with quality and patient
14 safety and patient outcomes.

15
16 So, if you think of patient safety and quality 14:22
17 outcomes, under that heading would have been the
18 Medical Director's report; you would have had the
19 Director of Nursing's report, the Director of Social
20 Services; anything to do with patient quality, patient 14:22
21 experience, any outcomes. Now, that did take quite a
22 bit of time.

23
24 The strategic overview; you might have had the
25 strategic plan for whatever or a new strategic issue 14:22
26 that was being worked through, maybe in imaging or
27 something. The big area then would have been another
28 performance report. I mean, I wouldn't be the first to
29 say that the performance report was extremely heavy and

1 to get it through it in the time. Then you would have
2 heard from other, and indeed maybe later on from
3 myself, that we decided that to really have a deeper
4 look at some of the performance issues that we had, we
5 would create another subcommittee of the Board, which 14:22
6 was really just getting embedded when I was leaving.
7 So you did have heavy agendas but what we tried to do
8 was we did always have a time at the end of every Board
9 meeting to reflect and see what did we really do today,
10 what decisions did we make, what did we learn together 14:23
11 and what were some of the salient messages.

12
13 we also at the very end always had a question to the
14 Executive Directors of Nursing, Social work, and
15 indeed the Medical Director, is there anything else 14:23
16 that hasn't been on today's agenda that you believe as
17 the responsible officer that you should be bringing to
18 the Board's attention. I introduced that sometime
19 before that. Another area to try to improve it was we
20 did a summary sheet at the front. That was very 14:23
21 important. It was what was the paper about, who was
22 its author, how was it linked to the strategic overview
23 and the clinical standards, you know, where was it
24 linked to. Then I called it the front page was what
25 keeps you awake at night, what are the risks and 14:23
26 concerns that you have that you need to report to us as
27 the Board. Yes, we all should be reading our papers
28 but it meant if you read the summary sheet, it gave you
29 some idea what the depth of the paper behind was.

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Now, we tried to lessen that by giving you links as we went on with better IT that you could look it up online, but that summary sheet was the opportunity for the Chief Executive, but definitely the author which was also the Director, to tell us what is it that you believe we should be talking about today. What, as I say -- and remember these reports were approved by the Chief Executive and the Directors. They were cleared, as we'll call it, at the senior management meeting.

14:24
14:24

118 Q. Just looking at this in light of the point made here about lengthy agendas, clearly a lot of the heavy lifting would be done in subcommittee?

A. Yes. Yes.

119 Q. You've talked in your statement about the importance of the Governance Committee and then the formation of a Performance Committee at some point, I think in 2019. No doubt it was helpful for reports to Board to be tilted in the direction of what you really needed to know, with summary sheets and that kind of thing. Is there any sense in this concern expressed here that such was the weight of the work before the Board that you as members, as Non-Executive Directors, weren't afforded adequate time to focus on the difficult questions, the issues you really needed to explore with executives to get to the heart of issues?

14:24
14:25
14:25

A. No. I believe we explored those to the best of our ability. I mean, the Non-Executive Directors would have asked a lot of challenging questions. One of the

1 criticisms may have been the Directors didn't always
2 ask a lot of questions of each other; could that have
3 been of time or because they would have said they
4 already really been through these in detail at their
5 senior meeting. I never got the impression we didn't 14:26
6 have enough time. Certainly I would have asked at the
7 end of the meeting did people feel that we had had
8 adequate time to discuss; was there something more that
9 needed to be discussed that we weren't in detail with.
10 Sometimes we maybe, you know, weren't able to get all 14:26
11 done, you know a paper that was coming of maybe
12 something that we wanted to learn. I think one of
13 those that jumps out at me, one of the local GPs who
14 had a link into respiratory, around cancer and lung
15 cancer, you know you may have moved that back to the 14:26
16 next meeting, because definitely the Non-Executive
17 Directors, not as familiar as the Executive Directors,
18 would have found the day quite exhausting. You know,
19 it just depends on your level of energy. If you were
20 in from 8:30 in the morning, we always had break for 14:27
21 lunch, certainly by 3:00 or 3:30 you were becoming
22 maybe not as alert as you should have been. But I
23 believe there was adequate time.

24 120 Q. Yes. This assessment went on to look at governance
25 structures, if we just take a quick look at that. 14:27
26 WIT-101654. It is three pages further forward. Just
27 maybe go back so we can see it in its full. Sorry,
28 just scroll down, please. There is some discussion of
29 the Hyponatraemia Inquiry recommendations, and over the

1 page there is discussion of governance structures. It
2 says as a finding:

3
4 "Clinical governance structures could be further
5 developed and strengthened as reflected in the
6 discussions with NEDs in recent internal audit
7 reports".

14:28

8
9 The implications of this finding were weaknesses in the
10 assurance processes to Governance Committee and
11 ultimately Trust Board. The recommendation is:

14:28

12
13 "The Trust should review its clinical governance
14 structures with a view to further developing and
15 strengthening current arrangements".

14:29

16
17 So, management action is recorded as being accepted.
18 This is, I think, the reference to the Champion Report,
19 "an independent review of clinical and social care
20 governance has been commissioned".

14:29

21
22 This review would seem to give credence to Mr. Devlin's
23 concern that all wasn't as it should be in clinical and
24 social care governance, there was a need to review
25 clinical governance structures, and, as appears here,
26 that independent examination had already been
27 commissioned. Again, this seems to be coming, at least
28 in part in terms of the evidence, from discussions with
29 Non-Executive Directors. Just your comment on that

14:29

1 set against the evidence you gave earlier, you didn't
2 seem to recognise the concern but some of your NEDs
3 did?

4 A. Well, none of the Non-Executive Directors brought
5 anything to my attention. I didn't attend the 14:30
6 Governance Committee or any subcommittees of the Board
7 like audit unless invited because there was a
8 presentation or something. But definitely none of the
9 Non-Executive Directors brought to my attention any
10 concerns. Certainly I knew about the lengthy agendas 14:30
11 and we talked a lot about how we could restructure
12 that.

13
14 The other thing to remember, Mr. Wolfe, is after every
15 subcommittee, to help the loop of governance the Chair 14:30
16 of, say, audit or governance, presented, brought a
17 report along with the Board Assurance Manager to meet
18 with the Chief Executive and I, and that had been going
19 on for a number of years. That would have happened,
20 say, within normally 10 days my personal assistant 14:31
21 would have, in advance, been preparing after the
22 schedule of meetings when we would meet that. So,
23 every Non-Executive Directors, especially every Chair
24 of a subcommittee, had opportunities to say on those
25 one-to-ones, as I would call them, they was giving us 14:31
26 feedback on the high level of the meeting and then,
27 remember, it still came again to the Board meeting. I
28 never had no Non-Executive Directors saying to me they
29 had concerns around reporting, information sharing,

1 what was coming.

2
3 I mean, we would have often said when we would have
4 been asking challenging questions, you know, this is a
5 different type of paper we want, or we need more detail 14:31
6 on this. That would have come up quite regularly at a
7 meeting; you know, don't give us so much of the
8 narrative, give us more of... You know, the non-execs
9 would have been exceptionally good at doing that. But
10 no one specifically, even at their performance review 14:32
11 when they came to meet me at a one-to-one and planning
12 their own training needs, ever said to me I have
13 concerns about the committee I sit on or I would like
14 to see changes there, because that was the opportunity
15 to do it there. Also, the feedback meetings. 14:32

16
17 we also had quite a number of away days. And our Board
18 development day every November was an excellent forum
19 of where we looked at ourselves critically as a Board,
20 how were we performing. We invited people in to speak, 14:32
21 we talked about committees, heavy agendas, who should
22 move, what else we could do. This was a very open work
23 away day, a team building day, whatever one wants to
24 call it. We had lots of opportunities for that. But I
25 don't recall any Non-Executive Director ever 14:32
26 specifically saying to me about concerns they had. We
27 were always looking to see what to do to improve
28 performance.

29 121 Q. I want to bring you to some of the evidence before the

1 Inquiry from other of the Non-Executive Directors, but
2 just a final footnote on this report. If we can go
3 through to Appendix A. Sorry, I don't have a page
4 reference in front of me. If you scroll down, I'll
5 tell you when to stop. Thank you. The survey that was 14:33
6 placed across the Board members as part of this
7 exercise asked for views around whether the
8 organisation has strong leadership and appropriate
9 culture. The footnote, if you like, to the right-hand
10 margin states: 14:34

11
12 "Discussion with Non-Executive Directors indicated
13 that this largely due to the Trust having 4 Interim
14 CEOs and other acting Directors for approximately three
15 years and this weakened leadership and culture in the 14:34
16 Trust".

17
18 That's reflecting on, if you like, the breakdown in the
19 results there. If we can scroll up to the top. In
20 terms of the strength of leadership and appropriate 14:35
21 culture, more than 50% tend to agree or strongly agree
22 but there's a significant number in the middle,
23 Mrs. Brownlee. As I say, that's reflected in the
24 comment expressing reservations about the culture and
25 the strengthen of the leadership. 14:35
26

27 Just scrolling down, to finish. It's also recorded,
28 however, those surveyed presumably felt that now the
29 CEO and Director posts were substantive, there was

1 clear evidence of improvement in this, and there to be
2 Board workshops on culture and vision in the current
3 year for improving this aspect.
4

5 Any observations to make on that, this sense among your 14:36
6 team that leadership and culture within the Trust had
7 not been as strong or as optimal as it should have been
8 because of the, I suppose, the impasse in putting a
9 substantive post holder in place?

10 A. Sorry, I didn't have the last page up but it's fine, I 14:36
11 remember what you've said there. Getting back to the
12 organisation, strong leadership and appropriate
13 culture. Yes, it has 11%; is that one or two people of
14 percentage. I mean, did everybody return? I do
15 recognise what is said. I note that senior team 14:36
16 thought the Chief Executive not being substantive was a
17 weak area. I mean absolutely, I think we've covered
18 this before, that having a permanent Chief Executive is
19 the ideal and we would have liked to have had that.
20 But what I was trying to say all along was those that 14:37
21 we did have were experienced, there was a good hand
22 over. I mean, many of these Non-Executive Directors
23 coming in at this time in 2017 --

24 122 Q. This report is dated 2019.

25 A. Yes. 14:37

26 123 Q. February 2019.

27 A. Yes, but at the time when they would have been looking
28 back, they only had -- you know, they came in in 2017,
29 the greater majority of them, they never worked

1 actually with a permanent Chief Executive, to be fair
2 to them, they had the interims until Mr. Devlin came.
3 But I note what was said, and we talked about that
4 quite a bit. We would have Non-Executive Director
5 meetings quarterly and I would have listened to them 14:37
6 about that. I did try very regularly through to
7 Mr. Pengelly, he was my first contact, about trying to
8 get the post advertised, but I was in that situation.
9 But I did hear what they say and we would have talked
10 about that. 14:38

11
12 The various types of leaders too. You know, when one
13 comes in and one goes off sick, you know, and they have
14 all different styles. It wasn't that I didn't listen
15 to them, I did understand that. And it wasn't a 14:38
16 surprise to me, you know, when you do a questionnaire
17 like this here that you'll have, rightly so, one or two
18 or whatever who are very strong in their opinions,
19 which I respect --

20 124 Q. Yes. 14:38

21 A. -- that that is what...

22

23 In relation to the culture, I mean, we worked
24 extensively on culture and had a lot of time out of the
25 boardroom to look at culture and our behaviours. But 14:38
26 you'll maybe want to come back to that.

27 125 Q. I wonder whether, and we look at some of the remarks of
28 your Non-Executive Directors now --

29 A. Okay.

1 126 Q. -- I wonder whether this was a watershed moment in some
2 respects, that the appointment of Mr. Devlin and the
3 removal or the ending of that unsettling period where
4 you didn't have a substantive figure at the head of the
5 organisation, and indeed the appointment of Dr. O'Kane, 14:39
6 there having been difficulties in securing a
7 substantive medical Director for a period of time with
8 Dr. Wright's illness and Dr. Khan coming in to sit on
9 that Chair for a period of time. I wonder would you
10 agree with me that those difficulties, contrary to 14:39
11 perhaps what you said earlier this morning, were a
12 really difficult period for the Trust, and key work,
13 particularly in the governance field, wasn't developed,
14 wasn't pursued, leaving gaps which were, from a patient
15 safety perspective perhaps, relatively dangerous gaps? 14:40
16 A. Well, Mr. Wolfe, I wasn't aware that we had dangerous
17 gaps or that there was weaknesses there. As far as I'm
18 concerned, I still continued to do my work and attend
19 and be at work like I should have been. As did those
20 Interim Chief Executives, they definitely were very 14:40
21 able, very skilled, I mean very experienced. I mean
22 they devoted a lot of time to it.
23
24 The backfill, yes, while it is a weakness with people
25 stepping up, they were very experienced people. These 14:40
26 weren't people who were coming out of a department not
27 with experience, but I didn't see that, or during the
28 interim, any dangerous or really concerning areas under
29 my watch at that time.

1 127 Q. Yes. Let me take you to what Mrs. Mullan has said in
2 her statement to the Inquiry, starting at WIT-100544.
3 At paragraph 46.1, just scrolling down, she is asked
4 "Do you think overall the governance arrangements
5 within the Trust were fit for purpose, and did you have 14:41
6 concerns about the governance arrangements and did you
7 raise these concerns with anyone?" She is saying:

8
9 "Looking back across my tenure through the lens of what
10 has evolved to my knowledge since 2020, it is clear to 14:41
11 me now that the Trust's governance systems were not fit
12 for purpose".

13
14 She goes on to say:

15 14:41
16 "At the centre of this unfitness is what appears to me
17 to have been a lack of triangulation of information and
18 or a culture of working in silos", and she cites
19 separate processes were being undertaken with no
20 joining up of the intelligence. She points out the 14:42
21 unhealthy churn in key executive positions in that
22 period which didn't help matters.

23
24 I think I should have started with this at 45.4, if we
25 just go back to that. She says: 14:42
26

27 "In my view knowing what I know now, the Trust Board
28 and the governance were not kept appropriately informed
29 in the period 2016 to 2020. This included explicitly

1 detailing the patient safety risk arising as a result
2 of the demand capacity mismatch".

3
4 She goes on to explain that:

5
6 "Since Dr. O' Kane raised matters at the Trust Board in
7 August 2020, I believe that the Trust Board and the
8 Governance Committee has been kept appropriately
9 informed".

14:43

10
11 Mrs. Mullan, to summarise from a position of
12 retrospectivity, is recognising that the information
13 flow into the governance system during that period of
14 four years was not good, that there was information
15 that ought to have come to the Board and to the
16 Governance Committee that didn't come. She includes
17 within that concerns about the impact of the demand
18 capacity mismatch.

14:43

19
20 Do you concur with her thinking?

14:44

21 A. First of all, the first reference that was made --

22 128 Q. Yes.

23 A. -- where she believed as an individual the Board, it
24 was not fit for purpose, I would disagree with that.
25 At that time I believe I had no concerns about it.

14:44

26
27 In relation to the patient safety arising as a result
28 of demand and capacity, we did know that the demand was
29 great and the capacity to fulfil quite a number, not

1 just Urology, quite a number unscheduled care, scopes,
2 I think of those, trauma and orthopaedics, so there was
3 quite a number where we knew the demand was
4 outstripping that. We did see that at Trust Board and
5 we worked very hard to see what was that telling us,
6 how long were people waiting, how was the feedback to
7 that. We also would have asked a lot of questions. I
8 attended and went -- because of the waiting lists, I
9 attended with the Chief Executive to the Health and
10 Social Care Board and the Department to try and
11 influence to get additionality.

14:45

14:45

12
13 One of the problems with the demand and capacity,
14 Mr. Wolfe, the Craigavon site, I think, was built in
15 the late '60s, early '70s. It was the last hospital,
16 and still is, in Northern Ireland not to have anything
17 new. If you look throughout the province, without
18 going into detail, all of the new hospitals are there.
19 So this was quite an aged hospital. Even if we think
20 back to the C-difficile and we think back to COVID, our
21 complexities we dealt with was we had very few single
22 rooms for infection control; we were sharing toilets.
23 This was an old hospital and we didn't have enough
24 theatre space.

14:45

14:45

25
26 If we look at just trauma and orthopaedics. You could
27 have had a list of orthopaedics today with consultants
28 to do hip replacements, knee or whatever; you only
29 needed one road traffic accident during the night or

14:46

1 one big catastrophic event that became the trauma list
2 for the next day. All of those patients, they may even
3 have been in hospital, would have had to be sent home.
4 We were dealing with actually very often. Many of the
5 consultants across different areas of speciality would 14:46
6 have brought this up. I am not making that as an
7 excuse, I am just saying we were aware of the capacity
8 and demand. If you look from when I started, even in
9 Urology the referrals to when I was leaving to now and
10 they are huge. That is the same in many specialities. 14:46

11 129 Q. I want to -- sorry to cut across you. I will ask in
12 due course, I don't want to deal with it now, I want to
13 ask you in due course what was done with the knowledge
14 that you had.

15 A. Okay. 14:47

16 130 Q. Just on the issue, as Ms. Mullan puts it, of not being
17 appropriately informed. You see no...

18 A. Well, the way I would look at that, Mr. Wolfe, is if I
19 am not being appropriately informed and I am a Chair of
20 a subcommittee or a Non-Executive Director, then you 14:47
21 need to ask for the appropriate information to come. I
22 respect what Eileen says, she was saying she didn't get
23 adequate information, there wasn't the flow of
24 information informing them of governance concerns. I
25 mean, when was that identified? I mean, that -- 14:47

26 131 Q. Just to be clear, she is looking at it with the benefit
27 of the hindsight and the information that she has now.
28
29 Mrs. Leeson, she maintains, so far as I understand her

1 evidence, that the governance arrangements were fit for
2 purpose, but she puts something of a caveat on that, so
3 far as again I understand her evidence. If we go to
4 WIT-99779, and at paragraph 10.2. She explains that
5 she thinks there is a more robust system around
6 clinical and social governance since Dr. O'Kane
7 commissioned the review in 2019. I'm not sure whether
8 it was Dr. O'Kane or Mr. Devlin who formally
9 commissioned the June Champion review. She says:

14:48

10
11 "Prior to 2019, since my appointment in January 2017,
12 in my view there was a less developed approach to
13 governance where there were separate reports to the
14 Governance Committee on specific areas".

14:49

15
16 She goes on to say:

14:49

17
18 "Governance is, however, a dynamic process where there
19 needs to be continuous improvement and I think it has
20 become more effective with the introduction of the CSCG
21 report to the Governance Committee which brings all
22 this information together in a summary report".

14:49

23
24 I think elsewhere in her evidence she talks about the
25 greater opportunity for triangulation of all of the
26 information, and that in turn improves the process of
27 doing governance. It opens the pathway for
28 Non-Executive Directors to better understand the
29 trends, the connections between various discrete pieces

14:49

1 of data, and helps to build a better and more
2 comprehensive picture of what is going on from a
3 governance perspective.
4

5 Now, conscious that your term in office didn't go 14:50
6 beyond November 2020, did you see any notable
7 improvements in how the Board was able to interact with
8 the changed governance structures and what appears to
9 have been a better flow of information after June
10 Champion's work had been endorsed? 14:50

11 A. Just first of all... sorry, I've lost my school of
12 thought. June Champion's work came in and the report
13 in 2019. 2019 was a horrific year, and the last six
14 months of my term. I think we all in this room will
15 know what the Covid pandemic did to health and social 14:51
16 care, and indeed to our community. For example, in
17 2019, February on, we had a hospital that I've said
18 before isn't fit for the capacity and demand. Just to
19 give you an example, our canteen --

20 CHAIR: Sorry to interrupt. I think you mean 2020, 14:51
21 wouldn't it be? Covid was 2020, the first lockdown.
22 March 2020 we were in lockdown.

23 A. Okay. Sorry, my apologies. Going back to the June
24 Champion's report, it came in yes, in my last six
25 months. We were starting to see that embedded. I do 14:52
26 remember seeing new staff and structures being put in,
27 but, to be honest, and sorry what I was going to say at
28 the start was would I have read all of the governance
29 papers before -- I didn't attend governance but I got

1 the papers. Certainly they were hefty documents. I
2 would have been able to -- you could see the number of
3 serious adverse incidents reported in a year; you could
4 see the litigation; you could see the falls bundle; you
5 could see the infection control. There was a lot being 14:52
6 fed into that committee. I mean, I can't remember very
7 many changes that were made. Now, that's not a
8 criticism, I just honestly can't remember of a lot of
9 changes that happened from her report when it was
10 started to be embedded into the organisation because 14:52
11 that would have started to take time and momentum of
12 getting -- putting extra allocation of money and then,
13 you know, quite a number of staff moving to work in
14 governance. So, that all takes time. So I don't
15 remember seeing a very different flow of information to 14:53
16 the Trust Board or to any of the subcommittees of a
17 huge difference to what it was before.

18 132 Q. MR. WOLFE KC: Yes. Let me take a particular example
19 of what some have described as an information
20 shortcoming in terms of sharing with the Board. 14:53
21 Mr. O'Brien is the subject of an MHPS investigation in
22 2017. It stretched into January 2018 and there was no
23 determination in respect of that process until October
24 of 2018. The Board was told about the process and the
25 commencement of the process at the very beginning in 14:54
26 January of 2017 but it didn't hear anything more about
27 it, anything more about it until the chaos of the late
28 summer of 2020 when an Early Alert went to the
29 Department.

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Maybe it's unfair to focus on one example but is that a shortcoming, in your view? Should the Board have been updated on progress and early findings and ultimate findings in that exercise, particularly where it touched upon patient safety issues or where it touched upon management issues?

14:54

A. If I could just say before I get into that one, Maintaining Higher Professional Standards, after it was notified to the Board generally, never came back to the Board again unless the Medical Director had concerns. I do hear from Eileen that now that has changed significantly and better reporting, and that's to be commended. Just to mention that they didn't come back. Certainly in relation --

14:55

14:55

133 Q. I suppose the point I am making is whether it is specifically this case or whether it's the generality of MHPS cases, should the Trust Board, allowing for the confidentiality of the clinician and his name or her name needn't be communicated to the Board, but where there are concerns identified during the process that touch upon patient safety, that touch upon management failures, are they not the very kinds of things that the Trust Board, and particularly the Non-Executive cadre of the Trust Board, should be expected to be told about?

14:55

14:56

A. Absolutely. Absolutely. Those concerns should have been raised very early in the process through the Medical Director or through the Acute Director.

1 Absolutely. If they believed, through an
2 investigation, the findings were around patient safety
3 or inadequacies or under-performance, absolutely should
4 have come back. What I was saying, sorry, at the
5 beginning was normally they didn't come back because 14:56
6 they were managed by the Medical Director. But if
7 there any concerns, you would have expected them to
8 come back for anyone else as well as this particular
9 case.

10 134 Q. But through your nine years in this post, you are 14:56
11 seeming to suggest that as regards MHPS, information in
12 terms of the outcomes or the findings, that didn't come
13 to you, didn't come to the Board?

14 A. I remember one where I referred to earlier where
15 another Non-Executive Director was working on a complex 14:57
16 one, it coming to the Board. But we didn't have them
17 routinely coming, no. We could have a year where maybe
18 there was none.

19 135 Q. Well, why not? Why, for example --

20 A. Well, we mightn't even have known. 14:57

21 136 Q. You knew about the commencement of MHPS, didn't you, in
22 the majority of cases?

23 A. Oh sorry. Yes, if it was reported to the Board. We
24 hope it was. We were dependant on the HR Director
25 informing us. I am just saying -- 14:57

26 137 Q. But you used the word too dependent" and this perhaps
27 goes to the culture of the Board that you chaired. You
28 are dependent obviously on the executives carrying out
29 their duties but can you not, as the Chair of the

1 Board, direct the Executives to improve the information
2 flow to you so that you are better positioned to
3 understand the risks facing the organisation and the
4 changes that might need to be made?

5 A. Oh, absolutely. I mean, we could have asked for any 14:58
6 information at any time as extra. What I was saying
7 was if there wasn't a reporting in of a maintaining
8 higher professional standard investigation, we wouldn't
9 have known. I was very dependent, and the Board, of
10 hearing that through the Director of HR or the Medical 14:58
11 Director. I mean, there wasn't one very often now that
12 I can think of. They would have been reported
13 definitely if there was one, but sometimes, you know,
14 you could have had six/eight months, maybe a year, none
15 reported. I just can't be specific as I look back. 14:59

16
17 But definitely I would have expected if there was any
18 consultant going through a Maintaining Higher
19 Professional Standards, it should have been reported in
20 to the Board through the Medical Director's report. 14:59
21 Also, if there was any concerns at all in relation to
22 that, that should have been reported back through the
23 Board. We could have asked for that information. I'm
24 not sure if you want me to expand on the one you're
25 referring to in January. 14:59

26 138 Q. No, we'll come to that in due course. You speak in
27 your witness statement about the specifics of some of
28 the governance tools that were available to the Trust;
29 for example, Serious Adverse Incident reporting. You

1 say that that was something the Board always wished to
2 learn and follow up on, including near misses and any
3 issues that flow from that.

4
5 If I could draw your attention to an email you sent to 15:00
6 Mr. Devlin on 1st February 2019. WIT-103218, and just
7 scrolling down. I put this in front of the Panel in
8 light of the questions I have just asked you. In all
9 fairness, there is clear evidence here of the Board and
10 the Non-Executive Directors expressing concern about 15:00
11 an aspect of governance, and let's see how that concern
12 emerged. You are working through the governance papers
13 for a meeting the following week. You say to
14 Mr. Devlin:

15
16 "You have probably noted, as I have mentioned before 15:01
17 under litigation, the number listed under maternity and
18 women's health".

19
20 You go on to say that you are noting the SAIs reported 15:01
21 between January 2018 and 31st December 2018, that the
22 high graph "blue" shows 10 to 60 days or more. "I
23 appreciate this area is under discussion". Then you go
24 on to cite a particular example of a tragic maternal
25 death, and you are recalling that Eileen - Mullan, 15:01
26 assumedly - and the Trust Board NEDs were especially
27 concerned about the length of time for reporting the
28 incident, and who and how escalated that to the Chief
29 Executive. That was back in Stephen's time as Chief

1 Executive. You are asking has the reporting mechanism
2 improved since that Trust Board meeting.

3
4 So, that's a concern that where incidents arise, there
5 is, judged by an example that you were pointing to, a
6 delay in reporting them in to the incident reporting
7 review system; is that right? 15:02

8 A. Yes, yes. This was me reading the governance papers,
9 and I had come on the maternity and women's health
10 issue. I say it would have been one that was on quite
11 regularly. Quite a large number, I think from memory 15:03
12 then it was eight or nine, were listed under the
13 litigation report, and I had seen that before. I was
14 also pointing out that the SAIs, and remember the SAIs
15 had had a lookback exercise in Northern Ireland, I 15:03
16 think in 2015, '16 by the then minister, looking at the
17 numbers and how those were being actioned, and I mean
18 the time and the reporting. So, I'm looking at the
19 SAIs reported for that year that were going to
20 governance, and here was still evidence showing that 15:03
21 they weren't being reported in 10 days or less, which
22 was the standard, and some were going as far as 60
23 days. So I was sending an email into Eileen as the
24 Chair and copying Shane in to say look, Eileen, because
25 he was new, Shane, remember we have discussed this 15:03
26 before in Stephen McNally's time, the length of time
27 reporting, has this improved because from me reading
28 the papers, it doesn't appear to have improved much,
29 mindful that I didn't go to the governance. I can't

1 remember, sorry, the reply.

2 139 Q. The reply from Mr. Devlin above I think recognises the
3 problem and states that this will be discussed at
4 committee as he isn't content with this area. February
5 2019.

15:04

6

7 Did you follow this through and pursue it? Was there
8 any change for the better that you noted?

9 A. I've followed that through. From memory, again I
10 attended governance meeting and again one in 20; I
11 attended one where I was saying I want to talk, if I'm
12 allowed, a few minutes about some of these pressing
13 matters. Some of them would have been around SAI
14 reporting and the timeframe, because I couldn't see a
15 change in the improvement of the 10 days or less. So I
16 did follow it up. Eileen didn't reply to me there but
17 because the Chief had said it's already on their radar,
18 they are looking at it at the SMT, he was too was
19 concerned or wasn't as content as he would like to be.

15:04

15:05

20

21 Governance met quarterly. That was me saying that to
22 Eileen. I can't remember if that was the meeting -- if
23 I did attend that meeting. I think the governance
24 meeting was maybe on 9th February. Anyhow, I didn't
25 see a big improvement for when I went back to another
26 one.

15:05

15:05

27

28 To me, SAIs is not only so important to report them so
29 that everyone knows what has happened, but for the

1 immediate learning of lessons and to sharing them
2 throughout the region. It's a requirement after a
3 lookback exercise. I think it was in that year I've
4 mentioned, and the Coroner. I think, I mean, we were
5 asked to be really diligent in that area. Of course 15:06
6 there was that the problem within women, you know, in
7 maternity services and the number as well, because it
8 had been showing for quite a while, the litigation
9 report for maternity services and indeed I think into
10 the next year, I mean around that. So, I did follow 15:06
11 that up.

12 140 Q. We asked you in your witness statement to provide us an
13 indication of how you might be expected to be made
14 aware of concerns regarding patient safety and risk. I
15 just want to bring you to your answer. It's at 15:06
16 WIT-90584. No, it's not. Thank you.

17
18 That's the question we posed. You explain:

19
20 "Normally concerns regarding patient safety and risk 15:07
21 would be brought to the attention of the Board via the
22 Chief Executive or relevant SMT member to the
23 confidential governance meeting or the confidential
24 Board meeting. The Governance Committee is a
25 subcommittee delegated schemes to subcommittees of the 15:07
26 Board and chaired by a NED. Meetings were held every
27 three months".

28
29 Is that an explanation around concerns about individual

1 patient safety or risk to individuals arising out of
2 care or treatment?

3 A. Well, I would have been replying in that way, that
4 normally concerns regarding patient safety, be it an
5 individual or a lessons learnt model or a risk, would 15:08
6 have come. It could have been individual patient or a
7 group. I mean, I could give you an example about the
8 endoscopes and the scopes and the problems around that.
9 It could have been in the wider organisation and it
10 could have been the individual. You know, I would have 15:08
11 been informed if a maternal death, or whatever like
12 that, which is an awful tragedy and you are always
13 looking to see the immediate learning.

14
15 But definitely any Chief Executive I worked with would 15:08
16 always have phoned me, if it was in between meetings,
17 about any patient safety risk that they were concerned
18 about, definitely. But if it was near, you know, if it
19 was coming to the governance meeting, it would have
20 gone there too. But we would never have sat on patient 15:09
21 safety risk that I would have been aware of, nor would
22 the Chief Executives.

23 141 Q. You explain in your witness statement that obviously by
24 2019, there was a Performance Committee. The Director
25 For Performance would have provided a report into that 15:09
26 committee and that report then with the Chair of the
27 Committee -- sorry, the Chair of the committee would
28 then provide a follow-up report and probably meet with
29 you in advance of the Board meeting. Is that how it

1 worked?

2 A. Yes. After every subcommittee meeting, it would have
3 been in the schedule of a calendar that the committee
4 Chair would have prepared a paper, alongside the Board
5 Assurance Manager who was pivotal to this all, and they 15:10
6 would have come and met with the Chief Executive, the
7 Chief Executive and I on every occasion. There was
8 always a feedback meeting and a high level paper
9 prepared.

10 142 Q. Yes. You comment in your witness statement - this is 15:10
11 at WIT-90862 - that no clinical concerns are reported
12 on the performance report. We'll come to look at this
13 specifically in the context of Urology in a moment, but
14 when you get a performance report and it is showing
15 significant waits, missed targets, is that not 15:10
16 indicative of clinical problems or likely clinical
17 problems for those who are not being seen? In other
18 words, with extensive waiting lists you are likely to
19 have significant morbidities and risk to health. Was
20 that how you viewed it? 15:11

21 A. Well, the Medical Director, I should say, would also
22 have brought if there were any clinical indicators that
23 weren't being met. In relation to the performance
24 report, we would have seen some areas that were very
25 good and we honestly didn't always talk about those 15:11
26 because they were meeting their targets. But we would
27 have looked very specifically and would have been
28 highlighted red areas on the report that needed
29 attention, and why. We would have looked at how long

1 some people were waiting, not just in Urology but in
2 other specialities. We would have asked a lot of
3 questions - how are these people being followed up,
4 have they gone back to their GP? The Director of
5 Performance I think was nearly always the same person 15:11
6 in my tenure, maybe two when they moved, but they would
7 have been reporting into the Health and Social Care
8 Board, the Commissioner, and also the Chief Executive.
9 The Director of Performance and the Chief Executive
10 would have had at least a three-monthly meeting with 15:12
11 the Health and Social Care Board. I mean, so we would
12 have been asking why. A lot of these reasons could
13 have been because of workforce; we maybe just didn't
14 have the consultants to see. We maybe didn't have the
15 capacity for either theatre or outpatient clinics. We 15:12
16 were also trying to look at newer ways of working to
17 see -- we had moved -- like, dermatology is one that
18 comes out high in the numbers that they had there. Was
19 there any other way and we got into looking at, you
20 know, maybe doing online remote dermatology. 15:12

21
22 Definitely, we would have seen those numbers high. We
23 asked a lot of questions about them. We got pretty
24 good answers, to be fair, around when we wanted to know
25 the deep reasons why. At times we did get -- I mean, I 15:13
26 think of some of the extra theatres that were modular,
27 the modular theatres, so we would have worked very hard
28 to get extra money to be able to meet the capacity. A
29 lot of this was not only workforce, it was the

1 financial end, so you had to prepare and present papers
2 and a commissioning plan why you needed it. I can
3 remember we got quite a number of modular theatres to
4 be able to reduce waiting lists for theatres. I mean,
5 going to the Department on numerous occasions about 15:13
6 funding gaps and capacity. Also, you would have been
7 looking to the rest of the region.

8
9 For example, if I was allowed, I always remember breast
10 screening. Now a lot of this is from memory but breast 15:13
11 screening from you visit your doctor to you are
12 referred to the system, you're meant to be seen in 14
13 days. In the Southern Trust during my time, we were
14 rarely not at 100%, 98%. We were seeing people fairly
15 quickly, and rightly so. Tragically, we had the loss 15:14
16 of our two consultant radiologists all within a space
17 of about 14 days. Honestly, Mr. Wolfe, our waiting
18 lists in where we were high performer dropped to, I
19 think from memory, 14%.

20 15:14
21 That was an alert to us fairly quickly, what are we
22 going to do about that. We engaged very quickly with
23 the Commissioner. We triaged and looked at patients
24 with their GPs. We talked to the Department and to the
25 region, as I call it, the other Trusts to see could 15:14
26 they help us so that if you were in the Northern Trust,
27 you weren't being seen greater than being seen in the
28 Southern Trust. We would have noticed that very
29 quickly.

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But in some areas that I've used already, trauma and orthopaedics, and the waits for routine hip, knee, whatever, some of those people were waiting far in excess of their times, and I have given you the reason why. I mean, the reporting on plain x-rays is another one that jumps out at me because of the shortage of radiologists. These are not excuses I am making, I am just saying to you when the performance report came to us, we did go through it in detail in preparation for the meeting, had our questions ready, and my Non-Executive colleagues asked many questions and we were looking to hear back from the Director and Chief Executive who were held to account, what are you doing about this, these are people at the end of this line and waiting.

15:15

15:15

15:15

Definitely, I would have attended - which would have been outside my remit - I would have attended the Health and Social Care Board, meeting the Chief Executive and their Director of Planning and the Department around concerns I had about our waiting lists. We did in some cases get extra money, and we then moved into share in the region some areas, and we got modular theatres; we maybe changed the profile of the hospital around. But our hospital was absolutely chockablock with mobiles and lots of things.

15:15

15:16

We did look at the performance report. We did

1 always -- I remember non-execs would have said at the
2 end of that, that's a patient waiting five years or
3 three years. We did take this very seriously, but we
4 were needing to really put the pushback to the Health
5 and Social Care Board and as well to the Department. 15:16
6 I'm not sure, I didn't hear Mr. Pengelly yesterday, but
7 a lot of that going back to the Department and the
8 Commissioner was every Trust doing it, we weren't the
9 only one.

10 143 Q. Let me come back to that external discussion in a bit 15:16
11 more detail in the context of Urology in a moment. Can
12 I ask you about a particular initiative that you
13 pursued in the governance context, and that was the
14 introduction of the leadership walks. If we go to
15 WIT-90855. You explain that you introduced leadership 15:17
16 walks, which were performed by Non-Executive
17 Directors, to all areas across the Trust looking for
18 evidence that what we heard in the Board was happening
19 on the frontline. These leadership walks, you explain,
20 enabled testing of the systems and an opportunity to 15:18
21 meet all grades of staff, listen, and be a visible
22 Board. You say this further completed the circle of
23 governance.

24
25 Can you clarify who amongst your team participated in 15:18
26 these walks?

27 A. The leadership walk was introduced by Mrs. McAlinden
28 and I after her big governance review. We wanted to
29 complete the loop of what we heard in the boardroom

1 that we actually saw at first-hand out. So,
2 Mrs. McAlinden put together with her senior team the
3 pillars of governance and what she believed was
4 necessary to ask. A lot of this came from her
5 leadership. Then her and I discussed it, and we had an 15:18
6 excellent tool of about - I'm sure it is before the
7 Inquiry - maybe 15 questions. So, I discussed it with
8 the Non-Executive Directors, who also were involved at
9 that time when they were introduced, of what we would
10 do. 15:19

11
12 The leadership walks were undertaken by myself and all
13 of the Non-Executive Directors. I do believe the
14 Chief Executive at that time had their leadership
15 walks, but we did these ones. I probably did the most 15:19
16 because I was there maybe more, but the Non-Executive
17 Directors would like to do at least three/four a year.
18 I found that an excellent tool. I heard before the
19 Inquiry that this was an inspection; I did not see that
20 as an inspection. It was very welcomed by then the 15:19
21 senior management team, and the Chief Executive
22 introduced it initially.

23
24 Also, when we went out to different areas, it was a
25 great opportunity to see frontline staff. We would 15:19
26 have not only visited the facility, we would have
27 looked around it to see what the estates were like,
28 thinking of infection control, thinking of they always
29 had a safety dashboard in the wards, so we were able to

1 see first-hand the safety dashboard around falls,
2 infection control, staffing. You know, you saw so much
3 when you went out on a visit, Mr. Wolfe.

4 144 Q. Sorry to cut across you. In terms of its arrangement,
5 was it by way of a surprise visit or was it formally 15:20
6 arranged with the relevant service provider?

7 A. Yes, it was. I mean, my personal assistant, Jennifer
8 Comac, along with Sandra, the Board Assurance Manager,
9 we worked out a programme of when we would visit and
10 who should have the visit. We would try to have went 15:20
11 for development areas to the Non-Executive Director,
12 but we also would have went to an area that we believed
13 was a bit troubled or were going through difficulties,
14 should it have been staffing.

15 15:21
16 So, it was very structured. We asked the Non-Executive
17 Directors for their diaries, when they would be free.
18 That was so important because it was normally a good
19 half-day and you might have had to travel to Daisy Hill
20 or South Tyrone Hospital; our Trust was very 15:21
21 widespread. So the Non-Executive Directors gave in
22 their diary and availability, and then Jennifer, my
23 assistant, would have worked with the particular
24 directorate, the Director. Also, we did try to make
25 sure the Assistant Director or Head of Service was also 15:21
26 available. They could join us if they wanted. Towards
27 the end of my tenure, we were trying to move towards if
28 we could maybe do it with a Director. That was just
29 becoming impossible because of getting diary dates to

1 suit a Director, to suit a Non-Executive Director.

2
3 They were very structured, they were planned. Also
4 before we would have went, say it was a ward, we went
5 to the ward sister the tool that we were going to be 15:21
6 looking at the different areas so that she could see.
7 Most of them had their work very well prepared before
8 you went so that, to save time maybe, their audits and
9 some of their innovative practices and their concerns.

10 If you look, which I know you have some before the 15:22
11 Inquiry, I think it is questions from 11 to 14, but
12 certainly question 11 does ask you - because I so
13 remember it - tell us in your ward what are your
14 greatest risks are you dealing with, what are your
15 concerns. So it wasn't a tick box exercise, you spent 15:22
16 quite a lot of time there. And I always --

17 145 Q. Sorry to cut across you. We'll maybe look at the two
18 Urology leadership walks of which we are aware. You
19 performed one in 2012, isn't that right?

20 A. Yeah. 15:22

21 146 Q. If we can bring that up on the screen, or the report
22 that flows from it. WIT-19178. That's the cover
23 sheet. You are going to the Thorndale Unit on the
24 23rd, I should say, May 2012. The person accompanying
25 you is the Urology specialist nurse, Kate O'Neill. 15:23
26

27 Is it fair to say that nurse, Ms. O'Neill, was the key
28 informant during your walk, and nobody else?

29 A. Oh no, you would have met -- and I can't remember this

1 one, but if we scroll through it you will maybe see
2 what other staff did I talk to, because normally we'd
3 have recorded if you had talked to a consultant or if
4 you had talked to nurses or if you talked to
5 administration staff; you just didn't dive in and talk 15:23
6 to the nursing staff. I mean, Kate O'Neill, from
7 memory, was one of the Urology specialist nurses. When
8 we would have booked that, or Jennifer, she would have
9 tried to make sure the most senior ward manager - or
10 indeed if you were going to the day centre or wherever, 15:24
11 the person in charge was on - so that you were meeting
12 the person but also they could give you all of the
13 information. But Kate O'Neill was very senior and a
14 very experienced Urology specialist nurse. I think
15 there was another girl, maybe Jenny or someone was 15:24
16 there. I can't remember all but I do think --
17 147 Q. we'll go through it, but before we do was there any
18 particular reason in selecting Urology as the place to
19 visit at that time? You said earlier we sometimes
20 directed our attention on areas in difficulty, or had 15:24
21 particularly special reasons or particular reasons for
22 doing a walk in that area. Was there anything coming
23 to your attention in Urology by 2012 that drew your
24 attention?
25 A. Not that I'm aware of. One of the reasons also we 15:25
26 would have looked back to see where didn't have a
27 visit.
28 148 Q. Yes.
29 A. What we tried to do, and I think we got through most of

1 them during my time to get around all of the sites,
2 we're talking about the laundry, the kitchen, the
3 pharmacy, all of these places had a visit. From
4 memory, the Thorndale Unit hadn't had a visit. I
5 sometimes would have filled in the gap because some of 15:25
6 the Non-Executive Directors, it was extremely busy,
7 their workload and they mightn't have got it done. It
8 would have been Jennifer in the office with Sandra who
9 would have been looking to see where a visit was due.

10 149 Q. Let's just scroll through it and if any particular 15:25
11 issue catches our eye, we'll deal with it. I assume
12 that you are not walking around clipboard-like asking
13 questions and recording answers, but you have a
14 conversation, is it, that embraces all of these
15 questions or is it the formal working through the list? 15:26

16 A. The way I would have done them - and everyone had their
17 own style - we used the same tool, of course, and the
18 Department would have got a copy, as I have said, in
19 advance. Normally when I would have arrived, I would
20 have went to a quiet area to meet with the lead person, 15:26
21 to take them through the form and to explain to them
22 this is what we are trying to gain at the end. I also
23 would have explained to them that when this tool is
24 completed by myself, I will spend it back to you, being
25 the lead, to make sure that there is no inaccuracies or 15:26
26 if I have recorded something wrong. Once they sent it
27 back to me, then the triangle of this was it went to
28 the Chief Executive. It was then the Chief Executive
29 who dealt with it with the Director. Normally you

1 would have got a response. Now, I'm assuming as I read
2 this here --

3 150 Q. It starts off with a positive, what works well. It is
4 set out in terms of the effectiveness of the team, its
5 skills; it points to the specific nurses who lead in 15:27
6 different areas. Then there is an area of what doesn't
7 work well. We can see that it's pointing to shortfalls
8 in staffing resources, particularly around middle grade
9 doctors; limitations in the size of the building; the
10 size of the team being small, so it's not responsive to 15:27
11 accidents such as illness, and a more practical issue
12 around car parking.

13
14 Just scrolling through it and we'll pick-up on the
15 questions -- 15:27

16 A. Sorry. I'm sure you are aware, Mr. Wolfe, that is me
17 listing in the black what I have been told as on my
18 walk around, not with a clipboard. Then this is the
19 response in red from the relevant lead in the
20 department or indeed from the Director. The red is not 15:28
21 my recording, mine would have been in the black. But
22 when you sent it in and were getting it back for
23 clarity, you would have seen this is just what way it
24 was recorded. The red is very much the response from
25 the -- 15:28

26 151 Q. From the staff member?

27 A. Yes, and indeed their team. You know, their Head of
28 Service or whatever would have been involved in this.

29 152 Q. Yes. Then questions around what would you like to

1 change. It focuses on expansion of the team. That's
2 explained, that there is a process in train.

3
4 Just working through it; I'm not in the time available
5 to us going to stop at every point. Just keep on 15:28
6 working through this. Obviously that's a reflection in
7 terms of improvements. The one-stop clinic was a
8 recent development which we've heard some evidence
9 about. Scrolling down. This particular example seems
10 to be very nurse-specific, it's the view from the 15:29
11 perspective of a nurse; is that fair?

12 A. Yes, but I'm just surprised I haven't yet come to
13 anywhere else that I met other staff because it would
14 be very rare you just spoke to one staff member. But
15 yes, this was what the leader, the team leader, was 15:30
16 telling us. But it is a small area, from memory. The
17 Thorndale Unit was one of the modular buildings that
18 was placed beside the Cancer Unit, so it was small. It
19 was a small select accommodation, and indeed select
20 staffing. It was very specialised. 15:30

21 153 Q. Just continue to the end then. You were drawing your
22 attention to the importance of questions, I think you
23 said 10 to 14?

24 A. I'm sorry. Just from memory I remember there was
25 always a question that you asked, the areas of concern. 15:31

26 154 Q. Yes.

27 A. So that you didn't leave the building having asked a
28 lot of maybe soft questions and yet here was a team
29 leader who had real risks they were trying to manage

1 and she didn't have an opportunity to tell you. That
2 was why, when we were putting this tool together, I
3 remember Mairead McAlinden, we looked at the pillars
4 then of governance and doing what we were doing. We
5 would have always asked, you know, what are the 15:31
6 concerns, what are some of the big issues that you are
7 dealing with, because that married then through to the
8 front reporting sheet of the performance report.

9 155 Q. Sure. Then just bringing us through to the end,
10 comments on the excellence of the facility. Then there 15:31
11 is an issue about a potential move, which, as I
12 understand, at least in terms of the Thorndale Unit
13 itself, didn't come to pass. There had been an earlier
14 move of the Urology ward which caused some
15 disgruntlement amongst the team. Just continuing on. 15:32

16 A. Yes. At one time it was in 2 South, a full ward, and
17 then moved to there.

18 156 Q. That's the first of the walks. Geraldine Donaghy, who
19 was one of your Non-Executive Directors, she performed
20 a further leadership walk some six years later in 2018. 15:32
21

22 Should there have been a repetition of the exercise
23 long before 2018, particularly in the context of a
24 service which, I'll demonstrate in a moment, was well
25 known to you and your fellow Board members to be 15:33
26 struggling in terms of its capacity? Does it not
27 strike you, thinking back on it, that you really should
28 have been directing somebody back to do another
29 leadership walk to better understand what was actually

1 going on on the ground?

2 A. Yes. I wouldn't disagree with you, Mr. Wolfe, but
3 remember we had many sites to visit from the Clougher
4 valley, which is quite a distance away, right through
5 to Kilkeel, to Coalisland. Our geographical spread of 15:33
6 the Trust was huge, and therefore we were trying to get
7 round all sites. It would have been difficult to do
8 many more visits above what we had done. However,
9 coupled with this, remember, was the head of services
10 visit; you had a governance lead in there as well that 15:34
11 you would have expected to be visiting; you had an
12 assistant Director. This is in the operational end.
13 You had a clinical Director. Also the Chief Executive
14 would have been out walking as well. I can't say if
15 was reported into the Trust Board where they went on 15:34
16 their walks, so I just can't remember. I mean, during
17 that period did any Chief Executive visit there or
18 indeed the reporting in of an assistant Director.
19

20 But no, as a Non-Executive Director, we didn't go back 15:34
21 again but I do remember Geraldine's visit in '18.

22 157 Q. Isn't it fair to say that the Non-Executives are
23 performing the walk for perhaps different reasons than
24 the executives? The Non-Executives are the challenge
25 function, you need to gather the information so that 15:35
26 you can challenge the Chief Executive and his or her
27 team as to what's going on on the ground. To say there
28 were other people walking that walk isn't a useful
29 substitution for the work that your Non-Executive team

1 should be doing?

2 A. Yes, and I respect your opinion on that. However, it
3 would have been difficult to ask the Non-Executive
4 Directors to do many more visits. If you look in their
5 schedule of work that they did for the overall Trust as 15:35
6 well as those walks, at least two of them were
7 struggling to get those visits completed. I think that
8 came up on an audit somewhere, an internal audit. But
9 that wasn't because of not a willingness, it was just
10 time pressures on their other work. 15:35

11 158 Q. Yes.

12 A. So I take that criticism but it would have been
13 difficult to fit in many more visits. Remember, we
14 were visiting other sites.

15 159 Q. Yes, I take that point. Geraldine Donaghy's visit on 15:36
16 5th March 2018, we can see that at WIT-26631. She is
17 accompanied by Jenny McMahon, who is another Urology
18 nurse specialist. We'll not walk through every aspect
19 of this form, the Panel can read it, unless you have
20 any particular observations to make. 15:36

21
22 Can I bring you directly to the question about what
23 doesn't work well, and we can find that at 26632, just
24 a couple of pages in. There we go. In the last
25 paragraph it explains that workforce issues are 15:37
26 generally stable, albeit with an ever increasing
27 workload so that additional staff are needed.
28 Incidences of prostate and renal cancers have resulted
29 in a case being made for an additional nurse to do

1 follow-up, and the reporter was hopeful that this will
2 happen.

3
4 "Currently there is a consultant urologist vacancy and
5 ongoing dependency on locum consultants continues".

15:38

6
7 Then, over the page, the question is asked what would
8 you like to change or see different? An explanation is
9 given about the need to discuss further opportunities
10 for nursing development, improvement of flexible
11 cystoscopy and improved succession planning for the
12 service.

15:38

13
14 In terms of challenges then, difficulties remain in
15 meeting the cancer targets for first appointment and
16 first definitive treatment. Lengthy waiting time for
17 what are considered to be non-urgent urological
18 surgery. However, many of these patients are
19 experiencing significant impact on their quality of
20 life while awaiting procedures.

15:38

15:39

21
22 I suppose by contrast with the picture that was
23 referred to you six years earlier, here is a clear
24 articulation of the pressures facing the service in
25 terms of its ability to manage capacity and the impact
26 that this is having on patients. These reports and the
27 information contained within them, they go to the Chief
28 Executive?

15:39

29 A. Yes. They go back after they are initially written up

1 by the Non-Executive Director or myself; went back to
2 the Department within maybe 10 days to allow them to
3 check the accuracy, and then they came back and then
4 they went to the Chief Executive, and then they would
5 have discussed it on a one-to-one for the Director 15:40
6 responsible for that area. Then, remember, they also
7 went to governance; they went quarterly to the
8 Governance Committee.

9 160 Q. Through the Chair, we will hopefully take a short break
10 in a moment. When we come back, we will look at the 15:40
11 kinds of information the Boards was receiving by this
12 point in relation to the pressures facing Urology
13 service. I suppose the question I'll ultimately be
14 asking you to think about is to what extent did the
15 Board adequately grapple with the concerns that were 15:40
16 coming through to you from Urology about the capacity
17 issue. So if we can pick that up maybe after the
18 break.

19 A. Sorry, could I just?

20 CHAIR: Go ahead. 15:41

21 A. I was going to say isn't this the report - and again
22 this is from memory - that Geraldine had the
23 opportunity - I didn't, there was no consultant on
24 during my visit - isn't this the report that Geraldine
25 had the opportunity to speak to Mr. Haynes? 15:41

26 161 Q. MR. WOLFE KC: I'll just check through that during the
27 break. I think that's right.

28 A. She spoke to a consultant and others, I think. On the
29 day of my visit, the two clinical nurses were on and

1 the admin staff, but Mr. Haynes was there on that day
2 and she had quite a conversation with him on a
3 one-to-one because I can remember her bringing back and
4 showing me this and telling me about a new consultant,
5 or I think he was new. But maybe it is a different 15:41
6 report but just checking if --

7 162 Q. I think he was five years new by this stage.

8 A. But there was something about then... Maybe a
9 different report.

10 163 Q. We will come back to that after the break. 15:42

11 CHAIR: we will come back at four o'clock, ladies and
12 gentlemen.

13

14 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

15

15:59

16 CHAIR: Thank you, everyone.

17 MR. WOLFE: If we could go back to the page we were
18 at, the leadership walk, to tie up a few loose ends.
19 WIT-26633. It's under the question of what challenges
20 do you face. We were looking, Mrs. Brownlee, to see if 15:59
21 there was any mention of engagement with Mr. Haynes
22 during this exercise. Certainly my eye hasn't picked
23 up on anything. You will be coming back to give
24 evidence tomorrow; if you have a recollection to better
25 bottom out that point, then feel free to bring it to 16:00
26 our attention.

27

28 I just want to deal with the utility of these walks and
29 how they were used. You've explained that -- I'll just

1 let you make your note.

2 A. Sorry.

3 164 Q. No, no problem. You have explained that these reports,
4 as the product of the walk, would end up with the Chief
5 Executive and go to the Governance Committee. Did I 16:00
6 hear you right?

7 A. Yes. Yes.

8 165 Q. Would you have expected any form of action or response
9 when they were passed to those people or committees?

10 A. Yes. Well, to be fair to the Chief Executive and 16:01
11 indeed the Director, they always did respond. That's I
12 think at an earlier one we saw the red writing. It was
13 always -- I would honestly say always the Director
14 would have replied. If there was anything highlighted
15 on it, definitely. If it went to governance, I can't 16:01
16 recall what would happen then. They went as a block
17 for a particular quarter if they were reported maybe
18 every three/four monthly into Governance. But
19 definitely the Chief Executive would have discussed it
20 on the one-to-one or sent it to the Director. 16:01
21

22 I have many, many recollections of the Chief Executive
23 sending it back then with the comments from the
24 Director, and action points. Definitely they did.

25 166 Q. Yes. I am going to move to look at some of the 16:02
26 occasions when the Board or the Performance Committee
27 was directly referred to concerns about the pressures
28 facing Urology. But just looking at the content of
29 this walk, for those, I suppose with a focus on this,

1 they would have seen the real expression of concern
2 about the impact of lengthy waiting times on the
3 quality of life of patients. I mean, that could
4 probably be written up in a variety of ways but it does
5 point to risk to patients, doesn't it?

16:02

6 A. Yes. Yes.

7 167 Q. Would you agree with me that passing this to the Chief
8 Executive, passing it to the Governance Committee, is
9 not enough of itself? It might be a useful first step
10 but in order to get to grips with I suppose big ticket
11 issues such as not meeting cancer targets, coming up
12 with solutions for lengthy waits, particularly where it
13 is impacting on or risking the quality of life of a
14 patient, it requires a rather more well thought out and
15 considered and developmental response than it just
16 going to one person?

16:03

16:03

17 A. Yes. But I keep using this one as an example, I do
18 remember Geraldine Donaghy was a very strong
19 Non-Executive Director who was very challenging, I
20 remember her bringing that up under performance around
21 her visit at that time, and I'm sure it's in a minute.
22 So it wasn't just written up, went to the Chief
23 Executive and a Director replied to you. We did try a
24 lot of these, if you put them under headings, we knew
25 we had a capacity and demand issue in many areas. We
26 knew ourselves about the cancer targets on the
27 performance report that we weren't meeting. You're
28 absolutely right, I mean, this shouldn't have been a
29 surprise to the Director or line management in Urology

16:03

16:04

1 as an example, because a Head of Service would have
2 known this and an Assistant Director would have known
3 this and certainly the Clinical Director, so this
4 wouldn't have been surprises.

5
6 I mean, what did we do about it? Are the actions
7 flowed then from governance into the Board and the
8 asking of questions.

9 168 Q. Yes. Let's look at this in a bit more detail. I'm
10 going to bring you to a minute of a Board towards the
11 very start of your tenure. In 2009 you were not yet
12 Chair, you were a Non-Executive Director. Mr. Beech
13 will help me with the date. If we go to WIT-90860.
14 Sorry, I'll bring you to a different reference, sorry.
15 TRU-105665. So, TRU-105665, halfway down the page.

16
17 Mrs. Clarke, was she Director For Performance?

18 A. Yes. At that time, yes.

19 169 Q. This is 24th September 2009, if I haven't said it
20 already.

21 A. Sorry, what date was this again, sorry?

22 170 Q. I'm not sure if I've said it three times now,
23 24th September 2009. Let just orientate ourselves by
24 bringing you to the first page of the minute.
25 TRU-105658. There you go. It is being held at the
26 Dungannon Council offices. Mrs. Balmer is in the Chair
27 and you are there as Non-Executive Director;
28 Mrs. McAlinden being the acting Chief Executive. As we
29 can see, jumping back to TRU-105665, Mrs. Clarke is

1 reporting on a number of risk areas. Number 1 is
2 described as "in-patient day case access target". In
3 the next sentence, we realise that number 1 is
4 referring to Urology because she says:

5
6 "In relation to 1, Mrs. Ewart advised that a trusted
7 undertaken a review of Urology services and this had
8 highlighted a capacity gap".

16:07

9
10 That issue of capacity gap would have been something
11 you were aware of from the earliest times in your
12 career with the Trust. You've said in your witness
13 statement, this is WIT-90860, just in the second
14 paragraph:

16:07

15
16 "Along with other services like Radiology, Endoscopy
17 and Unscheduled Care, to name a few, Urology came to
18 the attention of the Board as a service under pressure.
19 I do not remember Urology ever coming to the Board as a
20 single agenda item. We did know of the long waiting
21 lists as this was referenced on the performance reports
22 along with many other specialities".

16:08

16:08

23
24 So, you are aware of the problem and perhaps features
25 of the cause of the problem, as we'll see when I take
26 you to the references. The executives, you are
27 suggesting there, didn't bring forward to the Board for
28 discussion Urology as a standalone item to be discussed
29 and grappled with and for solutions, perhaps, to be

16:09

1 worked through. Is that what you mean by that?

2 A. What I mean, as a single item --

3 171 Q. Yes.

4 A. -- Urology didn't come, say, separate to Radiology,
5 Unscheduled Care, et cetera, there was many others. 16:09
6 That's what I meant when I was preparing my Section 21.

7 172 Q. Yes.

8 A. It didn't come because it came in a group with other
9 services under pressure. There is no doubt we had many
10 areas at that time that you are speaking of. We had a 16:10
11 lot of reconfiguration of Trust sites, of both South
12 Tyrone Hospital, at Daisy Hill Hospital, and even on
13 the Armagh site as well as Craigavon, to try and deal
14 with the pressures on any specialities, not only
15 Urology. 16:10

16

17 Can I just say that when you did and could have got
18 additional money, it wasn't always about getting extra
19 money. Some of the difficulties was on the site,
20 whereas we could have put in a building. Very 16:10
21 importantly, it was we may not have got the workforce
22 to manage that. That was a huge pressure that we were
23 dealing with every day in relation to recruitment of
24 consultants across most areas in both surgical,
25 specialised, and indeed in medicine. 16:11

26 173 Q. The Trust was the subject of a regional -- I'll put it
27 a different way. Urology was the subject of a regional
28 review in 2009, which created three teams to provide
29 Urology services across Northern Ireland. Team South

1 based in the Southern Trust was focused on the delivery
2 of Urology services to many populations west of the
3 Bann down as far as Kilkeel and into Newry.
4

5 Did you have any clear signs of how that regional 16:11
6 review was supposed to work in Urology in the Southern
7 Trust?

8 A. Again, some of what I have read in my bundle, the
9 letter from Mr. Mullan, I think it was, and the review,
10 I wouldn't have seen that before nor would I have 16:12
11 expected maybe to see it because they were operational.
12 As a Board member, I wouldn't have been -- I don't
13 remember any Non-Executive Directors involved in the
14 regional review of Urology. I definitely know our
15 Director of Performance, quite a number of her 16:12
16 clinicians in Urology, and indeed the Chief Executive,
17 would have been involved in that region. Again, from
18 memory, let me think, cystectomies was moved to
19 Belfast.

20 174 Q. I suppose the question -- sorry to cut across you but 16:12
21 just to focus on where I want your views. The
22 outworking of the regional review was supposed to
23 focus, or better focus, resources on Urology need
24 within your area, but you can quickly see in the years
25 after the Urology review that this service in the 16:13
26 Southern Trust remained under significant pressures.
27 For example, we have a performance report in August
28 2012. TRU-106597 is the cover page for this report,
29 and it's dated August 2012. If we go through to

1 TRU-10660?

2 CHAIR: I think you left out a 5, Mr. Wolfe. It
3 should be 106560.

4 MR. WOLFE: Yes, I think that is correct, Chair,
5 106560. 106600; that is another option. 16:14

6 CHAIR: Maths was never my strong point.

7 MR. WOLFE: TRU-106600. Under urology for this
8 performance report in August 2012, it's describing the
9 performance risks in inpatients, day cases and
10 urodynamics result from an established capacity gap for 16:15
11 which recurrent investment has been committed.

12
13 "Current in-house capacity is entirely absorbed in
14 managing red flag referrals and urgent cases. The
15 Trust has appointed three consultant urologists 16:15
16 starting in August, September and November. However,
17 the impact of this capacity will not manifest until
18 into Q3 and Q4, and so the independent sector has been
19 considered. However, they are unable to provide all of
20 the capacity required to achieve access standards". 16:16
21

22 So shortly after the implementation, or the
23 commencement of the implementation of the regional
24 review, recognition of the need to recruit more
25 consultants, and that is taking some time. Meanwhile, 16:16
26 there is a need to reach across to the independent
27 sector.

28
29 For the next several years, although recruitment does

1 take place, the service continues to experience
2 significant pressures; isn't that right?

3 A. Yes.

4 175 Q. We can see, for example in 2013, towards the end of the
5 year, Urology is identified as an area where there are 16:16
6 significant risks so that they are reflected in the
7 corporate risk register. If we go to that please.
8 WIT-52912. Just there on the third bullet point, it is
9 describing the largest volume of waits are in Urology
10 and ENT, with the longest waits being Urology. 16:17
11

12 The position, as we understand it, remains largely
13 unchanged, as I say notwithstanding recruitment, and in
14 fact might be viewed as getting worse. If we look at
15 the corporate risk register for February 2016 at 16:18
16 WIT-53073, we can see that it's been reported that
17 areas of risk highlighted to Health and Social Care
18 Board formally include Urology and in particular its
19 outpatient review backlog.

20 16:18
21 You have said in your evidence, I think, that on
22 occasion, almost beyond your remit, you have directly
23 engaged with the Health and Social Care Board. Can you
24 remember particular examples of that and why you saw
25 fit to engage with them directly? 16:19

26 A. Well, certainly from what you've shown here, we knew,
27 despite the current funding, even the recruitment of
28 consultants - and I'm not quite sure all of those three
29 consultants did arrive, I may be wrong - that the

1 capacity was still great. It was coming to the Board
2 and we were hearing back that the Director of
3 Performance had been to the Board about additional
4 funding and to get extra help from the region. I'll
5 come back about the region that you talked about 16:19
6 earlier. I mean, all of that was happening but as a
7 Board we couldn't see progress or anything getting
8 better. So I felt it important, as a Chair of the
9 Trust, looking at the risks, that I should go with the
10 Chief Executive. We would always have written a letter 16:20
11 to the Chief Executive of the Health and Social Care
12 Board, and through to the Department.

13
14 So I accompanied at least twice. I remember going.
15 Mrs. Watts was definitely the Chief Executive on one 16:20
16 occasion and going to Linenhall Street in Belfast for
17 that, to talk about capacity and demand and Urology. I
18 remember -- I am fairly sure I went with Mrs.
19 McAlinden, and I also went once with Mr. Devlin -
20 that's all from my recollection - to talk about 16:20
21 capacity and demand and how we were going to manage
22 this. To be fair to those departments we went to --
23 and I remember on top of that we were going to the
24 accountability meeting where we talked about some of
25 these pressures again with Mr. Pengelly, and there were 16:21
26 other meetings at the Department but those were the
27 meetings that I went to. There was always a
28 sympathetic ear. To be fair, we were received well.
29 They understood because they were seeing the report,

1 and our colleagues went before us to see what was it
2 they could do to help us. It wasn't all just money.
3 It was actually seeing, as you talked about in the
4 region and the region south, that actually you would
5 have thought helped us, but it involved our consultants 16:21
6 travelling to the Southwest Hospital, the new Acute
7 Southwest Hospital. Sometimes it's difficult maybe to
8 explain the geography, but that was a consultant
9 travelling in his time from the Craigavon site to the
10 southwest and trying to deal with that. 16:21

11
12 So, it wasn't just getting extra money, we were looking
13 the regional support, what was the region going do
14 about Urology. Because it wasn't just in the Southern
15 Trust, from memory the Western Trust had huge problems 16:21
16 as well, and we know the Belfast Trust had huge Urology
17 problems. The money was one thing, the capacity was
18 another, but there is no question about it - recruiting
19 skilled urologists was a problem. We were not able to
20 recruit from the Republic of Ireland. I don't recall 16:22
21 us ever recruiting a consultant urologist from within
22 Northern Ireland, if you know what I mean, from another
23 Trust. We would have been trying to recruit from the
24 UK. Sometimes we had no applicants. Sometimes would
25 you have had three/four and you would have tried to 16:22
26 take the three or four. One may have been going off
27 for a Fellowship to Australia, Canada, wherever it was.

28
29 Also, the pool of people that were applying, I mean the

1 Northern Trust could have been applying for urologists
2 at that time, and possibly the west. If you understand
3 how consultant interviews take place, I could have been
4 interviewing on a Tuesday afternoon, the Northern Trust
5 could have been interviewing on a Monday afternoon, and 16:22
6 if they interviewed and selected that person, by the
7 time you came to Tuesday, we already had two
8 cancellations. So, I did visit. We spent considerable
9 time on that. We didn't --

10 176 Q. Sorry just to cut across you in the interests of time. 16:23
11 If we go to another corporate risk register entry in
12 August of 2016. If we go to WIT-102924. That's the
13 front page; if we go to 102969. It explains that in
14 terms of planned patient backlog - I assume this is a
15 reference to elective patients - it is setting out the 16:23
16 figures there and it is saying that the longest waiting
17 patient dates back to October 2014 and relates to
18 Urology.

19
20 Was there a recognition - it's written there in black 16:24
21 and white - that Urology, albeit that there were other
22 services and disciplines within the Trust that were
23 also getting it hard and were under pressure, but
24 Urology was really, in many of the services it wished
25 to deliver, in a worse place than maybe any other 16:24
26 service?

27 A. It certainly would have been one of the worst, yes.
28 Maybe Radiology at that time was another. Yes, it was
29 recognised. I mean, the like of that patient in

1 October '14, when that would have come to the Board, I
2 definitely know a Non-Executive would have always asked
3 that's a patient somewhere who is waiting a long time,
4 who has been in touch with them? what type of letter
5 have they had? Have they been back to see their GP? Can 16:25
6 they be seen? We would have always thought of a number
7 as a patient. It wasn't that there was a thousand and
8 we didn't think these were people. All of these people
9 in whatever speciality it was, and especially Urology,
10 we knew these were patients awaiting a service, we were 16:25
11 very concerned about this. Certainly patients were in
12 the centre of all that we did. But it was extremely
13 difficult to get all of these patients seen on site.
14 We tried to do these outlying clinics. There was
15 clinics held in a variety of places, but the Urology 16:25
16 theatres were all in Craigavon site.

17 177 Q. But the problems, as they have been described to the
18 Inquiry so far, include the recruitment issue?

19 A. Yes.

20 178 Q. And as well as that, capacity or access to theatres. 16:26
21 You've said earlier that Urology didn't arrive on the
22 Board's agenda as a single item at any point, it was
23 always part of the mix of other services facing
24 difficulty. When you think about it now, should the
25 Board have given greater focus to Urology? Should it 16:26
26 have become a single item for consideration given that,
27 across some of the indices at least, it was a worst
28 performing service, or a service that was least well
29 able to deliver and was gathering the biggest waiting

1 lists?

2 A. Yes. With hindsight, it could have come as a single
3 item but there would need to have been other
4 specialities come as well, and it did get the focus of
5 the Board. Did it get the outcomes we expected when we 16:27
6 see the waiting lists still? It got lots of
7 discussion, it had a lot of performance management
8 reviews, there was a lot of meetings at the Board.
9 When I say the Board, I mean the Health and Social Care
10 Board. And also at accountability meetings through -- 16:27

11 179 Q. We've heard from time to time that there were waiting
12 list initiatives and any capacity made available
13 through that was snapped up by Urology clinicians to
14 the extent that they were available, but we don't ever
15 see any evidence of, I suppose, a focused plan on 16:27
16 Urology, notwithstanding the fact that we've seen
17 correspondence from the likes of Mr. Haynes writing in
18 to the Acute Director and saying, listen, we are really
19 concerned about this, patients are at risk, patients
20 are in danger. Is that the kind of thing you and your 16:28
21 Board appreciated? If so, was there any substantive
22 action taken to try to address it?

23 A. We were very aware of that, definitely those
24 discussions took place. We spent quite considerable
25 time talking about long waiting lists, and Urology with 16:28
26 particular reference. We knew how serious it was, we
27 knew each one of these were patients --

28 180 Q. Can you be specific, how was that manifested? How was
29 that awareness of the risk to patient health manifested

1 in the actions that the Trust Board performed?

2 A. Again, we would have said back to the Director of
3 Performance, and the Chief Executive as the accounting
4 officer, you know, we need to go back, we need to see
5 what more we can do. But, Mr. Wolfe, even by going to 16:29
6 these others, the Commissioner and our department, they
7 weren't able to help us fix this problem that we had.
8 Now, we did go out to the independent sector. I mean,
9 again we've quite a limited resource here in Northern
10 Ireland for that. It was taken up quite quickly, the 16:29
11 spaces, but it didn't reduce our lists very much
12 because you are talking about they would have maybe
13 done 30/40 people at a time, but it didn't bring down
14 the numbers. What was important was those who were the
15 longest wait; the patient with the longest wait would 16:29
16 have been seen.

17

18 If we're saying Patient A was waiting from October '14,
19 what we were saying was we wanted to see the action
20 that that person was being made contact with, and when 16:30
21 would they be seen by the independent clinic or
22 wherever. It wasn't as if you took them off at random.
23 Again, it was always urgent cases, you know, people who
24 were a priority, red flags, whatever. I'm not sure
25 what else we could have done than go and raise issues. 16:30
26 We put it in writing to the Board, as did the
27 Accounting Officer. We brought it up with the
28 Department. We got sometimes extra consultants. Also
29 in the regional review, we got the specialised nurses

1 to help to do with some of the urodynamics and the
2 stone clinic, and also to assist.

3
4 To be fair, it didn't make a big impact because the
5 referral through from GPs and emergencies was just 16:31
6 outstretching our ability to do it. But definitely if
7 there was an urgent case came in, we would have tried
8 to look to the region to see, because it was a regional
9 approach and we have tried that with many of our
10 specialties. 16:31

11 181 Q. If we just look in conclusion this afternoon at some of
12 the waiting lists which the Trust had to grapple with.
13 As I said by way of preface earlier, you came into the
14 Trust in or about I think it was 2007. 2009, we've
15 seen from Mrs. Clarke's input at that August 2009 Board 16:31
16 meeting, that already, in the development of Urology
17 service at a fairly early stage, already it was a
18 service under pressure; throughout the period after the
19 urology review in 2009 it remained under pressure.

20 16:32
21 Looking at the waiting list for the category of first
22 outpatient appointment, if we go to TRU-98238. This is
23 the waiting list for May 2016. I am just remarking
24 that TRU, for whatever reason, seems to be the slower
25 of our documents to come up. It's not pointing the 16:33
26 fingers at the Trust. I can see Mr. Lunny becoming
27 unsettled by that remark.

28 CHAIR: I'm sure he isn't. Mr. Lunny is usually the
29 one that gets the numbers on the pages right. Not like

1 the rest of us.

2 MR. WOLFE: I think the reference is right. Perhaps,
3 more seriously, we need to look at this system and see
4 if it can be improved in that respect.

5 16:33

6 what we see Mrs. Brownlee, is for number of patients on
7 a consultant-led first appointment as of May 2016.
8 There are a total of 2,743 waits, looking at the far
9 right-hand column, across each of the consultants
10 retained in the service. 420 are waiting more than a 16:34
11 year. That figure was to increase significantly, so by
12 April 2020 there were more than 2,000 waiting more than
13 a year.

14
15 If we can bring you to, at the risk of a significant 16:34
16 delay, TRU-98242. There we are. Albeit that there is
17 probably a COVID element to these figures, we can see
18 that there is a substantial jump both in terms of the
19 overall number waiting, and those waiting more than 52
20 weeks is now sitting at more than 2,000. 16:35

21
22 Were these figures regularly brought to your attention?

23 A. Yes. Yes, those reports all came to the Trust Board.
24 I use again as an example, colleagues would have been
25 asking, say - I've lost a bit of my screen - but if, 16:35
26 say, one waiting, tell me some of the people that are
27 waiting 52 weeks plus, say, under a particular
28 consultant, are these routine - I'm sorry, I don't
29 particularly like that word - are these routine versus

1 a red flag? Hopefully not but there may have been some
2 of those waiting a long time. So, we would asked about
3 individual feedback from the Director presenting this.
4 And that is where the Director of Performance would
5 have been looking to the Director of Acute Services as 16:36
6 well as the Medical Director to assist a lookback or a
7 look in to see how long are they waiting, what is their
8 condition, what is their follow-up like. So, they did
9 come to the Board.

10 182 Q. To summarise your evidence, you appear to be telling us 16:36
11 that the Trust Board were not strangers to this kind of
12 information; the Trust Board regularly discussed
13 pressures on services, not just in Urology but across
14 several services. You appear to be saying that as a
15 Board, you didn't lose track of the fact that patients 16:37
16 could come, and possibly were coming, to harm,
17 certainly at risk of harm while being on the waiting
18 lists. But in terms of the initiatives that the Trust
19 was able to take up to address such matters, you would
20 maintain that you did your best through the Health and 16:37
21 Social Care Board, with the Department, in making use
22 of whatever resources that you had available to try to
23 at least ameliorate matters?

24 A. Oh yes, definitely we did that in meetings. But also
25 as well as trying to get behind some of these numbers, 16:37
26 because we knew these were patients, we would have been
27 looking to know about -- we would have always said the
28 GP would have been the one who would have been
29 referring them in again if it was urgent so that they

1 would have been seen. That was definitely happening.

2
3 The other thing, when you ask what else we should have
4 been doing or could have been doing, we did try with
5 our own consultant urologists to see about taking on 16:38
6 extra work; I mean to do extra theatre lists. Our
7 theatres were extremely busy. You know, there was
8 rarely any time that the theatres weren't occupied by
9 other services but if there was a gap, we did try and
10 definitely extra theatre lists would have been put on. 16:38
11 It didn't really make a big impact because we are
12 talking about maybe only three/four that you could do
13 in a day. Or a Saturday, I think there was Saturday
14 and Sunday working. Other areas we tried to do
15 through, as I say, the independent sector, as well as 16:38
16 seeing could any of our other colleagues in the other
17 regions could help.

18
19 But whilst all of those seem small when it came to
20 reducing your number of 2,000, it didn't make a big 16:39
21 impact because as you got more people coming in and
22 being referred, it started at this side of the screen
23 and pushed these people waiting longer. So we would
24 have had a huge referral number through from GPs
25 usually was the referral or through maybe another 16:39
26 speciality of that. We had huge numbers. I suppose I
27 think back to when you refer, Mr. Wolfe, to 2007, what
28 consultants there was in post for urology then and the
29 numbers telling us -- I'm not sure, again this is from

1 memory when would I have been leaving, had we even our
2 full capacities of consultants at that time, the six or
3 seven. But even with the six and even with extra
4 theatre and even with the independent sector, all of
5 those extra resources and modular units, et cetera, 16:39
6 whatever was happening, our waiting lists in Urology
7 continued to rise.

8 183 Q. The point has been made to the Inquiry that the
9 factoring which took place at the time of the Urology
10 review in terms of the resources needed by the Southern 16:40
11 Trust Urology Service would have been sufficient going
12 forward, but when you added in the backlogs that
13 existed at the point of the conclusion that of regional
14 review, it was never going to be sufficient to enable
15 the service to catch up. Which probably prompts the 16:40
16 following question: You were there throughout this
17 period, you've observed what Urology was able to do and
18 what it couldn't do as manifested in the waiting lists.
19 Is it fair to say that the Trust was never adequately
20 resourced to meet the demand for urological care? 16:41

21 A. I absolutely agree with that. I mean, we weren't
22 resourced for the demand of people that we had but it
23 wasn't infinite resources. I'm sorry, I have just lost
24 the screen a bit. I am interested to point out,
25 Mr. Wolfe, if I am allowed, the consultant's name. I 16:41
26 think is down the left. Sorry, thank you.

27
28 I suppose the point I would like to say when I look at
29 this, and hopefully from memory, I think Brown is

1 Mr. Brown in Daisy Hill, who was a general surgeon,
2 from memory, and all of that. What I used to ask after
3 we made an appointment, and this is just my practical
4 question rather than knowing the specialism, if you got
5 a new consultant and you knew there was X number of 16:41
6 patients waiting, I could never understand - and I did
7 ask this at very senior level - why when they came in,
8 even for just the first six months, why could they not
9 have just dealt with those that were waiting the
10 longest? To me it just seemed the practical -- rather 16:42
11 than starting a new waiting list, why did a new
12 consultant - and I'm sorry for picking out some of the
13 ones that I may not know that are there longer - why
14 did they not, as part of the business plan and the
15 day-to-day operations, be allocated to look at the 16:42
16 longest waits and try and reduce them. We would have
17 brought that up quite a bit at the Board.

18
19 Also, like Mr. Brown is a general surgeon but
20 sometimes, you know, he would have been involved in 16:42
21 urological medicine as well. It's just a generality.

22 184 Q. Do you think, upon reflection, that engagement with the
23 clinicians themselves might have been an unusual course
24 to take? Obviously you had the opportunity with the
25 leadership walks to engage with two of the nurses, but 16:43
26 do you think, upon reflection, engaging with the
27 clinicians to see where they saw the problems and
28 potential solutions might have born dividends?

29 A. Certainly we, as a Board, Non-Executives, didn't engage

1 with the consultants unless on a leadership walk. I do
2 remember coming to either the Patient and Client
3 Experience Committee or else the start of a Board,
4 Urology, the specialism, coming to hear some of the
5 in-workings to try to reduce the waiting lists around 16:43
6 urodynamics and what the specialised nurses were adding
7 to in reducing waiting lists. I remember that coming
8 to the Board.

9
10 There is no doubt talking to consultants per se is a 16:43
11 wonderful experience, and that's why I found when I
12 went out walking, should it have been to the canteen, I
13 had probably more talks to the cardiologist, the
14 dermatologist - these were people all with a big
15 waiting lists - dermatology and also Obstetrics and 16:44
16 Gynae, you would always have bumped into consultants.
17 As I say, on the interview panels - and remember I met
18 many of these people on interview panels - so I did
19 have opportunities and I did hear their problems and I
20 did try to bring them back on any concern. If anyone 16:44
21 raised a concern with me around capacity demand or a
22 risk about patients, would I have always, even after
23 5:00, late evening, have talked to the Chief Executive
24 about it. I always would.

25 16:44
26 Did we routinely talk to consultants? No, we didn't
27 because there is that line between operational. But I
28 would have talked to a lot of the consultants, not in
29 Urology as such but --

1 185 Q. Did you ever speak to Mr. O'Brien about the capacity
2 concerns that he would have had?
3 A. Mr. O'Brien, never. No, no.
4 186 Q. And why not?
5 A. Well, I don't remember Mr. O'Brien ever speaking to me 16:45
6 about clinical issues in Urology or about his specific
7 pressures. He never came to my office. He never - I
8 can't remember, I may be proven wrong - was writing to
9 me until the latter stages about that. Certainly when
10 we have been doing interviews, and I would have 16:45
11 interviewed many Urology consultants, and I think
12 Michael Young was the clinical Director and I remember
13 appointing Mr. Glackin --
14 187 Q. He was clinical lead, just to be clear?
15 A. Sorry, clinical lead. So you would have picked up -- 16:45
16 I, at an interview, you would have heard while you were
17 maybe in between while waiting for candidates, but
18 before we started the interview we always asked the
19 Medical Director, and indeed the clinical lead or the
20 associate Director, tell us about this post, tell us 16:46
21 where the vacancy is, what is the speciality that
22 you're looking for. Because a lot of consultants have
23 their own specialism, you know, be it stone, to a
24 tumour or whatever. We would have talked quite a bit
25 about the speciality. So, definitely I didn't miss any 16:46
26 of those opportunities and I would have talked to many
27 of those consultants.
28
29 If I did bump into them out in the corridors of the

1 hospital or in the canteen, I mean these wouldn't have
2 been a group that ever came over to me and said
3 anything compared to maybe some other consultants.

4 188 Q. What you are saying, in conclusion, is they, as a group
5 of consultant urologists, didn't engage with you about 16:46
6 the specifics of the capacity problem and ways that
7 they might have had in mind to address it or mitigate
8 it?

9 A. No, well not me directly, but I would have heard that
10 at an interview because we would have spent a morning, 16:47
11 I mean, interviewing or waiting for candidates to come
12 who maybe didn't turn up, and you would have heard a
13 lot up. I call that the soft information that you
14 would have gathered from consultants. So absolutely
15 you would have heard from Mr. Young the pressures they 16:47
16 were under, I won't deny that, I mean. But did someone
17 come to me specifically, to my office or write to me
18 about Urology pressures or Urology concerns? I may be
19 proven wrong but I don't remember it.

20 189 Q. Yes. In any event, through the sources we have looked 16:47
21 at, you were clearly aware of those pressures?

22 A. Absolutely.

23 190 Q. And you took the steps that you have described?

24 A. I believe I did to the best of my ability with my
25 executive team, because I was tasked with that as well 16:47
26 by the Board to do that, collectively that we should
27 write, and I did write, and also I should go. I did
28 all of that right to the end of my tenure.

29 MR WOLFE KC: Thank you. Chair?

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CHAIR: It is ten to five, Mr. Wolfe, and it has been a long day for everyone.

We will start at 11 o'clock tomorrow, weather, gritting, non-gritting permitting. Hopefully see you safe and sound tomorrow morning.

16:48

THE INQUIRY ADJOURNED UNTIL 11.00 A.M. ON THURSDAY,
18TH JANUARY 2024