Urology Services Inquiry

Oral Hearing

Day 89 – Tuesday, 12th March 2024

Being heard before: **Ms Christine Smith KC (Chair)**

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

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THE INQUIRY RESUMED ON TUESDAY, 12TH MARCH 2024, AS FOLLOWS

CHAIR: Morning everyone. Mr. Wolfe.

MR. WOLFE: Good morning, Chair. Your witness this morning is Dr. Maria O'Kane, who you will recall joined us for the first time on the 6th December 2022, which was Day 15 of our proceedings. And the transcript for that day's hearing is to be found at TRA-01412. I think in light of the fact that she has been away from us for so long and essentially technically has not been under oath during that period, she would need to be re-sworn. 10:02 10:03

CHAIR: Very well.

MR. WOLFE: I'm obliged. 10:03

DR. MARIA O'KANE, HAVING BEEN SWORN, WAS QUESTIONED BY MR. WOLFE AS FOLLOWS

MR. WOLFE: Good morning, Dr. O'Kane. 10:03

A. Good morning.

1 Q. We remind ourselves for the record that your employment relationship with the Southern Trust commenced in or about December 2018, when you were appointed Medical Director for the Trust? 10:03

A. Yes, that's right.

2 Q. I think -- I've have never been quite sure, I think you started in December 2018, but became responsible officer in January 2019, is that the way of it?

A. That's correct, yes.

3 Q. And you held that Medical Director's role through to the 30th April 2022?

A. Yes.

4 Q. Is that correct? 10:04

A. Yes.

5 Q. You had, from the 14th February 2022, been appointed Interim Chief Executive, is that correct?

A. That's correct, yes.

6 Q. And you continue in that role substantively or 10:04 permanently as Chief Executive to today's date?

A. That's correct.

7 Q. Again, we recall that we've troubled you to reply to some, I think at the last count, eight Section 21 notices, and we have your response to all of them. 10:04 After you gave evidence on the last occasion you were served with Section 21 Notice No.4 of 2023, and I'm going to ask you whether you wish to adopt that statement? We didn't obviously get the chance to ask you that on the last occasion because this notice 10:05 post-dated your appearance. So if we could have on the screen please WIT-91953? In essence you will recall this was a notice which interrogated you on an issue to do with you're initial relationship with a number of managers within Acute. You were pointing to your 10:05 evidence to I suppose a certain difficulty in what you saw as the culture of Acute in relation to the sharing of information, responsiveness to your inquiries, do you recall that?

A. Yes.

8 Q. And we'll maybe touch upon that as we go on later this morning or into the afternoon. So that's the first page of your response. And if we go to WIT-91960, and that's the last page, and your signature, 18th April 2023. Are you content to adopt that response as part of your overall evidence? 10:06

A. Yes, thank you. Yes.

9 Q. Thank you. Now, the primary purpose in asking you to return to give evidence is so that the Inquiry can hear from you in terms of, I suppose, the insight which the Trust has gained in respect of the issues, primarily governance issues, that have emerged in relation to the issues set out in the Terms of Reference, and to hear from you also in terms of issues of reform and improvement within the organisation, and I suppose to get a temperature check on how well that process of improvement has gone and, I suppose, a status check in terms of where it is at and what's still to be done. So that's the primary reason for your attendance. But I also, as part of the first section of your evidence, wish to ask you some questions about some evidential issues or factual issues that have emerged since we last heard from you. So that's the first part of your evidence which I'm going to commence now. 10:06 10:07 10:07 10:08

Could I ask you to take a look at something you said in the transcript when you were last here? It's TRA-01441. This first set of questions, Dr. O'Kane,

just to be clear, relates to the impressions that you formed as Medical Director of Mr. O'Brien. I'm conscious that in your evidence you've said you never met him directly, you've never had a discussion with him? 10:09

A. That's correct.

10 Q. Yes. And what we are looking at here, if we go down to line 14, you're being questioned by counsel about your engagement with Mr. Carroll. Mr. Carroll was Assistant Director for surgery, isn't that right? 10:09

A. That's correct.

11 Q. And you're asked "Did Mr." -- this is line 14:

"Q. Did Mr. Carroll ever speak to you about Mr. O'Brien?" 10:09

And you answer:

"A. My contact with Mr. Carroll would have been through any of the surgical meetings or any of the discussions 10:09 that we would have had in relation to Mr. O'Brien. He would have mentioned him then. But I think he found, my sense was certainly he found him difficult to manage."

10:10

So, just in relation to that, that sense that Mr. Carroll found him difficult to manage, could you help us better understand that? Was Mr. Carroll, to the best of your recollection, pointing to any specific

difficulties which he was able to give by way of example in terms of his management of Mr. O'Brien?

A. It's a long time ago since I've had these discussions with Mr. Carroll, but certainly, as I've said in that, my sense at that time was if I had asked about, you know, did he have any concerns, were there any concerns within the team, you know, made reference to what I had picked up from the Maintaining High Professional Standards Investigation in relation to, you know, the triage of records, tardiness in dictation, all of those things, you know, there was certainly a strong sense from Ronan that, you know, "that was just Aidan", everybody -- would have been the phrase that was used -- everybody would have known that you had to work round him and that -- I didn't ever pick up that there was any animosity between either of them in any shape or form, but just that in terms of helping Mr. O'Brien and the Urology Service stay in a straight line essentially, that that was definitely a challenge for Ronan Carroll. 10:11

12 Q. So, MHPS and those issues, but was he pointing to any particular example that you can recall at this stage of difficulties?

A. No. No, the discussions would have been purely in relation to what came out of the Maintaining High Professional Standards recommendations in terms of what had to be managed, 10:12

13 Q. Mmm. And did you get a sense that Mr. Carroll needed help or was he asking for help to manage Mr. O'Brien?

A. He wasn't specifically asking for help. I mean, I think, you know, particularly whenever we were working through the recommendations that came out of that to understand if they were being implemented, I think what he was describing was that it was difficult to keep a, you know, it was difficult to make sure I think that Mr. O'Brien was, you know, following the rules. And certainly, mostly we got the sense that he did. Although I mean in other parts of the statement I make reference to, you know, the fact that he hadn't been compliant over the summer of 2018 before I arrived, and then 2019, but I think we approached this as a collective team in terms of thinking about how this could be managed rather than suggesting to Mr. Carroll, you know, any particular changes in terms of what he would have to do. 10:12 10:13 10:13

14 Q. If we can move forward in the transcript. If we go to TRA-01458. And if we just go down to line 11. Again, in terms of the impressions that you formed from your discussions with colleagues about Mr. O'Brien, you say: 10:14

"The history that was given about Mr. O'Brien was that he had always been problematic. That, basically, he was difficult to manage. He felt that the system was always to blame. Didn't take any personal responsibility for anything going wrong at any point in time. I think the sense I got from people was they were hugely frustrated with having to manage him." 10:14

I don't need to bring this up on the screen, but you say in one of your witness statements, it's WIT-45034, that it was your impression that:

"Mr. O'Brien's colleagues had developed ways of not confronting him for fear of having to deal with unpleasantness but had found ways of working around him." 10:14

Do you recall saying that? 10:15

A. Yes. Yeah.

15 Q. Again, did anyone actually tell you they were frustrated trying to manage him?

A. It's quite a long time ago since these things were discussed, so I couldn't hand on heart say they used the word "frustrated", right, but I've certainly, as I've said there, I was left with a sense of this, and certainly when you look through, you know, the Maintaining High Professional Standards Investigation and the paperwork around that is fairly extensive and, you know, when you refer back to, you know, some of the comments that were made by Heather Troughton, Eamon Mackle, some of the others that were involved, there was certainly a sense that they were trying very hard to work with the system that they had and to improve it and that, you know, what was communicated to me in that, and then, you know, in discussions as we went along, was that sometimes getting Mr. O'Brien to understand the point of what the ask was, was 10:15 10:15 10:15

challenging, and that rather than actually take on board and deal with the things that should be his responsibility - and I think I made mention of it there - there was this tendency to blame the system and not take personal responsibility. And certainly that came through in Maintaining High Professional Standards documentation. And I think, and particularly in relation to not taking any personal responsibility, I have to say I was quite taken aback at the time when I read down through all of that, that there was no mention of apology for, you know, harm caused to patients, or in creating, you know, the challenges to the system, not bringing to the manager's attention, you know, the backlog of untriaged referrals, the lack of dictation - the way that was being managed, that lack of insight, and that's what I described it as being at the time, I think was the one overriding sense I was left with in relation to what had happened in the past. 10:16 10:16 10:17 10:17

16 Q. I'm struck by your evidence that you never actually met Mr. O'Brien? 10:17

A. No.

17 Q. And I wonder whether, when you reflect upon it now, whether you feel that, as Medical Director, when you're getting this sense from people you're speaking to or from what you're reading in the report, whether you should have deployed somebody from your team, or yourself, to taking a more direct interest in this difficulty by either sitting down with the Urology team 10:17

or, indeed, sitting down with Mr. O'Brien, or both, to try to see what exactly was the problem?

A. So my role as Medical Director was to professionally manage doctors and to support the governance systems within the Trust. And, you know, certainly in terms of my review of the Maintaining High Professional Standards Report, which was undertaken before I arrived, there had been numerous attempts at this by very able people from a variety of backgrounds, you know, through a series of medical managers, a series of operational managers, to try and address all of this. And I think as I've written in another bit of my statement, you know, we were trying the traditional routes in order to manage Mr. O'Brien. He was not -- any other doctor who would be managed under Maintaining High Professional Standards would normally be subjected to the same process. You know, either in my role as I undertook it in the Southern Trust, or when I was involved in this work in my previous Trust, this is the way we would have approached this. And I think, and I've put it in as part of my reflection in relation to the Section 21s, I think what I came to an understanding of late was that the usual approaches to all of this did not address this problem. So I can't think of another case that I've been involved with over the years in relation to Maintaining High Professional Standards were there would have been that level of input from so many experts in terms of trying to manage the way an individual works that it would not have got

10:18 10:18 10:19 10:19 10:19

that person over the line, or got to a decision probably a bit sooner. So this is highly unusual. And you know, he was -- as I say, all of this was explained to him at various stages. He was asked about the management of all of this and, again, you know, when he 10:20
was under review, when he was being closely monitored, we were able to see that that made a difference, it took that level of containment to actually get him to the point of delivering on what he was supposed to be doing, but in between times, you know, if there was 10:20
distraction, for whatever reason, you know, when Martina Corrigan was off [redacted], or when, you know, the following summer whenever, sadly, [redacted], it fell by the wayside and he didn't declare to us that he hadn't been undertaking 10:20
the work that we had tasked him with.

So, you know, I know that this has been extremely difficult in relation to manage, but I have to say in relation to all of the cases that I've managed over the 10:20
years, this has been the most problematic of all.

18 Q. Yes. We'll go on in due course to look at the issue of idiosyncratic practice and the steps that the Trust has now got in place to, I suppose, focus on what might be described as low level concerns. So we'll look at that 10:21
directly in due course. But just in light of what we have just discussed, do you consider that there are lessons to be learned here? Your last answer was, "Well, we were managing this in just the way we would

manage everyone else." There was a template there, "I had the experience from elsewhere of managing people successfully according to this pathway, but now I see that it didn't work here." So what's the lesson in all of that? 10:22

A. So, I have to say other doctors I have been involved with in a similar process have found this extremely humiliating and quite a shameful position to find themselves in and have been preoccupied with the impact that their behaviour has had on the patients, right. I 10:22
was not picking this up with this doctor that was being managed in this process. And I think on the back of all of that, if we'd had better governance systems around this at a much sooner stage I think we would have got to the crux of this a bit sooner and realised 10:22
that the difficulties probably couldn't be resolved using the usual means. So as a result of all of this, and I think I've spoken about it in previous evidence, I, along with the Director of HROD, we have completely revised our approach to managing doctors in difficulty. 10:23
So, I set up oversight groups, we pulled in a lot more information in terms of a governance heat map, if you like, of how the doctors function, in relation to how all of that is reported through, and then certainly when it comes to re-validation and the different steps 10:23
that doctors have to step through, that all of that is scrutinised in great detail. And I think we are a lot more assertive now in relation to, you know, pausing the system and going back and having a very thorough

look at, you know, the environment the doctor is working in and what their practice has been, you know, if presented with any difficulties now. And you made mention of the low level concerns works. So that has been started over the last six to nine months within the Trust in earnest. We've had over 60 of the medical managers through that, or people involved in medical management, whether they're medical or not, through all of that in terms of addressing those concerns and, again, we're beginning to see that we are getting in at an earlier stage in terms of supporting doctors in difficulty to help them through, and by and large that has been really successful in terms of how we get people through this system. 10:23 10:24

19 Q. I'll pull some of that material up later. Just in terms of the sequence it's a bit out of time to do it. Sorry to cut across you, I want just to move on to one sort of final observation you've made in respect of Mr. O'Brien. If we go to one of your witness statements at WIT-45033. And you're recording at paragraph 28.1 that -- sorry, 28.1 and 28.2, that prior to the concerns that were raised in June 2020 in relation to Mr. O'Brien, you had limited engagement with all of the staff in Urology Unit. Your main points of contact were through one-to-one monthly Associated Medical Directorate group meetings, and that was primarily with Mr. Haynes. And then over the page, or, sorry, down the page, regular contact with operational management including Mr. Carroll and 10:24 10:24 10:25

Mrs. Corrigan.

So, if we move forward in your statement just over, down the page please, at 30.1, you say:

10:26

"From my limited interactions with them..."

- and Mr. Haynes, Mrs. Corrigan and Mr. Carroll I think you're referencing there:

10:26

"...my sense is that they did and do work well together, with the exception of the working relationship with Mr. O'Brien."

You say: 10:26

"My impression is that the remaining staff had the greatest respect for each other regardless of discipline and were very professional in their interactions with their patients and each other. They 10:26 appeared to work well together outside the challenges of having to manage and work with Mr. O'Brien."

So, are you intending to convey the message that exceptionally across the team of urologists, 10:27 Mr. O'Brien did not work well with his colleagues?

A. Yes.

20 Q. And struck by the fact that your contact within Urology was limited, as you have described, what was, I

suppose, your source of information, and what was the information that led you to form that view that he didn't work well with his colleagues?

A. Well, in my discussion with, you know, meetings with Mr. Haynes in relation to concerns that he would have had, you know, primarily about medical staff, the person that would have been mentioned most frequently, you know particularly as we were working our way through Maintaining High Professional Standards was, or not working our way through it, in the aftermath of it - because it had finished before I arrived - was in relation to ensuring that the system worked reasonably smoothly. And, again, it was that it seemed to be that Mr. O'Brien had one way of working and everybody else worked as a team, was the way I was left with that. 10:27 10:28 10:28

Now, again, I don't think there was any animosity there at all, I never picked up that this was aggressive in any shape or form, but it was just again this sense that Mr. O'Brien had to be worked round, whereas the others could function together really well as a team. And, you know certainly, you know, as my relationship with this team has continued, and deepened I think in the course of the Inquiry, I see that at large. They get on extremely well, they're very professional, they're very patient focused, and they embrace I think challenge and change and move on and get that done and, you know, are very enthusiastic about the work that they do. And I'm not now picking up any sense at all 10:28 10:28

that people are having to work round any individual in order to get the best outcome for the patient, they are working as a team, and I think that was always there but I think it's not now diluted by some of the workarounds that had to go on in relation to Mr. O'Brien.

21 Q. And just to be clear, your, I suppose, informant for these impressions was primarily Mr. Haynes on the clinical side?

A. It was. But it also came from the, as I say the extensive work that was done around the maintaining High Professional Standards work, the whole history of that, and then the discussions that I would have had with the series of managers who were involved with Mr. O'Brien in the course of all of this, whether that was Ronan Carroll, or Martina Corrigan or, you know, people who had previously been involved with Mr. O'Brien, such as Eamon Mackle, or Heather Troughton, or others, there was this sense that the team worked well but Mr. O'Brien did not work in the same way as everybody else.

22 Q. Would it be fair to suggest to you that your sense of this, the sense that, as you suggest here, there wasn't much respect for Mr. O'Brien, has been to some extent exaggerated by your knowledge of, I suppose by what we know now, to put it in those terms?

A. Mr. O'Brien was, and I'm sure is, was incredibly popular among staff in the Southern Trust. And, again, you know, I had people who approached me at various

stages to say to me that they felt how he was being treated was very unfair, that he had always been very kind and very supportive, and all of those things, and I have no doubt personally Mr. O'Brien, you know, has always had great relationships with people. Right. I wasn't so much interested in that, I was interested in the professional side of this actually. How was this relationship impacting on the functioning of the team and the outcome for patients? And, you know -- and, again, as I say, there was never any animosity picked up in the midst of all of this. There were slight tensions that I noticed came through in terms of some of the reporting that was done in relation to maintaining High Professional Standards where there seemed to be this sense that if Mr. O'Brien was challenged, you know, he would take legal redress and all of that, and that seemed to be a threat that was around - rightly or wrongly, I don't know - but by and large Mr. O'Brien was very highly respected, very well liked by staff, but the bit I was interested in was patient safety. 10:31 10:31 10:31

23 Q. Again, getting back to what we can learn from this?
A. Yes.
24 Q. My sense from your evidence is that in terms of the time when you're hearing this stuff, it's before 2020, you're getting through Mr. Haynes, Mr. Carroll, Mrs. Corrigan, these impressions of a senior clinician who is difficult to work, isn't a team player, "we have to work around him", and yet there wasn't any 10:32

particular initiative, other than the monitoring plan, or the action plan as we call it, to get to grips with him. Is that the way it would be dealt with today?

A. The attempts that had been made were through job planning process, appraisal process, the usual governance procedures that are in place for doctors and, again, the history with Mr. O'Brien had been that there was delays in all of those systems, in that, you know, it took him a while to get to actually undertake his appraisal, the job plans he was very tardy in signing off, all of those things. So there was something about, you know, the conversations that were had with him weren't landing him where he needed to be. There was always more work to be done, there was always more information that had to be brought to bear to improve in all of this, and the deadlines just kept getting pushed back and back. Right. So that, together with the discussions that were there, suggested to me, you know, together with the fact that he had been through a Maintaining High Professional Standards Investigation... 10:32 10:33 10:33 10:33

CHAIR: I think we have a tendency to speak quickly, but if we can slow down, because not only the stenographer has to get everything you say, but we have to try and keep a note as well. So if you can slow down, please, doctor. 10:33

MR. WOLFE: So, yes, you were saying - you were taking us through the various conventional governance steps in respect of Mr. O'Brien and you were pointing out delay

or tardiness in respect of compliance with those.

A. Yes. So when I think about that history, and I suppose - and I appreciate they've only been recently published, but when you look at the recommendations that have come out of the Neurology Inquiry in relation to appraisal, those mirror some of what we were dealing with in relation to Mr. O'Brien. And in relation to job planning obviously, you know, very tardy to sign off in relation to that too. I had, you know, he had been part of a Maintaining High Professional Standards Investigation. As I became increasingly familiar with the case, you know, I became aware of other aspects to his practice that there had been worry about previously but had been closed off, and I had referred him to the GMC. So this was someone that I was concerned about. 10:34 10:34 10:35

25 Q. Mm-hmm. And I suppose the focus of my question is, you, and those employed at senior level within the system, knew about these shortcomings, the non-compliance, the team work issue, the delays in co-operating with job planning appraisal. That's your evidence, or your perspective on it, and I'm sure Mr. O'Brien may have a different perspective. But from your perspective, with the knowledge of those things, what was the reaction to it? What was the response to this knowledge? And do you think it was satisfactory, looking at it from today's standpoint? 10:35 10:36

A. So, the overall response to this has been, as I mentioned earlier, a revision in our systems and processes in relation to how we manage appraisal,

re-validation and job planning. We now have much tighter structures around all of that. There's very timely escalation in relation to any of the challenges within all of that, and it's dealt with, you know, personally and in groups to try and help people get over the line. So, when I look at the history of the appraisal and job planning before, the numbers were low. I mean as of today we're sitting at over 90% compliance with appraisal. And job planning we're sitting at over 60% of compliance with that as we come into the new financial year. That's much better than it was previously. I think again with the training that has been done, you know, in connection between the Medical Director's office and the Director of Human Resource's office in relation to bringing all levels of staff to a greater understanding of their roles and responsibilities in relation to speaking up, whistleblowing, reporting low level concerns, you know, how that's escalated. You know, we've done training in relation to all of that to improve the visibility of all of that, and the systems and processes that are in place now are taken very seriously. I now get monthly reports in relation to how all of that is progressing, it's discussed at Senior Leadership Team, Trust Board, it's through the whole organisation in terms of being mindful that these systems and processes are there for a purpose and that we need to take them seriously and respond to them if we have concerns.

10:36 10:37 10:37 10:37 10:38

26 Q. But you're not saying - and we'll come later in your

evidence to look in more detail at some of those improvements - but just to be clear, you're not saying, are you, that how the Trust responded to this in real-time through those years until 2020 was adequate even by the standards of the day? 10:38

A. I think that, at the time any doctor who was coming through the Southern Trust would have got the same response. And my sense is, from the history of doctors in difficulty in the Southern Trust, that that approach that was used, even though it was light touch, actually 10:38 was helpful in other doctors responding to it and improving. Right. The same approach as was prevalent within the organisation was used towards Mr. O'Brien at that point in time and did not deliver, you know, the improvement that was actually needed in any sustainable 10:39 way, other than when he was constantly being monitored in relation to his performance to ensure that he delivered what he was employed to deliver.

27 Q. That doesn't directly answer my question. If he's getting, that is Mr. O'Brien is getting a response that 10:39 would have been used with every other doctor...

A. Yes.

28 Q. - with success.

A. Yes.

29 Q. The impression I get from your evidence is that you 10:39 were aware, and others were aware that he was, even though broadly complying with the action plan and the monitoring plan, he was still causing problems, and they went unaddressed. Is that fair?

A. In terms of the problems we were aware of that had been identified through the Maintaining High Professional Standards Investigation, those problems were being monitored. There was nothing else concrete coming through at that point in time in relation to his performance and behaviour. So it was when we got to June 2020 that we then realised that there were further problems in relation to the management of cancer patients, but none of that had come through in maintaining High Professional Standards and none of that had come through in various discussions that we'd had on the way through in terms of ensuring that he was compliant with the recommendations that came out of Maintaining High Professional Standards.

10:40

10:40

30 Q. But what was coming through? And we heard from you earlier on, this is through your conversations with Mr. Carroll, Mrs. Corrigan, Mr. Haynes, this sense still that he wasn't performing as the rest of the team would be expected to perform, you had to work around him, there was always this tension, is the impression from your evidence?

10:40

10:41

A. Yes, but that was a sense, but in terms of actually, you know, that translating into, you know, anyone saying "I have particular concerns about this patient", "I'm concerned that Mr. O'Brien isn't doing A, B and C", there wasn't anything concrete said in relation to that. I think the frustration certainly at that time was in relation to the monitoring of these different areas and making sure that he was compliant, and that's

10:41

where the focus was. But in relation to other concerns that, as I say, those weren't clearly identified then until June 2020. If they had been, you know, we were very vigilant in the system and, you know, in relation to all doctors at this point in time, because we did realise that some, you know, that the systems and processes in relation to appraisal and re-validation, or leading into re-validation, and particularly job planning, were not as tight as they could be. So, we were really vigilant then to any concerns about doctors in the system at that point in time. 10:42 10:42

31 Q. Let me take you to June 2020 and something you said on the last occasion. If we go to TRA-01467. Just the second half of the page, please. So it's from line 14, and I'm asking for your observations on: 10:42

"When Mr. O'Brien retired from the Trust on 17th July, when we had discovered..."

- sorry, I'll start again: 10:43

"Mr. O'Brien retired from the Trust on 17th July. When we had discovered the difficulties after, I think I was informed on 11th June in a clinical team, principally Mr. Haynes and Mrs. Corrigan had been working on an email that they had received that suggested there was a discrepancy in two waiting lists, and that caused them a bit of concern. When they worked their way through that they realised there wasn't a discrepancy, but what 10:43

they also discovered on the back of those explorations were the concerns then around the cancer multi-disciplinary team meeting."

So, what you appear to be saying is you were informed about a discrepancy on the 11th June by Mr. Haynes? 10:43

A. Yes.

32 Q. Mr. Haynes and Mrs. Corrigan worked their way through that at that time because there was a bit of concern, as you describe it. But when they worked their way through it they realised that there wasn't a discrepancy? 10:44

A. Yes.

33 Q. Can you explain to me just what you mean by that and what your knowledge of that was? 10:44

A. This is a clinical system that I haven't used in recent times, so I'm not familiar with all of the nuances of it. But, as I under - and I think it's a Cloud system, so as you update it, it changes. And the - sorry.

34 Q. I don't mean the technical information around the two patients concerned. 10:44

A. Mmm.

35 Q. It's the question of when they realised that there wasn't a discrepancy, what is your understanding of that? 10:45

A. I think we realised that there wasn't a discrepancy in and around late September, whenever they had gone back and revised all of this, looked at the comparisons across the different patient lists that they had, and

realised that the two patients that we thought weren't on - were on one list and should been on another list, weren't. So this was a red herring in terms of these two patients, thankfully. But, you know, what was fortuitous in all of that was that it provoked a review of systems and processes in relation to the management of cancer patients in relation to Mr. O'Brien's practice, and that's when we then realised that there was a problem in terms of the cancer multi-disciplinary teams and in terms of those patients getting access to that, being on surgical lists, all of that area, and we had been - certainly in terms of the information I had available to me in what was looked at in the Maintaining High Professional Standards Review, I hadn't been aware of that, until that point. 10:45 10:46 10:46

So these two patients were a red herring, but actually they were - it was fortuitous that that was approached in that way, because then that took us into realising that there were much bigger concerns about other patients. 10:46

36 Q. When you say "these two patients were a red herring", the initial concern, as the Inquiry understands it through Mr. Haynes's evidence, is that when he received an email from Mr. O'Brien in relation to a set of patients who were to come in for surgery, he initially formed the view that the two patients weren't on PAS, they weren't on the Trust's waiting list, and that then caused him to report to you on the 11th June, and then 10:46

in turn with Mrs. Corrigan, they carried out I think what you've described as a scoping exercise to see if there were any other problems, and as you say fortuitously you got to that and that's why, in essence, we're here today. 10:47

The red herring was identified as being a red herring by September 2020?

A. Yeah, in and around, yes. I think it was as we were, as we were working our way - as we went back to track what happened with those two patients in the context of what became known. Now, I became aware that actually then those two patients hadn't been part of that cohort of patients, that we then began to identify as nine Serious Adverse Incidents and then concerns about significant other numbers of patients, yep. 10:47 10:48

37 Q. And the person who spotted it as a red herring was who?

A. I think between Martina and Mark Haynes, I think - Martina Corrigan and Mark Haynes - I think when they revised the data and looked at the pathway through for those patients they realised that those two patients weren't patients that we should be concerned about based on the original information. So it would have been they who brought that to my attention. 10:48

38 Q. And it is the fact that the Department was briefed about the circumstances in which the Trust moved from a concern about those two patients into, if you like, this deeper dive, this scoping exercise in relation to Mr. O'Brien's practice, and I just want to look at what 10:48

the Department was told.

If we go to SPP - we don't often use that prefix, but it's SPP-00629. And this is now 14th October 2020, and this is a report to the Department of Health in relation to Consultant A. And if we scroll down, some of the background is explained. If we just go down a little further, please, next page. So it's explaining that on 7th June 2020, the Trust became aware that two out of 10 patients listed for surgery under the care of Consultant A were not on the hospital's patient administration system at this time. 10:49 10:50

"As a result of these potential safety concerns a review of Consultant A's work was conducted to ascertain if there could be wider service impacts." 10:50

And then the wider service impacts are explained. Going back to the red herring point, I think you've explained it was discovered as being a red herring the previous month in September, the Department is getting an explanation here as to why further concerns emerged, or the trigger for those further concerns. The reading of that first paragraph suggests that the two out of the 10 patients were not on the patient administration system at the time, whereas, as I understand your evidence, that had been corrected, or understood to be wrong in the previous month? 10:50 10:51

A. In and around. So I think it was in the course of

preparation for this. And I think, you know, when I reflect on this, this could have been more clearly written, and a sentence could have been put in there to say that, you know, something along the lines of, you know, when we've undertaken this more comprehensive review or scoping exercise, that we've realised that those two patients aren't patients that we should be concerned about, that actually they have been on the right lists, but actually what we've discovered as a result of all of this, you know, has been, as you say, eventually what has led to this Public Inquiry. 10:52 10:52

So I could have put - Melanie and I could have put a more clearly stated statement in there basically to explain out the end of that, that those two patients, as I say, were - and I don't like referring to anybody as a "red herring", but I know that was my language, but certainly fortuitously those patients were discovered and led us into understanding about all of these other patients. 10:52

39 Q. Yes. So just to be clear, what you had discovered in September or thereabouts...

A. Yeah.

40 Q. - was that these two patients were in fact on the waiting list and that the initial concern about it was unfounded? 10:53

A. Yes, the initial concern was unfounded, but the rest certainly hasn't been unfounded. Yes.

41 Q. Yes.

A. Yep.

42 Q. Do you consider that, when you look at this, the Department may have been misled by how the situation was described?

A. I don't, I don't remember, because bearing in mind this paper was prepared for what was to become the Urology Assurance Group with the Department of Health, I haven't looked recently at the minutes from those meetings, but I am fairly confident that we would have explained to the Department that those two patients weren't patients we were any longer concerned about, but that may or may not be in the minutes, but I do know that that was certainly communicated at a point in time. 10:53 10:54

43 Q. Just to be absolutely fair to Mr. Haynes, who was I suppose your primary informant around these issues. 10:54

A. Mmm.

44 Q. I think it's fair to say he cannot recall a precise date when he discovered that the two patients were in fact on the waiting list, but I think it accurately characterises his evidence to say he's doing his best in terms of his recollection, he thinks his discovery of that issue came more closely to the date when he came to give evidence to the Inquiry, which would have been in or around November 2022. Your evidence by contrast, both on the last occasion and today, is unequivocal I think, that it was discovered - the "red herring", as you put it, was discovered in the autumn of 2020. Can I ask you just to comment on Mr. Haynes's 10:54 10:55

evidence in that respect? Do you think he is clearly wrong, in your view, to put a much later date on it?

A. I haven't had a specific conversation with Mr. Haynes about this, but my sense of the realisation, as I say, was in and around September/October time, and probably a bit more fulsomely after that, but I think that came out of discussions back and forth that I would have had with Martina at that point in time. So I - as I say, I haven't spoken to Mr. Haynes about when, you know, specifically, you know, did he think it was a different date, I don't know. 10:56 10:56

CHAIR: Mr. Wolfe I hesitate to interrupt but, you know, I think we're spending an awful lot of time on what is essentially an admitted point, that we had two cases that were identified as a catalyst that led to greater discovery, and the actual timing of when it was discovered that those two cases were in fact on the patient administration system and were not, are really not the issue here. The issue is what that led, the discovery that that led to. So I think we're spending an awful lot of time on what is, to my mind, a minor issue. 10:56 10:56

45 Q. MR. WOLFE: Let me move on then to the point that you make, that notwithstanding the red herring, notwithstanding what was in essence, let's call it neutrally a mistake of interpretation, Mr. Haynes, with Mrs. Corrigan, went on to discover issues or shortcomings with Mr. O'Brien's practice that you have no concerns about, is that fair? 10:57

A. That's true, yes.

46 Q. And when I say "no concerns about", you've no concerns about the accuracy of the conclusions which they drew from their investigations?

A. No, because I think, you know, their concerns have been dealt with through Dr. Dermot Hughes' Serious Adverse Incident reporting on the nine cases, and then the work that we have undertaken to date in relation to identifying more than 2,000, or reviewing more than 2,000 cases and then identifying, you know, within that, the stratification of areas of concern. So I think that that work has shown to us that we were right to be concerned. 10:58 10:58

47 Q. Now, just briefly. One of the concerns that was identified and referred to Mr. O'Brien in correspondence in July 2020, was in relation to a concern about other patients not appearing on waiting lists. Let me draw that to your attention. It's at AOB-02534. So Mr. O'Brien is written to by Mr. Haynes, and he is in essence telling him to stand down from any clinical activity, and he sets out within the body of the letter the steps that were taken in light of the 7th June email. And if we just move through that to page 38 in the sequence, it's four pages down, and just scrolling down. So one of the issues raised with Mr. O'Brien is that there were other patients on Mr. Haynes and Mrs. Corrigan's estimation who had not been added to waiting lists, as we can see here, when they should have, and were mostly done a few days 10:58 10:59 11:00

before Mr. O'Brien had the patients admitted. It goes on to say:

"One patient re-admitted as emergency and had their stent removed under a different consultant. There had been no plan to admit them by Mr. O'Brien." 11:00

Is that what you were aware of at the time? Were you aware that there was a concern that patients had not been placed on appropriate waiting lists? 11:01

A. Can you remind me what date this was from, please?

48 Q. This is July 2020. So your attention was drawn to what you now accept was a red herring on the 11th June. Mr. Haynes, with Mrs. Corrigan, conducted certain further investigations by way of a scoping exercise 11:01 leading to this letter to Mr. O'Brien in advance of his retirement date. So the question is: in general terms were you made aware that, quite apart from the two patients that you've said was a red herring, that there was nevertheless a broader concern that there were 11:02 other patients who had not been added to waiting lists?

A. Yes, and I think I much prefer the word "catalyst" I think to "red herring" - I'm feeling anxious about having said that! I think that, you know, as I recall this, and in terms of how this process unfolded, on the 11:02 basis of Mr. Haynes raising concerns about these two patients and then the work that he and Martina Corrigan undertook in relation to understanding or searching to find out were there any other patients missing, I think

this started to come to light, and then based on all of that they began, I think with the other people that worked with them, to understand just the implications of all of this in relation to these patients and how they were being managed. So I would have been - I would have been aware that that was the growing pattern or concern in relation to all of this throughout the summer, yes. Yes.

49 Q. Before we leave this area, can I just bring you to something you said in your witness statement about it, or one of your witness statements. WIT-45159. If you just look at - just scroll down. Scrolling down. You have recorded "Patients found" - these are concerns about Mr. O'Brien, and the left-hand margin: 11:03

"Patients found to not have been added to lists for required surgery 7th June."

And you go on then to comment on what was done, you say: 11:04

"When this was discovered a review of Mr. O'Brien's clinical work was immediately commenced by Mrs. Corrigan to determine the extent of this problem. Ongoing discussions were held with the relevant directors throughout the summer until Mr. O'Brien retired on the 17th July. Progress to date in the timeframe 1st January 2019 until 31st May 2020 was formally reviewed by directors oversight on 6th July. 11:04

I discussed the unfolding concerns with Joanne Donnelly of the GMC, the Deputy Chief Medical Officer, and with the Department of Health."

- the latter being on the 24th August, and then you go on to detail some further discussions. 11:05

I'm struck that although you were aware at the time of finalising this statement that in fact these two patients, while being the catalyst for further investigations were not in fact the subject of any concern at all, but you don't take the opportunity within your statement to address that. Should you have? 11:05

A. Yes, I think I should have added that information at that point in time just as it unfolded, and I think, you know, we have been - there is the balance between, you know, looking at smoke signals and those two patients that I think who were the catalyst for this were definitely, you know, took us to other smoke signals in the system, and those have to be tested out to ascertain whether or not patients have come to harm in the process of all of that. And I think by that stage I wouldn't have been clear - by July/August I wouldn't have been clear if any of those patients had come to harm. I think as we got farther through the autumn and the winter that became increasingly obvious to us, certainly as Dermot Hughes pursued the Serious Adverse Incident Review. So, yes, in retrospect I 11:05 11:06

could have added in more information in relation to that.

50 Q. Can I then take you to a new issue? It concerns the events of the autumn of 2019, it was discovered that during a period of ill-health within Mr. O'Brien's wider family, he had not complied with what was expected of him in terms of dictation and triage, and it was determined that Mr. McNaboe would meet with him, and that's the context for what you say - if we go to TRA-01522, and at line, just line 9: 11:06 11:07

"I think Mr. McNaboe and Mrs. Corrigan wrote to Mr. O'Brien offering to meet with him in November. He came back to say he didn't have enough notice and cancelled the meeting but that would have been Mr. O'Brien's pattern." 11:07

Can you help us with that? You refer to Mr. O'Brien's pattern, which I think is intended to suggest that he didn't come willingly to meetings, or cancel meetings when he was expected to attend them, is that what you intended to suggest? 11:08

A. Well, I think this resonates with what happened during the Maintaining High Professional Standards Investigation, when I think it took Dr. Chada nine months to, you know, get through her investigation in relation to producing a report, and that was largely down to the fact - now bearing in mind this is the most important investigation any doctor can have in their 11:08

career. My experience of that always is that, you know, if you had that hanging over you, you would prioritise it above all other things. Right. But it took Dr. Chada, who is very skilled and experienced in this area, nine months to pin this down to get that report developed because of Mr. O'Brien's approach to meetings, and here it was again. 11:09

So this was, this was the outworkings of the 2017/2018 recommendations in relation to Mr. O'Brien. He knew that the Trust was taking this seriously. There had been a lot of work done around it. They wanted to speak to him about it, and when they offered to meet with him in a timely fashion, he came back again then to say he didn't have enough notice and he cancelled the meeting. That was his pattern, and that - when you look at the process throughout Maintaining High Professional Standards, when you look at the history of any of this, that tends to be my sense certainly of how Mr. O'Brien approaches what should be really important meetings for any doctor. 11:09 11:09

51 Q. Okay. There's obviously more than one perspective on all of this. Mr. O'Brien would no doubt say, and the records perhaps bear him out, that he made himself available at various times to meet Dr. Chada, but it was sometimes difficult to get a mutually convenient date. There were also issues about supplying him with material that he needed to be aware of before subjecting himself to an important, in fairness to him, 11:10

interview, which could affect his professional standing.

On the McNaboe incident - I don't have the email reference to hand, but a date was suggested for the meeting that coincided with Mr. O'Brien's attention to cancer review clinics, if my memory is correct. So do you think it entirely fair to criticise his willingness to attend meetings in the way that you have just done? 11:10

A. I completely understand that there can be clashes with very important clinical work, but in that situation I think what most doctors would reasonably do, given what Mr. O'Brien has been through in terms of maintaining High Professional Standards, would realise that there should be an urgency about complying with the requests and that they should come back themselves. You know, if they're not being offered other appointments, come back themselves with suggestions around when that might be done. So for example, on a Tuesday morning I know that Martina Corrigan had arranged with him to have additional administration time above and beyond what the other consultants were being offered in order to help him get his paperwork done. That might have been a time, for example, he might have suggested to Mr. McNaboe and Mrs. Corrigan that he could have met, or any other opportunities within his diary. But I'm not aware that he would have offered those appointments himself. He would have waited for other people to suggest them to him. 11:11 11:11 11:12

52 Q. We'll come to the issue of whether he was provided with support for his administrative work in a moment. But, why, upon reflection, was the meeting with Mr. McNaboe important or significant?

A. That meeting was important because it was to ask Mr. - 11:12
remind Mr. O'Brien that he was to complete I think both appraisal and job planning, but essentially job planning, that needed to be done.

53 Q. And it didn't take place in a formal setting. We understand that there was a brief corridor conversation 11:13
on Mr. McNaboe's account, or Mr. O'Brien's account - I can't remember which. So from a Trust management perspective, an important meeting didn't take place and the manager didn't make it take place, is that fair?

A. I think it didn't take place in the way it was 11:13
originally intended to take place, and I know that when I came back to ask about that, I think it was then in early 2020, it was still being pursued at that point in time.

54 Q. Another issue. You've said, if you go to the 11:13
transcript again at 01545, just scrolling down. Yes. You were asked about your recollection of the culture of the Board, and you recall that:

"At the end of Trust Board each of the executive 11:14
directors were asked for any comments."

This is during your time as Medical Director of course:

"Up until that point I hadn't brought anything to the Board because it wasn't anything particularly outside the confidential section that needed to be raised, until August 2020 when I was asked the question and I raised it in relation to Mr. O'Brien. I think the feedback that I got indirectly at that point in time was that it shouldn't have been raised in that way."

Could you help us understand - I see there wasn't any particular follow-up on what you said. What were you told about the way that you had raised the O'Brien issue at the August 2020 Board meeting? 11:15

A. My recollection of that was I had a - I think it was with Shane - Shane and I had a - Shane Devlin, the Chief Executive at that point in time - and I think in my one-to-one soon after that he had mentioned to me that some of the members, now he didn't say who they were, some of the members on the Trust Board felt it was inappropriate that I had raised this, and my response to him was, "Well, I was asked the question so I gave the answer, that's what that part of the agenda is for", and he said "I completely agree with you. I'm just making you aware that some people may not have been happy with that approach", and you know, I said to him "Well, if I was faced with that again I would - you know, and I had concerns and I was asked the question, I would answer the question", and he said no - you know his view was the same, I think the same as mine, which was "Yes, you were asked the question, you gave the 11:15 11:15 11:16

answer, you had concerns about it." You know, it wasn't a surprise to either of us because we had some conversations back and forth that this was being pursued. But that's what that's in relation to, he had mentioned to me at that time.

55 Q. Yes. I must profess a little confusion about the process. So 27th August 2020 was the first date on which the Non-Executive Directors, and perhaps some of the Executive Directors, became aware that there was this Aidan O'Brien issue? 11:16 11:17

A. So, if you...

56 Q. The Early Alert - just to fill in some of the background.

A. Sorry.

57 Q. The Early Alert that went to the Department at the end of July/start of August, had, as we'll discuss later in more detail, only been copied to Mrs. Brownlee, amongst the Non-Executives. So if we bring up TRU-158997. There was a so-called Trust Board Workshop on the morning of 27th August, leading into a full Board meeting, albeit remotely, in the afternoon. TRU-158997. 11:17 11:17

So this is the workshop. I don't need to bring you to the opening page. The Chair left the meeting at that point, Mrs. Brownlee - it's well worn ground. So you brought to the Board's attention - what's described here is: 11:19

"SAI investigations into clinical concerns involving a recently retired consultant urologist. Members asked that this matter be discussed at the confidential Trust Board meeting following the workshop."

11:19

Is that the point that you're getting at, that you were told that you should not have raised the issue in the way that you did? Is the point that it shouldn't have been raised at the workshop, it should have been brought to the Board meeting, or have I missed the point? 11:19

A. I think I was being asked at that point to bring it more fulsomely to the Board meeting, but it wasn't mentioned to me at that point in time that anyone thought it was inappropriate. 11:20

58 Q. Okay. And then if we just go to the Board meeting at WIT-90951. And, again, bottom of the page, it's again - do you know why it's being described as "SAI" when we know that an Early Alert, based on the catalyst event in June leading to the scoping exercise and the revelation of other issues, why it's being described as an "SAI"? 11:20

A. So I think probably the language around that would have been, we would have been describing what was ongoing as, you know, concerns about serious adverse incidents - I don't remember exactly. SAI means - using capitals like that particularly means something particular in Northern Ireland. So I think what was probably being, or would have been discussed at that point in time was 11:21

that we had concerns about there being Serious Adverse Incidents and we were undertaking a review at that point in time to understand just the depth and breadth of all of that. So that's what would have been discussed at that time and I - but at that point - I don't think at that - not on 27th August, I don't think we would have had that firmly, we wouldn't have been firmly of the opinion that these were all Serious Adverse Incidents and be getting into the realms then of approaching Dr. Hughes about undertaking the investigation. 11:21 11:21

59 Q. Okay.

A. I may have got the chronology wrong, but it is probably a misnomer in terms of how it's actually recorded.

60 Q. Yes. We'll come back to this issue in a slightly different way later, bearing in mind when the Early Alert was issued, and bearing in mind that the Early Alert isn't mentioned at this first opportunity meeting, if you like. But just going back to where I started in the piece that jarred with me in your earlier evidence, where you said that you were told that you should not have brought this issue in the way that you did, and that was a conversation with Mr. Devlin as you've now explained, and he agreed with you that it was appropriate to bring it to the Board at that time and in the way that you did, is that your evidence? 11:22 11:22 11:22

A. We didn't discuss - Mr. Devlin didn't form an opinion about whether it was appropriate or not.

61 Q. No, he was reporting what somebody else had said to him.

A. Yes. And, you know, the essence of our discussion, from my memory, was around essentially the communication of the information, that you know what I - I mean it was fairly concrete, I was asked the question and I gave the answer, you know. Do you - "As Executive Medical Director are there any concerns you wish to raise?", that would be the normal question. And I said "Yes, I've got a concern here." 11:23

62 Q. Right.

A. Yeah.

63 Q. And, again, just to be clear in the way that you have now explained it, does that suggest that you hadn't gone to that Board meeting or, indeed, the earlier Board workshop, with the intention of revealing what was, I would suggest to you an important event, the use of an Early Alert, and the investigation, the ongoing investigation of these initial concerns in respect of Mr. O'Brien, that wasn't your intention until you were asked the question? 11:24

A. If I had - it was certainly weighing on my mind because I was aware that this was a Board that, you know, I came in to, that should have been through the process of the Maintaining High Professional Standards Investigations and Report in relation to Mr. O'Brien previously. So they had - they should have had a whole history with Mr. O'Brien and what unfolded in relation to all that of before I ever arrived. I, I think, 11:24

would have assumed that they would have been familiar with that whole history, and I would have brought this by way of saying to them, you know - and it was an assumption on my part, which I probably should have tested out beforehand that - they would have been 11:25
familiar with all of that, and what I was saying to them was the person who was, you know, essentially drawing their attention to the fact that the same consultant I now had concerns about again. But without formulating it all, without all of the information 11:25
around it. Because, you know, at that point we weren't completely clear where this was taking us, we were still undertaking an excavation to try and understand, as I say, the breadth and depth of what was actually going on. So I hadn't anything fully formed at that 11:25
point in time, but I did have a sense that they needed to know, because they had been - first of all they should know and, secondly, they would had been involved before, I would have assumed.

64 Q. Yes. As I say, I wish to come at this issue in light 11:25
of Mrs. Mullan's evidence and about Board cultures in general from a slightly different direction later, but for now, thank you for that.

A. Mmm.

65 Q. Can I ask you to look at WIT-45070, and at 48A, again 11:26
you're looking at concerns in relation to Mr. O'Brien. Just scrolling down, you say - just that paragraph beginning "On my arrival":

"On my arrival I was aware that for patients about whom there were concerns these could be placed in hot clinics, that is same or next day clinics Monday to Friday. Consultants had the opportunity to use these hot clinics on their weeks as urologist of the week to review any patient about whom there were imminent concerns."

And you go on to say - just scrolling over the page. Yes. Sorry, at the bottom of the page: "It would appear..." you say: 11:26 11:27

"...that despite having long waiting lists with the propensity then for patients to deteriorate, these hot clinics were not used as intensively by Mr. O'Brien as they were by other consultants." 11:27

Can I ask you just about that and the factual basis or the information basis for saying that? First of all, who led you to form this impression, if it was an impression, that Mr. O'Brien wasn't using the hot clinics as intensively as others? 11:27

A. Could I suggest I come back to you with the answers for this, because this data is not at the front of my head? So I will revise that and come back to you in the next couple of days, if that's okay? 11:28

66 Q. Right. Certainly, by all means explore that. I think that's fair if you don't have the answer. I'm conscious that this witness statement was filed almost

18 months ago.

A. Mm-hmm.

67 Q. Just before we perhaps take a short break, could I bring you to the conversations that took place in relation to Mr. O'Brien's retirement. If we bring up to the screen, please, AOB-56498. And just while that's coming up - yeah, just scroll down to - thank you. There was, I suppose, a bit of a lead in to a conversation that took place on 8th June 2020 between Mr. Haynes and Mr. O'Brien. Mr. O'Brien had indicated in March 2020 his intention to retire from full-time employment with the Trust, but he had had conversations with colleagues about his wish to return on a part-time basis in August 2020, and he certainly had formed the understanding that there would be no barrier to that, and he was getting, if I can summarise his evidence as getting, I suppose, receptive or positive noises back in terms of whether that would be possible. This conversation with Mr. Haynes, again I paraphrase, takes the rug from underneath Mr. O'Brien's feet. He's told on 8th June, you'll not be coming back as a part-time worker following your retirement, and Mr. Haynes at item C, or number C on the left-hand margin, explains:

11:28 11:29 11:30 11:30

"I've taken that forward with a number of conversations within the Trust, with HR, and at Medical Director level. Okay. Unfortunately, the practice of the Trust would that they don't re-engage people while there's ongoing HR processes."

11:31

In terms of the discussions at Medical Director level around this subject with Mr. Haynes, can you recall participating in such discussions?

A. Yes. 11:31

68 Q. And was it explained to you that Mr. O'Brien had this intention or at least this wish to return following retirement on a part-time basis?

A. Yes, it was suggested to me I think both by Mark Haynes and I think at a stage Martina Corrigan, that 11:32 Mr. O'Brien had suggested that he would like to return post retirement. And my response was clear throughout, which was, this is a doctor who had been through a Maintaining High Professional Standards Investigation, who had not been able to comply, and by that stage, you 11:32 know, what we realised was on a couple of occasions with, you know, the recommendations that were being made, that it was, you know, he was difficult to manage as a result of all of that, and in addition to that I had concerns about the fact that he hadn't been 11:32 complying with appraisal and job planning throughout, and that I also, I remember also speaking to Melanie McClements about this as well, to explain to her that if - the difficulty in this process was going to be that if he were offered a post that I couldn't 11:33 authentically stand over him being there as responsible officer, because I have a - I had a responsibility, obviously professionally, to sit between the doctor and the GMC to say that they were a person of good standing

and someone that we could rely on going into the future, if I decided to go forward with that, and what I was explaining at that time was that it would be difficult for me to be his responsible officer, given all that I knew about his past and the concerns I had about the present. 11:33

69 Q. You had of course by this time referred him to the Medical Council?

A. Yes. Yes. Yep. Could I just ask? This conversation looks like it was recorded? 11:33

70 Q. Yes, indeed.

A. Was Mr. Haynes aware it was recorded?

71 Q. We've dealt with that with him.

A. Okay.

72 Q. It would appear that he wasn't. 11:34

A. Okay.

73 Q. In terms of this phrase that "the practice of the Trust is not to re-engage people while there's ongoing HR processes", when Mr. Haynes was asked about that I think it's fair to say that he acknowledged that this was really a term of convenience, the reality being that, if you like, the difficulties being caused by Mr. O'Brien in terms of the management of him and how he was perceived as a colleague and a team player, and I paraphrase, were really at the root of the decision not to have him back, as opposed to any formal or informal policy on the part of the Trust not to have people back when there's ongoing HR processes? 11:34 11:34

A. Well, I think, as you've reminded me, I had referred

this doctor to the GMC at that point in time and, you know, we had concerns about his behaviour and in relation to how he managed patients. So it would have been highly unusual in that circumstance for me, as Medical Director, to agree to take a doctor who was in this position back to work once they had retired.

74 Q. And is it fair to say that that's the sense of it that you communicated to Mr. Haynes?

A. Yes, I think maybe not just as precisely as that. And as you said, I think Mr. Haynes, you've just referred to the fact that this probably was an economic use of language in relation to how all of that conversation was described, but essentially we are talking about similar processes here, but the root of it all was concerns about, you know, what I knew about this consultant's previous and current practices and whether or not I would be prepared to continue as responsible officer knowing all of that, and I felt authentically, I couldn't.

75 Q. Ultimately whose decision was it to take? Who owned the decision, in your view?

A. Well it would be very difficult for any permanent member of staff to work in a Trust if they hadn't a responsible officer within that Trust, or as an alternative they weren't being managed by a responsible officer from another Trust or through the GMC. So what I offered to Melanie at that point was my view that I couldn't remain as responsible officer, given the concerns that I had and, again, that would have

impacted then on the decision whether to continue employment or not. But certainly in my opinion we couldn't continue to employ this man given the concerns.

76 Q. Okay. Thank you for that. Chair, would it be convenient to take a break? 11:37

CHAIR: Yes. We'll take a 15-minute break and come back again at 11:55, ladies and gentlemen.

THE HEARING ADJOURNED FOR A SHORT PERIOD AND RESUMED AS FOLLOWS 11:37

CHAIR: Thank you everyone. Hopefully the injury has been resolved? There's a few doctors about the place just, you know, if needed! Mr. Wolfe. 11:57

MR. WOLFE: Thank you. Just a few minutes before the break I was asking you about the subject of hot clinics, and you had made the point in your statement that despite having long waiting lists it appeared to you that Mr. O'Brien did not use such hot clinics or the opportunity of such hot clinics as extensively as his colleagues, and you invited me to come back to that issue in due course. 11:58

A. Mmm.

77 Q. If I could show you WIT-48519? And it's an email to you, I think probably shortly before you finalised the statement containing the reference to "hot clinics", and you're being told by Martina Corrigan that here is the breakdown of patients to hot clinics during that 11:58

five-year period. Just scroll down so we can see it all. So your point was Mr. O'Brien didn't appear to you to be using the hot clinic opportunity as extensively as others. It would appear, just confirm for me, that it's on the basis of this information that you made that point? 11:59

A. Yes.

78 Q. And in what sense was that significant, in your view?

A. It gave me -- well, I think that those hot clinics, as I understand it, are where consultants, if they have particular concerns about patients, will bring them up for review, you know, to monitor their progress, all of that, and they use the opportunity of being urologist of the week to actually, you know, get these reviews done in the context of the rest of the busyness of consultant of the week. It struck me that - I suppose what my concern was that there was less, and given how busy Mr. O'Brien, you know, was constantly concerned about being, it gave me an indication that actually in terms of the volumes of patients that he was seeing through that, it wasn't as high as others, and if there were concerns about patients and, you know, if patients had been phoning in, if that was being, you know, communicated into all of this and those patients actually being reviewed. So it was an observation because, you know, as you can see there, it's as much as half, and at times, you know, almost a third of what some of the others were seeing, and it seemed to me he was an outlier in relation to that and just, I suppose 11:59 12:00 12:00

it raised concerns to me about concerns about patients essentially.

79 Q. I'm conscious that you put this information, or the conclusions you formed from this information into your statement in 2022. Was it an issue that came to your attention during the time that he was employed within the Trust? 12:01

A. Would you mind scrolling, because I would have first known about this whenever Martina sent me the email? So the 26th June. 12:01

80 Q. So, yeah, she's writing to you in 2022.

A. Yes, yep.

81 Q. And we can go back to your statement where this issue arises. It's paragraph 48A at WIT-45070, and it's an answer to question 48 which in terms: 12:02

"What were the concerns raised with you? Who raised them? And what, if any, actions did you or others take?" 12:02

Et cetera. And if we scroll down the answer comes - there's various aspects to the answer, but from halfway down the page you're dealing with the hot clinics. On your arrival you're aware that this hot clinic option was available to consultants, and you then say in the last paragraph - I think I used the word "extensively" earlier, but it is "intensively": 12:02

"The opportunity to use the hot clinics was not used as

intensively by Mr. O'Brien as they were by other consultants."

So my question to you is: was this a real-time concern for you, or was it only a concern or an issue drawn to your attention at the time of filing your statement? 12:03

A. I think the first I would have been aware of that so explicitly was when Martina sent me that email in 2022.

82 Q. So it wasn't something which was the subject of query or investigation by you during the course Mr. O'Brien's employment? 12:03

A. No. No.

83 Q. Martina Corrigan, for example, in pointing the information out to you, would appear to have been aware that this was an indicator of Mr. O'Brien not using opportunities that were available to him to deal with patients which might have caused concern? 12:03

A. I think this came about in the context of - Mr. O'Brien raised concerns constantly about the busyness of the urologist of the week experience and, you know, on the back of the history of all of that where, you know there were delays in getting triage finalised, because as I understand it, and I am not a urologist so forgive me if I don't get this precisely, but as I understand it, when the urologists take on urologist of the week they take all - they don't do outpatient or surgery unless it's emergency surgery, and they basically take on the referrals, they see any patients that they're concerned about in relation to hot clinics and they do 12:04 12:04

the triage. So they'll take the ED referrals, they'll take any urgent GP referrals, they'll do hot clinics in relation to all of those and any other patients that they're worried about, and they'll also do the triage then in relation to the work that's coming in, and I think they also have an in-patient ward presence. So I mean it's a busy intense week. And Mr. O'Brien, as I understand it, constantly stated that he couldn't get to completing triage as quickly as the others could because he was so busy during the urology of the week discussions, and I think then eventually when we drilled down into that to try and understand what that was about I was surprised that his activity during these hot clinics seemed to be so different from everyone else's, given that the volume of activity that would have been coming from other sources such as GPs, ED, you know, ward referrals, whatever, wouldn't have been that much different for the rest, but yet there was still delays in terms of him getting this paperwork done. 12:05 12:05 12:05

84 Q. And what conclusion do you, did you form in light of that analysis or that process of thinking, in terms of Mr. O'Brien's activity?

A. Well, I think it was an observation on my part, right, and I think that it struck me that, you know, throughout all of the concerns that Mr. O'Brien raised, you know whether directly with managers or when he made reference to it in his appraisal, it was in relation to how busy he was and about the demands of all the 12:06

waiting times, but actually whenever we have drilled down into this and looked at it, there isn't an evidence base to suggest that Mr. O'Brien was a lot busier than his colleagues.

85 Q. Thank you. Could we turn to issues arising out of job planning and whether Mr. O'Brien was provided with assistance by way of extra administration time, for example, to enable him to cope with what he has described obviously as a very busy clinical practice. If we go to your statement WIT-45086, and at paragraph 53.3, just at the top of the page: 12:06 12:07

"It was reported to me in October 2019 that the first sign-off of Mr. O'Brien's job plan was not completed in a timely fashion, as Mr. O'Brien would not agree what was being offered, despite the fact that he was given the administration time on a Tuesday morning that he requested." 12:07

I just want to put that piece to you and let me join it with another piece in your statement further on. WIT-45158 at 62.4, and you say here: 12:08

"I'm led to believe that in the course of the development of the 2017 Action Plan, Mr. O'Brien was given a Tuesday morning, four hours, as extra SPA [Supporting Programmed Activity], to allow him to complete his dictation from the Enniskillen Clinic on a Monday." 12:08

So taking those two pieces of evidence together, it seems to be your impression that through the job planning process, more was being offered to him by way of hours to complete his administration, and you say here's a concrete example of four hours extra SPA being granted to him in a particular context. Can you recall who reported these matters to you? 12:09

A. Oh, Martina Corrigan and I had this conversation because I think she had, you know, reviewed all of that along with - I'm not sure whether it was Mr. Haynes at that point in time but, no, it was Martina I had the conversation with, because she drew to my attention that in order to support this Enniskillen Clinic this extra time had been given. 12:09

86 Q. Yes. And it's that concept of extra or additionality that I want to briefly explore with you. So it appears to be your understanding that take, for example, the Tuesday following the Enniskillen Clinic, that he was being given something additional to that which was otherwise provided for in his job plan, is that your understanding? 12:10

A. I am not - well I'm not sure whether it was that it was in place of something else or whether it was additional, but it certainly was ascribed time that was purely to deal with administration and it was out of keeping with what the rest were receiving. So, normally when any of us would have done clinical work you would expect that you would see your patients and 12:10

get the dictation done by the end of the clinic or, you know, you would have other administrative time in the week that would have been, you know, recognised for supporting clinical activity to get that done. My sense with this was this was four hours in his week that was carved out to get this completed, and I think I was left with the impression it was above what he was getting previously, but it might well be that it displaced something that he was doing previously, and I'm sorry, I can't remember the detail of it. 12:11

87 Q. Yes. I think Mr. O'Brien would say that rather than it being extra or additional SPA, that in fact the hours made available for this administrative work was in fact designated as direct clinical care. In other words, as I understand it, not additional, but regarded as part and parcel of what was required for the clinical work? 12:11

A. So I think it's probably a moot point, although I do appreciate it's important, whether it's described as SPA or DCC, but certainly the important part of it was that it was time identified in his working week to get his administration done. 12:12

88 Q. So is it your understanding, just to be clear, because it may be of some significance, that there was - however it is described, that there was a dispensation or a flexibility arrived at to enable Mr. O'Brien to progress the dictation work in this instance, that wasn't otherwise available to someone else or hadn't historically been available to him? 12:12

A. Yes.

89 Q. Just going back to the paragraph we left at WIT-45085, at paragraph 53.3 - sorry, I'm just scrolling down. There we are. So in terms of what was reported to you October 2019, in addition to what I've just read out, it was described for you that he was spending long hours on the ward at times, that he was neither required nor expected to be there, and then was asking for additional payment in recognition for this. Again, in terms of the request for additional payment, who was telling you that? 12:13 12:14

A. I think there had been - and, again, I don't have the dates in front of me - but I think in a previous iteration of a job plan he had raised this as a concern and he had been job planned to try and offset some of this, but there - what was reported to me, I think again through the operational managers, was that on occasion he had said to them that he was doing this extra work and that he felt that that should be built in to his job plan for additional payment, even though the Trust wasn't requiring him do it. 12:14 12:14

90 Q. I think there's certainly plenty of evidence before the Inquiry of Mr. O'Brien working into the night, late into the night perhaps.

A. Mm-hmm.

91 Q. Being seen on the wards. Never leaving the hospital is perhaps exaggerated a little bit. But have you seen actual documentary evidence, for example, of requests for payment in those circumstances, or are you relying on what you were told? 12:15

A. I don't think I have seen - I could be wrong, but I don't think I have seen a written request, but I can certainly go back and check on that, but I think it was communicated to me verbally.

92 Q. Thank you. Just staying with this paragraph, let me see if I can spot it. You seem to suggest, and I'm not quite sure if I can see the precise language, but was it your impression that there was a pattern of Mr. O'Brien agreeing to sign off job plans but then not following through? Yes, there it is: 12:15 12:16

"By the time I arrived in 2018..."

- it's about 6 lines down:

12:16

"...there was a pattern of him agreeing to sign off job plans and then not following through."

Who created that impression for you?

A. Well, again, I think certainly that was coming from the operational managers in that, you know, there was - I don't know how you would best describe it, but this sense that "well, you know, we've been trying that for a long time", you know, and again the example of the Tuesday morning was used, you know, "has promised to do it but actually then, you know, we never seem to get it tied down", and there just seemed to be - I wouldn't say it was hopeless or despairing, but there seemed to be a sense of inevitability around it I think and, you 12:16 12:17

know, what struck me, and I've put it into the bottom of that, is then around the process for escalation. I felt because it wasn't clearly delineated in the Clinical Director and Associate Medical job descriptions at those times, then it wasn't escalated. 12:17
Because in ordinary circumstances, if our governance processes had been tight, you know, once there's a failure for that to happen, then that should be escalated up through the system. So that's now in place, but it wasn't in place at that point in time. 12:17
So that shouldn't have allowed - as a system, you know, we should have responded to that I think medically a bit more strongly than we did in the past.

93 Q. What more generally is the impact for the organisation of allowing delay and, as you suggest, some 12:18
prevarication and excessive debate around the content of a job plan?

A. Well I think that, you know, the importance of the job plan is that it clearly delineates, it mostly focuses on activity rather than quality of care, right. So it 12:18
should be about the activity that is expected from a doctor at any given time, the hours that are worked, the on-call, the responsibilities, all of that. And I think, you know, it was suggested to me that, you know, he was working to one interpretation of what was 12:18
already on paper and other people were finding it difficult to get that contained in terms of having a very clear expectation of roles and responsibilities.

So it should be - the job planning process is a partnership, you know, and as a consultant what you want to do is make sure that you're very clear about what your roles and responsibilities are, because from a medicolegal point of view that's important, from a clinical responsibility point of view it's really important, and the system and you should work in tandem to do that. But there just seemed to be an inertia around this in that it was suggested that he would say yes, then it wasn't followed through on. He would say yes again, and it wasn't followed through, and all of that just lingered on and on until we got to an end point with it. 12:19 12:19

94 Q. Mmm. Yes. Of course, and maybe it's unfair to deal specifically with the substance of Mr. O'Brien's disputes, but any doctor can take the view that "I'm not being - my activity is not being fairly reflected in the job plan", whereas I think what you are perhaps suggesting is that in Mr. O'Brien's case he was taking an unreasonable or at least an unconventional view of the responsibilities that he held and which he expected to be reflected in the job plan? 12:19 12:20

A. The job plan is a joint venture, it's between the Trust and the consultant to agree. So the Trust should come with the expectation of the work that is to be done, and then the consultant, you know, will negotiate within that in terms of what they feel is reasonable and fair and how much time they need for various things and, you know, that will get described then usually in 12:20

allocations of four hours in terms of roles and responsibilities. So both parties have a responsibility in all of that. And, again, you know, where you have - and this is the vast majority of doctors, you know, where a clinician is very engaged with their clinical work, is very clear about what their roles and responsibilities are, realises that, you know, this is a really important contractual area that needs to be tied down to enable them to do their job safely, so they know what the Trust expectation is of them, you know, that's something that normally I would see consultants/doctors stepping forward to say, you know, "I need to get this done." 12:21 12:21

From the Trust's point of view, and from Mr. O'Brien's point of view, then in a very practical way it can affect the amount that you're paid, because you can be over or underpaid, you know, depending on what you're contractually required to do, and of course then that can create a whole tale in terms of, you know, catching up with that, which, you know, can add burden and stress to the individual and to the system. 12:21 12:21

Also then when it comes to understanding roles and responsibilities in particular in relation to patient care, that it is really fundamental in terms of understanding what the consultant's activity should be based around. 12:22

95 Q. Yes. Later we'll go on to look at job plan, appraisal

and re-validation, and the steps which the Trust has taken in more recent times to try and make improvements in that area.

Just one final point before leaving this paragraph. 12:22
You say that eventually the 2019 job planning process with Mr. O'Brien moved on into 2020, and he only signed off on the job plan before he retired to allow his pension to be finalised. Again, could you just account for that impression? Is that something that was said 12:22
explicitly, "I'm only signing off on this for these reasons", or is it something you infer or somebody else has inferred from the circumstances?

A. It was never explicitly said, but it struck me at the time that the job plans were signed off at that point 12:23
in time so that the - so it's simply a statement of fact, they were signed off at that point in time and that coincided with his pension being processed.

96 Q. Let me move on to what you describe as your first awareness of issues around Mr. O'Brien. It's contained 12:23
in your statement, if we move a few pages on to WIT-45091. And, just before - sorry, just after you commenced in the Trust you attended a meeting along with Dr. Khan, who was responsible officer at that time. You attended a meeting with the General Medical 12:24
Council's Employment Liaison Adviser, Ms. Joanne Donnelly, isn't that right?

A. That's correct.

97 Q. And I just want to ask you about an aspect of that.

You have written into this section of your statement - this is paragraph 55.4, as we can see. Mr. Gibson also attended the meeting. He was Deputy Director within the Medical Director's office at that time?

A. Yes. So he is - he was and he is Assistant Director. 12:24

98 Q. Assistant Director?

A. Yeah. For Medical Workforce.

99 Q. Yes. Yes. And you record within your statement some of the background that Joanne Donnelly was told through Mr. Gibson, and it's recorded - just where you see January 2019, towards the bottom of the page: 12:25

"Mr. Gibson reported that the doctor still had local restrictions on his practice, the 2017 Action Plan, and these were being kept under review." 12:25

The suggestion that Mr. O'Brien was the subject of local restrictions on his practice, what were those local restrictions?

A. So I think "restrictions" is probably not the right word now that I reflect on this. I think it was local supervisions on his practice, because he was undertaking all of his clinical duties at that point in time and he should have been undertaking all of his administrative duties, but in a much more controlled way in that there was oversight of triage, private patients, you know, the areas that we're familiar with out of that action plan. So "restrictions" is not the right word, I think it should have been local 12:25 12:26

supervisions on his practice.

100 Q. Yes.

A. Or enhanced supervisions on his practice.

101 Q. If we go to TRU-264716. This is an email from Ms. Donnelly on 9th January 2019. She had been promised at the meeting with yourselves, the meeting took place in I think it was 4th December 2018, that she would receive the outworking of the MHPS process, which had been earlier promised to her and hadn't materialised. So she receives the report and makes some observations on it, and she says, middle paragraph: 12:26 12:27

"On the basis of the information you have provided these concerns appear to me to meet the threshold for referral to the GMC." 12:27

And then at the end of that section she records:

"I acknowledge that the doctor's practise is currently restricted in the interests of patient safety and that the doctor is complying with a Local Action Plan." 12:27

So it would appear on the basis of that, that the GMC carried away from this meeting a belief that there were local restrictions in place in the interests of patient safety, albeit that the doctor separately was complying with the action plan. When you look at these various strands now, would you accept that the GMC should have 12:28

been more accurately informed about the situation?
A. I don't know what -- until I joined the Trust, and I had never worked in the Trust before, in December 2018, being present at the GMC meeting on 4th December and then became aware of this doctor and then started to review his notes throughout January/February, I wasn't cognisant at all of any of the discussions that had gone on between the Trust and the GMC at that date. In, again, reviewing that, I think "restricted" is not the right word, I think it should have been communicated that this was a supervision of some description, because as I understand it, you know, supervision and restriction are two different aspects in relation to medical practice. So the word is wrong, and the GMC - and I'm not sure whether they were mirroring what they heard from the Trust at a point in time, or whether that was their belief, but I think it's the wrong word on there. 12:29 12:29 12:29
102 Q. Certainly I don't think I need to take you to the other documents, but certainly it is recorded that when Mr. Gibson spoke to the meeting it's Ms. Donnelly's record that he used the term "restrictions"? 12:29
A. Okay.
103 Q. Whether he did or not we'll have to go back in time and be there, but that's certainly what she recorded, and it finds it's way into the note. Nobody sees fit to go back to her, and I'm conscious that you're just into the job and trying to learn on your feet, but nobody goes back to her and says "Actually, restrictions isn't 12:30

exactly what we're doing, it's more in the line of supervision", which is perhaps a significant shortcoming in terms the Trust's relationship with the GMC, particularly when she views the risks associated with the doctor so significantly, so significant that it, in her view, requires or suggests the need for referral?

A. Well I think she came to that decision after she and I obviously had had a conversation and I raised concerns about what I was starting to read in the midst of all of this. 12:30 12:31

104 Q. Sorry to cut across you, she forms that view on the basis of reading the MHPS report, as we can see from this email from her.

A. Mm-hmm. 12:31

105 Q. You're referral eventually comes through in April of 2019, isn't that right?

A. That's right, yeah.

106 Q. Could I move from there, please, to your witness statement at WIT-45143, and at paragraph 58.10, if we just scroll down, you're reflecting on the action plan and Mr. O'Brien's deviation from it in 2019. You record that he was offered support in clearing the backlog, and it was understood that this had come about at a time he had been supporting his family due to illness in the family. Could you help us in terms of the help that was offered, can you particularise who was offering him and what he was offered in terms of clearing the backlog? 12:31 12:32

A. I can't remember the - so this is more than four years ago, I can't remember specifically what was stated at the time.

107 Q. Yes.

A. But I think in relation to how I became aware of the information, that came through Martina and Melanie McClements at that point in time. And as I, and as I say, I cannot remember the specifics of it, but certainly the sense I was left with was they recognised with him that, you know, he had had this [redacted] event that had interrupted all of those, and they spoke to him about what would be needed to help him get this cleared, but I couldn't tell you chapter and verse exactly what that entailed. 12:33 12:33

108 Q. Certainly there's a record of Mr. Haynes writing to you at that time and saying, "Listen" - he doesn't touch upon the [redacted], but he says, "Listen, we tend to be somewhat flexible around triage, so if it's a particularly busy week we allow perhaps another couple of days for the triage to be completed", so don't hold the clinician to, you know, Friday evening or whatever the cut-off date is. But the question I suppose is, you're unable to recall any specific offers of assistance to Mr. O'Brien around his triage at that time? 12:33 12:34 12:34

A. Yes, I don't know - I can't remember specifically what those would have been. But in relation to Mr. Haynes's email, again that I think was not specific to this episode in September. I think he was drawing my

attention to that generally to say, you know, "We're not completely hard and fast in relation to this being on this date, because we appreciate that all of this clinical activity can impact", and I think was making me aware that they give an extra 48 hours in terms of getting this work done. 12:34

109 Q. Could I bring you to the issue of appraisals? We've touched on it briefly earlier, and your sense that there was often delay in association with the completion of that exercise in the case of Mr. O'Brien. 12:35

A. Mm-hmm.

110 Q. If we go to your witness statement WIT - let me just - no, it's a few pages back. WIT-45095, and at 55.9, you record that: 12:35

"There was no clear evidence in the appraisals that his appraiser had been made aware of any concerns."

That's an issue I'll come back to later when we look at appraisal. This is the point I want to focus on. You say? 12:35

"In addition to this, his 2017 appraisal had not been completed." 12:36

And this is by 11th March 2019, as appears in the question. So by that date his 2017 appraisal had not been completed nor had his 2018 appraisal, for which a 360 degree feedback was required, and this is

significant because his revalidation date was due for renewal on 4th April 2019. I just want to seek your observations on whether or not that is factually accurate.

12:36

If we look at TRU-294256, and Zoe Parks is writing to Therese McKernan, post Mr. O'Brien's retirement, and presumably information is being gathered perhaps for Inquiry purposes or whatever. And she says:

12:37

"I have spoken to our appraisal..."

- this is the bottom of the page:

"...our appraisal revalidation lead who has confirmed for me that Dr. O'Brien completed the following appraisals..." 12:37

And it seems that in terms of the 2017 appraisal, which you were suggesting hadn't been completed by the revalidation due date in 2019, it had been completed in fact, according to this, in October 2018. I'm conscious that you're maybe seeing this for the first time, but that clearly appears to jar with what you're saying in your statement? 12:37 12:38

A. Would it be possible, would it be possible for you to pull the appraisals up to have a look, or do you want me to have a look at it and come back because...

111 Q. We'll come back to that.

A. Yeah. Okay. Yeah.

112 Q. So on the face of it this jars with what you've said in your statement, but you'd like to check the appraisals themselves to see when they were finally signed off?

A. Yes. Yes. 12:38

113 Q. Very well. And you appear to be correct about the 2018 appraisal. It didn't, according to this, come in until October 2019?

A. Yes. Now, again I'm only thinking out loud, but if I - there is something in my mind that the 2017 appraisal 12:39 wasn't complete in that actually all the information wasn't there, rather than a signatory date, which is what that tends to be, but I will go and check.

CHAIR: I think in fact, in fairness to you doctor, you did say in that last paragraph that was read out, that 12:39 the 360 feedback had not been completed.

A. Yes. Yeah. Yeah, on the 2018. Yeah, I think that's right. I'm not sure about the 2017.

114 Q. MR. WOLFE: I'm not quite sure. If we could just go back, because I think there is - there's an issue just 12:39 to explore with the 360. If we go back to your statement WIT-45095. So what you're saying about the 2018 appraisal, you're saying - you're saying his 2017 appraisal had not been completed nor had his 2018 appraisal. So the document that I just brought you to 12:40 would seem to suggest that's right, the 2018 appraisal wasn't complete until late in 2019.

It would appear, if we can bring up on the screen

AOB-07937? This is a note from Dr. Scullion. He's now Assistant Medical Director, is that correct?

A. He's Deputy Medical Director, yes.

115 Q. Deputy Medical Director, yes?

A. Yes. Yes. 12:41

116 Q. So he is dealing with appraisal issues and he's writing to Mr. O'Brien just before this - actually on the date, I think, of the revalidation becomes due, and he is speaking to Mr. O'Brien about colleague feedback. Is this the 360 degree process or is it something that 12:41 sits beside that?

A. It's part of it. So in addition to colleague feedback there should also be patient feedback.

117 Q. I see. So it appears in any event that the colleague feedback has been completed by that date. Of interest 12:41 perhaps in this email is Dr. Scullion's observations on a respondent colleague who has scored Mr. O'Brien negatively against patient confidentiality, trustworthiness and ill-health, and what Dr. Scullion says is: 12:42

"Since all your comments have been supportive and commendable, I think this is a case of misinterpretation of the question. I think it is reasonable to ignore this outlier feedback. Otherwise 12:42 an excellent colleague feedback survey."

Just on that point, do you think that's appropriate to take the view that the respondent to the survey didn't

know what they were answering and decide ultimately to ignore the negative feedback?

A. The colleague feedback questionnaire as part of the 360 degree appraisal is an interesting concept, because within the realms of all of this you produce a list of colleagues that are then approached to give feedback. So there's - my concern about it is that there is already inherent bias because you get to chose. Right. That's the first thing. 12:43

The second thing then is that in terms of the completely disagree statements, usually where you would expect to find that is in the patient feedback, because it's not, these are not particularly sophisticated or well constructed forms very often, but they are the standard that's used, and sometimes what you'll find is that, you know, if someone has read it really quickly they'll put one thing when they mean another thing, and you usually pick it up through the outliers and, you know, we might make comment about that. 12:44

It will have depended - it may well be that that's what has also contaminated the colleague feedback questionnaire, and given that I mean he has said - it doesn't give any indication there as to how many colleagues fed back, or that because it's anonymised whenever it comes back to the appraiser and the appraisee, you've no idea what grades or where the colleagues were actually chosen from. So, I think 12:44

usually, or what would happen now I think is that there would be some discussion about that particularly at the revalidation meeting in terms of whether or not that was a reasonable assumption, and the way revalidation meetings work now is that Divisional Medical Directors are all together, along with the Medical Directors and the support from the Medical Director's office and HR, to review all of that and understand actually in the context of not just a standalone questionnaire but in the context of all the information available, is that reasonable or should there be further exploration of that to understand. 12:45 12:45

118 Q. The earlier part of your answer, if I may say so, was to I suppose criticise the weaknesses or point to the weaknesses of the process, but I suppose the point I'm making to you is that, this kind of response may point to something that needs to be investigated, in other words you shouldn't just cast it to one side as Dr. Scullion appears to have done, without further analysis. His analysis seems to be limited to "Well, your other colleagues say this, this person says that, therefore they must be wrong"? 12:45 12:45

A. And in fairness to Dr. Scullion, this was on the back of having being his appraiser and being presented with all of the information that didn't include anything to do with Maintaining High Professional Standards. So already, you know, he had been given a set of information in the context of this doctor that suggested that there weren't any concerns. So, you 12:46

know, that - if you were thinking about cognitive bias, you know, you can see where all of that would come together easily to assume actually this is just an average score rather than actually something that should be a smoke signal.

119 Q. Yes. And I'm sure when we go on to look at it you'll be explaining to us that the material, such as SAIs, MHPS, that kind of material, will now go into the process?

A. Yes. 12:46

120 Q. And what Dr. Scullion had to put up with, if you like, or had to address, is unrecognisable by today's standards, is that fair?

A. I think that's fair. And I think very helpfully I think again when you look at the recommendations coming out of the Neurology Inquiry, I think it underpins the position that we've taken in relation to this in terms of providing very comprehensive information whenever we come to describe a doctor's practice. 12:47

121 Q. Just one further issue. If we go to TRU-266 - sorry, yes, TRU-266586. And a GMC officer is writing to you on 12th August 2020, and if we just go - he's seeking from you further information in respect of Mr. O'Brien's employment and, indeed, some issues raised with the GMC, it appears by Mr. O'Brien in his dealings with them, and could I ask you just to go down three pages to 589 in the sequence. Thank you. He, in the left-hand margin is saying, he's dealing with a meeting which was lined up to take place in December 12:47 12:48

2018 between management and the consultants in the Urology Department, and he's asking that you provide an account of the circumstances of the cancellation of both the September meeting and the December meeting. And as regards the December meeting, it's recorded - I think this is your answer, or The Trust's answer: 12:50

"The meeting schedule for December 2018 did not progress as three of the six consultant urology staff were unable to attend." 12:50

Just scroll down. Yes. You sign off on that letter. This is an event, this December meeting, that didn't ultimately progress with management attendance. This was an event where the five substantive urology consultants were available and did attend, according to the evidence before the Inquiry, whereas you've said the meeting scheduled for December did not progress because three out of the six consultant urology staff were unable to attend. Can you help us in terms of how you formed the view that three of them were unable to attend? 12:50 12:51

A. Would you mind scrolling back to the top, please?

122 Q. Sure. Of this?

A. Yes. 12:51

123 Q. The top of the letter?

A. The top of the letter, yes.

124 Q. Yes. So it starts at 586. So you're writing to Chris Brammall.

A. Yes.

125 Q. And you're answering an email of the 30th July, and just in terms of how the letter is constructed. You're putting in the left-hand margin each of the queries raised by Mr. Brammall and then providing your answer on behalf of the Trust in the right-hand column? 12:52

A. Yeah. I think to set - the reason I'm asking just to see the date again was to set this in context. So I would presume I responded to this in early August 2020, which would have been nearly two years after that event, which I wouldn't have been aware of I think until I was asked for information from Chris Brammall to respond, because I was only just into the Trust and the information that I would have been relying on would have come from other people. And, again, I am not sure where that would have come from, but it presumably came from my correspondences with people within the urology service to ascertain whether or not the meeting happened and what it was supposed to be, who was supposed to be there. But I think until Chris raised this with me, I wouldn't even have been aware of the existence of that meeting. 12:52 12:52 12:53

126 Q. Yes. And just to be clear, the gathering of the consultants was the subject of recording on Mr. O'Brien's part. 12:53

A. So Mr. O'Brien recorded that meeting?

127 Q. Yes. And we can - just so that the Inquiry can see it, if we go to AOB-56478, and that's the title page, if you like, it's suggesting that Mr. O'Brien was in

attendance with Mr. Glackin, Young, Haynes, O'Donoghue, and with Mrs. Corrigan available, and the date is 3rd December 2018, and if one works through the transcript itself, it certainly suggests that each of the people named on the title page were in attendance. 12:54
The answer you gave on behalf of the Trust back to the GMC was three out of the six urology practitioners wasn't available. I think Mr. O'Brien's evidence would be that the sixth person, that is Mr. Tyson, was a locum at that point and hadn't been invited to the 12:54
meeting, but certainly the substantives were available, and that was not accurately communicated to the GMC. And if this transcript, or this recording is right, that would appear to be the case. I'm conscious that you weren't employed in the Trust until around about 12:55
that date and so, in real-time you wouldn't have known perhaps about the meeting, but who would have been the person giving you the information so that you could go back to the GMC some two years later?

A. It would be, it would be somebody within Urology. So I will track back and find out. But, again, I can't remember the specifics of it. 12:55

128 Q. Yes.

A. And can I ask, is there a sense that it makes material difference whether there were five consultants there or three? 12:55

129 Q. Well, it's - the suggestion is that that is the reason why the meeting didn't take place.

A. Right. Okay.

130 Q. That's what the Trust is communicating to the GMC as being the reason why it didn't take place?

A. Okay.

131 Q. And if that isn't the reason why it didn't take place, then the Trust - the Inquiry might think the Trust should explain what was the real reason for it not taking place? 12:56

A. Yeah. And I think what I also need to check is are we talking about the same meeting?

132 Q. Well... 12:56

A. Yeah.

133 Q. You can come back with whatever explanation you think is appropriate?

A. Yeah. Okay. Thank you.

134 Q. It's 1:00 o'clock, Chair. I think... 12:56

CHAIR: I think it's certainly lunchtime. We'll come back at 2:00 o'clock, ladies and gentlemen.

LUNCH ADJOURNMENT

THE HEARING ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon everyone.

MR. WOLFE: Good afternoon, Dr. O'Kane. So we now move into the, if you like, the second area or the second section of your evidence and, as I indicated this morning, this allows the Inquiry to, in essence, have a conversation with you through my questions about the opportunities that the Trust has engaged in to improve, reform and develop in light of the shortcomings in governance and related issues that have been, I suppose, unveiled or discovered as a result of primarily the events of the summer of 2020 and what followed. It's also an opportunity for you to inform the Inquiry of any residual concerns, disappointments, challenges, that the Trust hasn't been able to address to date. 14:01 14:01 14:02

I think it's useful before looking into, if you like, the reform or improvement work, to take a moment for you to explain to the Inquiry what, on reflection, you would define or diagnose as being the problems that the Trust has had to address. 14:02

On the last occasion when you were with us you, I suppose, referred to almost two stages of insight. When you came into the role of Medical Director you, and you might comment on this, you very quickly realised that clinical and social care governance was 14:03

weak and you commenced a review through Mrs. Champion, isn't that correct?

A. That's correct, yes.

135 Q. And that was in large part looking at the governance structures... 14:04

A. Yes.

136 Q. Within the Trust, and she provided a series of recommendations, some of which were grappled with and developed immediately and some were put on the backburner for reasons that the Inquiry is familiar with. Maybe we'll come back to that in a moment. 14:04

The second stage of knowledge for you, as you explained on the last occasion, arose out of the events of June 2020, and particularly in relation to Mr. O'Brien and what that revealed. Is that a fair way to put it, that there were these, if you like, two different avenues or two different stages to an awareness that things were not all that they should be? 14:04

A. I think that's a good summation, yes. 14:05

137 Q. And on the issue of Mr. O'Brien and all that came with that, I think you were asked to reflect on the last occasion on the weaknesses within the Trust which caused or contributed to a situation where shortcomings in his practice, which from the Trust's perspective placed patients at risk, you were asked to reflect on what caused or contributed to that, and I suppose the headline from your answer was that the Trust and those who were charged with responsibilities in the 14:05

governance area were unable to join the dots, and they were unable to join the dots and therefore unable to see what was, I suppose, hidden in plain sight, and that led to a situation where you and others, perhaps not deliberately as you suggested, were given false assurance. Is that again a fair reflection of how you see it? 14:06

A. Yes. Yep.

138 Q. So, you have problems with the governance structures identified by you quite quickly, and then a whole raft of other areas emerging from what you saw in June 2020. Would you like to give the, I suppose, the Inquiry a summation of looking back at it from today's standpoint, bearing in mind all that you've heard in a yet uncompleted inquiry. What's your key reflections on the state of governance within the Trust, pick any date, 2019/2020, which you have had to go about trying to fix, what were the key problems? 14:06 14:07

A. Em, so I think in terms of my reflection of the stages of all of these, I think that it is, you know, for any of us who have been involved in this throughout that period of time, I think it would be fair to say that it is a source of regret to us that we didn't know in 2019 what we learned in June 2020. Okay. And hence the reason that, as you say, it has been a two-stage approach. 14:07 14:08

So in relation to governance, or in relation to the state of play and what I see as the fundamental

challenges, it probably falls within the four areas of culture, governance - and within that I mean clinical and social care governance and corporate governance - how we've used data, and then the quality and safety within the organisation. And as I've mentioned in some of the previous submissions, we have brought on board an External Reference Group to help us with the thinking in relation to all of that, and I think, you know, in terms of those four main domains, then within all of that, if we apply, you know, a model for improvement such as, you know, the Vincent model, which looks at, you know, were we safe yesterday, are we safe today, will we be safe tomorrow, are our systems and processes sensitive enough to operations so that we understand that if things are going askew that we have the governance arrangements in there to pick that up at an early stage? And also the fifth leg of all of that, which is, then how do we drive improvement based on all of that? If I use that as the framework for thinking of this, this is my easiest way into it. 14:09 14:09 14:09 14:10

So in relation to where we were in relation to corporate governance. As you have pointed out, the June Champion review was undertaken across the summer of 2019 and, again, that was in response to my concerns about the lack of framework and structure around some of the patient safety and quality issues that we were dealing with. As you know, there were 48 recommendations in that report. We have filled out on 14:10

the vast majority of them. The first 13 were to do with corporate governance at a point in time and, again, I think in fairness, Eileen, as Chair of the Trust, has really grasped those 13 now, but there was a period of time when that took a bit of debate for us to try and understand, and I think, you know, fair to say before Eileen arrived a realisation and acceptance that actually the corporate governance across the organisation needed to be strengthened, along with all of the other governance aspects that were there. 14:10 14:11

So I think that gave me a framework then in terms of improvement in relation to the overall corporate governance of the organisation and has, you know, been helpful to me in developing then the operational governance within the Trust. So we have concentrated on completely reforming the way we undertake corporate governance and, again, that has taken a lot of engagement, reflection, discussion, and we now have a revised corporate governance structure in place that brings patient safety and the quality of care very much into the minds of staff within the organisation, and feeds into the Governance Committee and sits alongside the Risk and Assurance Committee - or, sorry, the Risk Assurance and Audit Committee - that basically then quality assures some of that work that comes in. And then the other committees that are developed, the other five committees that are alongside that then are to support the overall approach to corporate governance. 14:11 14:11 14:12

And I think the reflections that I'm getting back from the people that are involved in that now, is that we certainly have a bit of refinement to do in terms of how we report data and use data, but I think we feel that we have a stronger grip on the organisation in terms of understanding how all of the information flows throughout the organisation and we make decisions and drive improvement based on patient safety and quality.

14:12

At the operational governance level then, as part of the reaction to what went on before and a realisation that the Acute Directorate was too big to function properly, when I became Chief Executive I split the Directorate into Directorate for Surgery and Cancer Services, and a Directorate for Medicine and Unscheduled Care. And, again, those two directorates in particular are more immature than the other directorates in the Trust because we've had to develop more staff to actually support some of the functioning in there to make sure that we capture, you know, patient safety and quality issues through the governance system as robustly as possible. Right.

14:12

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14:13

So, what we have done is to try and support all of that, and this was introduced when I was Medical Director, have a weekly governance meeting. So it's a live governance feed, half eight to half nine every Thursday morning, when, under all of the headings that are to do with patient safety and quality, there's a

14:13

report done through to the Executive Directors in the Trust other than me. So it comes to the Director of Medicine, Nursing, Social Work, but not the Finance Director either, and all of that is run through and then that is escalated on a weekly basis to the Senior Leadership Team. We challenge the information that comes in there, and this is reported every week, and then pursue, you know, the agenda around improvement in relation to that. 14:14

We've now been doing that long enough I think that we have built up an awareness of some of the patterns. We've certainly driven improvement in some of the areas such as how we report out on incident reports. So Datix, for example, and the IR1 reporting system. We introduced additional software in May 2022 that has really bolstered that in terms of the usefulness of it. So I think that has given the Clinical and Social Care Governance teams, along with the operational teams, more information in terms of how we triangulate data. 14:14

So, for example, at the beginning when I went along in January 2019 to look for the supporting evidence around, you know, where is the heat in the system in relation to quality and safety incidents? It was he really difficult to pick it up, because the information wasn't speaking to itself internally. We have improved on that quite a bit in that there's a number of feeds now that go into Datix, including the reporting through 14:15

on Serious Adverse Incidents and the management of the action points out of that. But there's still a way to go in terms of really bolstering that. And, again, there's a direct feed, you know, comes into the governance feed, you know, a Thursday morning meeting in relation to that. Alongside other areas such as, you know, reports out in relation to, as I say, Datix, Serious Adverse Incidents, any workforce pressures that are in there in terms of us being concerned about the impact of workforce shortages in certain areas, standards and guidelines come in there, so that we make sure everybody in the organisation, you know, has access to information in relation to what the latest standards and guidelines are, you know, any feed that comes from RQIA as the Regulator, any college reports that are worthy of mention that come up through the various directorates, and so it goes on and on. It's a very comprehensive report. Plus, you know, a readout on any of the delays in the system, such as we're about to introduce the Ombudsman delays in respect of complaints, but we have readouts in terms of, you know, the timeframes around responding to complaints, Serious Adverse Incidents, those things. So it is basically live and in front of us every week and it gets talked about frequently. 14:15 14:15 14:16 14:16 14:16

Now, I think in terms of galvanising what has come into that, and now that we have got the Datix system better embedded, I think our next phase then we have been

approaching learning I think probably through different systems and processes, but not - we don't have an overarching approach to learning and embedding some of this in the system. So the discussions I've been having with the governance team and the Medical Director have now been around how do we bring that into the body of the organisation? 14:17

So one of the other things that has happened over the last 18 months or so since I was appointed Chief Executive is that I have replaced a lot of the staff who have retired or left to go to other places, by a new team of Directors. So we have just finished the last replacement of an Executive Director. And in addition to that, in order to make sure that we pursue the agenda of embedding improvement in the organisation, I have appointed for the next two years in the first instance a Director of Transformation and Improvement, who will take forward the outworkings of what we've learned, again under those domains that I mentioned earlier in relation to this Public Inquiry, but also to look at what is coming out of the Neurology Public Inquiry, potentially Muckamore Abbey, you know, any other learning that's there. Plus dealing with some of the issues within the Trust in terms of how we address specific areas in terms of concerns in relation to improvements, such as overcrowding, and all of the ED issues that you would hear about. So that's now in place. 14:17 14:17 14:18 14:18

And now that we are moving out of the phase of the External Reference Group that has supported us in terms of thinking about how we take forward on those four domains, our last meeting with the External Reference Group is this Friday. Once that's closed off then we will be moving to the position of having essentially our own Internal Reference Group, which is essentially the oversight through the Director of Transformation and Improvement to really drive and quality assure then the impact of some of the changes that we're making across the organisation. So that is kind of the grand plan, if you like, in terms of how that comes together. 14:18 14:19

139 Q. Yes. Okay. Well thank you for that overview. I'll pick up on some of the aspects of that in more detail as we move on. 14:19

But what I want to get clear from the outset, before we explore some of the improvements is, can you help us from your perspective to understand how below the acceptable standard was this Trust before this improvement work commenced and, secondly, and related to that, how could you have been standing in Craigavon Hospital - well not just you personally, but I mean you as a Senior Management Team, be standing in Craigavon Hospital in the early summer of 2020 thinking everything is working well, or working reasonably, and not understand that there were these raft of issues that we see addressed through the Serious Adverse 14:19 14:20

Incident reviews? So can you help us with those two points?

A. So, I think that in terms of the level of performance of the Trust, right, this was a Trust that probably up until there were a significant number of changes of 14:21
Directors, or Chief Executives and Medical Directors over a relatively short space of time, I think was seen as a high performing Trust, right, and it was recognised for that on the basis of it's activity and the way it used money, so based on those two parameters 14:21
essentially. And I think that then with all of the disruption that came with the constant churn in Chief Executives and Medical Directors, I think it lost its way a bit and, again, got stabilization back I think then whenever Shane Devlin was appointed and was there 14:22
for that period of time, and then, you know, obviously I came as Medical Director, continued on and, you know, there has been less churn certainly in the meantime in relation to that. And the Directors who are now appointed to the Senior Leadership Team have been in 14:22
the system either as Assistant Directors or have come in as very experienced people from other places and are very familiar with health. So that has been helpful to us.

14:22

So I think to some extent, and maybe this is - I think it probably rested on its reputation of the past, and I think didn't completely recognise that it was missing a lot of the governance processes that it required in

order to ensure patient safety and quality.

140 Q. Just - I'm anxious not to intervene too much - but how does that happen? How can experienced people fail to see that standards expected of Trusts in terms of governance are not being complied with, and why does it take an event such as, or a series of events such as what was unpacked from June 2020 onwards, to trigger that realisation? 14:23

A. Well, I think it was relying very heavily on really good clinical practitioners and people who were there as managers who were trying their best. I think it's difficult to describe, but the biggest parameter that we would tend to go to or, you know, it's not, it's a proxy for quality of care very often, rightly or wrongly, is the mortality review. It hadn't been reviewed for a number of years when I got there. So actually the evidence wasn't in front of people. Now we've since reviewed it and there wasn't anything out of kilter with it. But I think in terms of all the nuances of that, trying to understand actually, you know, where the serious problems were, you know, and these are common to all Trusts in terms of, you things like insulin prescribing, anticoagulation, you know, acts of violence and aggression and all of that. It wasn't robustly recorded and reported anywhere in terms of understanding about patient quality and safety. Right. So I think it was relying on the fact that on a day-to-day basis people did what they always did, which was they turned up to work, they did a really good job 14:23 14:24 14:24 14:24

for each individual patient as they saw it, but in terms of bringing the system together and the system learning that we need it in order to know whether or not, you know, where we were in relation to the mean, I think that was difficult and the evidence wasn't automatically there. It took quite a lot of work to understand where we were in relation to other people. 14:24

At a point in time to save money the clinical audit team had been stood down. Now we have, you know, as part of the whole governance review we have reinstated that and, you know, through the papers you will see some of the outworkings of that and what they've done with that in a relatively short space of time and, again, not all of that information was available to the organisation in terms of where it was, you know, in relation to its own activity, but also then in terms of driving improvement and being able to benchmark itself locally and nationally. So... 14:25 14:25

141 Q. Sorry, again. 14:25

A. Yes.

142 Q. Hopefully I don't take you off your track of thinking, but sometimes if I wait to the end of your answer I'll miss an important point.

A. Sorry. 14:25

143 Q. And the important point I think that you've just made is that at some point in history, I think from memory it was '16/'17, some time around then, the audit function was essentially sidelined, resources were

needed elsewhere, and this audit was seen as expendable. So when we think about that, and this may not be an entirely straight line, if we bring it to what we know about the urology multi-disciplinary team, but it could be any service in the Trust estate, you have a practitioner, according to the SAI outcomes, who is not complying with NDT recommendations. So patients don't get the recommended treatment, they don't get referred down the road to oncology and what you have, but behind that it can't be spotted, it can't be identified, or it's going to be difficult to identify it because you don't have resources into audit or tracking, or whatever label we put on it, it's - is it as blunt as that in some respects? 14:26 14:26

A. Yes, I think so, and I think, you know, if people had concerns in certain areas then they didn't readily have the tools available to them to help them understand what the problem was, you know. So if you were concerned about, you know, some of the clinical processes in relation to urology, it would have been very difficult to have had an audit project down around that because you didn't physically have the staff there do it for you. 14:27 14:27

144 Q. And obviously the commissioning process, and we'll come to that perhaps towards the end of your evidence, or at least that's my plan, we can't forget as we go through your evidence that you are existing as a Trust - in terms of your income, very much dependant upon what is allocated to you from the commissioners - but it 14:27

appears from what you're saying that those budgetary considerations, and the emphasis which your predecessors maybe put on delivery as opposed to quality and safety in terms of audit and all that goes with that, those were choices that are made because of the context, the budgetary context in which the Trust has to inhabit? 14:28

A. Yes, and I think, you know, there's an old adage which is "What gets measured gets done". Right. So at a point in time in the past what got measured was how much money you spent and how much activity you did. Right. There was less attention given to - and it's difficult to put a figure to it - quality and safety. So the two things that were easily measurable were done extremely well in relation to that. But then behind that, I believe that that was at a cost in terms of the clinical governance construction within the Trust. 14:28 14:29

145 Q. So when we go back to my question about how the senior leadership team - and maybe my premise is wrong? I said Senior Leadership Team standing in Craigavon Hospital June 2020, before Mr. Haynes and Mrs. Corrigan do their scoping work, you think all is well, obviously the June Champion Report freshly delivered late the previous year, and you have to work through some structural changes which are obviously very important, but it doesn't seem to me that you or your colleagues in the Senior Leadership Team had a sense of - and take the cancer services as our primary example, you didn't have a sense of how degraded the governance 14:29 14:29

arrangements had become?

A. I think that's a fair reflection. And if you think back to the Maintaining High Professional Standards Investigation, right, which I think at this point in time was misleading, you know there was a suggestion that a wide range of people were consulted with at that point in time and that the feedback they gave was - I mean, one of the ultimate decisions that came out of that was that there weren't any concerns about Mr. O'Brien's clinical practice and, again, that was - and what was presented through the Maintaining High Professional Standards Report suggested that this was about administration and about professional, you know, management, but actually wasn't about - there weren't any clinical concerns. And I think that reassurance, and it was a reassurance, it wasn't an assurance, I think blinded us to the fact that actually what really hadn't been looked at in there was the cancer side of the house. So in normal circumstances, you know, if I were, for arguments sake, asking for a dermatologist or a psychiatrist, you know, to be investigated, you would assume that all of the activity would be within their department. I think what wasn't appreciated within that investigation was the fact that there was a part of his clinical activity sat without the people who were spoken to and that there was information in interest, and that I think came to light very forcibly then in June 2020. 14:30 14:30 14:31 14:31 14:31

146 Q. Mmm.

A. So that side of the house, the cancer side of the house was quiet until we got to June 2020, and then there was a realisation that actually all of this was going on in there. And, in fact, you know, the concerns about workload, waiting times, triage, all of those things were important but didn't completely map on to what we found then in relation to cancer.

147 Q. That perhaps provides some of the explanation and understanding about what was deficient.

A. Mm-hmm. 14:32

148 Q. You know from your reading, and obviously it's before your time, that even amongst the triage dictation, private patients, notes at home shortcomings, they were known about for quite a long time?

A. Yes. 14:32

149 Q. So there was something deficient in the, whether it's the systems of governance or whether it's the people who work those systems in terms of their understanding of what they do when they are aware of shortcomings?

A. Yeah. 14:33

150 Q. So we'll come back to cancer in a moment.

A. Yeah.

151 Q. But is that a fair observation to make, that it's not - problems existed not just because stuff was hidden from plain sight, the cancer stuff, or it hadn't come, but there were problems on the other side of it as well amongst the stuff you did know about? 14:33

A. Yes. So I think at a point in time it functioned like two different departments almost, there was the urology

side and then there was the cancer side, and there were assumptions made I think about both parts of that and by each other, and I think that, you know, the individuals involved I think were very caught up - I mean these are really busy jobs, so I'm not - and I mean the volume of cancer activity and urology activity, you know, as you know from the statistics, you know, just has mushroomed over the years, and I mean the workforce hasn't kept up with that in terms of numbers. But, you know, they were very busy. I think they dealt with what was in front of them, and as you say, in terms of the connection across the system I'm not - it wasn't there at times. They didn't see the big picture, they saw the piece that was in front of them. And, again, you know, very busy jobs, people preoccupied with trying to get the best out of what they're doing, that's not completely unusual. But I think as a system where we could have been much better was actually taking a step back and understanding how that system should fit together, rather than leaving it always to the people on the ground to work that out for themselves. 14:34 14:34 14:34

152 Q. Mmm. Because I mean one of the explanations here, and perhaps the primary explanation that you've given so far for the deficiency in the governance arrangements, was the budgetary consideration forcing the Trust's choices or choice to go down one route, and to sacrifice, for example, audit and what flows from that. But I suppose the Department would say that there is a 14:35

limited purse and you have to make decisions that are balanced. You can't simply point to the person and say "Well, I can't do governance, or I can't do governance to the extent that I'm going to shrug my shoulders and put people at risk", I'm sure that's maybe to exaggerate the point. But the Trust made a decision here at one point in time to undernourish the governance arrangements? 14:36

A. The way commissioning works in Northern Ireland, it's different from Scotland, England and Wales, in that you're given an allocation per Trust and it's based on the activity that the Department buys from you on behalf of the population. Right. So, there is an increment built into that, usually about 10%, which is about providing systems to support that. So there was a tendency in the past when systems were commissioned basically to work it out on the basis of activity, the numbers of doctors and nurses for arguments sake that would be needed, and then some finance given towards administration. There was never a budget towards governance. I mean what every Trust does is make, internally make a decision about that in terms of how much or how little they want to put to it. Right. So when things tend to get tight, what happens is the governance gets stripped away and it is put into the patient facing activity to get the patients seen, but it doesn't necessarily mean that the quality of that activity is as good as it should be and, you know, it restricts the ability to quality assure it. So there's 14:36 14:36 14:36 14:37

always a balance to be struck on that. So I think the reason that, with the best will in the world, I think that there was high levels of productivity, but actually in terms of the government support to that to provide the quality assurance, that that's the part that was missing. 14:37

153 Q. Yes. Another aspect of this, and interested in your views about whether the diminution in governance activities may have had some impact on attitude or behaviours or culture amongst the middle management staff, you talk in your witness statement about your exposure to some middle managers, and you were asked about them on the last occasion and you came back with a Section 21 response and identified Mr. Carroll and Mrs. McVeigh as being examples, I suppose, of what you saw as being a problem culture. 14:38 14:38

A. Mm-hmm.

154 Q. And I think it's perhaps a little unfair to focus on the two of them directly, but perhaps let me set it in the context of the evidence that you gave. So if we go to your witness statement at WIT-91953. Sorry, if we go - just scroll down. Sorry, it must be I think over the page, please, towards the bottom of this page, yeah. Okay. Thank you. 14:38

14:39

This is setting out the question that counsel put to you on the last occasion. You were - just up a little bit - you were explaining in your evidence that coming into the Trust you got pushback from some staff, and

this is within the question, you felt that your queries - they felt your queries were criticisms, and you were asked about that, and the answer then towards the bottom of the page:

14:40

"There was certainly a number of occasions when I was very robustly challenged by middle managers within the Trust, not Martina Corrigan and not any of the other people who worked to her, in relation to what my role and function was, why I was asking these questions, and were a bit alarmed, I think, about the level of curiosity in relation to how this worked. That didn't stop me asking the questions, but it did make it more difficult in that I had to keep coming back and back to try to get the answers that I needed."

14:40

14:40

And then over the page. So just scrolling down, and not having perhaps refrained from giving the answers on your last occasion because of perhaps the sensitivities around it, you gave the names of the people here, and you go on then within your statement to set out some of your concerns.

14:41

If we go, just to go forward in this to the bottom of page 57 in this sequence. So what you're saying is that within the Acute Directorate it was your experience that it held on to its information under the guise at that time of managing its own governance, which is a system that had been instigated in the past.

14:41

"As a result of this it was very difficult for the Director of Nursing and me, as Medical Director, to access the governance information we required in order to provide accurate assurance to the organisation. By the same token, Acute regularly believed that it was left to fend for itself." 14:42

And then just finally just scrolling down, when you:

"...spoke to others in the organisation about these behaviours by the Assistant Directors, there seemed to be an acceptance that this was the way in which individuals behaved and business was done and everyone worked around them. I hadn't encountered attitudes like this from middle managers in previous organisations." 14:42 14:43

So you gave those two names as examples of people who appeared to be oppositional towards your requests for information, and you've seen their responses, and they denied behaving in any way that could be considered untoward. But what I really, and you can comment on that by all means, what I really am interested in asking you is, is it your observation that as well as the systems being undernourished in governance in terms of resources allowed towards governance, there was also a people problem. The culture was such that management, relatively senior management, wasn't 14:43 14:43

sharing governance related information with those who needed to know it?

A. Yes, and just in relation to, you know, naming Anne and Ronan. As you know, I was quite uncomfortable about doing that, and I think in fairness to both of them, I think they ended up being the voices I think of what was the culture in that Directorate at that point in time. So, you know, they were fairly discrete examples, which was the reason that they were mentioned. But I think they did - they were the voice of it. And, you know, in fairness to the two of them as well, they had been through numerous changes, and I think had been there a long time, had been trying to manage in really difficult circumstances. But the approach that was taken towards me was - and this is a fairly crass way of describing it - but it was, you know, "get your tanks off my lawn, this is not your business, we manage this, why do you want to know the answers to these questions?", and I think that's because the way that - that was the way they had been used to operating for long periods of time, and without a realisation that this was a systems problem that just didn't belong to the Acute Directorate. 14:44 14:44 14:44 14:45

So on the basis of that and, again, you know the changes that we have made in relation to operational governance have been to centralise it now. So it is all brought under the office of the Medical Director, and the governance leads and staff are business 14:45

partners along with the different directorates. Now, it's on the premise that there has to be a really close working relationship with these directorates, because we are completely dependant on their expertise and local knowledge to actually understand but also to try and help us develop and standardise what's going on there so that we're not getting these pockets where actually business is done differently and runs the risk of being unsafe.

155 Q. Yes. So you are no longer - so as an organisation you're no longer isolated as a senior management team from what is going on within each of the directorates, because there is now an energy or a requirement propelling the information out of the services up towards the top table on a very frequent basis, is that the position? 14:45 14:46 14:46

A. Yes. And I think, I mean I think the weekly governance report helps with that, and there is an expectation that we, you know, if anybody is worried about anything that they raise it. And, again, it may not be something that we're going to react to immediately, but in terms of building up the knowledge level of, you know, or taking, you know, a temperature check in relation to the organisation, all of that information is really useful. So, you know, we actively encourage people to speak up. And, again, you know, back to the piece of cultural work that we have started across the organisation in relation to being open, which came out of the IHRD Inquiry, and the work that Justice O'Hara 14:46 14:47

did, and the work then that we're pursuing in relation to being open and developing an open and just culture, all that of is embedded in that as we try to take that forward.

156 Q. Okay. Well we've touched upon a number of strands, hopefully with a degree of connectiveness by way of overview over the last 50 minutes or so. I want to go back a little. I want to ask you about, I suppose the External Reference Group is my starting point, but I think the Inquiry wants to get a sense from you about where the Trust is going from now. Having completed something of the journey, what are the next steps? So in terms of the External Reference Group leading in to the work that's been done around the Trust's vision through, I think it's Mrs. Wilson, is that right? 14:47 14:48 14:48

A. Yes, she's Director of Performance and Planning and Informatics.

157 Q. Yes.

A. Yes.

158 Q. And the work that's going to go into the five-year strategy. Could you help us first of all in terms of the External Reference Group. You've kindly supplied the Inquiry with a lot of papers in relation to it. The Inquiry is interested to know the origin of that group, why it was brought together, and what has it's role been over the past several months? 14:48 14:49

A. Okay. I think I was - I think we all where, but I know that I was particularly shocked by the fact that we'd had this blind spot that we discovered in the summer of

2020, and I felt that, you know, the history in recent times in relation to Mr. O'Brien and what had happened was full of blind spots and actually here was another one, and I had been, you know, inadvertently complicity with it and that troubled me, and I think that on the basis of that I started to have conversations with people, as, you know - I mean it resonated with some of the other members in SLT, just in relation to how we would take this forward. So I spoke broadly to, you know, trusted advisers around the system in relation to, you know, if you're faced with something like that, how do you develop a reflective mirror for your own organisation to spot things that you don't normally see, because, you know, there's a whole psychology of group think and, you know, finding yourself repeating mistakes and all of that inadvertently. So the advice I got back then was to maybe think about bringing together a group of experts, which I did. So I approached Dr. Frawley, who was Ombudsman for a long period of time, and a huge career in terms of NHS management throughout Northern Ireland, and has been involved, you know, nationally in various bodies, and a huge source experience and expertise, and on the basis of the conversations then with Tom Frawley then, you know, approached Mary Hinds who was previous chief nurse whenever I worked as a consultant in the Mater Hospital, and also, you know, had various other high profile roles across Northern Ireland, you know, very well regarded in terms of patient safety and quality.

14:50
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14:50
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I had done the patient safety, the Scottish patient safety fellowship a number of years ago, and the focus of that for those 18 months/two years is around developing systems around safety and quality, and had met - Simon Watson was the person in charge of all of that at that point in time. He's Medical Director for NHS Improvement Scotland, and Robbie Pearson is the Chief Executive of NHS Improvement Scotland. So I went to Scotland to have a conversation with them, just with Robbie in the first instance, and his Chair, to find out if they would be interested in supporting this work with us, given that they are involved in regulation and improvement, and then Robbie suggested to me to bring Simon on board given his background. 14:51 14:52 14:52

And then alongside all of that, Hugh McCaughey has been involved with us and, again, he, as previous Chief Executive of the South Eastern Trust, hugely recognised figure in relation to patient safety and quality, and was an NHS England lead director in relation to safety and quality in England in the last few years before he retired, and then Veryan Richards, who I worked with when I Chaired the Invited Review Service for the Royal College of Psychiatrists, and she originates from Northern Ireland but works, you know, across Wales and for Welsh government, and through one of the colleges in Oxford, she's an ethicist. 14:52 14:52

159 Q. Yes.

A. So that I felt gave us - and, again, that was built over time and conversations, and that I felt gave us a really robust group of experienced experts who wouldn't be frightened to challenge us as a group in terms of some of our thinking, had huge years of experience in the NHS and understood it intimately and, you know, had enough distance from the system at this point in time to be able to see us a bit more clearly than we could ourselves. 14:53

160 Q. Could I just - I think it might be helpful if we bring up on the screen, Mrs. Toal, I think it was her attempt to define or describe the group's purpose. TRU-303726. 303726. TRU. So this is taken from the record of the External Reference Group's seventh meeting which took place on 10th November 2023, and just scrolling down. So I think in this instance Mrs. Toal is describing what you said to a Trust Board meeting in describing the work of the External Reference Group, she is summarising a workshop or a talk you gave to the Board on the subject, and so, it said - she said: 14:53 14:54 14:55

"She had explained to the meeting that the purpose of the ERG is to fulfil the role of a critical friend by providing independent challenge and support to the Chief Executive and Directors who were leading the Southern Trust's Improving Organisational Effectiveness Programme." 14:55

She explained she had advised the subgroups - and we'll

come to this in a moment:

"...the subgroup representatives that the central aim of this programme is to improve organisational health, maximise safety, quality, and the experience for patients and service users and staff by identifying areas of concerns highlighted by the Inquiry into urology services. Heather continued that she also explained to the meeting that the External Reference Group had identified four themes which had led to the formation of the four subgroups." 14:55 14:56

And they are set out there as the Patient Safety and Quality Subgroup, the Governance Subgroup, Data Analytics, and Culture and Leadership. 14:56

So just help us to better understand this. So the External Reference Group, you've described it's membership, come together at some point in 2023.

A. Yes. 14:56

161 Q. And have a series of meetings, and it's due to conclude it's work this month. Is that right?

A. Yes.

162 Q. And we see, just scrolling back down, please, or back up, we see that it's being described as leading the Trust's Improving Organisational Effectiveness Programme, and also assisting the, as part of that, assisting the Trust to improve against the areas which are the subject of this Inquiry. So is it - tell us 14:57

how it works and what is the, if you like, the end game for the External Reference Group? Is it, for example, going to produce a report of recommendations or is it not that kind of group?

A. It's not that kind of group. And what it does is, it has led - it has helped - it has led the thinking in relation to this rather than the doing, if you know what I mean? So it's there to stimulate us to think and to guide us towards improvement and to think how things might be done differently. 14:58

So in the spirit of all of this, and given that this started out with concerns about a blind spot, what we will do and, again, it's the end stages of development at the minute, is we - those of us from the Trust, and that's myself, the Director of Nursing, Heather Troughton; Director of Medicine, Stephen Austin; Vivienne Toal, who is the Director of HROD, and Elaine Wilson, we will - and Jane McKimm who leads out in the Inquiry; and Margaret Higgins, who is now Director for Transformation and Improvement - we are putting together a report on where, what our progress has been over the last year with the involvement of the External Reference Group to report back to them to say, you know, "These are the problems that we brought to you in terms of what concerned us in relation to the Inquiry and what you heard yourselves", given that Veryan does, you know, an update in relation to each of these hearings, "this is what we heard from you and now we're

reporting back to you to make sure that what we said, what we all heard actually aligns and that we've got this right". So they won't produce a report, we from the Trust are producing a report, and then we will sense check it with them to make sure that we're all on the same page and that we have, you know, heard their suggestions and guidance in relation to this and that they can see that we have taken that on board and are enacting it as best we can as a bigger group.

163 Q. So can you put that to an example? We can see, and maybe I'll bring it up now, it might be helpful to assist the discussion around this, Veryan Richards, one can see from the papers supplied that she's following very intently the questions I'm asking of witnesses and the answers that come back, and the questions that the Panel is asking and the answers that are coming back, and she has provided the External Reference Group with extracts from the transcript, and a series, if you like, provocative, "have you thought of this?", kind of question, isn't that right? 14:59 15:00 15:00 15:00

A. That's right, yes.

164 Q. And I'll show the Inquiry some examples of that. So if we go to TRU-303646. And this is a matter that was discussed at the External Reference Group meeting on the 29th September. And so, the aims, she said, I think she's referring to this exercise, is set out there, and then she does a transcript, notes and analysis, and if we scroll down the page she sets out the various themes that she's going to explore, or have 15:01

been explored in the Inquiry, and then over the page, we can see, and this was I think Day 42 of the Inquiry's work, so she records the questions and the answers, and then in blue she extracts, as I understand it, and you can correct me if I'm wrong, an issue which 15:02
the Trust will have to grapple with, or she thinks might be wise to grapple with, arising out of the evidence that has been given. Is that a correct interpretation of her approach?

A. Yes. No, I mean as I understand it, Veryan listens 15:03
very intently to all of this, and then I think, you know, given her perspective, and particularly her perspective as ethicist, she comes back to ask these questions, you know. But she's very clear that this is coming from her alone, it's not coming from the group, 15:03
and it is to feed into a development of the group's thinking. But, yes, that tends to be the pattern of it in terms of how it is done.

165 Q. And if I could bring you to another document, because I think it originates from her, but maybe you can clarify 15:03
it, if not today at some future point, TRU-304137. And here we have across eight areas, here's the first one, the Trust Board, and it goes into Senior Leadership Team, workforce, quality, patient safety, MHPS, communications, all of the sort of themes that the 15:04
Inquiry is interested in, and on the right-hand side we have the Inquiry's Terms of Reference. So do you know, is this document something that has originated from her?

A. I think it has emerged from within that group and I think it was developed across herself and some of the other involved in the group, yes.

166 Q. Yes.

A. But I think it is bringing together some of the questions that she has put to us, yeah. 15:04

167 Q. Yes. Yes.

A. Yeah.

168 Q. The Inquiry Panel will no doubt look at this in its own time, but I think it sets out a series of questions under each, if you like, each of the themes to be extracted from the Inquiry's Terms of Reference. It doesn't answer the questions but sets them out as, if you like, issues to be thought about by the Trust. Is that right? 15:04 15:05

A. Yes, that's correct. Yeah.

169 Q. So, that exercise having been performed by her, where is that work going? What's the next stage of it?

A. So we have - we have - this is, in terms of the collation of all of this, this is being done in anticipation of the meeting on Friday, on the 15th. So we have been down through this as a Senior Leadership Team, you know, we've picked up the questions as we've gone through the meetings, but as a Senior Leadership Team now we've brought everybody together just to revise this to get this into everybody's consciousness again. And I think then as we go forward and we continue to improve, because a lot of our focus and activity has been about, you know, changing some of the 15:05 15:05

structures, you know driving up the quality of governance, you know, running the lookback review in relation to all of that, you know, against a whole backdrop of what was originally Covid, you know, the concerns about Daisy Hill Hospital, cytology, you know, 15:06
the Caudrey Review, all of those things that have been going on in the background, sometimes involving the senior staff. So against the backdrop of that, I think this is now part of how we start to test our systems in terms of some of the changes that we've made, to say, 15:06
"Actually, in terms of how we've put this together, is this representative?" So when I look at those questions, for example, in relation to Trust Board, you know, I will file down through all of the committees that are there, what actually gets discussed, and think 15:06
to myself "Actually, have we addressed these?", and I can see areas where we need to improve and other areas there where I think "yes, we're nearly there or we've got there with them", and the same with each of these sections. I think this is a good way for us to 15:07
challenge ourselves, you know, in terms of whether or not we've delivered.

170 Q. Yes. Yes. So again just for clarity purposes.

A. Mmm.

171 Q. You've described it I think quite well there. Before 15:07
the External Reference Group came together, you had done a lot of work in terms of changing structures, a lot of focus on governance. This is related but a different strand or a different exercise that the Trust

is now pursuing?

A. I think - so this was part of the reflection to us in terms of, you know, what we've done and what we need do.

172 Q. Yes. 15:07

A. Right. And I think the next step in this process then is the work that will be driven under the leadership of the Director of Transformation and Improvement in terms of taking the learning that we've got internally obviously, you know, and this is anticipating what this 15:08 Inquiry will report on, because I, I completely accept we may not have got this right. But what we're trying to do is improve as much as we possibly can in the interim, because we felt this was too important for us to put to one side and wait, you know, part of this 15:08 will be for us to continually consider this to drive the improvement within the organisation and to build on it. So, you know, in relation to this to think if we haven't got - if we're not answering these questions, if they're the right questions, then are there other 15:08 things that we could do to try and improve in all of this? And we will keep going with that and keep reporting on it.

173 Q. Yes. Yes. So if we go - I just want to highlight some issues or some developments that have emerged through 15:08 the external reference groups. If we go to the minutes for the 29th September last year, TRU-306 - sorry, 303681. That is 303681. And Vivienne Toal is updating the meeting, and she's explaining - if we just scroll

down - that - sorry, it's just down on over the page. Just down a little further, please. Down to the next page. Sorry, I've lost my place. Could you go back to the bottom of page 81. So, Ms. Toal - I can't find it on the page - but she's explaining to the Reference Group that Elaine Wilson, as you've said Director of Planning?

A. Mm-hmm.

174 Q. Has been asked to develop a new organisational vision?

A. Mm-hmm. 15:10

175 Q. And to be under-pinned by a new five-year strategic plan. I hope if I can just take another look down a page, she sets out - just keep going. Yes. So just below that bullet point. Yes. Is that something that has been agreed now that's being taken forward? 15:11

A. Yes, and the purpose in me presenting that to Trust Board in September was to essentially get their affirmation in relation to this, because we needed to be absolutely sure that Trust Board was behind all of this, you know, us as collective, in order to deliver. 15:11 So Elaine has started this week and essentially - and we see the five-year vision as being, you know, the vision for 2030 essentially, I know it's slightly longer, but, you know, within all of that, you know, she has - she and other members of the team have 15:11 consulted widely across the organisation with our external stakeholders, she's working our way through that, with our public, with patients and carers, and service users, in relation to what they see we should

be delivering over that period of time, and then, you know, internally with any of us who are Trust Board members. So that's a work in progress at the minute.

176 Q. Is that, just to be clear, this work on vision and work on strategic plan, is that something that comes up in the calendar every five years and now is the time do it, or is this, if you like, new thinking borne out of the experiences of working through problems with the External Reference Group? 15:12

A. So naturally in the lifespan of any Trust there will be a refresh in some of these things, okay, but I suppose in recent times because we haven't had a Stormont assembly until recently there hasn't been a programme for government renewed, and usually the corporate plan and corporate strategy falls out of that and then each Trust then designs its own interpretation of that in terms of taking that forward. In the absence of - although we don't imagine it will be terribly different, but we will keep an eye to it - in the absence, before this started, of a programme for government and, you know, the usual steer from Stormont, we went on ahead and started this anyway, because whenever you look at, and again this was pre-pandemic but, you know, has been a theme and was a theme that came through in relation to the changes made in Daisy Hill. One of the things that was constantly said was "We don't have a vision in terms of where we're going", and that was one of the reasons that people felt at sea, which I completely agree with, I 15:12 15:12 15:12 15:13

think that wasn't clear. So built into all of this was about us setting strategic direction so that, you know, particularly staff and service users would understand, you know, what it was we were trying to achieve. And within that I think, and what we're modifying at the minute are essentially the areas that we'll focus on. So it's about quality and safety, about adding value for money, and then about listening and acting intentionally. 15:13

177 Q. Yes, and I'm trying to - I've been struggling to find these key principles. I think they're just down the page. Yes. And so Mrs. Toal is explaining that the work to be taken forward in terms of the vision and the strategy will be under-pinned by, or she hoped that they would be under-pinned by these four principles as you've outlined: 15:13 15:14

"safety and quality of care.
Investing our resources were they add most value.
A commitment to following through all actions that are agreed, and all under-pinned by intelligent use of data." 15:14

So has that work started?

A. Yeah. Well this was part of the consultation. So based on what we learned in the process of the Inquiry, you know, the staff cultural survey that had been done at an earlier stage, and then some of the more recent learning that had come out of our experiences with 15:14

Daisy Hill Hospital and, you know, the Covid review and all of that, these are the themes that kept emerging. So that shaped our vision in relation to that. And they have been refined in terms of, you know, with the presentations to the different groupings, you know, it has been through various iterations, but essentially this is getting close to what we will see the vision of the Trust being.

178 Q. And we can see, jumping ahead to the next meeting of the External Reference Group. If we go, for example, to TRU-303732. And Ms. Richards is explaining that it's essential that a protected resource is agreed to support the process and also that an updated narrative was developed on the Trust's website so that that could be shared with the staff. In terms of the senior leadership, and I include you in that obviously, and the Chair of the Trust Board, to what extent is it important to bring the workforce and, indeed, other stakeholders along with you in developing the strategy and the vision? 15:15 15:15 15:16 15:16

A. It's pointless do it without them because, you know, I can stand at the front and talk about what we might aspire do, but if the hearts and minds of, you know the patients and service users and the staff who work in the organisation aren't with us as well, then we won't deliver on it. 15:17

179 Q. There is talk within the External Reference Group papers, to the need for an engagement plan?

A. Yes.

180 Q. That is engagement with the staff, with external stakeholders as well. Is that something that is being developed?

A. Yes, and that's ongoing at the minute.

181 Q. Yes. 15:17

A. So through the work that Elaine leads, she and her team lead in terms of these meetings with various groupings and getting their feedback on all of this, you know what they're doing is explaining the background to this, you know, what we're proposing to do and, you 15:17 know, then modifying anything that they hear in there in relation to that. So she will come back to present - she gives us updates on that at the Senior Leadership Team, but she will come back I think with a draft proposal in relation to that over the next number of 15:18 weeks, you know. So that will happen reasonably imminently.

182 Q. And the principles that I outlined there, we saw on the page in front of us, patient safety and quality, accountability and - sorry, I was reading from 15:18 something else. Sorry.

CHAIR: Resources.

A. The second one is adding value for money.

183 Q. MR. WOLFE: Yes. Sorry, I'll just get my note to get it absolutely - I'm sorry, I'm causing confusion. 15:18 Bottom of the page. So why were those principles selected? Do they, I suppose, give an indication as to where you and your team see the need for development and the need for clarity?

A. Yes, I think so. These came out, you know, they came out of our experiences through the Public Inquiry, the work that we undertook as I say in Daisy Hill and, you know, some of the learning that came out of the Covid experience, plus we had a big review to do in relation to that at a point in time, and then the culture review that was done 2016/2017 in relation to where the organisation was and, you know, some of the feedback we've had recently has resonated with that. So it came out of that because - and then underpinned by - we've two statutory duties in Northern Ireland; one is to provide safe quality care and the other is to break even and, you know, I think, you know, we also have to be pragmatic in the midst of all of this and be cognisant of the financial environment we're in, that we cannot waste resource. So it is really important that we do these, but not in an unrealistic way, and that we realise that what we do must add value and we must change what doesn't add value. Then I think, you know, one of things - again, I was very struck by whenever I arrived in the organisation but I think we are getting better at is, you know, a commitment basically to listen and to act intentionally, because I think, you know, one of the things that was, you know, I heard whenever I came into the organisation, and I think led to that apathy around understanding the impact of the loss of governance in all of that, was this sense that, you know, "It doesn't matter what you say, nothing changes", you know, it just felt all a bit

15:20 15:20 15:20 15:20 15:21

hopeless and, again, I think, you know, what has come through certainly in the consultations with particularly our, you know, the staff within the organisation, has been that we need to listen to what is being said and then we need to respond, and sometimes that response might be "I can't do anything about it at the minute", but people need to feel that they're being taken seriously. And then I think as well, it is again this intelligence use of data. How do we join the dots to actually make sense of all of this and try and reduce our tendency towards blind spots? 15:21 15:21

184 Q. Yes. There is another group that, as I understand it, has recently formed under Mrs. Toal's chairmanship, and that's the People and Culture Steering Group? 15:22

A. Yes.

185 Q. The Terms of Reference for that group are to be found at TRU-305063. And it's purpose is concisely described there at the top. And if we just scroll down. The key - just pause there. So the purpose of this group, it appears, is to provide support to the Strategy and Transformation Committee. Is that the Committee that Mrs. Wilson is leading to bring forward the strategy and vision or is that a different group? 15:22

A. So, the Trust Strategy and Transformation Committee is Chaired by Eileen Mullan as Chair of the Trust, okay, and that is again about bringing forward into the body of Trust Board by reporting, but also to hold within the organisation, you know, the strategic changes that 15:23

are being developed within all of this and any of the transformation that's made. So basically, I mean you've heard the quote, you know, "culture eats strategy for breakfast", and I mean we see at large all over the place. So it was really important that 15:23
actually, you know, the people plan was developed last year along the lines of wellbeing belonging and growing, again completely evidenced based in terms of how that was pulled out as being the things that are really important in developing, you know, an excellent 15:24
workforce that enjoys doing its job and does a good job. But in order to be able to do all of this, all of this needs to be aligned. So the people plan was developed and is developing, continues to develop alongside the strategic work that's going on, and these 15:24
committees then report into this, or these steering groups report into this Committee that's chaired by the Chair of the Trust, to make sure it gets right to the heart of the organisation.

186 Q. Okay. So just so that we're clear. The job of 15:24
bringing the strategy and the vision, it's being taken forward by Mrs. Wilson under the auspices of a Strategic Implementation Programme Board, is that right?

A. Yes. That's right, yes. 15:25

187 Q. It's going to report into Mrs. Mullan's Committee, is that right?

A. Yes. Yes.

188 Q. So that's the Strategy and Transformation Committee?

A. Yeah. Mm-hmm.

189 Q. But Mrs. Toal's group, it has an opportunity to connect into those processes, is that right?

A. Oh, yes. Yes. And that works hand in glove, because, you know, that's very much about how do we deliver what we've promised through the people plan, you know, strategically, in terms of making sure that staff are aligned with what this vision is going to be and see it as being worthwhile? 15:25

190 Q. Okay. So her committee, or her group, that is Mrs. Toal's group, is the conduit to ensure that your people, that is your workforce, are given an opportunity to have a say on the development of the strategy, the development of the vision? 15:25

A. It's the staff on the ground who are exploring all of this with the various stakeholders come through the Director of Planning's Directorate, their Directorate of staff from there, but they're supported by Vivienne Toal's HROD staff, okay. But both of them would say that that is very much about, you know, helping to test these concepts to understand if we are heading in the right direction with it, and we think we are, the iterations seem to be repetitively saying the same thing, which is good, in and around. But in terms of the delivery of this, this will be delivered out through each of the directorates across the Trust, because they can help shape it and describe it. But in terms of the delivery it has to come into the lived experience of staff every day, so that's the next bit 15:26 15:26

in terms of how do you make that transition so that this becomes the way we do business.

191 Q. Okay. So to summarise, the Trust is about to embark on a process where a five-year strategy and vision will be prepared. There are opportunities for staff and other stakeholders to contribute to the shaping of that? 15:27

A. Mm-hmm.

192 Q. And you have been supported in getting that project to the starting line by the expertise and experience of the External Reference Group, who have listened to your ideas, to your senior leadership team's ideas, and offered comment and advice? 15:27

A. Mm-hmm.

193 Q. How useful has been the engagement with the External Reference Group? 15:28

A. I think it has been enormously helpful because, you know, to have such ready access to so much expertise is rare and, you know, they come - the people involved externally I think come from a position of, you know, having had experience of some of these things themselves in previous lives, but come with, you know - and the knowledge of other people going through some of these things, and I think can provide us with a lot of information, point us in the direction of finding things out, that I think have given us the confidence to function because, you know, I haven't been a Chief Executive very long, some of the other people on our senior leadership team haven't been directors very long. I think in terms of providing us with the 15:28 15:28

confidence, you know, to be able to deliver out on some of these things, that has been enormously important.

194 Q. And in terms of looking in the rear view mirror and seeing the potholes and the problems that you're hopefully leaving behind, at least in terms of governance, but perhaps more broadly than that, what is your ambition for the strategic plan and the vision in terms of where it will take the Southern Trust as an organisation and the people it employs? 15:29

A. Well, I mean, we are embedding governance. I think, you know, in terms of growing our workforce, you know, we know that that has been a very unstable system over a period of time. So over the last year/18 months, I mean we have employed 155 international nurses, we have recruited 72 internationally trained doctors, I mean a huge piece of work in terms of bringing stability into the system and, you know, educating people to, you know, work in the NHS. I mean super colleagues, you know, really enthusiastic and ambitious, and very enthusiastic about the work that we do, and that has really opened up lots of possibilities. So there's all of that stabilization piece that has gone on. You know, I think we have developed ourselves in terms of just understanding our own business much better, being a lot more strategic and planned and purposeful in what we do. We're trying to get away from being reactive but, you know, you're constantly hijacked by horrendous winter pressures and overcrowding in emergency departments, which everybody had, which can very often 15:29 15:30 15:30 15:30

take you away from the business. But again I think, you know, as we - and we've had, you know, the concerns about Daisy Hill, which we've managed to stabilise in the medium term, you know, the cytology review, which was well documented as well, again that has all been about, you know, really making sure that all of these governance processes that we have in place now, which are sensitive to operations, are working well for us so we can get through these problems. So bit by bit, and I think as we encounter these difficulties we are approaching them with more confidence, we now have the armament in place to actually deal with them expediently and get them over the line and get stability back the system. So I can see, I can see from a maturational point of view that we are slowly but surely working our way through there and, you know, our intention each time that we're hit with a difficulty - and there will always be difficulties in Trusts - is that we touch at once and we make sure that what we leave behind is sustainable so that we don't have to keep coming back in crisis mode. 15:31 15:31 15:31 15:31

MR. WOLFE: Chair, I know we've been going for an hour and a half. Should we take a short break and aim to come back or can we sit to say ten past or a quarter past four. 15:32

CHAIR: Okay. So let's take a 15-minute break then and come back and ten to and then sit for a maximum half an hour after that.

MR. WOLFE: Very well.

THE HEARING ADJOURNED FOR A SHORT PERIOD AND RESUMED AS FOLLOWS

CHAIR: Thank you everyone. Just before you start, Dr. O'Kane, can I ask you again to slow down slightly, please. There's a great desire to get it all over with, I understand!

195 Q. MR. WOLFE: In the time that remains this afternoon, Dr. O'Kane, I want to break into some discussion about leadership issues, and we'll look at whether there was, if you like, a problem with leadership that brought us to the circumstances which give rise to the Inquiry, and we will want to explore what has been done to develop leadership both on the Board and among, in particular, the medical leadership. 15:46 15:47 15:47

Is it fair to say, you were reflecting just before the break on what was the perfect storm of issues that have confronted the Trust in recent times. Is it fair to say in your view that the work that has been done in relation to building leadership, developing leadership, has allowed you as a Trust to approach some of those issues with greater confidence? 15:47

A. I think so, but, you know, it's always in development, you know, just in terms of the learning that goes into all of that. So in terms of, you know, supporting the leadership of the senior team, we have partnered with Mersey Care, it's recognised as being a high performing Trust. You know, they recently again rated as 15:48

outstanding in terms of well-led review, you know, have given us some really robust support and help through their Chief Executives and their other senior leaders in terms of how we can develop ourselves. So, you know, we've taken that on board and used it. 15:48

We have taken time out on a regular basis to review or progress ourselves in relation to what we actually do and then to work with an organisational consultant basically to help us, you know, develop confidence as a 15:48
team to deal with issues, all of that. And a number of the senior directors have taken on national training. So, you know, with the support of the King's Fund, a number of them are, you know, have taken on top director training, all of that, to try and build that 15:49
confidence and resilience.

But we're not finished with that yet. We still have got others to help, you know, to develop their confidence just as they've come into the roles. And 15:49
also, you know, we have been in the process of trying to develop and embed coaching in all of that to help people along.

And then in relation to the staff. Throughout the 15:49
organisation, particularly through the Director of Nursing's office, she has led in leadership development among nursing staff, particularly at Band 7, 8A, 8B level, to drive that up to give the nurses there the

confidence, I think, to be able to speak up and to lead. And we appointed a cadre of divisional medical directors about 18 months ago and, again, they are being taken through, you know, a developmental process with each other. But, again, what we're planning to do now over the next financial year is to develop a leadership programme that will take in the senior leader - a collective senior leadership programme that will take in the leadership and the organisation. And then for the other disciplines as well, certainly through social work, AHP and others, that's being developed alongside, and they have a fairly strong tradition of support and supervision and development within all of that. 15:50 15:50

One of the areas I think that we noticed that certainly was put under a lot of stress at various stages was the administrative teams and, again, through the HR Department they have run a series of trainings with staff across the organisation, particularly those involved in administrative roles, to encourage them to step up and to start to think about the what the leadership opportunities are there. Because, again, if we are going to develop ourselves as a collective leadership organisation, you know, it's really important that everybody is given the opportunity to lead in the area that they can and that people are given, you know, the support to speak up. So all of that's in progress. And, again, it comes down through 15:51 15:51

the work that Vivienne Toal has been leading on in relation to the people plan and the cultural development with that.

196 Q. Yes. I'm going to touch on some of those aspects in a moment. One issue that arose in Ms. Mullan's evidence concerned you and the pressures on your diary and the time that you can commit to attendance at various meetings that she regarded as important, and I'm anxious to have your view in relation to that. 15:51

15:52

She explained that I suppose you face significant time pressures, perhaps not surprisingly given some of the issues that you outlined a few minutes ago, that no doubt required your personal and direct attention. But she explained - this is - I needn't bring it up on the screen - it's TRA-10154 and into 55, that as a result of the demands placed on you, you have not been able to attend four out of the five governance meetings, I think last year. 15:52

A. Mm-hmm. 15:52

197 Q. And you've missed two Audit Committee meetings in recent times, and this has caused a ripple of concern with the Non-Executive Directors. Albeit, in fairness to the evidence, and the balance in the evidence that she gave, she said it would be remiss of her not to acknowledge that whilst all this other stuff is going on there has been tremendous work done as a result of the outworkings of the Inquiry. 15:53

Do you have any concern that because you're perhaps being pulled in several different directions at the one time that there is a risk there in terms of your leadership role and the lead that you must give to staff and the assurances that you must find the time to 15:53
obtain across the Trust? In essence, are you sufficiently resourced to do your job safely?

A. So, in relation to the Governance Committee and the Audit Committee, I think it's fair to say - well I don't want to give the impression that those meetings 15:54
aren't important, they are. But, in terms of the papers do with all of that and my opinion going into that Committee either through the Deputy Chief Executive or other people, those are all discussed at the Senior Leadership Team meetings, and then the 15:54
papers are passed in, and if there's anything of concern I bring those up in my one-to-one with Eileen, which happens every fortnight, or through the Executive Directors meeting which happens every fortnight, or, you know, bring it to the NEDs meeting which happens 15:54
approximately every month or so in relation to me meeting with the Non-Executive Directors. So that's brought into there. I think - and the same with the Audit Committee. I think in terms of the non-attendance, I think the last year we've all been 15:55
trying to catch up on annual leave that was stored up over Covid in terms of trying do that, and then in terms of some of the other pressures on my team, those have been regional meetings or training courses.

So one of the things I've undertaken is a coaching course, and again that, you know, signed up for that in advance and then the dates clashed. The same with the PTED meetings, which tend to be the regional departmental meetings, clashes with the Area Integrated Partnership Board, which I Chair the pilot for for Northern Ireland. So there are significant demands on times. And I am also on a lot of committees. 15:55

So, again, getting the balance with that I think is important. I think as we have come into this year we have planned more purposefully around that so that, you know, now that we've a longer oversight I think of the timetable of the committees and when those are actually happening, it makes it easier then for me to attend, you know, either virtually or in person, depending on what's going on and, you know, I actively encourage everyone else who is supposed to be involved to be there. 15:55 15:56 15:56

So, I am very cognisant of the information that flows into that and I need to stay on top of that and, you know, I have nothing to suggest that I don't, but I'm also very aware of the example that it sets for other people if I'm not there and it is important that I do attend these things. And I think as we've got ourselves into a better system of planning that has improved. 15:56

Now some of the changes that we're making within the office of the Chair and the Chief I think have been important in relation to this. So we're in the process of appointing new secretarial staff in there. There have been, you know, there have been churn and change for a variety of reasons. I've also appointed an Executive Head of Office, which there wasn't one before, to try and manage all of this better and to make sure that, you know, everybody is in the right place at the right time. So that appears to be going to plan. And then in relation to again the streamlining of some of these processes and the sharing of information, you know, that's now being done. 15:56 15:57

So I would hope, you know, the aspiration certainly for this year is that it should be a bit better organised in terms of the use of my time in relation to that, and I think one of the things that we - that I asked the executive head of office to do was to do a review of my time usage and, again, I think what, you know, what really came to light in relation to that was the number of meetings that I am involved in, in terms of trying to attend. So, again, we had some internal conversations in relation to how some of that work could be delegated to free me up to, you know, give attention to the really important things and, again, that has helped in terms of re-organising that. 15:57 15:57 15:58

198 Q. Okay. So to summarise, you have this awareness of a perception?

A. Yep.

199 Q. That not being present rings alarm bells?

A. Yep.

200 Q. But you're understanding of your role is such that you're using mitigations, whether alternative means to communicate, additional staffing resources as well as prioritising, what you do to ensure that you're there when you need to be? 15:58

A. Yes. Yep.

201 Q. Let me move to the Board, Board membership, development and how it works, I want to briefly touch upon some of the issues that arise from that. Again, coming back to Ms. Mullan's evidence, she, I suppose makes two points which I want to have your views on. One is that at least until 2020 she was a member of a Board that, I hope I don't do injustice to her evidence by saying that it was a Board that wasn't asking all of the necessary questions. And, secondly, she was a member of a Board that didn't receive all of the information from the executive side that it needed to receive to do it's job effectively. Now, let me put meat on the bones of that. 15:58 15:59 15:59

January 2017, the Board is told a doctor in Urology is to be the subject of an MHPS investigation - Mr. O'Brien, and she acknowledged in her evidence that they, the Board, should have been asking is there a patient safety risk? They didn't, to her recollection, ask any questions about that event, and nor for that 16:00

matter until you brought the issue to the Board in August 2020 did the issue or the issues around Mr. O'Brien, and in particular the conclusions reached by MHPS, come back to the Board? So a clear example of a problem I think, would you agree? 16:01

A. Yes, yep. The communication should have been more robust, yeah.

202 Q. Yes. So - and equally on the other side, a clear problem on the part of Board members, they weren't asking the questions? 16:01

A. Yes, and I - yes, no, I think across the piece the communication wasn't what it should have been.

203 Q. Another example, if we go to WIT-101964, and Stephen Wallace, 3rd August 2020, writing to Roberta Brownlee with a copy of the Early Alert in respect of the 16:02 concerns that had arisen in relation to Mr. O'Brien. Just scroll down on to the next page. You're the author of the Early Alert, or the signatory to the Early Alert, which went to the Chief Medical Office four days previously. Only Mrs. Brownlee was sent the 16:02 Early Alert. The other non-execs didn't know about the Early Alert it would appear until - on Mrs. Mullan's evidence - until September of 2020. So, again, and maybe you could help us with this, another example of important information not being shared with the 16:03 entirety of the Board?

A. Yes.

204 Q. Is that something that was conscious and deliberate and, if so, what was the thinking behind it?

A. Well, I can't imagine for one minute that if Stephen Wallace sent that to the Chair of the Board that he was thinking that the Non-Executive Directors shouldn't be included. I think it was probably about, you know, any wider conversations outside all of that because, you know, we all, you know, it would have been knowing that Mrs. Brownlee's and Mr. O'Brien knew each other really well, so I think that was the suggestion - I imagine that's what the suggestion was to her. But it wasn't about not sharing it with the Board. 16:03

205 Q. So why wasn't it sent to the Board through your office or whoever owned it, Mr. Wallace's office? Why was it - was the - is the implication of your answer that the expectation was that Mrs. Brownlee would share it with her non-execs? 16:04

A. Yes, because that would, you know usually if there was an Early Alert that was concerning, you would expect that the Chair would take that up with the Non-Executive Directors, yes. Now since that time, if we send Early Alerts we send them to the entire Trust Board. 16:04

206 Q. Yes.

A. Yeah.

207 Q. From the centre?

A. Yes. That's how it is done now. 16:04

208 Q. It doesn't rely on the Chair to further share it?

A. No.

209 Q. So the fact that Mr. O'Brien's MHPS process could continue through to a conclusion with the report and a

determination, and that would pass without either information coming from the Medical Director's Office, or pass without questioning by the Board itself, poses clear questions about the governance instincts of the Board and the governance instincts of those in the Medical Director's office, or whatever level it's at within the operations side. Has that culture, if it is a culture, changed in your view? Is there a greater appetite on the part of the non-executive members, and indeed the executive members of the Board to ask questions, and is there a greater willingness to share information with the Board? 16:05 16:06

A. Yes, and I think, you know, I think there should be anyway, but I think possibly based as well on the outworkings of the Neurology Inquiry and, you know, the attention that was given to Michael Watt, I think certainly Boards are now - well, certainly our Board is a lot more curious about maintaining High Professional Standards and medical staff generally and, you know, the flow of information is a lot better than it would have been in the past. 16:06 16:07

210 Q. In terms of the Board that you inherited as Chief Executive, and maybe even in the period before that, is it your view that it wasn't, at least on - I'll focus on the non-executive side, that it wasn't sufficiently developed or attuned for the work that it needed to do on the governance side, or the holding to account side of their work? 16:07

A. I think that, you know, this was a Board that had been

through many changes and, again, hadn't had anything in particular raised with them over a period of time that wasn't good news, either in relation to financial break-even or performance and, you know, understandably thought they were presiding over a high performing Trust that didn't have any particular difficulties. So, on that basis I, I mean some of those Board members have been with us now in the last year/18 months and, you know, given the opportunity and the change of environment they're very able to challenge and ask questions and, you know, if the conditions are created they certainly have, you know, have been quite challenging to me and other people in a very respectful way, but the questions still get asked. So I do think that there was something about the cultural that created this sense that actually everything was okay, you didn't need to ask questions, it was all being taken care of, and that probably then, I think unfairly to them, I think lulled them into a false sense of security. 16:08 16:08 16:08 16:09

211 Q. And, again, as an observer as well as participant in some of this from 2019, where do you see the, if you like, the culpability for that? Is it a case that they were being fed the good news, "nothing to worry about here", or is it a case that the information was there and whether because of cultural issues or leadership issues they didn't ask the challenging questions? 16:09

A. Probably a combination of both because, you know, Shane Devlin had arrived in the Trust about - he arrived in

the Trust about six months before I did, and up until that point they'd had a whole series of rapid turnovers of Chief Executive and, you know, Medical Director. So nobody really had had the chance I think to settle and understand the organisation in the way it needed to be 16:10
understood, you know, after Mairead McAlinden left. So I think that rapid turnover I think meant that, you know, it was constantly, you know, and not through any individual's fault, it was constantly about superficial management and keeping the day-to-day going, but then 16:10
in terms of, you know, recognising some of these deep rooted problems and actually moving them on and sorting them out, I think there wasn't anybody there in post long enough to have that view of it all and to bring it together. 16:10

212 Q. Obviously the Chair of a Board is an important function.

A. Mm-hmm.

213 Q. He or she should arguably lead by example, set the tone for what is expected. You've had opportunity to work 16:10
with both Mrs. Brownlee and Ms. Mullan. Are there differences in style and is there, as a result of that, a difference in how the Board performs in terms of holding the executives to account?

A. Well, I think that Mrs. Brownlee was Chair of the Trust 16:11
for a long time, most of, you know, she had been on the Board in and around 10 years I think and, you know, since the development of the Trusts in 2007, you know, the nature of Board business has changed quite a bit,

and certainly whenever I would have started out as a consultant, you know, moons ago, you know it was largely an honorary position, you know, and that's not an unfair description of it, but it was very much, you know, about having, you know, an awareness of being accountable, but actually was very much about being a figurehead, about being out there selling the Trust, you know, doing all of those things, you know, presenting a very well formed optimistic profile in relation to what the Trust was. I think as health has become increasingly more complex and, you know, less able to meet demand, and difficulties have arisen, and as we have become more sophisticated in terms of understanding the business the Trust, I think the role of the Chair has changed. 16:11 16:12 16:12

So, you know, I imagine whenever she started out that the role was different from how it ended up having to be and, again, you know, if you are an incumbent in that position it is difficult I think to realise that change if you're staying with one organisation. 16:12

So, I think that, you know, there probably, you know, it was much - it was much a legacy of that as of anything else. And in fairness to her, you know, she was the one constant with all of these changes in Chief Executive and, you know, had to keep, you know, the public face going, if you like, in terms of business continuing. So I think it was probably lost in the 16:12

midst of all of that.

214 Q. Yes. And I don't wish to have my questioning interpreted as suggesting Mrs. Brownlee was unprofessional, but is there a difference between her role as the figurehead and perhaps a more - a greater professionalisation of the role of Chair under Ms. Mullan in terms of their approach to the work? 16:13

A. I think, I think over time the expectation of the Chair has changed in that there is an expectation of greater professionalisation. And if you think about the, you know, the composition of Trust Board, the majority of people who come on to Trust Board have never worked in health before. It's a very sharp learning curve. It's very different, I imagine, from many other Boards that I hear about and, you know, the level of responsibility and everything else tends to be much greater. So I think through necessity, in order to be able to make sense of the job and to, you know, be able to hold me to account, hold Trust Board to account, you know to report to the Permanent Secretary and the Minister, I do think there has had to be an increase in professionalisation of that over time, yes. 16:13 16:14 16:14

215 Q. Yes. It has always been the case, and we saw this through the evidence provided by Mrs. Brownlee, that the Non-Executive Directors have received training, and there'll be different views as to how adequate the training was, et cetera. We can see that - if we bring up TRU-306058, and this is the, if you like, the Trust Board workshops for the past year. 306058. And, 16:14

again, covering a broad range of subjects. And just scrolling down, regular workshops, you see there "Risk appetite in September, Board governance, self-assessment tool". So, the training, maybe you can help us with this, has it changed to any great degree over the years, or how can you account - because I think your evidence has been this is now a Board that does hold you to account, is much more - "interfering" may be the wrong word, but certainly asking the hard questions? Is there a sense in your view that this approach of the Board has changed for the better, and what do you put it down to? 16:15 16:16

A. I am - I can see - certainly during the time I have been Chief Executive I can see the Non-Executive Directors who have been there being more assertive, you know, in terms of challenging me, you know, and other people. Not in an unfriendly way, but in a very constructive way. And then, you know, the other problem I think for Trust Board Non-Executive Directors has been that we've been short of some for a period of time. Now before Christmas there were public appointments, and more have been appointed and, you know, we have lost some recently, we've gained a few others and, you know, there will be more change before the end of the year, and certainly, you know, when Eileen has taken this forward and developed it, it has been with that in mind. Because previously the induction was very much about understanding the purpose of the Board, the Nolan Principles, you know, how all 16:16 16:17 16:17

of that fits together. This starts to take us into more of actually the accountability arrangements in terms of what Trust Board has to be responsible for in terms of helping them think about, you know, the clinical and social care governance, and the financial governance, and how to understand how to join the dots and, you know, ask all of those questions. Because I think, I can certainly see that that is starting to come through more strongly than it would have done in the past. Yes. 16:17 16:18

216 Q. So is that a suggestion that the quality of the training has improved in the sense that it is more meaningful and directs the member more specifically to the kinds of questions that they need to be thinking about and raising in their work? 16:18

A. Yes, I think so. But bearing in mind that these Non-Executive Directors are extremely part-time and haven't come largely from a health background before, you know, this is about equipping them to hold the accountability and to understand health and social care at speed. 16:18

217 Q. Yes. Is it possible, sitting in your chair, to assess the effectiveness of the Board in terms of the challenge and support that it provides? Ms. Mullan referred to the assessment tool, which those who sit on Boards, whether it's Board of Governors in schools or wherever, are asked to complete - she described it as something of a box ticking exercise, I don't know whether that's fair or unfair, but how do you assess 16:19

the effectiveness of the Trust, of the Trust Board sorry, in terms of the work it's expected to do?

A. I think it's increasingly effective, and I think when we get the full compliment of Non-Executive Directors I think that will give it even more scope. One of the things that we have planned to do in this financial year is to carry out a well-led review. Now, we don't have that in Northern Ireland, but it is part of the function of CQC in England, just to look at the Governance structures and how the Board functions and all aspects in relation to all of that. The Chief Executive in Mersey Care certainly has helped us with some of that and has been part of, you know, he has visited our Board and watched it's functioning and everything else and has given some really constructive feedback in relation to that. So, you know, it is something that we take seriously. But I think in order to know if this is functioning as well as we think it is, I think it will be helpful to have the well-led review done so at least we get that reflective back to us in terms of, you know, what's functioning and what isn't. 16:19 16:20 16:20 16:20

218 Q. Yes. Just finally for today, in terms of Board membership, I'm thinking again about the Non-Executive side, what is the biggest challenge that your Trust faces in terms of that part of its membership? Is it recruitment issues and ensuring that you have a steady stream of well qualified Non-Executive Directors ready to step in to the shoes of the outgoing, or is it 16:20

finding the time to provide for their development needs? Maybe they're not issues at all, but are there any particular challenges in relation to the composition of your Board that you regard as risks?

A. So, some of the membership have recently changed and they do come from a variety of backgrounds, which I think, you know, it's not yet as diverse, I think, as it needs to be. But, you know, I know that that's the aspiration. And I think that, you know, it's always about getting the balance between having enough knowledge about health and social care and accountability mechanisms to be able to do that part of it. But also then to be able to think differently so that you can actually challenge the status quo, which is also really important. So I think I am beginning to see that in different ways in terms of the questions that come through. I think they need to get to a position of stability with full Board compliment and I think, yo know, their time is always pressurised, you know because there's a day of month - the most of a day a month taken up with the Trust Board, you know there are the statutory visits to children's homes which we get feedback on which is really helpful, and then we try to do the leadership visits around, and then chairing committees and attending to committees. So their time is really heavily used and I think, you know, ideally if we had more of their time I think it would bring even more value to the system, but the way it's constructed at the minute that's not where it is,

16:21 16:22 16:22 16:22 16:23

you know.

219 Q. Can the Department do anything to assist Trusts in this respect?

A. It's possible. I know that certainly, you know, the foundation Trust structure in England is different in that there are councils and there are Trust Boards, and there's probably a lot more input from the public, you know. But again, you know, we're - I imagine one of the limitations on this is we are working in a really financially restrictive environment currently and all of these things obviously have to be accounted for. But certainly, you know, anything at all that can add to the breadth and depth of the expertise and the time allowed to the Non-Executives I think would be welcome. 16:23 16:23

220 Q. Clearly a strong Trust Board, strong Non-Executive Directors, could have the potential, viewed from one perspective, to make life difficult for executive directors and leaders, such as yourself. From your answers you would wouldn't appear to see it that way. What do you see as the value of a strong set of Non-Executive Directors for the overall health of the organisation? 16:23 16:24

A. I think it's the informed challenge position, and that's really important. And, again, back to, you know, the issue of blind spots, being able to see things that we can't see because we're caught up in the day-to-day business, that's really important in terms of, you know, helping us to stay safe as an organisation in terms of patients. 16:24

221 Q. And in terms of the journey, if it has been a journey, do you think, finally, that you would have greater confidence in the Board as it is equipped today to do that work of challenge and identifying blind spots, than perhaps was the case four or five years ago? 16:25

A. I think so, but, you know, I am also mindful that I have a responsibility in helping them with that. So, you know, I am cognisant of that, and I know certainly the other members of the Senior Leadership Team are cognisant of that, you know, we need to help them 16:25 develop in terms of knowing what they need to know, but not actually, you know, influencing that so strongly that we just extend the group. I think they need to be separate and they need to be slightly separate from us to be able to hold us to account and to be able to 16:25 challenge.

222 Q. Okay. I'm at risk of being told off if I ask another question! So thank you for that, and we'll commence at 10:00.

CHAIR: 10:00 o'clock tomorrow morning. Thank you 16:25 Dr. O'Kane, and thank you Mr. Wolfe. See you all in the morning, ladies and gentlemen.

THE HEARING ADJOURNED UNTIL 10:00AM ON WEDNESDAY, 13TH MARCH 2024 16:25