Urology Services Inquiry

Oral Hearing

Day 8 – Thursday, 10th November 2022

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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Gwen Malone Stenography Services

THE INQUIRY RESUMED ON THURSDAY, 10TH NOVEMBER 2022 AS FOLLOWS:

CHAIR: Morning everyone. Mr. Wolfe, are you ready to continue? 09:57

MR. WOLFE KC: Yes. Morning, Chair, morning, Mr. Hanbury, good morning, Dr. Swart.

You'll recall that at the tail end of yesterday I had reached the point in the narrative where I had 09:57 described that a decision was reached on 26th January 2017 that there was a case to answer and this gave the MHPS investigation the green light to proceed. There were a number of issues to be resolved, however, before the process could begin. Due to a perceived conflict 09:57 between his professional role and his role as Case Investigator, it was decided that Mr. Weir should be replaced by Dr. Chada. This took place on 21st February 2017. There was also a need to finalise the Terms of Reference. There were a number of iterations 09:58 of those terms and a final version was only shared with Mr. O'Brien on 16th March 2017. It set the following are matters to be investigated:

Whether he was responsible for untriaged referrals and 09:58 whether this caused harm or unnecessary delay.
Whether he was responsible for storing patient notes at home for an unacceptable period and whether this had any implications for patients.

Whether he failed to dictate patient outcomes following outpatient clinics.

Fourthly, whether he had given undue priority to his private patients in the scheduling of treatments. 09:58

A fifth consideration had been added: Whether management were aware of the concerns prior to December 2016 and, if so, what actions they had taken. 09:59

The first witness was interviewed by Dr. Chada on 15th March 2017. By 5th June 2017 she had interviewed each of the witnesses who she considered necessary, with the exception of Mr. O'Brien. It may have taken almost three months for the investigation to actually 09:59 commence, but Dr. Chada made significant early progress once she was able to start her work and within a further period of just under three months she had gathered in much of the evidence. However, she was unable to finalise her investigation report until 12th 09:59 June 2018, more than 12 months later, meaning that the investigation took 17 months to conclude from the date of its conception, well outside the four-week timeframe envisaged in the Framework. 10:00

It is doubtless the case that most MHPS investigations, beyond the routine, will overrun this timeframe but it should be expected that serious questions would arise if the overrun stretches to this. The Inquiry,

however, is unaware of any significant expression of concern from within the Trust's hierarchy in respect of this delay.

It appears that the majority of the delay occurred in the context of Dr. Chada's attempts to interview Mr. O'Brien. Dr. Chada proposed a meeting for 28th June 2017, but this was rescheduled at Mr. O'Brien's request and didn't take place until 3rd August of that year. 10:00 10:01

Mr. O'Brien had not been provided with the statements of other witnesses prior to that meeting, nor evidence with regards to the private patient issue. So a further meeting was arranged and took place on 6th November 2017, after Mr. O'Brien had been given the opportunity to consider the witness statements and the private patient evidence. At that meeting, Mr. O'Brien indicated that he wished to provide further comment but would be unable to do so for some time because his priority at that time was to complete his appraisal. 10:01 10:01

The Inquiry may find it surprising that Mr. O'Brien was allowed to dictate the pace of progress. He failed to comply with the deadlines which were then set for various dates in February and March 2018 until finally, on 2nd April 2018, the comments were received by Dr. Chada. 10:02

Her report was subsequently submitted to Dr. Khan, the Case Manager, on 21st June 2018, when a copy was also made available for Mr. O'Brien. This delay, overall, was considered as part of Mr. O'Brien's Grievance Review. The Review Panel found that "if this investigation was as serious as it purported to be, the Investigator should have been given time out of her normal commitments to carry out the reviews necessary and have the report completed". He added that: 10:02

"While one might argue that the parties are equally culpable, the trust, as the employer, has the responsibility to take control of the process and timescale for completion." 10:02

The Inquiry will wish to consider the delay across the totality of the process and the reasons for it. Given that many of the core facts should not have been controversial, for example, clearly triage hadn't been done, dictation hadn't been completed, patient records were stored at home. It may, in that context, be considered astounding that the process continued for so long when the broader context invoked concerns about clinical performance, governance and patient safety. 10:03

The Inquiry is aware that the investigation report is a substantial piece of work, running to 43 pages, 36 appendices. Dr. Chada took evidence from a range of witnesses, including service managers, assistant 10:04

directors, consultant urologists and other relevant personnel from within the Trust. Dr. Chada worked through each of the four concerns relating to Mr. O'Brien's practise and considered the issues with regards to management. She outlined the data which had been gathered and made findings on each issue in turn. The key findings can be summarised as follows: 10:04

Triage - relying on the statistics that had been supplied to her from an exercise conducted by the consultant urologists, she found that 783 untriaged referrals had been identified, of which 24 warranted upgrading to red flag, five of which had confirmed cancer with delays in diagnosis and commencement of treatment ranging from between 151 days and 64 weeks. Summarising the evidence provided by Mr. O'Brien on this matter, Dr. Chada found that he accepted that he did not triage routine or urgent referrals during 2015 and 2016, although he made the case that he did not have the time to do so. He is said to have expressed surprise there was such a small number that had been upgraded. 10:04 10:05 10:05

Dr. Chada went on to observe that while it was a widely known fact among some staff within the Acute Services Directorate that Mr. O'Brien's triage was often not returned, she considered that the responsibility to complete triage rested with him. She remarked that: 10:06

"The failure to complete triage in combination of the use of the default process created the potential for 783 patients to be added incorrectly to the waiting list." 10:06

She then moved on to consider the issue concerning the storage of patient notes. She found that 307 sets of patient notes were returned by Mr. O'Brien to Trust premises on 3rd January 2017. She found that 10:06
Mr. O'Brien accepted that he kept notes at home. She remarked that it was well known that he often retained patient notes at home and pointed out that the Trust had not developed a system for tracking notes and nor had the Trust sought to determine the extent of the 10:07
problem prior to her investigation. Dr. Chada found that the number of notes stored by Mr. O'Brien was "excessive" and "outside normal acceptable practice" and constituted a serious data protection information governance risk for the Trust with the potential to 10:07
impact on patients, in particular those admitted as an emergency.

Regarding undictated clinics, Dr. Chada explained that there had been a failure to complete dictation from 66 10:07
clinics dating back to November 2014 affecting 668 patients. She reported that a full review of the charts for each affected patient was undertaken by the consultant urologists and that this exercise took

approximately six months to complete.

She remarked that Mr. O'Brien disputed the figures but accepted that there were 41 clinics which were undictated and sought to justify his approach of recording outcomes at the end of a patient's attendance. She found, however, that the consultant urology review of this issue demonstrated multiple attendances without reciprocal letters on file, cases of delay in sending letters and cases in which no entries had been made on the charts or on PASS. 10:08 10:08

As regards private patients, Dr. Chada found that 11 private patients who had been under the care of Mr. O'Brien had been recorded as having completed their procedures within much shorter timeframes than would have been expected for MHPS patients given their clinical priority. These cases had been reviewed by Mr. Young, Consultant Urologist, and he found that for nine out of the 11 there was no clinical justification to support their treatment within such a short timeframe. Mr. O'Brien disputed the dates put forward by the Trust and rejected the suggestion that he had been improperly advantaging private patients. However, Dr. Chada was not persuaded by his explanations, she concluded that as regards the nine private patients considered by Mr. Young, they had each been scheduled earlier than their clinical need dictated and Mr. O'Brien had afforded them advantages over HSC 10:09 10:09

patients with the same clinical priority.

Dr. Chada went on to find that senior managers were aware of triage and the retention of notes at home but were not aware of the issues concerning dictation and the private patient issue. The Inquiry may wish to consider this finding regarding private patients because Heather Trouton, Assistant Director, had told Dr. Chada that she was aware of this issue on some occasions and Mr. Haynes had told Dr. Chada that he raised this issue in an e-mail in June 2015 and also December 2015 to Michael Young and Martina Corrigan. Therefore, it is unclear how Dr. Chada could have found that senior managers were unaware when she appears to have had evidence to the contrary. 10:10 10:10 10:11

In general, Dr. Chada found that "there were earlier opportunities to address concerns prior to 2016 and that these opportunities were not taken in a consistent, planned or robust manner". Dr. Chada was clear that no concern had been raised about "Mr. O'Brien's hands-on patient care or clinical ability" but she pointed out that his failure to triage had resulted in potential harm for 783 patients and that his lack of dictation was "unacceptable practice". 10:11 10:12

The report concluded with Dr. Chada noting that Mr. O'Brien "displayed some lack of reflection and insight into the potential seriousness of the above

issues" in failing to appreciate the impact of delayed diagnosis and failure to accept the importance of administrative processes. Dr. Chada felt that it was important and appropriate to raise these issues with the Case Manager. 10:12

The Case Manager was Dr. Khan. On 10th July 2018, Mr. O'Brien submitted a detailed section-by-section response to the investigation report to Dr. Khan. Dr. Khan acknowledged receipt of this submission on 10:13
14th August and after seeking advice from NCAS in September and discussing the matters with the then Chief Executive, Mr. Devlin, and the HR Director, he prepared his Case Manager determination. This was shared with Mr. O'Brien at a meeting on 1st October 10:13
2018.

Again, Chair, it is unclear why it should have taken so long to produce an outcome.

10:13

In his determination, Dr. Khan explained that he considered that three actions were now necessary. First, "an action plan should be put in place with the input or practitioner performance advice, or NCAS as they were commonly known at that time, the Trust and 10:13
Mr. O'Brien for a period of time agreed by the parties". This action plan, he thought, should be reviewed and monitored by the Clinical Director and Assistant Director with escalation to the Associate

Medical Director if necessary. The plan would cover "any issues with regards to patient administrative duties and there must be an accompanying agreed balanced job plan".

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Second, in light of the "systemic failures by managers at all levels, he wrote, both clinical and operational", Dr. Khan recommended that the Trust would conduct an "independent review of the relevant administrative processes with clarity to be brought on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes". The review, he thought, "should look at the full system-wide problems to understand and learn from the findings".

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Thirdly, Dr. Khan determined that issues with Mr. O'Brien's conduct had been identified which required consideration by a Conduct Panel. Dr. Khan noted a failure to adhere to aspects of Good Medical Practice, the wider systemic failings and the potential harm caused to patients. He concluded that there was no requirement for a formal consideration by NCAS or a referral to the GMC, or a Clinical Performance Panel, as no concerns about Mr. O'Brien's clinical ability had been identified.

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The Inquiry will be concerned to find that after an elaborate and protracted investigation process, and

careful consideration by Dr. Khan, two of these recommended actions were not completed at all and one, the Independent Administrative Review, was delayed and not completed as intended.

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Consider the following: It is clear from the wording of the determination that an action plan was to be put in place and the development and implementation of that plan was to involve engagement with NCAS. It was directed to any issues concerning patient 10:16
administrative duties, which opens the possibility that properly scoped out, it would not have been restricted to outpatient work. No such action plan was ever put in place and nor does there appear to have been any discussions with either Mr. O'Brien's or NCAS to move 10:17
the matter forward, despite the offers of assistance which came from NCAS. Since the investigation had confirmed that there were significant concerns about how Mr. O'Brien worked and since he continued to practise, the Trust must explain to the Inquiry why it 10:17
didn't engage with NCAS, develop an action plan and implement an agreed, balanced job plan with monitoring.

The systemic failures of management at all levels required remedial action. That was the clear view of 10:17
Dr. Khan and that is why he directed an independent review of administrative processes. However, it was not until July 2020 that Dr. Rose McCullough and Dr. Mary Donnelly, both Associate Medical Directors at

the Trust were commissioned to conduct a review. In preparing this work, they were to be accountable to the Director of Acute Services.

The reviewers produced an initial report in draft on 21st September 2020, but their work was the subject of amendments, made or proposed by management in the Acute Directorate who may have been associated with the very failings identified by Dr. Chada and Dr. Khan. 10:18

Ms. Corrigan, for example, suggested a revision to the report in order to emphasise that what had gone wrong was "as the result of one consultant". It is unclear how the appointment of two Trust employees to conduct the review, allied to the fact that management was able to insert amendments to their work, could have secured the necessary quality of independence recommended by Dr. Khan. Moreover, the delay in commissioning the review may provide something of an insight into how seriously the directorate regarded the conclusions reached in the MHPS process. Indeed, the Terms of Reference for this review were only issued a short time after the General Medical Council asked the Trust whether a review had ever been completed. This delay demands an explanation. Despite the heavy criticisms heralded in the MHPS findings, was there an attitude of complacency amongst management that lessons had already been learned and that there was no need for a review? The Inquiry Panel will consider whether the failure of 10:18 10:19 10:19 10:19

the Trust to expedite this review amounted to a significant missed opportunity given the nature of the concerns which arose in 2020.

In November 2018, steps were being taken by the Trust to convene a Conduct Panel for early January 2019 in order to comply with Dr. Khan's determination in that respect. However, on 30th November 2018, Mr. O'Brien lodged a written grievance with the Chief Executive. He alleged, *inter alia*, that the Trust had mishandled matters since 2016, failed to follow its own policies and procedures and had breached his contract of employment. He asked the Chief Executive to confirm that no steps would be taken to take forward the conduct hearing until the grievance had been addressed and this was agreed. 10:20 10:20 10:21

Two years later, Mr. O'Brien supplemented his grievance shortly before the stage 1 hearing was held. This Stage 1 Grievance reported on 26th October 2020 and this was, in turn, subject to a review prepared by the Assistant Medical Director of the Western Health and Social Care Trust which concluded in June 2021. By this time, Mr. O'Brien had long since retired from practice and, of course, the additional concerns of 2020 had emerged. 10:21 10:21

The Inquiry will wish to consider who had responsibility for implementing the actions recommended

by Dr. Khan. That such a lengthy and elaborate MHPS process should fail at its end stages to take forward and resolve the issues of concern which were described in its findings raises alarm bells in the context and it is an area of which the Inquiry will anxiously scrutinise.

It was doubtless the case that the invocation of the grievance process prevented the Trust from moving directly to a conduct hearing and Mr. O'Brien was entitled to exhaust his contractual remedies in that respect. However, that was a process which took far too long for the Southern Trust to set up and complete. There is no obvious reason indeed why the Trust could not have sat down with Mr. O'Brien and NCAS to work out a sensible action plan, a balanced job plan and monitoring, notwithstanding the grievance.

There is a wider point to be considered. Mr. Haynes, for example, has told the Inquiry that with hindsight he regrets that he did not recognise that there were likely to have been additional issues which required investigation. He expressed the view that if this had been recognised and a comprehensive review of practise carried out at the time, he feels that it is likely that the clinical practise which was identified in 2020 and which led to the lookback exercise would have been identified earlier. In light of the findings reached within the MHPS process, the Inquiry will wish to

consider whether anyone performing a managerial role within the Trust, operational or medical, gave any thought at all to the necessity of conducting a far-reaching and comprehensive review of Mr. O'Brien's practise at that time. 10:24

Let me rewind for a moment to the start of the MHPS process.

It will be recalled that at the point where the Trust decided that Mr. O'Brien could return to work following a period of exclusion, it also decided that monitoring arrangements would be put in place in an attempt to ensure that Mr. O'Brien was practising safely. 10:24 Arrangements were developed by Ms. Gishkori and Mr. Carroll and addressed each of the four areas of concern triage, storage of notes, undictated clinics and private patients. The practical task of monitoring these limited aspects of Mr. O'Brien's work was left to Ms. Corrigan in the absence of any clinical input. 10:25 She monitored his work against the plan on a weekly basis and provided updates to Dr. Khan who wanted to see the reports on a monthly basis unless an issue arose. She has explained in her response to the Inquiry how she performed that monitoring. 10:25

The return to work plan included clear guidance on what process was to be followed in the event of any breach. Any deviation was to be referred to Dr. Khan

immediately in his role as MHPS Case Manager. In their responses to Section 21 Notices, it appears that during the period of the MHPS investigation, no deviations from the action plan were made known to Dr. Khan, Dr. Wright, Ms. Gishkori or Dr. Chada. Despite this, it is clear to the Inquiry from a review of documentation made available that there were a number of divergences both before and after the conclusion of the MHPS investigation, some of which were escalated to Dr. Khan amongst others. These instances are as follows: 10:25 10:26

On 14th April 2017 it was noted that Mr. O'Brien had 63 charts in his office. By 21st June 2017, this number had grown to 85 charts. Ms. Corrigan raised this directly with him. The number of charts then increased to 90 by 11th July 2017. By this time 30 untriaged referrals had also accumulated and this was raised with Mr. O'Brien. This was escalated to Dr. Khan by Mr. Carroll and there then followed a meeting between Mr. O'Brien, Mr. Weir, Ms. Corrigan and Mr. Carroll on 25th July. It appears that the outstanding triage had been returned by Mr. O'Brien by 12th July and that all charts had been removed by the end of that month, but it is unclear whether the importance of compliance with the return to work plan was impressed upon Mr. O'Brien, because, on 23rd January 2018, further slippage on triage was identified. The Red Flag Appointments Office alerted the Cancer Services Coordinator that 10:26 10:26 10:27

seven referrals were awaiting e-triage from 18th to 19th January.

Ms. Corrigan was absent from work in the summer of that year extending into the autumn from 25th June until 5th November, during which time a significant divergence arose. On 4th October it was reported that Mr. O'Brien had 74 sets of notes tracked to his office and 91 letters undictated dating from 15th June. This concern was passed on by Mr. Carroll to Mr. Young and Mr. Haynes, asking them to speak to Mr. O'Brien. This was forwarded to Mr. Weir. It would appear from responses received to Mr. Carroll's request that none of the aforementioned, the Clinical Lead, the Clinical Director and the Associate Medical Director, were aware of the monitoring arrangements which had been imposed. Mr. Carroll indicated that monitoring had ceased since Ms. Corrigan went off on sick leave. The issue was then escalated to Dr. Khan who was by then the acting Medical Director. By 22nd October 2018 the number of charts requiring dictation had decreased to 16 while 51 charts remained in Mr. O'Brien's office. It is unclear if Mr. O'Brien was ever spoken to about these departures from the standards set and it is unclear what steps were taken to clarify the arrangements under the plan with the Clinical Lead, Clinical Director and Associate Medical Director. 10:27 10:28 10:28 10:28 10:29

In September 2019, Ms. Corrigan identified a further

deviation arising from Mr. O'Brien's failure to triage 56 referrals and provide dictation for four clinics. This was raised with the Medical Director by Ms. Corrigan on 16th September. Some weeks later, on 5th November, Ms. Corrigan e-mailed Mr. O'Brien to inform him that she had been asked to meet him along with the Clinical Director to discuss "a deviation from your return to work plan when you were on call in September." 10:29

10:30

In response to this, Mr. O'Brien wrote to Martina Corrigan on 7th November 2019 indicating that it was his understanding that these arrangements "expired" in September 2018 at the time of the Case Manager's determination. 10:30

It will be recalled that the need for a new action plan, monitoring arrangement and job plan arising from the MHPS determination remained unaddressed, but it is unclear how Mr. O'Brien could have arrived at an understanding that his work could not be monitored, or for that matter, the departure from certain standards could not be addressed with him. 10:30

The Return to Work Plan was initiated to protect patients and failure to adhere to its requirements had the potential to cause harm and should have been considered a serious manner. The Inquiry will want to consider these divergencies and assess whether the 10:30

issues were afforded sufficient seriousness by those to whom they were escalated.

Ultimately, Chair, you will need to consider whether the Return to Work Plan was fit for purpose or whether it had so many gaps that other risks to patients were arising under Mr. O'Brien's care and were left unchallenged. 10:31

Mr. Haynes has suggested that this was the reality. He has told the Inquiry that he was concerned when he discovered that the Secretarial Backlog Report was being used as parted of the monitoring arrangements because this was not a reliable indicator that all appropriate dictation was being performed at the time of a clinic. He had previously raised this, he says, in 2017 in another context. He has also explained that he was concerned that Mr. O'Brien was not acting on all results requested in his name and that this was not being adequately monitored in the Backlog Report. 10:31 10:32

It will be recalled that he raised an Incident Report in respect of Patient 92 in July 2018 when Mr. O'Brien failed to action investigations that he had requested. Furthermore, Ms. Corrigan points out that the monitoring arrangements focused on the gaps in Mr. O'Brien's outpatient dictation and outcomes but they completely ignored his administrative responsibilities towards patients who came in as 10:32

emergencies or day cases.

In this respect, the evidence of Dr. Fitzpatrick, an associate with NCAS, is worthy of note. He states that "in order to formulate an action plan, there needs to be a clear diagnosis of concerns". He says: 10:33

"I am aware that the Trust put in place an action plan but it is not clear to me whether they had a sufficient understanding of the deficits in Mr. O'Brien's practise to ensure that this was focused and appropriate." 10:33

As you've heard, Chair, the opportunity to develop a new action plan following the MHPS investigation, as envisaged by Dr. Khan, was simply not taken. Mr. O'Brien may well have taken the view that the old one had expired. 10:33

I want to touch now upon a number of distinct issues in respect of the MHPS Framework which may be considered relevant to our Terms of Reference. 10:34

First of all, the role of the Designated Board Member and the Trust Board. The MHPS Framework prescribes a role for a Designated Board Member "to oversee the case to ensure that momentum is maintained and to consider any representations from the practitioner about his or her exclusion or any representations about the investigation". 10:34

Mr. John Wilkinson was appointed as the Designated Board Member in this case. He had been a board member for about a year at that time. He had minimal training prior to his appointment and no specific experience. 10:35
He has told the Inquiry that he considered that the role would require him to liaise with Mr. O'Brien and "to ensure the momentum of the MHPS process in respect of Mr. O'Brien was maintained by ensuring timely responses to requests made by him". Shortly after this 10:35
appointment, Mr. Wilkinson received a flurry of contact from Mr. O'Brien. Mr. Wilkinson has told the Inquiry that he felt that Mr. O'Brien misunderstood his role in the process and that he was ill equipped to carry out the level of inquiry which Mr. O'Brien appeared to 10:35
expect. Given his relative lack of training and experience it is difficult to see how Mr. Wilkinson himself would have been best placed to consider in response to the kinds of representations which were being raised by Mr. O'Brien. But this may not have 10:36
been made entirely clear to Mr. O'Brien.

More broadly, Mr. Wilkinson has explained that "the interrelationships and expectations surrounding the Case Manager, Case Investigator, HR, Medical Director, 10:36
the Trust board and Chief Executive were not explained sufficiently" to him. He has indicated that because of the complexities of the process and the intricacies of the specific case, he found himself "bewildered, if not

compromised, from time to time".

An important duty of the Designated Board Member is to ensure that momentum is maintained. There is evidence that Mr. Wilkinson urged the Trust to quicken the pace at an early stage, but such interventions would not appear to have been regular during the protracted life of this investigation. The Inquiry will wish to examine what tools are available to a Designated Board Member in this respect and whether, in this case, they were well used. 10:36 10:37

The Inquiry will also need to assess whether there was or should have been any continuing role for Mr. Wilkinson after the Case Manager had signed off on his determination. Mr. Wilkinson did not see himself as having any specific role in this respect and has indicated that he did not know whether the determination had been implemented. Nevertheless, Mr. Wilkinson did continue to receive updates from Ms. Toal throughout 2019 and into 2020 when he was informed of additional concerns. The Inquiry will wish to consider whether, in association with his role as the Designated Board Member, Mr. Wilkinson ought to have been more active in ensuring that the work of the MHPS process reached a complete and comprehensive conclusion, knowing the significant patient safety issues which were engaged. 10:37 10:37 10:38

In accordance with Appendix 6 of the Trust's Guidelines, the Designated Board Member was also required to report back findings to the Trust Board. As I highlighted towards the start of this opening statement, the Inquiry has not seen any documentation to show that the Board discussed the MHPS investigation after January 2017. It is unclear why Mr. Wilkinson did not bring to the Board's attention the outcome of the investigation, but he was not alone in that respect. 10:38

The role of the Designated Board Member was given detailed consideration by the Kennedy Review which was a review of the response of the Heart of England NHS Foundation Trust to concerns about the practise of Mr. Ian Patterson. The report of the Kennedy Review pointed out that the designation of a non-executive director appears, on the face of it, to be a "sensible mechanism of assurance for the Board". But for this to work effectively, the Board member must be helped or enabled. There must be some guidance or protocol to assist the appointee to carry out the role. He must be briefed as to the background to the issues. If such basic steps are not to be taken, that report found the role may reduce to "some form of window dressing", which provides the Board with no basis for assurance. The Inquiry will wish to consider whether Mr. Wilkinson's role as Designated Board Member provided the Board with any meaningful assurance. 10:39 10:39

The Inquiry Panel will also need to consider the nature of any communication that those responsible for the MHPS process had with organisations such as NCAS and the GMC, as well as with the Department. The role of NCAS, now known as the Practitioner Performance Advice, will be of particular interest to the Inquiry. 10:40

NCAS was established in 2001 and is a service delivered by NHS Resolution. The common purpose of NCAS and NHS Resolution is "to provide expertise to the NHS on resolving concerns fairly, sharing learning for improvement and preserving resources for patient care". As indicated in the statement of a NCAS associate, Dr. Lynn: 10:41 10:41

"NCAS provides services to the Health and Social Care Trusts in Northern Ireland pursuant to Service Level Agreements. These agreements enable the Trust to access NCAS services in the same way as any English Trust." 10:41

Dr. Lynn has described the advisory role of NCAS as follows:

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"The advice service is an independent advisory body. It does not have any statutory powers and as a result is unable to require any party to follow its advice or cooperate with its assessment functions."

In respect of its advisory functions, all of the assistance that the organisation provides is based upon information received from NHS bodies and other parties, such as the practitioner concerned. 10:42

Dr. Lynn is clear that NCAS is not a decision-making body and cannot adjudicate upon any concerns about the resolution of performance issues and decisions regarding employment or contractual status. 10:42

Another associate of NCAS, Dr. Fitzpatrick, points out that the role of NCAS is "reactive", meaning that if advice which is provided doesn't lead to a response, the organisation will not typically escalate matters. 10:42 NCAS can be asked by Trusts to conduct performance assessments of clinicians which, in accordance with Section 7 of the Service Level Agreement, aim to "clarify the nature of the concerns, identify the strengths and weaknesses of a practitioner's 10:43 performance, practise and help to identify a way forward". NCAS can also provide professional support and remediation services which "offer a wide range of bespoke action plans to support practitioners in their return to safe and effective practice". Such plans are 10:43 developed following a full review of the circumstances of a case and can include remediation plans, return to work plans and professional development plans. It is noted that at the heart of the MHPS Framework, at

paragraph 8 of the introduction, that NCAS has both an advisory and an assessment role. The Framework envisages a role for NCAS at various stages of the procedure.

10:44

In Section 1 paragraph (4), one of the key actions needed on the part of a Trust when identifying concerns is to consider discussing the case with NCAS on the way forward and if the case can be progressed, by mutual agreement, consider if an NCAS assessment would help. 10:44

While the MHPS Framework allows organisations to contact NCAS at any point, as they see fit, under paragraph (10) of Section 1 of the Framework, NCAS must be notified when an employer is considering exclusion 10:44 or restrictions. And under paragraph (20) of Section 1, NCAS should be contacted, where possible, before implementing an immediate exclusion.

NCAS can also provide advice on local action plans and 10:45 may conduct performance assessments.

NCAS was contacted by the Southern Trust, through Mr. Gibson, on 7th December 2016, by Dr. Wright on 28th December 2016 and by Dr. Khan on 20th September 2018 10:45 and 31st October 2018.

On each occasion, contact was followed up by a letter from the NCAS advisor summarising the advice offered.

The Inquiry will wish to assess whether NCAS were given a full and accurate picture of events at the time and what impact any inaccuracies may have had. The Inquiry will also wish to understand the extent to which advice from NCAS was followed and adhered to. The Inquiry will wish to understand why NCAS was not consulted prior to important meetings or following the occurrence of significant events. Most notably, NCAS was not consulted until after the meeting of the Oversight Group on 22nd December 2016, nor prior to the case conference on 26th January 2017. Dr. Wright was directed to update NCAS following the case conference, but it does not appear that this was done.

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10:46

Finally, in this respect, the Inquiry panel will wish to explore what, if any, consideration was given to availing of the assessment or professional support and remediation services provided by NCAS under the Service Level Agreement.

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In his screening report, dated 5th September 2016, Mr. Gibson recommended consideration of an NCAS supported external assessment of Mr. O'Brien's organisational practise. But it seems that this matter was not discussed in the Oversight Group and is not reflected in the minutes of its September meeting.

10:47

Similarly, during their conversation on 20th September 2018, after the MHPS investigation had reported, the

NCAS adviser, Dr. Lynn, drew Dr. Khan's attention to NCAS Professional Support and Pre-Mediation Team who, as outlined in correspondence from her the following day, could assist by "drafting a robust action plan with input from Mr. O'Brien and the Trust to address some of the deficiencies which have been identified to ensure oversight and supervision of Mr. O'Brien so that the Trust can be satisfied that there is no risk to patients, but also provide support to Mr. O'Brien to afford him the best opportunity of meeting the objectives of the plan". 10:48 10:48

NCAS even took the step of sending the forms for initiating this service directly to Dr. Khan, but it appears that this was not further considered by the Trust, even though, as we have seen, a role for NCAS had been written into Dr. Khan's MHPS determination. 10:48

The General Medical Council

During the period in which the MHPS investigation was ongoing, there was frequent engagement between the Trust and the General Medical Council's Employer Liaison Advisor for Northern Ireland, Joanne Donnelly. This service was established to work with medical directors or responsible officers to offer advice on whether the GMC thresholds for referral were met. The first such meeting in which Mr. O'Brien was discussed took place on 8th February 2017. 10:49 10:49

Dr. O'Kane, by now the new Medical Director, met with Ms. Donnelly on 4th December 2018. By that stage the MHPS process had been completed and Dr. Khan had determined that a referral to GMC was unnecessary. Following the meeting, Ms. Donnelly was sent a copy of the MHPS investigation report, though not the SAI report, as requested. I understand that to have been the SAI report in connection with Patient 10.

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On 9th January 2019, Ms. Donnelly wrote to the Trust to express her view that she considered that the threshold for referral to the GMC had been met. She explained that the MHPS report demonstrated concerns around probity, harm to patients, a failure to make contemporaneous notes and records and potential breaches of patient confidentiality associated with keeping records at home. She described these as serious and persistent failures to practise in accordance with the principles set out in Good Medical Practice.

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This e-mail from Ms. Donnelly raises some sensitive questions which the Inquiry must consider. Was Ms. Donnelly wrongly assured by the Trust? During her several interactions with the Trust from early 2017 in relation to the practise of Mr. O'Brien she was particularly concerned to know whether there were any patient safety issues or risk of harm to patients. The answers which she received may have suggested that

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there were no such concerns, when in fact the strong suspicion within the Trust was that failure to triage patients and to address important administrative actions following outpatient clinics gave rise to delay and risk of harm to significant numbers of patients, as well as actual harm. 10:51

It appears that Ms. Donnelly may have had to discover the true nature of the issues and the scale of the problem for herself when she read the MHPS report. The Inquiry will wish to understand why Dr. Khan, in particular, did not see fit to make a referral to the GMC as part of his determination, although there may well have been grounds for a referral long before that. 10:51

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The Department of Health

The Permanent Secretary of the Department, Mr. May, has explained that the Department "only has a limited role in the application of the MHPS and, therefore, limited direct knowledge of how Health and Social Care employers operate in practice". So far as the Department is concerned, their only role under the MHPS Framework is to review long-term exclusions, recruit and select appeal panels in clinical performance cases and provide support to smaller bodies. There is a requirement for Health and Social Care bodies to report the outcome of MHPS investigations to the Department. 10:52 10:52

In this case, Dr. Wright wrote to Dr. Michael McBride,

Chief Medical Officer, on 30th December 2016, to indicate that Mr. O'Brien had, that day, been excluded under the MHPS Framework.

The MHPS Framework did not require any further steps. Insofar as can be established no further steps were taken. 10:53

I think there was a typo in what I've just read out. So where I said there is a requirement, I should have said there is no requirement for HSC bodies to report the outcome of MHPS. So the communication between the Trust and the Department notifying the Department of the exclusion appears to have been the appropriate limit of the need for communication in that Framework. 10:53 10:53

There is no reference within the MHPS arrangements to the SAI procedure or the Trust guidelines. Clearly the MHPS process and the SAI process serve different purposes. MHPS addresses concerns about a doctor's performance and conduct, while the SAI focuses attention on learning from serious incidents. But it is clear that in practice there can be considerable overlap. For example, in December 2016, the initial findings of an SAI review in respect of Patient 10 fed into the Oversight Group's decision to commence a formal MHPS investigation. The Case Investigator was subsequently made aware of the likely commencement of a further SAI review in relation to the additional five 10:54 10:54

triage cases.

In consideration of its Terms of Reference, and, in particular, the need to assess whether the MHPS policy can be strengthened, the Inquiry may wish to evaluate how the SAI and MHPS processes, and those engaged with them, can better relate and communicate together, particularly where there are issues of mutual concern. Is there any good reason why the Oversight Group should not be provided with a full account of all adverse incident cases involving the clinician under consideration? I raise this question, Chair, because there's evidence before the Inquiry that there were incident reports and other potential lead ins to SAI incidents which were not brought to bear on the MHPS process and could clearly have influenced, one way or the other, whether an MHPS investigation was necessary.

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I conclude this section on the MHPS by looking at proposals for amendments and the reviews that have commenced in respect of the Framework.

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The Trust Guidelines were updated in October 2017. Ms. Toal has explained to the Inquiry that this update was specifically "linked to the Trust's reflections on the case involving Mr. O'Brien and, in particular, the difficulties at the early stages of the process involving the Oversight Group, which had led to some confusion about roles and responsibilities in the

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management of concerns".

The Inquiry will note that the 2017 Guidelines provide additional and more detailed consideration to clinical managers on what action to take after identifying a concern and the conduct of the screening process or preliminary enquiries. 10:56

The 2017 Guidelines also remove reference to the role of the Oversight Group which played a significant role in the early stages of the Mr. O'Brien case. 10:57

Ms. Toal has explained that this change was made as a direct result of a "Key learning" from that case. The Oversight Group approach has been "replaced with more definitive guidance for a Clinical Manager". 10:57
Dr. O'Kane has indicated that this change was necessary as "it was considered important to ensure that there was no confusion around the fact that decisions are taken by Case Managers and, whilst oversight directors can be consulted, they are not responsible for taking decisions in MHPS cases". 10:57

It has also been brought to the Inquiry's attention that the Trust is updating the guidance further and will be producing a 2022 version. It will be necessary for the Inquiry to understand precisely what issues were identified which led to the update of the Guidelines, what changes were made and how effective 10:57

these have been in dealing with the issues identified.

The Inquiry understands that the MHPS Framework has not been amended since its introduction in 2005. This is despite the significant regulatory reforms which have been made within the HSE system since that time, most obviously through the introduction of the role of the responsible officer and revalidation in 2010 and 2012 respectively. 10:58

The Inquiry is aware from responses to various Section 21 Notices, including from Mr. May, that reviews of the MHPS processes were commenced in 2011 and again in 2018. On both occasions the Trust provided submissions to the Department highlighting, for example, issues with regards to timeframes and the role of the non-executive director. The Inquiry will wish to explore the issues which both of these reviews may have identified with the MHPS Framework, the reason why none of these reviews were completed and the issues which require to be addressed. 10:59

The Inquiry is aware that concerns in relation to the operation of the Framework were examined by the Independent Neurology Inquiry. That Inquiry made a number of recommendations in the final report. The Inquiry has been told by Mr. May that the Department is considering the MHPS Framework following the publication of the Neurology Inquiry's report. The 10:59

Trust has indicated to the Inquiry that they are aware that a process is in train and await the establishment of the Department-led group to take the process forward. The Inquiry will no doubt wish to monitor the outcome from any review of the MHPS Framework as this is an area which touches directly upon the Inquiry's Terms of Reference.

I should highlight, Chair, that the Inquiry has received a number of helpful contributions which will allow you to address that part of your Terms of Reference which invites you to consider whether the MHPS Framework requires strengthening. In that respect, I would refer you to the considered remarks of Ms. Hynds who explains her experience of the difficulties with working the MHPS process.

I should also refer you to the reflections of Dr. Steve Evans of NCAS who explains the kinds of issues which generally impact a Trust's ability to adequately implement the MHPS Framework.

There is much to consider in this area of your Terms of Reference. Perhaps the single most important issue to be considered has been articulated by Ms. Toal. She calls it the "unanswered question". She says:

"Given the wider concerns that came to the fore from June 2020 regarding Mr. O'Brien's practise, I am left

with an unanswered question as to why the MHPS investigation did not uncover any of the further patient safety concerns which subsequently came to light."

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Chair, you may consider that the evidence suggests that there was sufficient cause for concern to justify placing Mr. O'Brien's practise under the microscope.

The concerns which came to light in 2020 were not identified during the MHPS investigation and the Inquiry will have to ask why? Was it because they did not exist or, as appears more likely, was it because the Trust did not subject Mr. O'Brien's whole practice to scrutiny and failed to grasp what Ms. Toal has described as the "real significance of the link between poor administrative practises and patient safety". 11:01 11:02

In any event, were there any limitations inherent in the MHPS Framework which led to what you might consider to be a less than satisfactory outcome? 11:02

I wonder, if people need it, would now be a convenient moment to take a five, at most ten-minute break, and then I will complete the final section, Part 4 of the opening statement by one o'clock? 11:02

CHAIR: Yes, I think it would be a good time. I think we will sit again at quarter past eleven, which is ten minutes from now, just over.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Good morning. Are you ready to conclude your opening statement, Mr. Wolfe? 11:13

MR. WOLFE KC: Chair, the final lap.

This is Part 4 of the Inquiry's opening statement. It concerns the Governance Framework. 11:14

Broadly, this section of our opening involves describing what the Governance Framework was designed to do and how it operated. I will focus on the reported patient safety failings and will examine 11:14 whether the governance systems in place ought to have prevented those failings. To illustrate the operation and effectiveness of the governance architecture, I will focus on the kinds of patient safety issues encapsulated by the problems identified by the Trust in 11:14 association with the practise of Mr. O'Brien. I will conclude by considering what barriers may have existed so as to impede the operation of robust and effective governance arrangements.

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I should say at the outset that there are a considerable number of governance systems and arrangements in use across all layers of the Trust. I do not intend to address each area in detail, nor do I

intend to provide more than a very general overview of roles and responsibilities of selective personnel. What follows is a focused description of the most relevant elements of the governance framework, the people involved in operating that framework, as well as an exploration of some of the actions which they took or failed to take in relation to the issues which with the Inquiry is concerned.

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The starting point for considering the governance issues is the Inquiry's Terms of Reference. Paragraph (b) of those terms requires the Inquiry to evaluate the corporate and clinical governance procedures and arrangements in the context of the circumstances which gave rise to the Lookback Review. This includes the communication and escalation of the reporting of issues related to potential concerns about patient care and safety within the Trust, the HSCB, the PHA and the Department. It also includes any other areas which directly bear upon patient care and safety. So what does that mean?

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In practical terms it means the Inquiry must peel back the layers of governance, roles and responsibilities to identify and stress test the effectiveness with which those systems and personnel handle concerns raised. Within the confines of part (b) of your Terms of Reference, the touchstone for what falls within the remit of the Inquiry's consideration is any area

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bearing on patient care and safety. This is reinforced by the language of part (c).

Lastly, part (f) of your Terms of Reference asks that the Inquiry identify any learning points and make appropriate recommendations as to whether the Framework for clinical and social care governance and its application are fit for purpose. To fulfil this term, the Inquiry will need to look at both the Governance Framework and the way in which it has been applied or could have been applied, question whether that application has been effective in resolving the issues, and assess the reasons for any identified failures. 11:16 11:17

What does governance mean within healthcare organisations? 11:17

In broad terms, governance is defined as the way in which an organisation is managed at the highest level and the systems for doing this. The Inquiry will hear how those various systems are interwoven within the Trust board and the Trust senior management team structures. In practical terms, the governance is the way in which the Board and the various tiers leading to the Board receive proper assurance regarding the quality of care provided. Understandably, this means that not only must the systems work effectively to provide information to inform the assurances provided, but that this information must be accurate and withstand robust scrutiny. Those two factors are key. 11:17 11:18

In relation to the Trust board, it is required by Standing Orders to have in place integrated governance structures and arrangements that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, social care, information and research governance aspects.

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The aim is that this will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory obligations as well as clinical, social care, quality, safety and financial objectives.

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The Trust, through its senior management team, must operate a system of healthcare provision which maximises patient experience and safety and which minimises risk. It does this by systems of governance embedded throughout its services at directorate, corporate and divisional level. The systems, processes and procedures in place within the Trust, and within urology services more specifically, aim to provide a check/balance system of oversight to enable governance issues, which have the potential to impact on patient care and safety, to be identified at the earliest stage and remedied so as to reduce or negate any rise in patient risk, whilst also promoting effective clinical care.

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In order to understand when and how these systems, processes and procedures operate, the Inquiry will need to have an understanding of the structures in place within urology. Furthermore, in order for governance 11:20
to operate effectively, the Inquiry may wish to consider whether an appropriate culture needs to exist. In this context culture means not only that the correct standards are set and measured, but also that practices are questioned, that learning takes place through audit 11:20
and from error, and that there is a focus in improvement and good clinical and non-clinical leadership. It also means that staff are valued, trained and that their interactions with each other and with patients are considered and respected. 11:21

Chair, you may also consider that a sound culture also requires that patients are afforded the opportunities to be partners in their own care and to know that they can be heard. 11:21

The Inquiry will hear that the focus of good healthcare management has moved away from a blame culture and towards looking at effective multidisciplinary teamwork. Nevertheless, you may consider that it is 11:21
important to identify culpable behaviour, if that is where the evidence takes you. That is not to say that the Inquiry cannot also highlight the much excellent work which is also performed within urology services by

staff who are patient-focused and driven to improve standards of care.

The Inquiry may consider that at the core of any good system of governance are sound human relationships. How, why, and when people interact form the bedrock of a robust confidence governance system. That is why the Inquiry will wish to explore the clinical and non-clinical leadership to establish whether the hierarchy in reporting concerns assisted or prevented those concerns from being addressed. 11:22 11:22

Despite the focus on operational level, the overall responsibility for the standards of clinical care at board level remains critical. To this end, the ways in which the Board seek to obtain assurance and discharge their responsibilities will be a matter for the Inquiry to explore. 11:22

What will become apparent, Chair, is that some of the components of good clinical governance are easier to spot than others and it is not always immediately clear or easily recognisable how clinical outcomes may be best measured. It may be that the key is to consider a broad range of information to obtain the true picture of what is going on. However, what is clear is that there are a host of metrics across the Trust's services and within urology which will allow the Inquiry to take a view as to how things were done and what might have 11:22 11:23

been done differently.

In terms of assessing the effectiveness of governance, the Inquiry might consider that not everything that is important can be measured and not everything that is measured is important. So the Inquiry will hear of other factors which may impact on the achievement of a robust system of governance such as human factors, including deference. 11:23

The key components of an effective system of governance will be discussed a little later but they necessarily include having clear lines of accountability for the quality of clinical care, starting from individual members of staff up to board level. Staff structures and interactions are key. The following section illustrates how this operates in practice by considering some of the post holders and their specific responsibilities for handling issues of concern. 11:24

Within urology, there is a staffing and management structure responsible for the implementation and oversight of governance. A brief introduction to some of the main frameworks in place is all that is required at this stage. 11:24

Urology sits within the division of surgery and elective care and the Directorate of Acute Services. From a broader operational viewpoint, the Directorate

is led by the Director of Acute Services with accompanying Assistant Directors relevant to their particular area or specialism. These Assistant Directors report to the Director and are responsible as relevant to this Inquiry for line managing the Heads of 11:25
Service of Urology. Each Assistant Director is supported by an Operational Support Lead and Heads of Service for each specialty or service area. Heads of Service are responsible for working with medical staff to ensure the effective provision of their services. 11:25
The Operational Support Leads collate information with regard to the Integrated Elective Access Protocol detailing compliance with referral obligations, triage, assessment or cancer pathway access and treatment targets, including individual patient data. 11:26

Booking and secretarial services are led by the Assistant Director of Functional Support Services who is supported by the Booking and Contact Centre Manager. Working to her is a Booking and Contact Centre Manager 11:26
and a Service Administrator.

Turning now to the medical structures of management.

These sit within the governance structure but operate 11:26
in parallel to administrative oversight. That is not to say that it is separate, indeed the Inquiry will hear of the importance of joint oversight of patient care. In his evidence to the Inquiry, a former Chief

Executive, Mr. McNally, explains the difference in the operational and medical management in the following way:

"The Director of Acute Services, along with the appropriate Assistant Director and Head of Service was responsible for the operation of effective systems of governance within Urology Services. The Medical Director, the Assistant Medical Director, the Assistant Director of Clinical Governance and the Clinical Director were responsible for ensuring that such systems supported clinical staff in exercising their professional obligation to their patients." 11:27 11:27

However, the Inquiry will also hear of failures in governance from both operational and medical perspectives and will want to know how those failures came about and whether any separation in roles or perception of separation in dealing with issues impacted upon or contributed to effective resolutions. 11:27 11:28

The first key medical post is that of the Medical Director who reports directly to the Chief Executive. This is the most senior tier of medical management. The Inquiry will note that the Medical Director sits in a different directorate to Acute Services, although all Associate Medical Directors report to the Medical Director. The Medical Director is an Executive Director and member of the Trust Board with 11:28

professional responsibility for the clinical outcomes and effectiveness of the Trust's medical services, responsible also for advising the Board on all issues relating to the professional medical workforce, clinical practice and quality and safety outcomes. The Medical Director has responsibility for clinical governance and patient safety, is a member of the senior management team and leads and manages the Trust's Corporate Governance Team. 11:28

Beyond the purely contractual aspects of the role the Medical Director has a specific role as Responsible Officer under the Medical Professional Responsible Officers Regulations Northern Ireland 2010 in relation to the conduct, safety and competence of the medical workforce, namely responsibility for revalidation and referrals to the General Medical Council when there are doubts about fitness to practise. 11:29

The Medical Director reports under this responsibility by regular reports to the Governance Committee under professional governance reports and to the Trust Board. 11:29

The Inquiry will hear that the Medical Director in post from 2015, Dr. Wright, expected the Associate Medical Director and Clinical Directors to contact him immediately when a new issue arose rather than waiting until a next meeting. The Inquiry will want to look in detail to see whether this expectation was met in 11:30

practice and what, if anything, was done when concerns were escalated within medical management.

Below the Medical Director sits the Associate Medical Director for Acute Services and Surgery, who is 11:30
responsible and accountable for the medical staff within that specialty and works closely with the Director and Assistant Directors of Acute Services to provide medical management within that Directorate. The Associate Medical Director is also responsible for 11:31
the safety and capability of the medical workforce within the specialty. The Associate Medical Director manages the implementation of appraisal and job planning and in conjunction with the Assistant Directors and Director of Acute Services is responsible 11:31
for the systems connected with incidents, complaints, risk identification and assessment, litigation, audit and clinical indicators. The Associate Medical Director reports operationally to the Director of Acute Services and reports professionally to the Medical 11:31
Director.

The Associate Medical Director for Surgery and Elective Care is the direct line manager for the Clinical Director. There are a number of Clinical Directors 11:31
within each directorate. Clinical Directors are responsible to the Director of Acute Services and operationally responsible to the Associate Medical Director for their division. The job description for

Clinical Director for Surgery and Elective Care can be found at TRU-02240 and indicates that the role is to "provide clinical leadership to support the Trust in developing high quality services". The post holders' key responsibilities include: Setting direction for the Trust and service delivery, ensuring quality, communication and information management and professional leadership in developing medical education and research. The Clinical Director supports the Associate Medical Director and has direct line management for the Clinical Lead and Urology Consultants who are, of course, governed by the contractual and professional obligations and duties as physicians and surgeons. 11:32 11:32

I pause here to highlight an example of how these roles interact in practice. While secretaries are allocated to report to their own consultant, they also report to the service administrator for escalating concerns and to provide update positions on dictation, typing and backlogs. The Service Administrator would collate this information into a Backlog Report to share with service administrators, Head of Service and consultants. 11:33 11:33

The Inquiry will hear that issues relating to untriaged referrals or consultants taking charts home were escalated to the specialty area to be addressed by the specialty team. This demonstrates that there were, in parts, practice management structures allowing for 11:33

operational oversight which, in turn, informed governance. A further example of such a structure is provided by the Assistant Director of Functional Support who has informed the Inquiry that issues such as untriaged referrals or charts tracked to a consultant, but not found in his or her office, would be raised with the Head of Service for her to address with the consultant concerned or to escalate with the Assistant Director of Surgery and Elective Care. 11:34

These examples illustrate the interplay of roles and responsibilities with all escalation routes leading, as necessary, to the Clinical and/or Assistant Director, Medical Director or Director of Surgery and Elective Care and ultimately the Chief Executive. 11:34 11:35

What they also serve to highlight is that some of the concerns raised appear to have been dealt with or attempts were made to deal with them at a more local level, in that they were not escalated beyond the level of the Head of Service or the Assistant Director or Associate Medical Director. Operationally, this is to be expected. What the Inquiry will also learn, however, is that out of all of the concerns upon which this Inquiry is based, only two appear to have ever reached Board level. That is the IV antibiotic administration issue and a notification of the commencement of MHPS, and the detail of those issues and the manner in which they reached the Board, as well 11:35 11:35

as how the Board responded will be matters for the Inquiry to explore.

A further example of how governance might work, though perhaps of a different type, is provided by one of the Assistant Directors in her response to the Inquiry. She indicates that the administrative workload is monitored by the service administrators through the use of backlog reports, activity reports on PAS and spot checks on secretaries' work. She states in her evidence that she would have expected secretaries to bring delays in dictation to the attention of the service administrator as, unless undictated clinics are included on the Backlog Report, management had no way of knowing about them. In her evidence she states that Mr. O'Brien's secretary was not doing this in respect of his undictated clinics. In her evidence Mr. O'Brien's secretary states that she was unaware that this was a growing problem for Mr. O'Brien during 2016. Mr. O'Brien reassured her that the urgent dictation was completed and it was routine dictation that was outstanding. The Inquiry will want to look at the evidence on this issue to identify if appropriate governance systems were in place and, if so, why information needed to inform those systems was not forthcoming. 11:36 11:36 11:36 11:37 11:37

In this context the Inquiry will also wish to consider the reasonableness, or otherwise, of a Trust relying on

a system of governance which was wholly dependent upon information being provided by one individual or by any one of the secretaries or any other staff. The vital role played by individuals with knowledge of issues and concerns, which I shall refer to as intelligence, will be explored further shortly. 11:38

The evidence which the Inquiry will hear will not be limited to those who have been employed within the Urology Department. Further, an important directorate is the Director of Human Resources and Organisational Development, led by a Director and supported by Deputy Directors of Human Resources, Heads of Service of Human Resources and Assistant Directors of Human Resources. 11:38

In concluding this section, the Panel will note from the descriptions I've just set out that there is both a distinction and an overlap of medical and operational management. The main links appear to be the Associate Medical Director who provides clinical advice to the operational management side, and the Head of Service who appears to have sight of the broad landscape of urology provision. 11:38

It is important for the Inquiry to understand these roles and structures in broad terms as the flow or absence of information from and between them will form an integral part in understanding how effective these structures were, where the areas of vulnerability lie, 11:39

and where the line of accountability may be drawn. Two of the key questions which this Inquiry will need to address in this context are: What were the features of a governance system which may have failed to adequately address risks to patient care and safety, and what were the frailties within urology that prevented a robust governance system from taking root? 11:39

I will now move on to look in more detail at the governance frameworks relevant to urology generally and within urology specifically to assist the Inquiry in understanding how governance did or should have worked. 11:40

In order to appreciate the lines of accountability and governance, it is necessary to set out, in summary terms, what the applicable layers are at corporate, directorate and divisional levels. The thinking behind these layers is undoubtedly to ensure the effective management and operation of the Trust as a provider of commissioned services, as an employer but primarily, and most importantly, as a major healthcare provider. These competing demands mean that Trust must have different ways to achieve the same aim, to find out how services are functioning within the Trust and to respond appropriately to any concerns arising. 11:40 11:41

One of the ways in which this is done is that the Acute Directorate links to the Corporate Senior Management Team, Governance Committee and Trust Board providing

ostensibly a clear line for information sharing. So, for example, the Acute Directorate has a range of key meetings which focus on clinical governance allowing for the possibility for governance issues to be raised and shared across the Trust via the links set out. An 11:41
example of one such meeting is the Acute Directorate Governance meetings which consider standards and guidelines compliance by utilising reports provided for these meetings and the Directorate Risk Register. These monthly meetings providing an opportunity to both 11:42
report and monitor governance concerns occur on a frequent basis. The Inquiry will recall the specific staff structures in urology which will assist in understanding the significance of having senior management from urology, including Assistant Directors 11:42
and Heads of Service, if required on the specific service issue, able to attend at these meetings to pass on governance concerns.

Others attendees include the Acute Clinical Governance 11:42
Coordinator and staff from the Medical Directorate for Clinical Incident Reports and the Complaints Manager for the Complaints Report.

I referred to the Directorate Risk Register in passing 11:42
a moment ago. Risk Register will be discussed shortly but at this point it is worth noting that the register at Directorate level may be utilised to highlight problems or concerns. Some concerns evident in some of

these registers will become familiar themes for the Inquiry. For example, the Inquiry will hear that from 2015 there are persistent staffing issues, including vacant radiology posts, noted on the Directorate Register. There is also acknowledgement of resource issues and the effect on patients awaiting appointments. The risk of not meeting the cancer pathway deadline is frequently raised having been on the register since 2014. It is also acknowledged that red flag referrals have increased. 11:43

While these concerns also existed within urology, it appears that very little about the specific problems in urology make it on to the Directorate Risk Register, that is until 2020 when at a meeting on 10th July there is discussion regarding the risk of harm due to there being no capacity for review appointments. The Inquiry might be keen to look at why the problems specific to urology appear not to have been included on this register. 11:44

Other meetings in which governance concerns could be raised include Cancer and Clinical Services Division Governance meeting and Acute Service at its Governance meetings. A helpful summary of the types and trust levels of governance oversight in place is provided by a former Chief Executive who explains that directorate governance meetings happen regularly with the intention of reviewing outcomes from all aspects of governance, 11:44

including complaints and incidents. He states that there are weekly Director and Clinical and Social Care Governance coordinator meetings and monthly Clinical Governance meetings, monthly Acute Clinical Governance forums, fortnightly Standards and Guidelines meetings and weekly divisional screening meetings and monthly divisional governance meetings. The Inquiry will begin to explore how, if at all, urology concerns found their way into these structures. 11:45

The Inquiry will hear that senior management devised structures for governance within the Urology Department including weekly urology meetings at which a broad range of issues could be discussed. Several examples of potential routes by which governance concerns might have been highlighted are provided now. 11:45 11:46

One such example is provided by a former Director of Acute Services who states that in early 2010 she commenced two meetings on governance, both held monthly, one including the Associate Medical Directors and Assistant Directors reviewing all the data used in the governance of services, and the second meeting involving a deeper review of the data. 11:46

A former Associate Medical Director for Surgery and Elective Care has also told the Inquiry that there were formal weekly governance meetings with the Assistant Director for Surgery and Elective Care to discuss all 11:46

sub specialties in the Surgical Directorate. He states that each month at governance meetings the Urology Lead Clinician and the Clinical Director joined. This appears to be a direct weekly opportunity for clinical governance concerns to be discussed and escalated for discussion and possible resolution. It is not clear yet if or when this was used for urology concerns. 11:47

Another example comes from a former Chief Executive. Who states that there are a range of multidisciplinary meetings chaired by the Assistant Director of Surgical and Elective Care, Mr. Carroll, and/or Mr. Barry Conway, the Assistant Director for Cancer Services and at these meetings there were, it is stated, a daily focus on performance levels as informed by referrals in triage, trends in cancer pathways, clinical volumes, do not attend rates, waiting lists and waiting times, as monitored by the Operational Support Lead. The Inquiry will wish to assess what, if any, quality metrics or patient care information could or should have been derived from this data to inform governance oversight. 11:47 11:48 11:48

The Inquiry will hear that individual clinician's performance was not discussed at acute performance meetings. 11:48

Following on from that, there are minutes of heads of service performance meetings showing discussions about review backlog and waiting times, but nothing specific

to problems with urology or any of or its clinicians is noted.

An individual`s performance is not discussed at either meeting. The Inquiry will want to consider what alternatives existed to raise individual performance and whether that was used at all. 11:49

One such possibility is appraisal. However, the Inquiry will hear evidence of how appraisal operated in the Urology Department and its limitations in governance terms. The Inquiry will wish to look at how it was used and what, if anything, came of any concerns or issues raised through that route. 11:49

So, what are the options when an issue arises with an individual clinician's performance and when this needs to be looked at and perhaps escalated? Direct complaint is one option. Escalation through MHPS is a further route. But in terms of drawing concerns in individual performance for the attention of the management hierarchy within the Directorate and the Trust, the Inquiry will have to consider whether processes for escalation were available, accessible and sufficient and whether, if they were used, did they provide for any sort of effective remedial action? 11:50 11:50

It is worth briefly looking at the Urology Team departmental meetings which were held weekly and

arranged by the Clinical Lead. Attendees included the Operational Support Lead, Lead Nursing Staff, consultants and registrars. Topics discussed included scheduling, on call arrangements and theatre utilisation, staffing, equipment, systems, waiting lists, performance and clinical issues. 11:51

Given the frequency of these meetings and the list of attendees from a wide range of roles within urology, the Inquiry might consider and explore with witnesses whether this forum represented an ideal opportunity for concerns to be raised, noted, acted upon, monitored or escalated? 11:51

Cancer performance meeting minutes show a concern is raised from at least 2015 regarding radiologists not being present at MDM. This is a continuing theme throughout those minutes. The effect of this on MDM's quoracy is noted. It is noted as having particularly affected urology and haematology. There are also concerns about oncology not always being present due to staffing levels and the consequential impact that this has on MDM quoracy. 11:51 11:52

A further example relevant to urology is found in the minutes of a meeting on 17th September 2015. These minutes indicate improvements in urology performance, despite difficulties with radiology cover and state that processes have been put in place to minimise 11:52

delays in pathways. The Inquiry will be keen to explore those processes which appear to be considered effective.

The material considered by the Inquiry to date points to the availability of a plethora of forums for raising issues of concern for escalation and for ensuring that those in managerial positions are enabled to take immediate steps as appropriate. 11:52

11:53

A simple illustration of this is that should a nurse or an auxiliary or an administrative staff member within urology have a concern or complaint about a clinical issue, then the first port of call is their direct line manager. For example, the ward manager or a lead nurse. The localised apex for any non-clinical concerns within the Urology Unit is the Head of Service, beyond which lies the Assistant Director and Director, should the concern not be capable of being addressed at her level. 11:53

Should concerns not be addressed and should they be deemed sufficiently serious then the next step is via some aspect of the formal structures in place. This may be a direct complaint or a grievance, dependent on the source and subject matter of the problem. This will be escalated by the line manager via Human Resources as appropriate and the normal channels of inquiry will commence. The nature of concern will 11:54

dictate the route and seniority of escalation which reflects both good governance and operational expediency.

It will be apparent from what I have already said that, on paper at least, there is no barrier which should prevent concerns percolating up from local level in urology via the governance teams through the weekly departmental meetings and the monthly Directorate meeting to the Risk Register at Directorate level and beyond. I will, however, come on to consider impediments to good governance which may be particularly applicable to the issues which are of concern to the Inquiry. 11:54 11:55

At this point, Chair, questions that arise for this Inquiry clearly include:
Were the issues within urology and relating to Mr. O'Brien's practise properly brought to the attention of these fora to be discussed? Were these fora the appropriate place in which these issues ought to have been raised and, if so, were staff aware of the procedures for doing so? Given that it appears that members of both operational and medical management were aware of the issues with Mr. O'Brien's practise, why did they not escalate the issues to be discussed at these fora? Or if they did, what is the evidence of that and what were the outcomes? Did any failure to escalate these issues stem from complacency, a lack of 11:55 11:55

understanding of the impact on patient safety or was it a lack of awareness of the appropriate processes or is there some other explanation?

I have explained, in broad terms, what governance is and how it operates within the staffing and management structures within urology. I will now turn to look at the key components of governance and explain how these components may be found within urology governance structures. 11:56

Good clinical governance requires clinical effectiveness as a core pillar. This is about using the best available evidence to achieve optimum outcomes for patients, which requires both good quality processes and standards of care. 11:57

Standards and guidelines

Examples of governance systems which might highlight problems include standards and guidelines relied upon by the Trust in the delivery of their services. These include, for example, NICE Guidance, cancer peer review standards, specialty association standards, as well as advice or guidance from the HSCB or the HPA, to note some examples. The Trust has its own standards and guidelines process which has two broad functions: 11:57 11:57

(1) To enable the Trust to ensure that the healthcare provided reflects industry best practice as well as providing a base against which the provision of care

may be assessed. The Inquiry will be keen to understand the interaction between the relevant standards and guidelines and the governance issues emerging within urology. Standards and guidelines are monitored by way of the Governance Committee and their reports so the Inquiry will wish to consider what might happen if guidance is not being followed. 11:58

Responsibility for identifying the applicability of a standard, risk assessment and the subsequent implementation of a standard within the Trust resides with the operational directorates and the individual practitioners. The key is that if the process of monitoring and dissemination works, no clinician should be in any doubt as to what is to be expected from them. 11:58

Patient safety standards

Patient safety standards are another way in which governance is monitored. This incorporates elements of clinical effectiveness, patient experience and risk management. By way of example, given the concerns before the Inquiry, these issues are relevant to clinical treatment administered, MDM outcomes being followed, and the overall care provided. 11:59

11:59

Risk management

For illustrative purposes I will briefly explain how one of those patient safety tools, risk assessment, operates at Trust level. Arguably, the central tenet

of risk management and assessment for the Trust and the Board is the Risk Register. The register acts as an assurance to the Governance Committee of the Board which that committee then uses to advise and ensure the Board of the governance risk for the Board and the Trust. These registers of are central significance from which reassurances can be derived and assurances given. 12:00

The Inquiry will become familiar with the various risk registers which are as follows: 12:00
The Divisional Risk Registers reflect risks within divisions and are overseen by the Assistant Directors.
The Directorate Risk Register reflects risks throughout the directorates and is overseen by the Directors. 12:00
The Corporate Risk Register is reviewed by the Governance Committee to satisfy itself that the risk management system in place is comprehensive. The lead for the Corporate Risk Register is the senior management team and the Governance Committee. In this way, there exists the possibility for the recording of a risk to be identified, managed and reviewed from operational level right through to corporate level. 12:01

The information provided to the Inquiry to date appears to point to the Head of Service as having knowledge about or the potential to inform all the various types of risk register. 12:01

The Inquiry might consider that one significant feature of the risk register is that it is completed by senior Trust management. The information they provide appears to be taken at face value with no apparent built-in system of interrogation by the Committee of the data they provide to inform the register. The Inquiry may wish to consider whether the absence of any, or any robust analysis of the data provided by senior management renders that information potentially vulnerable in forming the basis for the Board and Trust assurance around governance. 12:01 12:02

The Inquiry may also wish to consider the integrity of those systems given the very limited reflection of the governing concerns in urology in either the Corporate, Divisional or Directorate Risk Registers. 12:02

Other risk processes of governance interest are the Serious Adverse Incident Framework. The multiple SAI reviews are clearly central to the work of this Inquiry and have been discussed in detail already. 12:02

Aside from considering the content of those reviews to assess what they might say from a governance perspective, the Inquiry will also want to scrutinise how issues of clinical concern triggering those processes were managed, reviewed and escalated, including whether information relevant to patient risk found its way to Board level. The Inquiry will also 12:03

want to look at the nuts and bolts of the SAI process, including who was involved, how long did the process take, how well investigators were trained, how families and patients were involved in the process, how learning was disseminated and how the process is audited. The Inquiry will be cognisant of the need for a robust system of reporting and scrutiny to ensure that staff and patients can have confidence in the process. 12:03

Patient experience 12:04

No clinical care pathway or treatment policy can be complete without regard to the patient experience. The Inquiry's patient and family hearings have provided an invaluable insight into those experiences. Plainly, the Inquiry will be keen to understand how the Trust sought to capture information concerning the patient experience, whether that information was regarded seriously and explored and whether proposals for change and improvement were implemented by the Trust. An illustration of the importance of seeking feedback from the patient experience can be found in the material provided by the Public Health Agency with support from Macmillan Cancer Support. Together they submitted a Regional Cancer Patient Experience Survey in 2015. Access to Clinical Nurse Specialists came out as a key area from the perspective of patients. This is an already familiar issue for the Inquiry in light of my remarks yesterday. 12:04 12:04 12:05

This finding was further reflected in the National Peer Review Programme 2015, which I also touched upon yesterday in the context of the MDT.

Communication 12:05

A further component of good governance is communication. The nature and effectiveness of communication at all stages of the patient care pathway between clinicians and management and administrative staff, and with patients routinely, as well as when 12:05
things went wrong, will be an area of interest for the Inquiry. A range of questions will emerge. For example, the Inquiry may wish to ask how is communication to patients provided? What information is given routinely? What access do patients have to 12:06
their letters and notes? Who provides a point of contact to specific patient groups and is this contact sufficient? What is the trend in complaints relating to communication? Are there problems communicating appointments? Do GPs and patients get timely letters 12:06
about consultations?

The Inquiry will hear evidence of the Trust's methods of communicating and may consider, for example, how issues such as the delayed or absent review of Trust 12:06
results were impacted by poor communication across several levels.

Audit is a further key component of good governance.

Auditing of the components of clinical governance is good practice so the Inquiry will be concerned to identify the extent to which audit was used, how audit outcomes were implemented to improve services or whether, as I suggested yesterday, the use of audit was not particularly well embedded in urology services particularly, and if so, why? The Inquiry will wish to examine the quality improvement work which is ongoing within the Southern Trust, who is involved, what are the timeframes and expected outcomes? The Inquiry may also enquire whether the results of regional or national audits are shared with specialties such as urology and whether there is regular clinical audit report to the Board Committee and if so what actions are then taken? 12:07 12:07 12:08

Appraisal

The Inquiry will hear evidence that the key governance component with reference to staff evaluation of their role is appraisal. The Inquiry will have the opportunity to look at the Trust's system of appraisal, its frequency and efficacy and to assess how, if at all, it identified concerns or areas for improvement. Was there a failure to use the appraisal process in an effective way to draw out and to address areas of concern? The Inquiry will specifically consider the appraisals completed by Mr. O'Brien and the information and concerns he reflected in his appraisal process and what, if anything, the Trust did in response. 12:08 12:08

Information

A catch-all title of information is another key component of governance. This applies both to the way in which the Trust communicates corporately and how a range of metrics are used to monitor quality at Board and every other level. The robustness and integrity of this information, how it is interpreted and used, and what, if any, actions are taken based on information and how those actions are implemented, monitored and reviewed are all areas of interest for the Inquiry. 12:09 12:09

As mentioned earlier, information may also be described as intelligence as it informs subsequent decision-making. I will discuss this feature shortly. 12:10

Information captured by the Trust and specifically within urology will be examined. Trust systems of data collection and collation such as the patient administrative system or PAS, Box and Datex and their use will become familiar through the course of the hearings. Whether these systems contributed or hindered good governance will be examined with witnesses during the public hearings. 12:10 12:10

Education, training and continuous professional development

Other components which are integral to a healthy governance structure are education, training and

continual professional development. The Inquiry will wish to consider these issues as appropriate as well as looking at whether sufficient support was offered or provided when it became apparent that support was required. The Inquiry will wish to consider, for example, what, if anything, was done in response to Mr. O'Brien's indications that he was struggling administratively? If action was taken in response, how was it monitored, reviewed and altered as appropriate to ensure that it was effective? 12:11

Leadership

A further critical aspect of governance is leadership, including at clinical, service and administrative levels. Specific to the concerns within urology, you will now be aware, Chair, that concerns regarding, for example, triage were widely known, remained an issue for a considerable period of time, involved a considerable number of patients, but was only belatedly escalated and addressed. The Panel will wish to explore who were the relevant leaders at the relevant times, what did they do and what did they not do, the reasons for this and what might have been done differently? 12:12

In more general terms, the Inquiry will want to understand how leadership is evident throughout the Trust's structures. How is it fostered, rewarded and supported? How is the structure of the Trust set up to

support this? Do the leaders take ownership and is their presence felt in quality and service provision? What efforts are made to support a multidisciplinary clinical leadership model? What leadership development programmes are in place? Is there evidence of poor leadership and, if so, how is this responded to? The Inquiry will seek answers to these and further questions from relevant witnesses.

Having explained the management structure, the elements of the governance framework, as well as the important components which should form part of a governance system I will now briefly address governance in action. Within this context the key focus of the Inquiry's work is on the governance arrangements relevant to the circumstances which caused a Lookback Review to be established in 2020. While there is an understandable focus on how the governance framework responded to the activities of one clinician, a broader examination of the governance system will be helpful to better understand what has happened and why? Before doing so it might be of assistance to consider the categories of governance concerns arising. It will be noted, from what has been said already, that the governance systems within the Trust were working to some degree in some ways but not in others. It will be helpful to explore this through the prism of good intelligence, bad intelligence and partial intelligence in order to provide a better understanding of how the governance

concerns arose.

Good intelligence refers to those governance concerns which were well known by a broad range of staff and efforts, albeit apparently ineffective, had been made to get to grip with the concerns. This was done in a myriad of ways including cajoling, allowing more time or simply molding the system to fit the clinician rather than seek out the kind of improvement which was necessary. There are a significant number of patient care and safety concerns which can be viewed from this perspective about which much was known for a considerable time, though this did not appear to improve the prospects of resolution. Examples of areas where there was good intelligence including in relation to the triage issue and the non-completion of clinical dictation. 12:15 12:15 12:15

Bad intelligence involves situations in which information regarding the patient care and safety concern is effectively absent and no action is taken or can be taken until the issue is discovered or reported. Examples of this include the failure to consider and follow up on the results of CT investigations and non-compliance with MDM recommendations. It appears that in these areas the Trust's governance systems were particularly frail and were not established to provide information to demonstrate compliance. To some extent, safe governance of these areas may have depended to 12:15 12:16

some extent upon Mr. O'Brien's secretary communicating what she knew about non-compliance up the managerial chain, but that may not have been effective as a tracking mechanism across the range of patient safety concerns. 12:16

In cases of bad intelligence, if the issues of concern are known to some but not reported, management is deprived of the ability to do anything to address the issue. Of course, it is also key to look at what, if 12:17 anything, management did when they became aware of concerns. The Inquiry will also consider that any system of oversight which relies on an individual to report deviation from the rules may be vulnerable to being ineffective. The Inquiry may wish to consider 12:17 the effectiveness of such arrangements.

Partial intelligence

This refers to the governance scenario in which there is some information available in relation to patient 12:17 care and safety concerns to one or a limited number of personnel only. For governance oversight to work in such a system, the people in the know must bring that information to someone who can act on it, otherwise the issue will likely remain ongoing without triggering any 12:17 concern. The incident involving the administration of IV antibiotics is an example of a patient concern which was known but not put into the governance machine, as it were, to allow proper procedures to be put in place

to remedy those concerns.

The Inquiry will hear evidence of a variety of patient care and safety issues giving rise to patient concerns which date back many years. The way in which those issues emerged, how they were addressed and whether they progressed through the governance framework will require scrutiny by the Inquiry. 12:18

At this point I intend to briefly refer to the headline issues in summary form to provide a flavour of the longevity of some of the concerns and who knew about them. 12:18

Chair, the Inquiry will hear that from 2009 through to 2016 there was a significant volume of good intelligence about a broad range of concerns regarding Mr. O'Brien's practise, including in relation to triage, non-standard scheduling of patients, review backlogs, non-compliance with performance targets, benign cystectomies, notes at home, use of IV antibiotics and fluids and private patients on theatre lists. Various conversations and meetings were held on all or some of these concerns across a broad range of management. 12:19 12:19

Attempts were made to mitigate the impact of non-triage, for example, through input by other urology consultants. A work-around was also agreed regarding

triage. The default system in which the general practitioners' sometimes erroneous priority rating would be adopted for waiting list purposes if triage was not performed. The Inquiry will be keen to understand the rationale of this work-around and whether the management concerned with its implementation failed to recognise that moulding the system in the face of Mr. O'Brien's non-compliance was placing patients at risk. 12:20

You may consider that what emerges from these examples is that they were well known and recurrent patient care and safety issues. Well known, that is, in the sense that those at managerial level on both the operational and clinical sides were aware of the issues and yet they were not escalated within the governance framework in a timely or effective way and remained a significant problem over almost a decade. 12:20

The Inquiry might consider it informative of the approach taken by medical management to consider how they addressed one issue specific to clinical practise, the administration of IV antibiotics or fluids. 12:21

The issue of IV antibiotic administration was a concern as far back as March 2009. This was a practice which had been going on for some time and was known by some others before its appropriateness was questioned. The then Medical Director oversaw an investigation of the 12:21

practice and obtained independent advice. He introduced a protocol involving a Multidisciplinary Team that there was to be followed in respect of the management of these patients.

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The therapy was to be stopped for all patients in the cohort receiving it. A new protocol was introduced for these patients and was agreed between the consultants, including Mr. O'Brien and the Urology Services Coordinator. However, the Inquiry will hear evidence that the unorthodox administration of IV fluid and antibiotics continued until 2012.

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This concern was ongoing when the then Chief Executive, Mr. Donaghy, left the Trust at the end of August 2009. In his written evidence to the Inquiry he states that he has subsequently become aware of issues regarding Mr. O'Brien's practise because of the Inquiry but he does not know if these issues existed during his tenure. He also states that Mr. O'Brien's practise of admitting patients for IV therapy may have been an indication of other issues that were not obvious at that time. He says:

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"With the benefit of hindsight a wider review of his practise at that time may have been appropriate ."

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However he does not accept that problems were not properly addressed prior to his departure. His opinion

is that overall the governance arrangements were fit for purpose.

The Inquiry will note that Mr. Donaghy acknowledges that steps were not taken to risk assess the emerging concerns despite considering that this IV therapy practice did potentially constitute ineffective care. He says that he was not one aware that there were patient safety issues. The Inquiry will wish to explore the approach to risk assessment and management by the Trust throughout all periods of concern, not just during Mr. Donaghy's tenure given the perhaps obvious risk to patient safety. 12:23 12:24

The Inquiry will also hear that the issue of the unconventional administration of IV fluids and antibiotic continued despite the involvement of the Health and Social Care Board and the Medical Director and despite the use of monitoring by the Head of Service and the adoption of a bespoke system to address the concerns. The Inquiry will wish to explore how governance oversight of this issue failed until 2012. 12:24 12:24

The Inquiry may also wish to reflect on the potential similarities in the repetitive governance patterns in subsequent years of the following: 12:25

Identifying an issue, usually inadvertently or outside existing governance structures.

Establishing remedial action or action plans to be

managed at Head of Service or clinical management level.
Not escalating the issue beyond to Director level.
Ineffective monitoring and reviewing of clinical and administrative practise resulting in deviations from clinical practise, all within the context of potential or established patient risk.

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As I mentioned yesterday, the Inquiry will also hear evidence about the use of the action plan and monitoring at the commencement of the MHPS process which contained the basis for a sound governance response to known concerns, albeit belatedly. But even then it will be necessary to ask whether this governance response was sufficient to address all of the potential clinical shortcomings of Mr. O'Brien's practise.

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Barriers to robust governance

From what I have already said, it is apparent that all forms of intelligence have the ability to interfere with effective governance. The Inquiry may need to critically assess steps taken by the Trust to address concerns when the intelligence itself, or the approach taken to it, represented a risk to patient care and safety. In the round, the Inquiry will seek to identify what was known by whom and what did they do with that information. Clearly, good data is essential, as is staff willingness to engage with

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available governance solutions and systems in a timely and effective manner.

The Inquiry might consider that, should something go wrong or have the potential to go wrong, then contemporaneous or real-time reporting of that issue plays a fundamental part in reducing risk and maximising positive patient outcomes. Also breaches or flaws in the system in any system of governance should be reported immediately. If a plan of action is not working, why not? Recommendations for improvements should be followed and systems might be stress-tested to ensure their viability and sustainability. These are all issues which the Inquiry will wish to explore. 12:27 12:28 12:28

When considering the available systems of governance the Inquiry will need to look, not only at what was in place, but also what other options might have been available? So, for example, if the Trust was unable to put sufficient technological resources in place where they may have helped, then the Inquiry will need to understand the reason for that, the alternatives deployed and the efficacy of those alternatives. On this theme, the Head of Service briefly references the limitations on the possible remedies brought about by a lack of funding. She has said that: 12:28 12:28

"The storage of patient notes was always a concern of mine. Whilst in principle the Trust supported the move

to electronic tagging, there was never the funding made available to implement this so I had to use the workaround of physically visiting Mr. O'Brien's office at 6:30 a.m. on a Friday morning to perform a check, something which also didn't happen when I was off." 12:29

The Inquiry may consider it useful to explore what, if any, impact the absence of funding for systems of governance which may have enhanced patient safety in care pathways had on the Trust's ability to properly address the established concerns and risks. 12:29

Barriers to effective governance also include human factors. By way of one example, the material so far considered suggests that Mr. O'Brien's secretary was an important cog in the governance wheel, given the nature of the information she is likely to have held about his practise. If she was not disseminating information about difficulties, shortcomings or failings, and it may not always have been her responsibility to do so, and in real terms she may not have had the ability to do so, what can be done to gather that information so important to good governance and patient safety? 12:30 12:30

In considering the reasons for what went wrong in urology services, the Inquiry may consider it useful to consider the views of some of the managers, clinical and non-clinical. These replies range from staffing absences, workloads, to acknowledgements that a greater 12:30

scrutiny of the problems at an earlier stage should have been carried out. The Head of Service accepts in her evidence that all concerns raised regarding Mr. O'Brien's practise may have impacted on patient care and safety. She believed that she and others involved recognised this and that this was why they instigated the various responses, because, she says, they perceived them to be appropriate actions to address the risks that Mr. O'Brien created. She adds that she is no aware, however, of any formal risk assessments having been undertaken in this regard. The Inquiry will be keen to unpack this belief to understand the basis for it, as well as to explore the evidential base to support any view that patient safety was truly at the core of many of the measures taken. The Inquiry will also want to understand more fully what, if any, risk assessments, whether formal or informal, were carried out or what balancing exercises were undertaken or what factors at all, from a patient safety and risk perspective, were taken into account when decisions were made to act in a certain way about the risks posed. 12:31 12:31 12:32 12:32

The Inquiry will seek to understand why, if patient safety was known to be potentially at risk, this did not trigger either more robust, informal action and record keeping by senior management, or the commencement of formal investigations much sooner. If the evidence does suggest that informal attempts were 12:33

inadequate, the Inquiry will wish to establish why.

A further relevant factor when considering the informal actions taken in response to governance concerns will be whether Mr. O'Brien was given sufficient opportunity 12:33
to address matters and work consistently with support and reflection to agreed action plans.

Lack of agency and insight is another example of a barrier to robust governance. The Inquiry will hear 12:33
evidence from staff who both had information and failed to pass it on or who might be expected to know what was going on within urology, but apparently did not. It will be a matter for the Inquiry to consider whether and to what extent ineffective role fulfilment and 12:34
leadership adversely impacted on the attainment of good governance.

The considerable reputation enjoyed by Mr. O'Brien may be a further factor which interfered with effective and 12:34
robust governance as it may have played a part in his colleagues choosing not to raise a concern about him or seeking to deal with him in less robust or formal ways.

Dr. Chada formed the following impression of 12:34
Mr. O'Brien as:

"An old school consultant surgeon who had been supported by a personal secretary for many years and

who had worked under a system he had essentially set up until increasing demand, more consultants, and a review of the services and processes meant he was no longer able to continue to operate as a sole practitioner and needed to work as part of a team." 12:35

She adds:

"I believe Mr. O'Brien had difficulties adapting but failed to adequately bring to people's notice the 12:35
things that he wasn't doing. He continued to work in the way that he always had, for example, by taking notes with him and not always dictating following a clinical contact. These were outdated practices which were not consistent with GMC guidance or Trust policy." 12:36

The Inquiry will want to consider what, if any, role these issues played in the concerns arising around Mr. O'Brien and whether they impacted on the Trust's governance of him. Lack of knowledge about the 12:36
existence of a governance system by those who should rely on it or invoke it will also impact the efficacy of the system.

The Inquiry may consider that not knowing that a system 12:36
or procedure is in place, how it may be used, and the line management required to be followed are fundamental features of good governance. Yet, Chair, the Inquiry will hear evidence that not all staff were aware of the

possible routes for addressing concerns. For example, an Assistant Director of Acute Services in her response to the Inquiry states that she was completely unaware of the MHPS process. The Inquiry might consider how it is possible that a member of the senior management team in the Trust could not know about the MHPS process. This apparent ignorance of a vital procedure deprived her of access to a governance tool and arguably the only one which had the potential to produce any proper results. 12:37

Another example of a potential barrier to the operation of good governance is the suggestion that operational staff and clinical staff with parallel or overlapping roles in governance may not be immediately minded to work collaboratively. So, for example, operational managers may feel that they cannot and should not challenge clinicians on clinical practise. The clinicians may agree. This will be an area the Inquiry will be keen to explore. 12:38

The Panel of the Inquiry may also want to explore whether, if at all, medical colleagues facilitated or turned a blind eye to errant medical procedures and practices. This is directly relevant to the issue of what was done to try and address the governance concerns about Mr. O'Brien's practise. 12:38

The Inquiry might consider that this is a legitimate

line of enquiry, most especially given the informal attempts to address the concerns raised which caused a considerable input of time and resources. This issue is particularly prescient given evidence from an Assistant Director to the Inquiry that she has no reason to believe that the concerns regarding triage, record keeping or patient notes at home are still issues. However, information on these issues does not currently come to the senior management team or Trust board for oversight. This should be considered. Standards of clinical practise within urology do not come to SMT or Board for oversight. 12:39 12:39

The Inquiry may consider that a further barrier to a robust system of governance is the reliance on and pressure associated with obtaining metrics rather than a focus on governance and safety issues. The Inquiry will hear evidence that some managers felt the focus was too much on targets and on the need to provide favourable data. 12:40 12:40

A further consideration for the Inquiry will be staffing and resource allocation and the negative impact on good governance when either is insufficiently resourced. Evidence from the associated Medical Director states that he did not believe that he had sufficient support and time available to fulfil all of the duties of his role. Other witnesses make similar comments. The Inquiry will want to look at what role 12:40

staffing and resources played in the maintenance and application of the Trust's Governance Framework.

It is also important to look at matters from the perspective of the person causing or contributing to the governance issues. As previously mentioned, the Inquiry will be mindful, when hearing evidence, to understand what, if any, support was asked for, offered or provided to Mr. O'Brien to allow him to adjust and adapt his practices to comply with relevant standards, guidelines and Trust policies and practice. 12:41 12:41

The Inquiry will wish to understand the views of those who are and were responsible for governance within the Trust, what they say went wrong, how things could be improved and what actions the Trust may take to try to prevent recurrence of these and yet unknown patient care and safety problems for the future. 12:41

The Inquiry will also wish to test the viability and sustainability of any such suggestions and further reflect on the best way to learn lessons from the various strands of ineffective governance so as to make recommendations which will enable the formation of a, more robust, user-friendly and effective system of governance within the Southern Trust. 12:42 12:42

Chair, that brings me to the end of the Inquiry's opening statement. I would like to thank everyone for

listening so attentively. As can be seen, the Terms of Reference for this Inquiry precipitate many issues and many more questions. We begin the task of trying to address those issues and of asking those questions when we commence the public evidence phase of the Inquiry on Tuesday of next week. 12:43

That concludes my remarks. I understand you're going to hear from the Core Participants at two o'clock.

CHAIR: Well, Mr. Wolfe, thank you very much. I was about to say that as we have finished at quarter to one would I think, Mr. Lunny, you're first up, is that correct? 12:43

MR. LUNNY KC: That's correct, Chair.

CHAIR: Would you be ready to commence at quarter to two so that we could hope to finish earlier today, if possible? 12:43

MR. LUNNY: Absolutely, whatever time is convenient to the panel I will start.

CHAIR: Very good. Quarter to two we'll reconvene. Thank you. 12:43

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon everyone. Welcome back. Mr. Lunny, when you're ready. 13:44

MR. LUNNY KC: Good afternoon, Chair and good afternoon Dr. Swart and Mr. Hanbury.

At the outset of this opening we, on behalf of the Trust, wish to express our gratitude first for Mr. Wolfe's extremely detailed and characteristically fair opening statement on behalf of the Inquiry. That opening statement has provided us with greater insight into many of the areas upon which the Inquiry is likely to focus, the questions that the Inquiry is likely to ask of witnesses, the information gaps that remain to be plugged, and some of the difficult issues with which the Inquiry is ultimately going to have grapple. 13:45

Just as the Trust is grateful for Mr. Wolfe's opening, it's also grateful that you have afforded it an opportunity to provide a brief oral opening statement at the start of the Inquiry's public hearings. The Trust appreciates, having regard to your procedural protocol, that the making of an oral opening statement isn't a right, nor is it an opportunity that has been afforded to all of those whose acts or omissions might be scrutinised by the Inquiry. 13:46

The Trust acknowledges it's an opportunity that has only been afforded to it, to Mr. O'Brien and to the Department of Health because of their status as Core Participants. 13:46

At the outset, it is perhaps important that I set out what this opening statement will not do. It will not contain detailed submissions on the myriad of issues

that the Inquiry is investigating whilst they are still being investigated and whilst our knowledge of them is necessarily incomplete. The Trust will, if afforded the opportunity in due course, make more detailed submissions orally or in writing, or both, after the Inquiry's evidential hearings are complete. 13:47

Similarly, this opening could not hope to be, nor will I attempt to make it, a meaningful reply to the extremely detailed ten to 11-hour opening speech made by Mr. Wolfe. So against that backdrop I can reassure you, perhaps, that this opening will not involve me attempting to call up lots of documents on your system. 13:47

Moving on to what this opening statement will attempt to do; it will attempt to cover a number of things that the Trust considers to be important and the first of these is perhaps the most important and that is to apologise. 13:47

Cognisant of your call, Chair, for frankness and openness, the Trust wishes, at the very outset of these hearings, to apologise sincerely, unequivocally and publicly. To whom does the Trust apologise? Well first and foremost it apologises to affected patients and to their families. It also apologises, more generally, to the public whom it serves. And finally, it apologises to its staff, many of whom do, as Mr. Wolfe eloquently put it in his opening, every day 13:48 13:48

go beyond the call of duty.

For what does the Trust apologise? It apologises for the fact that the care given by it to a number of patients fell below what was acceptable and that in some cases this has caused or contributed to harm, sometimes very grave harm, suffered by those patients. It also apologises for the fact that this substandard care was the result not only of failings on the part of individuals for whom the Trust is responsible, but also of broader failings of Trust's systems, processes and structures. 13:49 13:49

This public apology is made in the presence of the Inquiry panel and it is also made in the presence of both the Trust Chair, Eileen Mullan, and its Chief Executive, Dr. Maria O'Kane, both of whom are present in person in the public gallery today. Now, they are present for a number of reasons. First, because the Trust's apology is their apology as well. Second, to show how seriously they and the Trust treat this Inquiry and its work. And third, to emphasise the Trust's commitment to continued cooperation with the Inquiry. 13:49 13:49

As the panel, perhaps not the public, will be aware, this isn't the first hearing that the Chief Executive and Chair have attended. One or more of the Chair, the Chief Executive or other members of the Trust's Senior 13:50

Management Team have been present for every one of the patient experience hearings, with your permission, Chair, that have taken place to date.

Now, I will mention some of the evidence given at the patient hearings shortly but I mention them at this point because the Trust wishes formally to acknowledge the importance and value of those hearings. They have been, in the Trust's submission, much more than a mere fulfilment of the Inquiry's Terms of Reference (d). They have served as a reminder that patients are at the heart, not only of the Trust's work, but of the Inquiry's work. They have served as a reminder that it is patients who have been failed and they have provided all of us with an opportunity to hear evidence from some of the persons most directly affected by the failings that the Inquiry is examining. Their evidence, at times, made for difficult listening for my client and no doubt also for other Core Participants, but the Trust agrees that it was essential to have heard it and to continue to hear it and, as I said, I will touch upon some of that evidence shortly. But for the time being the Trust would formally endorse what has been said by the Inquiry in its openings this week and it encourages patients to engage with the Inquiry by completing the Inquiry questionnaire and, if appropriate, by giving oral evidence. 13:50 13:51 13:51 13:51 13:52

Returning to the Trust's apology. It is not an apology

in the abstract. It is an apology for the many failings that have been identified to date and for the impact that those failings have had. In respect of failings, the Trust's apology includes, but is not limited to, the failings that have already been identified through a number of different processes which have been described already in some detail by Mr. Wolfe and those include, by way of brief recap, the relevant SEAs, RCAs, SAIs and overarching reports, the relevant MHPS process, the Lookback exercises, including the current lookback and the SCRR, and the invited review by the Royal College of Surgeons and the British Association of Urological Surgeons which reported recently. 13:52 13:52

These failings have been numerous. These failings have included clinical failings involving Mr. O'Brien. Of these, it appears that concerns or failings can broadly be split into two main categories: Those that were known about for some time but not adequately addressed and those that were not known about, but which ought to have been known about. 13:53 13:53

However, and importantly, failings have extended beyond those at the coalface, as it were, to failings of management and leadership and of Trust's systems and processes. And the Trust fully appreciates that, as the Inquiry progresses, further failings will in all likelihood crystallise or come to light and at the 13:53

appropriate time the Trust will acknowledge and address those as well.

In respect of the impact of the Trust's failings on patients and their families, the Trust's apology includes, but again is not limited to, those impacts about which we have heard compelling oral evidence during the patient experience hearings. In this regard we submit that it is important to acknowledge, on behalf of the Trust, all impacts and with this in mind I propose very briefly to refer to just some of the evidence we heard from patients or their families. 13:54 13:54

At one end of the scale we have a case like that of Patient 1 where the SAI Review Team found that an opportunity to offer him radical treatment with curative intent was lost due to failings for which the Trust are responsible. Just over a month ago, on 29th September in this chamber, we heard Patient 1's daughter provide powerful evidence, evidence that was again difficult for all to hear, about how her father, Patient 1, and his family suffered during his final year and how they suffer still. 13:54 13:55

Towards the other end of the scale, there are impacts of a type that, whilst they may not be life-ending or life-changing, and whilst they may receive little or no recognition in a traditional legal context, nonetheless require recognition here in this forum. An example of 13:55

this is perhaps the case of Patient 15, whose son described, in again compelling terms on 27th September, the effect of a six-month delay in triage following his father's referral to urology with a raised PSA in August 2015.

He spoke about how his father's mood became depressed during what he described as the silence of that first six months because he was convinced that his raised PSA was "a death sentence" and he described how, when his father finally received the all clear he was "dancing on air" and how, to use his words, "we saw our Dad back".

Again, the Trust acknowledges that we will likely hear further evidence and obtain further detail of the impact its failings have had upon patients as more patient experience hearings take place and as we receive and work our way through more disclosure of patient questionnaires from the Inquiry.

Whilst this apology today may be the first apology by the Trust made both in public and to the public, as the Inquiry is aware, it is not the first time that the Trust has apologised for its relevant failings. The Trust has apologised directly to affected patients and their families in various ways before today and as you have heard, for example, a number of patients have received apologies in letters written to them or at

meetings held with them after the completion of Serious Adverse Incident reviews. Indeed, as Mr. Wolfe pointed out on Tuesday of this week, documents like Dr. Hughes's 2021 overarching report expressly record and I quote: "An unequivocal apology to affected patients and their families". 13:58

Many more patients have received apologies in letters written as part of the Lookback Review exercise. Such letters have been sent either following the completion of the lookback exercise in relation to a patient and in some cases during the currency of the lookback exercise apologising for the length of time it was taking and for some other issues. Some further patients have received written apologies following completion of an SCRR of their care. 13:58 13:58

I can indicate that the Trust will continue to apologise directly and individually to affected patients and their families as it continues to work through the current and any future lookback and SCRR processes. 13:58

The final point that the Trust wishes to emphasise in respect of its apology today is that it is neither an empty nor a token apology. Whilst, as you have quite correctly acknowledged, Chair, on more than one occasion, and by reason of Section 2 of the Inquiries Act 2005, whilst you cannot determine the civil 13:59

liability of the Trust in respect of its treatment of any patient, the Trust nonetheless wishes to state in respect of any cases where harm has occurred that ought to have been avoided, its clear commitment to meeting any resulting claims in a timely way. 13:59

I want to move on, Chair, briefly, from the Trust's apology to cover what the Trust considers to be another important issue and that is its engagement with and commitment to the Inquiry. 14:00

The Trust has facilitated a substantial number of its current and former employees in engaging with the Inquiry. It has provided assistance to those staff, assistance of an administrative, of a legal, and of a welfare type so as to enable them to engage fully with the Inquiry. This has been a time-consuming and resource-intensive process and we recognise that it is a continuing process. 14:00

As the Inquiry knows, the Trust has, since late 2021, assisted in the provision of several hundred thousand pages of disclosure to the Inquiry. The Trust, and its current or former employees, have been the recipients of, by our count, 99 of the 111 Section 21 Notices 14:01 issued by the Inquiry to date, very substantially more than any other participant before the Inquiry.

The Trust and its legal team have assisted in what is

often a labour-intensive exercise of responding to those notices. As of the start of this week, I understand that 83 of the 99 Section 21 Notices have been answered and we understand that these comprise the lion's share of the 80,000 + page witness statement bundle provided by the Inquiry.

The Trust has also, albeit to a much lesser extent, provided support such as the collating of documents to some doctors and nurses who've been served with some of the 200+ questionnaires that the Inquiry has issued and, as you know, this has been undertaken against a backdrop where the Trust and its witnesses continue to provide their services in a healthcare environment that has, for a variety of reasons, including the pandemic, become ever more challenging.

I should also mention, in passing, that the Trust facilitated a guided visit to the Craigavon Area Hospital campus in June of this year for the Inquiry Panel and legal team so that they could see the locations where, at material times, relevant Trust personnel worked and where relevant patients were treated.

As the Chair correctly alluded to during her opening remarks, the Trust's engagement with the Inquiry to date has of course not been without significant challenge and we acknowledge, by way of non-exhaustive

examples in this regard, that deadlines for the submission of statements and documents have been missed on several occasions, both by the Trust and its staff, and that documents have not always been provided in an acceptable form or format. For this, too, the Trust 14:03
expressly and publicly apologises, Chair.

The Trust also specifically expresses its gratitude for both the patience of and constructive engagement by the Inquiry with it and, in particular, the collaboration 14:03
of the Inquiry's Information Management Team headed by Mrs. Casey.

Fundamentally, the Trust wants to reassure the Inquiry, and the public, of its continued commitment and 14:03
cooperation. And as for the Trust's lawyers, both solicitors and counsel, we can assure the Inquiry of our continued desire to keep open the two-way street of collaboration and cooperation that the Inquiry's procedural protocol mentions at paragraph 44. 14:04

I would like, if I can, Chair, to briefly turn to two broad points of background or context which have been touched upon by My Learned Friend, Mr. Wolfe, and which we hope the Inquiry will bear in mind when completing 14:04
its important work.

The first point relates to the Southern Trust itself. Whilst this Inquiry is primarily, but not exclusively,

focus on the Trust's Urology Service, this service forms just one of many constituent parts of a much larger entity. As Mr. Wolfe set out, the Southern Trust was formed in 2007, following the amalgamation of four legacy Trusts and they were: Newry and Mourne Health and Social Services Trust, Armagh and Dungannon Health and Social Services Trust, Craigavon and Banbridge Community Trust and Craigavon Area Hospital Group Trust. 14:05

The Southern Trust provides an integrated health and social care service which includes hospital, community and primary care. Its inpatient hospital services are located at Craigavon Area and Daisy Hill Hospitals but it also delivered community-based care including children's services, mental health services and older people's services such as domiciliary and residential care. It currently has an annual budget of just under £1,000,000,000 and it manages an estate worth approximately one-third of one billion pounds. It has a staff of between approximately 13,000 and 16,000, depending, I am told, on whether you perform a human head count and a post holder count and whether or not you count bank staff or staff on a career break or seconded staff. But in any event approximately 4,500 staff members are located on the Craigavon Area Hospital site that the Inquiry has visited. 14:05 14:05 14:06

The Trust serves a population of approximately 390,000

persons with an additional population from County Fermanagh of approximately 65,000 persons for Urology Services. The geographical reach of its Urology Service is across almost the entire breadth of Northern Ireland from Annalong in the east to Enniskillen in the west. And I am also instructed that the Trust has one of the fastest growing older populations in Northern Ireland, which, in turn, places greater demand on certain services such as Urology. 14:06

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In terms of patient contacts per annum, these run to several hundreds of thousands, as you would expect. For example, very briefly, in the financial year 2021-2022 patient contacts in key areas were as follows: 14:07

Diagnostic procedures - approximately 230,000.
Emergency Department and minor injury unit attendances - approximately 160,000.
Outpatients - approximately 150,000.
Inpatients and day cases - approximately 90,000. 14:07
Births - approximately 5,000.
That gives a total across those five key areas of approximately 635,000 patient contacts in one year.

As for complaints made by patients in the same year, these numbered 1,313 with 4,537 compliments. 14:07

These figures, whilst they are no doubt a very rough measure, do perhaps provide some high level evidential

foundation for the sentiments of the former Minister for Health, Robin Swann, in the Northern Ireland Assembly on 24th November 2020 at the time he announced this public inquiry when, whilst rightly voicing his concerns about the issues that had emerged in the Trust and acknowledging their potential impact upon the confidence of those that use the Health Service, he stated that he remained convinced that, and I quote: 14:08

"The experience of patients who use our Health Service is overwhelmingly that of a safe and quality service." 14:08

The second broad point of context I want to make at this stage relates not to the Trust as a large corporate entity, but to its staff, whether they be doctors, nurses, allied health professionals, porters, administrators, or those involved in the management of persons and systems. There are a number of things that we submit are worth remembering here. 14:09

First, Trust staff do not generally set out to cause risks to patient safety or to harm patients. This is an important point, in our submission, and it's also one that has been made in some of the witness statement evidence submitted to the Inquiry. One example of that is the statement of former Acting Chief Executive, Mr. McNally, to whom Mr. Wolfe has referred earlier today. 14:09

Second, it is important, in our submission, to acknowledge that the overwhelming majority of Trust staff work hard, sometimes in very difficult and trying circumstances. They work long hours, often in excess of what they are obliged to work, and they are dedicated to helping sick and injured people get better. This particular point of context was perhaps best articulated, and certainly more eloquently articulated, by the husband of Patient 10, if you recall, who gave evidence on the first day of patient experience hearings back in June. 14:10 14:10

In his evidence, which for your record, can be found at page 43 of the Day 1 transcript, he said the following:

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"I want to make this general point that what I'm dealing with here are three very negative or major mistakes. Patient 10 was in Craigavon Hospital and other hospitals but primarily Craigavon for ten years. Everything else, other than this, was unbelievable from doctors, nurses, the lot, so I wouldn't want that to be forgotten and I know the Inquiry is not to look at the good things, those go by. But this is all negative coming from me and I didn't want to be here and I wasn't going to come and I'm here purely out of duty. But I certainly want to make sure that the Panel, who may not be really as familiar with the workings of Craigavon Hospital as I am, I now know nearly every nurse and surgeon in it, that the work that was being 14:11 14:11

done outside of these mistakes was absolutely first class and Patient 10 appreciated that right up to her death and I think it's important that that is set in context in this Inquiry in relation to it."

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So, whilst there have undoubtedly been failings, serious failings, it is important that they are, as Patient 10's husband said, set in context, a context in which the majority of the care delivered by the Trust is delivered appropriately and safely.

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In respect of those occasions when that has proved not to be the case, when appropriate and safe care has been absent, the Trust is committed to exploring, both inside and outside of this Inquiry, why those failings occurred. So perhaps moving forward to consider the task facing the Inquiry and the questions it will have to consider, the Trust readily acknowledges Mr. Wolfe's theme that the Inquiry is about more than the failings of any single individual such as Mr. O'Brien. However, the Trust also appreciates that the Inquiry has to look at some individual failings in respect of some patients and use these sometimes as a springboard for exploring broader questions in respect of systems, governance, management and leadership.

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The Trust also appreciates that any examination of the causes of its problems will have to have regard to issues that, to differing degrees, are not entirely

within the control of the Trust, such as by way of non-exhaustive examples, the following issues touched upon by Mr. Wolfe.

First, the increasing length of Urology waiting lists over the last decade; and second the difficulty experienced by the Trust in attracting and retaining urologists, especially Consultant Urologists and nursing staff over the same period. 14:13

The first of these two issues, waiting lists, is addressed in various witness statements that have been submitted to you, including, for example, statement number 24 of this year from Martina Corrigan, the former Head of Service for ENT and Urology where she charts, in her answer to question 15, the exponential rise in waiting lists between 2009 and 2022. 14:14

The second of these issues, attracting and retaining staff, particularly Consultant Urologists, is also addressed in various witness statements, including that of Mrs. Corrigan, but also that of Mr. Michael Young, former Clinical Lead For Urology, who explains that, save for a brief period between 2014 and 2016, the Urology Service has lacked a full complement of Consultant Urologists. 14:14

The reasons for these waiting lists and recruitment and retention problems, as well as the impact that they

have had upon some of the failings that this Inquiry is investigating are, we submit, matters that should properly be considered in due course by the Inquiry.

Also, looking forward or ahead, the Trust confirms that it is committed to improving and reforming so that failings are not repeated, whether by it or by any other Health and Social Care Trust. It wishes to embrace what Mr. Wolfe described on Tuesday as the genuine opportunity to change healthcare in Northern Ireland for the better that this Inquiry represents. It wants to assist in ensuring that the Inquiry's detailed report and, in particular, its recommendations will, when produced, be a key point of reference for the Southern Trust and other Trusts in respect of improvement and change. However, the Trust takes this opportunity to reassure you and to reassure the public that it doesn't seek to delay or abdicate its responsibility to identify and implement necessary changes until the Inquiry's work is complete. And in this vein I can indicate that the Trust has already taken a number of steps on this front. Some examples of those are as follows:

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The Trust has sought to determine the extent of its failings, including through the already mentioned SAI reviews, lookbacks and so on, and by inviting the independent assistance of both the RQIA and the Royal College of Surgeons. It is also currently in the

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process of engaging with the Urology Assurance Group regarding what the next phase of its Urology Lookback Review will involve, an exercise that is being informed by the results of the current lookback and SCRR to date and the RQIA Review. And as Mr. Wolfe pointed out, the UAG brings an element of oversight and assurance to the work of the Trust on this front. As Mr. Wolfe also mentioned yesterday, the Southern Trust has already implemented some changes to its structures, processes and systems. I won't go through the detail of those today, but they have been detailed across a number of Trust witness statements and in various documents provided to the Inquiry. One of example of those is the witness statement number 29 of this year from the current Chief Executive, Dr. O'Kane, where she addresses changes that have been made or are being made in areas including clinical and social care governance, medical and professional governance and in the strengthening of Trust medical leadership structures.

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I should also say that the Trust, being conscious of the overlap of issues between this Inquiry and issues confronted by the Independent Neurology Inquiry has set up a number of relevant subgroups as part of its Quality, Learning and Assurance Group to digest relevant learning from that report from June of this year and to consider potential reforms.

And finally in this regard, in the particular area of

openness and candour mentioned by Mr. Wolfe in the context of the Hyponatraemia Inquiry's report, I can indicate that the Trust as part of its new People Framework 2022 to 2025 has committed to the development of a just and learning organisational culture. It has 14:19
engaged with Mersey Care NHS Foundation Trust and Northumbria University and some staff have undertaken training already on the principles and practices of a restorative, just and learning culture. This I am instructed forms part of the Trust's efforts to support 14:19
a culture of fairness, openness and learning across its organisation and it is currently establishing a number of work streams associated with improvements relating to openness and candour, raising, listening to and acting on concerns and respect and stability in the 14:19
workplace.

So to conclude, Chair, the Southern Trust's hopes and expectations for the Inquiry can be summarised as follows: 14:19

It hopes, as I've indicated, that the Inquiry provides detailed recommendations about what still needs to change so as to help the Southern Trust and all Trusts avoid repeating past mistakes and so that no other 14:20
patients suffer harm.

It also hopes that the Inquiry gets to that end point by engaging in an investigation that is robust, that is

forensic, that asks what Mr. Wolfe described as challenging questions, but also an investigation that is fair. An investigation that shines a spotlight not only upon the Trust but upon other Core Participants and other relevant persons or bodies. An investigation 14:20
that takes account of the broader contextual issues that are beyond the control of the Trust, some of which I've mentioned. And an investigation that guards against the lure of hindsight. And in this regard we would commend to the Inquiry the observation of Anthony 14:21
Hidden QC when delivering his report into the Clapham Railway Junction disaster in September 1989, and I quote:

"There is almost no human action or decision that 14:21
cannot be made to look more flawed and less sensible in the misleading light of hindsight. It is essential that the critic should keep himself constantly aware of that fact."

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Finally, Chair, the Trust wishes to finish where it started by saying sorry, unequivocally and expressly, for having failed those people who have been harmed or put at risk of harm and by expressing its firm commitment to work with the Inquiry in an open, candid 14:21
way so as to ensure that mistakes are not repeated, either by it or any other Health and Social Care body. That's all I propose to say by way of an opening, Chair.

CHAIR: Thank you, Mr. Lunny. We are very grateful for those comments and for the indication as to how work will continue with the Inquiry going forward. We're going to take a short break now, then I think Mr. Boyle is next to address the Inquiry. If we could say half past two? Thank you, Mr. Lunny. 14:22

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

MR. BOYLE KC: Chair, Dr. Swart, Mr. Hanbury. This is the opening statement on behalf of Mr. Aidan O'Brien, Consultant Urologist. It is made in the hope that it will assist the Inquiry in the work that it is undertaking. Mr. O'Brien welcomes the opportunity to provide the Inquiry at this early stage in its task with some background and context and to highlight a number of concerns that he has had about the Urology Service commissioned of and provided by the Southern Health and Social Care Trust and it's governance. You will be relieved to hear that I do not propose to go over Mr. O'Brien's training and background, Mr. Wolfe very kindly did that job for me on Tuesday. 14:30 14:31 14:31

Following Mr. O'Brien's appointment as a consultant in July of 1992 he remained a Consultant Urologist from then until 17th July 2020 when his employment ended. His career at the Trust accordingly spanned the best part of three decades. Over the course of his career, he would have conducted many thousands of consultations 14:31

with patients and their families and thousands of operations.

From July of 1992 until the appointment of a second consultant in 1996 he was the only Consultant Urologist at the Trust and provided a continuous, acute and elective urological service. You have heard how he effectively built up the service single-handedly. The scale of the task he undertook should not be underestimated. As a single consultant with a patient population of approximately 290,000 citizens, his patient to urologist ratio was one of the worst in the whole of western Europe and the urological service being provided at that time was grossly inadequate.

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So it was that following his appointment, Mr. O'Brien committed himself wholeheartedly to the task of enhancing and improving that service for the benefit of the patient population he served. And his wholehearted commitment to that service and each and every one of his patients endured for the entirety of the remainder of his working life. His has been a life of selfless dedication to his patients. The reality is that throughout his tenure as a consultant, the Urology Service at the Trust was seriously and significantly underresourced for year after year after year.

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The lack of resources and increasing demand is not a recent development. It is not a Covid-related

development or a Brexit-related development. There has been a profound and continuous failing, presided over by Trust management, the Health and Social Care Board and the Department of Health for over 25 years to adequately resource the Urology service at the Trust. 14:34

To have found ourselves as we sit, or in my case stand, here today, with reports that Urology patients have had to wait six years, and in some media reports, seven years for a first appointment is a scandal and an 14:34
outrage. Mr. O'Brien, like so many of his dedicated colleagues, urologists, radiologists, oncologists, anaesthetists, junior doctors, nurses and others, worked tirelessly within a system which has been failing its Urology patients in an appalling fashion. 14:34

Mr. O'Brien worked extraordinarily hard for decades to assess and review patients and provide the treatment which patients required. He worked so hard to try and mitigate the very risks posed by under-resourcing, 14:35
under-resourcing over which he had no control but regularly raised. He committed to undertaking additional sessions. He continued to use his usual operating sessions even when he was on periods of annual leave. He used operating sessions vacated by 14:35
other surgeons when they went on annual leave. He used administrative time and Supporting Professional Activity time to operate. He availed of additional operating sessions at weekends. He worked extended operating

days. The Trust knew he was working every waking hour, and so it continued year on year.

In March of 1997 in his own paper entitled "The Future Development of Urological Services" which is in the disclosure, Mr. O'Brien, drawing upon his own experience working at the Trust, his familiarity with national and international standards, and increasing awareness of men's health issues, pointed out that the demand for urological services far exceeded the existing level of service provision by the Trust, and that demand would be ever increasing. 14:36

On Tuesday afternoon Mr. Wolfe mentioned the recent model, moving to one of seven consultants, which has been introduced but bound to fail from its inception. Seven consultant urologists. Mr. O'Brien made precisely that point in 1997 - 25 years ago. And yet, despite that warning and issues arising ever since, that imbalance has never been properly addressed and the dire under-resourcing, with the burdens that places on staff and the delays in treating Urology patients, has sadly continued. 14:36 14:37

For years Mr. O'Brien has been raising concerns about workload and patient safety in his annual appraisals and in the job planning process, and he did so in the clearest of terms. In his appraisal for the period 2011-2012, ten years ago, he stated the following: 14:37

"The main issues compromising the care of my patients are my personal workload."

He then made a reference to the number of sessions he was having to undertake before adding: 14:38

"Almost all inpatient care and administrative workload arising from those sessions has to be conducted outside of those sessions." 14:38

The following year he stated:

"I work long hours every day, contracted or otherwise, paid and unpaid, in an attempt to mitigate the worst outcomes." 14:38

His appraisals over the years, the Inquiry may feel, are a valuable resource, setting out, as they do, contemporaneously detailed descriptions of the extent of his commitments, the roles he was performing, the surgery, the clinics, the different locations he was working at. These are not documents looking back with the kind of hindsight we heard just a moment ago. These are not documents that are some after the event, exculpatory production for the purposes of an inquiry. He was telling the Trust, at the time, of the compromise to the care of his patients, the factors contributing to it and the personal length he was going 14:38 14:39

to try and mitigate it. He also raised concerns over the course of many years during the job planning process. He frequently rejected suggested job plans as they inadequately reflected the role that he was performing. He didn't sign the majority of the job plans and he was perfectly open about it. He expressed himself, again clearly, saying that the allocation was "inappropriate, inadequate and unsafe". Unsafe. He was warning the Trust management that his intolerable workload and the inadequate provision for his administrative burden was "unsafe" for patients. 14:39 14:40

In an e-mail in December of 2013, Mr. Robin Brown, then Clinical Director wrote about Mr. O'Brien and I quote:

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"I do recognise that he devotes every wakeful hour to his work and is still way behind..."

In relation to his administration.

14:40

"... Aidan is an excellent surgeon and I'd be more than happy to be his patient. I would prefer the approach to be: How can we help?"

But little changed and there was little help. 14:41

The Trust have, therefore, known that the excessive demands on his time reviewing patients, operating, performing the role of Urologist of the Week and the

other significant responsibilities he had from time to time, compromised his ability to, in addition, address certain aspects of administration, which he was telling them was unsafe, but they condoned it. They knew he did administration at home. They knew he did it when he was on leave and they knew, in terms of triage, that he wasn't the only one who was unable to triage routine referrals; it was the Trust who created the informal default process that Mr. Wolfe mentioned this morning, in the event that referrals were not triaged whereby the appointments office would list in accordance with the category of urgency designated by the referrer. That wasn't Mr. O'Brien's bright idea. One might have thought that the solution to that problem might be to employ more staff or permit existing staff more time, or preferably a combination of both. Instead, the default position appears to have been not to commit resources to Urology to address the problem. 14:41 14:42 14:42

Earlier this year, in June, we heard evidence in relation to the case relating to Patient 10 and it's a classic case in relation to this particular point. Let me read to you from his comments of 25th January 2017 regarding the final draft report of the Root Cause Analysis or the SAI in that case. Mr. O'Brien wrote of triage in response: 14:42 14:43

"Another system or method or time was needed for them to be done if by a consultant at all and the triage of

non-red flag referrals should be revisited to discuss who, when and how this challenge can be satisfactorily resolved."

There was no response to Mr. O'Brien's proposals in his response to that SAI. 14:43

It was thus against a backdrop of years of him expressing his concerns about overwork and appalling underesourcing that on 23rd March 2016 he was called to a meeting at which he was handed the letter that you have heard about which raised concerns about his administrative backlog, the triage, the records at home, the delay in dictation after clinics. 14:43

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The letter begins:

"We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist." 14:44

It is not a formal letter in the sense that it refers to any particular process. It is not written pursuant to any Trust policy or procedure. It doesn't refer to any guidelines that he has supposedly breached. It makes no suggestion of misconduct or poor performance. It's not a warning, formally or informally. 14:44

Mr. O'Brien asked what do you want me to do about it? What was the Trust's plan moving forward? What did

they suggest? And as you heard he was met with a shrug of the shoulders. You needn't take his word for that. As the report of the investigation subsequently found:

"There appears to have been no management plan put in place at the time and Mr. O'Brien seems to have been expected to sort this out himself." 14:45

He had been trying to do that for years.

14:45

We have an organisation that knows there are issues, either systemic or individual or both, either way, where was the governance addressing that? No changes to the underlying systemic issues. No additional support provided. No support identified. No plan 14:45 drawn up. No additional time. That was in the March of 2016 and there was no follow up.

What Mr. O'Brien did not appreciate, or know, was that come September of 2016 some steps were being taken that 14:46 he was not aware of. First, on 7th September 2016, the Trust sought assistance from NCAS, as you have heard now known as NHS Resolution, which, and Mr. Wolfe read to you their mission statement, provides expertise on resolving concerns and disputes fairly, sharing 14:46 learning for improvement, preserving resources for patient care. The latter, that is NCAS, provided some very sensible advice or options to the Trust. They encouraged the Trust to meet with Mr. O'Brien and agree

a way forward. They advised relieving Mr. O'Brien of theatre duties to allow him to clear the backlog. They advised that Mr. O'Brien would likely require significant support. They offered to attend the meeting to facilitate what you may feel is a very sensible approach or plan. 14:47

The Trust, for reasons the Inquiry will wish to explore, ignored that advice and didn't communicate with Mr. O'Brien about it at all. He was thus not afforded the opportunity of acting in accordance with an action plan which NCAS were offering to assist with. NCAS themselves recognised that further input from it would be likely so they kept their file open. 14:47
Mr. O'Brien first discovered that his employer was advised to relieve him from operating for a period and adopt a collaborative approach in October of 2018 - two years later.

Then on 13th September, as you've heard, there was an Oversight Committee meeting that had been convened and rather than any formal process being advanced, a less formal alternative approach was proposed by Ms. Gishkori, the Director of Acute Services, and agreed by Dr. Wright, Medical Director. But again, the very existence of that meeting and the plan proposed wasn't discussed with Mr. O'Brien. That was followed by a further meeting on 12th October 2016 and yet again no progress was made to try and address the areas of 14:48 14:48

concern. Mr. O'Brien was still given no support, no additional time away from theatre or plan of any kind to work to.

Mr. O'Brien had himself needed elective surgery, which was planned for mid November of 2016. In November, some six or seven months post the March letter, having received no plan or proposals from the Trust, he then made a suggestion about clearing the backlog. He offered to do it while he was convalescing after his own surgery. He was due to be off until the early part of 2017. 14:48 14:49

The Trust, which two months beforehand had rejected the NCAS suggestion that the Trust should relieve him of operating to allow him to address his administrative backlog while he was in work, instead agreed his proposal that he could address the backlog when he was off sick from work. That, of course, required him to have a host of patient medical records at home, which was one of the very criticisms he faced, but that didn't seem to concern the Trust in these circumstances at all; presumably because it rather suited its purposes. 14:49 14:49

The duplicity and hypocrisy should not be lost on anyone. 14:50

From a governance perspective we hope that the Inquiry

will acknowledge the responsibility on the Trust for welfare here. Mr. O'Brien was volunteering to clear this backlog literally from his sick bed. Sometimes, Panel, we can be our own worst enemies, dedicated employees or public servants in this instance who feel 14:50
a duty and feel they can and will be able to do it all. There is an onus on you as a Trust or an employer to protect such individuals from themselves at times. By doing so, of course, you are fulfilling your duty to patients also, overworked, overstressed, overburdened 14:51
staff are not best placed to serve patients, try as they might.

After his illness and the four-week period of exclusion which took place in the early part of 2017, Mr. O'Brien 14:51
duly returned to work on 20th February. He returned under the shadow and stress of being the subject of an ongoing investigation and he returned subject to an agreed Return to Work Plan. For the avoidance of any doubt, his practice itself was not restricted in any 14:51
way. There was a process of monitoring in relation to triage, note keeping, storage and the like.

From the February of 2017 until the Case Manager reported in the October of 2018, there was, therefore, 14:52
a plan in place which he complied with. In October of 2018 the Case Manager concluded, Mr. Khan, he worked successfully to the action plan during this period. And all of this, therefore, rather begs the question:

Would we even be here if the Trust had acted on the very issues that Mr. O'Brien had himself been raising in the likes of his appraisals and his job planning for years, or put in place proper plans for addressing administrative concerns in 2014, '15, or '16? 14:52

The investigation which commenced in late December 2016, as you have heard, was carried out by Dr. Chada. Mr. O'Brien cooperated with that investigation. He was interviewed more than once, answered the questions 14:53 asked of him and provided relevant materials. A report was produced by Dr. Chada in June of 2018, some 77 weeks after Mr. O'Brien was told he was under investigation, even though the Trust policy dictated that such investigations should be concluded within 14:53 four.

Save for the initial very short period of exclusion, Mr. O'Brien continued to work full-time reviewing patients and operating. He responded to Dr. Chada's 14:53 report within three weeks on 10th July 2018 and the Case Manager, Dr. Khan, as you know, provided a determination on 1st October of 2018. The Case Manager's recommendations were that Mr. O'Brien should be referred to be dealt with before a Trust Conduct 14:54 Panel. That recommendation was made on 1st October and no such disciplinary meeting ever took place.

It is important that this Inquiry appreciate that the

investigation alone did not establish any facts in relation to Mr. O'Brien or his practice. That was the purpose of the referral to a hearing for those issues to be ventilated and findings to be made, save of course where Mr. O'Brien had himself made admissions during the course of the investigation, which as a matter of record he did. 14:54

From October of 2018 until 17th July 2020, a couple of months short of two years, a formal hearing, at which any evidence relating to Mr. O'Brien could have been tested, never took place. When his employment ended on 17th July 2020 it had been four years and four months since the March 2016 letter, with no conduct meeting or performance meeting or hearing of any kind, nor any hearing at which any finding was made in relation to him. 14:54 14:55

The Case Manager in October also recommended that moving forwards, as you have heard, the Trust put in place an action plan with input from NCAS. That recommendation, as you know, was not actioned and no plan was ever suggested. The irony of that should be lost on no one. NCAS had offered to do just that in September of 2016 - two years earlier. And whilst the Trust never disclosed that fact to Mr. O'Brien, he found out that NCAS followed through on their promise to keep the file open and not only that, attempted to assist by contacting the Trust in January, March and 14:55 14:55

May of 2017 but the Trust ignored their attempts and their offers of help. Why? Why did the Trust ignore the attempts of the National Clinical Assessment Service? Why did they ignore the help on offer? Why did they not tell Mr. O'Brien NCAS had offered to intervene to help? 14:56

On 27th November 2018, Mr. O'Brien lodged a formal grievance against the Trust in relation to its handling of the concerns about his administrative practises. It is a lengthy, detailed document and it spells out, in stark terms, very real and disturbing failings on the Trust's part, many of which have been laid bare already in Mr. Wolfe's opening. That grievance itself was not resolved before Mr. O'Brien's employment ended in July 2020, the best part of two years later. 14:56 14:56

It is also worth noting that Mr. O'Brien and his colleagues had already arranged to meet with Senior Trust Management on 3rd December 2018 to discuss and agree upon the expectations of the role of Urologist of the Week, triage and waiting list concerns. However, on 30th November, two days after he submitted his grievance and three days before that very meeting was due to take place, the meeting was cancelled without explanation. Eventually, approaching the age of 67 in March of 2020, Mr. O'Brien submitted notice of his intention to retire from full-time employment at the end of June. He did so having received beforehand 14:57 14:57

assurances of his ability to return part-time thereafter, a situation which was not uncommon at that time, particularly at that time when we were in the midst of the Covid pandemic.

14:58

Nobody suggested to Mr. O'Brien that he would not be able to return part-time because there was an ongoing HR issue. He was not contacted by HR, or anyone else for that matter, to explain that the Trust had such a policy in existence. Nor was he contacted by HR or 14:58 anyone else in the weeks or months prior to June to explain to him that regrettably he would not be able to return post-retirement. He continued working full-time, unrestricted, as committed as he ever was to his patients. 14:58

On 7th June 2020 Mr. O'Brien sent an e-mail regarding patients to be listed for admission for surgery, there was nothing serious or unusual about that course at all. The following day, on 8th June, Mr. Haynes, in a 14:58 telephone call, informed him that the Trust had a practice of not reengaging people with ongoing HR processes. Leaving aside the fact that the ongoing HR processes should clearly have been resolved months, if not years, beforehand, this was news to Mr. O'Brien and 14:59 he had been working away continuously, since March, in the expectation of retiring and returning part-time. So this was very concerning.

Incidentally, Mr. Haynes raised no issue at all about the e-mail which had been sent the previous evening, on 7th June, about the patients.

Not surprisingly, Mr. O'Brien, who had always harboured the wish to continue to care for patients and serve the public of the Southern Trust, took the view that if the Trust did not reengage people who had retired in such circumstances then he would revoke his intention to retire. If he didn't retire then of course the question of reengagement post-retirement didn't arise. So on 9th June, he duly revoked his notice of intention to retire. 14:59

The Trust refused to accept that. They told him that his employment would end on 30th June and a return would not be facilitated. That resulted in pre-action correspondence being sent to the Trust on 23rd June with talk of an injunction and the like. The Trust asked to have until 17th July 2020 to respond. 17th July 2020 being the date upon which it is said Mr. O'Brien retired. 15:00

The Director of Legal Services, on behalf of the Trust, by letter dated 7th July 2020, raised an issue by way of a recent development, namely the allegation that two out of ten patients had not been added to the patient administration system, the PAS. There were no other concerns raised in that letter. 15:00

Remarkably, and this Inquiry may think not at all coincidentally, only after revoking his intention to retire, and shortly before the 17th July response date, on 11th July 2020, Mr. Haynes sent Mr. O'Brien a letter, referring to the addition of two patients out of ten for surgery who'd not been added to the patient administration system at the appropriate time. In other words, what was being alleged was that Mr. O'Brien had delayed those patients' surgery by having failed to add them to the system at the appropriate time. It was an allegation which was completely untrue. 15:01 15:01

Mr. Haynes and the Trust had a month from the 7th June e-mail to get their facts straight in relation to that. All that it required was for the PAS to be looked and checked in a fair, unbiased, objective, competent and impartial manner. It simply wasn't true. What is worse and all the more disturbing is that Mr. Haynes had been privy to e-mail correspondence in relation to the patients which showed that those patients had been added to the system at the appropriate time, and yet it was that untrue allegation that two out of ten had been delayed that led to the so-called informal lookback exercise/review of records to January 2019, carried out by the Trust and the springboard for what has followed. 15:01 15:02 15:02

This false allegation about the two patients was

repeated by the Trust to the Department of Health in the Early Alert Notification of 1st August. The Trust was informed during the hearing of the grievance on 7th August that the allegation was untrue. Even so, and when the Trust was tasked with checking the Minister's draft statement for factual accuracy, the Minister repeated the allegation unaltered in his statement to the Assembly on 24th November when the Public Inquiry itself was announced. Thus, when considering the events which led to the establishment of this Public Inquiry, you are invited to scrutinise, with the greatest of care, whether the instigation of this Trust-led informal Lookback Review was bona fides. Was it borne out of some wish by some that Mr. O'Brien should not be permitted to keep working there? Until the two out of ten issue arose in July there had been no suggestion of a lookback, no issues raised at all about Bicalutamide, the use of which incidentally by him in relation to patients was widely known and discussed at MDTs attended by other urologists and oncologists. 15:02 15:03 15:03 15:03

So far as the informal Lookback exercise itself goes, the Trust did not involve Mr. O'Brien in that at all before passing on information to the Department. 15:04

Even though these were his patients, treated by him and others, without any concerns being expressed by anyone in relation to medication, consent, treatment and so

on, he was given no opportunity to have any input into that exercise at all. He was frozen out. And before its details were communicated to the Department, he was given no opportunity to comment or correct.

15:04

The Trust also invoked the SAI process, again without involving Mr. O'Brien in that in any way. The Inquiry should have serious concerns about that process, given the manifest unfairness in proceeding with it, without asking for Mr. O'Brien's comments until after the authors of the reports had expressed their opinions.

15:04

In addition, the SCRR process was embarked upon, again without involving Mr. O'Brien in that in any way. He has sought information in relation to that particular process and what's being adopted and whether he is to be involved, however he has received no substantive response. Had he been asked, he would have been happy to contribute.

15:05

15:05

And so it is that another process where conclusions will be reached, reports drafted and families informed, before Mr. O'Brien has been asked for his input at all.

There has been very limited disclosure thus far of SCRR reports. In the one SCRR report he has been able to review in detail, the contents of which the Trust appear to have accepted because it has been copied to the patient's family, the author has made basic

15:05

mistakes of fact and flawed opinions, such as suggesting there were elevated PSA readings, when there were not, suggesting Mr. O'Brien was the Chair of an MDM in 2009 when they didn't exist, and claiming that Mr. O'Brien had been the Chair of an MDM in 2012, when 15:06
incorrect prostate cancer recommendations had been made. Mr. O'Brien hadn't even been present at the MDM, let alone Chair it. Thus in the one SCRR he has been able to comment upon and check there are egregious errors. The Trust appear to have blindly accepted it. 15:06
Scrutiny of the documentation shows that the author of that particular SCRR completed the task in just 90 minutes.

It was, therefore, with considerable alarm that we 15:07
listened to Counsel to the Inquiry open this Inquiry on the basis that you may be prepared to permit space for ventilation of serious and significant disputes about the clinical aspects of cases and only where considered necessary in furtherance of the Terms of Reference. 15:07
Findings were referred to and themes already having been identified, all without any input from Mr. O'Brien or even full disclosure to Mr. O'Brien, but with a very clear signal that the outcomes of those SAIs and SCRRs on clinical aspects of care, are going to be, and it 15:07
appears have already been, accepted. Yet the Terms of Reference say, expressly, the clinical practise of Mr. O'Brien is being investigated by the GMC and it would, therefore, be inappropriate for the Inquiry to

encroach on the GMC's remit.

Not only that, and without prior notification to Mr. O'Brien or prior disclosure to him, detailed reference has been made to reports from the RQIA and RCS - we appreciate of course that those have only been recently received - but neither Mr. O'Brien nor his legal team have even seen those documents. A number of references were made to clinical aspects and rehearsed in opening and at length. 15:08

There are ongoing concerns about the fairness of the process that has been adopted and which I have referred to going way back to Trust time thus far. He's a 69 year old gentleman. He does not have a secretariat of information managers or staff that he can call upon and self-evidently he is not a government department. Of the three Core Participants, he's a single individual. 15:09

There was an initial disclosure, as we know, of some 217,000-odd documents. He was served with a Section 21 notice which for him was a massive undertaking personally. There were patient hearings in September to prepare for, statements of witnesses for next week being served, including a statement from Mr. Haynes who is a key witness from his perspective with a 5,000-page witness bundle, assistance to me for preparation of this opening and a further 100,000 pages of Trust disclosure within the last with two weeks. We 15:09

understand from the opening that perhaps there may be a further 100,000 documents that yet remain to be provided.

It's simply impossible to expect him to be able to cope, particularly with a protocol that requires suggested lines of questioning of witnesses when there's insufficient time to consider what or even where the relevant documents may be and if further records are to provided, that may be relevant to lines of questioning he may wish to explore. 15:10

The production of his Section 21 response, some 200+ pages, placed an intolerable amount of pressure upon him. He has been relentless in his attempts to comply and he is physically and emotionally exhausted by the strain of all of this. It is not just the volume of the information provided, but the nature of that information, you will not be surprised to hear, is a cause of considerable distress. It is important that he does not become overwhelmed by the process, as not only will the Inquiry be deprived of his ability to fully participate, but his own health may deteriorate. 15:10

On his behalf, we invite this Inquiry to consider the following: 15:11

Why the Urology service has been so seriously underresourced for decades?

Given the contents of Mr. O'Brien's appraisals and correspondence around his job planning about the inadequacies of the resourcing and time allocated for administration for years prior to 2016, why didn't the Trust obtain and provide additional support? We were told yesterday that support of such nature has now been obtained.

Why has it taken the establishment of a public inquiry, decades later, before that occurred?

Why was the Urology Department such an outlier in terms of resourcing, as evidenced by the waiting lists, when compared to other departments within the very same Trust?

When they knew that clinicians did not have the time to triage all referrals, why not obtain additional support rather than adopt a policy of deferring to the referrer's categorisation?

Did the Trust inform the Commissioners of Healthcare or the Department of Health that administrative backlogs of this scale were occurring? If so what was the response? Was there any additional funding provided for example?

Why didn't the Trust provide Mr. O'Brien with a plan to address the administrative backlog in March of 2016 at or after that meeting?

Why did they ignore the advice of NCAS in September 2016?

Why did the Trust refuse or ignore the offer of NCAS to facilitate and be present at a meeting when an action

plan could have been agreed in September of 2016?
Why did the Trust continually refuse to accept the offers by NCAS to review the ongoing situation in late 2016 and up until May 2017?

15:13

Why were the recommendations of the Oversight Committee not actioned?
Once the investigation commenced, why did it take 18 months for the report to be produced?
Why were the recommendations of the Case Manager at the end of that process not followed? No hearing to establish the facts? No NCAS action plan put in place? 15:13
Why was Mr. O'Brien's grievance not answered before his employment ended the best part of two years later?
When, if ever, did the Trust introduce a policy or practice that anyone under a HR process could not be reengaged? 15:13
What checks and balances did the Trust have in place to ensure that allegations such as those made by Mr. Haynes regarding the two out of ten were fact checked before being acted upon? 15:13
Was the Department of Health made aware of the requests for support, the NCAS offers of help and factual inaccuracies before the Minister announced a public inquiry? 15:14
Why has Mr. O'Brien not had appropriate disclosure and been fully involved at appropriate junctures, during the SAI and SCRR processes?
Has anything improved since Mr. O'Brien left the

employment of the Trust?
If improvements have now been made, why did that not happen sooner, many, many, many years ago?

Chair, Mr. O'Brien, as you know, has attended each day of the patient hearings to listen to the accounts that the patients and their families have given in relation to the circumstances that you are considering. His focus, throughout his entire professional life, has been to do the best for all of his patients, notwithstanding the circumstances and he fully and frankly acknowledges the difficulties and the concerns that have been raised in the context of the investigation thus far and this Inquiry. 15:14 15:15 15:15

Madam, those are my observations.
CHAIR: Mr. Boyle, I have made it clear before that I fully appreciate the challenges that this Inquiry presents for those, all of whom are engaged, and Mr. O'Brien is in no different position to any of the other witnesses who come before this Inquiry. He has been afforded Core Participant status simply because he is in a different position to any other witness who will come before the Inquiry, so I do not accept any criticism on your behalf or on behalf of Mr. O'Brien that this Inquiry is not fully cognisant of the difficulties which he faces and which other people who are asked to come to speak to this Inquiry face and I want that made abundantly clear. 15:15 15:15

MR. BOYLE KC: Yes.
CHAIR: We'll take a short break now and then we'll start again at half past three with Mr. Reid.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 15:16

CHAIR: Ladies and gentlemen, I'm told that there is an issue with the sound from the speakers in the back few rows. It's being recorded, the transcript, those of you who have got CaseView should be able to follow what 15:34
is being said anyway on CaseView and the transcripts will go up on the website as soon as possible, probably tomorrow. So, I'm just going to ask Mr. Reid to come up and, Mr. Reid, if you wouldn't mind speaking up so that everybody can hear you as clearly as possible. 15:34
MR. REID: Thank you, Madam Chair. I'll speak as loudly and clearly as possible.

Good afternoon, Madam Chair, Dr. Swart, Mr. Hanbury. As you are aware, I appear as Counsel on behalf of the 15:34
Department of Health instructed by the Departmental Solicitor's Office, Ms. Sarah Wilson from that office is in attendance. At the outset, I'd like to thank the Inquiry for the opportunity to make this opening statement. Mr. Robbie Davis, Director of General 15:35
Healthcare Policy in the Department of Health is present now at the back and he has been present throughout Mr. Wolfe's detailed opening statement.

Given the detail of the comprehensive opening provided by Mr. Wolfe, I don't intend this opening statement on behalf of the Department to be lengthy in nature. The Inquiry has a wealth of documentation provided to it by the Department and the other Core Participants and in the witness statements recently provided by Mr. Peter May, the current Permanent Secretary of the Department of Health, and Mr. Ryan Wilson, the Director of the Secondary Care Directorate and the Inquiry is set to hear evidence from those individuals next week. 15:35 15:36

The relative shortness of these submissions is not to in any way undermine the seriousness and significance of the issues the Inquiry has been investigating and is set to probe further in the course of the oral hearings to come. 15:36

As the sponsoring department for this Inquiry, the Department is confident that the Inquiry's investigations will be comprehensive and examining in nature and the Department pledges to continue to engage with the Inquiry in a full and transparent manner. I intend this opening statement to concentrate upon two main issues, firstly a brief outline of Department's actions following the receipt of the Early Alert from the Southern Trust regarding Urology Services on 31st July 2020, and the setting up of this public inquiry. Secondly, the work that is currently underway and the future action being taken by the Department to improve 15:36 15:36

systems for governance and assurance of safety across Health and Social Care.

Any comments made by the Department at this stage are in no way an attempt to pre-empt the findings of this independent Inquiry. Instead, they are a reflection of the more limited and focused nature of the reviews carried out by the Department to date and the need for the more comprehensive overview that will be provided by this independent Inquiry. 15:37

At the outset, the Department wants to make clear that it is extremely concerned about any issue that involves the potential for patients to come to harm within our Health and Social Care system. The Department wishes to unreservedly apologise to those patients affected, and their families, for any upset and distress this has caused. 15:37

While the experience of patients who use our health services is, as stated by Minister Swann to the Assembly on 24th November 2020, overwhelmingly that of a safe and quality service, these incidents regrettably dent the confidence of service users. 15:38

The Department fully acknowledges this and will do all that it can to ensure that lessons are learnt and to prevent situations such as this occurring again. 15:38

The Department first became aware of concerns relating to Urology Services in the Southern Trust upon the submission by the Trust to the Department of an Early Alert on 31st July 2020. The Early Alert was submitted on the basis of the likelihood of the Trust needing to contact patients about possible harm. That Early Alert advised the Department that the Southern Trust had become aware, on 7th June 2020, of potential safety concerns regarding a Consultant Urologist who had been employed by the Trust from 6th July 1992 until his retirement on 17th July 2020. 15:38 15:39

As a result of these potential patient safety concerns, the Trust advised that it had conducted a Lookback exercise in relation to some of the consultant's work over a 17-month period to ascertain whether there were or could potentially be matters of wider concern regarding the care and treatment of patients. 15:39

Prior to 31st July 2020, there was no awareness within the Department of concerns relating specifically to Mr. Aidan O'Brien or the issues referred to in the Early Alert which gave rise to the Trust initiating the Lookback exercise in relation to his patients. 15:39

The extent of any knowledge or concerns in relation to Urology Services generally held by the Department would have regarded the increasing gap between the capacity of Urology services and the growing demand across the

region, which was common across many clinical specialties and Trust services.

The Department would have been aware of that through routine analysis and the reporting of waiting list statistics as well as the performance monitoring and service improvement which were functions of the Health and Social Care Board, HSCB at the time. 15:40

The increasing gap between capacity and demand was detrimentally impacted further by the effects of the Covid-19 pandemic on capacity across virtually all services. 15:40

Following further discussions with and updates from the Southern Trust on 3rd September 2020, the Southern Trust hosted a Zoom meeting with a view to updating the Department, the HSCB and the Public Health Agency. These became weekly progress meetings to enable the Department to be cited on developments and to form a collective view with its commissioners, the HSCB and the PHA, about the level of oversight that would be required to assure the Trust's response to and management of the emerging situation. 15:40 15:41

Given the seriousness and the extent of the concerns identified by the Trust in relation to Mr. O'Brien's practise, on 20th November 2020 a submission was provided to the Minister. That submission recommended 15:41

the establishment of a public inquiry under the Inquiries Act 2005, and that would be appropriate to ensure that the full extent of any concerns could be identified and suitable lessons learned to improve our healthcare systems and for the patients and families affected to see that these and all relevant issues are pursued in a transparent and independent way. 15:41

That recommendation was accepted by the Minister who subsequently provided an oral statement to the Assembly on 24th November 2020 regarding Urology Services in the Southern Trust. The statement confirmed the impending establishment of a statutory public inquiry on the matter in addition to providing an update on actions in progress, including the Trust's initial Lookback exercise. 15:42 15:42

On 8th March 2021, Minister Swann announced the appointment of yourself, Madam Chair, as Chair of the Urology Services Inquiry by way of a written Assembly statement. This was followed on 31st August 2021 by a further written Assembly statement from Minister Swann announcing the Terms of Reference for the Inquiry, a date for establishment and the appointment of a panel member and assessor for the Inquiry. 15:42 15:42

If I can turn briefly to the provision of documentation. The Department has engaged in extensive searches of its records, both electronic and hard copy

held both by the Departments and at the office of the Public Records Office of Northern Ireland. The discoverable documentation, as it relates to Section 21 Notices, have been catalogued and to date in the region of 5,400 documents have been identified as of potential relevance to the Inquiry's Terms of Reference. A total of approximately 5,000 documents have been identified in response to the initial request by the Inquiry and uploaded to the Inquiry system. 15:43

The Department recognises the importance of the Inquiry having all relevant documents and is engaging in a quality assurance process to ensure no stone has been left uncovered. The Department has made and will make every effort to apply a serious and diligent approach to its duties to this Inquiry. 15:43

Finally on this topic, the Department wants to welcome the constructive approach of the Inquiry team to all engagements to date and to recognise the clear benefits of this collaborative approach. 15:44

If I can move then to the work underway and the future action being taken. The Department considers it a priority that any learning arising from this Inquiry into Urology Services in the Southern Trust must be identified and implemented at the earliest opportunity, both within the Southern Trust and across the Health and Social Care system as a whole in order to prevent 15:44

any risk of further recurrence or potential harm to patients.

Without wishing to pre-empt the Inquiry's findings at this stage, the Department has to date identified a number of areas where work is already underway or where revised policies and processes are necessary to mitigate or prevent further the chance of recurrence of similar issues and risks which I will touch upon briefly now. 15:44

The first is the establishment of the Urology Assurance Group. On 22nd October 2022, the then Department of Health Permanent Secretary, Mr. Richard Pengelly, wrote Mr. Shane Devlin, CEO of the Southern Trust to advise that a Department led Urology Assurance Group or UAG would be established. The Terms of Reference were agreed in October 2020 and the central focus of those terms was patient care. 15:45

The UAG consists of senior officials from the Department of Health, the HSCB, now the SPPG, the Public Health Agency, the RQIA, and the Southern Trust and it is chaired by the Permanent Secretary of the Department of Health. 15:45

The UAG held its first meeting on the 30th October 2020 and since its inception 17 meetings of the UAG have been held.

Since the Minister's oral Assembly statement on 24th November 2020 the UAG has been updated and advised of work progressed by the Trust and its outputs and the learning emerging as the work was progressing, including the completion of the SAI review, the Lookback Review and the SCRR process by the Southern Trust and the patient safety concerns relating to Mr. O'Brien's private patients. 15:46

The Department-led UAG continues to be provided with progress reports and the learning emerging from the current Urology Lookback Review as well as the Structured Clinical Record Review, SCRR process. 15:46

The Trust is then responsible for managing the Lookback Review process with SPPG and the Public Health Agency having a key role overseen by the Southern Urology Oversight Steering Group which is chaired by the SPPG. 15:46

The Trust is also responsible for determining any requirements for further Lookback Review and any matters arising concerning patient care and safety raised and is expected to work with the SPPG and PHA to submit a recommended option and supporting rationale to the UAG for approval. 15:47

In addition, the Chief Medical Officer wrote to the Chief Executive of the RQIA on 11th August this year to

outline the Department's commissioning of the RQIA to undertake an independent review of Southern Trust Urology Services and the Lookback Review in relation to potential concerns for patient safety. The review Terms of Reference are currently being finalised which have been developed to ensure there is no infringement on the remit of this Inquiry. 15:47

I'll move then to reviews of Urology Services.

The Bengoa Report published in 2016 recognised the increasing demand for hospital-based services influenced by demographic changes, particularly a growing, aging population with more chronic health problems and complex health needs. It also recognised the demand for care had been outstripping the ability of the system to meet it for many years and that this trend will increase in the years ahead and will only be addressed by action to increase capacity, promote healthier lifestyles and tackle health inequalities. 15:47 15:48

The Bengoa Report set out a rationale and a proposed criteria for reviewing services and proposed a number of Priority 1 individual services which should be prioritised by the Department for review. 15:48

It proposed that Urology services should be among a number of Priority 2 services for review. The Department's Transformation Implementation Group or

TIG, which is chaired by the Permanent Secretary and comprises senior officials from the Department and Chief Executives from the HSCB, now SPPG, PHA and the six Health and Social Care trusts oversees the planning and implementation of the prioritised service reviews. 15:48

The TIG continued to provide this function during the period in which the Northern Ireland Assembly was suspended from January 2017 to January 2020, providing strategic direction and endorsing the progress in 15:49 individual review projects during that period in order to develop and provide policy recommendations for a decision by an incoming Health Minister once the Assembly was restored.

15:49

Unfortunately upon the start of the Covid-19 pandemic in February 2020, work on the programme of Service Transformation Reviews was paused indefinitely as the Department entered what became a prolonged phase of responding to the pandemic and working in business 15:49 continuity arrangements which required resources to be wholly diverted to managing and overseeing the Health and Social Care system-wide response to the pandemic.

The Health Minister published a Strategic Framework For 15:49 Rebuilding Health and Social Care Services in June 2020 to address the impact of Covid-19 on the Health Service and on patients awaiting care and treatment. The Framework acknowledged the pressures the Health and

Social Care system was under prior to the pandemic and also included an assessment of the impact of Covid-19 across secondary care services. In particular, it noted that service reviews are clinically led and require significant clinician input. The projects would not be able to proceed until the impact of Covid-19 reduces significantly. It stated: 15:50

"The longer the current situation persists the more delay will be incurred in respect of all the projects." 15:50

Although a number of high priority reviews have progressed since the start of the pandemic, it is currently envisaged that work on Priority 2 service reviews, such as Urology, will therefore only progress when sufficient capacity becomes available within the Department's and its arm's length bodies, either through the release of resources once ongoing priority reviews are completed, or through further investment to increase resources and capacity or both. 15:50 15:51

If I can speak briefly then on how the Department is implementing recommendations from previous public inquiries. 15:51

The Department is currently considering how to appropriately implement the recommendations of the Independent Neurology Inquiry or INI Report which was published on 21st June this year and included 76

recommendations. The INI Implementation Programme Board has been established to oversee the implementation of the report's recommendations and is chaired by the Permanent Secretary. Detailed work to support the implementation of the report recommendations is being progressed, including stakeholder engagement which will then support the ability to support a detailed action plan and is intended to be available in early 2023. Further, the Department is continuing its work on the implementation of the 96 recommendations set out in the report of the Inquiry into Hyponatraemia Related Deaths which was published in January 2018. The Department published an update on that on 28th October 2022 and a copy has been provided to the Inquiry.

In total 57 recommendations have been identified as actioned in the first phase of the programme which means that there's adequate evidence they have been implemented across the Health and Social Care system.

As part of the IHRD Implementation Programme the previous Minister for Health has asked Departmental officials to progress focused work on the implementation of a Being Open Framework across Health and Social Care in Northern Ireland. The Being Open Framework will underpin ongoing work to cultivate and maintain an open and candid culture where concerns and complaints can be raised freely without fear.

Work on implementing the Framework will include engagement with relevant stakeholders, including patients, their family members and carers and staff. The Department will work on proposals to support the dissemination and implementation of Being Open Guidance and Training across the Health and Social Care system to ensure that staff have the appropriate knowledge, skills and supports to play their part in creating and maintaining an open culture. Guidance will also be developed for patients, service users, carers and their families in relation to openness when accessing and receiving Health and Social Care services. This guidance will outline what they can expect, how they will be involved and how to access support, including when things go wrong. 15:53 15:53 15:53

Concurrent with the work on the Being Open Framework, Departmental officials will continue to further work to develop detailed proposals on how a statutory duty of candour might work in practice. 15:53

These proposals will take account of the potential impacts of introducing an individual duty of candour with specific reference to any legal and workforce implications. 15:54

An aim of any statutory duty of candour will be to support the cultural change being facilitated by the

Being Open Framework. A just culture will support staff to be open and honest, will have a focus on learning and not blame, will ensure patients and service users are valued and listened to, and will enable all parts of our Health and Social Care system to be committed to a safe and supportive environment.

I'll mention briefly Serious Adverse Incidents and Early Alerts. In relation to those, and in line with the recommendation of the Independent Neurology Inquiry the Minister for Health recently published an RQIA review of the systems and processes for learning from Serious Adverse Incidents in Northern Ireland. The Department is preparing to implement the recommendations of the review. 15:54

An internal review of the Early Alert System will also shortly commence and the Department has recently published updated policy and guidance for Health and Social Care organisations on the Lookback Review process which was published on 16th July 2021. 15:55

I'll move to the issue of Maintaining High Professional Standards or MHPS.

Issues with the Maintaining High Professional Standards Framework were highlighted by the conclusions and recommendations of the report of the Independent Neurology Inquiry published in June of this year and

were also mentioned in detail during Mr. Wolfe's opening.

The Independent Neurology Inquiry recorded its view that reform of the existing MHPS Framework is long overdue. That is a view that the Department fully accepts. It is evident that a substantive review of the MHPS Framework is overdue and the Department is committed to starting and completing a thorough review of MHPS as soon as possible and as a matter of priority. 15:55 15:56

The Department has taken soundings from colleagues across the UK and locally and has identified potential experts that might assist with this project. Officials hope to engage with individuals in the coming weeks and the expectation will be that the project will commence early in the new year. 15:56

The timescale for completion will be agreed with the Panel once appointed. The Department would envisage the review would report within six months of commencing. 15:56

It is also the Department's intention to lead a thorough review of regulation across Health and Social Care in Northern Ireland. A draft consultation document on such a review entitled: "The Right Touch: A new approach to regulating Health and Social Care in 15:56

Northern Ireland" had been completed in 2020 but consultation was not progressed owing to the Covid-19 pandemic. That draft consultation document is currently being updated to take account of lessons learned during the pandemic as well as recommendations made by and learning emerging from a number of recent reviews and the Independent Neurology Inquiry.

15:57

I would like to conclude by welcoming, on behalf of the Department of Health, again, this opportunity to provide an opening statement. It is hoped that this overview has assisted in setting the scene for the Inquiry and explaining the ongoing work of the Department. It is clear, from the issues identified and the actions underway to date, that opportunities to improve processes and prevent or mitigate risks exist at a policy and oversight level for which the Department accepts it has direct responsibility as well as at an operational level.

15:57

15:58

As opportunities are identified to improve approaches, such as has already been identified through the IHRD and INI inquiries, the Department seeks to take these forward diligently as well as ensuring appropriate action is taken to address any immediate issues emerging such as those relating to reviews of patient records. These programmes of work are now firmly recognised as Departmental priorities and are being progressed accordingly.

15:58

Those oversight structures and assurances already in place are being refined and will be refined to provide appropriate assurance, detection and escalation when things go wrong and these continue to provide a means of supporting the Southern Trust in its work. 15:58

The Department reiterates that it stands ready to cooperate with and assist the Inquiry in any away it can. In particular, given the important task of this incident Inquiry, the Department welcomes the difficult questions which are likely to come and recognises that these will be essential to ensure fulsome answers and recommendations are produced. 15:59

As we enter this stage of the Inquiry process, it is recognised that in due course the Department may be afforded the opportunity to provide a closing statement at the end of the oral hearings. It is anticipated that at that stage the Department will be in a more informed position in relation to any identified failures and missed opportunities which no doubt will form the basis of learning and your recommendations. 15:59

Finally, the Department wishes to repeat what was said by Minister Swann in his statement to the Northern Ireland Assembly on 31st August 2021: 15:59

"The Urology patients and families affected remain in

my thoughts as the Inquiry embarks on its statutory responsibilities. I would like to again acknowledge the upset, distress and anxiety these matters have caused. Patients and families affected and who have concerns are encouraged to avail of the support which 16:00
the Southern Trust has made available, including the family liaison service and related support services. I am confident the establishment of the Independent Urology Services Inquiry will enable a full and transparent investigation of the circumstances leading 16:00
to the Urology Lookback Review and ensure lessons are learned in order to improve our healthcare systems and restore public confidence in our healthcare services."

Thank you, members of the Panel. 16:00

CHAIR: Thank you, Mr. Reid. Mr. Reid, in the spirit of collaboration and assisting the Inquiry perhaps you could assist me with one thing. I have written to Mr. May asking about legal representation for what is now the SPPG and I'm still awaiting a response from 16:00
that. I'm not expecting you to give me a response on your feet today, but if you could please ask that that response be forthcoming and you can, for what it's worth, advise Mr. May that I am still of the view that I expressed in my letter to him, that I think there is 16:01
a potential conflict and that due consideration should be given to the Department for separate representation for the SPPG before the Inquiry.

MR. REID: I can only apologise on behalf of the

Department for any lack of a reply to date. I can assure the Inquiry that the contents of the Chair's letter have been considered carefully by the Department. Correspondence will be hopefully with you either today or tomorrow, I am assured, as a response to your letter.

CHAIR: I'm grateful for that, Mr. Reid.

Ladies and gentlemen, that concludes our first week of public hearings. We will sit again next Tuesday morning at ten o'clock when we will hear from Mr. Peter May as our first witness and I hopefully won't have to raise the question of the letter with him at that stage. But thank you all very much for your attention here for what has been quite a long week for everybody concerned and I look forward to seeing you all again next Tuesday. Thank you.

16:01
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16:02

THE INQUIRY WAS THEN ADJOURNED UNTIL TUESDAY 15TH NOVEMBER 2022 AT 10:00 A.M.