Urology Services Inquiry

Oral Hearing

Day 24 – Tuesday, 21st February 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

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THE HEARING RESUMED ON TUESDAY, 21ST FEBRUARY 2023 AS FOLLOWS:

CHAIR: Good morning, everyone. Good morning, Mr. Beech.

MR. BEECH **BL**: Good morning, Madam Chair. The first witness is Mr. Colin Weir.

MR. COLIN WEIR, HAVING AFFIRMED, WAS EXAMINED BY MR. BEECH **BL** AS FOLLOWS:

CHAIR: Thank you. Please sit down, Mr. Weir.

MR. BEECH **BL**: Good morning, Mr. Weir. There should be a glass of water in front of you on your table. Any documents I refer to should appear on the screen as we work our way through this morning.

Can I start by referring you to your two responses to Section 21 Notices, both of which are dated 21st June. If we start at WIT-19902, which is your response to Notice 22 of 2022. Are you familiar with that document?

A. Yes.

1 Q. If we move to the last page of that response, which is WIT-19964, please. Can you confirm that is your signature on the last page of that?

A. That's correct.

2 Q. Are you content to adopt that witness statement as your evidence before the Inquiry this morning, subject to

one or two minor amendments; is that right?

A. Yes, that's correct.

3 Q. The Inquiry is in receipt of correspondence with regards to those amendments, and I think they have been marked at the various points. If we go to WIT-19903, please. Paragraph 4. The amendment itself isn't marked on this version of the screen, but I believe you wish to make an amendment to paragraph 4; is that right? 10:04

A. That's correct, yes. 10:04

4 Q. It is with regards to Mr. Haynes; is that right?

A. Mr. Haynes did not commence his post in January 2017. I can't recall the date. It was on the amendment as typed up, but it was later than that, I think.

5 Q. In ease of you, you amended it to October 2017. 10:05

A. Yes, that's correct.

6 Q. What was the cause of that confusion?

A. During that time there was a -- because of the sudden or relatively unexpected departure of the Associate Medical Director, it was just when I was writing this I couldn't recall exactly when Mr. Haynes took up his post as Acting Associate Medical Director. It was just a failure of recollection on my part. 10:05

7 Q. If we look again at WIT-19937, paragraph 104, please? I believe you wish to make an amendment to the third sentence there where you say: Dr. McAllister at least approximately to December 2016, you wish to amend the reference to December there? 10:06

A. Yes. So he was no longer in that post. I think that

was around the end of October, early November 2016. Again, just a failure of recollection given the duration since these events took place.

8 Q. Thank you. There is one more very minor amendment, which is a typo of how you spelt Ms. Trouten's name at one point in the response. 10:06

A. Yes.

9 Q. You would like to --

A. Yes, I'd like that amended.

10 Q. -- paragraph 118 accordingly. Thank you. If we go to WIT-1993, please? This is your response to Section 21 33 of 22. Are you familiar with that document? 10:06

A. Yes.

11 Q. Again, if we go to the end which is at WIT-20015, please. Can you confirm that's your signature at the end? 10:07

A. That's my signature, yes.

12 Q. You wish to adopt this as your evidence to the tribunal.

A. Yes. 10:07

13 Q. Is there any amendments you wish to make to that response?

A. No.

14 Q. Thank you. Perhaps before we get into the substance of your handling of, Mr. O'Brien, I wish to ask you some questions about your role in your time as Clinical Director. Before doing so, could you just outline your role and experience in the Trust up to becoming Clinical Director in June 2016? 10:07

A. I was appointed 1st August as Consultant Surgeon, Consultant General Surgeon with a specialist interest in vascular surgery. I took part in the acute general surgical rota. During my time I undertook a number of other additional roles. Some of these were appointed by competitive interview, namely Audition Programme Supervisor, Associate Medical Director for Education and Training, which is a senior role supervising education, training of junior doctors throughout the Trust. I was also appointed Undergraduate Lead for Surgical Education for Queen's University students, and I'm an Honorary Lecturer at Queen's, a clinical lecturer for that role. Those would be the main additional duties or roles that I would have had.

10:08

10:08

Q. If we just can call up WIT-19902 on the screen. We'll have a look at paragraph 3, please. I think it would be helpful, perhaps, at the outset to set some perimeters on your time as Clinical Director. You were appointed on 1st June 2016 and you finished as Clinical Director on 31st January 2022. However, at paragraph 3 there you say that you had:

10:09

10:09

"My area of responsibility initially until December 2018 was urology."

10:10

Why did urology come outside of your remit after 2018?

A. The areas are enumerated there, but there are also; I have in the system, if you like, we have General Surgery across two sites, Craigavon and Daisy Hill, and

Trauma Orthopaedics, so they all have to be managed under this system, if you like. Because there were arguments as to whether it was better to be a Clinical Director in the team that you were working, or whether it was better to be disconnected and be a Clinical Director for a team which you weren't working, but at the time, because Mr. Haynes was then appointed Associate Medical Director, a realignment of the teams was considered necessary. It wasn't my choice, but I had no difficulty with it. And I think a fresh individual undertaking the role as Clinical Director of Urology was probably deemed a good idea and a good thing. I certainly felt, for me, that it was a good thing to switch my role of management to the team in which I worked at Craigavon and later on at Daisy Hill Hospital for general surgery. 10:10 10:10 10:11

16 Q. So from December 2018 onwards, did you have any management responsibility for you Urology?

A. Zero.

17 Q. I think perhaps at the outset, it is also an important context to note that, sadly, you didn't enjoy the best health in the years which you had responsibility for Urology. If you look at paragraph 5, I think it should be on the next page. It is heavily redacted, as you can see, but you had periods of sick leave, November '16 for four weeks. August '17 for six weeks. Late November '17 to February '18 and then November '18 through to the end of your time with Urology. Are those dates accurate as far as you can recall? 10:11 10:11

A. Yes.

18 Q. Although you had management responsibility for Urology for approximately two years, for a reasonable portion of time you were unavailable to discharge your role?

A. Yes. 10:12

19 Q. In your role as Clinical Director you formed part of a medical management line within the Trust, could you just explain from say, the Medical Director, down to an individual consultant in the Trust?

A. So the structure would have been Medical Director, then 10:12 working through Associate Medical Directors. So those Associate Medical Directors had various areas, broad areas of responsibility. For us it was surgery and elective care, encompassing surgery, acute surgery, and all the specialties that I have mentioned earlier. 10:13 Then, within that, one or two -- usually two Clinical Directors with their areas of responsibility across specialists, urology, trauma and orthopaedics, general surgery. Then the next level would have been, there would have been lead consultants within each of those 10:13 areas or each of those subspecialties.

20 Q. If we focus for now on the chain going up, so we if look at you to the Associate Medical Director and the Medical Director, you already said that Dr. McAllister had to leave his role in October 2016. You said 10:13 Mr. Haynes didn't take up his role until October 2017.

A. Yes.

21 Q. How did the absence of an Associate Medical Director for about a year there, how did that impact on your

ability to discharge your role?

A. Well, the main -- it was left, in a sense, between myself and Mark Haynes to manage as best we can -- or discharge our roles, if you like. I guess we both had the advantage in that we were able to communicate, Mark being on the ground in Neurology, me being on the ground in General Surgery did help that to a degree, it helped us to deal with any on-the-ground issues. What we were lacking, I think, would have been a sense of direction or a bigger, a broader sense of what the Unit was doing in terms of long-term goals and also, perhaps, yes, another chain of someone to talk to, basically, is what we needed. I think that was missing. 10:14 10:14

22 Q. In the absence of that Associate Medical Director level -- 10:15

A. Yes. The absence of an Associate Medical Director meant there was a gap, there was a lack of maybe other conversations that could have been had.

23 Q. To what extent during that gap were those conversations being had between you and directly with the Medical Director? 10:15

A. The Medical Director, did you say?

24 Q. Yes?

A. None. I can't recall any direct conversations between ourselves and the Medical Director on sort of medical management issues. 10:15

25 Q. If we just have a quick look at TRU-163346, please. This is an email from Dr. Wright to yourself and

Mr. Haynes on 11th November 2016. You'll be aware -- this is to yourself and I assume Damian Scullion and Tariq S, are they other Clinical Directors on the Surgery side of the house?

A. Correct.

26 Q. "You will be aware that Dr. McAllister has stepped temporarily aside as AMD for Surgery and Anaesthetics to facilitate an ongoing internal Trust process. During this period I would expect management issues to be dealt with by the Clinical Directors in liaison with Mrs Gishkori and myself in relation to professional issues". 10:16

There, at least, appears to be email correspondence that there an expectation that you would be acting up, to a certain extent, but you are telling us that wasn't reflected in reality in terms of closer engagement with the Medical Director or from the Medical Director?

A. I think we acted in our role, I think we discharged our role as Clinical Directors on the ground we were able to do that, but I think we were missing a more, a broader picture approach to things, and another line of communication, and someone to be able to have discussions with. But my recollection, there were no direct conversations around that with the Medical Director. 10:17

27 Q. Had you had issues on your concern on your patch as Clinical Director? Would you have felt comfortable discussing any types of issues with the Medical

Director?

A. Absolutely. Yes, he would have been approachable. That is something I would have felt easily I would have been able to do, if need be.

28 Q. In your response at WIT-19937, you start at paragraph 104, at the very bottom of the page: "I had some support from the medical hierarchy". 10:18

Is the word "some support" there loaded in any sense as in that you felt you could have had more support from the medical hierarchy? 10:18

A. No. No. I wouldn't put that spin on it. Support, then, if you like.

29 Q. If you go on down in the paragraph on to the next page, please. This is in the discussion about Mr. O'Brien but for present purposes I'm trying to broaden it out a bit. 10:18

"I do not feel there were enough more formal meetings or minuted meetings or opportunities to gain advice or communicate a complex and challenging case with the management team". 10:19

Did you feel supported in exercising your role as Clinical Director from the broader team, including, say, Mrs. Gishkori, the Assistant Directors? 10:19

A. When there was a complex issue, more complex than first realised, I felt that was missing, that degree of having an idea of the enormity of it and how the rest

of the team around me were going to support me in dealing with the problem. I felt at times a little bit isolated in that respect and somewhat reluctant, I suppose, or hesitant to deal fully with the problem, or at least to feel it's not something I could have done on my own.

30 Q. I preface the discussion we've just had with we were going to look up the medical line. Perhaps now if we turn to look down towards, say, the Clinical Lead and the individual consultants. What role, if any, did you feel you had to managing individual consultants within Urology? 10:20

A. I would have felt, as I came into this post, that I was aware that the Lead Consultant, Mr. Young, was already undertaking day-to-day roles and responsibilities for the Urology team. There were day-to-day matters, if they arose or came across me, I could certainly deal with those. But my expectation was that some of those day-to-day issues, for instance, you know, on-call rotas, things like that, that would have been the responsibility of the team, the Urology team and the Lead Consultant. 10:20 10:21

31 Q. Do you feel as if during your time as Clinical Director issues were coming up from that line? Was Mr. Young raising issues of concern about various matters with you? 10:21

A. Yes. They would have been raised with me, either through Mr. Young or Martina Corrigan would have been very valuable in that respect.

32 Q. You described Mr. Young's involvement in this. What did you see Mrs. Corrigan's role and how did it relate to your own?

A. She had a very good working relationship with everybody in the team, and was very tuned to whatever the live issues were; if they were staffing issues, shortage of staff, equipment issues that would have affected the delivery of the service, or issues with trainees. Really, a whole host of technical, personnel issues, she would have been very au fait with those and would have regularly communicated anything relevant to me on that basis. 10:22 10:22

33 Q. I think perhaps in this context it might be helpful to have a quick look at your job description, which appears at WIT-19974. I don't intend to linger on this. It outlines your role across 39 relatively detailed bullet points. Perhaps if we just look at the first page here, where it says: 10:23

There are two posts available, he, she will. Then there are two bullet points. 10:23

You are going to be responsible for medical operational issues within surgery across the Trust. What did you under as a "medical operational issue"? 10:23

A. I think that would have been, again, rota issues, equipment issues, that came across my desk. Things that would have hindered or affected the throughput of work in whatever setting.

34 Q. Then the third bullet point there says:
Provide professional advice to the Associate Medical Director and divisional team on the professional medical issues of the division.

10:24

What was the dividing line between this operational type idea and this professional type idea, and was that clear what the difference between the two was?

A. I think there was quite a bit of overlap on that. I think professional medical is, I suppose, those two, you know, the doctors' duties, duty of care to the patient and anything that might have affected that, health issues, things like that, that might have impaired someone's ability to discharge their duties, and standards, governance, quality of care, things like that. 10:24

35 Q. We'll come on later this morning to address some of the issues with regards to Mr. O'Brien but taking at this stage issues with triage, notes being stored, either at home or in the office, issuing of dictation; in your mind was that an operational issue or was that an professional issue? 10:25

A. Both.

36 Q. Saying it's both, who then is responsible for tackling that, or dealing with it, or escalating it? 10:25

A. It depends on the enormity or not of the problem. If it's a systemic and large problem that's not going to be a simple operational or professional issue, that needs something much bigger. But if it's reported to

me that Dr. X has got 20 un-dictated letters from last year still sitting in the office, well that might be much more easily dealt with on a professional or medical basis. You could see how that is both medical and professional behaviour and an operational issue. You know, for the patients, to protect patients that is important that these things are done. It's all just matters of degrees. It is a bit, sort of, grey, you know, how far you take this and how far up the line you take this. 10:26

37 Q. From your experience as Clinical Director, was there ever any confusion about who was to handle issues of that nature, or was it all suitably clear?

A. I think it was clear. I think with a Head of Service in Martina, the communication was excellent. I think any relevant issues would easily come to me via her or the consultants or the Lead Consultant, if need be. I think in my mind, I suppose, it's a professional judgment how far you take someone. Does this need to be taken up the line? Do I need to pull in other resources or other people to assist me in this? I guess there's no handbook for this aspect of it. 10:26 10:27

38 Q. If we just refer back to your response at WIT-9929, paragraph 82. That's the very last sentence there. So the estimate, and I fully appreciate this is an estimate, working weeks would be different: You estimate that on average Urology Unit work occupy an hour a week. Is that a fair summary of your time? 10:27

A. That's fair.

39 Q. In your job plan did you have set aside time for being Clinical Director?

A. Yes. So there would have been an allocation when .5PAs within my Job Plan, so you know, some weeks would take more, some weeks would take less. Just on the ground and on average over a period of time that's what we were looking at in terms of time commitment. 10:28

40 Q. And reflecting, just reflecting back on your time as Clinical Director, do you feel you had adequate time to proactively do the job, or were you reduced, in effect, to a rather crude term, a fire-fighting type role of just putting out fires, tackling issues as and when they arise? 10:28

A. I think the events of -- the things I ended up firefighting were quite profound and complex and time consuming. So I think the role to be strategic, to make it into a strategic aspect of the role and to do good governance definitely needs, you know, more commitment or more time for that, or set aside for that. 10:29

41 Q. As you outline in your response, you were, up until July 2017, you were also the Foundation Programme Director and Associate Medical Director for Education and Training. Surely those are busy enough jobs in their own right? 10:29

A. Well, yeah, and I was encouraged to drop at least one of those, and I did, in 2017. The only thing I would say, there was quite a bit of overlap between Associate Medical Director for Education and Training, Foundation

Programme Director because they were both relating to junior doctors and trainees. In addition, I had the help of another Foundation Programme Director on the Daisy Hill Hospital site and that helped me discharge some of those duties in relation to Foundation Programme Director. But, you know, after a year of this and once sick leave was out of the way I realised this was not sustainable. So that's why I dropped Foundation Programme Director initially and then a year later Associate Medical Director. 10:30

42 Q. I know you are saying that you subsequently dropped the role but, on reflection, was it right for you to be appointed Clinical Director whilst having these two relatively major jobs in hand?

A. I don't know if "rightness" is the word, it's whether I could do it with the teams that I had around me. But in retrospect I would have said it probably would have made sense to drop one or both of those roles at a much earlier stage. 10:31

43 Q. Just to be clear, you actually applied and went through a competitive prose to get the Clinical Director job? 10:31

A. Yes.

44 Q. Before we, perhaps, get into some of the complex issues you were handling, I want to just chat to you briefly about MHPS and the Trust's own guidance. If you we go back to June 2016 when you get appointed as Clinical Director, what extent were you aware of the Frameworks, the MHPS Framework and the Guidelines themselves in the Trust? 10:31

A. Well, I was aware of them. I hadn't ever been asked to use them or utilise them. I'd certainly seen the Trust implementation of those Guidelines and, in fact, had given a presentation to that effect in 2013 which was just drawn from The Trust's Guidelines on MHPS. So I had some awareness of the processes and protocols, but no previous actual experience or being involved in any investigation.

45 Q. On the issue of training, if we have a quick look at WIT-1997. Let me repeat that WIT-1997, paragraph 15. At these four bullet points then you outline some of the training you recall receiving. You received an email from 3rd February inviting me and others to NCAS for investigation training, but you could not attend. Point B then: 10:32 10:32 10:33

"I also recall a half day of one-to-one training or update session from NCAS Officer Grainne Lynn in early 2017. I am currently trying to find a record list." 10:33

Have you been able to find any record?

A. No.

46 Q. Do you recall that training taking place?

A. I recall, but in the -- over the years I thought that The Trust had arranged in advance of the investigation a quick refresher of some sort with Grainne Lynn, but I can't find any, because it would have been, if it did happen, and I'm not saying I have complete recollection and being completely honest about this, but there was 10:33

a vague recollection that there was some sort of half-day training prior to the initiation of the investigation in 2017.

47 Q. For completeness then, Point C outlines a training session in 2014 and B outlines in 2010. I am jumping a bit out of sync here, but I am formally being appointed as the Case Investigator into Mr. O'Brien. Did you feel confident that you had a sufficient knowledge of the guidance and sufficient training to be able to discharge that role? 10:34

A. No. I don't think that -- it's okay doing courses, but you know, you do a course and three years later you've never put it into practice. It's like learning a technical skill or a procedure. You can go and attend a lecture but if you don't actually do it your skills will never evolve or develop and you won't be able to, I don't think, discharge that. 10:35

So I felt, I felt that the only way that I could undertake this role at the time was the assurance that I would have an assistance from HR to help me. And I asked -- I do recall asking or at least being told that that would happen to help me go through the process and help me with the process. But if you said, de novo, would you be able to do this prior to 2017? I don't think I would have been able to. I don't think I would have been -- had the experience or even a recall of all the factual knowledge needed to undertake this role as either manager/investigator. 10:35 10:35

48 Q. Now we will have an option at the end I think to provide some reflections on how to make the process better, but is the solution to that issue, in effect, more focused, meaningful, training and experience in some way for consultants of your level? 10:36

A. We'll all sign up for courses and do this, and do that, and management training and whatever, but it has to be close to the time. It has to be -- and then you do it and then you probably need somebody to be alongside you to direct you and help you do it. You cannot go into 10:36 these things with one course or one lecture or a half-day, and then away you go. It's just not the way to do it.

49 Q. You've indicated this morning you have never had cause to implement the Framework or the Guidelines yourself. 10:37 Now, have you ever been involved in any other type of investigation of a consultant or medical colleagues?

A. I have.

50 Q. Now, assuming that the specifics aren't necessarily relevant to the Terms of Reference, there were not to 10:37 do -- I don't want to call Mr. O'Brien out here, but they nothing to do with Mr. O'Brien, something in the background. It is nothing to do with urology is the point I am trying to make?

A. It's nothing to do with urology. 10:37

51 Q. How did you find that experience of conducting an investigation into a consultant colleague in the past?

A. Very challenging, because investigating another colleague where you might meet and see that colleague

almost daily, in a coffee room or in theatre, or whatever, and have worked with the person or individual clinically, then you are put in a position of doing whatever form of investigation, that makes it -- it makes it less objective. Like obviously it does. It changes your relationship with that person, your working relationship, never mind your personal relationship. So that lack of disconnect is very difficult and challenging. 10:38

52 Q. These challenging experiences you've recounted, were any part of that in your mind as you worked through 2016 and you're trying to manage Aidan O'Brien, was that at the forefront of your mind? 10:38

A. Absolutely, yes.

53 Q. And let me rephrase the question so I don't lead you almost, was it in your mind, I will not say it was at the forefront, but to what extent was it in your mind? 10:38

A. It was forefront in my mind, that experience. So I had a reluctance, let's put it that way, because of previous experience of being asked to investigate a person that you knew, I have worked with clinically, professionally, and had seen frequently day-to-day, I'd referred patients to, and seen patients referred to me from. All of that is tied-up in it. It just -- it makes it very difficult. 10:39

54 Q. We're going to get into specifics here of what actions you took between June '16 and October '16, but at any stage did you raise that reluctance with let's say the Medical Director, the Associate Medical Director? 10:39

A. In the initial period of between June 2016 and October 2016 I expressed some reluctance about this and about the difficulty of undertaking a less formal, let's say, investigation. Secondly, in January 2017, my recollection is that I expressed reluctance to the Medical Director about being his investigator on that same basis.

55 Q. We will perhaps come to your substantive investigator role a bit later this morning. If we turn then to the period I just described, June '16 to October '16. On taking over as Clinical Director, were you aware of any issues in Mr. O'Brien's practice as of 1st June 2016?

A. No.

56 Q. Can you recall receiving a hand-over from the outgoing Clinical Director?

A. No, I did not receive a hand-over.

57 Q. What was the outgoing Clinical Director? Who did you take over from?

A. I think Sam Hall retired and I think there may even have been a gap between the two. There was nobody to kind of say here, here's the baton, here are the issues, here's what you've got to deal with.

58 Q. Just so we are perfectly clear, there was no orientation, say, from the Associate Medical Director, the Medical Director, the Assistant Director?

A. No.

59 Q. When did you first become aware there were issues with Mr. O'Brien's practice?

A. Somewhere between the 1st and 15th June 2016 I was made aware at a -- there was a weekly meeting or often, or nearly weekly meeting between myself, Mark Haynes' two Clinical Directors and Dr. McAllister where, I believe, it was mentioned, and at some point I received an email, Martina Corrigan had sent me an email with the copy of the letter that was sent earlier in the year to Mr. O'Brien.

60 Q. Yes. I think we can get that email up on the screen. It is TRU-274695. It is a relativity short email. It says: Hi Colin, as discussed, Martina. Attached thereto is a copy of the March letter. You've described a meeting with Dr. McAllister and Mark Haynes. Which came first, the letter or the meeting?

A. I think it was mentioned, you know, during those meetings on a Thursday. I think likely what has happened is one of us, or myself, had said: "Martina, where's this letter? Where's the information that gives me an idea of what's going on?"

61 Q. Perhaps then we'll start with your account of the meeting. If we go to WIT-19904, paragraph 7, please.

"I believe this was sent to me because Dr. McAllister, in around June or July 2016" -- having seen it all in context you think it would be about June 2016?

A. Yes.

62 Q. "... asked me to try and resolve the outstanding issue. More specifically, he asked me to try and resolve this with negation with Mr. O'Brien and have him agree to an

action plan with recourse to formal investigations or procedures."

A. I do recall it was very much couched in terms of trying to avoid a formal investigation that if we could come up with some sort of action informally with Mr. O'Brien to try and resolve this issue, that that's the limit of my recollection. 10:44

63 Q. Can you recall why there was such a desire to avoid formal procedures?

A. I don't know the reasoning. It was never made clear the reasoning for that, but I think I know that Dr. McAllister and the Director of Acute Services, Esther Gishkori, had met and I think my understanding was that between them they felt that this was the correct approach, the best way to achieve an outcome to resolve this problem. Then, in turn, they felt that I was going to be able to do that. 10:44 10:45

64 Q. Just so we are clear, by the time of 15th June 2016 you were aware that Dr. McAllister had meetings with Mrs Gishkori on this subject? 10:45

A. I can't recall that. I don't think I put that down in my statement, but I think they were having regular meetings, and this would have been a discussion.

65 Q. If we perhaps just try to deal with a discrete point. If we could jump to TRU-00782, please, which is your statement to Dr. Chada on 24th May -- 10:46

A. Yes.

66 Q. -- 2017 in the context of the MHPS investigation. We're looking at paragraph 6 at the top there. You

told Dr. Chada:
Dr. McAllister first mentioned to me that there were concerns about Mr. O'Brien's triage, keeping notes at home, and un-dictated clinics in or around August 2016.

10:46

You now think it was around June '16?

A. Yes. Yes.

67 Q. He then said he: "put it in terms of there being a bit of an issue with charts, triage and clinics but it wasn't put to me as a really serious problem." 10:46

Do you still stand by that? Is that your recollection?

A. That is my recollection. I don't know, it would be difficult for me now, after all these years, to change that. But that's, yes. 10:47

68 Q. Do you recall how you reacted? Did you think it was a serious problem?

A. I thought it was with a serious problem as, over time, I became more aware what, you know, the size of the problem. I don't want to jump ahead, but I had 10:47 a reluctance right from the start that this was more than just have a chat, tell somebody to do something, come up with a plan and they'll implement that, and that will be the end of the problem. I didn't think that was going to be the case. 10:47

69 Q. We can see that Martina Corrigan e-mailed you a copy of what is called the March letter, I'm going to refer to it as, on 15th June. Having received that letter, what action did you take to attempt to address these issues?

A. We received that and then, I think -- my recollection is that pretty much we had July, summer holidays, there wasn't much happening. Then during the course of August I was again feeling reluctance and concern about getting involved as being the person to tackle this. I, therefore, thought the best way to deal with this was to produce an action plan, but to share that with a number of individuals. I felt that the only way forward on this basis was to have everybody agree this action plan. I felt I needed some cover, back-up, that it was not entirely on me, and part of the next stage would then be a series of meetings with myself and Dr. McAllister to meet Mr. O'Brien. That was going to be how we were going to implement this action plan. 10:48 10:48

70 Q. We'll come to your actions, perhaps, August/September momentarily. From June to August did you make any efforts to engage with Mr. O'Brien? 10:49

A. No.

71 Q. You mentioned the summer. I don't want to be slightly unfair, I know people are away in the summer, it's Northern Ireland, but this was mid-June you found out about this? 10:49

A. Well, July.

72 Q. You found out about this -- you got the letter mid-June? 10:49

A. Yeah.

73 Q. Was there not enough time there to, at least, engage with Mr. O'Brien to try to sort this out?

A. Yeah, but I was being presented with something that

in looked like it had been an ongoing issue for a long time and there was no timeframe set on it. We were still having regular meetings on a Thursday, and so, I suppose, a natural hesitancy and reluctance on my part maybe just held me back a bit from really delving into this, is why there was, if you like, a delay.

74 Q. In your response to Section 21, there is a WIT-19934, specifically at paragraph 97. I'm going to start reading from about five lines from the bottom of this paragraph. You say: 10:50 10:51

"At this time I was not informed of precise numbers, how long this has been occurring, what previous action plans and meetings had occurred to address this, or any other significant briefing." 10:51

Which, I believe, is the sentiment you just expressed. You then go on to say:

"I consider it a failure of good governance to ask a newly appointed Clinical Director with, no previous experience, to resolve informally a long-standing and complex problem with only a weekly meeting with my Line Manager." 10:51

And while you were newly appointed, you were Mr. O'Brien's Clinical Director, surely this is precisely the type of issues that Clinical Directors are paid and have time to sort out?

A. Well, there are things that they may sort out, but this was made clear as it was a long-standing and complex problem. It was going to take time to sort this out. So at that -- that was kind of where my initial reluctance to deal with this came from. It wasn't, I guess, in the normal remit of a Clinical Director, and, yes, it would fall under governance, but it was more than that, it was more complex than that, and deeper than that and long-standing than that. 10:52

75 Q. At the meeting on the 15th June, at or around the 15th June 2016, do you recall raising with Dr. McAllister that you felt this wasn't for you to deal with, that it was a bigger issue than you? Did you raise that Dr. McAllister? 10:52

A. I think subsequent to that I would have raised that it was a complex issue and it was not going to be easy to sort out for the reasons -- because of the long-standing nature of the problem. And the fact that it had been addressed before and still was an issue. 10:52

76 Q. Was there anything stopping you approaching, say, Mrs. Corrigan and finding out what had happened in the past? You say you didn't know precise numbers, you didn't know how long this had been occurring, could you not easily have got that information from someone like Mrs. Corrigan? 10:53

A. Well, yes -- well, I did get the letter subsequently with some of those patient numbers from March 2016, so that was, I suppose, the basis or the start of it. But, yeah, I'm sure if I was really going at this on my 10:53

own then, yeah, that would have been a valid thing to do, yes.

77 Q. Is there any specific reason why you didn't approach Mrs. Corrigan at that time to find out exactly what had happened. I know you got the letter, but is there any specific reason you didn't go back about these other issues? 10:54

A. I think just needing to think it through, a bit of time just to think how is this going to be addressed, what's the right way to do this, is this the right way to do this? Those were my concerns and that's the nature of the -- or the cause of the delay. 10:54

78 Q. You have already told us today this wasn't addressed in June or July, then we get to August. If you look at WIT-19904, which is paragraph 10. I should say there is highlighting on these versions. I'm not entirely sure where the highlighting comes from. I don't think much turns on it, nothing of significance as far as I am concerned for the reasons highlighted. You say: 10:54

"I recorded in my handwritten notebook, a meeting with Mr. Young, on the 9th August 2016. I noted 'Aidan-MY' will discuss with him, namely lead consultant Mr. Young, will discuss with Mr. O'Brien issues in relation to some or all of the four concerns raised above." 10:55

You have provided the notebook. I don't think it will take us much further going to look at it. What led to this discussion with Mr. Young on the 9th August 2016?

A. I recall that some of the preexisting issues had been discussed between Mr. Young and Mr. O'Brien is my -- and so there was already a background of that happening. And in my meeting Mr. Young met -- or declared that he would at least discuss these issues with him as his lead consultant. So it would -- as an initial approach and, in fact, as part of an ongoing process where Mr. Young had spoken to Mr. O'Brien in the past about this, to me, at that stage seemed a satisfactory approach. 10:55 10:56

79 Q. Your meeting with Mr. Young is recorded on the 9th August. Was that a regular meeting with Mr. Young?

A. Not a regular, but it was just -- there would have been ad hoc meetings with Mr. Young or the Urology Team, as required. I think this was specifically -- there was a number of issues discussed at that meeting, I think, in relation to, I think, job planning or equipment issues, what have you, and then, in particular, this issue came up. 10:56

80 Q. But you can't recall the specific trigger which led to Mr. O'Brien being discussed at this meeting? 10:56

A. Well, other than we were all aware that this was an ongoing problem and we were trying to work our way towards finding out a solution to that.

81 Q. Are you aware if Mr. Young did meet with Mr. O'Brien? 10:57

A. I'm not aware. I can't answer that.

82 Q. Did you follow that up as his Clinical Director?

A. I don't think I had a follow-up with that, but then we were moving into the next phase of what I was going to

do with this, in parallel to this. So I think the approach was, again, Mr. Young quite informally was going to speak to Mr. O'Brien to see if he could deal with this issue, this backlog issue, but still remaining for me to come up with this action plan to deal with it in a more structured way.

83 Q. So you never chased Mr. Young and so far as you recall Mr. Young never reported back?

A. No.

10:57

84 Q. You mentioned there that the next stage -- it appears as if you had a meeting with Dr. McAllister on 18th August 2016, and that is outlined in his Section 21 response, WIT-14862. Do you recall this meeting on 18th August 2016? Dr. McAllister refers to as:

10:57

10:58

"Our regular Thursday meeting, we discussed what steps could be taken to sort this chronic problem out once and for all. Among the things we discussed I suggested that removal from theatre, until the backlog was cleared, would be the most effective incentive for Mr. O'Brien to address the triage backlog and other issues. Mr. Weir appeared concerned at this suggestion and said that Mr. O'Brien would go mad."

10:58

Now, let's unpack that a wee bit. Do you recall a meeting with Dr. McAllister on 18th August?

10:58

A. Well, if you had asked me to recall it without that I wouldn't have recalled it but, yes, I think, yes, in retrospect, that sounds familiar.

85 Q. Do you know what would have been a prompt for this meeting on 18th August?
A. What would be? Sorry.
86 Q. What would have been the prompt for this meeting or for discussing Mr. O'Brien at the this meeting on 18th August? 10:59
A. I suppose, I'm just surmising that Dr. McAllister is basically saying what can we do to sort this out? What is the action plan going to be? That's it, just the ongoing issue. 10:59
87 Q. Dr. McAllister records that he made or suggested removing Mr. O'Brien from theatre until the backlog was sorted. Can you recall that suggestion?
A. Sounds -- yes, as far as I can recall. Yes, that sounds familiar. 11:00
88 Q. Was removing a consultant surgeon from theatre, or the threat of that, is that a management tool which was usually used?
A. I never heard that tool used before to deal with a problem like this, but I never came across a problem like this before in my practice dealing with anybody. I can understand what he was suggesting and why he was suggesting it. Yes, free up the time, clear the backlog, and then just keep it like that. I think that, knowing Mr. O'Brien and knowing how much he felt the need to operate on patients and be in theatre and operate on his patients and put through work in that way, that he would be resistant to that. So that was -- I'm just reflecting my working knowledge of 11:00

Mr. O'Brien, I guess.

89 Q. The last aspect of that then was Dr. McAllister records that you, Mr. Weir, appeared concerned at this suggestion and said that Mr. O'Brien would go mad. Do you recall expressing concern? 11:01

A. I think, yes. It sounds familiar. Yes.

90 Q. Is this an outworking again of this reticence you were talking about earlier, a nervousness about challenging a consultant colleague?

A. Yes, just a nervous reluctance to say, is this the right way to do with this problem, this backlog of work? This hasn't happened in the last three months, this is a much deeper, long-standing issue. Also, as I said, knowing how Mr. O'Brien's professional -- how professionally he works and his commitment to wanting to operate and put through patient workload in the operating theatre, I think he would struggle with that suggestion. That's my personal opinion and, you know, that's it, that's all I can say in relation to that. 11:01 11:02

91 Q. Would you have voiced those sentiments to Dr. McAllister at that meeting? 11:02

A. Yes. Definitely.

92 Q. Do you think this threat of removal from theatre was overly Draconian at this time?

A. I mean, I don't think -- I mean, I can understand it. I mean, I think, as a suggestion, it's not a bad one. But I have -- you know, but asking -- it's his suggestion and I have a concern about why I think that may not entirely be the best way to deal with this. 11:02

93 Q. If we just finish paragraph 11.6 of Dr. McAllister there.

He says: "I asked him" -- that's you, Colin Weir -- "to think about it over the weekend and come up with a solid plan that would sort of the problem out once and for all and speak to Mr. O'Brien the following week." 11:03

At this stage, 18th August 2016, did you revert to Dr. McAllister with a plan? 11:03

A. Not at that stage, as far as I can recall. Not immediately.

94 Q. He also goes on to say "and consider speaking with Mr. O'Brien the following week." Did you speak with Mr. O'Brien in August 2016? 11:03

A. I honestly can't recall. I don't know.

95 Q. Your next involvement in this appears to be on 23rd August. If we look at TRU-281130, please. We'll just start at the bottom there, which is an email from 22nd August from Simon Gibson to Dr. McAllister, amongst others. You weren't copied into this at that time, but it says: 11:04

"Dear all, I have been asked by the Medical Director to consider a range of issues in relation to Mr. O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you received any plans or proposals." 11:04

In August 2016 before seeing this email were you aware

the Medical Director was starting to show an interest in this again?

A. No.

96 Q. Go up, please. This is Dr. McAllister to you the following day, 23rd August 2016. 11:05

"Strictly in confidence.
Hi, Mr. Weir, please see below. This has come to light subsequent to our discussion on this subject last Thursday" -- which presumably would have been 18th August. "It appears that the boat is missed. I note you are on leave this week and I'm off for the following two so won't get a chance to meet/discuss. Please hold off on attempting to address this issue until the dust settles on the process below." 11:05

If the Medical Director had been looking into Mr. O'Brien, even at a high level at this stage, Mr. Gibson is looking to know if anyone has heard anything from him in terms of plans and proposals. 11:06 Would that have stopped you and Dr. McAllister from trying to tackle the issue yourselves?

A. I heard that the Medical Director was looking into this? Absolutely. That would have been the perfect moment for me to stop. I mean the Medical Director 11:06 could have investigated or come to us, but if that's -- if they were undertaking a separate process, of which I was not aware was happening, then -- or if I was aware of that, then it would have been -- you know, it

would have been wrong for me to continue, you know, with my own process or our own process.

97 Q. If you just go back down -- sorry, James -- to Mr. Gibson's email:

11:07

"I have been asked by the Medical Director to consider a range of issues in relation to Mr. O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr. O'Brien to address the issues." 11:07

It does not necessarily sound as if the Medical Director is kind of, you know, about to launch into a full scale process at that stage, it simply sounds that the Medical Director is trying to gather some 11:07 information. Should this have stopped you and Dr. McAllister, really, from at least trying to engage with Mr. O'Brien, even simply just to say, listen, Aidan, the Medical Director is sort of asking questions, we need to try to sit down and sort this 11:07 out?

A. Yeah, I mean if that was the case then it would have made sense to say, right, let's just move this on to something else, the Medical Director's Office is looking into this, then -- I mean, yeah, that would 11:07 have been my issues, at least for that point, resolved.

98 Q. While I note Dr. McAllister's email to you implies you're on leave, do you recall if you did speak to Aidan O'Brien after this email or did you follow his

order to --

A. No, I didn't. We were on leave. There wouldn't have been any contact at all during that time.

99 Q. At this juncture again, can I just take you back to your evidence to Dr. Chada. So if we did get TRU-00782 back up on the screen. I just want to deal with a discrete point. If we go back to paragraph 10, please. You say: 11:08

"I don't think people knew the enormity of the problem or how far back it was going. I know I was told at a point not to meet with Mr. O'Brien about this issue. I can't recall who said this to me, it may have been Ronan." 11:08

Referring to Ronan Carroll, the Assistant Director. On reflection, could this email of the 23rd of August from Dr. McAllister be what you were referring to here? Was it Dr. McAllister who told you, perhaps, to not engage with Mr. O'Brien? 11:09

A. Well, it sounds from the -- if someone is saying leave this until the dust settles, I don't -- you know, that meant, to me, do nothing and wait for the outcome. I mean, it didn't say that I wasn't -- that we weren't going to come back to this at some point. That's my -- that's what I took the meaning of that to be, that "dust settles" means wait and see what happens. If nothing happens then it comes back to us to initiate an action plan. 11:09

100 Q. So despite the reference to Dr. Chada -- or, sorry, Ronan Carroll there to Dr. Chada, could that have been this email you were talking about or something else?
A. I don't recall.
101 Q. Can you recall ever being issued with instruction by Mr. Carroll not to engage with Mr. O'Brien? 11:10
A. It would be wrong for me to say yes. I couldn't, with all honesty, say yes or no.
102 Q. Apart from this email from Dr. McAllister on the 23rd of August, can you recall anyone else issuing you an instruction to -- 11:10
A. No.
103 Q. -- not engage with Mr. O'Brien?
A. No.
104 Q. Looking at your statement to Dr. Chada there, you are clear that you can't recall who said this at the time, said this to me, "it may have been Ronan". Is there any reason you put Mr. Carroll's name there, can you recall? 11:10
A. I really honestly can't recall.
105 Q. If you could pull up TRU-00026, please. This is the minutes of an Oversight Committee meeting which met on the 13th September 2016. Before we launch into that, again, just being clear, from the 23rd August to 13th September, had you spoken to Mr. O'Brien? 11:11
A. From the 23rd of August --
106 Q. About these issues?
A. I can't recall. I don't think there was a formal meeting at that stage, no.

107 Q. This Oversight Meeting was attended by Dr. Wright, Ms. Toal, Mrs. Gishkori. You weren't there. When did you become aware that this meeting had taken place?

A. Sorry, what's the date of this?

108 Q. 13th September 2016. 11:12

A. I wasn't aware of any such meeting, in fact, at any point in time or an awareness of an Oversight Committee prior to December 2016, perhaps, at the earliest when Mr. O'Brien was excluded from work. So I wasn't aware of this Committee or these meetings at any time. 11:12

109 Q. If we just scroll down ever so slightly to the four bullet points there. You say you weren't aware of it. The first bullet point there says:

"Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB." 11:12

Mr. O'Brien, and then four bullet points:

"Esther Gishkori to go through the letter with Colin." 11:13

Presumably that's yourself:

"....Ronan and Simon, prior to the meeting with Mr. O'Brien." 11:13

Even though you were given specific tasks and referred to by name and "Colin is going to do this", you weren't aware of that meeting?

A. No. There was no such meeting, or at least no such meeting that I was at.

110 Q. This meeting takes place on 13th September 2016. By 16th September 2016 you're e-mailing Dr. McAllister an eight-point plan to resolve issues with Mr. O'Brien, with a view to resolving issues with Mr. O'Brien. How, as far as you understand it, did that eight-point plan come into existence? Who asked you? What instructions were you given and how did it come about? 11:13

A. It was my initiative. So Dr. McAllister, as I recall, was, I suppose, asking me, you know with a plan of what we were going to do. So I thought of my own initiative that the best way to do this was to put it in writing by email with what I thought a plan of action should have been. That I wanted to share that with a number of individuals because I felt it needed ownership not just of one person, I needed kind of input from other individuals to see if they agreed to this proposed action plan. Because, again, I go back to the fact that I felt that this was much bigger than it seemed at first sight, it is more complex, a much deeper problem that was going to take some time to resolve. 11:13 11:14 11:14

Then subsequent to that, it also stipulated a request that in the implementation of that action plan in any potential meetings with Mr. O'Brien that it wouldn't be just me and Mr. O'Brien, there would need to be somebody else, and that would be -- I think I requested Dr. McAllister in the first instance to be present so 11:15

there were at least two people in the room. I felt that everybody was saying: Colin Weir is going to sort that out and I felt very -- I feel cross, actually now when I think about it, everybody was pointing Colin Weir will sort that out, Colin Weir will sort that out. Get Colin Weir to sort it out. I expressed a reluctance that this was not the way to do this. So hence an action plan that was shared with others and the implementation of that involved at least two people in the room with Mr. O'Brien. 11:15 11:16

111 Q. This action plan you propose, it is different from what's envisaged at the Oversight Committee. At that Oversight Committee, if we look at the third bullet point on the screen there.

11:16

"The letter should inform Mr. O'Brien of the Trust's intention to proceed with an informal investigation under MHPS at this time."

Your action plan had a different process?

A. I had no knowledge there was even an Oversight Committee in existence. 11:16

112 Q. Were you --

A. Sorry to interrupt. I'm emphasising again, the action plan was mine, entirely mine based on what the evidence I had been presented up to that point, and my best initial view as to how to approach Mr. O'Brien and deal with the problem. 11:16

113 Q. Were you involved at this time in any discussions with Mrs. Gishkori about how to handle Mr. O'Brien?

A. There may have been one meeting I might have been in the room with Dr. McAllister and Mrs. Gishkori. I have a recollection, at best, that there may have been one meeting in her office where, I think, this was discussed briefly.

114 Q. When did that meeting take place?

A. Around about this time, as far as I can recall.

115 Q. If we look at TRU-257636. The email in the middle there from Dr. McAllister, please. It says Dr. McAllister to Mrs. Gishkori on 14th September 2016. 11:18

"Hi Esther. Further to our meeting today here is the only communication that I have received on this subject."

11:18

I understand that was a regular meeting between Dr. McAllister, Mrs. Gishkori and Mr. Carroll. Were you at that meeting?

A. No.

116 Q. If we go up, please? The context for this is Mrs. Gishkori was at the Oversight Committee and would have known what was agreed. Following this meeting of Dr. McAllister she says: 11:18

"I am clear that I wish you and Colin to take this forward and explore the options and potential solutions before anyone else gets involved. We owe this to a well-respected and competent colleague." 11:18

Were you in any discussions with Mrs. Gishkori about the oversight group?

A. No.

117 Q. An informal MHPS investigation?

A. No. 11:18

118 Q. And what appears to be, perhaps, a change of course to your action plan?

A. No.

CHAIR: Mr. Beech, I'm conscious of the time. Might it be an appropriate time to take a short break? 11:19

MR. BEECH **BL**: Yes, ma'am.

CHAIR: Can we come back, please, at 11.30?

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 11:19

CHAIR: Mr. Beech.

MR. BEECH **BL**: Thank you, Madam Chair.

119 Q. Mr. Weir, perhaps if we start at WIT-23373, which is an extract from Mrs. Gishkori's response to her Section 21 Notice. If we start at the very stop. Now before the 11:32 break we were discussing whether or not you had met with Mrs. Gishkori. At the very top here she says:

"Sensing real and meaningful remedial action was necessary, I spoke with both Mr. O'Brien's CD, Mr. Weir 11:32 and AMD, now Dr. McAllister, and asked if they could suggest an efficient solution to address Mr O'Brien's issues with administration in particular."

You recall meeting her but you can't recall the specifics; is that right?

A. As I said before the break, I do recall one meeting between Mrs. Gishkori, Dr. McAllister and myself. That's my recollection, so presumably that's the same meeting. 11:32

120 Q. Then if we look at AOB-01053, please. Perhaps if we start right down at the bottom, please? This is an email from Mrs. Gishkori to Richard and Vivienne, so that's Dr. Wright and Ms. Toal, the Medical and HR Director. She says: 11:33

"Following our Oversight Committee on Tuesday 13 September, I had a meeting with Charlie McAllister and Mr. Carroll, my AMD and MD for surgery to mention the case that was brought to the Oversight meeting in relation to Mr. O'Brien and the plan of action." 11:33

Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr. O'Brien's performance was, of course, part of that. Now that they both work locally with him they have plenty of ideas to try out and since they remain relatively new into post I would like to try out their strategy first." 11:33 11:34

He then requests that they be given three calendar months to resolve the issues in relation to Mr. O'Brien's practice or performance. He says:

"...owing to the trust and respect that Mr. O'Brien has earned over the years."

If you go up, please, to Dr. Wright's response. He says: 11:34

"Esther, as Director of the Service, naturally we have to listen to your opinion before I would consider conceding to any delay in moving forward and with what was our agreed position after the oversight meeting 11:34 I would need to see what plans are in place to deal with the issues, understand how progress would be monitored over the three-month period."

Then lastly, please, on up. Mrs. Gishkori forwards 11:34 this to you on 15 September and Dr. McAllister and Mr. Carroll saying:

"FYI, below and my response will be." 11:35

Is this the trigger to you reducing this eight-point plan to writing the following day?

A. Yeah, I had been thinking about it but I think that's the trigger to get it down and share it.

121 Q. In preparing your plan, which we will come to in 11:35 a second, would you have sourced further information. There is an email to you from Martina Corrigan from you on 15 September flagging missing triage from Mr. O'Brien, would you have requested information from

Martina in preparing that plan?

A. I think I was needing an update on the situation with Mr. O'Brien and triage, just to see where we were, as far as I can recall.

122 Q. Before the break you said it was your plan, you were very adamant it was your plan? 11:35

A. Yes.

123 Q. It might have been your plan, but at this stage Mrs. Gishkori is inviting you to produce it, is that right? 11:36

A. Yes. I think she -- yes, that's -- yes.

124 Q. So while it was your plan and perhaps you had had this formulating in your mind for a while, you produce it on 16 September on direction from Mrs. Gishkori, is that fair? 11:36

A. Yes.

125 Q. Could we have a look at the draft plan on TRU-257641. If we zoom in on Mr. Weir's email of 16 September, thank you. You say: "Further to discussions" -- this is to Charlie in the first instance, Dr. McAllister: 11:36

"I propose that I, as CD, and you, as AMD, implement the following action plan in relation to outstanding issues in respect of Mr. O'Brien." 11:37

Move on, please. You then have got eight bullet points. At this stage you're well aware that the issues with Mr. O'Brien have been long-standing. You may not be aware of the precise extent, they had been

long-standing. How was this specific plan, as put out in these eight bullet points, going to resolve or at least start the process of resolving that issue?

A. Well, I suppose it was -- it was to set down some markers for clearing the backlog and, really, to specify clearly and in writing, a timeframe for -- or negotiate with Mr. O'Brien, and this was the basis of a discussion with him, on how he was going to clear the backlog, how were we going to get him to deal with the new to review ratio, the returning of patient notes. I think it just -- that's the plan. That's the basis for what a series of meetings or discussions face-to-face with Mr. O'Brien and Dr. McAllister was going to be and ask him for his proposals on how to clear this backlog. 11:37 11:38 11:38

126 Q. So let's just take Points 2 and 3, for example: To implement a clear plan to clear triage belong. Point 3: Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this. There isn't much of a plan in those bullet point, per se, to address this behaviour from Mr. O'Brien. Was your intention to sit down and collaboratively work --

A. There was to be a two-way collaborative discussion between myself and another person, in this case, Dr. McAllister, and Mr. O'Brien. 11:39 11:39

127 Q. At the top of the email there it says that:

"I propose that I, as CD, and you as, AMD, implement the following action plan."

What support were you imaging Dr. McAllister was going to give you in bringing this plan into action?

A. I was very clear right from the outset of this that this was not to be entirely me to manage this, to implement it. I felt it was important that somebody else more senior in the management team or medical management team was involved in this. And I was very clear about that right from the start, that I didn't feel comfortable. That I was one person being asked to deal with a very long-standing, complex problem which seemed to me to be getting worse over time, not better. It was very easy -- I could see scapegoating issues being -- you know, if this didn't happen then, you know -- I felt that I needed some cover from the more senior medical management team to help me do this. I was happy to do it. I was happy to have those meetings. But that's -- I felt it was important for me to have back-up for that. 11:39 11:40 11:40

128 Q. If we just go up, please, further up the email chain. Thank you very much. This is Dr. McAllister's reply on 21 September. He says that: 11:40

"Apart from the fact you spelt his name wrong, it is absolutely excellent and I agree completely. It would be important to do this in a positive constructive supportive role that Mr. O'Brien be aware of this." 11:40

Did you feel at that time as if you were getting the support of Dr. McAllister to go ahead?

A. Yes, that was very supportive, excellent. Very happy with that.

129 Q. If we keep moving up, please. Mr. Carroll himself has some additions and some comments to make on 22 September. 11:41

So from 21st September, whenever Dr. McAllister comes back and endorses your plan, and you say you were happy with his engagement, what steps did you take to put this plan into action? 11:41

A. There was no -- I don't think there was any steps. I think that was as far as we got in producing the plan. So there was nothing -- we didn't progress it beyond that into an actual face-to-face meeting -- or at least that didn't happen in that timeframe. 11:42

130 Q. I'm sure the Inquiry will be interested to know why. What reason stopped this plan which had been endorsed, which you created, which you say you are wanting by, in from the Associate Medical Director, you said you had that? 11:42

A. As far as I can recall it was just a matter of getting everybody available to meet up to start this process.

131 Q. I'm not trying to be difficult, Mr. Weir. You say you needed to get everyone to meet up to start the process?

A. To have myself, Dr. McAllister, and Mr. O'Brien, I suppose, in the first instance available. 11:42

132 Q. You had Dr. McAllister's blessing and, according to your own plan, which we can see here copied by Mr. Carroll into his email, you were to have the

initial face-to-face meetings with Mr. O'Brien. It was on you to have these meetings with Mr. O'Brien. There doesn't really seem to be a suggestion that the Assistant Medical Director was --

A. No, the first meeting would involve you, me and Mr. O'Brien. That was written to Dr. McAllister. 11:43

133 Q. You're quite right. But having got this plan green lit, are you simply telling the Inquiry it was because you couldn't get yourself and Dr. McAllister in a room with Mr. O'Brien? 11:43

A. Yes. Just having a time to get things, yes.

134 Q. We know, as you said at the start, that Dr. McAllister subsequently left his role as Associate Medical Director. That wasn't until 13th October 2016. Was there really no time that you and Dr. McAllister could meet with Mr. O'Brien before that departure of Dr. McAllister? 11:43

A. You know, there may have been. I just don't recall what circumstances were driving against that. I mean, you know, all of us at the time had busy clinical practices and other commitments as well. I think it was just a matter of finding the time available to get the thing started, and kick started. 11:44

135 Q. This is a matter which has raised concern at pretty high levels in the Trust. You have the Acute Director Mrs. Gishkori interested in this. You have the Medical Director, Dr. Wright looking to take some type of action. Did you not appreciate there was some level of urgency to try and work this out with Mr. O'Brien 11:44

before it spiralled into something much more serious?

A. Yes there was. Yes, I guess there was a sense of urgency or needing something to get started on this. But that, I suppose, regretfully, we didn't get to the point of that first meeting within that, you know, within a few weeks of that email being sent. 11:45

136 Q. I know that you, yourself, had a period of absence from the Trust in November. Mr. O'Brien was off on sick leave from 15th November 2016. Even after McAllister has stepped down from Associate Medical Director, was there no opportunity for you to meet with Mr. O'Brien to action this plan? 11:45

A. Once there was no Associate Medical Director, that was, to me that was -- because all of this was coming from Mrs. Gishkori and Dr. McAllister. It was their view that this was the way to deal with this. It was their asking that something be done in this less formal way. So, once Dr. McAllister was no longer available, I felt that everything was up in the air again. 11:45

137 Q. On the end, perhaps if we could just refer back -- 11:46

A. Sorry, can I also say as well, once you lose Dr. McAllister, then that changes all our roles in an instant, and what we're required to do as well as our clinical work and take on, you know, our managerial roles, that has changed. 11:46

138 Q. If we could get AOB-01053 back up on the screen, please?

You've been very candid today about your reluctance to tackle this without support. Yes, you're correct that Dr. McAllister was off from 13th October, but if we go down to Dr. Wright's email of 15th September, albeit somewhat reluctantly, he does, in effect, endorse the approach which McAllister has been trumpeting, i.e. that you were to sit down with Aidan O'Brien, work out a plan and you had 3 months to do so. You had the Medical Director on your side too. Was that not a sufficient support for you to go in and meet with Mr. O'Brien? 11:47 11:47

A. Yes, but the whole thing was predicated on the chain being -- to Medical Director, Mrs. Gishkori, then Dr. McAllister. Their meetings. Oversight Committee meetings of which I was completely unaware. A desire to run this in this way. The requirement for me to work with somebody else to do this. And suddenly that was taken away from me. You know, so it left me in a difficult position and exposed, again, as to how I was the going to run this investigation single handedly. I know you feel that there may have been a sense of urgency, but we were dealing with something that was going back a long way that was deep and complex and recurrent and persistent, as far as I could see. I felt, again, that I was being left to be the one person to deal with this and sort this out. I don't think I was happy with that. 11:47 11:48 11:48

139 Q. We'll see from Dr. Wright's email on the screen, 15th September, that he says:

"I would need to see what plans are in place to deal with the issues and understand how progress would be tracked."

You produced a plan the next day. The evidence we have got is that the Medical Director's office never received a copy of your plan. Did you take steps to share it with the Medical Director? 11:49

A. No, but I wasn't asked to. I did share it with my Associate Medical Director and the Director of Acute Services. I heard that the Medical Director had a degree of involvement or in terms of an Oversight Committee, so to me it seemed natural to go up the chain of command that I had already been working with. 11:49

140 Q. I suppose, before we leave this period of time which the Inquiry is interested in, I would like to raise an issue concerning Patient 93, who I believe you refer to in your Section 21 response at WIT-19904, paragraph 13, please. I'm aware we're jumping back. 11:49

11:50

"On 31st August Mr. Haynes noted a patient of Mr. O'Brien's was not triaged.
After the square brackets it picks up: "The patient was seen by me for leg pain, possibly due to a circulation issue, but metastatic disease was noted in keeping with metastatic prostatic carcinoma. The triage delay was 3.5 months and apparently this would not have changed the outcome". 11:50

We'll get the emails up here which you refer to, which are TRU-274753. While it's coming to the screen, just so I'm clear, who raised the concern about this case? Was it you speaking to Mr. Haynes or was it Mr. Haynes himself? 11:51

A. The concern about the delayed diagnosis was nothing to do with me. The diagnosis was an incidental, unexpected finding during the course of investigation or circulation problem, namely a CT scan. During the course of that, the results of that CT scan highlighted 11:51 an individual with what was likely metastatic prostatic carcinoma. I immediately referred the patient to Mr. Haynes, who, I think, in turn had detected that there was a delay in the triage from a urological point of view. 11:51

141 Q. Perhaps let's work through this email chain it will help us. 31st August, the very bottom please, from Mr. Haynes, he largely summarises what was in your statement there but at the very end he asks a question, he says: "SAI?" 11:52

If we work up that chain then, Mr. Carroll's involvement on 31st August 2016. Mr. Carroll emails Dr. McAllister. 11:52

"Please can you see the series of emails. Suffice to say that although the outcome for the patient would not be any different this, as you know, is not the issue that needs to be dealt with."

I know you weren't copied into that, but reading it now what do you think the issue is that needed to be dealt with here?

A. That there was a delay of 3.5 months in triage. So irrespective of the outcome, I would say the reading of that is that a delay in triage has the potential for patient harm. 11:52

142 Q. If you just move up, please? Dr. McAllister then, also on 31st August, says: "My thoughts are this should go to Mr. Young first, as Urology Lead, and Mr. Weir second as the CD". 11:53

If we go up again. This is Martina's email of 2nd September to Michael Young.

11:53

"Michael, please see email chain and Charlie's comments below. Can you please discuss with Colin when you are back from annual leave and advise a course of action?"

Do you recall discussing this with Mr. Young? 11:53

A. No.

143 Q. If we just move on, please. Michael Young provides some comments on 8th September. The Inquiry, no doubt, will wish to ask questions of Michael Young with respect to his comments, but if we move up slightly. 11:54 Martina Corrigan emails you on 16th September.

"Hi Colin, I'm not sure if I forwarded this to you already. The initial query here from Mark Haynes was

whether this was an SAI. I don't believe this ever became an SAI, despite it having some similarities with other SAIs declared and to be declared with regards to a failure to triage."

11:54

What involvement did you have after Mrs. Corrigan emails you on 16th September?

A. None after that. I can't recall what Michael Young had said, but he had reviewed -- I do recall there was an email -- emails exchanged indicating that it wouldn't have affected patient outcome. So there was no -- I felt at that point -- I'm not -- I don't want to make things up that I'm not clear about, but there was no further mention or discussion about an SAI or initiating an SAI at that point and just on the basis of a reading of Mr. Young's investigation of this case. 11:54 11:55

144 Q. Was Martina Corrigan forwarding it to you on 16 September for you to make the call about --

A. No. I think it was for information on this case and -- it wasn't -- I don't think the implication was to make a determination on an SAI, yes or no. 11:55

145 Q. Who would have been making the call if this was an SAI?

A. Well, I would have thought that Mr. Young and the team would have -- as being the experts -- would have initiated that, if required. They would have known whether this was, in their view and their expertise, of significant nature to initiate an SAI. 11:56

146 Q. I suppose the last question on this is really that these emails are all between 31 August and 16

September, which is a relatively heavy traffic time in your considerations of issues about Mr. O'Brien. You are producing your plan that very same day. Whenever you were producing your plan, did it ever cross your mind that there were ever patients at least at risk of being harmed by this? 11:56

A. I don't think it quite in my mind fitted with everything. I think once I'd seen what Mr. Young had said, I felt that that was -- as a team, as a group of urologists, there was a delay, but no harm and nothing further at that point needed done. I suppose my focus was on all these other issues. So it didn't -- to me it didn't quite dovetail in with that. Maybe it should have, but I think the other issues were longer standing and there were bigger problems, I guess, in retrospect. 11:57

147 Q. I'm just perhaps now going to move on to a slightly different period of time. You go off sick in November. Do you recall whenever you recover from your convalescence, when you would return to work?

A. I was off for at least six weeks, so we're talking, we're in to mid-December before I was able to -- 11:57

148 Q. Upon your return to the Trust in mid-December, what was your awareness of the state of play of Mr. O'Brien in these issues?

A. There was no -- I suppose just coming back, you are just feeling your way back into things. So not aware of any change in status, or any action, or any new events at that point. 11:58

149 Q. And the situation does develop quite rapidly towards

the end of December. When did you become aware that there was to be further action?

A. I recall on 30 December I was informed that Mr. O'Brien was to be excluded from work, pending an investigation, a formal investigation. 11:58

150 Q. On hearing that Mr. O'Brien had been excluded, how did you react?

A. Well, to be honest, I felt that, you know, there was a process that in retrospect should have been the case long before 30 December. I felt relieved that I was 11:58 not being isolated into dealing with something complex and deep on my own; that there was a proper Trust-based process for investigating and dealing with things further, so a sense of relief.

151 Q. You were Mr. O'Brien's Clinical Director, did you see 11:59 yourself as being his clinical manager for the terms of MHPS Framework and the Trust Guidelines?

A. So I had some reluctance when I was asked --

152 Q. Sorry, are you talking about your role as case investigator? I'm talking about a slightly earlier 11:59 point. On one reading of The Trust Guidelines, as Clinical Director, you are Mr. O'Brien's clinical manager. In theory, they should at least be involved in these calls about exclusion and stuff like that. Were you surprised, as Mr. O'Brien's Clinical Director, 12:00 to suddenly find out that he had been excluded from the Trust?

A. I wasn't surprised. I mean, if I had been asked to inform him, I would have happily have -- been happy to

do that. That wasn't an issue or problem for me. So I don't have -- I didn't have an issue with that.

153 Q. You do then subsequently get appointed as the Case Investigator into this formal process. I am, at the same time you're aware he is going to be excluded, you're aware there's going to be an MHPS investigation? 12:00

A. Yes.

154 Q. When and how was it communicated to you you were going to be the case investigator?

A. So we're into the first -- not even, I think not even second week of January 2017, I was asked to be case investigator by Richard Wright, Medical Director. I was given a timeframe under Maintain High Professional Standards to complete an initial investigation. I was advised I would have assistance from HR, from Siobhán Hynds who would help me with the process, and that my role was to investigate and report back to an oversight committee. 12:00 12:01

155 Q. I believe you indicated earlier on that you may have expressed some reluctance in this discussion with Dr. Wright. Could you elaborate on that? 12:01

A. As far as I can recall I felt resistant to this, to doing this, to be a case investigation. As I said earlier, I had been involved in a completely unrelated and different style of an investigation of a colleague. So that was very -- at the forefront of my mind. I found that very challenging and difficult and here I was being put in this difficult position and feeling reluctance to do that for that same reason. And 12:02

I think I expressed that. But I was then -- I think it was insisted that I do it and also the fact that I had support from HR and that it was merely being the investigator and reporting to an oversight committee. So it kind of made it a little bit easier for me to take on the role but there were -- I had some concerns about it.

156 Q. Whenever you're having this discussion with Dr. Wright, to what level do you pitch these concerns. Is it I shouldn't be the person doing this or I have reluctance? 12:02 12:03

A. I have reluctance doing it because of previous experience and it would probably be better somebody else doing it, as far as I can recall.

157 Q. And on his suggestion that somebody -- on your suggestion that somebody else would be maybe better placed to do this, how did he... 12:03

A. I can't -- I think -- I've seen discussions elsewhere in one of the transcripts, recorded transcripts, where I had a conversation and I'd said to Mr. O'Brien and expressed that I did have discussion with Richard Wright expressing my reluctance to do that, but he was more or less insistent that I did do it. That's the totality of my recollection of any discussion. 12:03

158 Q. You date this conversation as being some time in the second week of January? 12:03

A. Yes.

159 Q. Where you aware of the Oversight Committee meeting on 2nd December?

A. No.

160 Q. In that meeting you were given a series of jobs to do in conjunction with Ronan Carroll about drawing up action plans and stuff. It is at AOB-01280. When did you become aware that you had been asked to prepare various action plans? 12:04

A. I can't recall. Let me just see what the ...

161 Q. Down at the bottom there, please? A written action plan to address this issue, which is triage, of a clear timeline will be submitted to the Oversight Committee on 10th January 2017? 12:04

A. I wouldn't think even by 10th January I was aware of that, of an action plan. I can't recall that.

162 Q. If we look then at WIT-19906, please. In particular we're looking at paragraph 22 at the bottom, please. 12:05

"Martina Corrigan, (Head of Service) and I met the remainder of the urology consultants on 3rd January 2017 to explain Mr. O'Brien's exclusion."

12:05

In what capacity were you at that meeting with the urology consultants?

A. As clinical Director.

163 Q. You're sure at that stage you weren't aware you had been appointed as case investigator? 12:05

A. It's a week here, there, I honestly couldn't. Yeah, but the exclusion was, I think I was made aware on 3rd December about the exclusion, and that's what we were informing the group -- in my role as the Clinical

Director because obviously it would have an impact on the practice of the other consultants in terms of their on-call or triage. But an action plan on the 10th, I don't recall seeing that.

164 Q. You put this conversation with Dr. Wright as being the second week of January. You're aware that having immediately excluded Mr. O'Brien there was a relatively tight period of four weeks in which the Trust had to conduct some type of investigation. If this conversation took place when you say it did, by the time you spoke to Dr. Wright, half that time almost had already elapsed? 12:06 12:06

A. Yes.

165 Q. What was your reaction to that then, that you only had 2 weeks in effect? 12:07

A. I just thought we have to work within this. I thought an initial preliminary meeting could have been arranged within a couple of weeks. I mean I was keen not to allow the process to drift beyond the four-week time frame. At that point I felt, with the support of HR, that we could do this within two 2 weeks and report back. 12:07

166 Q. Your job title in the process is case investigator. I know you meet with Mr. O'Brien on 24th January, but what actual investigation did you do between finding out you had been appointed and meeting with Mr. O'Brien on the 24th? 12:07

A. We had no other investigation, other than the update on the numbers of patients awaiting triage and un-dictated

letters, which we had an update on that. So we were -- basically the two of us were going in for this first meeting with Mr. O'Brien to put this range of issues to him as our -- basically our first investigation and report back to the management committee. So I was taking the lead from, you know, the process and the fact that it was an oversight committee and a clinical manager was making the decisions. They were happy, as I understood it, for me to have a meeting with Mr. O'Brien with Siobhán Hynds and then to report to them, then they made the determination after that. So that's, basically, the only thing that we achieved in that two weeks. 12:08 12:09

167 Q. But for receiving an update of the numbers?

A. Yes. 12:09

168 Q. That was the only real information you had or you had gleaned in this period?

A. Yes.

169 Q. Who was responsible for the providing of those figures?

A. As I recall, Martina Corrigan was probably able to pull the figures for us. Usually it was Martina. But I'm not one hundred percent sure. 12:09

170 Q. Referring to your meeting with Mr. O'Brien then 24 January 24 with Ms. Hynds in attendance, what did you see the purpose of that meeting as? 12:09

A. Well, we were going in, putting the issues to him, and then trying to find how we were going to resolve those issues over time. So the meetings sort of evolved from an investigation of what had been happening to -- and

why it had been happening, in which Mr. O'Brien made representations about his workload, and the nature of his workload, and the intensity of his practice. So we were cognizant of all of those things, recording a background as to why this was happening. 12:10

Then, as the meeting progressed, we discussed potential action plans to come out of that. So it went, really, from an investigatory meeting into a kind of an action plan developing a way forward for Mr. O'Brien in which 12:11 he expressed what he wanted to do and how he might achieve that. Then finally we came up with some stipulations around targets and what he needed to do in order to avoid exclusion or continued exclusion from practice. 12:11

171 Q. In what capacity did you see yourself in that meeting under. Were you case investigator or clinician director?

A. Both. And that's the -- you know, I've said this all along -- that this was a failure or fault in the 12:11 process. That to have a clinical director, to have somebody who is a day-to-day clinician colleague, and be an investigator, and somehow completely separate those roles was, at best, challenging. And it was blurred. It quite quickly in that one and only meeting 12:12 became quite blurred. It did was quite a long meeting and we discuss a lot of issues, but it was blurred and it did drift into management and action plans and how to avoid exclusion.

172 Q. We'll return to the workload pressures perhaps towards the end of today.

Your next involvement is at a case conference where a report offered by yourself was presented. How much input did you have into the preparation of that report? 12:12

A. Siobhán wrote the contemporaneous notes and typed it up, and we reviewed the document. So, I had oversight of that document.

173 Q. If we look at the minute of that meeting, which appear at TRU-00037? 12:13

You're in attendance at the meeting. You're listed in the attendance in your capacity as the case investigator. If we go down to TRU-00038, under the heading of "discussion." You are recorded at this meeting as follows: 12:13

"In terms of advocacy, in his role as Clinical Director Mr. Weir reflected that he felt Mr. O'Brien was a good, precise and caring surgeon." 12:14

"At this meeting" -- so we're now at 26th January, are you clear in what capacity you were to attend this meeting in? 12:14

A. Yes. I was presenting the outcome of our meeting on the 24th and reflected all the discussion and how I felt that Mr. O'Brien could work, return with a lifting of his restrictions or exclusion from

practice, and how that could be achieved with targets around triage and charts and completion of dictation in a timely fashion, and clearing the backlog.
So there was overlap. It was an investigation in a very limited fashion with one person, without any time for triangulation or more in-depth investigations but, as I say, it drifted into how to manage, negotiation, trying to find a way through that would keep Mr. O'Brien productive and safe in terms of his practice and for his patients. So, there's a subjective element to that, yes, but that's where that, sort of, comes from. 12:15 12:15

174 Q. Whenever it records you as advocating for Mr. O'Brien, were you challenged? Were your views teased out as to -- 12:16

A. Well, my own, yeah. I felt I'm saying these things to a committee that makes the final determination. So I suppose, yes, I can say things that might swing their decision-making, and they are reliant entirely on our report and what we say so them. Yes, I think that perhaps there's a fault in that in a sense, because there hadn't been enough time to do a fuller investigation. I wasn't challenged on that, I don't think. I think there was a bit of discussion around that but I think -- I was given assurances by Mr. O'Brien and the committee assurances about how he could return to work and manage his practice better and clear his backlog. I thought that that was achievable and that's what I was expressing. 12:16 12:16

175 Q. As an attendee at the meeting, the decision is ultimately Mr. O'Brien is to return to work. There is to continue to be a formal MHPS investigation. Who did you perceive as being the decision maker at that meeting? 12:17

A. The case manager and Dr. Wright, I think would have been -- it was Dr. Khan, the case manager, was making the final decision. That was my understanding and that was how the process should have worked. Because I think he did write, he did the communication and the writing, so it was his final determination. 12:17

176 Q. Dr. Khan and Dr. Wright both record in their Section 21 responses you offered an assurance regarding Mr. O'Brien's clinical practice. If we look at D Mr. Khan first. It is at WIT-31985, please. 12:18

Paragraph 12.2:

"Mr. Weir (CD and then case manager) reflected there had been no concerns identified in relation to the clinical practice of Mr. O'Brien." 12:18

Then Dr. Wright at WIT-17885, paragraph 57.2, the very first sentence:

"I was reassured by Mr. Weir's assessment that the issues raised were largely administrative and no Patient Safety issues had arisen." 12:18

Do you recall offering an assurance to both the Medical

Director and the Case Manager that there were no clinical issues?

A. I would not have used those words and I don't reflect -- we were presenting a discussion. I don't think I said no Patient Safety issues had arisen. That's not -- it wouldn't have made sense to say that in any case. 12:19

177 Q. In fairness to you, if we can just refer to WIT-19951, please, paragraph 127. In the middle of that paragraph? 12:19

"The meeting agreed there was a 'case to answer' and a formal investigation was required. I noted at the meeting that I had no concerns identified in relation to Mr. O'Brien's clinician practice...". 12:19

Is that not the precise assurance?

A. An aspect of operating skilled decisionmaking, I mean I think that's, you know, in those terms, and I felt that if we could get him to clear the backlog, then we would be back to having a productive and safe surgeon at the end of the day which is, in my view, would have been a better outcome. 12:20

178 Q. Do you consider there's any way that Dr. Khan and Dr. Wright could have taken that to mean that there were no Patient Safety concerns here? 12:20

A. Well, it's very -- it's -- "no Patient Safety concerns ." It's inherent in the fact there's un-triaged referrals. If you look at the broad picture, you can't

say 'no Patient Safety concerns'. So I can't account for that statement at all. I would stand by aspects of his practice that I felt were safe, but no more than that.

179 Q. Had you, at any time, in the preceding two weeks, let's say from your point of view as case investigator, looked in any depth at Mr. O'Brien's practice? 12:21

A. No.

180 Q. Did you think that was part of your job to go away and look at Mr. O'Brien's practice? 12:21

A. As case investigator? Yes. But I think that, you know, I suppose in the first instance my priority was to get this first meeting with Mr. O'Brien out of the way and done as the time was running out. To be honest, I wasn't aware or knew what the Oversight Committee was going to do in the long run. Were they going to want a fuller investigation and more triangulation of evidence? You know, so we just had a kind of -- that one meeting to try and make as much progress as we could. 12:21 12:22

181 Q. Would you, as a Consultant General Surgeon, have felt qualified to offer any type of assurance about Mr. O'Brien's clinical practice?

A. Well, I have worked alongside Mr. O'Brien on occasions. I referred patients to him. He has referred patients to me. He has helped me out in theatre, I helped him out in theatre. I've seen letters of his. So, you know, we can't -- I don't want to say that I don't have an awareness of his practice and how he operates and 12:22

works and, as I say, his operating skills, decisionmaking, his letters are detailed and precise, you know, when he was dictating letters. So I can see, in the round, aspects of his practice that were more than acceptable. 12:23

182 Q. Following on from that meeting then 26 January 2017, what further involvement did you have with Mr. O'Brien as his case investigator under the MHPS --

A. None.

183 Q. When were you informed that you were to be removed as case investigator? 12:23

A. I don't have the -- it was certainly before, I know, 16 April, because Dr. Chada interviewed me. So I would have thought around the middle of March, some weeks afterwards, March 2017. 12:23

184 Q. Can you recall who communicated that decision to you?

A. Dr. Wright.

185 Q. Was it out of the blue almost so far as you were concerned?

A. Yes, almost out of the blue. I was at a meeting, a sort of a management teaching meeting and it was Trusts or DLS solicitor, I was talking to -- who intimated that there was some discussions around the legality or appropriateness of the case of a Clinical Director being a Case Investigator, whether there was a conflict of interest. So it was kind of a casual discussion. At that point I thought, oh, there's something -- maybe there's something going to happen here with respect to that. So that's the only other 12:24 12:24

previous awareness I had of that.

186 Q. How did you react whenever Dr. Wright told you that you were to be removed as Case Investigator?

A. I was relieved.

187 Q. And where does that relief come from? 12:24

A. Not because of the complexity of the investigation that was likely to come, but because I was Clinical, I decided -- the three components, Clinical Director, person that you work with, have worked with, know, meet in the canteen, in the operating theatre, and then Case 12:25 Investigator. So putting that off to one side made life a lot less complex.

188 Q. You've reflected in your statement that it was very challenging being both Clinical Director and Case Investigator at the time. Did you feel you could have 12:25 performed both roles?

A. I think -- no, I don't think it's a good idea. I think there's too much of a conflict. It's easy to drift into negotiation and trying to get somebody to change their practice, rather than standing back being 12:25 objective, forensic, in terms of your investigation. When you work in clinical practice to a degree with somebody, I found that very difficult. I would say don't do it.

189 Q. Having lost your case investigator hat, you continued 12:26 to be Mr. O'Brien's Clinical Director. To what extent did you remain involved or aware of the investigation over the next, it must be 18 months?

A. Obviously I had an interview as part of that process.

I wasn't, I mean, and that's it, I wasn't aware of what other investigations or interviews or, indeed, how long the process was taking. I wasn't aware of that at all.

190 Q. Do you think, as Mr. O'Brien's Clinical Director should you have been informed of the progress of the investigation? 12:27

A. Yes.

191 Q. With regards to your role as Clinical Director, should you have asked at any stage for an update as to what was happening with Mr. O'Brien? At the end of the day you are part of his management team. Should you have chased that information? 12:27

A. No, to me that's the wrong way round. I mean the Trust's original 2010 guidelines for Maintaining High Professional, their implementation of it states the case investigator should be the Clinical Director but, to me, in retrospect, that's wrong. If the Oversight Committee is taking control of that, surely it's their role to let us know what's happening. I mean if there was a change or an implementation or change or a change in practice that needed implemented, obviously I would expect to have been told that or that to be communicated to me. 12:27 12:28

192 Q. While the investigation is rumbling on, did you have any specific role with regard to the monitoring of Mr. O'Brien's practice? 12:28

A. I didn't do the monitoring but I was updated really very regularly by Martina Corrigan, certainly in the first instance, especially in that initial period where

the backlog was cleared and we were continuing to monitor his compliance with that. For instance, the dictation of letters in a timely fashion, the completion of triage; all that in that initial period was monitored by the operational team and I was kept regularly up-to-date with that, and that seemed satisfactory. 12:29

193 Q. Have a look at TRU-258877, please? You had become aware of issues with the monitoring plan in July 7; is that correct? This is correspondence from Martina Corrigan: 12:29

"Aidan, as per your Return to Work Plan", it outlines the responsibilities as to triage. You are copied into that? 12:30

A. Yes.

194 Q. Scroll down. 30 paper outpatient referrals are outstanding at that stage. If we also look at TRU-268995, please? It is the same day, 11th July, again an email from Martina, and you copied in. 12:30

"Aidan, as per your Return to Work Plan, notes should never be stored off site and should only be tracked out and in your office for the shortest time possible. Having checked on PAS today there are 90 charts as e-mailed previously on 21st June, therefore Colin has asked that I arrange for you to meet with him, Ronan and myself on your return from annual leave next week and we can discuss when this best suits you on Monday." 12:30

How concerned were you about these breaches or the potential breaches of the Return to Work Plan?

A. It really should have been a zero tolerance approach to this. So this shouldn't have been happening given the fact that the Return to Work Plan was very clear that there were to be no such charts stored in the office and outcomes dictated and triages completed. So that was a concern.

195 Q. You do subsequently meet with Mr. O'Brien, Mrs. Corrigan and Mr. Carroll on 25 July, do you recall that meeting? 12:31

A. Yes.

196 Q. Who would have been taking the lead in that meeting, who would have been in charge from your side?

A. Gosh, I would have thought the Lead -- well, more likely me. Well, I think jointly probably between myself and Mr. Carroll would probably be the honest answer to that. 12:31

197 Q. At that meeting there was a discussion about charts, primarily about charts. No note of the meeting was ever prepared or kept by yourself or Mr. Corrigan or Mrs. Corrigan, why would that be? 12:32

A. I don't know. An oversight. In retrospect, it would have been a better thing to record that one, that minute meeting. 12:32

198 Q. You could suggest that having to meet with Mr. O'Brien about potential breaches of the action plan is a pretty serious step? As far as you're concerned, was the Case Manager or the Medical Director ever informed that

Mr. O'Brien was met with about this?

A. Honestly, I don't know. I don't know that they were informed of that. At least they may have been, but I wasn't aware of that.

199 Q. As far as you're concerned, who would have been responsible for passing that information up to the Case Manager? 12:33

A. I don't know, actually. Because the monitoring was done by different people. So I'm not sure. I'm not quite sure who would have been responsible for that. 12:33

200 Q. At or around this time then you become aware of another potential concern: If we look at AOB-01654. I'm aware this is jumping back slightly in time to 18 July. If you go down a bit, please, to the email from Mr. Weir: 12:34

"Pamela, are you aware if any other patients were similarly 'booked" over the weekend? The carry over affects for capacity, urgent cases and emergency theatre utilisation. I hope this isn't true as it would be a gross misuse of theatre emergency time." 12:34

Just go back over the page, down to where the initial concern was, down to Pamela Johnson's email. There seems to be a concern about an elective admission affecting an emergency slot. What exactly was the concern here and what were the implications if it was found to be -- 12:34

A. The concern was that, I think, the theatre manager looked at the weekend's emergency operating, which is

a list that's available to all -- to General Surgeons, Urology, Gynaecology, sometimes Trauma and Orthopaedics. So everybody feeds into that list all weekend. There's a lot of pressure on the spaces on that list. Patients are booked in terms of priority, clinical priority, and then, sort of, the order in which they are added to the list. That list runs all weekend, day and into the evening. 12:35

The concern is that there were so many urology cases booked on the list that it seemed like an unusual cluster of activity, and the implication is that these weren't emergency or urgent cases. That was the implication. It was sent to me to look into that further to see if that was the case. 12:35

201 Q. If we just have a look at some more relevant emails. This is at TRU-281641. By 28th July you report back to Corrigan, Mr. Carroll and Pamela Johnson saying: "I wouldn't take this further." Mr. Carroll simply: "Why?" 12:36

A. Yes.

202 Q. You respond to Mr. Carroll. "Too many look genuine cases of stone disease and urgent admissions."

What work did you do between becoming aware of this concern on the 18th and your conclusion on 28th July this is not to be taken any further? 12:36

A. So we looked at, or I looked at the nature of the cases and the reasons that they were booked into theatre, the

pathology and the procedures undertaken, and, in my opinion, they looked to me in the main like true urological urgent cases deserving of a place on the weekend operating, emergency operating list, apart from one case. 12:37

203 Q. You say this was your opinion. As a Consultant General Surgeon did you feel qualified to opine on whether or not this was the appropriate clinical priority?

A. It's a fair question but I would say that having myself feeding patients into that list and having sat in theatre half the weekend waiting to get a case done and at night, you know when the urologists come and speak to you and present a case that they say has got sepsis or a stone blocking ureter with impaired renal function, all of those things, I felt I had enough knowledge to say that those were urgent cases, that they were adequate or there was enough to justify them being done at the weekend rather than being delayed to after the weekend. 12:37 12:38

204 Q. If we just scroll up, please. The response you mentioned. You email Mr. Carroll. 12:38

"Can only see the first one being a bit iffy but another (locum) consultant asked for it to be done."

12:38

I'm not trying to be pejorative at all here, but how iffy does something have to be before it needs properly looked into. You are not saying this is clean cut?

A. Of all the cases being booked, the implication was

Mr. O'Brien had booked all these cases, and therefore there's something wrong. When I looked at it, I couldn't see that. Those cases, in my opinion, were quite appropriate to be put on that list, apart from one, that was put on by another consultant for apparent social reasons. That's a different matter, and the decision making of that consultant could have been looked at, but that's not what I was being asked.

205 Q. If we scroll up a little bit more? Is it fair to say that Mr. Carroll, from his response on 28th July, isn't quite so keen to let this drop. He is saying: 12:39 12:39

"I would say we, as AD AMDs CDs, need to enforce the agreed rules otherwise chaos rules. This was an elective patient operated on in an emergency theatre. We need to take a stance on this and Charlie endeavoured to do this." 12:39

Was there any further action on this?

A. No. 12:39

206 Q. Did you ever have any cause to look back on other weekend that Mr. O'Brien had been on?

A. No. I wouldn't have thought there was a need to do that. I think that's ...

207 Q. Just so we're clear, why did you think there was no need to do that? 12:40

A. Because on face value of the investigation I did do, and having worked -- there's kind of a self-policing aspect of this. If people are routinely putting

inappropriate cases on at the weekend or at night, the anaesthetists will figure this out, the other surgeons will figure this out, and complaints will be made. If it is systemic and it is one person that will very quickly come up. You know, people will make that very clear. A misappropriation and utilisation of an urgent theatre, you can't carry on doing that. I can't see any reason to have investigated further if none of those issues had arisen before. 12:40

208 Q. Based on your opinion, having looked at this as well as your knowledge of Mr. O'Brien and how the theatres operate at these times, it is your opinion that this didn't meet the threshold requiring any further investigation? 12:41

A. I thought it was a cluster, a statistical cluster up the system. 12:41

209 Q. You didn't feel this needed escalation up the system?

A. It was already escalated to the Assistant Director, and I investigated it. I don't know what else we would have done at the time. 12:41

210 Q. If I take you to TRU-258912: Is it fair to say to after July 17th you're not aware with any other issues with the action plan until October '18, is that fair?

A. With the action plan, no.

211 Q. No, and if we look here at this email on the screen, this is October 2018, so by this stage the MHPS process is concluded. There has been a Case Manager's determination which has a number of actions to be taken forward. I believe at this time Mrs. Corrigan is off 12:41

from The Trust. There appears to have been some type of issue with the monitoring and this comes across your desk, and you email Dr. Kahn, and Mr. Gibson, Mr. Carroll, Ms. Clayton and Mr. Haynes. You say:

12:42

"Ahmed, Simon, please for your urgent consideration/action. See email correspondence below. Please see attached Excel spreadsheet. Mr. O'Brien has accumulated a large backlog of dictated letters and a large number of charts in his office. I am his 12:42
Clinical Director and I HAVE NOT seen the review and results and recommendations into his practice, but I am assuming he is in breach of this given these findings. Can you instruct me on how you would like me to proceed. We can certainly meet with Ronan to discuss 12:43
recorded outcomes from the meeting."

Are you expressing some degree of frustration here that you haven't been made aware of the outcome of that MHPS process? 12:43

A. Yes. Yes.

212 Q. When do you consider you should have been made aware of that outcome?

A. As the process evolved, any determinations, we should have been made aware of those as they happened. 12:43

213 Q. Do you consider that without that knowledge of the precise outcomes, did that hamstring your ability to engage with Mr. O'Brien, or to try and tackle issues as they came?

A. No, I think if this suddenly appeared then, obviously, there was an immediate concern and it's clear that I would have been very happy as a Clinical Director to engage with Mr. O'Brien and say, look, you're in breach of this action plan. I didn't see a difficulty with that. In fact, I'm saying, what do you want me to do? I'll be happy to do it.

214 Q. From the line which reads:

"I have not seen the review and results and recommendations into his practice." 12:44

You're clearly aware by the time you send this email that that process has, in fact, concluded?

A. Well, I'm assuming. I actually don't know that it is concluded, to be honest with you. I didn't have a final report or that. So I was assuming that it had concluded. 12:44

215 Q. I'll ask you the same question I asked earlier, and I'm expecting the same response: Could you not have chased the Case Manager to find out what was happening with the investigation? 12:44

A. Could the Case Manager not have chased me? And that's -- yeah.

216 Q. Now, there's perhaps one final substantive MHPS-type issue I want to talk to you about today, and that's at TRU-251964. This is an email from -- if you go right down to the bottom, please. This is an email from Mr. Carroll to Siobhán Hynds to which you are copied 12:44

in:

"Siobhán, Mr. Young has advised me this morning that he received calls from members of Mr. O'Brien's family. Both these 'phone calls centred on the Mr. O'Brien investigation. Give me a ring if you require anything further."

We go up then to you -- you respond to that email on 15 November 2018 and disclose that you had an encounter with Mr. O'Brien on Thursday, 8 November. You say the conversation centred around his investigation. Slightly further down:

"He did ask me about the evidence I had given. The investigation related to a meeting with Dr. McAllister."

You say: "I now feel he should not have made this approach. His questioning and my response is undermining the investigation action plan. He put me in a difficult and awkward position."

The last point you say: "I cannot meet to discuss anything with Mr. O'Brien, anything other the day-to-day activities in his work as a urologist."

What was your level of concern and frustration when you sent that email?

A. I got a flavour that the conversation was being steered in a certain way to get me to say certain things, in retrospect, and that -- and I couldn't quite figure out why that was going on, why he was coming back to, you know, the issues regarding Dr. McAllister. 12:46

And I knew that that was inappropriate, it felt that was inappropriate. If he wanted to have those conversations, then there was perhaps a better route or process for doing that. And also, because the formal 12:46 Maintaining High Professional Standards Process had superseded everything, I felt that this was an inappropriate approach to make.

217 Q. You say you felt this was "inappropriate". It does take you a week to flag this. It is only in response, 12:47 this meeting took place on 8 November, you a flag it on the 15th in response to Ronan's earlier email. Why did you not flag it up the chain of management at the time?

A. I've had a clinic, an operating list, busy on Friday, weekend, Monday all-day operating, Tuesday in Armagh 12:47 doing a clinic, you know. It's not -- it's not my only job. We have so many other things going on. The fact is it's there, it's done within a week. I think that's -- I think it was the important. And what I was clearly doing was putting something in writing because 12:47 I felt that there was a potential -- I had a concern that this was some sort of strange fact-finding, digging into things, and I wasn't -- I just couldn't get the flavour of it. I felt a bit exposed. I was

protecting myself by sharing it with these people.

218 Q. Your final sentence there:

"Can we please be protected from this, as I suspect evidence is being gathered from us and make the Medical Director is aware." 12:48

Now, before your attendance before this Inquiry Panel today, you're aware that Mr. O'Brien was in fact recording that conversation? 12:48

A. Yes, I've seen those transcripts.

219 Q. And had, in fact, recorded a number of interactions with yourself.

A. Six.

220 Q. Just, perhaps, on reflection, how do you feel as a professional colleague of Mr. O'Brien? 12:48

A. It's totally -- well, like, breaking bad news it's like anger and denial. The immediate response is sheer anger about a breach of trust and then can't quite believe that somebody has done this. I never heard of such a thing. Then I thought -- then obviously it made me think that any conversation I had around any issues, that conversation was obviously or potentially being steered for the purposes of this recording. So it just sort of questioned then in retrospect the engagement and honesty and support that I tried to provide to Mr. O'Brien. 12:49 12:49

221 Q. Finally, you ask to be protected by The Trust. Dr. Khan subsequently wrote to Mr. O'Brien. Was there

any further instances?

A. No.

222 Q. I am very aware that time is perhaps not on our side here, but I wonder if we could have a very quick discussion about Job Plan? 12:50

A. Can I just, sorry, can I please?

223 Q. Sorry, you have something to add there?

A. At that time I was undergoing some really pretty brutal treatment. It was right in the middle of that period of time. So that's another reason that might explain things. 12:50

224 Q. Thank you, Mr. Weir, and sorry if I cut across you in my desire to move forward.

I do want to do this issue justice, but I just want to have a quick discussion about job planning, if that's okay. If we look at WIT-19936, which is your Section 21 response, paragraph 102. You accept that you were responsible for job planning the Consultant Neurologists? 12:50

A. Yes.

225 Q. With regards to the other consultants, Haynes, Young, Glackin, Donoghue, did you ever have any significant issues with their job plans?

A. No. 12:51

226 Q. Here at paragraph 102 you say

"In one case (Mr. O'Brien) this was complex and repetitive and required many hours work by me to

achieve an agreed job plan."

What made Mr. O'Brien's job planning complex, whereas the others appear to be relatively straightforward?

A. So Mr. O'Brien wanted to -- so one of the issues with job planning is that when you have a week of emergencies, urologist of the week, or surgeon of the week, whatever, all your other elective work stops and you totally are committed to that week of emergency and urgent care. 12:51

So there's a cycle; like typically a 1-week-in-6 cycle, that has to be job planned. But then the complexities became around Mr. O'Brien wanting to work in the Southwest Acute Hospital in Enniskillen where he did a clinic on alternative weeks. So then we went from a 6-week cycle to a 12-week cycle. Added to that, he was Chair of a Cancer MDT and felt he needed additional time to prepare for that in the style that he wanted to. 12:52

So I was having to factor out a complicated pattern of alternating weeks, between rosters of the week and outlying clinics, and then other activities. Some of those were calculated to be done week-to-week, but some of them, what we do, is we analyse them to say you deliver so many activities of over a year and that has to appear in the job plan. It's an exceedingly complicated process when you get into sort of details 12:52

and nitty-gritty like this.

227 Q. Would you look at WIT-1994, please, paragraph 113, sorry 116. In the preceding paragraphs in fairness to you, you outline various attempts to meet with Mr. O'Brien, October '16, the process drifts into August '17 and then it is into April '18, but the key point here I suppose is: 12:53

"By the commencement of my sick leave in mid-October 2018 through to December 2018, the job plan was not finalised, resolved, or signed-off in this Zircadian system." 12:53

So you are not able to get an agreed job plan?

A. No. 12:54

228 Q. At any stage during that two-year period did you put a flag up to someone on the system, the Assistant Director, the Medical Director, to say: Despite my efforts, I can't get this agreed? Did you ever raise and say, I need help to sort this out? 12:54

A. No, I did discuss it with Martina, Ms. Corrigan was fully aware, and I did discuss it with Martina. She knows how difficult it was, even to get the meetings and engagement to work through this process, and I honestly gave as much time, and it was a considerable amount of time to try and get this resolved and I thought I could. I got better and more experienced in using this zircadian system. It's complicated. Thankfully they've just replaced it this month with 12:54

a new system. You needed to have the engagement, but I felt I could do it and I felt at that point I was an experienced job planner. In any case, any job plan has to be signed-off by two other people. So once I sign it off, the consultant signs it off, it goes to the Assistant Director, it goes to the Assistant Medical Director. So there's a lot of input into it once you get to an agreed job plan position. 12:55

But, yes, you're right, I mean maybe somebody else could have done it or done it better than me. But I don't know who because I know that everybody struggles with the system. 12:55

229 Q. I suppose with Mr. O'Brien's case, it's not just a difficult job planning exercise, but there's this MHPS investigation where a lot of the issues appear to be administratively based? 12:55

A. Yeah.

230 Q. And at various times during your tenure as Clinical Director, there are statements that a key part of this process is a job planning exercise. So I'll give you an example of the case conference on 26 January 2017, which you were in attendance. The actions record: 12:56

"It was noted that Mr. O'Brien had identified workload pressures as one of the reasons he had not completed all administrative duties. There was considerations about whether there was a process for him highlighting an unstainable workload, it was agreed an urgent review 12:56

of Mr. O'Brien's job plan was required."

And the action to that is to you. Similarly, the Return to Work Plan in the second paragraph says:

12:56

"An urgent Job Plan Review will be undertaken to consider any workload pressures to ensure appropriate supports can be in place."

Finally, I am sorry for just reading these out to you, so this is the determination you don't actually see: 12:56

"The action plan must address any issues with regards to patient related admin duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time and enhanced appraisal programme." 12:57

Now, I accept that after February you were a step removed from that MHPS process, but were you coming under pressure from above, from, say, the Case Manager, from those involved in the MHPS investigation to make sure this process was completed and completed promptly? 12:57

A. No. But myself and Martina, we did know there was still no proper sign-off job, it was my role to ensure that everybody had an up-to-date job plan every year. We were supposed to have an updated job plan every year. So it was very easy for me to see there's a red flag on the system saying there's still not a completed job 12:57

plan. So the system will flag that up, in a sense.

231 Q. In the context you just described, do you accept that agreeing a new job plan would have potentially assisted Mr. O'Brien in working through some of these issues, it could have provided him with support he may or may not have needed? 12:58

A. I met and discussed this many times, including on one occasion unsolicited 'phone calls on a Sunday afternoon when I wasn't working from Mr. O'Brien regarding, I think, job plans. It was complex and the complexity was trying to squeeze everything in to his job plan. There were certain things he wanted to do and there was things that I wanted him to do to get the balance right. And even agreeing quite reasonable numbers of patients to be seen at clinics, quite manageable numbers, so that it would help with his administration. So it was all -- it was kind of job planning but management of the person via job planning at the same time. So it was actually quite a useful tool and a powerful way of doing that. 12:58 12:59 12:59

So, you know, I was aware that maybe Mr. O'Brien didn't see as many patients in the clinic as other people, or me, for example, but that's fine, we just work at different speeds and work in different ways. So I was factoring all those things in and trying to be an honest broker in that sense. But I was trying to complete the process through engagement, which I just -- it was difficult to get the full engagement 12:59

we needed to get this over the line.

232 Q. One final issue from me at this stage is WIT-19906, please. We're looking at paragraph 17. There was an email exchange with Mr. O'Brien between 5th and 18th October to try and meet him to try and undertake a job plan review. So we're back in 2016. 13:00

You had no hesitation meeting with Mr. O'Brien about a job plan in October 2016, but you obviously had hesitation about meeting him with those other issues. If you could meet him to discuss a job plan, why could you not meet him to discuss your action plan you were proposing? 13:00

A. As I said, the action plan was kind of -- I felt exposed, vulnerable, that I was the only person doing this, that I needed back-up. I needed other people involved in that process and I didn't feel that had yet happened or -- you know, to me, it was a much longer term problem that we were trying to resolve. Whereas, not having done it before at that stage, to me it looked like, I've done loads of job planning before, it was pretty straightforward for most people. 13:00 13:01

233 Q. Thank you, Mr. Weir.

MR. BEECH **BL**: Madam Chair, I've taken us quite close to 1 o'clock. I have no further questions. 13:01

CHAIR: I think we have a few questions, if you don't mind staying on, Mr. Weir.

A. Of course.

MR. WEIR WAS QUESTIONED BY THE INQUIRY AS FOLLOWS:

234 Q. CHAIR: Did you, as Clinical Director, find it difficult to deal with other members of staff or was this unique to Mr. O'Brien in terms of how you felt vulnerable with dealing with issues? 13:01

A. No, I didn't during that time frame did not feel it was a difficulty with other members of staff. Yes, there were challenges and difficult interactions, and the odd argument and stuff, but not to that depth and extent. 13:02

235 Q. Why, in particular was this difficult for you? Was it because of a personal relationship that you had with Mr. O'Brien or you felt you had, that you had a friendship there that made it difficult for you to manage him? 13:02

A. It was, yes, a friendship, familiarity, a day-to-day dealing, someone you've had many conversations, you know, in many other areas of your life, nothing to do with surgery. That to me is fundamentally a flaw in the process. 13:02

236 Q. Then in terms of, if I can widen that out to more generally the whole medical culture in Northern Ireland, we have heard -- and it will be repeated, I'm sure, that most people train in the same medical school or certainly a generation of people did, and their relationships would be very close. I mean, I'm sure most of the people in this room would say it is equally applicable to the legal profession. 13:02

A. Yes.

237 Q. Is there then a possibility of looking at having external people dealing with MHPS procedures? Would that be a good idea?

A. It would be a -- if you were asking me what one thing would you want to change in the system, it would be that one thing when it's a complex -- I mean there might be times when it's, you know, when it's better not to do that. It's degrees of difficulty. When it is complex and sustained over a period of time and despite previous efforts over many -- you know, a long period of time, and it's quite systemic, then, yes, external -- to me external review or external process has to be the most objective way to deal with this and to deal with it as quickly as possible. 13:03 13:03

238 Q. It is clear that you felt, you know, because of your relationship with Mr. O'Brien you felt a certain degree of loyalty to him and you wanted him to get back to work because you knew that's what he wanted and, as you rightly said, you advocated for him at that committee. Do you feel that -- I think I got the message from you loud and clear that you were the wrong person to discipline him, if you like? 13:04 13:04

A. Yes.

239 Q. I mean that really comes back to all of the difficulty that you had dealing with -- I'm personalising this to Mr. O'Brien because he is obviously the person who brought us to this point, as it were. I suppose it's true of any personal relationship that you have, close personal relationship or relationship that you have 13:04

with a colleague, it makes it difficult to manage that person and to isolate what you know, for example, about their good clinical skills, from what the difficulties might be and how to address them. Would that be fair?

A. I think that's the flavour of my bit of the Maintaining High Professional Standards. I thought yes, knowing that person and how they work and, as I said, their capabilities as a surgeon and a clinics, I've seen those things first hand, and indirectly through correspondence, and patient feedback, so and so is a great surgeon and they have every confidence in him or her. All of that over years, and this isn't just managing somebody, this is somebody I have known since 1996. When you think about it, that is a bigger factor of knowing somebody over such a long period of your working life might have an influence as well. 13:05 13:05 13:06

240 Q. As you have said, the external input you feel would be a good approximate to the MHPS process?

A. I would say it would make it robust and strengthen it, yes. It would be my ultimate recommendation to the Inquiry from my point of view having been -- and I suppose it's weird and unique that I have had these dual roles, so that makes me, in a sense, somebody who could say that, who has had that experience, and it wasn't great, it wasn't ideal, and I didn't enjoy it at all. I was very relieved to be removed from the process. I was very relieved to come out of urology as Clinical Director. Maybe that shouldn't be the case. 13:06 13:06

241 Q. Just one other thing, a more specific question, really,

about the SAI issue. When you were being asked by Mr. Haynes, is this query an SAI issue. Surely that was the your call to determine?

A. I thought on Mr. Young's review of that, that there wasn't but, I suppose, it's not being clear to who makes determinations, who refers patients for SAIs, the IR1 process as well. I suppose that's a process where anybody can flag up, and that's a kind of strength of that process. So, yeah, I suppose I would accept what you are saying. I'm not arguing with you over that. 13:07 13:08

242 Q. I wonder with hindsight now that was flagged up. We know in this particular instance of Patient 93, that there was no actual harm caused by the failure to triage, but you were aware that failure to triage was, first and foremost, a patient safety issue. 13:08

A. Yes.

243 Q. I wonder, with the benefit of hindsight, might you have taken a different viewpoint.

A. Yes. Definitely.

CHAIR: My colleagues will have some questions for you. 13:08 Dr. Swart?

DR. SWART: Thank you for your candid evidence today.

A. Thank you.

244 Q. I think there's a lot of things that have come through, some of which we have heard also from other people. 13:08 I don't know any Clinical Director over any period of time that doesn't find it difficult to deal with problems with colleagues, and I think you have brought that to life very well. My question to you is around

the guidance and support from the Trust in this area. You start off as a Clinical Director, fairly quickly an issue lands on your desk which you realise has the potential to be extremely problematic. Were you, as Clinical Director, involved in regular meetings with other Clinical Directors, Associate Medical Directors, the Medical Director leading it, for example, to talk to you generally, on a regular basis, about different ways of handling concerns? I'm not talking about going straight to MHPS now. 13:09

A. Yes.

245 Q. Much more in terms of normal medical management, the use of NCAS as support, trying to understand doctors in difficulty. Did those things happen? Did anybody say to you, somebody needs to sit down with the doctor involved and find out how they feel and think about this and look at what's driving it? Was that the atmosphere you worked in? 13:09

A. I think when Dr. McAllister did undertake his role he did have -- and I had not seen this before -- but a regular meeting of two Clinical Directors and himself, that was, to me, a strength, that was a good way of doing it, it did offer guidance. It did offer somebody from the top down telling you what to do but also an opportunity to discuss, for instance, with Mark, when he was Clinical Director, we would talk around issues using, for instance, Zircadian and job planning, using regular issues. So a regular forum like that was a great thing to do. Very occasionally 13:10 13:10

a Head of Service could be brought in. I think that's -- you know, if it was me, I think that's a great model. I think that's what I would want to emulate that, but I would, maybe periodically, have maybe a meeting of a wider team and a better channel to channel the information. But that two-way flow I think was a good way of doing it.

246 Q. But it wasn't wider across the Trust?

A. I couldn't see that being replicated anywhere else. I know in my own role managing trainees we had a regular monthly meeting with -- we had all the trainees come and meet us. It was all about, again, a two-way flow of information and traffic. So I quite like that model. I think I would sort of say definitely go with that. 13:11

247 Q. A similar vein; there have been quite a few references to assurances around the clinical paragraph of Aidan O'Brien, but this could be about the assurance of clinical practice of anybody. What direction did you have from the Medical Director, for example, as to how, as a Clinical Director, you should be developing ways of assuring the quality of your service so that it was safe patient experience? Were you given strategic direction on that? 13:12

A. No. The job plan, which is just too much -- there's far too much in the job plan for Clinical Director. That is not a template, really, for working as a Clinical Director. I mean the Trust at that time, and I'm sure continues to send consultants with 13:12

potential management role and interest on, you know, medical management courses, but I think within the Trust there needs to be some sort of induction programme into your role. We get inducted into everything else, so why can't we be inducted at local Trust level as to what's needed of you, who do you report to directly, what's the chain of command. I guess we're supposed to know these things, yes, but just somebody to say, right, here, this and this and this, and then here's somebody else to tell you what the current live issues are and what you need to do. 13:13

248 Q. The public will want to know now how are we assured that urology services, because we are here now, but any services are safe? As a Clinical Director did you regard it as in your job description to try and develop a way of doing that? 13:13

A. Yes, but there wasn't enough. I guess because there were so many other issues going on there wasn't enough time to dedicate yourself to that role. It is probably a role, if you are going to be strategically thinking, doing good governance, then you need a lot more time to it. You need a day a week perhaps to do it. 13:14

249 Q. Looking back on it now, you can, I'm sure, see these things even more clearly in the context of this, but one thing that stands out as well is a reluctance to sit down with the individual concerned, and meet and talk and understand. Do you think, with hindsight, there should have been someone undertaking that role, and who should that have been? 13:14

A. To undertake the role to?
250 Q. Sitting down with Aidan O'Brien to say what's going on here and how is this going for you during this whole procedure. It's a long time, and it's not all in your remit, I'm just asking your opinion. 13:15
A. It could have been me, it could have been the Lead Consultant, it could have been the Associate Medical Director, it could be the Director of Acute Services and that's the problem. It just moves in all these different directions, and whose actually doing this. 13:15
Then when it becomes so complicated and multi-layered does everybody else think, you know, who is ultimately responsible for doing this and to make those lines a little bit more explicit and clear, particularly when there's a complex investigation ongoing at the same 13:15
time. I think that's -- yeah, that's it.
DR. SWART: Thank you.
CHAIR: Mr. Hanbury?
MR. HANBURY: You have answered a lot of my questions already. I have a couple of left. 13:15
Charts at home in the office.
A. Yes.
251 Q. Did Mr. O'Brien ever explain why he needed so many chart at home?
A. Not to me. 13:16
252 Q. And what the problem was, if there was a problem?
A. No. When the time it came to me doing my investigation, 24 January 2017, the bulk of those had been returned. I did think part of the problem was

that the clinic in Enniskillen, I understand Enniskillen is where Mr. O'Brien lives, it might have been easier for him to bring charts from that clinic to home. Perhaps that was certainly one explanation at a time. So why they accumulated I don't know the reason for that, but it's just I don't know the reason for that, but there's just no straightforward explanation other than that.

253 Q. On a similar sort of theme, the dictation immediately after patient consultation, which many would say should be standard, was there an explanation why, again, that -- did you ask him? 13:16

A. You'll see, or maybe you'll have read that we tried very hard to fix that problem. It just may be he felt that he could see more patients without having to dictate after each patient or at the end of the clinic. 13:17

I do know that Mr. O'Brien did write very detailed comprehensive clinical letters, incredibly detailed with really profound knowledge of patients on occasions, so I'm assuming that that was very time consuming. You know, by the time a clinic finished he just maybe felt, right, I'll do that another time. I guess that would be, obviously -- that's my understanding of why it happened, but... 13:17 13:18

254 Q. Just one last thing. Just on activity and theatre timetables, which you would obviously have a good handle on from a general surgical point of view, but also Urology, and I guess General Surgery, had problems

with waiting times just as Urology, but we're led to believe that Urology was worse. Now, you may not agree with that. But in your role as Clinical Director, would you have allocated extra theatre time to a speciality that needed more?

A. Well, there would have to have been for extra work or waiting lists. So there would have been waiting list initiatives. But that funding would have been had to have been approved and that was not my remit obviously to prove the funding. 13:18

Certainly, I would be aware if there were waiting list happening in Urology. But, you know, I would not have been involved in the planning of those, or the organisation of those or, indeed, around discussions other than, you know, if funding became available, that that was released to the Urology Team. 13:19

255 Q. So that was the only method of extra activities.

A. Of extra activity, yeah. So extra work or extra clinics, or weekend working, in some specialities that would so, you know, people would do extra clinics to get over the backlog at weekends or an extra endoscopy list would be been made available. Just across all aspects of backlog generally. So, or as we do now, and some of it is outsourced to the independent sector, but at that time there was a bit of both going on I remember, but mostly around that time it was mostly in-house waiting listing initiative. 13:19 13:20

MR. HANBURY: Very lastly, you use an expression: "The

challenge of unbalanced endoscopy versus open surgery, addressing urology activity". I just didn't know what you meant by that?

A. I don't know what I mean by that, I'm not a Urologist.

MR. HANBURY: Thank you very much. 13:20

CHAIR: Thank you very much, Dr. Weir.

MR. BEECH **BL**: Can I have one clarification. There was a brief exchange between ourselves about Dr. Khan's and Dr. Wright's impression that some type of assurance was offered, there was no clinical concerns. At AOB-01401, 13:20 at the last page of Dr. Wright's report, which was before the case conference, he does flag that:

"Some patients have potentially been adversely affected, harmed, as a result of these failings." 13:20

I just wish to clarify that in the presence of Mr. Weir. I am very sorry for interrupting you, Madam Chair.

CHAIR: That's fine, Mr. Beech, thank you very much. 13:21 Again, thank you, Mr. Weir. I'm not sure if we need to hear from you again. I think your involvement with this Inquiry was largely confined to the MHPS section of our work. I'm hopeful that we won't need to see you again, I'm sure you are very hopeful that we don't. 13:21

A. I'm hopeful!

CHAIR: If we do need to hear anything further from you, we may try to do that by way of a written statement. Thank you very much.

MR. WEIR: Thank you very much.
CHAIR: It is now twenty past, I know the next witness is due at 2 o'clock, but I think a quarter past two.
MR. BEECH **BL**: Yes, I am very grateful.

13:38

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon, everyone. Mr. Beech, when you're ready.
MR. BEECH **BL**: This afternoon we'll be hearing evidence from Dr. Charles McAllister. 14:18

DR CHARLES McALLISTER, HAVING BEEN SWORN, WAS EXAMINED BY MR. BEECH **BL**, AS FOLLOWS:

14:18

256 Q. Good afternoon, Dr. McAllister. There should be water available to you. Any documents I refer to this afternoon will appear on the screen. I understand you have brought hard copies and you might just prefer to use them. I'll do my best to steer you around the hard copy bundles as well. 14:18

If I just could start with your Section 21 response which appears at WIT-14848, please. This is a response to a Section 21 Notice, No. 32 of 2022, and it's dated 29 April. Are you familiar with that document? 14:19

A. Yes.

257 Q. Perhaps if we could jump to the last page of that which appears at WIT-14873, please. It's electronically

signed by yourself there, but are you content that that is in fact your statement?

A. Yes.

258 Q. Do you wish to adopt that as your evidence to the Inquiry this afternoon, subject to one or two minor amendments? 14:19

A. Yes.

259 Q. Now, the Inquiry has received correspondence with regard to these amendments. So if you could look at WIT-14862, please. It's paragraph 11.6. What amendments do you wish to make to paragraph 11.6, as its presently... I believe it might be about six lines down "armed with this information"? 14:19

CHAIR: Mr. McAllister, are you struggling with the screen? Feel free to look at your statement in your folder, if that makes it easier for you. 14:20

A. Oh, yes. The bit from "and the subsequent rumour that former procedures under MHPS were being considered/discussed" should come out. I think this was August, yes, that should come out. 14:21

260 Q. Now, you wish to remove reference to subsequent rumours that formal procedures under MHPS were being considered/discussed. Why are you looking to remove that sentence?

A. Because that wasn't in August, that subsequently. 14:21

261 Q. You're saying to us that at some point you were aware of rumours?

A. Yes.

262 Q. Can you recall when that might have been?

A. Yes, it was when Esther had her oversight meeting with Dr. Richard Wright and Vivienne Toal.

263 Q. We'll work through these various meetings, so it is perhaps closer to the 13, 14, 15 September as opposed to August? 14:21

A. Yes, one hundred percent.

264 Q. So you're not saying that you didn't hear a rumour there was to be a formal process, it just wasn't at that time?

A. Yes, I got the timing wrong. 14:21

265 Q. If we could have a look please at WIT-14852, which is paragraph 4.4. I believe it is the first line there you wish to make an amendment to:

"I set about trying to get my head around as many of the issues of surgery as quickly as I could by talking with...". 14:22

This is the relevant part:

"...many relevant parties over the month of April 2016." 14:22

What amendment do to you wish to make to that?

A. Well it was the end of April, beginning of May. 14:22

266 Q. So it was sent on 9 May 2016, is that right?

A. Correct.

267 Q. So discussions had been ongoing with various parties up to the time you sent the email?

A. Yes. I was only appointed around 29 April.
268 Q. Okay. Thank you very much. There's no other amendments or alterations you wish to make?
A. No.
269 Q. If we could start then, perhaps, Dr. McAllister, at the start of your Section 21 response. So if we go to WIT-14848, please. Again, if it is easier for you to refer to the hard copy, please do so. Down to paragraph 1.1, please. 14:22

14:23

You provide a bit of your background here in terms of your involvement with The Trust. So you were appointed as a consultant anaesthetist and intensivist in The Legacy Trust in August 1994, is that right?
A. That's correct. 14:23
270 Q. You retired in April 2018. Just in terms of your experience, apart from the AMD role we're going to be talking about today, what other management roles had you held during your time at The Trust?
A. Well, I was Lead Clinician for ICU for several years. 14:23
Then I was appointed Clinical Director for Anaesthetics and Intensive care, otherwise known as "ATIC," I would say around 2008 and then appointed AMD for Anaesthetics, Theatres and Intensive Care in and around 2012. 14:24
271 Q. If we look over the page at WIT-14849, paragraph 1.2, you say:

"I was appointed as Associate Medical Director for

surgery in April 2016 in addition to being AMD for Anaesthetics, Theatres, Intensive Care and Chronic Pain."

How, could you explain to the Chair how you came to be AMD for two different sections of the Acute Division at the same time? 14:24

A. Well, Stephen Hall died, Eamon Mackle -- Stephen Hall was AMD for radiology. Eamon Mackle stepped down in April that year. There were no CDs in surgery and hadn't been for a while, so there was a shortage. So Esther Ghiskori asked me would I take over the role of surgical AMD in addition to my anaesthetics, theatre and intensive care. 14:25

272 Q. So this isn't a case where you applied to become a AMD, you were asked you said by Mrs. Gishkori? 14:25

A. No, I wouldn't have applied.

273 Q. Whenever you say you were asked by Mrs. Gishkori, were you asked or were you told, perhaps, that you had to take on this responsibility? 14:25

A. No, she couldn't have told me to do it.

274 Q. Why, then, did you feel moved to take on this responsibility?

A. It was a difficult situation for her. She had lost two AMDs and two CDs and she asked me to help her out. 14:25

275 Q. Was this to be a long-term solution or was it a sticking plaster.

A. No, a sticking plaster.

276 Q. Were you aware when you were supposed to step out of

this role?

A. On or before 12 months.

277 Q. Can you recall the exact date you took over again, sorry?

A. I would say 29 April. 14:26

278 Q. Now, the Inquiry Panel has already heard evidence from your predecessor on the other side of the house, Mr. Mackle. The impression he gave us was quite a taxing job. Would you agree with that?

A. I would. 14:26

279 Q. You're obviously in the -- I'll say unique position of being AMD for two sections at the same time. Was it possible for any one person to do this job?

A. Well, that depends on the support you have above and below. 14:26

280 Q. Perhaps, then, why don't we turn to what support you may have had. So you were in the medical management line. How did you find any support you were receiving from the Medical Director?

A. Not as much as would have been helpful. 14:27

281 Q. Well, what support was there from the Medical Director, first?

A. With regards to what?

282 Q. With regards to discharging your duties as Associate Medical Director? 14:27

A. Well, in the previous -- he was appointed, I would say, in July 2015. I think in that time up until April we had two one-to-ones.

283 Q. So that's two one-to-one meetings in, approximately,

shall we say 9 months, is that a fair enough?
A. Yes.
284 Q. These one-to-one meetings, were they a crucial part of you being able to do your job, did you feel?
A. Crucial? No. But certainly helpful. 14:28
285 Q. Helpful in what way?
A. Steering direction, information.
286 Q. What impact did the absence of these one-to-one meetings have on your ability to discharge your role?
A. Well it is hard to know what the priorities are or what the direction of travel is. 14:28
287 Q. And how regularly should these one-to-one meetings have been taking place?
A. Every month.
288 Q. Under previous regimes had they been taking place every month? 14:28
A. I couldn't say every month but certainly far more frequently than twice in 9-months.
289 Q. So between yourself and Dr. Wright you have, maybe, two meetings over a nine-month period? 14:28
A. Uh-huh.
290 Q. What's your understanding of why the other seven didn't take place?
A. Well, we had our first one -- he was appointed in July. I think we had our first one in February. 14:29
291 Q. And why had there been no meeting before then, so much as you can understand it?
A. Well one-to-one meetings are organised by the Medical Director's Office.

292 Q. Did you ever take the initiative and ask what was going on, or, could we have a meeting, or, we should get these meetings set back up on a regular basis?
A. No.
293 Q. Any particular reason why you didn't do that? 14:29
A. The one-to-one meetings were organised by the Medical Director. That was their purview.
294 Q. What about your engagement then with the Director of Acute Services who would have been Mrs. Gishkori during your time? 14:29
A. Uh-huh.
295 Q. How did you find that line of communication or engagement?
A. Excellent.
296 Q. How often would you have met with Mrs. Gishkori? 14:29
A. Officially once-a-month.
297 Q. You said the word "officially" there. Are we to infer that there were perhaps unofficial meetings?
A. Yes.
298 Q. When would those unofficial meetings have taken place? 14:30
A. Whenever there was yet another crisis.
299 Q. With regard to these meetings with Mrs. Gishkori, how did you find her in terms of supporting you in discharging your roles?
A. I found her very supportive. 14:30
300 Q. You mentioned that one thing that was perhaps lacking through the absence of regular channels with the Medical Director was direction. Were you getting appropriate direction from Mrs. Gishkori?

A. We had free, open discussions, and she would ask my advice, I would ask her advice. Yes, I had no problems.

301 Q. If we just talk about, perhaps, the official monthly meetings with Mrs. Gishkori. Would anyone else have been regularly attending those? 14:30

A. Ronan Carroll.

302 Q. Would there ever have been an occasion where say a Clinical Director would have attended any of those meetings? 14:31

A. Not usually, I can think of one occasion. But it wasn't -- there may have been more, but it wouldn't have been a regular feature.

303 Q. What about your engagement with Urology Services then? So if we were looking up the Director and the Medical Director, what about going down the way, down through the system. How would you have engaged with Urology Services? 14:31

A. Through the Clinical Director.

304 Q. Now, I think you said at the very start of your evidence today that there was no Clinical Director whenever you -- 14:31

A. There was from 1 June.

305 Q. So for approximately a month your --

A. Yes. 14:31

306 Q. -- you have no Clinical Director?

A. Yes. That's correct. The interviews were held on 23 May.

307 Q. What would that engagement with the Clinical Director,

once they were in post, have looked like?

A. From my point of view, good. We met every Thursday.

308 Q. Where I've been saying the word Clinical Director, but there were two Clinical Directors for Surgery. Would you have met them together or separately? 14:32

A. Together.

309 Q. Mr. Weir, Mr. Haynes, how did you find working relationships with those two?

A. Excellent.

310 Q. These meetings with the Clinical Directors, were you sending them off with clear instructions on what to do, or were they reporting issues to you. What was the dynamic like between you? 14:32

A. Yes, it is a two-way street. They would bring up issues. I would ask them to do various things. One of the big pushes on at that time was job planning. The job planning situation in surgery had fallen way behind. So I was encouraging them to get on with the job planning. There had been a lack of attention to job planning or successful job planning previously. And there was a big emphasis to get job planning done. 14:32

There was reluctance on the part of some surgeons to complete the job planning, understandably, because they were on quite high PAs and the push was on to get the PAs down to 12, so, for very good reasons, they weren't enthusiastic about engaging. 14:33

311 Q. Would you ever have had any direct engagement with Urology?

A. Through my role, no.
312 Q. Through your role as Associate Medical Director?
A. No.
313 Q. Even in that same month when you didn't have the support of a Clinical Director? 14:33
A. No.
314 Q. How could you be satisfied in that month period, say May 2016, that there were no issues within Urology if you weren't meeting with say, Michael Young?
A. I knew there were issues in urology. 14:33
315 Q. How could you be satisfied they were being dealt with if you didn't engage with Urology Services?
A. Well, I wasn't aware of any new issues that weren't already known.
316 Q. During this afternoon we'll, of course, turn to some of those specific issues in Urology. But I just wonder if we could turn to WIT-14875. It is at page 141 of your core bundle, if that's of any assistance to you. This is an e-mail you sent to Mr Carroll, Mrs. Gishkori and Dr. Wright on 9 May 2016. Have you got that in front of you, okay? This is, roughly, say two weeks after you take over as Associate Medical Director for surgery. You sent an e-mail saying: 14:34 14:34

"Dear all, since being asked to take over responsibility for the surgery as AMD. I have been trying to get my head around as many issue as possible to date. 14:34

1. There is no real functioning structure for dealing with governance."

If we just scroll down, I think a total of 22 perhaps, 21 different issues you had identified in a two-week period in surgery. Were you surprised being an experienced Associate Medical Director to find this amount of issues in your in-tray? 14:35

A. No. I'd say I was horrified.

317 Q. What horrified you in particular? Was it the scale of the problems? The amount, the extent, the length of them? What horrified you? 14:35

A. All of that. It was the breadth and the depth.

318 Q. You sign-off your e-mail with: 14:35

"That's what has appeared so far. Basically a very disturbing picture. Significant governance risks."

Did you consider that this was almost a mission critical type issue, this needed to be escalated? 14:35

A. Yes, absolutely.

319 Q. This email was sent to Mr. Carroll, who is the Assistant Director, relatively new in post. Mrs. Gishkori has probably been there at least from some time in 2015, and Dr. Wright again from 2015. Why did you take it upon yourself to email them this list of issues? What were you expecting? 14:36

A. Well there were several reasons in my mind. Number one, I wanted to ensure that the issues were clearly

defined and shared so that they were aware of them so that I wouldn't be just left holding the baby, or babies in this case, and to get some feedback on what part of this elephant we were going to eat first, or at least start chewing on, and get some direction of priority.

320 Q. You do receive two responses to this email. The first one -- if we just scroll up again, please -- is from Mr. Carroll. "I think it's safe to say you have a good handle on things." 14:37

A. Mm-hmm.

321 Q. Did that response go any way to dampening your concerns?

A. No.

322 Q. You then receive a response from Dr. Wright, which appears in your witness statement or your Section 21 response, rather, at WIT-14854. That's paragraph 4.6. Dr. Wright responds: 14:37

"That seems a fairly accurate summing up. Can't all be fixed in a day. Should we have a get together to work up an action plan." 14:37

Can you ever recall meeting Dr. Wright to discuss the email of 9th May?

A. I attempted to the following Friday. 14:38

323 Q. You say you attempted to. Were you able to meet with Dr. Wright?

A. He suggested that it wasn't the time or the place and it should wait until the next one-to-one.

324 Q. The conclusion of your email is a very disturbing picture and significant governance risks implies there was some degree of urgency in your mind to resolving these issues?

A. I was having sleepless nights. 14:38

CHAIR: I missed that. What was that? Sorry.

A. Sleepless nights.

325 Q. If we could scroll down to paragraph 4.7. 4.8, sorry. You say at WIT-14855:

14:38

"I have been unable to find a reply from Esther Gishkori, Director of Acute Services, which would have been unusual but I recall we discussed it."

What do you recall of that discussion with 14:39 Mrs. Gishkori?

A. I can't remember.

326 Q. What you recall is you discussed it, you can't recall what was said?

A. Correct. 14:39

327 Q. On receiving those three responses to your email, how did you feel?

A. I wasn't reassured.

328 Q. Having attempted to raise a degree or a number of issues with the Acute Director and the Medical 14:39 Director, having received a less than satisfactory response in your own opinion, did you raise these issues again?

A. I raised it at the one-to-one.

329 Q. With who? Sorry?
A. Dr. Wright.
330 Q. Again on raising that, did Dr. Wright take any action?
A. Not that I remember.
331 Q. Having raised this quite substantial list of issues, what action did you take to set about addressing points 1 to 21 of that email? 14:40
A. Some of them were not possible for me to address on my own. Some of them required the help of a CD. The issues -- well, there wasn't a lot I could do. I said about planning the issues around urology, which were certainly in the forefront. 14:40
332 Q. I think we'll return, perhaps, in due course to the specific issues about urology in the course of this afternoon. During your time as Associate Medical Director, you ultimately leave that role in October '16, were you any less concerned about this list of issues at the time you left your role as whenever you started? 14:41
A. No, I thought it was inevitable there was going to be problems in the future. 14:41
333 Q. Just so I'm clear, as an experienced Associate Medical Director these aren't the type of issues you might expect to come across in a division or in a part of the Trust i.e. Surgery, this is something over and beyond what you might have expected to see whenever you came into the role? 14:41
A. Well, I heard Mr. Mackle say that this was -- he would expect us to be fairly normal for a GTH and a lot of

those issues are still extant. I would be surprised if this was normal. I mean some of these issues have actually gone the way I expected. The Daisy Hill situation, the surgical rotas, the breast situation.

334 Q. If I could clarify one point before we go on to a discussion about MHPS. Whenever you took on this role as Associate Medical Director for Surgery, did you receive a job description? 14:42

A. No.

335 Q. Whenever you took on this role as Associate Medical Director for Surgery, were you aware of what was required of you? 14:42

A. I would say so, yes.

336 Q. With regards to MHPS, what I'll refer to as the MHPS Framework and the Trust`s internal guidelines, in your Section 21 response at WIT-14851, paragraph 4.1 of your hard copy, you said that you were of both the framework and the guidelines. You say: 14:42

"I was aware of these guidelines and the MHPS guidelines published in 2005. They were two of a tsunami-like wave of guidelines, policies and protocols produced by the Trust, the Department of Health and various other relevant regional and national bodies disseminated to staff by the intranet increasing frequency between 2005 and 2016." 14:43 14:43

Were you aware of the mechanics, the practicalities of those two policies?

A. I would say well, I had read the documents.

337 Q. You mentioned earlier you had been Associate Medical Director for quite some time. Had you ever had cause, during your other Associate Medical Director role, to initiate or conduct any part of the process described in the guidelines or the framework? 14:44

A. Before Surgical AMD I would say no, not under that flag.

338 Q. I'm not going to ask you to go into any specifics at all in terms of your anaesthetics AMD role, but one would suspect that surely issues of concern did arise. How did you resolve them, address or investigate such issues without recourse to either the Trust guidelines or the MHPS Framework? 14:44

A. There wasn't really a major issue of competence or lack of application. There was occasionally resistance in moving in certain directions but we worked through that by getting group agreement and then peer pressure among colleagues. 14:44

339 Q. Just so I'm clear, what do you mean by "peer pressure" in this context? 14:45

A. For instance, I was the keen that the anaesthetists would work cross-site between Daisy Hill and Craigavon. That wasn't welcomed enthusiastically by all, but the situation was that you would have a surgeon and a theatre available in Daisy Hill but no anaesthetist because the anaesthetist in Daisy Hill was on holidays and there was availability in Craigavon so it would make sense there was cross-site working. There wasn't 14:45

universal support for that but there were enough people supporting it that the others were persuaded.

340 Q. In your time at the Trust had you ever received any type of training on how to utilise the MHPS Framework or the Trust guidance? 14:46

A. Not that I recall.

341 Q. Again, the fact that you had been Associate Medical Director for quite some time, is there any particular reason why you didn't get trained?

A. I didn't say I didn't get trained. I didn't recall it. 14:46 Apparently I went on a training course in 2010 but I have no memory of it.

342 Q. If I can just quickly refer, then, to WIT-14856, which is paragraph 8.1 of your Section 21 response. In this you describe a scenario where: 14:46

"Shortly after taking over the role for AMD for Surgery I was asked to take over the role of Case Manager in the case of a consultant. This case had been running for some time before my involvement." 14:47

The preceding Case Manager had died and you were asked to take over.

If you just go down to 8.2, please? 14:47

"My role, as I recall it, was limited to signing letters provided to me by HR, which were sent to the consultant every 4 weeks."

Is this the only time you have ever been involved as a case manager, case investigator in an MHPS process?

A. Yes.

343 Q. Was the extent of your involvement simply just signing a letter, as you say, every four weeks? 14:47

A. Yes. I never met the individual. No, that's not true. I didn't meet him in the course of this. I obviously met him because he was an employee in the hospital.

344 Q. I'm curious to understand, Dr. McAllister, how these processes work and impact on professional 14:47 relationships. Whether or not it was an MHPS process or not, have you ever been involved in an investigation conducted by another consultant?

A. Yes.

345 Q. I'm not necessarily sure of the facts and circumstances 14:48 are relevant to this Inquiry, but was that an investigation into yourself?

A. Yes.

346 Q. The parties doing the investigation, were they other consultants? 14:48

A. Yes.

347 Q. How do you think, based on your experience, that impacted on professional relationships between you and that particular consultant?

A. It was conducted, it was driven by outside forces that 14:48 there was no choice but to go ahead with it. It needed to be done in a thorough and comprehensive way that it would stand up to external scrutiny. It was conducted fairly and reasonably. It was embarrassing for me and

was embarrassing for the person conducting the interview. Well, it seemed to be.

348 Q. That professional embarrassment, mutual professional embarrassment, how did that impact outside of the interview room, in theatre, about the hospital? How did it impact on relationships, in your experience? 14:49

A. I think we got over it and worked well together.

349 Q. Having been through that professional embarrassment yourself, were you in any way reluctant to put another consultant through a similar experience? 14:49

A. No.

350 Q. You don't think any of that experience impacted upon your ability to utilise formal Trust processes if you had to?

A. Absolutely not. 14:49

351 Q. Now I will start moving in to your time as Associate Medical Director, but before I do, prior to becoming AMD for surgery and having direct management responsibility, what was your impression of Mr. O'Brien? 14:50

A. Well, as I say in my Section 21, I did very few lists with him in theatre. I can't remember how many I did. But in theatre I saw no issues. I did meet him regularly in ICU because he did a lot of big surgery and regularly had patients in ICU. Everything I saw was positive. 14:50

Also, anaesthetists tend to gossip and the feedback I was getting from theatre to theatre -- it was an

anaesthetist that raised the alarm over the cardiac surgery in Bristol. Anaesthetists see what goes on. The feedback I was getting was that there were no issues and, in fact, both consultants and trainees liked working with Mr. O'Brien.

352 Q. If we look at WIT-14871 which is paragraph 2.11 of your statement and it is page 34 of your hard copy bundle if that is of any assistance to you. If we pick it up halfway through this paragraph:

14:50

14:51

"In 2016, Mr. O'Brien was generally considered to be extremely hardworking, if not the hardest working surgeon in The Trust. He was regarded as technically excellent in theatre with the most demanding of major urological surgery and, just as importantly, excellent and direct pre-op and post-op care."

14:51

A. Where is that?

353 Q. Paragraph 2.11?

A. Okay. Is it?

354 Q. 11. Sorry, forgive me. Is it fair to say you held Mr. O'Brien in pretty high regard coming into your job in 2016?

14:51

A. He was a good surgeon.

355 Q. If we could just have a look at AOB-50009. There is a reference provided by yourself to Mr. O'Brien's solicitors on 11 December 2020. Are you familiar with this?

14:52

A. Yes.

356 Q. If you scroll down, please, just a wee bit. In the

second paragraph you note that:

"Mr. O'Brien was appointed a short time before my appointment but had already established a Urology Service single-handedly from scratch." 14:52

So in your mind, Mr. O'Brien, even to this day, is responsible for building up Urology Services in the Southern Health and Social Care Trust?

A. He was, yes. 14:53

357 Q. I think you say in your Section 21 response, this was despite opposition from Commissioners and various other struggles?

A. Well, the Belfast Trust had a monopoly on urological surgery at that stage and they were less than 14:53 enthusiastic, according to John Templeton, who was the Chief Executive in the old Legacy Trust, and they were not supportive.

358 Q. So it is quite clear at the time in 2016 you hold Mr. O'Brien in high regard and you still appear to do 14:53 so, yes?

A. He's a good surgeon.

359 Q. Whenever you were handling issues with regards to Mr. O'Brien between April and October 2016, was this in your mind at all points, that Mr. O'Brien was, as you 14:53 say, a good surgeon? Were you always cognizant of his ability?

A. Yes.

360 Q. To what extent did your awareness of Mr. O'Brien being

a good surgeon, as you have just said, prevent you or stop you from going in and perhaps challenging him or trying to address issues?

A. It didn't stop me at all.

361 Q. Let me just ask you, were you and Mr. O'Brien particularly close? 14:54

A. I beg your pardon?

362 Q. Were you particularly close, were you and Mr. O'Brien close?

A. Do you mean were we friends? 14:54

363 Q. Yes?

A. No.

364 Q. What was your relationship like around the hospital?

A. Excellent.

365 Q. Had you any previous experience of trying to manage Mr. O'Brien or deal with issues prior to your appointment in April 2016? 14:54

A. I did.

366 Q. Could you outline those, please?

A. Well, I received a phone call from Paddy Loughran some time around '09/'10 asking me to come down to Trust Headquarters to meet up with him. That wasn't that unusual. He would do that every now and then for coffee and chocolate biscuits and we would discuss various issues. 14:54 14:55

So I went down and walked into the office. There was no coffee or chocolate biscuits. He was sitting there and Dr. Damani was there, I thought that was strange

and not a good sign. Dr. Loughran outlined that he was in some difficulty, that Diane Corrigan was in contact with him about an issue with IV fluids and antibiotics being given for prolonged periods to urology patients by Mr. O'Brien. He said that he was under some 14:56
pressure and that he was having difficulty resolving it.

Dr. Damani said that there was no published evidence for what was going on, that it would lead to resistant 14:56
infection, Clostridium difficile breakout, and basically Armageddon and we had to sort it out.
I said, that's great, why am I here? And for the first and only time Dr. Loughran got cross and said that he was in -- he had been struggling with this and he 14:56
needed help, and if I didn't want to be involved, then I could leave. Clearly the temperature was higher than I had appreciated. I said, fine. Mr. O'Brien arrived.

They gave their points of view to Mr. O'Brien. 14:57
Mr. O'Brien said that he didn't need to see published evidence, he had the evidence of his own eyes, he had the evidence of the testimony of the patients and they were ringing him up asking him to provide this treatment for them and he wasn't prepared to leave them 14:57
suffering.

Dr. Loughran then said, "Charlie, what do you think?"
I told him what I thought which was that Diane Corrigan

was on this, that she was like the eye of Sauron and she wasn't going to let this one go. She had the bit between her teeth and she was going to drive this to an end. And she also had significant control over purse strings for The Trust. 14:58

Diane Corrigan was easily the best public health doctor in Northern Ireland. I had had numerous interactions with her and I had always been impressed. And I sat back, waited for the balloon to go up, and looked 14:58 across. Mr. O'Brien was to my right, Dr. Damani was there, Dr. Loughran was there, I looked across at them. Mr. O'Brien paused and then said that -- how much he respected me clinically, basically said a lot of nice things about my clinical side of things, and then he 14:58 said how much he respected my opinion, and then he said, and I'll never forget it, he said in fact yours is the only opinion in this room that I do respect. Dr. Damani and Paddy Loughran reacted to that. And he said if that's what I thought, then he would have to 14:59 accept it and he wouldn't do it anymore.

367 Q. Have you any idea why Mr. O'Brien would regard your opinion with particularly high regard, as opposed to say some of those others in the room?

A. Well, he clearly thought I was good at my job and I had 14:59 also had some interaction with a member of his family which turned out positively. Also, we'd always got on very well.

368 Q. You placed this interaction, this meeting in 2009/'10,

sorry, was that right?

A. It was about then.

369 Q. You are aware that the issue of IV antibiotics rumbled on probably for a couple more years after that, the issue wasn't sorted then and there? 15:00

A. I'm not sure about the date. There's no email on it. I don't know. I know for certain Paddy Loughran was the Medical Director.

370 Q. Just to be clear, do you know why Dr. Loughran asked you specifically to be at that meeting? 15:00

A. Well, I asked him that. I thought it was a bit strange. It must have been -- whenever it finished, it was a consequence of that meeting. Because I met Paddy Loughran afterwards and he said that there had been no more issues. 15:00

371 Q. Perhaps, then, if we move on to consideration of the five or so months in which you acted as Associate Medical Director for Surgery in your various interactions.

15:01

On taking over the role, when and what circumstances did you first become aware that there were issues with Mr. O'Brien's practice, assuming you were not aware beforehand.

A. Well, I wasn't beforehand. Oh, I would say first day. 15:01

372 Q. How did you become so aware?

A. Well, Martina Corrigan and Heather Trouton handed me the letter that they had presented to him. No, handed me the letter that Martina and Mr. Mackle had presented

to him on 30 April, and said that this had been done following a meeting that was held in January following Mr. Mackle approaching Dr. Wright in December.

373 Q. I'll just offer you the opportunity to correct yourself. You said it was 30 April, I think it was 30 March 2016 if we are talking about the same letter? 15:02

A. Yes, 30 March, yes.

374 Q. If we can get on the screen WIT-14788? This is at page 85 of your hard copy bundle, if you wish to have a look at it? 15:02

A. 85, you say?

375 Q. 85. It is an extract from Mr. Mackle's response to the Section 21 notice?

A. Oh, yes, Mr. Mackle told me as well.

376 Q. It would appear that Mr. Mackle gave you a quite detailed overview of what actions had taken place to date. Can you remember when you had this hand-over meeting with Mr. Mackle? 15:02

A. You mean the date?

377 Q. Yes. 15:02

A. No. It was some time in -- after he was no longer AMD and I took up the post.

378 Q. Was it before or after your meeting with Ms. Corrigan which you have just described?

A. I couldn't tell you that. 15:03

379 Q. If we take a look at AOB-00979, please? This document appears at page 136 of your core bundle, if you wish to have a look at the hard copy. This is a copy of that letter to Mr. O'Brien which you just referenced. When

did you first see a copy of this letter?

A. End of April.

380 Q. How did that letter come into your possession, as far as you can remember?

A. It was handed to me by either Heather Trouton or Martina Corrigan. 15:03

381 Q. If you just have a little look through the letter while we're here. The first issue is recorded as un-triaged outpatient referrals. The second there is an issue with regards to the current review backlog up to 26th February 2016. Third issue, patient centre letters and recorded outcomes from clinics. Then the last issue recorded there is patient notes at home. Whenever these issues were explained to you, or whenever you first saw the letter, what was your impression on the seriousness of these concerns? 15:04 15:04

A. I thought they were serious.

382 Q. Why did you think they were serious?

A. Because, sooner or later, there was going to be a misadventure. 15:04

383 Q. What was your fear in this context?

A. Someone was going to have a late diagnosis as a result of the letters not being triaged. The review backlog was certainly impressive. Not recording outcomes clearly makes life difficult for other people involved in the care of the patient. Patient notes at home, obviously from the administration point of view, if you haven't got the patient's notes -- it wasn't as crucial then as it would have been before hand but you're not 15:05

having all the information that is available.

384 Q. On reading that letter and having these concerns explained to you, did you consider these were Patient Safety matters?

A. Did I? I'm sorry. 15:05

385 Q. Did you consider these were matters of Patient Safety?

A. Yes.

386 Q. If we just scroll down ever so slightly, please. This is the very last sentence of the letter. 15:05

"You appreciate that we must address these governance issues and therefore would request that you respond" -- this is to Mr. O'Brien, obviously -- "with a commitment and an immediate plan to address the above as soon as possible." 15:06

What were you told about Mr O'Brien's follow up to this meeting and letter?

A. I wasn't.

387 Q. You weren't told anything? 15:06

A. Sorry, ask the question again?

388 Q. What were you told about Mr. O'Brien's follow-up to the meeting and the letter?

A. Follow-up to the meeting and the letter? I'm not aware of anything. 15:06

389 Q. Whenever this was explained to you by Mrs. Corrigan, did you ask her, having seen the last sentence there about a plan, did you ask her has a plan been received?

A. I can't remember. I would have expected so but I can't

say whether I did or not.

390 Q. You place this interaction becoming aware of these concerns at the end of April 2016. On becoming aware of these concerns and not being entirely aware of what, if any, follow-up there had been, what actions did you take as the Associate Medical Director to satisfy yourself that these issues were being looked into and addressed? 15:07

A. I spoke with Martina Corrigan and I asked her to keep me in the loop and let me know; whether there was improvement or deterioration in the situation. 15:07

391 Q. At that time, at the end of April 2016, did you take any steps to address these issues or to follow-up on the March correspondence?

A. No. 15:07

392 Q. Why not?

A. Because this had been going on for years. There had been various attempts previously by engaging, apparently, with Mr. O'Brien. These were all undocumented. They were all un-minuted. There were no emails. What seemed to happen was things would improve for a while and then things would get bad again. It was a recurring cycle. 15:07

393 Q. Have a look, please, at WIT-14866. This is paragraph 11.13 of your Section 21 response. You say: 15:08

"By the time I came on the scene, in April 2016, informal steps had already been taken a week or two previously by Mr. Mackle and Heather Trouton as

evidenced in their letter of 23rd March 2016. I don't know what advice they had received or what discussions they had other than I was made aware that there had been discussions with Mr. O'Brien (on more than one occasion), that the Director of Acute Services, Esther Gishkori was involved as was the Medical Director, Dr. Wright. Consequently, since an informal approach had already been made initiated by others very recently, I did not when presented with this information specifically engage with Mr. O'Brien." 15:08 15:09

Did the fact that an informal attempt had been made the month before you took over, did you see that as stopping your ability to challenge or engage with Mr. O'Brien on these issues? 15:09

A. No.

394 Q. Because if you read that sentence again, "consequently, since an informal approach had already been initiated by others." What's the significance of the informal approach by others? Could you not have ascertained what had happened, what any follow up had been, and made your own attempts to sort out this issue? 15:09

A. I was planning to sort out the issue. I didn't think this letter would have any effect. No, I didn't think it would sort out the issue on an ongoing and permanent basis. 15:09

395 Q. From becoming aware of these concerns in April, did you make any attempt to sort out this issue?

A. No, because I didn't want to repeat the same mistakes

that had happened previously.

396 Q. If we could return, perhaps, then to your email to Dr. Wright, Mrs. Gishkori and Mr. Carroll, of 9th May 2016, which appears at WIT-14875. We'll focus this time on the urology section of that email. 15:10

You say: "Urology, issues of competencies, backlog, triaging referral letters, not writing outcomes in notes, taking notes home, and questions being asked re appropriate prioritisation of NHS of patients seen privately." 15:10

If we take each of those in turn, I think it's fair to say from the discussion we have had today that issues of competency, did that concern Mr. O'Brien? 15:10

A. No.

397 Q. Would it be fair to say that the backlog issue referred to, did that relate to Mr. O'Brien?

A. Not exclusively.

398 Q. What other concerns were you aware about the urology backlog at that time? 15:11

A. I was aware another consultant had a significant backlog.

399 Q. It is not exclusively a Mr. O'Brien issue but it is in part a Mr. O'Brien issue? 15:11

A. Yes.

400 Q. Triaging referral letters, was that a Mr. O'Brien issue?

A. Yes.

401 Q. What about any other consultants, urologists?
A. No. I think that was specifically Mr. O'Brien.
402 Q. Again I'll ask you the same question, not writing out common notes, was that a Mr. O'Brien issue?
A. Yes. 15:11
403 Q. Did it affect any of the other Urology Consultants?
A. Not that I knew.
404 Q. Notes at home or taking notes home, that's an Mr. O'Brien issue?
A. Yes. 15:12
405 Q. Affecting any of the other Urologists?
A. Not that I knew.
406 Q. Then this final issue, questions being asked re inappropriate privatisation onto NHS of patients seen privately. Was that a Mr. O'Brien issue? 15:12
A. Yes.
407 Q. What was the concern at that time in May 2016?
A. Martina told me that there had been questions asked about patients that were -- seemed to be appearing out of order who may or may not have been private patients. 15:12
408 Q. This is May 2016. So at this stage there wasn't a Clinical Director?
A. Correct.
409 Q. So Martina Corrigan is, in effect, raising this with you as the next, probably, most successful or the next 15:12 available level of medical management, is that fair?
A. Correct.
410 Q. What steps did you take to try and address this issue or understand and appreciate was in fact an issue of

concern?

A. Well I asked Martina to let me know if there was any evidence going forward of this happening.

411 Q. Did you ask Martina for any evidence going backwards, of it having happened in the past? 15:13

A. No.

412 Q. Why did you not do that?

A. Well, I presumed if there was evidence, I would have been given it.

413 Q. Is that a serious issue in itself, in effect, the inappropriate referral of private patients? 15:13

A. Yes. I thought, actually, that would have hit the red button. There had been a training session in February on private patients in the hospital. I went -- I was AMD for Anaesthetics at the time and Anaesthetists don't have -- they don't bring private patients in the hospital. Patients don't go to the hospital to see an anaesthetists, and anaesthetists don't use private facilities in the hospital. 15:13

15:14

And it was Dr. Wright had taken that, I was struck with what he said, that as far as he was concerned anybody who was giving unfair advantage to patients having been seen privately that that was a GMC issue as far as he was concerned. So I expected that that would get a response. 15:14

414 Q. By this stage -- sorry to cut across you there, Dr. McAllister. At this stage, 9 May 2016, had you spoken to Mr. O'Brien about any of these five issues?

A. No.
415 Q. These issues were concerning enough that you have to email the Medical Director about them. Why did you not take the step of speaking to Mr. O'Brien, seeing if you could address them? 15:15
A. Because I was waiting to get a Clinical Director appointed who was a surgeon. I don't do outpatients. I don't do triage. I don't do letters on outpatients and I don't do review clinics. These issues, it needed someone who could engage with them and make suggestions 15:15 about how he could modify his practice to eliminate this. He had previously been spoken to many times before over the same thing but had always -- had always -- fallen back again.
416 Q. I think it is easy to look at the absence of a Clinical 15:15 Director, but you did have Mr. Young who was the Clinical Lead. Could you not raised these with Mr. Young and sent him out to try and engage with Mr. O'Brien on this?
A. And repeat, trying the same thing that had been tried 15:16 before and expecting a different outcome? No.
417 Q. As we discussed a moment ago, I think fairly to you, you said that four of these issues are Mr. O'Brien specific?
A. Yes. 15:16
418 Q. One of them at least in part or half relates to Mr. O'Brien?
A. Yes.
419 Q. Nowhere in this email to the Medical Director do

you flag that these are, in fact, Mr. O'Brien issues and these issues which -- most of which have been known about are, in fact, unresolved. Why did you not flag that to the Medical Director?

A. He already knew the Aidan O'Brien issues. 15:16

420 Q. He already knew the Aidan O'Brien issues, but he may not have been aware that they were unaddressed or unresolved. Why did you not flag that to him?

A. Well if they had been addressed or resolved, I wouldn't have put them in the email. 15:16

421 Q. Do you accept that this is perhaps not the most overt manner in which you could have referred to these being Aidan O'Brien issues? You could have flagged that this was in fact Mr. O'Brien causing the majority of these concerns? 15:17

A. I could have put a lot of names down on that email, but it was a summation of various issues.

422 Q. Specifically of Point 6, though?

A. Sorry?

423 Q. Specifically of Point 6 in Urology, could you not have flagged directly to the Medical Director? 15:17

A. I could have, yeah.

424 Q. Is there any specific reason why you chose not to?

A. No. If you are suggesting it was because I was reluctant to engage with Mr. O'Brien, that's totally untrue. What I wanted to do was to make sure that whatever step was put in place would work and would be sustained going forward. Bear in mind, I was only going to be there a few months. I didn't want a system 15:17

put in place that was reliant on me.

425 Q. There has been some discussion today about the absence of a Clinical Director and, perhaps, some of the issues that that might cause. Mr. Weir was subsequently appointed on 1 June. If we have a look at his evidence to us in his Section 21 response, WIT-19904, specifically paragraph 7. If you are looking for the hard copy, Dr. McAllister, I think it is page 70 of your specific bundle. 15:18

15:18

At the very top of the page, it says paragraph 7. Mr. Weir here is referring to receiving a copy of the March letter from Martina Corrigan on 15 June. He says:

15:18

"I believe this was sent to me because Dr. McAllister, acting AMD, in or around June or July 2016, from a personal undated handwritten note, had asked me to try to resolve the outstanding issue. More specifically, he asked me to try to resolve this with negotiation with Mr. O'Brien and have him agree to an action plan without recourse to formal investigation or procedures." 15:19

Do you recall having a meeting with Mr. Weir about June or July 2016 on these issues? 15:19

A. It was June.

426 Q. June. Do you think it was around about 15th June, which was the time Mr. Weir received the March letter?

A. It would have been the following day.
427 Q. Just so I'm clear, sorry. You received the letter the day before the meeting?
A. Yes.
428 Q. Why have you suddenly had a change of tact here from saying not necessarily making moves to address these issue to now that Mr. Weir is there attempting to address them? 15:19
A. I thought it would be more sensible if a surgeon were to address a surgeon discussing surgical issues and surgical management. What I wanted him to do was to open up lines of communication with Mr. O'Brien, flagging up that -- reminding him that there were issues and to start discussions about how best to resolve it. 15:20
429 Q. Whenever you say it was best if it was surgeon to surgeon, you're not hinting at some kind of cultural issue about an anaesthetist telling a surgeon what to do here?
A. If Mr. O'Brien came up to me and told me how to do one long anaesthesia on one of Mr Mackle's suturectomies he might have great insight but it wouldn't have a lot of credibility. We wanted solutions here. Telling Mr. O'Brien he needed to speed up and do whatever wasn't going to work. He actually needed systems, support systems put in place to help him overcome his undoubted issues. 15:20
430 Q. I'm not sure if you were following this morning's evidence, but I don't have anything to put to you in

terms of a transcript, but Mr. Weir certainly gave the impression from his earliest involvement he was perhaps indicating that he was nervous, perhaps, about engaging Mr. O'Brien without appropriate support. Did he ever express anything of that nature to you in this meeting? 15:21

A. He was reticent.

431 Q. In what way did he come across as reticent?

A. I asked him to do it in June and nothing happened in June or July that I could see. Now, admittedly July in the hospital is a dead month, but nothing happened. 15:21 I wasn't expecting Mr. Weir to solve this. What I wanted was to start a process that would be ongoing.

432 Q. So at a meeting, perhaps on 16th June 2016, did you explain to Mr. Weir you wanted him to start this process? 15:22

A. Yes.

433 Q. Did you explain to Mr. Weir when you wanted him to start this process?

A. I didn't give him a date by. I just said I would like him to speak with Mr. O'Brien and to find out what was 15:22 going on, what were the problems, and why he was having these difficulties.

434 Q. Was it your expectation that Mr. Weir would have spoken to him some time in June?

A. I don't know what his holidays arrangements I can't 15:22 remember that. I would have expected it to have taken place over the next...

435 Q. Any time over June or July did you follow up with Mr. Weir to say, 'have you spoken to Mr. O'Brien,

what's the current state of play'?

A. You're asking me to remember. We had weekly meetings. I would have expected I would have.

436 Q. Just so we are clear, you think this discussion on 16th June took place in the context of one of your weekly meetings? It wouldn't have been a specifically arranged meeting to discuss Mr. O'Brien? 15:23

A. I don't remember any specifically arranged meetings to discuss Mr. O'Brien.

437 Q. Would Mr. Haynes have been present? 15:23

A. He was, the vast majority of time he was present.

438 Q. Can you remember Mr. Haynes at this stage expressing any view or a plan how to go about resolving this?

A. Not that I recall.

439 Q. A bit of a discrete point but if we go to TRU-00782. 15:23 I don't have the reference in the page bundles, but it's a statement Dr. Weir made to Dr. Chada on 24th May '17 in the context of the MHPS investigation. If we look at paragraph 6, Mr. Weir told Dr. Chada:

15:23

"Dr. McAllister first mentioned to me that there were concerns about Mr. O'Brien's triage, keeping notes at home and un-dictated clinics in or around August 2016".

We now understand that was probably closer to June 15:24

A. Yes, it was June.

440 Q. Then Mr. Weir says: "He put it in terms of there being a bit of an issue with charts, triage and clinics, but it wasn't put to me as a really serious problem".

How did you express these concerns to Mr. Weir? Did you express them as a serious problem.

A. This was in the context of having a letter which was the end result of three and a half months gestation period involving the Medical Director, the Director of Acute Services, the previous AMD, the previous AD resulting in a letter that was handed to Mr. O'Brien tabulating these issues that had been going on for some time and hadn't been resolved in front of Mr. Haynes. I think it's inconceivable that anyone would characterise this as not serious. 15:24 15:25

441 Q. Can you recall if you expressly emphasised the seriousness to Mr. Weir?

A. He had the letter in his hand so it was clear that this was -- this is not normal. In fact, it is probably unique that somebody is given a letter in this fashion. But if we can just scroll down a bit to number 8. It says here: 15:25

"I was appointed Clinical Director around April 2016". That's incorrect. It was 1st June. 15:25

442 Q. As I pointed out to you whenever I was asking the question. I think there was an issue in paragraph 6 about the dates. He said it was August, you think it was June. Were you aware of anyone speaking to Mr. O'Brien about these issues, either Mr. Young, Mr. Weir or yourself? June? July? Did anyone speak to Mr. O'Brien? 15:25

A. If Mr. Weir didn't, I didn't.

443 Q. This next comes across your desk, so to speak, in August 2016. Would that be right, so far as you can remember?
A. I'm sorry, could you give me the first bit of that again? 15:26
444 Q. This first comes back to your attention in August 2016.
A. Yes.
445 Q. If we have a look at TRU-274718. This is Martina Corrigan, Mrs. Corrigan forwarding you information, updated figures, perhaps, on Mr. O'Brien. It's dated 15:27 17th August 2016. There's an update with regard to triage. There are currently 174 un-triaged letters dating back to May 2016. I think that is a slight improvement, improvement of about a third from the situation in March. Then there's the current review 15:27 backlog which is essentially the same figure.
Why were you being sent this information from Martina Corrigan on 17th August?
A. Because Martina told me that Dr. Wright had contacted her and asked her for those figures, and it had been 15:27 shared with Esther as well.
446 Q. When did Martina mention this to you?
A. I presume that day perhaps. That day I would think.
447 Q. I think, in fairness, if we go every ever so slightly up the email, it says: "This morning attached"? 15:28
A. That day then. Yes.
448 Q. What were you doing with these figures? You get sent these on 17th August 2016. What's your reaction? What is your next step here?

A. I had a meeting with Mr. Weir and asked him to come up with some suggestions about how this could be addressed and to speak with Mr. O'Brien.

449 Q. Perhaps it might be helpful to have a quick look at what you recorded in your response about that. If we have a look at WIT-14862, please? That's paragraph 11.6. It's down the bottom. Thank you. If we pick up, perhaps, two-thirds of the way through that. 15:28

15:29

"I discussed the situation with Mr. Colin Weir, CD for Urology, at our regular Thursday meetings on 18th August 2016."

This is again one of your routine meetings with Mr. Weir? 15:29

A. Correct.

450 Q. Can you recall if Mr. Haynes was present?

A. I can't. I don't think he was but I can't say.

451 Q. "We discussed what steps could be taken to sort this chronic problem out once and for all. Among the things we discussed I suggested that removal from theatre until the backlog was cleared would be the most effective incentive for Mr. O'Brien to address the triage backlog and any other issues". 15:29 15:29

Where did this idea of removing him from theatre come from?

A. Out of my head.

452 Q. Have you ever seen that be used for any other surgeons in the Trust?

A. No.

453 Q. It's your idea. What do you think this would have achieved? 15:30

A. It would have given him time and it would have given him incentive.

454 Q. Incentive in what way?

A. To clear the backlog.

455 Q. I imagine it would be a pretty, perhaps even an embarrassing situation for a consultant to be taken out of theatre. Is that what you were hoping to encourage here? 15:30

A. No. No. I couldn't force him to. He would have to agree to this as a process. 15:30

456 Q. Were you going to go in all guns blazing and just try and do it, or were you just going to plant the seed that there was a threat of this coming down the line? What was your plan here?

A. My plan was to propose that he should come out of theatre until his backlog was cleared. 15:30

457 Q. We're are at the very bottom of this page here. It says:

"Mr. Weir appeared concerned at this suggestion and said that Mr. O'Brien would 'go mad." 15:31

Was this another example of Mr. Weir's reticence at challenging Mr. O'Brien?

A. I'm not sure. I think he was more -- I'm not sure whether it was reticence of challenging, or whether he thought doing that to a surgeon was a bit harsh.

458 Q. You perceive that Mr. Weir was nervous about going after Mr. O'Brien in this way? 15:31

A. I would say.

459 Q. Aware of that knowledge, did you, as Associate Medical Director, try and re-assure him he had your support?

A. Well I hope he had no doubt he had my support.

460 Q. You go on "I asked him" -- that is Mr. Weir: 15:31

"...to think about it over the weekend and come up with a solid plan that would sort this problem out once and for all and consider speaking with Mr. O'Brien the following week." 15:32

At this stage did Mr. Weir revert to you with a plan?

A. Revert to my plan?

461 Q. Revert to you with a plan?

A. He reverted with a plan subsequently, but I couldn't say whether it was the following week. 15:32

462 Q. I think he reverts to the plan on 16 September, which is about a month later, but following your meeting on 18 August, according to your own response, you told Mr. Weir to think about it over the weekend and come up with a solid plan? 15:32

A. Yeah, if he didn't like my idea about the theatres then he had to come up with something else.

463 Q. Do you recall him ever bringing something else to the

table at that time?

A. No.

464 Q. Madam chair, it is half-three. I am not dying for a break myself, but now might an appropriate point.

CHAIR: Are you happy to continue? 15:33

A. Of course.

CHAIR: Is everybody in the room happy to continue? I mean, if anybody needs to take a comfort break I can certainly leave. But I think it is preferable that we continue on and get through this witness' evidence today, if at all possible.

465 Q. Can we have a look, please at WIT-14883, please. Can we scroll down to the bottom? This appears at page 46 of your hard copy bundle. But what it is, is, it's an email from Mr. Gibson to yourself, Mr. Mackle, 15:33 Mr. Carroll, Ms. Trouton, marked "Confidential AOB". It says:

"Dear all, I have been asked by the Medical Director to consider a range of issues in relation to Mr. O'Brien. 15:34 As part of this, I would be grateful if each of you can confirm back to me if you have received any plans or proposals from Mr. O'Brien to address the issues outlined in the attached letter questioned." 15:34

He goes on to say he was asking all four of you because of the recent change in the occupiers of the various Assistant Medical Director and Associate Medical Director roles. He said:

"I would be grateful if you could respond to this email, even if you have not received any plans or proposals."

What did you take this email to mean? Did you think the Medical Director; what did you make of the Medical Director's interest of this at this time?

A. Well, this came three weeks after my one-to-one with the Medical Director. Now, the email to Martina Corrigan on 9 September came three weeks after my one-to-one with the Medical Director. And then it was on 17 August, I think, that Martina replied with those figures. And then this came in from Simon. And when you see "confidential," and when you see "given the sensitivity of the subject", that would indicate that we're looking at either MHPS or GMC or both. 15:34 15:34 15:35

466 Q. Did you reference there -- sorry, did you reference there one-to-one with the Medical Director?

A. Uh-huh. 15:35

467 Q. When did that take place?

A. That was in July, 13th.

468 Q. Approximately a month has passed by the time you receive -- over a month has passed by the time you receive this email in that one-to-one? 15:35

A. Well it was three weeks after that that the Medical Director contacted Martina, then Martina sent an email about nine days after that.

469 Q. If we can have a look at your response, please. If you

scroll back up, you say:

"Dear Simon. As you know, I came into this midstream. I have received no communication from Mr. O'Brien on this topic." 15:36

You were asked had Mr. O'Brien provided a plan. You said you hadn't received it. You don't indicate to Mr. Gibson, who is the Assistant Director in the Medical Director's Office that you and Mr. Weir have 15:36 been discussing this very issue the week before, on the 18th, the Thursday before even, and perhaps were starting to formulate your own plan for addressing this issue. Why would you not have indicated that to Mr. Gibson? 15:36

A. He didn't ask.

470 Q. I can fully see that he didn't ask, but the email is marked "confidential AOB". As you just indicated, perhaps indicates that the Medical Director is considering their options. Should you at this stage 15:36 have flagged that, hold on, Mr. Weir and I have discussed this, we think we can work with Mr. O'Brien? Did that thought ever cross your mind to flag this to Mr. Gibson?

A. No. 15:37

471 Q. On reflection, do you think you probably should have flagged that to Mr. Gibson?

A. If he had asked, I would have answered. He didn't ask, 'do you have any plans'?

472 Q. I fully appreciate that you answered the question which was asked, but do you think, on reflection, you could have been slightly more open about your understanding of the issues and what it might take to sort them?
A. Well, I think there was a lot going on and he asked me a direct question, I gave him a direct answer. 15:37
473 Q. If we could look then, please, at WIT-14885. For your hard copy, Dr. McAllister, it's at page 48. Please go down. This is an email you sent to Mr. Weir on 23 August, so it's the day after Mr. Gibson has contacted you. You say: 15:38

"Strictly in Confidence. Hi Mr. Weir, please see below. This has come to light subsequent to our discussion on this subject last Thursday. It appears that the boat is missed. I know that you are on leave this week and I'm off for the following two, so won't get a chance to meet/discuss. Please hold off on attempting to address this issue until the dust settles on the process below". 15:38 15:38

So the next day your attempts to manage Mr. O'Brien or proposals to manage Mr. O'Brien because you email Mr. Weir about it?
A. Uh-huh. 15:38
474 Q. You never once considered letting Mr. Gibson in on this?
A. No.
475 Q. Is it necessary because the Medical Director is looking

at something, does that mean that you as an Associate Medical Director, Mr. Weir as a Clinical Director, does that mean you just can't go anywhere near it?

A. It's been a process taken on by the Medical Director and his agent. Mr. Weir was away. I was going to be away very shortly. There wasn't a lot of opportunity to get involved. 15:39

476 Q. Again, on reflection, should you have at this stage -- I know you said you were going to get away, but should you have perhaps tried to engage with Mr. O'Brien before the Medical Director gets involved and however serious that might become? 15:39

A. In hindsight, yes, that may have helped the situation temporarily, but it would have come back again.

477 Q. If we just complete the email chain by scrolling up. On 30th August 2016 Mr. Weir responds: Okay, got it. He has clearly got the message. He was off for a week, then above you say: 15:40

"Thanks. V disappointing. This is not the direction of travel I wanted for many reasons." 15:40

Could you outline what those reasons were?

A. I think we hadn't been given a chance to come up with a strategy for effectively dealing with Mr. O'Brien's issues on an ongoing basis. 15:40

478 Q. You considered the intervention from the Medical Director to mean that you'd lost that chance?

A. I thought that was likely.

479 Q. You never picked up the phone to Dr. Wright and said:

Hold on a second here, Colin and I might have a plan.

A. No.

480 Q. If you had have done that, do you think Dr. Wright would have been receptive?

A. I couldn't say. 15:41

481 Q. Could we get on the screen, please, TRU-274370? This is a slightly discrete issue this time. Sorry, it is 274730. What is coming on the screen is an email chain with regards to a patient. While the patient's name is on the screen I would be grateful if you could 15:42 refer to them as Patient 93 for the purposes of this discussion.

Scroll down to the bottom. This is an email from Mark Haynes to Martina Corrigan at this stage about Patient 15:42 93.

"The story here is raised PSA referred by GP on 4th May. GP referal is routine. Not returned from triage, so on well is routine. If had been triaged would have 15:42 been RF upgrade. PSA 34 and 30 on repeat. Saw Mr. Weir for leg pain and CT showed metastatic disease and prostate primary. Referred to us and seen yesterday. As a result of no triage delay in treatment of 3.5 months. Mr. Haynes's view is that it wouldn't 15:43 change the outcome and queried if it should be called an SAI."

Do you have any recollection?

A. I do.

482 Q. Scroll up to the top of this page. Mr. Carroll emails you, Dr. McAllister:

"Charlie, please can you read the series of emails. Suffice to say that although the outcome for the patient would not be any different, this, as you know, is not the issue that needs to be dealt with."

What do you consider to be the issue to be dealt with here? 15:43

A. The lack of triage.

483 Q. This is 31st August. This is again at a time perhaps two weeks after you met Mr. Weir to discuss a plan to discuss this type of issues?

A. Mm-hmm. 15:43

484 Q. Did the penny drop in your mind that this is, in fact, the same issue. This is a Mr. O'Brien issue and this is the logical outworkings of this triage problem?

A. Correct.

485 Q. Before we move on. On receipt of this correspondence here did you suddenly think, 'gosh, we need to take action here against Mr. O'Brien or get this addressed'? 15:44

A. To take action against him?

486 Q. To get this addressed is perhaps a...

A. I thought that we should gather the information from Mr. Young, that we should gather the information from Mr. Weir and get the facts, get their perspective on it. 15:44

487 Q. Sorry, I didn't mean to cut across you. If we do

scroll up, that is what your email back to Mr. Carroll says on 31st August.

"My thoughts we should go to Mr. Young, Mr. Weir second, then happy to become involved." 15:44

A. Yes. I was happy to become involved.

488 Q. So far as you're aware, what happened to Patient 93? Did this come back across your desk? Did you receive any more correspondence about this?

A. This was an important case for several reasons. There was an issue with the system around triage and although it strictly may not have been an SAI, I was keen that this should be investigated. 15:44

489 Q. Was this investigated further?

A. The problem is I was actually in Moscow when that email was sent. I was away for two weeks and when I came back that would have been the week beginning 12th September, then we were overtaken by subsequent issues. 15:45

490 Q. Perhaps at this stage there's a distinction to be made between what might be called the concerns or the issues about Mr. O'Brien and this specific Patient 93. Whose call was it to declare this as an SAI? 15:45

A. That would have been a joint decision. Well, anybody can ask for an SAI. That would probably be a joint decision between Ronan Carroll and myself. 15:46

491 Q. Do you recall ever having a discussion with Ronan Carroll about whether this should be declared an SAI?

A. It never came back.

492 Q. The last you hear of Patient 93 then is on 31st August

you recommend it goes to Young, and then Mr. Weir, and you never received any correspondence back?

A. No, not that I recall. I'm sure you're going to put up an email, but I don't recall any further correspondence on that. 15:46

493 Q. Believe it or not I'm about to put up an email. But not having heard any response from Mr. Young or Mr. Weir, having sent them off on 31st August to look into this, is it not incumbent on you as an Associate Medical Director to follow up and make sure this 15:46 patient is going into the appropriate process if they need to?

A. This is 31st August. I declared that I was happy to become involved. I thought this would be a useful and productive exercise. As I said, I was away on leave. 15:47 I didn't come back until the 12th. The 12th is my day all day in ICU after being away, so you're kind of somewhat occupied. Tuesday is my day all day with Mr. Mackle, and that's definitely a stretch. So there was a lot going on. Then there was the issue of the 15:47 Oversight Committee, and that tended to be a bigger distraction than this. It would normally be Ronan Carroll who would have followed up on this and would have brought it to my attention, reminded me of it again, and would normally have brought the notes with 15:48 me. Normally we would go over the notes and get all the information before going off half cocked.

494 Q. Just so I'm clear, we're still in the context of Patient 93. You would have expected perhaps Ronan

Carroll to have brought it back to your attention or make sure an appropriate decision was made?

A. Yes, he was the admin person. Well, he was the one brought it to my attention.

495 Q. You referred there being off until 12th September and then also to the Oversight Committee of 13th September. Perhaps that's an appropriate place to have a look. If we could get up TRU-00026, please. Minutes of an Oversight Committee on 13th September, attended by Mrs. Gishkori, Mrs. Toal, Dr. Wright, Mr. Gibson and Mr. Clegg. Were you aware this meeting was about to take place? 15:48 15:49

A. No.

496 Q. When did you become aware this meeting had taken place?

A. When Ester Gishkori told me. 15:49

497 Q. When was that?

A. Either the day of it or the day following.

498 Q. Perhaps while we're here, if we have a look at what was agreed at that meeting. Mr. Gibson is to draft a letter for Mr. Weir and Mr. Carroll to present to Mr. O'Brien. The meeting will take place week commencing 19th September. The letter should inform Mr. O'Brien of the Trust's intention to proceed with an informal investigation under MHPS at this time, which include action plans with a four week timescale to address the four main areas of his practice. Mrs. Gishkori is to go through the letter with Mr. Weir, Mr. Carroll and Mr. Gibson prior to the meeting with O'Brien, and Mr. O'Brien should be 15:49 15:49

informed a formal investigation may be commenced if sufficient progress is not being made.

This meeting you had with Mrs. Gishkori, was that one of your monthly meetings with the Acute Director? 15:50

A. I would have thought so.

499 Q. Was anyone else present at that meeting?

A. I can't say.

500 Q. I think just, if we try and have a look. It's TRU-257656. You say: 15:51

"Hi, Confidential AOB, further to our meeting today there`s only one communication that I have received on this subject."

15:51

This meeting with Mrs. Gishkori appears to have taken place today, 14th September 2016?

A. Wednesday, yes.

501 Q. Which would have been the day after that Oversight Committee meeting. This appears to be a relevantly 15:51 significant email in the grand scheme of things because, as we discussed there, there's quite a clear agreed plan by the Oversight Committee meeting on 13th September. At this meeting on 14th September there appears to be some type of change of course agreed 15:51 whereby you and Mr. Weir are to be given the opportunity to tackle the issues?

A. Mm-hmm.

502 Q. What can you recall was discussed at that meeting?

A. My recollection is that Esther said that the Director was going to go for a formal investigation and was planning to suspend Mr. O'Brien.

503 Q. We have just seen on the screens there, I took you through the various bullet points, you can see having read the minutes of 13th September, at that stage there was no envisaged formal investigation or intention to suspend Mr. O'Brien. Having read that, can you see that? 15:52

A. Well, can we just go back to that one? 15:52

504 Q. Yes, of course. It is TRU-00026. You're saying Mrs. Gishkori came in to the meeting and said that there was an intention to start a formal process and the Medical Director wanted to suspend Mr. O'Brien, is that right? I haven't misquoted you there? 15:52

A. No, that's what she said.

505 Q. These are the minutes of the meeting or the action points, perhaps. Simon Gibson is to draft a letter. The meeting with Mr. O'Brien should take place next week. The letter should inform Mr. O'Brien of The Trust's intention to proceed with an informal investigation under MHPS at this time. The final bullet point there refers to potential for a formal investigation? 15:52

A. Yes. 15:53

506 Q. Were any of those points communicated to you by Mrs. Gishkori at that meeting?

A. No.

507 Q. And you're certain she told you that the Medical

Director wanted a formal investigation?
A. Was planning a formal investigation.
508 Q. Planning. You are certain she also mentioned that the Medical Director was keen to suspend Mr. O'Brien?
A. Correct. 15:53
509 Q. How did you react to that?
A. I was amazed. If you actually go back to the figures that Martina sent, you said there wasn't much of a change in the triage figures. They were actually a 31 percent reduction, which, considering there's 175 15:53 triages coming in a week, I mean I know 31 percent is not perfect over six months, but for Mr. O'Brien that was a significant improvement. As regards the review patients, this was a complete red herring.
510 Q. Maybe perhaps we'll come back to the issue of the 15:54 review backlog in a couple of minutes, what I really want to understand is what went on at this meeting on 14 September. Of so Mrs. Gishkori, who was at the oversight committee on the 13th, would have been part of the group of people who agreed to these five bullet 15:54 points, you say, came into that meeting and in effect came up with a very different version of events to what's on that screen right now?
A. Correct.
511 Q. On hearing this, then, you said you were shocked. How 15:54 did you respond to Mrs. Gishkori?
A. Well, there was a -- we had a discussion and I said that Mr. Weir and I had discussed it before in August and had a strategy that we were hoping to put together.

512 Q. How did Mrs. Gishkori respond to that?
A. She was keen.
513 Q. You say "she was keen". She, again, emphasises at that Oversight Committee the fact that she was keen doesn't get out of what was agreed from that. What was her response? You say she was keen. Was she keen to go with you? Did she mention what impact that would have on the agreement with the Medical Director? 15:55
A. No, she didn't. That was her problem.
514 Q. When you say "she was keen", what exactly did she say to you after you told her that you and Mr. Weir were keen to be given a crack to resolve this? 15:55
A. She said that we should look into coming up with a plan.
515 Q. From memory, how long did this meeting last? 15:56
A. It's six years ago, you're asking me how long a meeting was.
516 Q. I'm asking if you can remember it?
A. No.
517 Q. Can you remember, I know you aren't certain if Mr. Carroll was there, but can you remember if Mr. Carroll had any input into this discussion? 15:56
A. I don't remember.
518 Q. Walking out the door of that meeting, what did you understand was to happen? 15:56
A. That Esther was going to speak with the Medical Director or communicate with the Medical Director.
519 Q. If we have a look at Mrs. Gishkori's communication to the Medical Director, which I think can be found at

AOB-01053, please. I think this is at page 172 of your core bundle, if you are looking for a hard copy. It's not the best copy on the screens here. Have you a copy of that in front of you, Dr. McAllister?

A. Yes. 15:57

520 Q. If we start with Mrs. Gishkori's email to Dr. Wright and Mrs. Toal:

"Following our Oversight Committee on 13th September I had a meeting with Charlie McAllister and Ronan Carroll". 15:57

She seems to think Mr. Carroll was there. I appreciate you can't recall.

"I mentioned this case that was brought to the Oversight meeting in relation to Mr O'Brien and the plan of action. Actually Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was, of course, part of that. Now they both work locally with him they have plenty of ideas to try out, and since they are both relatively new in the post I would like to try their strategy first." 15:57

Does that largely accord with what you would have told Mrs. Gishkori on 14th September? 15:58

She says: I am therefore respectfully requesting that the local team be given three more calender months to resolve the issues raised in relation to Mr O'Brien's performance".

Where did the suggestion that three months were required come from?

A. I can't say whether that was her or us.

521 Q. She then says: "I appreciate you highlighting the fact that this long running issue has not yet been resolved. However, given the trust and respect that Mr. O'Brien has won over the years, not to mention his life-long commitment to the Urology Service which he built up single-handedly, I would like to give my team the chance to resolve this in context and for good." 15:58 15:58

Would you have impressed on Mrs. Gishkori at that meeting that Mr. O'Brien had built up urology single handedly? 15:59

A. No.

522 Q. If we have a look at WIT-23372, which is a response to a Section 21 notices compiled by Mrs. Gishkori.

The paragraph there, Mrs. Gishkori says: "I did not know Mr. O'Brien at all nor did I know his history in the Southern Trust. However, Mr. Mackle and Heather Trouton did know him well". 15:59

In response to the Inquiry's questions she was telling us that she was largely unaware of Mr. O'Brien. Does the suggestion that he built up the urology services single handedly, did that come from you? 16:00

A. I can't say. I don't see -- I can't say. I wouldn't

have thought so, but I can't say whether it is or not.

523 Q. I am not just going to ask you in this context, if we refer to WIT-14872. This is paragraph 12.13 of your witness statement. In your response to this Inquiry you use that kind of language, pain staking narrowly focused is what enabled him to single handedly set up the urology service. That is the turn of phrase you have used there. It also appears at AOB-50009, which is the reference we discussed at the start of today's hearing. The language appears similar to the language you might use. Did you, when discussing these issues with Mrs. Gishkori, make it perfectly clear to her the esteem with which you held Mr O'Brien in and the amount of effort you perceived he put into establish the Trust's urology services? 16:01

A. I can't say.

524 Q. Is there any suggestion here that perhaps while Mrs. Gishkori might have caught the wrong end of the stick or misrepresented in some way what was agreed at the Oversight Committee, you provided a different view based on your understanding of all that Mr. O'Brien had contributed to the Trust. Could that have happened here? 16:01

A. No.

525 Q. You're certain? 16:02

A. 100%.

526 Q. If we can go back to -- and I know we have gone back a fair amount to this page -- AOB-01053. I think if, in fairness, perhaps, we could just briefly turn back to

that subtract from Mrs. Gishkori for a point I will just clarify. It appears she was talking about her knowledge at a slightly earlier time. It might have been February or March as opposed to in September but I think the point remains that she didn't know Mr. O'Brien particularly well. In response to this email we just discussed from Mrs. Gishkori, Dr. Wright comes back: 16:03

"As Director of the Service naturally we have to listen to your opinion. Before I consider conceding to any delay in moving forward with what was agreed with our agreed position after the oversight meeting I would need to see what plans are in place to deal with the issues and understand how progress would be monitored over a three-month period." 16:03

Rather reluctantly it seems Dr. Wright is giving you and Mr. Weir to deal with these locally. Do you accept that? 16:03

A. Mm-hmm.

527 Q. If we go up further, there is an email from Mrs. Gishkori to yourself, Mr. Weir and Mr. Carroll. And my response will be. What your response?

A. The response was Mr. Weir's plan which was then annotated by Ronan Carroll. 16:04

528 Q. If we have a look at that plan. TRU-357640, please. Just back to 257641, please. On 16th September then Mr. Weir emails you: "These are my initial thoughts".

If we scroll down he produces an 8-point plan. Did you have any role in creating that 8-point plan?

A. No. Well, I asked Mr. Weir to do it.

529 Q. When exactly did you ask Mr. Weir to produce this?

A. I can't say. 16:05

530 Q. Was it further or following on from those emails we were just discussing from the Medical Director?

A. I never saw that email from the Medical Director.

531 Q. It was copied to you by Mrs. Gishkori and she said FYI, and my response will be? 16:05

A. No, sorry, that's quite right. It was following on Esther's, and "my response will be."

532 Q. Looking at this 8-point plan, would it be fair to say it is relatively high level?

A. Yes, it's lacking detail. 16:05

533 Q. For example, point 2 to implement a clear plan to clear triage backlog. That's effectively the plan is we're going to make a plan?

A. Mr. Weir hadn't come up with -- if there wasn't an alternative it would revert to stepping out or aside 16:06 from theatre.

534 Q. You respond to this -- go up, please. This is on 21st September, so a couple days ad passed:

"Apart from the fact that you spelt my name wrong this 16:06 is absolutely excellent and I agree completely. It would be important to do this in a positive, constructive supportive role and that Mr. O'Brien would be aware of this. I think this approach would have the

best chance to achieve this and for approving the current"?

A. Can you just scroll back down again? See it says here -- sorry a bit more. These are my initial thoughts. So it was an evolution. It wasn't a fixed concept. 16:06

535 Q. Did you raise with Mr. Weir the plan was perhaps lacking in a bit of detail? You say it was "absolutely excellent"?

A. The important thing was to get the process going and then modify it as we went along. 16:07

536 Q. If we keep scrolling up, please. I think, as you said, whenever we started discussing this, Mr. Carroll provides some comments on 22nd September. I'm not entirely sure the detail is important for present purposes. From 22nd September Mr. Weir and yourself have a plan. It's got, albeit reluctant, it's got the backing of the Medical Director to go ahead with it. It has Mrs. Gishkori, whose the Acute Director, again very supportive. Was this plan ever actioned with Mr. O'Brien? 16:07

A. No.

537 Q. Why not?

A. Because at the end of September I was involved in a completely separate imbroglio and I was distracted with that and, without me, things went a different direction. 16:07

538 Q. So this ultimately, the process, the issue you have just referred to, it ultimately ends up with you having

to leave your role as Associate Medical Director in October '16, is that right?

A. I think it was October 13th.

539 Q. 13 October 2016. So from 22 September, whenever this plan is good to go, do you take any steps to action it? 16:08

A. No, I was distracted elsewhere.

540 Q. The first step of this plan of Mr. Weir, he says initially:

"I initially have a series of face-to-face meetings with Mr. O'Brien and aim to have resolution or a plan for resolution in the next three months, this is by mid-December. I propose the first meeting will involve you, me and Mr. O'Brien." 16:08

Were there any attempts to set up that meeting?

A. Not that I was aware of.

541 Q. Were you aware of any attempt -- did Mr. Weir ever contact you in any capacity about this?

A. No. 16:09

542 Q. Did he raise it at your next Clinical Director and AMD meeting?

A. Not that I remember.

543 Q. So it seems as if this plan, which at this stage seems to have the backing of most of the hierarchy of The Trust just, in effect, withers, is that fair, is that what happened? 16:09

A. I think Mr. Weir would have been unlikely to go ahead without my support.

544 Q. And why do you say that?
A. Mr. Weir was -- he would have been reticent.
545 Q. You did make it clear in your response to Mr. Weir you thought his plan was absolutely excellent. Should he not have been encouraged by your positive endorsement of these proposals? 16:09
A. I hope he was. That was my intention.
546 Q. And yet, it still doesn't appear that Mr. O'Brien was ever met or communicated with?
A. I was keen that Mr. Weir would take responsibility and go forward with this on an ongoing basis. Whatever happened, I wasn't going to be there after April. 16:09
547 Q. Then rather unexpectedly you end up leaving your role as Associate Medical Director in October 2016. Had you had any further engagement with Mr. O'Brien or the MHPS process after that date? 16:10
A. No, apart from Amy Crilly in Tughans emailed me asking for a testimonial this for Mr. O'Brien in around December '20.
548 Q. And that's the reference that we discussed? 16:10
A. It was for the GMC. Then a year later she emailed me again asking for my permission, well, would it be okay if they use the reference for this Inquiry.
549 Q. Just so we're clear, that is the reference we have had on the screen a couple of times which we discussed earlier? 16:10
A. Correct.
550 Q. I don't want you to give away any personal material, but it appears as if your case was discussed in the

Oversight Committee in October 2016, and yourself might have some involvement with an MHPS process from a slightly different angle. I don't want to go into the specifics, I don't think it is relevant to our Terms of Reference.

But this Inquiry's Terms of Reference ask us to look at the MHPS framework and see if there's any issues. As a person who has been on the other side of the fence, and been investigated under the framework, how did you find the kind of doctor experience in the process?

A. It was certainly stressful.

551 Q. Do you think that was the way that your specific process was conducted, or the way the process is set up?

A. I think probably both.

552 Q. Having had a foot in both camps to a certain extent, what changes could be made to MHPS to make it work better? I'm mindful it's ten-past-four, so...

A. I think, and I put it in my Section 21, that the informal approach should be used much more often with a much clearer structure at the early stage with the view that -- which is in the policy, which isn't followed -- of getting engagement from the individual and having an agreed process going forward. Although you didn't reference it, it's interesting that NCAS followed exactly the same suggestions that I did. They suggested a positive engagement with Mr. O'Brien, getting an agreed plan going forward, and relieved of

his duties, including theatres, until he was able to catch up.

553 Q. That's the NCAS advice on 13 September 2016 that you're referring to?

A. Which I hadn't seen until this Inquiry, I think. 16:13

554 Q. Just one or two points almost to finish.

A. Can I just go back to one point?

555 Q. Yes, of course.

A. I did listen to Mr. Weir and he said that somebody from outside should be involved, but there's the availability of somebody outside, NCAS will sit in on any meetings if you wish. 16:13

556 Q. So perhaps then, as opposed to a fundamental reform, you're saying perhaps a better use of the services which are already there? 16:13

A. Well I think blaming the process is like blaming the patient when it doesn't go well. If you don't use the process and follow the steps recommended in the process with all the safeguards, it's hard to blame the process. The process, looking through all this documentation, was not followed appropriately in this case. 16:14

557 Q. On the utilisation of the informal stages of MHPS, you know, today we have discussed your various engagement, you became aware of these concerns in April '16. You sent an email to the Medical Director in May '16. You met with Mr. Weir in June '16. There were further discussions taking place in August '16. There were further discussion again with the backing of the 16:14

Medical Director and Mrs. Gishkori in September 2016. Ultimately, throughout your entire tenure as Associate Medical Director, Mr. O'Brien is never once engaged with informally. Why was that the case?

A. Because that had been done multiple times previously and it hadn't worked. What I wanted to do was -- I was only going to be there -- this was not a life job, I was going to be there for a year or less. Dr. Wright announced in May that the jobs were going to be -- all the MD posts were going to be advertised and re-interviewed. So it was only going to be a short period. There was no sense of we had to sort this out this month or next month. 16:14 16:15

Between the meeting with Dr. Wright and handing the letter to Mr. O'Brien was three-and-a-half months. There wasn't a sense of a Doomsday clock ticking here. My concern was to put something in place that would be lasting. 16:15

558 Q. But, ultimately by the end of your tenure, nothing was in place, do you accept that? 16:15

A. Correct. So in the six months I was there, it was not sorted.

559 Q. I'll ask you one last time to offer any further reflections you have on why that was the case, what stopped that work taking place? 16:15

A. Well, I've tried to say that I was trying to get all the various parts into place so that there would be a sustained system put in place to ensure that this

wasn't a recurring theme which had been going back for many years.

560 Q. Was there anything stopping you trying to put that system in place during your time as Associate Medical Director? 16:16

A. Well I needed a Clinical Director, I needed engagement from the Clinical Director with Mr. O'Brien, and I needed him to take ownership of it and go forward, which I was fully supportive of.

561 Q. Were all those conditions not in place by 16 September 2016, whenever Mr. Weir produces his plan? 16:16

A. Yep!

562 Q. Yet Mr. O'Brien still wasn't spoken to or met with to address these issues?

A. As I say, by 23 September, I was involved in something else and my focus was not on that. 16:16

563 Q. I do promise you this is the last question. I think I've given you a few false dawns. You didn't end up giving evidence to Dr. Chada's --

A. Yes, I noticed that. 16:17

564 Q. We have noticed that too. Is there any particular reason why you didn't give evidence to Dr. Chada?

A. Well you would need to ask them. I would expect that they would give the reason that I was on sick leave, however, I wasn't on sick leave for 17 months, and I wasn't asked. I would presume they didn't want to hear what I had to say. 16:17

565 Q. No doubt the Inquiry Panel will pick that up with Dr. Chada when we hear from her. Madam Chair, I have

no further questions, thank you.

CHAIR: Thank you Mr. Beech. I'm sorry we can't release you just yet. We have some questions for you ourselves, Dr. McAllister.

DR. McALLISTER WAS QUESTIONED BY THE INQUIRY AS FOLLOWS:

566 Q. CHAIR: One of the first things you say in your statement to us was you talked, and Mr. Beech drew this to your attention, about the tsunami of policies and protocols that were produced by the Department between 2005 and 2016. I just wondered what time, as a busy clinician, you would have had to read, assimilate those policies and protocols? 16:18

A. You wouldn't.

567 Q. You wouldn't, and would all those policies and protocols -- well, would any of them have training attached? I mean you don't recall the training you had in MHPS, but you do remember there was some now? 16:18

A. I think, and I said it in my statement, I think that for something as fundamental as MHPS and the Trust Guidelines, just to fire out guidelines and maybe to train one or two people misses the whole point.

It is important that every permanent medical employee is aware of the guidelines, aware of the process, and gets training in it so they understand what they are facing into if they are subject to either informal or

formal, what their rights are and what the correct process should be.

568 Q. In terms of how that could be achieved?

A. Well, there's mandatory training. Every year we had fire training, every year. And the fires didn't change from year to year. Every year we had infection control training and, again, that didn't change from year to year. But something as fundamental as this I think it should be provided to all new starts within their first year and then it should be renewed at least every three year. I think it should be mandatory. This is their employment. It is expected of them. How they should behave. I think it's important. 16:19 16:20

569 Q. In terms of a more specific point about the removal of Aidan O'Brien from his operating list, or removing the operating list from him, why did you think that would work? 16:20

A. Because it would give him time, because it would give him motivation.

570 Q. When you say it would give him motivation, was that because of your personal experience that he actually enjoyed operating on patients or -- 16:20

A. Surgeons are not like normal people. Everything they do is geared to supporting their lists in theatre. All the outpatients, all the letters, all the ward rounds, all the pre-op and the follow-up, that is all for that half-day, day in theatre. It is their raison d'être, and that's what they -- I'm sure the adviser would agree with that. Otherwise, why would you become 16:21

a surgeon?

571 Q. Well I'm sure there are many people that can certainly answer that question. I'll certainly ask Mr. Hanbury afterwards. So you felt this was a good way of getting him, perhaps, to change his ways on a more permanent basis than had been previously tried? 16:21

A. It was one part of it. Mr. O'Brien was 62 at this stage. He was still seeing new patients. The obvious thing was to stop that and just do the reviews. He had, theoretically a very long list of review patients. Yes, but he had been there for 24 years, so of course he had a lot of review patients. The three consultants that were there in 2012, 2013, they had not built up the body. Mr. O'Brien's review patient backlog was no different from Mr. Young's, but Mr. Young had been there six years less, so his review patients weren't the issue. The problem was, there wasn't capacity. But for Mr. O'Brien to go on seeing new patients at 62, in my mind, there's no logic to it. You want the new patients to go to the young guys so that they get follow-up over a longer period of time. You don't want to change surgical horse mid-stream. 16:21 16:22 16:22

572 Q. You seem to be expressing a view that you didn't seem to express from the information we have been shown this afternoon. For example, when Mr. Weir came along with his plan, you weren't saying: Why not take away all the new patients? You weren't adding to that? 16:22

A. No. The important thing was to get Mr. Weir onboard and take ownership of it. Then you can add and modify

it as you go along. I was also planning to do a Paddy Loughran and ask Zoë Parks to become involved.

573 Q. Zoë Parks is HR?

A. Yes. Zoë Parks is really excellent. I had done some work with her before. She has always been helpful. That would give some intestinal fortitude to Mr. Weir going forward. She is non-threatening, very calming, and she would have been a real asset. 16:23

574 Q. I'm just curious, because I am listening to what you are saying, Mr. McAllister, and it is quite clear that you did have, in your head, a plan as to how to address these issues. I just wonder how much of that you shared with Mr. Weir, or did you just ask him to do this by himself? 16:23

A. Mr. Weir was a reluctant bride. He had kept on his AMD role in Education. He wasn't all-in on the CD. He was dipping his toe in. I was conscious that I didn't want him to be so perturbed that he wouldn't continue going forward. 16:24

575 Q. Might I suggest that by putting it on to his shoulders, as it were, had a counterproductive? 16:24

A. I'm not asking him to do an Inquiry. I'm not asking him to do what he had been through before. I was asking him to be supportive, constructive and to provide follow up with add-ons from -- I was more than happy to provide all the support I could give but I wanted a successful result. 16:24

576 Q. Forgive me maybe I'm misunderstanding this, but it seems to me that if you wanted a successful result and

you had a plan of how to achieve that successful result, then it was incumbent on you to communicate that to the person you were asking to deliver that result?

A. The important thing was to start the process. There was an urgency here. We were given three months. The important thing was to get it going and off the ground rather than coming up with the perfect plan that everyone could agree on beforehand. 16:25

577 Q. You're saying there was an urgency, and we know that this was a problem of longstanding, yet you seem to be taking the same approach that had been taken all along in trying to deal with this long standing issues, dealing with them softly rather than trying to address them in a whole? 16:25

A. No, no, I didn't say we would deal with it softly. I said we would deal with it constructively, positively and firmly. No theatre lists. If Mr. O'Brien refused to do that then, as far as I was concerned, that was straight to formal process. If that meant -- 16:26

578 Q. Do you feel you communicated that clearly to Mr. Weir?

A. I can't say how firmly. Well, I did say he should be removed from theatre. For a surgeon that is as big a sanction as you can do.

579 Q. Yes. 16:26

A. Because then you have to do all the out patients, all the other bits but not the --

580 Q. The part you want to really be getting on with?

A. Yes.

581 Q. You say in your statement that you felt the Trust underused the formal approach at an early stage. It strikes me that the one thing they have done -- are you saying by that the informal approach under MHPS? Because it strikes me they had tried many, many informal approaches to resolve this?

A. A structured approach under MHPS.

582 Q. We have seen that was what they were planning to do after that Oversight Committee meeting in September.

A. That wasn't what was communicated to me. Also, if you look at the emails, if you look at the Section 21s from Ronan Carroll, he thought it was formal. If you look at the Section 21 from Simon Gibson, he thought it was formal. If you look at the minutes of the Oversight Committee in December, the approved minutes, it was described as formal. 16:27

583 Q. Yes. I think one of the things that may be said, and I would be interested in your view on this, is that people's understanding of MHPS, having an informal and a formal element to it, is maybe not that clear. Would that be fair? 16:28

A. They should have. Those people in those positions.

584 Q. Yes. Thank you. I'm just curious, you talked earlier this afternoon about the list, and we've seen the email of all the difficulties that you had when you took on this role of AMD, did Esther Gishkori, for example, give you any steer as to which part of the elephant to chew? 16:28

A. No.

585 Q. Did anybody ever give you any steers as to which part of the elephant to chew?

A. No. Or a time scale that it was expected to be eaten by.

586 Q. You clearly had worked to some extent with Mr. O'Brien and it's clear that you thought highly of him, you were asked to give a reference, and we've seen that. You considered him to be a good surgeon. Were you then surprised to learn about all of these issues relating to his practice? 16:28 16:29

A. Yes. Until I took over as surgical I knew nothing about this. You have to realise there was another surgeon there who was a subject of restrictions within the practice. He couldn't do open surgery. Well, he tried to do open surgery, his post operative care, I met him once and he gave me instructions about what he wanted about the management of a patient in there with renal failure. It was complete rubbish. Michael Young came along afterwards and he asked me has the Surgeon been in, I said yes, this is what he said. Mr. Young said just forget that and do whatever you think, and if he comes back again give me a call. This was a surgeon who was not competent in this surgery. 16:29 16:29

587 Q. Yes, but I think the question I'm asking you is you knew Mr. O'Brien to be a competent, indeed more than competent surgeon and, therefore, what I'm asking you is when you learned that there were all of these other issues with his practice, in terms of the triage, in terms of not dictating letters, in terms of keeping 16:30

files at home, I just wonder how shocked you were or were you surprised?

A. I mentioned Mr. Young, Mr. Young is also an absolutely outstanding surgeon. Mr. O'Brien is the slowest human being I have ever seen. Everything, everything is slow. Everything. So was I surprised when I heard? It added up. 16:30

CHAIR: Thank you. I'm just checking my notes here to make sure there's nothing else I want to ask you before I hand you over to my colleagues. Yes, I think you've answered the questions I had for you. Thank you very much. Dr. Swart? 16:31

588 Q. DR. SWART: I'm particularly struck by your letter about the 21 things you discovered in your first couple of weeks as AMD that you wrote to the Medical Director and others and the lack of response to that. When you said there's no ineffective governance, basically, what was it you were particularly thinking about? What was the thing that shocked you the most or you thought was the most important in that big long list? 16:31

A. What shocked me the most?

589 Q. Yes.

A. It would be hard to choose what shocked me the most. It was the lack of overall structures for ensuring practical and effective governance. 16:32

590 Q. For example, did you think there was any effective mechanism for assuring Patient Safety, quality of outcome, that kind of thing?

A. Sorry, Patient Safety?

591 Q. Patient Safety, clinical outcomes?
A. The clinical outcomes -- we were very fortunate that the vast majority of surgeons were excellent. I never saw any results from reported outcomes, but I certainly saw all the complications of all the surgery because they came to us. I wasn't aware of any trends that were causing any concerns so that wasn't a major concern of mine. 16:32
592 Q. What were you concerned about? What did people not know? 16:33
A. Well, that's the problem. You didn't know what you didn't know. That was the problem. If you don't go looking for it you can't you can't find it and you can't find it and you don't know how you can improve the situation if you can't measure it. 16:33
593 Q. I would say we haven't seen a lot of measurements of things?
A. No.
594 Q. We haven't seen a structure of meetings whereby --
A. Correct. 16:33
595 Q. -- you go to a meeting, you have data to look at, you don't have to wait for somebody to tell you a tale because the data is telling you the tale. Would you agree with that?
A. Yes. The triage system, this was changed from a normal triage system to what they called an unofficial switching of the triage system where, instead of being, if they weren't triaged they would go on to the waiting list. Also the patients who were triaged, if they went 16:33

up or down there was no audit of that to figure out the trends in that and to point out the GPS who were getting it wrong and feeding back to those GPs why it was wrong. For instance, that case of the prostate. It was obviously a red flag. How any GP could put that down as routine is extraordinary. So there's something wrong there. But did that GP ever get feedback? Do we have the figures on the numbers being regraded up or regraded down? There was none of that and there was no feedback of it. 16:34

596 Q. Do you think that was something confined to that section of the Trust or was this the case in other Directorates, as far as you know?

A. I think there were significant issues in Radiology.

597 Q. When you produced that list, which a very significant list, receiving that -- if I had been receiving that as a Medical Director, I would have thought perhaps some conversations needed to be had. You didn't have those conversations. What were you options in terms of doing something with your concerns, bearing in mind your duties as a medical manager and so on? Did you feel you had anywhere else to go with it? 16:34 16:35

A. No. I thought it was to do with it what I could. I know this is a Urology Inquiry but, believe it or not, that back in June, July, August 2016, there were lots of other issues that could easily have ended up, certainly in Coroner's court if not other court or an Inquiry. It just so happens that we were lucky and we got urology instead of something else. 16:35

598 Q. I understand that. That's partly why I'm asking these questions. You have picked something up which came partly on the back of urology but there were other things that you noticed. You go to the Medical Director, you don't get an immediate meeting. You don't get what you consider to be an open door. Where else could you have taken it, you're not sure. Did you feel there was any ongoing mentoring for this kind of issue for Associate Medical Directors or any forum where you could say, look, you know, I'm really struggling with this, should we be doing something different? 16:36 16:36

A. The forum for Associate Medical Directors was the AMD meeting, which was every month. I think it was the first, second Friday of the month, something like that. Previously, up until February 2016, there was always an agenda item for governance issues for the various specialties. That went through John Simpson and Paddy Loughran. That was the meat of the meeting. I had intended to bring up the state of the nation email and go through some of those issues at that meeting on 9th May. I hadn't been at the AMD meeting in April, I was in London, and there wasn't one in March, and the standing order on the agenda of governance issues for AMDs had been removed. So there was no option to bring it up at that section. That was the first time -- it had, in fact, been removed in April, but I wasn't wasn't at the April meeting, and it never appeared again. 16:36 16:37 16:37

599 Q. Do you know why?
A. I can't say. That option of bringing it up and having people in similar roles with similar problems of discussing it was removed. That's all minuted, it's all there. I don't know whether you have seen that, but it is there. 16:38
600 Q. I looked at some of those meetings.
A. There was a distinct trend from 2015 right through to September 2016 when it became, essentially, a useless meeting. 16:38
601 Q. Something slightly different. There has been a lot of mention of the Oversight Committee in the discussions that we've had. What was your understanding as AMD of the actual role, purpose, status, hour, of that Committee? Was it something that everybody understood well or? 16:38
A. No, not at all. It was basically -- it wasn't really a Committee, it was the Medical Director.
602 Q. So it was -- how did you see it then? Can you give us your view of how that operated? 16:38
A. The Medical Director -- this was a committee that looked at Maintaining High Professional Standards, GMC issues, and it was the Medical Director and it was the HR. The HR role, as I understood it, my experience of HR is they don't take responsibility. They give advice, they give you options, and then you make the decision, and then they ensure that due process is followed, ostensibly so it is fair but really so there is no chance of any comeback in any appeal or legal 16:39

process. Then there's a Director from whatever division is involved. But these are medical issues so the divisional director really has less of a call.

603 Q. So as Divisional Medical Directors it is my understanding in looking at the minutes that there was no attendance at these meetings even when it involved something in your division; is that right? 16:39

A. You mean for me?

604 Q. Yes?

A. No. 16:40

605 Q. So it was done without you?

A. I was never involved, ever, in Oversight Committees. That was always at Director level.

606 Q. What's your view of that? The appropriateness of that?

A. Totally inappropriate. But you need to have -- if you're going to have a Clinical Director there, they need to be someone who is prepared to be robust and to be prepared to be robust. I think for a Clinical Director it would be difficult. I think for an AMD it would be easier. 16:40 16:40

DR. SWART: Thank you. That's all from me.

CHAIR: Thank you. Mr. Hanbury?

MR. HANBURY: Thanks very much for your evidence and your remarks about surgeons! Many would say that a successful surgeon is a physician who operates. 16:40 Modern urology is a conversion rate of no more than 20 percent, so actually don't operate on more than we do.

I would also like to go back to your May, email, or

your May 2016 email. And we've already discussed aspects under Section 6, urology. There are a few other sections which were interesting because those themes were flagged-up in everything we have done already. One was the sign-off of results, did you see that pertaining to urology or not? 16:41

A. I was quite clear that the responsible -- the responsibility for consultants on the wards was to ensure that results were signed-off. Some surgeons believed that if they hadn't ordered the test themselves, that it wasn't their responsibility, it was the trainee's responsibility. The trainee's responsibility was to do 12 hours and then leave. So there wasn't any continuity, so there was a problem there. 16:41 16:42

607 Q. Okay. Did you have a view on results on an outpatient basis or radiology results? We've seen that in a couple of cases.

A. Well, as regards radiology results, the two issues that I'm aware of with the SAI, with the retained swab, and the SAI with the hypernephroma, there should have been direct contact from -- with something like that, well, if you're aware that there's an issue then you should contact the surgeon involved and not a gastroenterologist. 16:42 16:42

608 Q. Thank you. Another comment about backlogs of IR1s or SAIs, and seemingly no action on IR1s. Did that affect urology or was that other specialties?

A. That was everywhere.

609 Q. And also mortality, morbidity meetings being somewhat dysfunctional, again, that was other?
A. That was in general. They weren't very constructive and there weren't a lot of lessons coming out of them. I mean the purpose of M and M is you get a light bulb moment, then you change something. 16:43
610 Q. So on a similar theme, you made interesting remarks in your witness statements about critical incidents and, perhaps not spending more time looking at near misses, as opposed to things that do cause actual harm or death. Could you expand a little bit more on that for the Inquiry? 16:43
A. That required going through a formal structured process with Maintaining High Professional Standards with proper documents, with all the documents with Mr. O'Brien there wasn't even an email or a minute taken. There was no record. So for follow-up and to see how things were going, there was nothing there. So it needs to be far more structured and with a clear plan of follow-up. So, basically, you address the problem before it becomes a big problem and this has turned into a big problem. 16:43 16:44
MR. HANBURY: And that should be discussed at Departmental level? You'd agree with that?
A. (Nods). 16:44
CHAIR: Thank you very much, Mr. McAllister. I know we sat on quite late and we didn't take a break, but I thought you would prefer that to get finished today.
A. Good plan.

CHAIR: So 10 o'clock tomorrow, everyone.

THE INQUIRY WAS ADJOURNED UNTIL WEDNESDAY, 22ND FEBRUARY 2023 AT 10 O'CLOCK