



**Oral Hearing**

**Day 26 – Thursday, 23rd 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.

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1           THE INQUIRY RESUMED ON THURSDAY, 23RD FEBRUARY 2023 AS  
2           FOLLOWS:

3  
4           CHAIR: Good morning, everyone. Ms. McMahon.

5           MS. McMAHON BL: Madam Chair, members of the Panel, 10:01  
6           this morning's witness is Martina Corrigan, who is the  
7           Head of Service for Urology Services from 2009 to 2021,  
8           and I believe she's going to take the oath.

9  
10          MRS. MARTINA CORRIGAN, HAVING BEEN SWORN, WAS EXAMINED 10:01  
11          BY MS McMAHON BL AS FOLLOWS:

12  
13          Q. Mrs. Corrigan, thank you for coming along. I know you  
14          were here yesterday. Best laid plans. It didn't work  
15          out. Apologies for that. Thank you for coming back 10:01  
16          today. We have this morning until 1 o'clock to get  
17          through your evidence. Obviously, because of the  
18          duration of your employment and tenure in Urology  
19          Services you have quite a significant amount of  
20          information that might be relevant to the Inquiry. For 10:02  
21          the purposes of today, I want to try and concentrate  
22          solely on the MHPS period of time and your involvement  
23          or your actions in and around that period. If we can  
24          both exercise some discipline and try and stick to  
25          that, hopefully we'll get everything covered this 10:02  
26          morning.

27  
28          As I said, you were the Head of Service, including  
29          Urology Services -- I know you covered other part of

1 the hospital -- from 2009 to 2021 when you changed  
2 posts. We'll look at some of your roles since then and  
3 your job description. Just in relation to the evidence  
4 you have provided so far to the Inquiry, you've sent in  
5 four replies to Section 21 Notices?

10:02

6 A. Yes.

7 1 Q. Two substantive. One the bulk of the information to  
8 the Terms of Reference and the second more substantive  
9 in relation specifically to MHPS?

10 A. That's correct.

10:03

11 2 Q. And two further replies attaching supplementary  
12 documents. I just want to take you to those and ask  
13 you if you recognise them, confirm it's your signature  
14 and if you'll adopt them as your evidence.

15 A. Okay.

10:03

16 3 Q. If we could call up, first of all, the Section 21 reply  
17 dated 6th July 2022 at WIT-26146. Do you recognise the  
18 front page of that notice 24 of 2022?

19 A. Yes.

20 4 Q. If we go to page WIT-26318. There is a signature just  
21 at the bottom of that page dated 6th July 2022. Do you  
22 recognise that as your signature?

10:03

23 A. That's correct, yes.

24 5 Q. Do you wish to adopt that as your evidence today?

25 A. Yes, please.

10:04

26 6 Q. The second Notice dated 29th April 2022 is at  
27 WIT-39879.

28 MR. MILLAR BL: Excuse me, Chairman, I'm not seeing  
29 anything on the screens here.

CHAIR: If we just take a pause, Ms McMahon. Is this something that is readily sortable?

(Technical difficulties)

CHAIR: Would you like us to rise so you can check it all out?

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Hopefully we'll not have any further technical difficulties and Mrs. Corrigan can finally start giving us some evidence.

7 Q. MS. McMAHON BL: I think we were on to the second Section 21 reply dated 29th April 2022 at WIT-39879. That's Notice 40 of 2022. If we go to page 39933. Just to confirm that's your signature. That one is 15th July. I've got the wrong date on my -- so 15th July. The next Notice -- I'll just correct that for my note. You wish to adopt this in your evidence?

A. Yes, please.

8 Q. The next Notice is WIT-40945. This is a Notice in relation to supplementary documents. We'll come back to that one. We'll try the next one. WIT-41803.

We'll check the index on those two, but they're documents that came in subject to your main Notices giving us documents that hadn't been -- I think they were discovered later on and provided to the Inquiry.

1 we'll come back to those. They're not substantive  
2 evidence documents, for the purposes of the other  
3 Section 21s. In relation to amendments, I understand  
4 there are two amendments you wish to make?

5 A. Yes, please.

10:14

6 9 Q. The first one is at WIT-26205 at paragraph 20.1(d)  
7 where it says:

8  
9 "Mr. Haynes title should be changed to Clinical  
10 Director of General Surgery and Trauma and  
11 Orthopaedics".

10:14

12 A. Yes.

13 10 Q. You have put in ENT there?

14 A. Ayes.

15 11 Q. The next amendment is at WIT-26306 at paragraph 69.1.  
16 I think that's six lines down where you've referred to  
17 Dr. McAllister and you want to change your reference.  
18 There you have written "he was interim AMD" and you  
19 want to change that "Dr. McAllister started his role on  
20 29th April 2016 and not in June 2016"?

10:15

21 A. That's correct.

22 12 Q. Just a date error there?

23 A. That's all. Yes.

24 13 Q. I also know from consultation that you want to make  
25 reference later on to a meeting that you had with  
26 Mr. O'Brien on 25th July 2017?

10:15

27 A. Yes.

28 14 Q. You haven't referred to that in your statement. We'll  
29 deal with that when we get to that point.

1           A.    Okay.

2    15   Q.    Are there any other amendments or corrections that you  
3                    need to inform us about at this stage?

4           A.    No.  Thank you.

5    16   Q.    Thank you.  Just as a very brief outline in relation to 10:15  
6                    your role, and for the Panel's note, your occupational  
7                    history is contained within your Section 21 Notice at  
8                    WIT-26161.  In brief terms, prior to taking up the role  
9                    as Head of Services in 2009 you worked in various  
10                   management roles in the Western Health and Social 10:16  
11                   Care Trust and its predecessor Trust?

12          A.    That's correct, yes.

13    17   Q.    Just to confirm that you're not clinically quantified?

14          A.    No.

15    18   Q.    Your area of expertise and your undergraduate degree 10:16  
16                   was in Public Policy --

17          A.    Yes.

18    19   Q.    -- and Management, and you have an MA in Business  
19                   Improvement?

20          A.    That's correct, yes. 10:16

21    20   Q.    You started your role for the Trust as Head of Service  
22                   in September 2009 and you were in that role right up  
23                   until June 2021?

24          A.    That's right.  Yes.

25    21   Q.    I just want to briefly touch on your current role. 10:16  
26                   You're the Assistant Director for the Public Inquiry  
27                   and Trust liaison since June 2021?

28          A.    That's correct, yes.

29    22   Q.    I wonder, just in relation to that specific role, if

1           you could just explain what that role involves?

2           A.   Yes. I suppose I applied for the job and was  
3           successful in it in June 2021. At that stage it was to  
4           be bringing together evidence and, you know, responses  
5           to Section 21s and sort of being the Trust liaison with 10:17  
6           the likes of the Inquiry. It became apparent that  
7           there would be -- and my Director at that stage was  
8           Mrs. Trouton, Mrs. Heather Trouton, but it became  
9           apparent that there would be a conflict of interest  
10          with regard to the fact that I had been working in 10:17  
11          urology since 2009 along with Mrs. Trouton, so they  
12          appointed a Director, Mrs. Jane McKimm who has never  
13          worked operationally with urology, and also we have  
14          Mrs. Margaret O'Hagan, who is an independent adviser  
15          for the public Inquiry so that anything -- to make sure 10:18  
16          there was no conflict of interest, that everything goes  
17          through them. Basically, pulling together evidence  
18          like your Trust policies and things like that wouldn't  
19          have a conflict, but would have worked through it  
20          making sure Jane and Mrs. O'Hagan were involved in 10:18  
21          whatever was going through. But I will be fair to say  
22          that really since I took up post and most recently,  
23          a lot of my time has been spent trying to prepare for  
24          my Section 21s and for today. It's my own personal  
25          evidence. I've had no contact with anybody else with 10:18  
26          regard to their Section 21s apart from if they ask me  
27          a specific question about a document that is in the  
28          evidence. So it wouldn't have been influencing anybody  
29          or anything like that with regards to anybody else's



1           Section 21. I've seen nobody else's. I've been taken  
2           totally out of that loop with regards to independence,  
3           that there would be no conflict.

4   23   Q.   The Trust have inserted a layer --

5           A.   They have, yes.

10:19

6   24   Q.   -- as it were, of two other individuals in relation to  
7           their engagement with the Inquiry because of the unique  
8           position that you and Mrs. Trouton are in, where you  
9           actually have evidence relevant to the Inquiry in order  
10          to ensure that level of independence?

10:19

11          A.   Yes. I was just going to say, I suppose my  
12          knowledge then, because at one stage I thought I would  
13          better stepping totally back, but it's just the  
14          knowledge I had since 2009 just felt it would be  
15          relevant, so I've been kept in the post or remained in  
16          that post, I should say.

10:19

17   25   Q.   I think you are probably unique in being the only  
18          individual who has been in post for the entire duration  
19          and also at the one level, as it were?

20          A.   Yes.

10:19

21   26   Q.   The key level in the middle operationally. Clearly you  
22          have lots of information that's relevant. Just in  
23          relation to that role, I just want to say a little bit  
24          about and discuss with you your responsibilities.  
25          Hopefully that will put in context the nature and level  
26          of your involvement in the MHPS time period and why you  
27          were engaged in that.

10:20

28  
29          For the Inquiry's note again, the narrative of your job

1 description is at WIT-26163. I just want to read from  
 2 this before I can ask you some more information about  
 3 it. I'll just read from the second line that's on your  
 4 screen:

5 "This role entailed being responsible for the 10:20  
 6 operational management and strategic development of  
 7 ENT, Urology, Ophthalmology and Outpatients across the  
 8 Southern Trust. I was responsible for Leadership,  
 9 Service Provision and Service Development of ENT,  
 10 Urology, Ophthalmology and Outpatients, and ensuring 10:21  
 11 high quality patient-centred services. I was  
 12 responsible for achieving service objectives through  
 13 the implementation of national, regional, and local  
 14 strategies and access targets. I worked in partnership  
 15 with the Assistant Director, Associate Medical and 10:21  
 16 Clinical Director to define a service strategy, which  
 17 support the Trust's and Directorate's overall strategic  
 18 direction and ensures the provision of a high quality  
 19 responsive service to patients within resources. As  
 20 a Head of Service I was a member of the division's 10:21  
 21 senior management team and contributed to policy  
 22 development within the division towards the achievement  
 23 of its overall objectives."

24  
 25 You're a member of the senior management team but you 10:21  
 26 don't sit on Board committees; is that right?

27 A. I suppose what I mean by that is that it's the  
 28 division. I would have sat within the Acute  
 29 Directorate then you have the Surgical and Elective

1 Care division, so part of that was the Assistant  
2 Director and the Heads of Service, along with the  
3 Associate Medical Directors and the Clinical Directors.  
4 When I say there senior management team, I don't mean  
5 sort of your Directors, it's more the next tier down 10:22  
6 rather than, sort of the Chief Executive and all the  
7 other Directors.

8 27 Q. You reported directly to Assistant Directors?

9 A. That's correct, yes.

10 28 Q. In your tenure, who was that? 10:22

11 A. When I started in 2009, actually for about two or three  
12 days it was Mr. Simon Gibson. Then Simon moved post  
13 and it was Heather Trouton from that until 2016. In  
14 April 2016 then it was Mr. Ronan Carroll and  
15 Mr. Carroll was still my Assistant Director when I left 10:23  
16 post in 2021.

17 29 Q. In relation to Mrs. Trouton and Mr. Carroll, what was  
18 the nature of your engagement with them on a daily  
19 basis, for example, or weekly basis?

20 A. On a daily basis I would have been in contact either 10:23  
21 sort of through e-mail or face to face. I suppose the  
22 nature of the job was it just varied from day to day  
23 depending on how many, perhaps, meetings we were at.  
24 I'm just thinking, for example, in the middle of winter  
25 pressures, it would probably have been within every 10:23  
26 hour because we were needing direction on whether  
27 we cancel patients or how we get our emergency  
28 departments cleared. I would have worked very closely  
29 with both Assistant Directors.

1 30 Q. would you say your lines of communication with them  
2 were good? Effective?  
3 A. Very good, yes. Very good, yes.

4 31 Q. What about the Assistant Directors over the same period  
5 of time? Who were they? 10:24  
6 A. When I started it was Ms. Joy Youart but I had no  
7 contact with her at all because she had left in  
8 December. Then Dr. Gillian Rankin. I just can't  
9 remember all the dates just off the top of my head.  
10 I think she was 2013. Then it was Mrs. Debbie Burns 10:24  
11 from '13 to '15, and Mrs Esther Gishkori from '15 until  
12 '18, I think, to read Melanie McClements from '15 until  
13 I left the post in June '21.

14 32 Q. What was your contact with Directors within the Acute  
15 Services? 10:24  
16 A. It varied. Ms. Youart I would never have had any  
17 contact with her. Dr. Rankin, I would have had a lot  
18 of contact with her because it was during the time of  
19 the review of the Urology Services and we would have  
20 had regular meetings, particularly on a Monday night. 10:24  
21 Then there would have been meetings ad hocly to do with  
22 the review. I also was involved -- Dr. Rankin would  
23 have been there at the time that we would have been  
24 going through the likes of the issues with regard to  
25 the IV antibiotics and the benign cystectomy. 10:25  
26 She would have come to ask for information, for  
27 example. She was also involved with me when we were  
28 doing an escalation with regards to Mr. O'Brien's  
29 triage. We would have weekly meetings to do with

1 performance with Dr. Rankin, every Tuesday morning, but  
2 that would have been with the teams as in each of the  
3 divisions, not only Surgery and Elective Care. I would  
4 have had quite a bit of contact with Dr. Rankin. The  
5 same with Mrs. Burns, I would have had a lot of contact 10:25  
6 with her. Regular meetings. We would have had  
7 meetings with regards to if we had, for example, needed  
8 more staff on the wards and sort of the whole  
9 recruitment process also I would have been very much  
10 involved. Mrs. Burns had a very good working 10:26  
11 relationships with the ADs and the Heads of Service.  
12 I'm not sure if you were able to come and see sort of  
13 the layout of the admin floor, but she would have been  
14 down, as we called it, the corner office. Both her and  
15 Dr. Rankin would regularly walked into the Head of 10:26  
16 Service if they needed anything, any information.  
17 Mrs. Gishkori, I have to say, no, I didn't have any  
18 contact with her. She was very clear at the start of  
19 her tenure that she expected that any information she  
20 needed would come through the ADs as opposed to the 10:26  
21 Heads of Service which takes a bit of getting used to  
22 because we would have had an open door policy with the  
23 other Directors. If you think about it, from  
24 day-to-day, all the stuff that might happen, the AD  
25 mightn't be about so you needed to have that 10:26  
26 relationship to go to speak to the Director if you  
27 needed, if the AD was on annual leave or maybe offsite  
28 in Daisy Hill, or something like that. Finally,  
29 Mrs. McClements I had a very good relationship again.

1 Again open door policy, would have called down to the  
2 office and we would have been able to go into her for  
3 any issues.

4 33 Q. You have mentioned a lot of information that we'll deal  
5 with when we come back, because you know you will have 10:27  
6 to come back. I know your counsel has already advised  
7 you of that. Just in relation to Mrs. Gishkori,  
8 because her tenure is relevant to the period of time  
9 for MHPS. I just want to probe that relationship a  
10 little bit more, if you don't mind, both in relation to 10:27  
11 the communication aspects and also any impact her style  
12 of management or your style of engagement with her may  
13 have had on the culture of dealing with issues as they  
14 arose.

15  
16 when you say that her approach was different so that it  
17 perhaps wasn't open door that you had been used to, as  
18 Head of Service, what impact, if any, did that have on  
19 your day-to-day operation or ability to seek help or to  
20 make decisions? 10:28

21 A. Working with the previous Directors it probably did  
22 hinder because if you had something -- like you needed  
23 to give a heads up on something, for example, the  
24 Emergency Department was really, really busy and you  
25 needed to know was it okay to open -- you know, bring 10:28  
26 in extra staff to open a bay, you couldn't go in to her  
27 to ask her that. She had always said if you needed to  
28 highlight anything to me you just needed to go to one  
29 of the other ADs. If Mr. Carroll was not about I would

1 go find one of the other ADs I wasn't directly  
2 reporting to, for example Mrs. McVeigh, and sort of  
3 speak to them. I suppose I sort of got used to it  
4 because she had been there for a while but didn't have  
5 the same relationship and, you know, didn't feel that 10:29  
6 I could go to her if I had to escalate something.

7 34 Q. You mentioned there about having to free up beds or  
8 make some operational decisions which presumably  
9 directly relate to patient care.

10 A. Mm-hmm. 10:29

11 35 Q. If you weren't able to go to Mrs. Gishkori and you had  
12 to go to an AD, would that have resulted in, perhaps,  
13 delay or, in fact, a decision not being taken about  
14 that?

15 A. It could have, yes. Although the AD normally would 10:29  
16 have made the decision if she or he couldn't get to the  
17 director, you know, talk it through with me.

18 36 Q. If it wasn't your direct AD and another one from an  
19 ancillary Department, did you assume that they would  
20 inform Mrs. Gishkori of the conversation, or was it 10:29  
21 your view that you were getting your decision signed  
22 off, effectively at the level you needed to?

23 A. Yes, because if my own AD wasn't about the other AD was  
24 able to make the decision, so I would have taken it as  
25 their decision. 10:30

26 37 Q. Is it possible then that decisions made didn't reach  
27 the Director, the relevant Director, Mrs. Gishkori?

28 A. I can't really answer that but it could be possible.  
29 I don't know because I don't know sort of what would

1 have been discussed with Mrs. Gishkori with the ADs.

2 38 Q. Just from a perspective of how things operated, I know

3 you said that Mrs. Gishkori indicated that there was

4 a line of communication and there was someone between

5 you and her. Is it the case that you wouldn't have 10:30

6 felt comfortable just going to her door and rapping the

7 door and saying, 'this situation has arisen. I can't

8 get my hands on an AD, and I need to discuss that'.

9 Was there, in effect, a barrier to you for doing that?

10 A. Yes, I felt that. Not with the other Directors. 10:31

11 I suppose that was the difference because we said I was

12 there from 2009 to '21.

13 39 Q. How was that barrier presented to you? Was it said to

14 you that you shouldn't do this or that you did do it

15 and the response was not welcoming? What was it that 10:31

16 happened that made you reluctant or to know that you

17 couldn't do that?

18 A. Not long after Mrs. Gishkori started in the role, and

19 I was used to just popping in to the office to her

20 personal assistant, Ms. Stinson, I would have said to 10:31

21 Emma, 'are they free?', because you obviously wouldn't

22 just knock the door and then go in, which is what

23 I have done, you know, right from the start. This

24 particular day I just said I just need to give Esther

25 the heads up on something. I knocked the door went in 10:32

26 to Mrs. Gishkori. She said, 'I'd prefer this didn't

27 come from you, it came from an Assistant Director. I'm

28 clear that the lines of communication is Heads of

29 Service, Assistant Director to myself'. That was near



1 enough at the start of it. I was a bit taken aback  
 2 because I had such a good relationship with the other  
 3 Directors, so I was a wee bit taken aback. In saying  
 4 that, I would have still been at meetings with her and  
 5 Mrs. Gishkori would have been in the patient flow team 10:32  
 6 room and was always polite. It wasn't that. It's just  
 7 when it came to actual, I suppose, decision making.

8 40 Q. Do you think that culture, when we look later on at  
 9 what happened during the period of time '15 to '18, do  
 10 you think her approach to management had a detrimental 10:32  
 11 impact on governance?

12 A. I don't know how to answer in the sense of that I am  
 13 confident that the governance within the AD to the Head  
 14 of Service lead nurse level was taken very seriously.  
 15 Obviously, both Heather and Ronan would have had weekly 10:33  
 16 meetings. They had weekly meetings but one of them was  
 17 dedicated to governance. I don't know -- like,  
 18 obviously, there was Acute Governance meeting on the  
 19 second Friday of the month with the Director and the  
 20 ADs. 10:33

21 CHAIR: I think, as I said to Mr. wolfe yesterday, this  
 22 is an issue for the Inquiry to determine, rather than  
 23 the witness.

24 41 Q. MS McMAHON: Just as you were saying that, I was  
 25 thinking it might be a better question to ask when you 10:33  
 26 take you to the e-mails you sent during '16, '17 and  
 27 '18 escalating breaches, and you can answer that in  
 28 context of anybody replied to you.

29 A. Okay.

1 42 Q. We can do it that way.  
2  
3 Your role in governance, you deal with at WIT-26225 in  
4 your witness statement at paragraph 31.1:  
5 10:34  
6 "My role in governance for all my areas was to promote  
7 and ensure that there was high quality and effective  
8 care offered to all patients and to ensure that  
9 services were maintained at safe and effective levels.  
10 I can confirm that I didn't have a direct management 10:34  
11 role regarding the consultants and other clinicians in  
12 the Thorndale unit."  
13  
14 The evidence presented to the Inquiry and from witness  
15 statements would seem to indicate that there were two 10:34  
16 almost separate lines of communication within Urology.  
17 One was operationally, and one was the medic side.  
18 Would that have been your experience?  
19 A. That's correct, yes.  
20 43 Q. In some ways those two lines coalesce with you in some 10:35  
21 respects. Would that be a fair description?  
22 A. That's fair, yes.  
23 44 Q. On the medic side, and if I include the nursing staff  
24 in that, the lead nurses reported to you?  
25 A. Operationally to me and then professionally to the AD, 10:35  
26 with me not being a nurse or a clinical person. For  
27 example, annual leave, and things like that would have  
28 been to myself, but anything professionally wise would  
29 have went lead nurse then direct to the AD.

- 1 45 Q. The other operational aspects, booking, referrals,  
 2 people like Katherine Ford, you would have been dealing  
 3 with that side of the branch of the day-to-day running  
 4 of the unit?
- 5 A. That's right. Yes. Yes. Yes. All the operation 10:35  
 6 clinics, theatre lists, and things likes that, yes.
- 7 46 Q. We will go through it on the next occasion in your  
 8 evidence, but you have had a significant involvement  
 9 with matters and issues of concern around Mr. O'Brien's  
 10 practice from, I think, 2009, almost since you started 10:36  
 11 in the unit?
- 12 A. That's correct.
- 13 47 Q. The person in post prior to that in Head of Service was  
 14 a lady called Louise Devlin?
- 15 A. That's correct. 10:36
- 16 48 Q. When you started in the Service in 2009, did she give  
 17 you an indication of her experience with issues arising  
 18 from the practice of Mr. O'Brien before you took up  
 19 your substantive post?
- 20 A. Louise was responsible for Outpatients as opposed to 10:36  
 21 Urology. The Urology and ENT post was a new post that  
 22 had been created. But Louise was the other Head of  
 23 Service then for Trauma and Orthopaedics so we would  
 24 have shared an office. She advised me of an occasion  
 25 whenever she'd been in charge of Outpatients been 10:36  
 26 tasked to go to Mr. O'Brien's office to get the some  
 27 letters that was in his drawer because he was on annual  
 28 leave. She removed the letters and Ms. Devlin said he  
 29 came to see her, he was very confrontational and cross

1 with her, and that he said she had no right to remove  
2 the letters. She tried to explain that they needed to  
3 be added to the patient administrative system at that  
4 stage. But she basically said she never really  
5 communicated with him again. She had a hard time on  
6 that occasion. That was to do with letters in his  
7 drawer.

10:37

8 49 Q. Just in general terms, what was your experience and  
9 your relationship with Mr. O'Brien from the start of  
10 your taking up post?

10:37

11 A. I have to say I had a very good relationship with  
12 Mr. O'Brien. He was a wee bit off with me when we were  
13 introduced. I think he just seen me as another  
14 manager. But after that initial meeting I have to say  
15 I had a very good working relationship with him.  
16 I suppose I was the person that was able -- I would  
17 have been in regular contact with him and all the  
18 escalation, et cetera, would have been through myself  
19 to him.

10:38

20 50 Q. Again, it is not for today but I just want to take  
21 a brief trot through the issues that you ultimately had  
22 to deal with under the MHPS banner, and your knowledge  
23 of them over the years. If we just start with triage.  
24 That was something that was first raised with you in  
25 2010 by the booking staff?

10:38

26 A. That's correct. Yes.

27 51 Q. The patient notes at home was first escalated to you in  
28 2013?

29 A. Yes.

1 52 Q. The issue around non-dictation, again that was first  
2 raised in 2014 with you?

3 A. Yes.

4 53 Q. The issue of not conforming with booking patients, you  
5 don't specify the date but there seems to be 10:39  
6 correspondence with you and Heather Trouton and other  
7 staff on that issue over the years. Then you mention  
8 in your statement what you call clinical issues that  
9 you weren't aware of around IV fluids, benign  
10 cystectomies and an issue around notes being placed in 10:39  
11 the bin in 2011?

12 A. That's correct, yes.

13 54 Q. You also were aware of an issue around the allegation  
14 that private patients were being given priority towards  
15 the end of 2015? 10:39

16 A. Yes, that's correct.

17 55 Q. The issue around no access to key worker for Oncology  
18 patients. You say that you became aware of that  
19 in November 2020?

20 A. That's correct. 10:39

21 56 Q. The issue of not following up on results, you say you  
22 became aware of that in June 2020?

23 A. That's correct, yes.

24 57 Q. The same with the bicalutamide issue?

25 A. Correct, yes. 10:40

26 58 Q. We will go in depth into those particular areas on the  
27 next occasion when you give evidence. I think it would  
28 be a fair summary of all of that to say that there are  
29 many, many e-mails, either from you or you're copied

1 into, in which you raise issues or respond to issues on  
2 all of those topics?

3 A. That's correct, yes.

4 59 Q. I just wonder if I could ask you, generally, on those  
5 issues, given the length of time over which you had an 10:40  
6 awareness -- you and others had an awareness of varying  
7 degrees of concerns around those issues. Was there  
8 ever a point from 2010 when it was realised that these  
9 had the potential to impact on patient care and safety?

10 A. I've had quite a bit of reflection on this. I suppose 10:41  
11 pre -- the notes at home, the un-triaged, un-dictated,  
12 was always classed as being admin issues, wrongly for  
13 me now. On reflection, I didn't associate that with  
14 Patient Safety up until probably 2016, and it really  
15 hit home with me personally whenever, in 2017, 10:41  
16 I recovered the 783 letters and one of the patients,  
17 I think Patient 13 maybe, one of the patients actually  
18 was just a couple of weeks younger than my own husband,  
19 and the first line of the letter just rang alarm bells  
20 with me. Even though I'm not clinical, the fact 10:42  
21 I worked for 35 years in the Health Service I have sort  
22 of picked up some clinical terms. It was that  
23 realisation that because of what had been classed as  
24 admin was really Patient Safety and, you know, that  
25 patient became part of the 2016 -- sorry '17 SAIs. Up 10:42  
26 until that I would have said they were admin issues.  
27 When you read the report it says "admin issues" but it  
28 was obviously a Patient Safety, on reflection.

29 60 Q. You just mentioned the SAIs. You first became aware of

1           those in January 2016?

2           A.    2017. Yes, there was one SAI in 2016.

3   61   Q.    The final reports, you weren't aware of until 2020.

4           They were shared with you --

5           A.    I was aware of Patient 10's SAI because it sort of was 10:42

6           what started everything in December '16. But, no, the

7           SAIs, the sort of the five SAIs that came out of the

8           un-triaged I didn't know about until 2020.

9   62   Q.    You didn't have anything to do with the SAIs,

10          effectively? 10:43

11          A.    No.

12   63   Q.    If we look at the MHPS period, and you deal with that

13          in your second Section 21 Notice. Just for the Panel's

14          note, it's at WIT-39879. There's been a lot of

15          evidence about the MHPS Framework and you tell us in 10:43

16          your statement that you didn't know of its existence.

17          When did you first become aware of it?

18          A.    I became aware of it, I think it was because it was

19          mentioned as sort of from Mrs. Hynds and Mr. Gibson in,

20          probably, the latter end of 2016, December time, when 10:44

21          everything, sort of, had come to a head. Pre that,

22          because it isn't part of my responsibility, and I would

23          not have been managing doctors, I never knew -- it's

24          obviously in the Trust policies but I never would have

25          any occasion to read it or need to use it. 10:44

26   64   Q.    In relation to Trust policies, you also say you weren't

27          aware of the Trust guidelines around doctors?

28          A.    That's correct.

29   65   Q.    It was only discussed with you in the context of MHPS?

1           A.    Yes.

2    66   Q.    The two formal mechanisms, if we could call them that,  
3                   that were available, you didn't have any awareness of?

4           A.    That's correct.

5    67   Q.    Was it your understanding then, as the Head of Service, 10:44  
6                   that if there were issues with doctors, then those  
7                   issues were dealt with by other doctors?

8           A.    Yes.

9    68   Q.    Was that an expectation that you had for those in  
10                   senior management, the medics in senior management in 10:45  
11                   urology, that you would have assumed or hoped that they  
12                   would deal with the issues arising from other medics?

13          A.    I did, yes. Because I would have had a, again, good  
14                   relationship with all of my CDs and AMDs and Clinical  
15                   Lead. Any issues that I would have brought to them, 10:45  
16                   I wouldn't feel that I was cope fit to deal with it.  
17                   So, yes, I expected that.

18    69   Q.    You referred in your witness statement the way you  
19                   considered that things should be escalated or, in your  
20                   experience, were, at WIT-39882, paragraph 7.1 where 10:45  
21                   you've said:  
22

23                   "I can confirm that I had not previously implemented or  
24                   applied the MHPS Framework or Trust guidelines in my  
25                   role but my understanding, and what I confirm I did 10:45  
26                   during my tenure, was that, if there was a concern with  
27                   a member of clinical staff highlighted or brought to my  
28                   attention, I raised with this with either the clinical  
29                   Lead of Urology, which was Michael Young, and/or the



1 Clinical Director, Mr. Brown, and/or the Associate  
2 Medical Director, which is Mr. Mackle from '09 to '16  
3 Dr. McAllister from April '16 to October '16, and  
4 Mr. Haynes from 2017 to 2021, and with your Assistant  
5 Directors Mrs. Trouton from '09 to '16, and Mr. Carroll 10:46  
6 from '16 to '21, and they would have addressed the  
7 concerns or issues raised."

8  
9 was it your expectation that if you brought anything to  
10 them that they would tell you what the resulting 10:46  
11 outcome of that was?

12 A. It was my expectation. Usually, depending on what the  
13 issue was, it would have closed the loop. They would  
14 have come back to me on it.

15 70 Q. Did that happen? 10:46

16 A. On some things, yes. On others, no.

17 71 Q. Could you give us examples of the things that it did  
18 happen and those that it didn't? If you can recall any  
19 at the moment?

20 A. For example, the notes in the bin that you mentioned, 10:47  
21 it was escalated to me by the ward sister. I shared it  
22 with Mrs. Trouton and Mr. Mackle. Then I know it went  
23 to HR, and until the Inquiry started I wasn't aware  
24 that there was actually a disciplinary process with  
25 regard to that, so I didn't get closed in that loop. 10:47  
26

27 with regards to other issues that I maybe have raised,  
28 say, for example -- I'm just thinking the time I would  
29 have raised with regards to un-triaged back in

1 Dr. Rankin and Mr. Mackle's time, Mr. Mackle did come  
2 to me to advise me that he went and spoke to  
3 Mr. O'Brien, he had triaged all the letters. I do  
4 remember that one distinctly because it was the time he  
5 was supposed to be going to a conference in Barcelona 10:48  
6 and then he had done the triage and didn't get because  
7 of the ash cloud. On some occasions, yes, on other  
8 occasions, no.

9 72 Q. Would it be fair to describe that as a bit of an  
10 inconsistent approach? 10:48

11 A. Yes, that would be fair.

12 73 Q. Do you have any explanation as to why there was that  
13 inconsistency? Do you think it was lines of  
14 communication with individuals, personalities, or  
15 people were busy? Is there any basis for that that you 10:48  
16 think the Panel would be informed by hearing?

17 A. One of the things, sort of thinking about things like  
18 this, is I think everybody about, and this process and  
19 all, is the confidentiality of it for the doctors.  
20 With regards to even all the investigation and then the 10:48  
21 monitoring and all, which I know we'll talk about, it  
22 was all to be kept confidential to protect the doctor.  
23 In, for example, the likes of the disciplinary,  
24 probably didn't need to know because that's a HR  
25 confidential issue between HR and the Consultant. 10:49  
26 I suppose it depends on the circumstances and nearly  
27 feel there was also the busyness of it as well because  
28 sometimes you would see the AMDs or the CDs maybe  
29 a couple of times in the week and then you mightn't see

1           them until the next meeting because of their clinical  
2           commitments.

3       74   Q.    If we look at the period around November 2015 there was  
4           an IR1 raised by Mr. Haynes. I just wanted to ask you  
5           the process by which IR1s make their way to the  
6           relevant people to have a look at them. If an IR1 is  
7           raised where does that go?

10:49

8           A.    If an IR1 is raised it depends on the speciality. For  
9           example, Urology, ENT, Ophthalmopathy I would be copied  
10          in, but it also goes to the governance people. It goes  
11          to the Assistant Directors, the Associate Medical  
12          Directors for that particular area. Everybody gets --  
13          it's like an e-mail from the IR1 to tell them it's  
14          there, you click into it, and you go into the system to  
15          read it. For example, if there was things like --  
16          we'd get them for a clinical medical incident, so you  
17          would go to the ward, check that out, speak to the  
18          staff and that. If it's a fall, then the lead nurses  
19          would deal with that. For the likes of Mr. Haynes  
20          raising it, that would come to myself, the Associate  
21          Medical Director and the Medical -- sorry, Assistant  
22          Director. The Assistant Director and then the AMD  
23          would actually decide whether it needs to go to  
24          screening or not. I don't be involved as a Head of  
25          Service in the screening end of things.

10:50

10:50

10:50

10:50

26       75   Q.    But you do see IRs as they come?

27           A.    I do.

28       76   Q.    An IR1 can be raised for anything, for example, from  
29           notes not being returned up to a patient incident?

1 A. Correct.

2 77 Q. If something is put in through the system on an IR1, is  
3 that a way in which it is brought to the attention of  
4 the hierarchy, if I can put it that way, in a more  
5 formal way examine, and a paper trail then is 10:51  
6 identified?

7 A. That's correct, yes.

8 78 Q. Were you aware of other IR1s being brought to that  
9 level on the issues relevant to the MHPS period?

10 A. No, not leading up to it. IR1s was raised for, 10:51  
11 ultimately, the five patients who came to harm but that  
12 was after the event as opposed to before it.

13 79 Q. Did Mr. O'Brien have any IR1s raised for triage?

14 A. Not that I'm aware, apart from individual ones that  
15 Mr. Haynes would have raised. 10:51

16 80 Q. If that had been done, would that be a way of  
17 escalating that problem up in a more formal manner to  
18 have it dealt with at an earlier stage?

19 A. I think it would, yes.

20 81 Q. The Panel will hear and will know from your statement 10:52  
21 that you have been involved in, if I can call it,  
22 significant informal interventions over the years to  
23 try and resolve matters. Would you accept that has  
24 been your input into the issues around Mr. O'Brien's  
25 practice? 10:52

26 A. I would accept that, yes.

27 82 Q. The absence of IR1s, I know the booking staff and the  
28 records, there were IR1s raised every time they  
29 considered it was appropriate, I think in order to flag

1 issues, and we'll discuss that. Do you think if the  
 2 same approach had been taken earlier on on some of the  
 3 other issues that it might have galvanised people to  
 4 take action earlier?

5 A. I suppose the only thing about the IR1s for the notes 10:53  
 6 at home -- I'll be honest, they don't seem to have went  
 7 anywhere because, obviously, there was the ultimate in  
 8 January 2017, the amount of notes that came back from  
 9 home. But the triage, yes, I think potentially, if  
 10 we had been getting every time there needs to be an 10:53  
 11 escalation, it was just via e-mail as opposed to doing  
 12 an IR1 about it.

13 83 Q. The reason I ask that question generally is because the  
 14 Panel is obviously interested to look at the governance  
 15 systems that were in place, why they weren't used, what 10:53  
 16 happened when they were, and what might have made  
 17 a difference?

18 A. Yes.

19 84 Q. Apart from the IR1 process and the Datix, obviously the  
 20 resulting Datix, there doesn't appear to be any other 10:53  
 21 formal way in which the issues that ultimately became  
 22 subject to MHPS and this Public Inquiry could have been  
 23 made known through the governance system. Is that  
 24 a fair description, or do you think there are other  
 25 ways it could have come through the governance route? 10:54

26 A. There is e-mails in the system where people have raised  
 27 concerns. I think if they had have gone through the  
 28 IR1 route, that probably would have ultimately led to  
 29 maybe more SAIs because, like just to put it in

1 context, one particular day I was looking for an e-mail  
2 for evidence for the Inquiry and I had received 375  
3 e-mails that day. You know, so e-mail wasn't the right  
4 way of doing things. I think ultimately the IR1  
5 process is the best process to raise it. I suppose the 10:54  
6 problem with IR1 is it's quite a complicated system and  
7 I know when you would have spoken to consultants about  
8 raising stuff, they just didn't feel they had the time  
9 to actually sit and put all the information in. If it  
10 was just to put in what had happened, but you have to 10:55  
11 go through a number of pages, so I think the learning  
12 from this is to make the process a wee bit easier.

13 85 Q. Is the process the same now for passing any concerns  
14 along? Is the IR1 system in place at the moment?

15 A. It's still the IR1, although there seems to be more use 10:55  
16 of it now than previously.

17 86 Q. Is it "one form fits all", whether it's a patient fall  
18 or a potentially catastrophic incident?

19 A. Yes.

20 87 Q. Is there a way in which that IR1 is graded so if you 10:55  
21 have 375 e-mails, then that's brought to your attention  
22 at the top of the e-mail that this is a significant IR1  
23 as opposed to perhaps one that requires system change  
24 rather than patient risk?

25 A. It doesn't in the e-mails highlight it. You just read, 10:55  
26 it gives you a synopsis of what the issue is. You  
27 know, you sort of can read it and you automatically --  
28 like, if says a patient fall -- and I'm not  
29 underestimating that as not being serious but maybe

1 "patient fall" or, you know, "bed sore" or something  
2 like that, or somebody nips their fingers in the door,  
3 whereas if you start to read through and see there's  
4 a significant issue, then you go in and it will be  
5 categorised by the author of the IR1, whether its 10:56  
6 major, minor or catastrophic.

7 88 Q. That sounds like a triaging of IR1, is that right?

8 A. Yes.

9 89 Q. Who deals with that then?

10 A. It is part of the governance of the division led by the 10:56  
11 Assistant Director and either the Associate Medical  
12 Director or the CD, and somebody from governance. So  
13 governance will bring the cases that has come in as  
14 major catastrophic to the meeting and then they will  
15 read (as in the group) will read through and determine 10:56  
16 then if more action is needed.

17 90 Q. In your experience, just before you left post for the  
18 Inquiry's information, was it your view that IR1s were  
19 effective in both dealing with the issue and responding  
20 appropriately in a governance way? 10:57

21 A. They were effective to a certain extent. But I think  
22 the fact that there was never any -- again, going back  
23 to what we were saying -- any loop closed. So, for  
24 example, if an IR1 went via SAI, if I put in an IR1  
25 today and it actually went as an SAI, most likely 10:57  
26 wouldn't know that unless it was discussed, you know,  
27 because it was me put it in. So I don't know the  
28 effectiveness of it for the users because they don't  
29 know whether they've put in an IR1 whether -- what the

1 ultimate end is of the IR1.

2 91 Q. So no-one goes back to the staff member and says: "The  
3 outcome of the IR1 or training has been identified" or  
4 "This is the actual result." It goes into the machine  
5 and they don't know what happens? Is that a fair 10:58  
6 description?

7 A. A fair description, yes.

8 92 Q. Now just back to the MHPS timeframe. In December 2015  
9 there was an issue in relation to clinical letters not  
10 being dictated and some of the clinicians drew that to 10:58  
11 your attention. You spoke to Mrs. Trouton at that  
12 time?

13 A. That's correct.

14 93 Q. This was escalated to Mr. Mackle and Mrs Gishkori.  
15 That triggers then the January 2016 meeting. Now a lot 10:58  
16 of information that I'm going to speak through is just  
17 really to jump through the chronology but I do want to  
18 stop on some points where you have a particular  
19 involvement.  
20 10:58

21 There was a meeting on the 11th January, I know you're  
22 aware of that meeting, that Mr. Wright had with  
23 Mrs. Trouton and Mr. Mackle.

24 A. That's correct.

25 94 Q. Now this seems to be the start of the process that 10:59  
26 would lead to MHPS that ended three years later. But  
27 Mr. Wright -- did you have much contact with Mr. Wright  
28 as Medical Director at that point?

29 A. To be fair to Dr. Wright, we would have -- when he took



1 up post, he was the first Medical Director that  
 2 actually approached the Heads of Service to say that  
 3 he would like to attend the speciality meetings so to  
 4 get introduced to the consultants. So I knew him from  
 5 his taking up post because I had facilitated him 10:59  
 6 attending a urology and an ENT consultant meeting. But  
 7 day-to-day dealings or escalations of any issues like  
 8 that, no, I wouldn't have worked closely with him at  
 9 all.

10 95 Q. Now you weren't at that meeting. Was the contents of 10:59  
 11 the meeting or discussions or outcomes discussed with  
 12 you afterwards?

13 A. They were, yes. It was a discussion where both  
 14 Mr. Mackle and Mrs. Trouton came to me to say they had  
 15 had the meeting, I don't recall the actual total 11:00  
 16 conversation, but I do know that they requested me to  
 17 do a draft letter covering some of the facts and the  
 18 figures around four areas, four areas un-triaged,  
 19 review backlog, charts at home and -- I'm taking  
 20 a blank -- oh, un-dictated letters. 11:00

21 96 Q. Now, that letter was provided to the Inquiry yesterday?

22 A. Yes.

23 97 Q. I know that after consultation, you went and sought  
 24 that letter and we received a copy yesterday. We have  
 25 managed to Bates number it and it can be found at 11:00  
 26 TRU-164660 to 164663, for the Panel's note.

27  
 28 The first page, we can move past that. That's a letter  
 29 from Ms. Frizell, Solicitor, yesterday sending this to

us. The next page should be your e-mail with, your cover to the draft letter, 164661, on the next page. So that's an e-mail that you have sent on the 18th January 2016 to Mrs. Trouton and Mr. Mackle:

"Dear both,

11:01

Apologies for not getting this to you sooner but I wanted to rerun and update the information before including this in the correspondence. I wasn't sure if this was a joint letter but I have put it from a plural perspective, so this may need changed.

11:01

Hope it is okay and if there is anything else needed, please do not hesitate to give me a shout."

11:02

And you have attached a draft letter. Now there are no notes of the conversations with yourself and Mrs. Trouton and Mr. Mackle.

A. No.

98 Q. But the contents of the letter would seem to indicate that they have given you a steer as to the sort of information not only they want you to cover but the data they would like you to put in the letter?

11:02

A. Yes.

99 Q. I just want to look at some aspects of this. Now the reason why I want to take you through this is because the letter that was subsequently presented to Mr. O'Brien differs from the contents of this letter.

11:02

A. That's right, yes.

- 1 100 Q. So this draft, the 18th January 2016, and the ultimate  
 2 letter handed on 30th March 2016 have been altered,  
 3 just in detail, and I want to identify that. But did  
 4 you do another draft of this letter or is this the last  
 5 draft that you sent to Mrs. Trouton and Mr. Mackle? 11:02
- 6 A. This is the last draft I sent. I did update the  
 7 figures but I didn't do anything with the draft of the  
 8 letter. That's this last one.
- 9 101 Q. We'll look at that in a second. I think you updated  
 10 the letters on the day of the 30th March, is that 11:03  
 11 right?
- 12 A. That's right. Yes.
- 13 102 Q. Okay. So the first part of this, I just wanted to read  
 14 some of this out, as I say, because it has just been  
 15 received by the Panel. The first paragraph in that, 11:03  
 16 you speak to un-triaged outpatient referral letters.  
 17 And you have said:  
 18  
 19 "There are currently 253 un-triaged letters outstanding  
 20 from the period of time when you were on call. These 11:03  
 21 are dating back to November 2014."  
 22
- 23 I just want to ask you about that. Where did you get  
 24 those figures from for this letter? Where was the  
 25 source of your hard data, as it were, for this 11:03  
 26 correspondence.
- 27 A. For the un-triaged letters, I would have got that from  
 28 the Referral and Booking Centre, so most likely through  
 29 Mrs. Robinson. I would have asked her and she would

1 have provided me with that data.

2 103 Q. I'm just inquiring if it is possible to put the two  
3 letters side by side. It would perhaps make this  
4 process a bit easier. The letter that was given to  
5 Mr. O'Brien is at TRU-274672.

11:04

6  
7 I'm trying to find the east way to do this without  
8 moving to move back and forward. Perhaps the easiest  
9 way at the moment is if I read out the parts  
10 that didn't find their way into the final draft, ask  
11 you the motivation for including them and then we can  
12 ask others why they were removed, is that a fair enough  
13 thing to do? If we go back to the original.  
14 TRU-164662. Okay, back on track.

11:05

15  
16 So we're under the heading: "Un-Triaged Outpatient  
17 Referral Letters". I'll read out the bits that have  
18 been left out.

11:05

19  
20 So the second line:

11:05

21  
22 "We have been advised that whilst the booking centre  
23 does not book these patients on to clinics as their  
24 date comes up..."

11:06

25  
26 You had put in your original, which isn't in the  
27 ultimate letter:

28  
29 "There is a clinical issue for us in that we do not

1 have assurance that these patient letters have been  
2 read so as to give an indication on their priority.  
3 Therefore, the Trust do not know which waiting list  
4 they should actually be on. For example, do they  
5 remain on routine? Should they have been updated to  
6 "red flag" and "urgent". "

11:06

7  
8 Now that information isn't in the original letter. Now  
9 when you put that in, you specifically mentioned about  
10 there being a clinical issue?

11:06

11 A. I suppose when I was drafting the letter, really it was  
12 under the four headings and the actual information, the  
13 data. I just put everything down knowing that when  
14 Mr. Mackle and Mrs. Trouton would get it that they  
15 would consider it. So it's just one of those things of  
16 putting as much in as I possibly could, whenever I was  
17 drafting it.

11:06

18 104 Q. Now the next part of your letter that doesn't find its  
19 way in is the line that begins:

20  
21 "We have been informed that none of the original 253  
22 letters have not been returned from you to the Booking  
23 Centre. "

11:07

24  
25 Then the bit that's not in the next letter, the rest of  
26 that sentence:

11:07

27  
28 "The integrated elective access protocol which governs  
29 the turnaround time for triage states that this should

1 be done within 72 hours (although we recognise that  
2 this is not always possible, the maximum time to return  
3 letters is 1 week). At the moment, the longest  
4 un-triaged letter is now 60 weeks."

11:07

6 Now, again, you will appreciate the next line, and it  
7 is a matter for the Inquiry and for the other witnesses  
8 to explain why they removed this and if it has any  
9 significance or any bearing on the element of risk that  
10 you seem to have identified in the body of your text.

11:08

11 The next part is the next paragraph:

13 "You will appreciate. ."

15 And almost all of this I think didn't find its way in.

11:08

17 "...the issue for us is that we do not know what is  
18 within these un-triaged letters, as you are the only  
19 consultant to have seen these, and whilst we have been  
20 given assurances that they will be seen within their  
21 timescales (therefore not disadvantaged), we are not  
22 sure if the priority given by the GP is correct and  
23 then from this end the patient is disadvantaged in that  
24 their treatment has not been started at an earlier time  
25 if that was what had been agreed if the letter had been  
26 upgraded."

11:08

11:08

28 Now I wonder if I could just ask you to talk me through  
29 that? where did you get that information from in

1 relation to there may be outcome issues for patients?

2 A. I suppose it's just -- it was just my knowledge that,  
3 because I have been working with un-triaged letters --  
4 like, even pre working in the Southern Trust I would  
5 have worked as an outpatient manager so I was familiar 11:09  
6 with the whole concept of referral letters and triage.  
7 So I would have known that there was a potential amount  
8 of patients that maybe needed to be upgraded, and  
9 that's basically where I was coming from. Now when  
10 I started in 2009, waiting times were nine weeks for an 11:09  
11 outpatient appointment. So if the letter wasn't  
12 triaged it still would have been seen within nine  
13 9 weeks. Potentially, yes, if there's a cancer patient  
14 in it, that wouldn't have been good, but there was  
15 always a potential of only nine weeks. Before I left, 11:09  
16 it was up to four years, I think, the waiting times.  
17 So we don't know that somebody in there was graded as  
18 a routine would end up as maybe an urgent or a red flag  
19 missed if they weren't seen for four years.

20 105 Q. But even in the drafting of this letter, with your 11:10  
21 nonmedical background, you realised that that system  
22 alone could disadvantage patients?

23 A. Yes. Yes.

24 106 Q. Would it be fair to say that that disadvantage, for  
25 you, presented a clinical risk? 11:10  
26 A. Yes.

27 107 Q. The next part of the letter, it is more the wording,  
28 I think. Now the information in boxes was updated for  
29 the letter, I think you were asked to update the

1 figures before sending it through.

2 A. Yes.

3 108 Q. Just the second line where you've started the paragraph  
4 saying:

5  
6 "Aidan, we need assurances that there are no patients  
7 contained within this backlog are cancer surveillance  
8 patients."

11:10

9  
10 Then you say:

11:10

11  
12 "We have been advised that you have now a separate  
13 oncology waiting list."

14  
15 I just wonder if I could ask you about that sentence  
16 was not framed in that way in the ultimate letter. It  
17 sounds as if you just found out about a separate  
18 oncology waiting list, that may be wrong but certainly  
19 reading that at face value, it seems to be the case.  
20 Could you explain that?

11:11

11:11

21 A. It used to be all the consultants had a general waiting  
22 list that everything went on. Now Mr. O'Brien was  
23 Chair of the NICaN and part of Peer Review and part of  
24 our oncology DT business meetings. It was advised that  
25 we would be better to separate out any patients that  
26 were oncology so that they -- because if you think  
27 about it chronologically, if you have somebody waiting  
28 back to 2013, which I can assure you it wasn't cancer  
29 patients, but if you look at that, we have no way of

11:11



1 knowing how to pick out a surveillance patient. So  
 2 there was a new oncology list. So it was CAOBUO for  
 3 Oncology. It meant that when the booking centre were  
 4 sending for patients they would probably take -- they  
 5 were instructed to take from that list first for 11:12  
 6 a review clinic. So yes, and that was a fairly new  
 7 thing, and it went across the Board, all the  
 8 consultants ended up with an oncology review waiting  
 9 list.

10 109 Q. So that was a way in which it was trying to be 11:12  
 11 effective and targeted?

12 A. Yes. Yes.

13 110 Q. So it was a beneficial approach, was it?

14 A. It was a beneficial approach, yes.

15 111 Q. You also say in that paragraph, third line from the 11:12  
 16 bottom:

17  
 18 "We have no assurances that those patients in the  
 19 'older' backlog are not clinically urgent patients."

20 11:12  
 21 Then under: "Patient centre letters and recorded  
 22 outcomes from clinics", just the last three and a half  
 23 lines of that first paragraph:

24  
 25 "The lack of a record means that no decision can be 11:12  
 26 made on whether a patient needs to be reviewed,  
 27 discharged, et cetera, and when they do come to clinic  
 28 they have to be treated as a new patient because there  
 29 is no previous information to base decisions on."

1  
2 okay, that's not dictating outcomes. That information  
3 wasn't reflected in that way. And then the next  
4 paragraph:

5  
6 "We have also had it escalated that there are no  
7 outcomes recorded from your clinics and as there's no  
8 letter dictated, staff are not able to record  
9 a decision on the patient."

11:13

10  
11 Then you have said:

11:13

12  
13 "Example: "

14  
15 And this wasn't included.

11:13

16  
17 "Should they be add to a review list, should they be  
18 added for urodynamics, flexible cystoscopy, inpatient  
19 day procedure or actually discharged back to the GP, I  
20 am sure you would agree that this lack of documentation  
21 is not fair on the patient nor on the admin staff who  
22 are trying to manage this."

11:13

23  
24 Then patient notes at home issue, the last two  
25 sentences weren't reflected in the final draft:

11:13

26  
27 "We have been advised that you are being requested  
28 a few times a week to bring patient notes in from home.  
29 These are needed for clinics, patient admissions or

1 filing. This is a big governance risk and needs  
2 addressed and ceased immediately."

3  
4 So in your detail in the letter, you have identified  
5 both clinical risk and governance risk. There's 11:14  
6 probably more of a context detail in your draft. Did  
7 you ever get any direct feedback on that draft or asked  
8 to look at another draft after you sent that through.

9 A. No. The next thing I had heard was on the 16th March,  
10 I think it was, when Heather requested me to update the 11:14  
11 figures and then on the 30th March, the day that we met  
12 with Mr. O'Brien, I got a copy of the final letter,  
13 a hard copy, because it was printed off, and I copied  
14 it for Mr. Mackle and a copy for Mr. O'Brien.

15 112 Q. The 16th March Heather Trouton e-mailed to you -- 11:15  
16 we don't need to go to this, it's just for the Panel's  
17 note -- TRU-277940, and then your e-mail to Mr. Mackle  
18 on 30th March is at TRU-282021. Now in that one,  
19 you didn't copy Mrs. Trouton in, just Mr. Mackle. Was  
20 he the one dealing with the final version? 11:15

21 A. He was, yes, and I think it was because I think both  
22 him and I were going to the meeting, and it's  
23 possibly -- because none of us can remember whey it was  
24 me, it was possibly Mrs. Trouton must have been on  
25 annual leave or something because it was coming up to 11:15  
26 the end of financial year. So that's probably why  
27 I didn't copy her in.

28 113 Q. Now Mr. Mackle in his evidence, about the 23rd March  
29 letter, seemed to indicate that you principally drafted

1 that version.

2           A.    The final version?

3 114 Q. Yes.

4 A. No, definitely not.

5 115 Q. we don't have to go to it, it's just for the Panel's  
6 note, TRA-02256. So in your mind, this was the last  
7 time you had anything to do with the correspondence?

8           A.     Absolutely.

9 116 Q. Except for updating the information?

10 A. Yes.

11 117 Q. Now that letter, even though you had updated the  
12 information on the 30th March, the version given to  
13 Mr. O'Brien was dated the 23rd March?

14 A. Yes.

15 118 Q. And you had nothing to do with that either, I presume,  
16 had you?

17 A. No. No, I didn't.

18 119 Q. You met with Mr. O'Brien on the 30th March with  
19 Mr. Mackle?

20           A.    I did, yes.

21 120 Q. Now in relation to that meeting, did you keep a note of  
22 that?

23 A. I didn't. It was actually a very short meeting.  
24 I don't even think it lasted 10 minutes. It was whilst  
25 both Mr. O'Brien and Mr. Mackle were very courteous to  
26 each other and talked about the business of the  
27 hospital just generally, the meeting was very short and  
28 succinct and I think it was just we gave him the  
29 letter, Mr. Mackle just gave the headings, he didn't

1 read the letter in detail. I do recall Mr. O'Brien  
2 folded up the letter and asked: "What am I going to do  
3 with this?" And I can't recall whether it was myself  
4 or Mr. Mackle but I definitely know that we said we had  
5 four weeks, we needed a response. Now I do know from 11:17  
6 reading -- from information in preparation for this  
7 that there was a -- Mr. Mackle is supposed to have  
8 shrugged his shoulders and rolled his eyes. I honestly  
9 can't say if that happened or not, but I could have  
10 just been looking at Mr. O'Brien at the time. And 11:17  
11 I did offer Mr. O'Brien, as I would have always done,  
12 if you need any help give me a -- my phrase is, as you  
13 can see from e-mails, "give me a shout".

14 121 Q. Just to deal with the shrug issue, that's a contention  
15 of Mr. O'Brien's where, when he was asked about what's 11:18  
16 expected, he was met with shrug of the shoulder and he  
17 says that at AOB-1367. That's not your recollection?

18 A. No.

19 122 Q. So going back to your recollection, that's the first  
20 time that it had been written in a formal way, the 11:18  
21 letter to Mr. O'Brien, about issues that had sought to  
22 be addressed, at least informally by you over the  
23 years?

24 A. That I'm of aware, yes.

25 123 Q. Now the Panel have seen the letter. I don't need to go 11:18  
26 to it but I don't think it is contentious to say that  
27 there's no mention of a plan or timeframes or specific  
28 actions that were expected from Mr. O'Brien?

29 A. That's correct.

1 124 Q. Was your understanding of that letter that he was to  
2 triage, to get on top of his review backlog, to dictate  
3 the letters and not store notes at home?

4 A. I suppose my view was, yes, that we would get  
5 a response back to say that he had done his triage, 11:18  
6 maybe tell us how he was going to address the review  
7 backlog and to let us know that he had returned the  
8 charts. I assumed we would get a response back.

9 125 Q. At that stage, were you aware that you would have any  
10 subsequent oversight of Mr. O'Brien's actions after 11:19  
11 this point at all?

12 A. I wasn't. I didn't think -- wrongly, I didn't follow  
13 up on it because I think it was -- in my head it was  
14 the Assistant Director and Associate Medical Director  
15 who were leading on it. My role was originally just to 11:19  
16 provide the information, the data, and then ultimately  
17 it just happened to be that I attended the meeting with  
18 Mr. Mackle because of previous encounters, Mr. Mackle  
19 couldn't attend a meeting on his own. So with Heather  
20 not being available, it's obviously the reason why 11:19  
21 I was there. So it was being led by the AD and the MD  
22 so I, wrongly, didn't follow up on it.

23 126 Q. Was there any reason why Mrs. Trouton didn't go to the  
24 meeting instead of you?

25 A. I really can't recall why that happened. 11:19

26 127 Q. Did you know well in advance you had to go to the  
27 meeting or was it something that you were informed of  
28 just before?

29 A. I think I was just informed relatively before it,

1           whether it was that day or the day before, that I had  
2           to attend.

3   128   Q.   You've said about previous encounters with Mr. Mackle.  
4           Could you just give us some context to that, why he  
5           couldn't be alone, as you say, with Mr. O'Brien?

11:20

6           A.   Yes.  I'm not aware of the time scales but I think from  
7           reflection, it was sort of later on in the evening of  
8           a working day, Mr. Mackle, after theatre or clinical,  
9           would have popped up on to the admin floor.  Again,

10          that's in context of sort of he would walk right round  
11          from the Director's office right rounds to ourselves.

11:20

12          I was in the office on my own, which is why I think it  
13          must have been later evening.  Mr. Mackle came in,

14          closed the door and put his back against the door and

15          looked visibly shocked and actually looked very unwell  
16          and said to me:  "I've just been accused of bullying.

11:20

17          I've just been pulled into an office and been accused  
18          of bullying."  He didn't tell me which office it was so

19          I know, listening to Mr. Mackle's evidence, he did

20          contact me when the inquiry was announced and said to  
21          me did I remember who it was.  I really don't.  I said

11:21

22          to him at the time it had to be either Dr. Rankin's

23          office, which was the first one, or Helen Walker who

24          was the AD for HR, before he would have come round to

25          me.  He just said:  "It has come from down the hill",

11:21

26          which is what we would call Trust Headquarters and

27          I was more concerned that evening for his actual

28          health.  I was trying to get him to sit down and take

29          a glass of water because he was very distressed, and he

1 definitely said: "I've been accused of bullying by  
2 Mr. O'Brien."

3 129 Q. Just in relation to time frames, we're on to 2016. Do  
4 you have any idea when that conversation directly with  
5 Mr. Mackle occurred?

11:21

6 A. I think it was in and around 2011/12. I can't be more  
7 precise than that. I know at the time Mr. Mackle's  
8 late wife was quite unwell. So I do know it was in and  
9 around that time, but I can't be more precise.

10 130 Q. So just in summary form, he spoke to you directly about  
11 an allegation of bullying. His reference to "down the  
12 hill" you took to mean headquarters?

11:22

13 A. Headquarters, Yes, Trust headquarters. Yes.

14 131 Q. You think it was possibly either Gillian Rankin or  
15 Helen Walker who brought the allegation to his  
16 attention?

11:22

17 A. Yes.

18 132 Q. Now the Panel have heard from Helen Walker that she has  
19 no recollection of that but Dr. Rankin will be giving  
20 evidence so that can be brought up with her. So that's  
21 the context you were saying earlier in your evidence  
22 that Mr. Mackle didn't attend meetings alone with  
23 Mr. O'Brien?

11:22

24 A. Yes. And I suppose after that meeting with me there  
25 was a decision, which was shared with us all, that  
26 Mr. Mackle would take a step back from managing  
27 Mr. O'Brien and that it would be Mr. Brown who was the  
28 Clinical Director of General Surgery in Daisy Hill  
29 would have direct responsibility then in any meetings

11:22



1 he would take forward.

2 133 Q. Just having brought up that issue with Mr. Mackle, that  
3 allegation that was made, did that become more widely  
4 known among staff?

5 A. I'm sure it did, yes. It would have sort of ruminated 11:23  
6 through the -- a bit like what Dr. McAllister said,  
7 they all talked in theatre to each other so I'm sure  
8 that it did, yes.

9 134 Q. Did you perceive that as having, or did it have any  
10 actual impact on how people dealt with Mr. O'Brien? 11:23

11 A. I think it did. I think it did, because people knew,  
12 as was described by Mr. Mackle, when you sort of try to  
13 hit it head-on that something -- an allegation is made  
14 that just makes you run scared.

15 135 Q. I see the time but I wonder if I could just be indulged 11:24  
16 to just finish off just another couple of sections on  
17 this? Now there's nothing in the letter that said it  
18 had to be responded to within four weeks but that's the  
19 evidence being given to the Inquiry. Did you or anyone  
20 else follow up after this meeting with Mr. O'Brien 11:24  
21 about plans that he had to try to address some of those  
22 issues?

23 A. Not directly with Mr. O'Brien, no. Not me, and  
24 I assume just looking at everybody else's evidence over  
25 this last few days, nobody else did either. 11:24

26 136 Q. Would it be usual to ask -- to draw to a Consultant's  
27 attention concerns around issues of governance and  
28 clinical risk and not provide him with some kind of  
29 framework of support to address those concerns?

1 A. I would say yes. I know I offered support, as I always  
2 did, but it wasn't formal support.

3 137 Q. When you say it wasn't formal support, what's the  
4 difference between the support you've offered in  
5 previous years to the support that you might have 11:25  
6 offered at this time?

7 A. I suppose always my support was sort of informal, you  
8 know, but Mr. O'Brien never took up any offers in all  
9 the years. He still maybe -- I would say to him, you  
10 know, will we spread the likes of the triage maybe out 11:25  
11 with others or -- he would always still want to do it.  
12 Now I do know Mr. Young did help out on two occasions  
13 but, you know, Mr. O'Brien had a way of working that  
14 was probably inefficient. So it was his way or no way,  
15 sort of thing. So it was probably very hard to offer 11:25  
16 support. But, you know, if we would have been able to  
17 sit down, there might have been things like the review  
18 backlog, we maybe could had the nurses do a validation  
19 on it, for example, the CNSs, clinician nurse  
20 specialists. 11:26

21 138 Q. Just at this key point in April 2016 there were staff  
22 changes?

23 A. That's correct.

24 139 Q. Now those staff changes were as a result of a decision  
25 by Mrs. Gishkori, is that right? 11:26

26 A. That's correct. Yes.

27 140 Q. Would staff changes have been unusual in your  
28 experience or was it something that was routinely done  
29 by directors?

1 A. well, I had worked from 2009-2016 without any change.  
2 I know Mr. Gibson, but that had been done before --  
3 Mr. Gibson and Mrs. Trouton, but that had literally  
4 been done before I had taken up post. But, no. And  
5 from '16 to 2021, I still had the same AD. So it 11:26  
6 wasn't normally...

7 141 Q. So at this point the two individuals who were tasked by  
8 Dr. Wright in dealing with this issue, Eamon Mackle and  
9 Heather Trouton, both changed roles?

10 A. well, Heather changed roles but Eamon resigned from his 11:26  
11 role as AMD in April. So that was his choice.

12 142 Q. Yes, but they were replaced by other people?

13 A. Yes, they were.

14 143 Q. who had no history with this issue?

15 A. No, that's correct. 11:27

16 144 Q. And the Inquiry has heard evidence from Mr. Weir and  
17 Mr. McAllister in relation to that. Were you aware of  
18 the staff changes at that point?

19 A. We knew they were happening and I actually didn't know  
20 sort of the reason for it until, actually, yesterday 11:27  
21 Mr. Gibson's -- when he was giving his evidence,  
22 actually, had given the reason why the changes -- why  
23 Mrs. Gishkori wanted the changes and that she wanted  
24 clinical people in the operational AD roles.

25 145 Q. would that have been a significant issue ongoing that 11:27  
26 a consultant had been given a formal letter? would  
27 that have been something that was pretty significant  
28 within the unit at that time from a management  
29 position?

1           A.    It would have been, because it hadn't happened  
2                    previously.

3   146   Q.    Are you aware if there was any hand-over in relation to  
4                    that for the people coming into the roles of Mr. Mackle  
5                    and Mrs. Trouton? 11:28

6           A.    I'm not aware of if there was a hand-over. I did  
7                    myself, because I was concerned that we didn't have  
8                    a Clinical Director and Associate Medical Director.  
9                    Towards the end of April, I updated Mr. Carroll on --  
10                  there was a three areas I had to update him on 11:28  
11                  clinically-wise.

12   147   Q.    And in your statement at WIT-39890, you have accepted  
13                    that the change in personnel meant that the letter of  
14                    2016 was not followed up as it should have been. Do  
15                    you think that the change in staff was the only reason 11:28  
16                    that it wasn't followed up or was there a general  
17                    reluctance to follow it up?

18           A.    I think the change of personnel was probably the  
19                    most -- it was the biggest thing with regard to that  
20                    because this was the first time since I had started in 11:29  
21                    2009 that anybody had actually, you know, addressed it  
22                    in writing and seemed prepared to take it on. Then  
23                    I don't know then about the subsequent post holders,  
24                    whether there was a reluctance there or not.

25   148   Q.    The Panel will be aware while you e-mailed Mr. Carroll, 11:29  
26                    nothing really was done until August 2016?

27           A.    Yes.

28   149   Q.    -- in relation to this issue. Because I'm going to  
29                    move on to that and a new topic, I wonder if that would

1 be an appropriate time to take a break?

2 CHAIR: we'll take a break now and come back at quarter  
3 to 12.

4  
5 THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

11:40

6  
7 CHAIR: Ms. McMahon.

8 150 Q. MS. McMAHON BL: Just before we move on to the rest of  
9 the timetable, I know we spoke about Mr. Mackle telling  
10 you that it had been alleged about bullying, obviously, 11:48  
11 that's an allegation that Mr. O'Brien denies completely  
12 and he can deal with that in his evidence. The other  
13 issue we touched upon with the SAIs, and you mentioned  
14 about harm coming to patients, obviously that's  
15 a matter for other witnesses to deal with, so the 11:48  
16 particular phraseology used wouldn't be accepted by  
17 Mr. O'Brien in relation to harm but, as I say, you  
18 weren't involved in that. So I'm just putting that on  
19 record.

20 A. Okay.

11:48

21 151 Q. Now when we talked about Mr. O'Brien had been asked to  
22 respond within four weeks, although it's not in the  
23 letter --

24 A. That's correct.

25 152 Q. -- there is an e-mail to that effect, and again, it's 11:48  
26 just for the Panel's note, 28th April 2016, an e-mail  
27 from you to Ronan Carroll at TRU-274671. This is where  
28 you inform him of the letter that was given to  
29 Mr. O'Brien and you mention that he had been asked to

1 respond within four weeks but nothing had been  
 2 received. So just to tie that point up, that's  
 3 a record of the four-week turnaround being recorded at  
 4 that point.

5 A. That's correct, yes.

11:49

6 153 Q. Now there were steps and stairs along the way later  
 7 through 2016 and you weren't necessarily involved in  
 8 a lot of discussions that were ongoing. I don't want  
 9 to take you to all of the ones that you were involved  
 10 in because I want to get to the Return to Work Plan and  
 11 your involvement in that? 11:49

12 A. Okay.

13 154 Q. But I just want to point out a couple of e-mails and  
 14 I'll give references for the Panel and for core  
 15 participants to note where your level of involvement  
 16 sat. 11:49

17  
 18 There was an e-mail from you on 15th June, it was  
 19 discussed I think with previous witnesses, to Colin  
 20 Weir, where you have updated -- you have provided the  
 21 letter of March 16th and just said "as discussed"? 11:50

22 A. Yes.

23 155 Q. I presume that was on the back of --

24 A. Yes, it was on the back of -- I do know I updated  
 25 Dr. McAllister and then he's obviously updated Colin.  
 26 I don't recall the conversation but as you say, I said  
 27 "as discussed", so he must have asked me for it. 11:50

28 156 Q. And were those conversations, could they be described  
 29 as a hand-over of the issues that were currently being

1           aired in relation to Mr. O'Brien?

2           A.    They could be, yes.

3   157   Q.    Again, on 9th August 2016, and the Panel will find this  
4           at TRU-274723, Mr. Wright sought an update from you.  
5           I'll just quote from that: 11:50

6

7           "Did we ever make progress with regard to the issues  
8           raised re urology which Eamon had been dealing with?"

9

10          This is just in advance of him asking Mr. Gibson to 11:51  
11          undertake his scoping exercise. Is that the first that  
12          you had been directly asked about an update since the  
13          meeting with Mr. O'Brien?

14          A.    Yes, that's the first.

15   158   Q.    You had never thought to follow up from that meeting? 11:51

16          A.    I suppose in my head because there was sort of informal  
17          conversations with Dr. McAllister and Mr. Weir that it  
18          was being followed up but I personally didn't follow  
19          up, and that is a regret that I probably didn't sort of  
20          bring it to their attention more, that we needed 11:51  
21          a response from it.

22   159   Q.    Well, just to be balanced on that in relation to the  
23               evidence you provided, it had been dealt with by Eamon  
24               Mackle and Mrs. Trouton?

25          A.    Yes. 11:51

26   160   Q.    You discussed earlier in your evidence that the  
27               hierarchy of the medics, dealing with medics, was  
28               something that was custom and practice, if I can put it  
29               that way, within the unit, and so the people who

1 replaced those posts, Mr. McAllister, Mr. Weir, was it  
2 your expectation they had taken up the mantle in this  
3 regard?

4 A. Yes. Yes.

5 161 Q. So you provided a letter to Mr. Wright that you had 11:52  
6 given to Mr. O'Brien on the 30th. There then is  
7 a period of time when Mr. Gibson is carrying out his  
8 work. There's an oversight meeting then on 13th  
9 September. Now did you have any knowledge of the  
10 oversight meetings? 11:52

11 A. No, I had no knowledge of any of them until the  
12 December 1st.

13 162 Q. And you didn't know that they were being planned or  
14 that they had happened?

15 A. No. 11:52

16 163 Q. Did anyone approach you in advance of the meetings to  
17 just get a further update on figures or facts or  
18 anything about practice?

19 A. Well, Simon, Mr. Gibson had actually asked for -- when  
20 he met with me with regard to figures -- but it was 11:52  
21 never in the context that there was an oversight  
22 meeting. I assumed it was just from follow-up of  
23 Mr. Wright's e-mail.

24 164 Q. But Mr. Gibson had informed you that he had been tasked  
25 with undertaking the work by Mr. Wright in order to get 11:53  
26 what could be described as a global view of the  
27 situation as it was at that moment in time?

28 A. Yes.

29 165 Q. And did you give him any information to inform his



1 report or did he just let you know he was doing it?

2 A. I would have given him some information. Yes, probably  
3 give him an update on the situation with regard to the  
4 triage, the review backlog and I couldn't do the  
5 un-dictated on the chart at home and he did ask 11:53  
6 a specific question from Ms. Lawson with regards to  
7 records, did we know how many charts were at home.  
8 I didn't see any responses to that and I didn't respond  
9 because it wouldn't be my area of expertise to know  
10 that information. 11:53

11 166 Q. Now when you come back to given evidence, we'll go into  
12 some detail about the systems that were in place to  
13 give you data and how reliable that data may have been  
14 and how you relied on it operationally outside of these  
15 issues. But just you've mentioned there, and I think 11:54  
16 you're probably in a unique position that you can reach  
17 out to different parts of The Trust?

18 A. Yes.

19 167 Q. Like Katherine --

20 A. Katherine Robinson. 11:54

21 168 Q. Katherine Robinson, I'd just forgotten her surname,  
22 apologies?

23 A. Yes.

24 169 Q. Asked them for information that was fed in to you  
25 obviously to inform you? 11:54

26 A. Yes.

27 170 Q. But you touched upon the un-dictated clinics issue and  
28 I just wanted to ask you briefly about that. From  
29 reading your Section 21 and others, was that

1 a particularly difficult issue to get proper  
2 information on because is it fair to say you don't know  
3 what you don't know. If a clinic hasn't been dictated,  
4 how do you find that out?

5 A. I suppose its easier now with digital dictation, but 11:54  
6 before it used to be the hand-held Dictaphones. So the  
7 only person who would probably know if a tape hadn't  
8 arrived back with the charts is the secretary.

9 I suppose there would have been -- it was never  
10 escalated. And the other thing would have been that 11:55  
11 the charts needed to come back so the secretary would  
12 know there had been no dictation. So it would be very  
13 difficult to know.

14 171 Q. So you were dependant on an individual then to alert to  
15 the absence of information. 11:55

16 A. Yes.

17 172 Q. And you say that's different now with digital  
18 dictation. Does that mean that there's a system that  
19 flags up the absence of dictation rather than an  
20 individual or is there still individual involvement? 11:55

21 A. There's still individual involvement. I know they are  
22 looking at a system to try and -- that when there's  
23 a clinical and a patient arrive at the clinician that  
24 it automatically flags up there needs to be a letter,  
25 but they're looking at the technology of that. The 11:56  
26 health service system are all full of fire walls so  
27 I think it's just trying to get -- and I am not at all  
28 and I will never claim to be technically knowledgeable,  
29 but I have been advised that it will. But at the

1 moment the answer to your question is it still depends  
2 on individuals.

3 173 Q. Is it still -- well, if I can frame the question this  
4 way. In your experience, do you see that dynamic or  
5 that particular system to be as vulnerable now as it 11:56  
6 was then?

7 A. Not as vulnerable because there is a lot of audits goes  
8 on from -- it's a different division, but they will  
9 ensure that everybody who has been to a clinic gets  
10 a letter. The downfall, and I'm sure we'll get to 11:56  
11 this, for me, was that there's 10 patients in the  
12 clinic and when I asked the question about the  
13 dictation, they told me there was 10 letters on the  
14 system. But I did spot checks but towards whenever  
15 there was a big deviation, when I went in and 11:57  
16 discovered there was 10 letters, the 10 letters weren't  
17 for the 10 patients. It might be one had three letters  
18 and one had none. So there is still that vulnerability  
19 in the system. And I really -- I know you're hoping to  
20 address this, I don't know if anything more has moved 11:57  
21 on because obviously I haven't been in that post  
22 since June '21.

23 174 Q. We can explore that, the Panel can explore that with  
24 other witnesses.

25  
26 The other issue about the notes at home, is that  
27 another particular issue that requires on reporting  
28 from individuals? Notes not being where they should be  
29 rather than just being at home with an individual.

- 1 A. Yes, the system that we have, the patient  
2 administrative system is very, very dependent on human  
3 input in the sense of that -- so I have a chart but you  
4 come up and lift that chart out of my office. If you  
5 don't case note track that chart, it is still, 11:58  
6 accordingly, to me, in my possession. whilst charts  
7 may have been case note tracked out to  
8 Mr. O'Brien's office, they might not necessarily --  
9 well, as we know, weren't actually in his office, but  
10 people -- and it was a lot in the system and it's only 11:58  
11 now we're discovering how much, but basically if they  
12 couldn't find a chart that was case note tracked out of  
13 the office, they would go looking for it in the  
14 different areas; the ward, outpatients, the secretary's  
15 office, and then if it wasn't, we would contact 11:58  
16 Mr. O'Brien and he would bring it but we didn't know  
17 the extent of how many charts were at home.
- 18 175 Q. Is that system still flawed in that way?
- 19 A. It is, yes. There's a business case has been done up  
20 for a system called I-Fit that basically barcodes and 11:58  
21 tracks the chart wherever they move around the  
22 hospital, but that hasn't been implemented yet.  
23 I can't comment on why or whatever, but I do know that  
24 they are hoping to move to paperless within Compass  
25 say, which is quite imminent. 11:59
- 26 176 Q. Thank you for that slight deviation, but it will  
27 explain some of the e-mails you subsequently sent  
28 during your monitoring of Mr. O'Brien's return to work.  
29

1           You said you were aware of the 22nd December 2016  
2           Oversight Meeting?  
3           A.    That's correct.  
4   177   Q.    Were you informed in advance of that, that it was  
5           taking place? 11:59  
6           A.    No. No. It was after the meeting that I knew about  
7           it.  
8   178   Q.    Who they you about it afterwards?  
9           A.    It would have been Mr. Carroll, the system director.  
10   179   Q.   What was the context in which he discussed that with 11:59  
11           you?  
12           A.    Because there had been a letter received in from the  
13           Chair of the Patient 10 SAI which raised issues with  
14           regards to non-triage. I am aware now that the 22nd  
15           December meeting was called and there were a number of 12:00  
16           issues raised. Mr. Carroll approached me and  
17           Mrs. Clayton to help gather some of that information  
18           up.  
19   180   Q.    That was the period between 22nd December and the end  
20           of January? 12:00  
21           A.    That's correct, yes.  
22   181   Q.    You were involved with Mr. Carroll in another scoping  
23           exercise, really, to --  
24           A.    Yes.  
25   182   Q.    Was that to try to fine tune the figures that you 12:00  
26           wanted to rely on, or?  
27           A.    Yes, to fine tune the un-triaged letters was really  
28           sort of towards the end of December up until 30th  
29           December. January was more to do with the fact that

1 the notes had been returned and there was 307 case  
2 notes from home, and the fact that there were 783  
3 letters in the drawer, and I think 66 clinics not  
4 dictated. It was quite a substantial piece of work had  
5 to be done after the December.

12:00

6 183 Q. All of this work eventually became the preparation for  
7 the subsequent MHPS investigation and provided the hard  
8 data for that. What's your view as to whether more  
9 could have been done in preparation for that  
10 investigation or for the areas that were actually  
11 explored? Do you think that, number one, enough was  
12 done to look at what was currently current issues and,  
13 number two, do you think it should have gone a little  
14 bit wider than what was already known?

12:01

15 A. My personal issue, it should have went a lot further  
16 because as we know now from 2020, at the time I thought  
17 it was quite targeted, small areas looked at. I do  
18 believe that outpatient, for example, outpatient  
19 dictation should have went to include, ultimately the  
20 day case discharges and also the MDT. Dictation wasn't  
21 only for outpatients only.

12:01

12:02

22  
23 I do believe that -- and I can understand why they  
24 needed Mr. O'Brien -- wanted to come back to work but  
25 I think the investigation should have went on a wee bit  
26 further, a bit more as, to coin a phrase, deep dive,  
27 because if it had been anybody else, in the sense of  
28 a nurse or an admin person, potentially wouldn't have  
29 been allowed back until the investigation was

12:02

1 completed. But that's my personal view.

2 184 Q. It's your opinion. What's the basis for that? Why do  
3 you think that's the case, that it was, as you have  
4 suggested, was treated differently?

5 A. Like on reflection I think, and it is no criticism of 12:02  
6 the people that's at the Oversight Meeting, but I think  
7 it should have been expanded to be nearly -- and I know  
8 the directors is operational, but at the end of the day  
9 a director has quite a wide remit. For example, the  
10 likes of the systems and processes, whilst I am in, 12:03  
11 probably, a wee bit of more unique position in that all  
12 of my experience has been admin and systems, like the  
13 patient administrative system, and case note tracking  
14 and my background, outpatients, things like that, most  
15 other people wouldn't have the wider view of it. 12:03  
16 I think more experts or people of specialism in the  
17 admin systems should have been brought in and asked,  
18 'is this workable?'

19 185 Q. We'll talk in a minute about the monitoring and where  
20 you say the deficiencies are in that. In this period 12:03  
21 early January 2017 Mr. O'Brien returned patient notes  
22 from home as a result of a request from you. Was that  
23 as a direct result of you being asked to do that or was  
24 that just part of you identifying that the notes were  
25 missing? 12:04

26 A. That actually came from Dr. Wright. Dr. Wright  
27 requested that he brought all the notes in and left  
28 them with me. Mr. O'Brien did contact me and said that  
29 they would be leaving them in his office, which is on

1 the second floor, and he had said that he would be  
 2 doing it over the weekend of the New Year bank holiday.  
 3 I arrived in on the Tuesday, I think it was the Monday  
 4 was the bank holiday, and I went to his office and  
 5 retrieved the notes from there.

12:04

6 186 Q. This is at TRU-257707 for the Panel's note. There were  
 7 307 sets of note returned?

8 A. That's correct.

9 187 Q. Including 94 Trust patients who had been seen privately  
 10 by Mr. O'Brien. Is that just you collecting the notes  
 11 rather than -- in total numbers, rather than breaking  
 12 down whether he should have returned them all, or was  
 13 he able to hang on to some because they were private  
 14 patients?

12:04

15 A. No. These were actually -- what it was, Mr. O'Brien --  
 16 and it was only at that stage in 2017 that I realised  
 17 that this was happening. He was going to see me as  
 18 a private patient, for example, on the Saturday, he  
 19 actually brought my hospital notes home and wrote in  
 20 the hospital notes of the private consultation.

12:05

21 I suppose he needed -- I don't know, Mr. O'Brien will  
 22 have to be asked. I am assuming he needed the hospital  
 23 notes to find more information, I don't know. They  
 24 were NHS notes but for a private patient consultation.

25 188 Q. There was a process undertaken in relation to  
 26 un-dictated clinics --

12:05

27 A. Yes.

28 189 Q. -- that involved the other consultants becoming  
 29 involved in looking at that?



1 A. That's correct.

2 190 Q. That was a process that was not completed. It started  
3 in January but not completed until June 2017. That was  
4 due to the number of patients involved. Was that  
5 something that was passed on to other consultants on 12:06  
6 top of their own workload to look at, or what way was  
7 that organised?

8 A. Dr. Wright agreed that they would get a waiting list  
9 initiative payment to do them outside of working hours.  
10 Obviously we couldn't displace clinical activity 12:06  
11 because Urology, as we know, their demand capacity is  
12 through the roof. But that was outside of hours, so  
13 evenings, weekends.

14 191 Q. Although that wasn't completed until June 2017,  
15 Mr. O'Brien came back to work in the February. 12:06

16 A. That's correct.

17 192 Q. In your witness statement, for the Panel's note at  
18 WIT-26315, you expressed a view that you don't think  
19 that Mr. O'Brien should have been allowed back to work  
20 so soon and you called that a mistake. Can you give 12:06  
21 a bit of context to why you have that view?

22 A. It's just back to what I had said previously. This is  
23 in hindsight, I didn't say this at the time, but it is  
24 a reflection when I was doing my Section 21, I think  
25 the investigation should have been a wee bit further. 12:07  
26 At that stage it hadn't even really started. I think  
27 there needed to be more of a -- you know, to extend it  
28 to talk to the likes of the people I'm saying there to  
29 say what other areas do we need to look at. It was

1 a decision made inside a confined group of people  
 2 without actually expanding it out. It's a bit like  
 3 everything -- just back to what I said there, you  
 4 know -- any of the rest that go through disciplinary,  
 5 they would be properly investigated before allowed back 12:07  
 6 to work.

7 193 Q. When you say it was a confined group, who do you think  
 8 made the decision to allow Mr. O'Brien in?

9 A. I think from reading, ultimately it was the Case  
 10 Manager, Dr. Khan. 12:07

11 194 Q. Did anyone ask your views about the appropriateness of  
 12 Mr. O'Brien coming back to work, or was that something  
 13 you wouldn't have expected to be done?

14 A. No, I wouldn't expect it. I think it was, albeit  
 15 a senior manager was too junior to make a comment. 12:08

16 195 Q. You said in your statement at that point that  
 17 Mr. O'Brien's return to work was not accompanied by  
 18 a proper plan to manage him. Did you have sight of his  
 19 Return to Work Plan at that point?

20 A. The plan was shared with me by Mr. Carroll and 12:08  
 21 Mrs. Gishkori because it had come out from one of the  
 22 Oversight Meetings. It was the four areas that  
 23 Mr. O'Brien was to be monitored on as part of his  
 24 return to work.

25 196 Q. When you say that it wasn't a proper plan, I suppose 12:08  
 26 what I'm asking is did you look at the plan and say,  
 27 'that's not a proper plan', or did you form that  
 28 opinion because you were left to try and help implement  
 29 it?

1           A.    I think I formed the opinion because I tried to  
2                    implement it, and I think it should have been, as  
3                    I said, wider than those four areas.

4   197   Q.    You have specifically said, and you did mention it  
5                    before but I just want to get a little bit more detail   12:09  
6                    from you. The monitoring arrangements focused on the  
7                    gaps in his outpatient dictation and outcomes but  
8                    completely ignored responsibilities towards patients  
9                    who came in as emergencies or day case. Is that an  
10                  opinion that you formed on your own knowledge of what   12:09  
11                  was happening or did someone say that to you?

12          A.    That's from the findings that I had when I did the  
13                    exercise in June 2020, when I looked at the emergency  
14                    patients. The emergency with stents patients and then  
15                    the elective patients.   12:09

16   198   Q.    When you saw the Return to Work Plan and that sort of  
17                    detail wasn't included in it, did you express that  
18                    opinion on anyone or draw it to anyone's attention,  
19                    that you thought it perhaps wasn't detailed enough?

20          A.    Not at the time, no, because I think the plan came to   12:09  
21                    me as a nearly a fait accompli, just for me to manage  
22                    it.

23   199   Q.    By the time you got to June '17 the plan was in place?

24          A.    That's right.

25   200   Q.    Was there ever a suggestion that the plan could have   12:10  
26                    been updated to reflect those findings that there were  
27                    gaps in, potential deficiencies in oversight?

28          A.    No.

29   201   Q.    Did you feel that you could have brought that to

1 anyone's attention, to say, 'well, we may ostensibly be  
 2 covering this potential lacuna, but the work I have  
 3 done or the work that's been undertaken shows  
 4 a vulnerability for emergency and day case patients'?

5 A. To be honest, I didn't actually look at the ins and the 12:10  
 6 days at that stage. I was concentrating in the midst  
 7 of a very operationally challenged busy job and trying  
 8 to make sure that the four areas that I had been tasked  
 9 with, that I monitored them. In hindsight, yes,  
 10 I should have thought of that, but I didn't. 12:11

11 202 Q. Might it have been something that the medics involved  
 12 in both the work to prepare for the Return to Work Plan  
 13 and looking at the work that had completed in  
 14 June 2017, might it have been something that they  
 15 noticed and could have adapted the plan to reflect? 12:11

16 A. Yes. I think because the people that would have been  
 17 seeing -- as in medics -- would have been seeing  
 18 patients without that information on them, if they had  
 19 escalated then we would have known, but nobody every  
 20 said there was -- at that stage, in between the '17 12:11  
 21 and, sort of, '19, that there's letters missing. An  
 22 in-patient discharge wouldn't be so bad because  
 23 obviously there is electronic discharge from the ward  
 24 so the juniors would have done that, it would be signed  
 25 off. It was more to do with the day cases. They 12:12  
 26 weren't dictated on, but nobody every said they were  
 27 missing. It's one of those things, unless you're told,  
 28 you don't really --

29 203 Q. Does it go back to your point that this was an

1 opportunity at this point to perhaps delve a little bit  
2 more deeply into what was happening as regards  
3 Mr. O'Brien's practice and also procedures in place?  
4 Do you see that as a missed opportunity now?

5 A. I do, yes. 12:12

6 204 Q. For the Panel's note the Return to Work Plan can be  
7 found at TRU-00732. It was given to Mr. O'Brien at his  
8 Return to Work meeting on 9th February with Dr. Khan.  
9 How did you end up in the role of monitoring that plan?  
10 Can you just explain the process or who spoke to you 12:12  
11 about it?

12 A. It would have come from Mr. Carroll to say it has come  
13 from the Oversight Meeting that it needed to be  
14 monitored. I suppose I was the best placed to do it  
15 because I knew the systems and processes and I worked 12:13  
16 in Urology so I just done it.

17 205 Q. When you say you were the best placed to do that, do  
18 you think that was based on a belief at the time that  
19 this was an administrative problem?

20 A. Yes. 12:13

21 206 Q. Was that something that you were happy to accept given  
22 your clear identification of clinical risk issues in  
23 your draft letter the previous year?

24 A. I suppose I accepted it, but I had the knowledge that  
25 if there was going to be any issues it would be 12:13  
26 escalated to medical, as in the CD and the Case  
27 Manager, who was also Clinical. But for a medic to  
28 actually do the work that I ended up doing for the  
29 monitoring, it was probably suited to an admin person

1 but with the knowledge that it could be escalated --  
2 which I did -- to the medical.

3 207 Q. The Inquiry has heard evidence from Colin Weir and  
4 Charles McAllister, and the tenure of both of their  
5 approaches to dealing with Mr. O'Brien, if I could 12:14  
6 summarise as saying, they both were reluctant to do  
7 that alone. Also they indicated that they felt more  
8 comfortable if they had back-up, that there was  
9 somebody else involved in the process of overseeing  
10 with them. Did you have that sense that you needed 12:14  
11 that comfort?

12 A. Comfort from? Sorry? The?

13 208 Q. Somebody else helping you monitor, oversee  
14 Mr. O'Brien's practice?

15 A. I think one of the faults with all of this is that for 12:14  
16 Oversight and MHPS, it's a very confined group of  
17 people. It was discreet. You were told it had to be  
18 discreet, confidential, it was very sensitive. It  
19 couldn't be spoke outside of the people, nearly on  
20 a need-to-know basis. My comfort was I was able to 12:15  
21 escalate any concerns to Mr. Carroll, my AD, and then  
22 my CD. I never would have went direct to Mr. Khan  
23 because I wouldn't have seen that in the chain, but  
24 would have expected Mr. Weir to pass it on to Dr. Khan.  
25 In hindsight, there was a vulnerability there in the 12:15  
26 sense of -- for me -- because it was nearly on  
27 a need-to-know basis and so few of us actually knew.

28 209 Q. Did you feel any discomfort at the time about having to  
29 take this role on alone?

1 A. The stuff I could do from afar I had no issue with.  
2 For example, the electronic triage I was able to do  
3 that from my desk. It didn't matter whether I was in  
4 the office or at home. The dictation, I got that  
5 information from the -- basically Katherine Robinson's 12:16  
6 team, her service administrators, and that was fine.  
7 Private patients was fine as well because I did that  
8 monitoring again from my desk. The one that gave me  
9 the most discomfort was the case note tracking or the  
10 case notes in the office, because that was a physical 12:16  
11 thing that I had to do that I felt I was sort of --  
12 kind of nearly sneaky doing it because I used to have  
13 to go up to Mr. O'Brien's office and it was -- him and  
14 I would always have said we're at the opposite ends.  
15 I was a morning person and he was a night person. 12:16  
16 I always would know when I would be in the office at 6,  
17 half 6 in the morning the likelihood that he wouldn't  
18 be in the office. It just made me uncomfortable.

19 210 Q. Just so I'm sure of your evidence. Are you saying that  
20 you made a point of going to the office when he wasn't 12:16  
21 there --

22 A. Yes.

23 211 Q. -- because you just wanted to have a look at the notes?

24 A. Yes.

25 212 Q. Was that more to do with the practicalities of two 12:17  
26 people being in the office at once or did it reflect  
27 your discomfort of having to do that job at all?

28 A. It reflects my discomfort of having to do the job at  
29 all. You know, I go back to Mr. O'Brien and I had

1 a very good working relationship, so much so that  
 2 usually it was me who was the person sent to talk to  
 3 him about any of the issues. I always was happy to do  
 4 that because I kind of seen that as my role as Head of  
 5 Service. But I just felt that -- and I know 12:17  
 6 Mr. O'Brien probably would have challenged me if he  
 7 knew when I was in the office. I have since read when  
 8 I was off on extended sick leave after shoulder surgery  
 9 that he took exception to some of the staff being in  
 10 the office looking, counting the notes, what I would 12:17  
 11 have done.

12 213 Q. Part of your strategy in going earlier when he wasn't  
 13 there was because you didn't want to be -- and correct  
 14 me if I'm wrong -- there for a confrontation, or if one  
 15 took place, you didn't want that to happen? 12:18

16 A. Correct.

17 214 Q. would it have been possible for someone else more  
 18 junior -- I know you are the Head of Service and you  
 19 have a very significant workload, as the Inquiry will  
 20 see later on, was there any way possible for another 12:18  
 21 more junior member of staff to undertake going to  
 22 a consultant's office and counting charts, or was there  
 23 a reason why it was someone of your seniority asked to  
 24 do that?

25 A. A very fair point. I suppose, yes, anybody probably 12:18  
 26 could have done that, but I think it was back to the  
 27 need-to-know, trying to keep it confined to a certain  
 28 amount of people to protect Mr. O'Brien, the  
 29 confidentially of what was happening. There would have



been very few people -- well, that's my view of it, I don't know what was talked about outside of it, but they wouldn't know the detail of what I was actually doing.

215 Q. Two of the issues that you had to engage in in the oversight of the Return to work plan, the dictation and the notes, they also would have involved, perhaps, Mr. O'Brien's secretary, the dictation issue?

A. The dictation issue would but we didn't involve her directly. That would have been through the service administrator. The service administrator have access to the digital dictation, so they didn't even have to ask. They would just be able to go in and look at the clinics and see did the number of letters match up.

216 Q. They fell foul to the analysis that the number of  
letters, the number of clinics, and the number of  
patients weren't reflective of what was outstanding?

A. Yes.

217 Q. was that something the secretary might know?

A. She would have known, yes.

218 Q. would it have been appropriate perhaps to have gone to her and say, 'what are the clinician numbers?' I know you speak about confidentially, it could have been perceived as an audit across all consultants, which is something the Trust may have considered doing in any event, given your views on the level of analysis they undertook to outstanding work. would it have been appropriate at any point to go to her and ask directly at source, 'what's the situation with dictation?'

1           A.    It did happen because there is the e-mail with regards  
2                to the backlog report. I know Mr. Gibson was  
3                questioned about it yesterday. That originally had  
4                been set out for -- it actually was more the purpose  
5                for using the secretary's workload to sort of make sure 12:20  
6                that everybody had an equal amount of work to do. As  
7                we know now, that came foul to the fact there was  
8                underreporting with respect to Mr. O'Brien. With  
9                regards to that they did ask but, as we know now, they  
10              weren't given the information. I know she has said 12:20  
11              since because I've been shared in the e-mail of  
12              un-dictated clinics, she just assumed everybody knew  
13              that Mr. O'Brien didn't dictate but she didn't report  
14              it either. To answer your question the long way round  
15              is yes, the secretary would have known and yes the 12:21  
16              secretary had been asked.

17   219   Q.    There was a return to work meeting with Mr. O'Brien,  
18                Mr. Weir and yourself on 9th March 2017. That can be  
19                found, just for the Panel's note, at TRU-267952. If  
20                we do put that up because I want to refer to a specific 12:21  
21                part. TRU-267952. This follows up from a meeting on  
22                24th February that you had as well with Mr. O'Brien?

23           A.    I was off on leave on that actual date. Mr. Weir met  
24                him on his own. It was me has done these notes.

25   220   Q.    It says at the top of this: 12:22  
26  
27                "The purpose of the meeting was as a follow on from  
28                Mr. O'Brien's return to work meeting that took place  
29                with Mr. O'Brien and Mr. Weir on Friday, 24 February."

1

2           You were on leave. In advance of this meeting had you  
3 spoken to Mr. Weir about expected outcomes after this?

4           A. I can't recall but I'm assuming we did. We would have  
5 met, or we would have spoken about the agenda for what 12:22  
6 we needed to discuss with Mr. O'Brien.

7 221 Q. We don't need to go into the detail of this meeting but  
8 what is discussed at this is that Mr. O'Brien gave  
9 assurances in relation to outpatient clinics and turn  
10 around. Do you recall that? 12:22

11           A. Yes.

12 222 Q. He also indicated at that meeting that he didn't want  
13 to take on any new patients?

14           A. That's correct. Yes.

15 223 Q. Was that the first time that had been raised? 12:22

16           A. That was the first time it had been raised and I had  
17 come back to say that that wasn't possible because, at  
18 the end of the day, at that stage five or six  
19 consultants, I can't remember how many in post, and to  
20 take out on an already growing waiting list that 12:23  
21 Mr. O'Brien, you know, had quite an opinion on that  
22 we needed to make sure the people who were on that,  
23 advanced triage, enhanced triage, and that we couldn't  
24 just stop him from seeing new outpatients. He did say  
25 that it was to do with his theatre list being long, but 12:23  
26 in comparison everybody else's was the same. It would  
27 have been very difficult to argue that we were taking  
28 new patients from him and then not expecting the rest  
29 of the team to pick them up.

1 224 Q. In fact at that meeting it was clarified to Mr. O'Brien  
2 that he didn't have the longest waiters I think they're  
3 called?  
4 A. The longest waiters, yes.

5 225 Q. In relation to the review backlogs of that meeting, 12:23  
6 Mr. O'Brien assured that all patients were on the PAS  
7 system?  
8 A. He did, yes.

9 226 Q. Did that give you some sort of reassurance that he was  
10 up-to-date with reviews, or what was your view when 12:24  
11 he said that?  
12 A. I was assured because, understandably, he had spoken to  
13 me that this whole process was very stressful,  
14 understandably. At that stage he said he was  
15 determined to get back on track. That was a verbal 12:24  
16 conversation outside of the meeting. Him and I walked  
17 to the Departmental meeting, I think, together. So,  
18 I was assured from that.

19 227 Q. He mentions in this as well, and I think you said in  
20 your evidence, in your Section 21 you didn't have 12:24  
21 anything to do with job plans?  
22 A. That's correct, yes.

23 228 Q. That was entirely on the medic side. Mr. Weir asked  
24 Mr. O'Brien was this fair about the hours he had for  
25 dictation at the end of a clinic, and he said nothing 12:24  
26 about jobs plans was fair. The Inquiry will see  
27 evidence and hear evidence in relation to job plans.  
28 would it be fair to say that the job planning issue did  
29 seem to take up quite a lot of time and discussion

1 among medics?

2 A. It did, yes. It did. I suppose my only thing thing,  
3 just to clarify that, is they would have come to me to  
4 say, 'we want to do three outpatient clinics in a week  
5 and have you got the accommodation to do that?' But 12:25  
6 I wouldn't have been agreeing anything apart from that.

7 229 Q. If I ask you to look at TRU-251846. This is an e-mail  
8 from 8th May 2017. The one is from 5th May from you to  
9 Ronan Carroll where you are giving a case update.  
10 well, you're not giving a case update, I think you are 12:25  
11 providing your update on the oversight?

12 A. Yes.

13 230 Q. In this you said that Dr. Khan wants monthly updates as  
14 opposed to weekly, which had been previously; is that  
15 right? 12:26

16 A. That's correct, yes.

17 231 Q. Was there any reason Dr. Khan asked for the updates to  
18 change frequency at that point?

19 A. I don't know why he asked for that. I think it was  
20 because he was getting an e-mail from me every week 12:26  
21 that there was no issues at that stage. That's only an  
22 assumption, sorry. I don't know.

23 232 Q. What was your view when he asked for that? Did  
24 you feel that that was in any way premature at that  
25 point or were you content to go along with that because 12:26  
26 there had been no particular issues at the Oversight?

27 A. I did think it was a wee bit soon, yes. But I did  
28 give, and Mr. Carroll asked me to continue doing it  
29 weekly, which I did continue to do.

1 233 Q. Did you copy Dr. Khan and Mr. Carroll into your weekly  
2 updates, or just Dr. Khan monthly?  
3 A. Dr. Khan monthly. I didn't with Mr. Carroll because  
4 I only started to do it by exception, but I did keep it  
5 on my calendar the monthly updates with all the 12:27  
6 information on it. It is just, as I said earlier, we  
7 get so many e-mails, it's just I need to escalate when  
8 there's an issue.

9 234 Q. When Dr. Khan decided it was by exception, only if  
10 there was a problem arising, did that give you any 12:27  
11 reassurance that that meant if you were to let him  
12 know, something would be done about that?  
13 A. It did, yes.

14 235 Q. When did you subsequently let him know of concerns, was  
15 something done? 12:27  
16 A. Concerns with regards to the charts in the office when  
17 it started to -- there were two concerns. First of  
18 all, there was a slip in the triage, the length of time  
19 of triage, but we had a conversation, Mr. Weir and  
20 I had a conversation and we had then had the caveat in 12:27  
21 on a busy week that as long as it was done by the  
22 previous Monday. But I don't know if that was  
23 discussed with Dr. Khan or not, but it was definitely  
24 with Mr. Weir. Then the one with regards to the  
25 charts, it was Mr. Carroll, Mr. Weir, and myself. 12:28  
26 Again I don't know, even though Dr. Khan would have  
27 been informed, I don't know whether he'd asked us to do  
28 anything. It was actually on the instructions of  
29 Mr. Carroll and Mr. Weir.

1 236 Q. Did you know Dr. Khan to have done anything when  
2 breaches were identified at any stage?

3 A. No, I don't. I'm not aware.

4 237 Q. Is that based on your belief that once it went to him  
5 it was a matter for him to deal with from the medic 12:28  
6 side?

7 A. Yes.

8 238 Q. Does that also reflect the tradition, if I can call it  
9 that, that you spoke about earlier of when people raise  
10 issues, nobody generally comes back to tell them how 12:28  
11 they was resolved?

12 A. That's correct, yes.

13 239 Q. You not being informed about that was usual practice,  
14 I suppose, was it?

15 A. It was usual practice. Again, I didn't feel it was my 12:28  
16 place to actually contact him direct.

17 240 Q. You didn't feel it was your place to follow up as well?

18 A. Exactly.

19 241 Q. I want to take you to a couple of your reports of  
20 breaches around at this time. The first one is at 12:29  
21 TRU-268966. This is an e-mail 21st June 2017 that  
22 you have sent to Mr. O'Brien and you have copied in  
23 Mr. Weir:

24

25 "Dear Aidan, as you are aware I have been asked to 12:29  
26 monitor the points that were discussed with regards to  
27 your return to work.  
28  
29

1 One of the points was that notes should never be stored  
 2 offsite and should only be tracked out and in your  
 3 office for the shortest time possible. I have been  
 4 monitoring this regularly and noted that the amount of  
 5 notes in your office has increased, and therefore the 12:29  
 6 length of time they are being kept is increasing."

7  
 8 Then you provided a list of patient names and dates of  
 9 when notes were missing. You have copied Colin Weir  
 10 into that. Is that something that might helpfully have 12:30  
 11 gone to Dr. Khan at that point?

12 A. I think it was probably -- my assumption would have  
 13 been that Mr. Weir would have forwarded it to Mr. Khan.  
 14 It was one of the first breaches and it was  
 15 operational. It was me directly contacting 12:30  
 16 Mr. O'Brien, but copying Mr. Weir in.

17 242 Q. would Mr. Weir have been aware that Dr. Khan had  
 18 changed the procedure for alerts for exception only?

19 A. He was, yes.

20 243 Q. If I can ask you to look at TRU-258877. This is 12:30  
 21 another e-mail from Ronan. That is an e-mail to  
 22 Mr. O'Brien. Move it up so we can see the detail. You  
 23 have reminded Mr. O'Brien, it seems, from this e-mail,  
 24 of the terms of the action plan?

25 A. Yes. 12:31

26 244 Q. which is now the Return to Work and the action plan,  
 27 same thing, effectively. You have provided him with  
 28 the detail of that. What prompted that particular  
 29 e-mail to set that out like that; do you recall?



- 1 A. Yes. This is one about the triage. I recall, if  
2 we move down, I think there was 30 paper referrals that  
3 hadn't been returned. I could monitor the triaged  
4 referrals. Still some of the GPS hadn't been using the  
5 GP system. I could monitor them. It had obviously 12:32  
6 been escalated to me from the booking centre that there  
7 were still 30 outstanding.
- 8 245 Q. Colin Weir, again, is copied into that, as is  
9 Mr. Carroll?
- 10 A. That's right, yes. 12:32
- 11 246 Q. Do you recall did these e-mails result in a back and  
12 forth with you and Mr. O'Brien about his explanation  
13 about why, or what was your experience when you did  
14 identify potential divergence from the action plan?
- 15 A. With regards to the notes, it was a verbal conversation 12:32  
16 where he said to me he would action any of the notes  
17 that were sitting in the office. This one in  
18 particular I think from memory he did respond to me.  
19 He had said about coming in from leave and he had sent  
20 me a long e-mail about the 30 paper referrals and it 12:32  
21 would be better if he had done a tick box exercise  
22 instead of enhanced triage with regards to that. He  
23 had sent it and I had forwarded it on to Mr. Carroll,  
24 I think, and Mr. Weir.
- 25 247 Q. You have mentioned two things there and I just want to 12:33  
26 touch on them briefly, because they will be mentioned  
27 again.  
28  
29

1           The first one is the idea of enhanced triage.

2           Mr. O'Brien had a particular view on how triage should

3           be carried out. That was something that he engaged in

4           with you?

5           A.     Yes. 12:33

6   248   Q.     In e-mails?

7           A.     Yes.

8   249   Q.     Your understanding of the way medics should do triage

9           was in accordance with the Trust protocol, effectively,

10          of GP designation and then being reviewed by the 12:33

11          consultant on call?

12          A.     That's correct, yes.

13   250   Q.     When you were indicating problems with triage you were

14          working from your framework?

15          A.     Yes. 12:33

16   251   Q.     Mr. O'Brien was articulating his adherence to a system

17          he had developed which he considered to be more

18          effective for patient care. Would that be a fair --

19          A.     That's fair, yes. I suppose, just to say, the other

20          consultants did a form of triage or advanced triage 12:34

21          because of the long waiting times. If they seen

22          somebody that had come in with a stone, they might have

23          sent them for, sort of, a CT scan, they ordered it

24          there and then. They would have done that.

25          Mr. O'Brien took his enhanced triage a step further in 12:34

26          that he would potentially ring the patient and go

27          through the detail with the patient on their symptoms.

28          Obviously that then was like an actual scuttle so it

29          took longer. He was counselled, and the rest of the

1 team said to him he didn't need to do that, just do  
2 what they had done.

3 252 Q. The other consultants worked on an enhanced triage  
4 basis only if it was triggered by clinical  
5 presentation?

12:34

6 A. Yes.

7 253 Q. If I can put it that way. Then they fell back into  
8 place with the rest of the expected way of doing  
9 things?

10 A. Yes.

12:35

11 254 Q. You mentioned again about Mr. Mr. O'Brien being on  
12 leave?

13 A. That's right, yes.

14 255 Q. Doing some of the catch-up on his admin duties on  
15 leave. Was there an expectation from the Trust at all  
16 that Mr. O'Brien should be doing that while he's on  
17 leave?

12:35

18 A. Absolutely not. The amount of times, you know, we  
19 would have said, 'but you're on leave, take your  
20 leave'. Early on Mr. O'Brien would have said to me,  
21 'you know, it's my choice. If I do this work outside  
22 of working hours, it's the only time I can do it'.  
23 I suppose it was like everything else, it nearly became  
24 custom and practice. You knew, and you'll see from all  
25 the evidence in the e-mails that's been sent in,  
26 he would come back and say, 'well, I'm on leave  
27 tomorrow and I'll address that'. I would have said to  
28 him, and I can nearly hear people saying kettle calling  
29 pot black, because I'm inclined to do the same thing

12:35

12:35

1 when I'm on leave. He would have insisted that it was  
 2 his choice. For example, Sunday afternoons were spent  
 3 contacting patients for the following few weeks'  
 4 theatre lists, but again told not to do it or advised  
 5 not to do it. Mr. O'Brien had strong views and it was 12:36  
 6 very hard to turn him from them.

7 256 Q. From the Trust's perspective is there any suggestion  
 8 that the fact he was having to work on leave was a bit  
 9 of a warnings sign to the Trust that he just didn't  
 10 have the capacity to do the work that was expected from 12:36  
 11 him?

12 A. From the Trust perspective, no. There was lots of sort  
 13 of warnings that that was the case, but Mr. O'Brien had  
 14 more or less the same job plan as everybody else. The  
 15 expectation was that he should have been able to see 12:36  
 16 less patients, for example, at Outpatients. He should  
 17 have been able to do it within the allocated time of  
 18 the job plan if he had listened to the areas that just  
 19 took him longer.

20 12:37  
 21 For example, when he did do an outpatient letter it was  
 22 pages and pages and pages long; great detail but, you  
 23 know, GPS would have said a paragraph will do. I just  
 24 want to know what's happening with my patient. Instead  
 25 of dictating three or four pages, one page would have 12:37  
 26 been fine.

27  
 28 From the Trust's perspective, again custom and  
 29 practice, and I've slipped into it as well, I've often

1 heard people saying, including myself, 'sure, that's  
2 just Aidan, that's the way he works'.

3 257 Q. We will look at AOB-01646. This is Mr. O'Brien's  
4 response on 3th July 2017 to your reminder of the terms  
5 of the action plan. This gives the Panel an indication 12:37  
6 of where Mr. O'Brien was coming from in his view of how  
7 he could operate as a clinician within the expectations  
8 of the action plan.

9  
10 This one is dated the 12th and Mr. O'Brien sent an 12:38  
11 e-mail to you where he's explained his view, but he's  
12 also indicated that he finds the e-mail about the  
13 action plan and his need to adhere quite demoralising.  
14 Do you recall this particular correspondence?

15 A. I do, yes. 12:38

16 258 Q. If I mischaracterise it, because you know more about  
17 the background of this that's not written down, so if  
18 I mischaracterise either you or your experience with  
19 Mr. O'Brien, please just say. He's explained the  
20 reasons why he returned referrals. One of the points 12:39  
21 I want to show is that he makes a point of saying that  
22 he takes the time to ensure patients are contacted.  
23 You'll see near the bottom of the screen he says:

24  
25 "I know how referrals are triaged and returned on time. 12:39  
26 It is most certainly not by taking the time to ensure  
27 that each patient's current state is most appropriately  
28 and expeditiously assessed and managed."  
29

1 This is the one where he said, the quotation you relied  
2 on earlier:

3  
4 "I personally would have been better off ticking the  
5 box being at home on my leave" -- then a redaction -- 12:40  
6 "should also be at home with persistent colleague  
7 awaiting the urgent outpatient appointment."

8  
9 Just the tone of the reply to you, if I could just and  
10 their styles, if I can put it like that. I don't mean 12:40  
11 to be pejorative, but you, with your administrative  
12 oversight of the action plan, have indicated some  
13 divergences or potential breaches of what had been  
14 agreed. Mr. O'Brien has come back with clinical data  
15 really, and clinical information to patients who are 12:40  
16 named in order to respond to you. It does read, from  
17 this remove, as being very different tones in e-mails.  
18 Would that have been your experience of a typical  
19 response from Mr. O'Brien?

20 A. Normally, at the beginning, Mr. O'Brien, his e-mails 12:40  
21 would have been always quite courteous and there would  
22 have been no sort of -- nothing like this. This is the  
23 start of -- and that's why I know that it was  
24 a difficult time for him. It just goes back to the bit  
25 the part I was monitoring him made me feel 12:41  
26 uncomfortable because he is basically telling me I know  
27 how to triage. I was doing my job. He seen himself  
28 doing his job, but he missed the point that he was  
29 supposed to return his triage within a given period of

1 time and he still sat with the 30 referrals. This  
 2 e-mail is a change in tone and, I suppose, going  
 3 forward this was what I was faced with.

4 259 Q. Was there an underlying suggestion in this, and I know  
 5 when we go to your evidence on another day you've said 12:41  
 6 in other Section 21s, the fact that you weren't a medic  
 7 was an issue for Mr. O'Brien when pressed on his  
 8 particular practices. You would agree that was  
 9 reflected in this reply?

10 A. Yes, that is reflected in that. On two occasions at 12:42  
 11 least that I recall, Mr. O'Brien did say that to me,  
 12 'you're a non-clinical person challenging my clinical  
 13 decision'. To be fair, the two occasions, I will say  
 14 that stands out in my mind, on both them occasions  
 15 I hadn't made the decision on my own, I had spoken to 12:42  
 16 one of his colleagues. It wasn't me as a non-clinical  
 17 person coming to him, but that was his phrase of  
 18 terminology to me.

19 260 Q. Some of the detail provided in that letter, would it  
 20 also be fair to say that it is impossible for you to 12:42  
 21 reply to because it is based on his clinical  
 22 assessment?

23 A. Absolutely.

24 261 Q. And the justification for his actions based on  
 25 information that either you couldn't possibly know or 12:42  
 26 couldn't comment on, not being a medic?

27 A. That's correct. Yes.

28 262 Q. On reading that reply, and you said this seemed to be  
 29 a change in tone in the replies, did you think at that

1 point that you needed assistance with monitoring  
2 Mr. O'Brien so that these sorts of responses to your  
3 oversight could be dealt with by, for example, one of  
4 the medical managers?

5 A. I did share the e-mail with Mr. Weir and Mr. Carroll 12:43  
6 and I know as a result of this, we had the meeting --  
7 the meeting that I had forgotten about. So it was led  
8 by Mr. Weir. So at that stage I had -- the reason  
9 I had passed that on was, number one, Mr. Weir was the  
10 case manager but also I knew I needed help with this 12:43  
11 one. This was something I couldn't deal with on my  
12 own.

13 263 Q. We'll go on to that meeting just in a moment. But  
14 whose idea then was it -- did you ask for help or when  
15 you copied them in, they thought; 'Okay, Martina needs 12:43  
16 help here' or 'We need to get behind her.' what was  
17 the sense of response among your managers to this  
18 reply?

19 A. Well, there was probably no e-mail response back to  
20 this but I do know Mr. Carroll was very supportive and 12:44  
21 any issues that I would have had with regards to this,  
22 I could have spoken to him, and depended on him taking  
23 it forward. And I do know then that's when he asked  
24 for a meeting to deal with both the slippage in the  
25 triage but also the slippage in the amount of 12:44  
26 notes that was in the deviation that was in the office.

27 264 Q. Just before we go to the meeting on 25th July, there  
28 are two references I just want to give the Panel.  
29 We don't need to go to the documents; AOB-01652.



1 That's an e-mail of 19th July 2017, when there is  
2 a reduction of 30 notes in the office at that point.  
3 So there was compliance. I want to point out these  
4 e-mails were the monitoring provided information that  
5 Mr. O'Brien was making changes to his practice. Then 12:45  
6 AOB-01660. That's a reply from Mr. Carroll to that on  
7 the same date when he said all notes need to be  
8 returned. I think the expectation was that it would  
9 get to zero, but there's obviously a movement in the  
10 right direction evidenced on those e-mails. 12:45

11 A. That's right, yes.

12 265 Q. So the meeting on the 25th, which seems to have been  
13 triggered by the tenure of that response, the 25th July  
14 2017, now you haven't referred to that in any of your  
15 Section 21s, and that was a meeting with Mr. Weir, with 12:45  
16 yourself, Mr. Carroll, and Mr. O'Brien.

17 A. That's correct. Yes.

18 266 Q. Is there any reason why that wasn't included in your  
19 original evidence at that meeting?

20 A. It's just a true -- it's just truly an omission; 12:45  
21 I forgot. And I genuinely had forgotten about that  
22 meeting. I usually would pride myself on having a good  
23 memory. I do recall at the time speaking to  
24 Mr. O'Brien about the notes and he said to me that he  
25 was clearing them. Then in my mind, that was it 12:46  
26 sorted. And it was only when I received the transcript  
27 of an audio -- a transcript from an audiotape that  
28 I remembered the meeting.

29 267 Q. For the Panel's notes, that's at AOB-56210 to

1 AOB-56221.

2

3 So you're making reference to the fact that Mr. O'Brien

4 recorded this?

5 A. That's correct, yes. 12:46

6 268 Q. Did you know it was being recorded?

7 A. I didn't. No.

8 269 Q. Do you know if Mr. Weir or Mr. Carroll were aware of

9 it?

10 A. No, none of us were aware. 12:46

11 270 Q. Now you became aware of it as a result of the Inquiry?

12 A. Yes.

13 271 Q. What was your view or your feeling, knowing that had

14 been recorded without you being aware?

15 A. Well, there was actually four recordings. Three of 12:47

16 them, I was with other colleagues. Initial reaction

17 was quite angry, but I suppose the one that annoys me

18 the most is....

19 272 Q. If you need to take a moment. If you need to stop for

20 a moment, we can do that, just to give you a short 12:47

21 break. There's no problem. Do you want to take

22 five minutes.

23 A. Yes, thank you.

24

25 THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 12:47

26

27 CHAIR: Ms. McMahon?

28 273 Q. MS. MCMAHON BL: Are you ready to continue?

29 A. Yes.

1 274 Q. As a general point, you mentioned that there were  
2 several meetings with Mr. O'Brien that had been  
3 recorded without your knowledge.  
4 A. That's correct.

5 275 Q. I just asked you what your views were on that? 12:54  
6 A. That's right. Yes. Sorry about that. I suppose the  
7 three with the colleagues, I was angry about, but there  
8 was other people in the room with me. The one that  
9 annoyed me was on the 9th January when I agreed to meet  
10 Mr. O'Brien outside of the hospital. I facilitated 12:54  
11 a meeting in his car when he was handing over the  
12 outcome sheets and advised me of the letters in his  
13 drawer. So I actually feel quite violated about that,  
14 that a colleague would, on a one-to-one basis record me  
15 because I don't know what he expected me to say or do. 12:54  
16 The other three meetings, it's very obvious from  
17 listening to them that there was an agenda of  
18 Mr. O'Brien's because the meeting is steered to the  
19 areas that he wanted to talk to us about.

20 276 Q. Okay. The Panel have those transcribed and they can 12:55  
21 take a view on that.  
22 A. Okay.

23 277 Q. But that's your view on what you consider to have  
24 happened.  
25 A. It is, yes. 12:55

26 278 Q. I just want to give a list of e-mail references to  
27 either potentially what could be construed as breaches  
28 of the action plan or compliance with the action plan  
29 so the Panel have a note of that and the core

1 participants are aware that I'm bringing them to the  
2 attention of you in your evidence.

3 The first one is TRU-258891 to TRU-258892. And that's  
4 an e-mail of 31st July 2017 when all charts had been  
5 removed from the office. So there was no more can  
6 compliance, effectively, with the requirements of the  
7 plan.

12:55

8  
9 TRU-275133 to TRU-275134, and that's a breach of the  
10 action plan and a failure to triage. TRU-275148,  
11 that's an e-mail of 22nd February 2018, confirmation  
12 that triage issue had been resolved again. And  
13 TRU-258902, e-mail of 22nd May 2018 where you confirm  
14 that the plan has been adhered to, save for triage  
15 issues.

12:56

12:56

16 A. Yes.

17 279 Q. Then you had a planned period off sick from the  
18 25th June 2018 that went on a bit longer than was  
19 anticipated and you didn't come back to work until  
20 5th November?

12:57

21 A. That's correct.

22 280 Q. 2018.

23 A. That's correct.

24 281 Q. During your period of absence, did you hand over to  
25 anyone on the oversight role regarding the action plan  
26 before you went off sick?

12:57

27 A. I didn't because, originally, it was shoulder surgery  
28 from the result of a car accident and I was advised by  
29 the consultant I would only be off for about a month.

1           So a month out of the system is probably not -- it's  
2           just like being on annual leave because I have said in  
3           my statement to the Inquiry that, you know, monitoring  
4           happened every Friday apart from being on leave. So,  
5           unfortunately, the surgery turned out to be much more 12:57  
6           major and I ended up off for 18 weeks. I didn't hand  
7           over and, I think, two things there. First of all, it  
8           was getting back to the need-to-know basis. My  
9           colleagues wouldn't have known the detail of what I was  
10          doing, they knew I was doing something with regards to 12:57  
11          return to work but they wouldn't have known the detail  
12          because we had to keep it confidential.

13 282 Q.   But given the fact that you were able to do some of  
14           this, if I can say remotely?

15          A.   Yes. 12:58

16 283 Q.   We were given information from Katherine Robinson, for  
17           example, was that something that Ronan Carroll could  
18           have arranged to have sent to him directly?

19          A.   Yes, that could have, yes.

20 284 Q.   So there were aspects of the action plan that could 12:58  
21           have been followed up without there being any potential  
22           breach of confidentiality as regards Mr. O'Brien's  
23           practices?

24          A.   Probably.

25 285 Q.   I don't think from the e-mail chains that are available 12:58  
26           that anyone was monitoring, was that your understanding  
27           when you came back?

28          A.   That's correct, yes.

29 286 Q.   Did you then pick up that in November 2018 when you

1            came back?

2 A. For a period of time in October, the two Heads of  
3 Service, two of my colleagues, Ms. Clayton and  
4 Mrs. Kelly, they would have done monitoring because it  
5 would have been brought to light in one of the backlog 12:58  
6 reports that there had been an issue. I provided the  
7 information -- I know I was still off on sick leave,  
8 but I still provided the information on what way  
9 I would have done the monitoring and they done that for  
10 a few weeks until I came back from leave. 12:59

11 287 Q. So that was towards the very end of your period of sick  
12 leave?

13           A.    It was, yes, it was the last month

14 288 Q. Now what was your understanding of how long the  
15 monitoring period was to last? I know there has been 12:59  
16 some deviation in understandings. Mr. O'Brien is of  
17 the view that it was only to last the duration of the  
18 MHPS. Did you understand at any stage, firstly, that  
19 it was time bound, the monitoring?

20 A. No. 12:59

21 289 Q. Or that it was to be replaced by anything else?

22           A.    No.  I just assumed it was going to go on for forever,  
23                if you know what I mean.  But, no, there was no end  
24                time.  No end time for me.

25 290 Q. when did it actually end for you, your role in that? 12:59

26 A. It didn't. It ended sorted of in around March 2020 but  
27 that was due to circumstances of COVID because  
28 we didn't have any patients coming in, there was no GP  
29 referrals, there was no notes being allowed to move,

1 everything was quarantined, and then obviously no  
2 clinics and no theatre lists. But I had continued up  
3 until March 2020 monitoring.

4 291 Q. Again, for the Panel's note and for core participants,  
5 there are e-mails during your absence of breaches. You 13:00  
6 won't have any information of this but I just want to  
7 put it on record. So the first one is an e-mail of the  
8 18th October 2018, TRU-251525 to 251530, TRU-28888,  
9 I think that is, three eights. 19th October 2018  
10 e-mail, again about slippages. Then WIT-55773. This 13:01  
11 is when you are back again, 30th March 2019. That's an  
12 e-mail about Mr. O'Brien not triaging.

13 A. Yes.

14 292 Q. TRU-275324, and that's dated 12th September 2019, an  
15 e-mail we escalate to Siobhán Hynds, that Mr. O'Brien 13:01  
16 is not doing the red flag triaging.

17 A. Yes.

18 293 Q. TRU-275331. That's an e-mail from 5th September 2019  
19 and you e-mail Mr. O'Brien about outstanding  
20 dictations. 13:02

21 A. Yes.

22 294 Q. TRU-275344 is an e-mail from 16th September 2019 where  
23 you've e-mailed Dr. Khan and Siobhán Hynds with  
24 updates, including backlog in dictation. Another  
25 e-mail on 24th October 2019, WIT-55763, where you have 13:02  
26 e-mailed Dr. Khan, Siobhán Hynds, Mr. Gibson and Marie  
27 O'Kane. At that point, was she the Medical Director?

28 A. She was Medical Director, yes.

29 295 Q. Noting letters not dictated from Mr. O'Brien's clinic.

1 E-mail of the 6th November 2019 at TRU-275587. E-mail  
 2 from you to Mr. O'Brien. And you've copied in  
 3 Mr. McNaboe about the deviations and MDM  
 4 recommendations not followed up.

5 A. Yes.

13:03

6 296 Q. Do you recall that? Those give a flavour, both in your  
 7 absence and when you come back, of issues still  
 8 arising.

9 A. That's correct, yes.

10 297 Q. Just from all your involvement with Mr. O'Brien  
 11 throughout the years before this more formalised  
 12 process began or more intensive of him began, do you  
 13 feel you offered him support as and when necessary to  
 14 allow him to try to change practices to fit in to what  
 15 the Trust expected he would do?

13:03

16 A. I do think I offered it to him. I think, perhaps,  
 17 sometimes I was, on reflection, possibly, you know  
 18 a wee bit lenient in that he wouldn't do something and  
 19 I would go and cajole him, and he would do it. I never  
 20 would have escalated that because he would have done  
 21 it. I think I have said in my Section 21, one of the  
 22 things is I should have been more formal, now in  
 23 hindsight, because, you know, we ended up where we did.  
 24 And I would have always said to him, as I said, you  
 25 know; 'If you need me to do anything, I'm more than  
 26 happy to help', whether it was printing off letters or,  
 27 you know, maybe getting some of the other doctors or  
 28 junior doctors or CNSS to help him out with regards to,  
 29 perhaps, triage. I think I was more than helpful to

13:03

13:04

13:04



1 him over the years.

2 298 Q. Now you have said in one of your statements at  
3 WIT-26290, just for the Panel's note, that you felt  
4 there was an overreliance on you as you had an already  
5 demanding operational day-job and that the system 13:05  
6 failed when you were on sick leave, seemed to fail when  
7 you came back as well, but do you feel that you weren't  
8 supported in trying to take on this role as well as all  
9 the other things you had to do as Head of Services?

10 A. I suppose I'm the sort of person that just says, 13:05  
11 probably, yes, and just gets on with it. I do think  
12 there was always an overreliance on me in the sense  
13 that everybody perhaps used the working relationship  
14 that I had with Mr. O'Brien to get things sorted rather  
15 than people tackle it because we did get on -- we were 13:05  
16 amicable to each other. I could never change him  
17 because he was sort of very set, stubborn in his ways.

18  
19 with regards to support, I probably -- it's my own  
20 fault, I probably didn't reach out for, you know, to 13:06  
21 say; "I'm struggling with this", I just did it. I had  
22 a demanding job, would have worked easily 15 hours  
23 a day, and then on call, acute on-call on top of that,  
24 but, you know, always tried to get it done. So from my  
25 point of view, I probably didn't reach out and ask for 13:06  
26 support, but I do think there was an overreliance on  
27 me, on reflection.

28 299 Q. The Panel will see from your Section 21, and we'll  
29 speak to it again when you come back, you did try to

1 develop a lot of workarounds, if I use that phrase, to  
2 try to resolve issues?

3 A. Yes, that's correct.

4 300 Q. Given that they weren't resolved and given the breaches  
5 I've just identified as a result of more formal 13:06  
6 oversight, do you think the governance systems in place  
7 were fit for purpose?

8 A. On reflection, no.

9 301 Q. You gave an interview on 15th March 2017 as part of the  
10 MHPS process and you indicated in that that you'd 13:07  
11 always had difficulties with certain parts of  
12 Mr. O'Brien's practice since your commencement of your  
13 Head of Service role. What was your view on the MHPS  
14 process as a whole once it was eventually completed?

15 A. The main thing for me out of it is, first of all, it 13:07  
16 was ongoing. I didn't get any feedback and I don't  
17 know, as Head of Service managing directly the Return  
18 to work whether I should have been given some  
19 information. I never seen the case determination  
20 report until this Inquiry started. There's a number of 13:07  
21 areas in it, but I think if it had been discussed with  
22 even me as the operational person who knew how things  
23 worked, there's the admin review, and I know we'll  
24 probably touch on that the next time, it was very  
25 woolly, it was very wide. I ultimately ended up having 13:08  
26 to work on it. For me, it went on too long. The  
27 determination -- and I know now there was to be another  
28 action plan -- was never filtered down. I actually  
29 don't think it worked because, as you said, there were

1 still breaches and we ultimately ended up in 2020  
 2 having the issues that we did, that brought us here  
 3 today.

4 302 Q. If I can just give the Panel two brief extracts from  
 5 Section 21, just for your note WIT-39930, at  
 6 paragraph 24.1 where you have said:

13:08

7  
 8 "The investigation was, in my opinion, a very long,  
 9 drawn out process and therefore in the time it took to  
 10 complete it Mr. O'Brien was deviating from good  
 11 practice in other parts of his practice. In my  
 12 opinion, because of the length taken to reach  
 13 a determination it would appear that more patients have  
 14 been exposed to potential harm."

13:09

15  
 16 That's just your view on because of the length of the  
 17 process.

13:09

18 A. Yes.

19 303 Q. You also said at paragraph 24.2 in relation to  
 20 Dr. Khan's determination that it was: "Vague and quite  
 21 wide-reaching, and I feel had been difficult to  
 22 implement"?

13:09

23 A. Yes.

24 304 Q. That's a summary of what you said just previously, but  
 25 do you think that the process undertaken by MHPS and  
 26 the outcome on this occasion didn't result in any  
 27 practical outcomes for you as a manager to make changes  
 28 to the areas that had been established as being  
 29 vulnerable?

13:09

1 A. I agree with that.

2 305 Q. Just in summary form, for the Panel's note, WIT-26299  
3 to 301, you have set out what you consider to be  
4 failings generally --

5 A. Yes.

13:10

6 306 Q. -- in your Section 21. You've indicated you felt there  
7 was a lack of respect for non-clinical managers in  
8 doing this role?

9 A. Yes.

10 307 Q. Is it still the situation at the moment? Do you know  
11 if non-clinical managers are still expected to  
12 undertake this kind of oversight and monitoring role?

13:10

13 A. With being out of the role now, the operational role  
14 since June 2021, I couldn't comment on that at all.

15 308 Q. Was it up until that point, June 2021?

13:11

16 A. Up until that point, yes.

17 309 Q. You've also said nothing had been done about  
18 Mr. O'Brien for years. Just in relation to any  
19 potential outside influence, was it your view that  
20 there was even the perception that there was an  
21 influence over how Mr. O'Brien should be treated? Did  
22 you have any experience of that, personal experience of  
23 that?

13:11

24 A. Not direct experience but, yes, there was a perception.  
25 There was the close working relationship with the Chair  
26 of the Trust Ms. Brownlee, and Mr. O'Brien would have,  
27 if you like, name dropped at meetings that he had been  
28 out at a dinner the night before, or that he had met  
29 her maybe down in Trust headquarters, and that he had

13:11

1 filled her in with regards to the likes of the waiting  
 2 times in Urology. Because I would say I had another  
 3 area as well, obviously you know that, ophthalmopathy,  
 4 and ENT, and they have as long a waiting list as  
 5 Urology, so I just wanted to put that on the record. 13:12  
 6 He would also have, on occasions, just mentioned his  
 7 legal connections, but they would never have been used  
 8 in a context of making you persuade not to do  
 9 something, but the inference was there.

10 310 Q. Mr. O'Brien would say that those perceptions of 13:12  
 11 influence were entirely matters for others, that was  
 12 never a matter for him. Also Ms. Brownlee would reject  
 13 any suggestion that she in any way advocated for  
 14 Mr. O'Brien. On one analysis, a consultant speaking to  
 15 the Chair of a Board about wanting funds may not be 13:12  
 16 that unusual, but I just want to put that context, that  
 17 slight balance there?

18 A. I suppose just to say I had 13 consultants and none of  
 19 the rest of them ever would have been sort of speaking,  
 20 as we say, about the Trust Board. 13:13

21 311 Q. I think we have covered all of the issues, the main  
 22 issues that are required for the purposes of the MHPS  
 23 module?

24 A. Okay.

25 312 Q. Just while you're here, in relation to that time frame, 13:13  
 26 is there anything you feel we've missed or you might  
 27 want to say about that process and about your part in  
 28 it that you haven't already covered in your evidence?

29 A. I think I have covered it in most of my evidence

1 because I took a long time to try and make sure that  
2 I went through the years, did a lot of reflection  
3 before I put it on paper.

4 MS. MCMAHON: I have no further questions. The Panel  
5 may wish to ask you questions. 13:13

6 CHAIR: we will have questions for you but we're not  
7 going to ask them today.

8 A. Okay.

9 CHAIR: we will save them up and spend some time with  
10 you in due course. 13:14

11 A. Okay.

12 CHAIR: But not day. Thank you very much for coming.

13 A. Thank you.

14 CHAIR: It is now a quarter past one. The next witness  
15 Mr. Wolfe is taking, I think. It will be a quarter  
16 past 2. 13:14

17 MS. MCMAHON: Madam Chair, may I clarify to release the  
18 witness from her oath or do you want her to remain  
19 under oath? It might be some time before she's back  
20 and she may want to consult with her legal team. Just 13:14  
21 to confirm if you want to release her from her oath.

22 CHAIR: If she is happy to take the oath on another  
23 occasion I can release her from her oath. we'll have  
24 you sworn in again next time.

25  
26 THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS: 13:14  
27  
28  
29

CHAIR: Good afternoon, everyone.

MR. WOLFE KC: Chair, your witness this afternoon is Mrs. Esther Gishkori. I understand that she wishes to take the oath.

MRS. ESTHER GISHKORI, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS:

313 Q. MR. WOLFE KC: Good afternoon, Mrs. Gishkori. Now let's start by looking at the witness statements that you have kindly prepared for the Inquiry in advance of today. The first one is number 7 of 2022. We find the first page. If we can have it up on the screen, please, WIT-23366. You're, of course, familiar with that, Mrs. Gishkori?

A. Yes.

314 Q. Just scroll through to the last page to see your signature, WIT-23385. I know that you're going to tell me about some corrections in a moment, but subject to anything you wish to correct, do you wish to adopt this witness statement as part of your evidence?

A. Yes.

315 Q. Then your second statement is number 35 of 2022. First page is WIT-23400. Again, you're familiar with that Mrs. Gishkori?

A. Yes.

316 Q. We will scroll through to the last page of this statement. It's WIT-23412. You've signed on 27th June. Do you wish to adopt that as part of your

1 evidence?

2 A. Yes.

3 317 Q. Now just before we came in, you mentioned that you had  
 4 communicated some changes to the Inquiry, or proposed  
 5 changes. I'm sorry, I'm unsighted on those but can you 14:25  
 6 highlight those for us?

7 A. Yes. It was just on an e-mail I sent to Owen yesterday  
 8 or the day before, and it was in relation to some dates  
 9 that I think were wrong, just sick leave dates and  
 10 things. 14:26

11 318 Q. Okay. We'll perhaps try to adjust that later.

12 A. Yes. That will do.

13 319 Q. I think I've explained to you that the expectation is  
 14 that you might have to come back to give evidence to  
 15 the Inquiry. 14:26

16 A. That's okay.

17 320 Q. But just on the dates of your sickness, and this might  
 18 be a way of dealing with the issue in the alternative  
 19 to your e-mail, we have obtained from The Trust some  
 20 indication of your sickness absence. 14:26

21 A. Okay.

22 321 Q. Over the period from 2017 through to 2020. I'll just  
 23 bring those up on the screen now and ask for your  
 24 observations. TRU-164659. You can see in the table in  
 25 the middle of the page the dates of various sickness 14:27  
 26 absence. We're taking the precaution of taking out the  
 27 reason for your sickness, we've blacked that out on the  
 28 right-hand column.

29 A. Okay.



1 322 Q. So you can see from that document that the longest  
2 periods of sickness were three months in the summer of  
3 2018.  
4 A. Yes.  
5 323 Q. 14th June to 14th September? 14:27  
6 A. Uh-huh.  
7 324 Q. And then going into the following year, you didn't  
8 return to work after 6th June.  
9 A. That's right.  
10 325 Q. Yes. 14:27  
11 A. That's right.  
12 326 Q. It says "end date 30 April 2020." But as we'll discuss  
13 briefly in a moment, you didn't return to work after  
14 the 30th April.  
15 A. That's right. 14:28  
16 327 Q. Are you satisfied that that is an accurate account?  
17 A. Yes, I, am. Perfectly. Thank you.  
18 328 Q. Thank you. Now if we can go to one of your witness  
19 statements, WIT-23366. Just scrolling down, please.  
20 You are telling us here that you came to work in the 14:28  
21 Southern Health and Social Care Trust in August 2015,  
22 isn't that correct?  
23 A. That's right.  
24 329 Q. You took up a job at Director level, isn't that right?  
25 A. That's right. 14:29  
26 330 Q. You were Director of Acute Services?  
27 A. Yes.  
28 331 Q. This was your first job in the Southern Trust?  
29 A. It was.

- 1 332 Q. And prior to coming to that role, you'd occupied  
 2 several roles in the Health Service, particularly with  
 3 the South Eastern Health and Social Care Trust?
- 4 A. That's right.
- 5 333 Q. Within your statement, you've described those roles as 14:29  
 6 being across several operational and governance roles  
 7 and management roles?
- 8 A. That's right.
- 9 334 Q. Your employment with the Southern Trust in the Director  
 10 of Acute Services role ended on 30th April by way of 14:29  
 11 mutual agreement, isn't that correct?
- 12 A. That's right.
- 13 335 Q. Now you've said -- just scrolling down the page,  
 14 please. Can we go to the top of the next page. Your  
 15 predecessor in the role of Director was 14:30  
 16 Mrs. Debbie Burns?
- 17 A. Yes.
- 18 336 Q. You had an opportunity to shadow her on occasions prior  
 19 to taking up the position?
- 20 A. That's right. 14:30
- 21 337 Q. But you didn't have a hand-over?
- 22 A. No.
- 23 338 Q. Does that mean that even though you were shadowing her  
 24 you didn't have an opportunity to discuss, whether  
 25 formally or informally, the kinds of issues that you 14:30  
 26 might face in your role as Director?
- 27 A. That's right, yes. I had a chance to shadow Debbie but  
 28 most of the time she was just going over performance  
 29 templates with the staff. I didn't really -- she

1 walked me around the hospital but in terms of the  
2 issues that were going on at the time, in terms of, you  
3 know, things that were happening, other things that  
4 I might have needed to have known, just a formal or an  
5 informal hand-over, I didn't have one. The only thing 14:31  
6 she said to me when she was leaving was: "You'll never  
7 stick it." But that was it. Nothing more.

8 339 Q. Did you enquire as to what she meant by that?  
9 A. I did, yes. Yes.

10 340 Q. Did she explain? 14:31  
11 A. No. She was moving -- she was staying within the Trust  
12 herself, she said, so she didn't want to discuss much  
13 more. She was going back to the role I think that she  
14 had occupied before she became the Director. So when  
15 the Director's post came up, she decided she wasn't 14:31  
16 going to apply for it and she said it was a very  
17 difficult post. She said: "I think you'll find it  
18 difficult too." That was all.

19 341 Q. Yes. And you've described in a summary sense your  
20 role. "Mine was an operational role". And you go on 14:32  
21 in that paragraph to describe it. Do you see there?  
22 A. Yes.

23 342 Q. Stepping through this relatively quickly this  
24 afternoon, was it a challenging role?  
25 A. Very much so, yes, extremely. 14:32

26 343 Q. Why did you find it challenging?  
27 A. Well, first of all, as I said before, I was completely  
28 new to the job. I didn't know what -- you know, the  
29 "elephant in the room" always is; what is the

1 organisational culture, who's who, what's what, who are  
2 the -- I knew nothing about it. But into the bargain  
3 I was in charge of seven divisions, probably upwards of  
4 14,000 staff. I honestly turned down more meetings  
5 than I attended because I just simply couldn't go to 14:33  
6 everything that was -- so I just had to juggle, you  
7 know, decide at that time, send people in my place if  
8 it was important, me go every other month. Things like  
9 that. I always tried to communicate as well as  
10 I could. I had an excellent secretary, she helped with 14:33  
11 that. But probably I was expected and did go to about  
12 three or four meetings every day. Then after that you  
13 had to follow up with the actions, the outcomes of what  
14 those meetings were, probably 120 to 200 e-mails were  
15 done at home because I just simply couldn't do them. 14:33  
16 There was never a day when there wasn't some sort of  
17 firefighting or an issue. As you can imagine in acute  
18 services, it was a very old hospital and that brought  
19 all of its own challenging. You know, we had to  
20 replace pipes at one point, you know, move patients 14:34  
21 around, there was always building going on, new  
22 pharmacy. It was one of the busiest roles I've ever  
23 had and I do note that there are now two people doing  
24 that job.

25 344 Q. Yes. 14:34

26 A. So, you know, I assume that the Trust understands how  
27 big it was and have put two people into the post of the  
28 job. But it was almost as though I was setting myself  
29 up for failure because I couldn't do the job properly.

1 345 Q. Yes.

2 A. There was always something at the end of the day that

3 you knew hadn't been done. It was always a worry

4 a lot.

5 346 Q. Did you feel well supported by the staff that you had, 14:34

6 whether at Assistant Director level or below, even

7 though you may feel that you were under resourced?

8 A. Yes. I would have to say yes. All of my ADs I met on

9 a regular basis, and all of them, as well, were on the

10 admin floor where my office was, so it was very much 14:34

11 I could go and find them and seek them out at any time.

12 But all of the information that I got about the Trust

13 came from my Assistant Directors, or the AMDs, or just

14 walking around. But, yes, I did feel supported by my

15 Assistant Director, I would have to say yes. 14:35

16 347 Q. Obviously you have, below you in the management chain

17 the ADs, the Assistant Directors?

18 A. Yes.

19 348 Q. Then across on the professional --

20 A. That's right. 14:35

21 349 Q. -- medical side you have AMDs, CDs and Clinical Leads.

22 A. Yes.

23 350 Q. Do you think communication was good both on the

24 operational management side and medical management

25 side? 14:35

26 A. Yes. The AMDs, again, I met on a regular basis, some

27 of them, and I completely understood some of them

28 couldn't always make the meetings because their

29 clinical job was so busy, so I understood that and took

1 the hit for that. Sometimes it wasn't just as easy to  
2 get them into the room. But any time I went seeking  
3 information or asking them for the AMDs were also very  
4 supportive. Yes, I would have to say yes.

5 351 Q. You speak in your witness statement, at paragraph 5  
6 WIT-27300, of having monthly meetings with the  
7 Associate Medical Directors?

14:36

8 A. Yes. The AMDs had a monthly meeting and sometimes they  
9 were joined by the AD, depending on what was on the  
10 agenda.

14:36

11 352 Q. What was the focus of those meetings?

12 A. Mostly anything that was operational. It was a lot to  
13 do with waiting lists, and theatre lists, things going  
14 on around the hospitals. Too many medical patients in  
15 the hospital, and therefore not a lot of time to do the  
16 surgery that was planned. We had an orthopaedic ward,  
17 for example. The orthopaedic staff didn't like any  
18 medical patients in there because of the risk of  
19 infection. For bones, you can imagine how hard that  
20 would be if someone got -- so there were a lot of  
21 operational -- even just the hospital was getting built  
22 around all the time, bits added on. Sometimes that  
23 encroached on, for example, the Day Procedure Unit or  
24 Theatres or Daisy Hill, you know, what would go down to  
25 Daisy Hill and what would have to stay because  
26 they didn't have laminar flow theatres and they didn't  
27 have -- all those operational types of things.

14:36

14:37

14:37

28 353 Q. Yes.

29 A. There was plenty.

1 354 Q. You had two AMDs or three AMDs, but for present  
2 purposes I wanted to speak about Mr. Mackle and  
3 Mr. McAllister. Mr. Mackle stepped down from his  
4 role --

5 A. He did.

14:38

6 355 Q. -- in March April of 2016 --

7 A. Yes.

8 356 Q. -- to be replaced by Mr. McAllister for a short time.  
9 Then there was a gap --

10 A. That's right.

14:38

11 357 Q. -- through to the following year before Mr. Haynes took  
12 up the role?

13 A. Yes.

14 358 Q. In terms of what we are going to be looking at today,  
15 and that's performance issues in association with  
16 a particular clinician's practice, Mr. O'Brien, what  
17 would be the meeting or the mode of communication to  
18 bring issues around clinical performance affecting the  
19 Service to your attention?

14:38

20 A. That would have been brought -- sometimes they would  
21 have -- it was always brought to the AMD meeting, no  
22 matter what that was. I would have recorded it in my  
23 red book and whenever we obviously would have needed to  
24 take further steps, whatever that may have been,  
25 involved probably the Medical Director, very probably,  
26 the Chief Executive, but depending what the problem and  
27 the issue was, we decided at the one-to-one what we  
28 would do and how we would take it, if it was brought to  
29 me.

14:38

14:38

1 359 Q. Yes. Did you find you had a good relationship with  
2 both Mackle and McAllister in communication terms?  
3 A. Yes.  
4 360 Q. If there's a caveat to be added to that, may I ask -- 14:39  
5 I put the two names together but please feel free to --  
6 A. Yes. To be fair to both of them, yes, they brought  
7 what they believed to be the main issues of their  
8 Directorate at that time every month. They didn't hide  
9 anything, hopefully.  
10 361 Q. You've said in your witness statement, if you go down 14:39  
11 to WIT-23369, just the second paragraph there. In  
12 terms of the Medical Director it was arranged that you  
13 would meet fortnightly but this was difficult to  
14 arrange with ongoing time pressures and the meeting did  
15 not always take place. 14:40  
16 A. Yes.  
17 362 Q. The Medical Director, for the purposes of today,  
18 I suppose, is Dr. Wright?  
19 A. That's right.  
20 363 Q. Does that suggest that your meetings with him more 14:40  
21 often than not did not take place fortnightly, or?  
22 A. Yes. It would be fair to say yes, that is the case.  
23 364 Q. Did that create any particular communication  
24 difficulties for you?  
25 A. Yes, it would have. Although Mr. Simon Gibson very 14:40  
26 often assumed responsibility for Dr. Wright and  
27 I assumed that he was delegating the job. Quite often,  
28 you know, Simon would have come and asked me for  
29 whatever, but it was the very, very difficult for the



1 Medical Director. I think at a point in time he worked  
 2 four days a week only and during those four days, a bit  
 3 like myself, he had an awful lot of others things to  
 4 do, so our meetings quite often went on the back burner  
 5 it is fair to say.

14:41

6 365 Q. You've said at WIT-23370, just at the bottom of the  
 7 page, please. Maybe it isn't there but I think I've  
 8 got the -- I can put the point to you in this way.  
 9 There was no governance team in place when you joined?

10 A. No. Well, there was one person, one 8B.

14:42

11 366 Q. Who was that?

12 A. Her name was Margaret Marshall.

13 367 Q. When you say no governance team was in place, what does  
 14 that mean? So within the Acute Directorate --

15 A. Yes.

14:42

16 368 Q. -- there was nobody looking at governance issues apart  
 17 from her?

18 A. If I can just explain probably what I mean. If you  
 19 don't mind I'll just explain it through. In my view,  
 20 governance is actually everybody's business because  
 21 governance runs through all of what all of us do:  
 22 documentation, standards and guidelines evidence-based  
 23 practice, risk management, complaints, audit research,  
 24 all of that is good governance, so it is everybody's  
 25 business. The governance team for me draws everything  
 26 together. For example, with the Serious Adverse  
 27 Incident, that would have been reported by the staff on  
 28 the ground, but the governance team drew together the  
 29 team to look at that Serious Adverse Incident and, you

14:42

14:42

1 know, to report back on it. Or they would have looked  
2 at -- I was very keen at looking at trends and  
3 patterns, for example, in relation to incidents or near  
4 misses, because that will tell you if there's something  
5 wrong in an area around one particular person or  
6 whatever. When I say a governance team, I mean that  
7 that team would have dealt with all of those things  
8 being pulled together. Good governance, as I said  
9 before, is everyone's business and we should all,  
10 everyone who practices, make sure that they deliver  
11 good evidence-based practice.

14:43

14:43

12 369 Q. You've explained in your statement that there was  
13 resource available for you to --

14 A. Yes.

15 370 Q. -- to fill that gap?

14:44

16 A. There was. That's right.

17 371 Q. What exactly did you do?

18 A. Governance was the only thing that I didn't have an  
19 Assistant Director to report to me on, and I felt that  
20 was very important because I wanted to keep all of my  
21 service the same. So actually Kieran Donaghy, who was  
22 the previous Director of Human Resources, told me -- he  
23 was very helpful in the beginning, and he told me that  
24 Tracey Boyce, who was the Director of Pharmacy, had  
25 just done a Diploma in Governance, a postgrad Diploma,  
26 I think, I am sorry, it may have been a postgrad, but  
27 it was a postgrad, anyway, qualification in Governance  
28 and he said: "You know, you should use that as  
29 a starting point." So I spoke to Tracy and she was

14:44

14:44

1 happy enough to do it, based on the fact that hers was  
2 a very busy job as well. But she then was able to  
3 appoint an 8B and then, more importantly, three Band 7s  
4 who did the "legwork", if you like, of the governance  
5 team. They were the people who went and gathered the 14:45  
6 information and brought it together and got the review  
7 team sorted out, et cetera. Then there was a team  
8 below that of, you know, 4s, 5s, 6s, and they were  
9 admin and all those people.

10 372 Q. Can you give us a practical example of a governance 14:45  
11 shortcoming that existed when you came into post that  
12 you were able to solve and pursue a better course as a  
13 result of the action that you took?

14 A. Well, there was a few that I didn't manage to crack  
15 and, to be honest with you, those were important, 14:45  
16 I felt, but I did speak to the two medical directors in  
17 turn. But, for example, when I came in to my position,  
18 there were more than 200 Serious Adverse Incidents that  
19 hadn't been reported on, more than 200. So this team  
20 began very quickly to look at those Serious Adverse 14:46  
21 Incidents, get teams together. It was difficult  
22 because there had to be one of the surgeons or  
23 physicians, whoever it was on the team. So by the time  
24 I pulled the team together and then they sat, they  
25 looked into it and they followed the SAI procedure, and 14:46  
26 by the time I left, most of those SAIs had been  
27 reported on or were being dealt with. I resurrected  
28 the Friday morning governance meeting that had been set  
29 up by Dr. Gillian Rankin, because it had sort of gone

1 by the wayside. Actually, governance was one of my  
2 passions in both prison healthcare and in the South  
3 Eastern Health and Social Care Trust. So I was looking  
4 forward to getting on with doing more audits or, you  
5 know, taking "near misses" and looking at them and  
6 seeing what we could do. But I wasn't able to really  
7 get into some of the more enjoyable side of governance,  
8 the prevention side of it, because every Friday, the  
9 completed SAIs were brought to my governance meetings  
10 so, really, that's all we did during the time I was  
11 there. But at least it was done.

14:46

14:47

12 373 Q. Okay. And on the operational side, if we focus on the  
13 role of Assistant Director and then below that, within  
14 each service, the Head of Service.

15 A. Yes.

14:47

16 374 Q. How did information come up from the Service, Urology,  
17 to you if there was a problem?

18 A. The information would have come up -- again, I was very  
19 clear, it's not that I wouldn't have spoken to anybody  
20 on the team, but I needed it to come through a proper  
21 line. The information would have come from the ground  
22 to the Head of Service, to the Assistant Director, and  
23 then to me. From the medical side the same thing. It  
24 would have been probably the Clinical Director to the  
25 AMD and to me. In essence, the two people that brought  
26 the information to me were the Assistant Director and  
27 the AMD. If they weren't there or, you know, somebody  
28 else quite often came in. I mean if Ronan Carroll  
29 wasn't there, for example, Martina would have stood in.

14:48

14:48

1 But I don't ever remember, actually, an occasion when  
2 it happened. In anaesthetics, for example, or  
3 medicine, the Head of Service would have stood in for  
4 AMD at times. But that's how it came, how information  
5 came.

14:48

6 375 Q. Listening to Mrs. Corrigan's evidence this morning, she  
7 was Head of Urology for all relevant periods -- this is  
8 page 13 of the current stenography or stenographic  
9 reproduction, we may not have it on the screen?

10 A. Okay.

14:49

11 376 Q. I'll read it out to you. She says that you were very  
12 clear at the start of your tenure that you expected  
13 that any information that you needed would have come  
14 through the Assistant Directors as opposed to the Head  
15 of Service, and that took her a bit of getting used to  
16 based on her previous experiences, perhaps with  
17 Mrs. Burns and before that.

14:49

18 A. Yes.

19 377 Q. She said that she didn't feel that she could go to you  
20 if she needed to escalate. Do you recognise that  
21 description in terms of the framework of management and  
22 communication that you sought to implement?

14:49

23 A. First of all, I have to say I really am disappointed  
24 that she felt she couldn't come to me at any time.  
25 However, the only way that I felt that everybody who  
26 should know did know was by coming through the  
27 Assistant Director. If I can give you an example. If  
28 Martina had come in to me and said something to me  
29 about urology, and Ronan didn't know, I might have gone

14:50

1 off and done -- it creates all sorts of problems if you  
2 don't follow the proper lines of communication. I got  
3 along very well with Martina, and I hope she said that.  
4 But in terms of communicate the business of the  
5 Directorate, then I did prefer everything to come up 14:50  
6 through the Assistant Director. I couldn't manage it  
7 properly any other way.

8 378 Q. Yes. When you think back now, do you think that caused  
9 any difficulties in terms of your ability to manage?

10 A. I don't think so. The ADs had, in turn their -- I mean 14:51  
11 I had meetings separately with my Assistant Directors  
12 and a Tuesday afternoon SMT of my own meeting, that was  
13 all of my Assistant Directors. The Assistant Directors  
14 did the same with their Heads of Service. I cannot --  
15 unless there was something, and I don't remember this 14:51  
16 happening -- but unless there was something that the  
17 Heads of Service didn't feel that the Assistant  
18 Director was taking seriously, I would have expected --  
19 but I would always have had them and the Assistant  
20 Director in the room and say, 'can we talk this 14:51  
21 through? what are the barriers to communication?'  
22 Communication is one of the biggest issues in the  
23 Health Service anyway, you know.

24 379 Q. You're here today, Mrs. Gishkori, primarily to focus on  
25 the issue of the MHPS process. 14:51

26 A. Yes.

27 380 Q. You've told us in your witness statement, WIT-23407,  
28 just to have that up, please, at paragraph 5.

29 You didn't receive any training on either MHPS or the

1 Trust guidelines during your time in the Trust?

2 A. No, I didn't receive any formally training. However,

3 because of my two previous jobs and because I sat on

4 every single consultant interview I was quite -- it was

5 almost like, for want of a better word, osmosis. As 14:53

6 I went along in my previous two jobs I understood MHPS.

7 When I went to look at it, it reminded me very much of

8 the previous Leadership and Qualities Framework and the

9 holding to account was actually quite similar, so

10 I kind of was able to grasp it and look at it. The 14:53

11 answer to your question is no, I didn't get any

12 training.

13 381 Q. But you had a working knowledge --

14 A. I did.

15 382 Q. -- of MHPS and something similar to the 14:53

16 Southern Trust's local guidelines from previous work?

17 A. That's right. And NCAS too, because the South

18 Eastern Trust were employing GPs at the time, so there

19 was a lot of work in relation to doctors.

20 383 Q. You used an acronym there N? 14:54

21 A. NCAS. That's the National Clinical Advisory Service.

22 384 Q. Yes. We've been calling it NCAS.

23 A. Sorry.

24 385 Q. Don't worry. Entirely my fault.

25 A. Sorry. 14:54

26 386 Q. You had familiarity with that organisation?

27 A. Yes, I did.

28 387 Q. Had you occasion to contact that organisation yourself?

29 A. I didn't ever contact them but the senior doctor -- and

1 I notice Colin Fitzpatrick he actually worked with us  
2 in prison healthcare, I don't know if it's the same  
3 person or not, he would have been the person who dealt  
4 with them a lot because he was the lead, but I was  
5 always involved with them as well. 14:54

6 388 Q. When it came to September 2016 --

7 A. Yes.

8 389 Q. -- and you were a member of the Oversight Committee,  
9 the Oversight Group of the Southern Trust dealing with  
10 an issue concerning Mr. O'Brien and, indeed, other 14:55  
11 clinicians during the meetings but focusing on him  
12 today, this wasn't a foreign planet to you. You knew  
13 what that MHPS processes involved?

14 A. Yes.

15 390 Q. Had you read the local framework document, the local 14:55  
16 guideline document produced by the Southern Trust?

17 A. Yes. I always --

18 391 Q. If we could have that up on the screen, please? It is  
19 TRU-83685.

20 A. There was a flowchart I found very useful. I had it 14:55  
21 here but I don't know where it is.

22 392 Q. That's the Trust's guidelines. Did you have a copy of  
23 those?

24 A. The guidelines were there for everyone to see on the  
25 Trust's website. I don't know if I had it in hard copy 14:56  
26 or not, but they were there, yes.

27 393 Q. Would it have been something you consulted?

28 A. Yes.

29 394 Q. In terms of your awareness of Mr. O'Brien,



1 Mr. Aidan O'Brien --

2 A. Yes.

3 395 Q. -- did you know him before you became employed in the

4 Trust?

5 A. No. 14:56

6 396 Q. Starting your employment in August 2015 --

7 A. Yes.

8 397 Q. -- did you become aware of him?

9 A. No, not at all.

10 398 Q. When do you think was the first time that you became 14:56

11 aware of him and of concerns, however those concerns

12 might have been described, with his practice?

13 A. Yes. The very first time I became aware of him was in

14 March 2016 at one of the one-to-ones. Heather Trouton

15 and Eamon Mackle were there. 14:57

16 399 Q. That's March 2016?

17 A. That's right.

18 400 Q. I want to test that with you, because other people, you

19 might imagine, have come and give evidence about that

20 and I want to work through that with you. 14:57

21 A. Okay.

22 401 Q. We'll get to March 2016.

23

24 Could I have up on the screen, please, WIT-12130? At

25 paragraph 425, this is an extract from Mrs. Trouton's 14:57

26 Section 21. She's here talking about the concerns such

27 as triage, patient notes held by Mr. O'Brien at home,

28 review backlog. She's being asked did she have

29 discussions with anybody about that. She said:

1  
2 "These discussions directly with Mr. O'Brien were  
3 primarily via the Head of Urology and ENT but on  
4 occasion by Mr. Young, Mr. Brown, Mr. Mackle,  
5 Dr. Rankin, Mrs. Burns, Mrs. Gishkori or myself. 14:58  
6 Following discussion with Mr. O'Brien his practice  
7 would improve for a period. However, this improvement  
8 was not sustained and through alert systems we would  
9 have been alerted to delay, triage, missing notes which  
10 was then followed up for action. Review backlog 14:58  
11 numbers were also constantly monitored."  
12  
13 we know from the evidence that we've heard that triage  
14 was a problem in late 2015 --  
15 A. Yes. 14:58  
16 402 Q. -- and for several years before that.  
17 A. Mm-hmm.  
18 403 Q. We know from evidence that we've heard that a new issue  
19 came on the Services agenda towards the end of 2015  
20 because recently appointed consultant clinicians were 14:59  
21 discovering that Mr. O'Brien was, on occasions, failing  
22 to dictate clinician encounters, those kind of things.  
23 Of course, notes at home was seen to be a constant  
24 battle. Can you remember, as suggested here by  
25 Mrs. Trouton, participating in a meeting with 14:59  
26 Mr. O'Brien and her to discuss any such issues?  
27 A. Never. I never met Mr. O'Brien with Heather Trouton,  
28 not ever.  
29 404 Q. Can you remember, prior to March 2016, discussing

1 issues such as this with Mrs. Trouton?

2 A. No. I saw on one of the documents that was provided to  
3 me that in December 2016 that Heather Trouton had  
4 discussed at one of her one-to-ones. But the first  
5 time, according to my recollection, and it is 15:00  
6 five years -- it's a long time ago, Mr. Wolfe, and  
7 I hope I'm being correct here, but the first time  
8 I remember Mr. O'Brien being discussed was in  
9 March 2016.

10 405 Q. Can I just deal with that December meeting that you 15:00  
11 refer to?

12 A. Yes.

13 406 Q. If you go to Mrs. Trouton's statement at WIT-14811. At  
14 paragraph 11, please, she says:

15 15:01  
16 "Following the emerging concern relating to the lack of  
17 clinic outcomes recorded on patient centre in 2015 and  
18 following verification of this concerned by  
19 Mrs. Corrigan, advice was sought by Mr. Mackle from  
20 Dr. Richard Wright as to the best next steps. As I 15:01  
21 recall, it was notification of another concern  
22 regarding Mr. O'Brien's administrative practise that  
23 prompted a request for a direct meeting with the  
24 Medical Director.

25 15:01  
26 I also alerted my Operational Director,  
27 Mrs. Esther Gishkori, of this latest concern and I have  
28 a note of a one-to-one meeting with Mrs. Gishkori which  
29 records same."

1 So that note, if I can just ask for your comments on  
2 it, is at TRU-277934. If you can highlight the top  
3 section, where it is highlighted in pink, please.  
4

5 Now this, as you can see, is a note dated 21st December 15:02  
6 2015. It is described as a one-to-one with Esther.  
7 We have evidence that it's in the hand of Mrs. Trouton  
8 and she recalls meeting with you in December to discuss  
9 Mr. O'Brien as per that note. Are you saying that  
10 meeting didn't take place or you simply don't have 15:02  
11 recollection of it?

12 A. No, no. It is highly possible -- I mean, I had monthly  
13 one-to-ones with all of the ADs, of which Heather was  
14 one. It is possible that yes, we met. My red books,  
15 as you know, weren't able to be retrieved so my 15:03  
16 one-to-one would have been recorded in it. And all of  
17 the other things on Heather's note there I can remember  
18 about. So those are things that would have been  
19 discussed. But I don't remember that, or plan letter  
20 in one month, what did that mean, another letter didn't 15:03  
21 go to March? I do know that.

22 407 Q. Yes. Could we just revise on something you said there.  
23 You said the red books have not been retrieved. They  
24 have, in fact, been retrieved?

25 A. Some of them. 15:03

26 408 Q. Well, quite a number of them, and they've been sent to  
27 you for review?

28 A. Yes.

29 409 Q. Isn't that right?

1 A. That's right.

2 410 Q. Do you think some of them are missing?

3 A. I think the earlier ones probably later ones were --

4 you know, with the later ones, 17, 18 especially were

5 the one's that I received but there was no record of 15:04

6 that particular one-to-one at the end of December,

7 unfortunately.

8 411 Q. Okay. You can't remember the meeting. You don't deny

9 that it took place?

10 A. Yes, that's right. 15:04

11 412 Q. You don't deny that these are the kind of issues that

12 were drawn to your attention?

13 A. Mm-hmm.

14 413 Q. What subsequently emerged following a January meeting

15 on the evidence that we've received so far between 15:04

16 Trouton, Mackle and Wright was the idea that

17 Mr. O'Brien would be met with and asked to produce

18 a plan, a remedial plan to address the shortcomings in

19 his practice.

20 15:05

21 Were you privy to that information --

22 A. No.

23 414 Q. -- in January of 2016?

24 A. No, I was not.

25 415 Q. The record here from your meeting in 2015 seems to 15:05

26 allude to a plan, a letter, with one month to improve?

27 A. Yes.

28 416 Q. Clearly if this note is a contemporaneous note made of

29 that meeting, that is something you were discussing.

1 Does it not ring any bells to you?

2 A. No. I'm really sorry but it doesn't. I am being  
3 really honest, that really does not ring any bells to  
4 me.

5 417 Q. Can we leave it at this. Would you have thought that 15:05  
6 a plan from Mr. O'Brien with a period of time to  
7 improve was a worthwhile pursuit?

8 A. Absolutely. I mean there's there no patient centre  
9 letters on triage. Triage is one of the most important  
10 part of the urologist's business. If the patients 15:06  
11 weren't being triaged, what was happening then? That  
12 would have rang, as far as I'm concerned, warning  
13 bells. I really don't remember -- I'm really sorry but  
14 I just don't remember it.

15 418 Q. We maybe can't take that much further then. 15:06  
16 A. Yes.

17 419 Q. You didn't get any feedback from the meeting that they  
18 had with Dr. Wright in January?

19 A. No. Do you mind if I comment on that?

20 420 Q. Please. 15:06  
21 A. Because the reason is whenever the Oversight Meeting  
22 was called in September I wondered why or how, because  
23 I thought I was the only one that knew. Heather and  
24 Eamon told me in March they were going to write  
25 a letter to Mr. O'Brien. Then the next thing I knew or 15:07  
26 remembered was the September meeting. I wondered how  
27 the Oversight Group had gotten to know about it since  
28 it was only Heather, Eamon and I that had known. Then  
29 I realised that there had been a meeting in January.

1 Plus, also, there was an e-mail in February from  
2 Richard Wright to me saying he thought --

3 421 Q. I think we're conflating too many things. Let's  
4 structure this a little bit better?

5 A. Okay. 15:07

6 422 Q. Let's put January behind us. There had been a meeting  
7 between Wright and the two others. You weren't aware  
8 of that meeting?

9 A. No.

10 423 Q. You weren't aware, you're telling us, of the plan that 15:07  
11 was hatched at that meeting to meet with Mr. O'Brien,  
12 at least at that time?

13 A. No.

14 424 Q. Let me take you forward a step. On 8th February  
15 Mrs. Trouton's records show there was a further meeting 15:08  
16 with you. If we can have TRU-277937 on the screen,  
17 please? Down to the highlighted section. Maybe just  
18 at the top so you can show the date. This is  
19 8th February. Just to the top, please. 8th February.

20 A. Mm-hmm. 15:08

21 425 Q. "Esther one-to-one". You did have regular one to one  
22 meetings with Mrs Trouton?

23 A. Yes, I did.

24 426 Q. The note, it says, reading across, an abbreviation for  
25 "urology" urol. It says: 15:08  
26  
27 "Apart from review backlog", and the next word might be  
28 `working`, that is urology is working apart from the  
29 review backlog.

1 A. Review backlog, yes.

2 427 Q. Is one way of interpreting that?

3 A. Yes.

4 428 Q. But AOB plan.

5 A. Yes. 15:09

6 429 Q. Again, it might make sense to suggest to you that  
7 following the meeting in January between Trouton and  
8 the Medical Directors and Mr. Mackle that this plan was  
9 being taken forward?

10 A. Mm-hmm. 15:09

11 430 Q. And that she was telling you about that?

12 A. Mm-hmm.

13 431 Q. Does that ring any bells?

14 A. It's funny because -- I'm just having to be honest with  
15 you here, I really remember the other things. [REDACTED] 15:09

16 [REDACTED] I remember that  
17 distinctly, having a long conversation. CD posts and  
18 the ins and days activity. She may have mentioned  
19 Mr. O'Brien, trauma, cancel elective activity. If  
20 it didn't jump out she may have mentioned it. 15:10

21 I can't --

22 432 Q. Let me step forward again.

23 A. Yes.

24 433 Q. It's certainly the case that in your opinion at that  
25 time the main concern for Urology was the increasing 15:10  
26 waiting lists and the backlog of patients?

27 A. That's right.

28 434 Q. To the extent that refers to backlog being the main  
29 issue for Urology, that's correct, isn't it?



1 A. It is.

2 435 Q. 9th February Dr. Wright sends you an e-mail. It is  
3 TRU-657616. Just scrolling down. Mr. O'Brien has  
4 written an e-mail talking about his heavy work  
5 commitments. Not to overly exaggerate, but he 15:11  
6 suggesting he's working all day and all night, very  
7 little time for rest.

8 A. Yes.

9 436 Q. Then that's copied through to Dr. Wright.

10 A. Yes. 15:11

11 437 Q. Then he copies it to you, as you can just see at the  
12 top of the page.  
13

14 "This almost sounds like a cry for help. We should  
15 discuss"? 15:11

16 A. I remember that clearly.

17 438 Q. There's a picture emerging here --

18 A. Yes.

19 439 Q. -- and you don't remember the early parts of it, but  
20 information being fed through to you about 15:11  
21 Mr. O'Brien's performance, the need to address that,  
22 and coming from a different angle, perhaps, Dr. Wright  
23 telling you about this e-mail. Did you meet with  
24 Richard Wright to discuss what was being interpreted as  
25 a cry for help? 15:12

26 A. Yes. I think Richard and I -- I don't know that we met  
27 about that but I do know that the next time we met or  
28 thereabouts we did discuss it. I suppose by this stage  
29 this slowness, you know -- if I can give you an

1 analogy. The way I looked at this was -- I called it  
 2 the speed continuum in my mind. There were people who,  
 3 when they got under pressure, went very slow and others  
 4 went very, very fast. That brought its own problems  
 5 too. I wondered, and I said that to Richard, 'where is 15:12  
 6 he on this?' Because people were saying by now -- as  
 7 I said to you I didn't know this man at all, but people  
 8 were saying by now, 'he's just so slow. He goes into  
 9 theatre all day. He knocks the theatre list off. He's  
 10 not a team player'. Other people will have seen 14 15:13  
 11 patients, he'll only have seen 10. But never at any  
 12 point ever did I ever hear that there was an incident,  
 13 an accident, an IR1, anything in relation to his  
 14 practice. It was just the slowness.

15 440 Q. Let's just be careful here because, of course, you did 15:13  
 16 hear about IR1s?

17 A. Later on, yes.

18 441 Q. Yes. The issue here built on top of what you may not  
 19 remember hearing but certainly it, as it appears  
 20 brought to your attention by Mrs. Trouton is, can 15:13  
 21 I suggest, a need to assist this --

22 A. Man.

23 442 Q. -- doctor and provide some support?

24 A. Yes.

25 443 Q. You said you can remember speaking to Dr. Wright about 15:14  
 26 it?

27 A. Yes.

28 444 Q. Did anything arrive in practical concrete terms in  
 29 respect of that or how was it left?

1           A.    I think it was left that Richard was going to meet  
2                Mr. O'Brien shortly after 9th February to discuss  
3                things through with him.  If I can remember right, it  
4                was in relation to job planning and he was going to  
5                talk to him about job planning and what should be in           15:14  
6                a job planning plan and SPAs, and how many of those.  
7                I think he said would raise that at that particular  
8                event or arena.  But I didn't have anything from any of  
9                my ADS, or come up through Martina or Ronan, or Heather  
10               at that point that there was any issues with           15:14  
11               Mr. O'Brien feeling that he was crying out for help,  
12               even though, apparently, he had sent e-mails way before  
13               me that he was finding it hard to deal with the  
14               workload.  I wasn't aware of those.

15   445   Q.    What you're saying is you did speak to Mr. Wright about   15:15  
16               this?

17           A.    Yes.  Yes.

18   446   Q.    It was your understanding that he would take the issue  
19               away and deal with it with Mr. O'Brien in the context  
20               of job planning?           15:15

21           A.    Job planning.

22   447   Q.    Did you ever receive any feedback to say job planning  
23               has been discussed and we found a solution to this  
24               problem?

25           A.    No.  The next time I remember was the March meeting   15:15  
26               with Heather and Eamon.  That was the next meeting.

27   448   Q.    Let's move them to the March meeting.  If we could have  
28               up on the screen an extract from your statement.  It is  
29               WIT-23372, paragraph 7, please.  It seems that what

you're telling us is in February or the beginning of March you met with Trouton and Mackle and they told you they were going to write to Mr. O'Brien --

A. Yes.

449 Q. -- telling him he needed to complete his triage  
referrals quicker, complete timely dictations and that  
he needed to be quicker in general?

A. Yes.

450 Q. Is that how it was expressed to you?

A. Yes. I didn't see the letter. The letter hadn't been written at that point. They were going to write it at that point. They were telling me they were going to write a letter.

451 Q. what do you mean when you say "I didn't see all of the  
contents of the letter"? Does that suggest you saw the letter -- 15:16

A. No. It suggests that they told me -- I didn't see the letter at all and I didn't see all of the contents. There was one about a cancer clinic that he had. They told me about the other things that were in the letter except one or two, when I see eventually saw the letter, if you understand what I mean. They told me. I said why don't you just talk to him about it. Eamon said that that had already been tried dating right back to Dr. Rankin, that he was a person who did his own thing, he very much felt as though he was in charge of urology, it was his, as they talked about, baby, he would do what he wanted to do, and he had a very slow style of working. They told me at that point if

1           you were one of his patients you would have been lucky  
2           because once you get in to see him he knew the name of  
3           your cat, he knew everything about you, but it was the  
4           ones who were waiting was the problem. What they were  
5           saying was he was a good enough clinician but he 15:18  
6           really, really had to speed up.

7   452   Q.    Just if we look at TRU-277941. This is a meeting on  
8           21st March.

9           A.    Mm-hmm.

10   453   Q.   It's marked: "One-to-one Esther and Eamon" not, but 15:18  
11           I understand this is the handwriting of Mrs. Trouton --

12           A.    It is.

13   454   Q.    -- who was also at the meeting. If we can scroll it  
14           down, please. It says: "Need to get letter to  
15           AOB-this week". So do you think this is the meeting 15:19  
16           that you have referred to in your statement? It's  
17           a bit later than the start of March.

18           A.    Yes. This is the meeting that I'm referring to that  
19           I was told that they were going to write to him.

20   455   Q.    Yes. 15:19

21           A.    Yes. That's it.

22   456   Q.    And the letter, let's look at that, AOB-0979. No? Try  
23           00, please. Thank you. Now this is the letter. The  
24           note says: "Need to get the letter to AOB-this week".  
25           Do you think that was your instruction? 15:20

26           A.    No. That was from Heather and Eamon to say: 'We're  
27           going to do this as soon as possible.'

28   457   Q.    Yes. Were they taking ownership of this process?

29           A.    Absolutely.

1 458 Q. Yes. To what extent did the process interest you?  
2 A. Well, it interested me because going back to governance  
3 and all the issues in and around governance, this  
4 person was not completing his triages, which is a risk.  
5 He wasn't doing his dictations -- which is a big risk. 15:21  
6 He's the only person who can do dictations, and the  
7 charts, et cetera. So I wanted this to be fixed very  
8 quickly. And I did say -- I remember saying to them:  
9 "But, you know, are you going to sit down with him and  
10 discuss..." You know, it's one thing handing someone 15:21  
11 a letter who is deep down into trouble but it's another  
12 thing handing him the letter and sitting with the  
13 person to see can you bring them up out of that  
14 trouble. That was very important to me that that would  
15 happen. 15:21

16 459 Q. Yes?  
17 A. Yes.

18 460 Q. So you wanted an assistance or support-based approach?  
19 A. Absolutely, I did.

20 461 Q. Did you discuss with them what they might look like? 15:22  
21 A. They said that they absolutely would sit down with him.  
22 They told me at the meeting that they were going to sit  
23 down with him, that they were going to discuss how, you  
24 know, how it was possible for this to happen, if he  
25 needed any help, if there was anything that they could 15:22  
26 do. And I said, you know, patient safety comes  
27 absolutely first here and if this person needs help  
28 then we need to give it, but we need to sort of the  
29 problem, whatever the problem is.

1 462 Q. Yes. Well, we know what the problem was for the  
2 service, don't we?

3 A. Yes, of course.

4 463 Q. When did you first see the letter, do you think?

5 A. Even when it came to the September Oversight Group, the 15:22  
6 letter wasn't presented there. It was a report from  
7 Simon Gibson.

8 464 Q. Yes.

9 A. They called it a screening report, I think.

10 465 Q. Yes. 15:23

11 A. The letter itself wasn't presented there.

12 466 Q. I'm asking you when you first saw that letter?

13 A. I don't know. Probably, maybe when it came to December  
14 and when the SAIs all started to come through. To be  
15 honest with you, I don't know when I first saw that 15:23  
16 letter.

17 467 Q. Let's just look at it briefly. It tells that the  
18 reader there are currently 253 un-triaged letters  
19 dating back a year and a half to December '14.

20 A. Yes. 15:23

21 468 Q. Tell me this, were you aware of the data, even if  
22 you didn't see the letter at these meetings?

23 A. Yes. When it came to -- I wasn't aware of the  
24 particular data at the March meeting, no, not at all.  
25 It was just a letter that was going to this man for 15:24  
26 being slow.

27 469 Q. Can I ask the question another way?

28 A. Yes.

29 470 Q. To what extent were you aware of the gravity of the

1 problem?

2 A. I became aware of the gravity of the problem in

3 September 2016 when I went to the Oversight Meeting.

4 471 Q. Although you have two senior managers in front of you

5 at a meeting planning to go to another meeting with 15:24

6 Mr. O'Brien --

7 A. Mm-hmm.

8 472 Q. -- you're not extracting from them any sense of the

9 seriousness of the problem?

10 A. No. 15:24

11 473 Q. why not?

12 A. well, Mr. Mackle, I clearly remember Mr. Mackle saying

13 to me, 'we're going to write to Aidan O'Brien because

14 he's slow and he's becoming slower. He is creating

15 havoc within the theatres. He is creating havoc in 15:24

16 terms of triage. His other colleagues see more

17 patients than him. He phones people up to come in

18 tomorrow to have an operation, nobody knows'. You

19 know, he was just completely not a team member.

20 Honestly, that is all I heard, that type of thing at 15:25

21 that meeting.

22 474 Q. You did hear that it was a triage issue?

23 A. Triage issue, slow.

24 475 Q. An un-dictated letter issue?

25 A. No, just slow. 15:25

26 476 Q. Did you not tell us a moment or two ago --

27 A. Yes, they did. They told me that he wasn't doing his

28 triages as quickly as he should.

29 477 Q. Yes. And he wasn't dictating.



1 A. He wasn't dictating.

2 478 Q. You regarded those at that time, at that meeting as  
3 potentially Patient Safety issues?

4 A. Yes.

5 479 Q. Just scroll down. He's telling you about, he's giving 15:25  
6 you statistics on triage. Then this letter, I am  
7 conscious you didn't see it, the backlog figures are  
8 there. It is recorded:  
9

10 "We are aware that you have a separate oncology waiting 15:26  
11 list of 286 patients, the longest of whom was to have  
12 been seen in September 2013. Without a validation of  
13 the backlog we have no assurance that there are not  
14 clinically urgent patients on this list."  
15 15:26

16 Were you aware of that particular nuance?

17 A. No, I wasn't, and that was the one bit. When I was  
18 provided all those papers I was provided in the core  
19 bundles, that was the part of the letter that I don't  
20 -- (a) wasn't told about in their meeting, and (b) 15:26  
21 wasn't told about in September 2016 when we had the  
22 oversight, because the screening letter didn't have  
23 that in it.

24 480 Q. If we scroll down. It's telling you about patient  
25 centres and recorded outcomes. This is the dictation 15:26  
26 issue.  
27

28 "Colleagues are frustrated or often frustrated that  
29 there's no record of your consultations or discharges

1 on the patient notes".  
2  
3 scrolling down. Then "patient notes at home".  
4  
5 Of those issues you were generally aware of the triage 15:27  
6 issue?  
7 A. Mm-hmm.  
8 481 Q. Generally aware of the dictation issue.  
9 A. Dictation issue.  
10 482 Q. Generally aware of patient notes at home? 15:27  
11 A. Yes, generally.  
12 483 Q. You knew there was a backlog with review, but  
13 you didn't appreciate --  
14 A. No.  
15 484 Q. -- you didn't appreciate that he had a separate 15:27  
16 oncology waiting list?  
17 A. It was almost as though -- the thing about urology was,  
18 and I suppose in terms of context, there was backlog,  
19 you know, in a lot of areas. A lot of the urologists  
20 did have waiting lists, but his were way over and above 15:28  
21 what everybody else's was. Urology in Northern Ireland  
22 was a regional problem and needed a regional solution.  
23 At no time was there going to be 0, 0, 0 in terms of  
24 waiting the whole way down. That was a given. I'm  
25 just saying as a background to this. Urology was a big 15:28  
26 issue in Northern Ireland -- still is, I understand.  
27 485 Q. why do you think these particular issues were being  
28 drawn to your attention at this meeting?  
29 A. Mr. Mackle left very soon after the letter was sent and

1 Heather moved also very soon after the letter was sent.  
2 I'm assuming I was being told at that point, you know,  
3 there's an issue about this man and here's what we're  
4 doing. Although I didn't know, by the way, at the  
5 meeting that Mr. Mackle was going to leave so soon as 15:29  
6 he did. I'm assuming this is a rounding up of  
7 business, as it were, in terms of Mr. Mackle.

8 486 Q. Yes. They went and they had their meeting.  
9 Mrs. Corrigan actually attended instead of Mrs. Trouton  
10 who was absent that day. 15:29

11 A. Okay.

12 487 Q. But Mrs. Trouton shortly left for a new role.

13 A. That's right.

14 488 Q. And Mr. Mackle stepped down to be replaced by  
15 Dr. McAllister. 15:30

16 A. That's right.

17 489 Q. So you left that meeting with the sense that there were  
18 patient safety issues, even if you didn't know the  
19 granular detail of the letter. You must have been  
20 awaiting some outcome from that meeting? 15:30

21 A. I suppose going back to the very beginning and what  
22 we discussed and the burden of the job that I had to  
23 do, I absolutely had to delegate work because if  
24 I didn't, I couldn't do it all myself and, certainly --  
25 so I delegated as appropriately as I could. And they 15:30  
26 left my office, they were in my office that day, so  
27 when they left my office, I was sure that I had  
28 appropriately delegated the task of sitting down with  
29 Mr. O'Brien to organise, you know, a way forward.

1 Because again -- and I'll say it again -- Mr. O'Brien  
2 was -- I didn't know the man at all but everybody had  
3 told me he was an excellent clinician, he was very well  
4 respected, this man had no "black marks", for want of  
5 a better word, against his name. So I knew or  
6 I believed that it was possible to sort this, and  
7 I felt as though I had appropriately delegated it to  
8 them.

15:31

9 490 Q. Yes, but you delegated it, if that's the right word,  
10 because they were always taking the initiative and not  
11 you, the task that they were to perform was coming from  
12 them and they were telling you about it.

15:31

13 A. Yes.

14 491 Q. Not delegated in that sense.

15 A. Well, I didn't write -- I wasn't going to be writing  
16 the letter, it was them.

15:31

17 492 Q. Yes.

18 A. They came to me with the problem and the solution, if  
19 you like. And they agreed to write the letter.

20 493 Q. Yes. And then they exited stage left?

15:32

21 A. Yes.

22 494 Q. Shortly after the meeting, leaving you with the  
23 knowledge with the acute services directorate that you  
24 have a clinician who has got practise problems that are  
25 potentially harmful to patients.

15:32

26 A. Um-hmm.

27 495 Q. So did you receive any feedback from that meeting?

28 A. No, I didn't receive any --

29 496 Q. Did you seek any feedback from the meeting?

1           A.    I didn't seek any feedback from the meeting but what  
2                I did do, because all of my ADs were moving around at  
3                that time, and everything was really fluid, but  
4                I remember saying to all of my ADs in -- you know, in  
5                meeting rooms: "Look, you must hand over whatever is 15:33  
6                on you're caseload to the AD coming in. You must. You  
7                have to. I can't do it and I can't run around finding  
8                out before things." So that was a given that everybody  
9                who was moving -- and it wasn't a difficult job to do  
10               because we were all on the same floor next door to each 15:33  
11               other, nobody moved rooms. So as far as I was  
12               concerned, and given, I suppose, the pressure that  
13               I was under, I didn't go seeking anything. No,  
14               I didn't.

15 497 Q.    Okay. Mr. McAllister, when he took up his role, he 15:33  
16               wrote to you. If we could have up on the screen,  
17               please, WIT-14875, so you're copied into the e-mail,  
18               it's 9th May, and Dr. Wright, Ronan Carroll. Item 6,  
19               urology. Obviously there's lots of other issues  
20               sketched out there. But the issues that he identifies 15:34  
21               within urology include the very issues that you are  
22               aware from your meeting in March relate to Mr. O'Brien.

23           A.    Yes.

24 498 Q.    And at the bottom of the page -- just scroll down to  
25               the end of this e-mail, please -- he said: 15:34  
26  
27               "That's what has appeared so far. Basically, a very  
28               disturbing picture with significant governance risks.  
29               I'd be interested in your thoughts".

1  
2 And he receives replies from Mr. Carroll and Dr. Wright  
3 but we can't find any reply from you.  
4 A. Well, respectfully, a lot of the things that are on  
5 that list were ongoing in the directorate. 15:35  
6 499 Q. Yes.  
7 A. I'm not sure that he discovered them all himself.  
8 Could we scroll back down?  
9 500 Q. Of course, yes. Do you want to get to the top of the  
10 e-mail? 15:35  
11 A. Yeah.  
12 501 Q. Of course.  
13 A. You know, the structure dealing with governance, what  
14 we knew and what we are doing and whatever -- mind you,  
15 what he's talking about there is the governance within 15:35  
16 medicine.  
17 502 Q. Yes.  
18 A. The monthly meetings with the Clinical Leads, the ADs  
19 and Heads of Service. The FY1 rotas were on the agenda  
20 all the time. Staff side were always meeting with us 15:35  
21 in relation to that.  
22 503 Q. In a nutshell, a lot of these issues are already on  
23 your agenda and were being dealt with?  
24 A. Yes, a lot of them. But I do remember saying to  
25 Charlie about urology and I remember him saying: "Yes, 15:36  
26 but Colin and I have got ideas about that." But,  
27 again, Charlie McAllister now was the AMD for all of  
28 these areas. He had identified the problems.  
29 504 Q. Yes.

1           A.    I knew, Ronan knew, Richard knew, and there was a lot  
2                   of overlap as well between Richard and I.

3   505   Q.    Just on Mr. O'Brien's issue, Mr. McAllister is putting  
4                   it on to each of your agendas, perhaps. He obviously  
5                   has a responsibility as well as AMD and he has answered 15:36  
6                   for that. But in terms of your role, who is being --  
7                   you being with this issue from Christmas of the  
8                   previous year if Mrs. Trouton's account is to be  
9                   accepted, and you have met with Trouton and Mackle, you  
10                  know that the meeting has taken place and you know the 15:37  
11                  content, broadly, of the letter that Mr. O'Brien is to  
12                  receive and has received?

13          A.    Yes.

14   506   Q.    But you hadn't sought any feedback from the meeting and  
15                  you haven't discussed this with Mr. McAllister 15:37  
16                  directly, have you?

17          A.    Yes, I did. I discussed it with Mr. -- because he came  
18                  for one-to-ones with me as well and I remember at his  
19                  first one-to-one, you know, just briefly going down all  
20                  of the issues here. I mean, the middle grade cover is 15:37  
21                  scant and is unable to provide -- you know, we've known  
22                  that for a very long time. I think he is writing the  
23                  obvious down there, to tell you the truth.

24   507   Q.    But with Mr. O'Brien, you met with Mr. McAllister?

25          A.    Yes, I did. 15:37

26   508   Q.    Spoke about the O'Brien situation?

27          A.    Yes. He said that he and Colin Weir had ideas about  
28                  how to fix it. And I said: "well, will you go on  
29                  ahead and get it fixed really quickly, please, because

1           it is rumbling on", is the word I used. It wasn't  
2           warning bells but it was just rumbling, it was just  
3           mentioned here and there, you know.

4   509   Q.    Uh-hmm. Now we get to August and September.

5           A.    Yes. 15:38

6   510   Q.    And you know the issue comes back on the agenda and  
7           oversight and all of that, and we'll look at that just  
8           now.

9           A.    Okay.

10  511   Q.    How come this issue has gone from March on to an 15:38  
11           oversight Committee agenda without any action being  
12           taken by you to make sure that it was brought to  
13           a conclusion as quickly as you wanted it to be brought?

14           A.    Yes, I think -- you see, are you asking me how it got  
15           to the agenda in September? 15:39

16  512   Q.    I'm asking, I suppose, given that the issue was first  
17           brought to your attention in December?

18           A.    Yes.

19  513   Q.    You identified it in March as a patient safety issue,  
20           at least potentially? 15:39

21           A.    Mm-hmm.

22  514   Q.    It comes on to the agenda in September in an unresolved  
23           state. In other words, the better part of nine months  
24           have passed and you have a clinician within your  
25           Directorate who, apart from a short meeting in March, 15:39  
26           hasn't been spoken to about this in circumstances where  
27           he has been asked for a remedial plan and hasn't  
28           produced it?

29           A.    Again, I was under the impression that other people



1 were dealing with it. Heather and Eamon were going to  
2 sit down with him and work a plan out. When I spoke to  
3 Charlie, it wasn't in May I spoke to Charlie, it might  
4 have been slightly later. I'm not going to say a date  
5 because I can't remember a date. It was, in my mind, 15:40  
6 that this particular issue was well within the bounds  
7 of being sorted by his CD and AMD and his colleagues in  
8 the urology team.

9 515 Q. At any point before you met Mr. McAllister and Mr. Weir  
10 on 14th September 2016, did you receive or seek any 15:40  
11 feedback from him or from them?

12 A. From?

13 516 Q. McAllister and Weir.

14 A. They sent out an appeal very shortly after. I spoke to  
15 Charlie on the -- just after the -- sorry. Sorry. 15:41

16 517 Q. What I'm asking you is that you met them after the  
17 Oversight Committee meeting on 14th September?

18 A. I think it was a few days after that.

19 518 Q. It was 14th September?

20 A. I brought them into my office. 15:41

21 519 Q. Yes. We'll come to that.

22 A. Yes.

23 520 Q. Before that, at some unspecified point shortly after  
24 Mr. McAllister's appointment, you spoke to him?

25 A. Yes. 15:41

26 521 Q. He told you that himself and Mr. Weir had plans to sort  
27 this out.

28 A. Mm-hmm. In fact there's e-mails to -- he said at one  
29 point to Colin, 'I think we've missed the boat here'.

1 522 Q. Yes, that's in August?

2 A. Was that August?

3 523 Q. That wasn't to you?

4 A. No. No. That wasn't to me but --

5 524 Q. What I'm really asking you, Mrs. Gishkori, is you have 15:41  
6 asked Mr. McAllister to sort this out and sort it out  
7 quickly. You can't remember when you asked him to do  
8 that, but the question is: did you pursue it with him?  
9 Did you seek feedback from him? 'Charlie, what are you  
10 doing to sort this out and have you reached 15:42  
11 a solution?'

12 A. No, because he left very quickly after that as well,  
13 after the September.

14 525 Q. No, you really are missing the point, Mrs. Gishkori.

15 A. Sorry, I beg your pardon. 15:42

16 526 Q. Let's think about the period before the Oversight  
17 Committee meeting.

18 A. Okay.

19 527 Q. The several months between McAllister's appointment in  
20 May and the Oversight Committee Meeting in September. 15:42  
21 That period of three to four months?

22 A. Yes.

23 528 Q. He knows about the O'Brien issue, he knows about the  
24 letter?

25 A. Yes. 15:42

26 529 Q. You know about the O'Brien issue and you know about the  
27 letter.

28 A. Mm-hmm.

29 530 Q. You asked him to produce a solution quickly?

1           A.    Mm-hmm.

2   531   Q.    Did you ever go back to him?

3           A.    No.

4   532   Q.    Why not?

5           A.    Again, probably based on how busy I was. You know, the 15:43

6                urology issue wasn't the only issue going on at the

7                time, Mr. Wolfe. You have to understand that there was

8                fires all over the place to be put out. You know,

9                retrospect is a very good weapon to have when you are

10              looking back on things, but whenever at the time it was 15:43

11              just another one of an awful lot of issues. If I had

12              gone -- you have nine or three or how many issues

13              there, I couldn't have had the time to go back to him

14              and say, 'did you do that, that, that or that'. You

15              know. I had to trust my colleagues, that's what they 15:43

16              were there for. I had to trust my AMDs, my ADs, the

17              Clinical Directors below them. They had a job of work

18              to do. I was doing loads --

19   533   Q.    You also have to manage them, Mrs. Gishkori.

20           A.    Yes. Yes. 15:44

21   534   Q.    You have to, because you're at the top of pyramid,

22                say to them --

23           A.    Operationally, yes.

24   535   Q.    -- you have to say to them, do you not: 'Listen, this

25                is a doctor who appears to be struggling. His 15:44

26                struggles are causing potential harm or patient risk.

27                I want this addressed, and I want it addressed quickly,

28                and I want you to report to me with how it has been

29                resolved'. At no point did you receive assurances of

1           that nature; is that fair?

2       A.    Only after September Oversight Meeting. That was  
3            whenever I really took the issue into my own hands to  
4            try and sort it out.

5 536 Q. Yes. Let's come to September then. 6th September, 15:45  
6 Mrs. Toal sends you an e-mail?

7 A. Mm-hmm.

8 537 Q. Let's bring that up onto the screen, please. It is at  
9 WIT-41560. Scroll down a little, please? Vivienne  
10 Toal, 6th September, is writing to you and Dr. Wright. 15:45  
11 She is saying:

13 "There are a number of issues which would be good to  
14 touch base on. Could we meet for a hour or so after  
15 the Governance Committee on Thursday by any chance?" 15:45

17           within that list, number 2, "Mr. Aidan O'Brien -  
18           potential MHPS case."

20 Do you remember that and do you remember touching base, 15:46  
21 as she puts it, to discuss the O'Brien issue?

22           A.    Yes, I think it was my secretary had gone back, a full  
23                diary, four meetings a day, et cetera, I think  
24                I couldn't make this one, I think, was the answer to  
25                that.

26 538 Q. So you didn't --

27           A.    But we dealt with those at the Oversight meeting.

28 539 Q. Yes, and this is to set up an informal, it appears  
29 "touch base" kind of meeting to consider what's going

1 to happen, perhaps, with those cases. So it is not the  
2 oversight itself I'm asking about.

3 A. No.

4 540 Q. But it is giving you information that Mr. O'Brien's  
5 case is potentially an MHPS case. Now presumably, 15:47  
6 having reminded yourself of this e-mail, can you help  
7 us, was that the first time you might have appreciated  
8 that your colleagues on Oversight were thinking of an  
9 MHPS process?

10 A. Yes, that would be right. 15:47

11 541 Q. Yes. You can't remember touching base?

12 A. It's very possible that we did because that's when  
13 sometimes most of the business was done, you know, like  
14 gathering people up after a meeting that was organised.  
15 You know, it was quick and it happened, everybody was 15:47  
16 there. So it's very possible that did -- I suppose  
17 I need to go back, you know, and.... Please go on.

18 542 Q. I'm sorry, are you okay?

19 A. Yeah.

20 543 Q. Are you sure? 15:48

21 A. Yes.

22 CHAIR: If you do need to take a break, we can.

23 A. No, it's okay.

24 CHAIR: In fact, it might be an appropriate time anyway,  
25 Mr. Wolfe. It is ten to four now. 15:48

26 MR. WOLFE KC: I'm in your hands.

27 CHAIR: we'll take a short break and we will come back  
28 again just after 4.00.

29

1           THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

2  
3           CHAIR: Mr. Wolfe, just during the break, just to be  
4           clear, we're not going to sit beyond 5 o'clock today,  
5           just so that Mrs. Gishkori knows that and she knows she 16:03  
6           has to come back anyway. If it makes it any easier,  
7           we'll reserve our questions until she returns.

8   544   Q.   MR. WOLFE KC: I may not go up to five o'clock, I'll  
9           park at a convenient point in the questions. Now I was  
10          asking you just before the break, Mrs. Gishkori, about 16:03  
11          the e-mail that Vivienne Toal sent on 6th September  
12          suggesting that it would be good to touch base on  
13          a range of issues, including potentially an MHPS  
14          investigation concerning Mr. O'Brien. I think you  
15          agreed with me that if you considered that e-mail at 16:04  
16          the time, that might have been the first occasion in  
17          which you would have been aware that an MHPS was in  
18          consideration?

19          A.   That is right, yes.

20   545   Q.   What you might not have been aware, and let me ask you 16:04  
21          about this, was that in advance of this, Mr. Simon  
22          Gibson had been tasked with the role of carrying out  
23          a screening report or a preliminary investigation into  
24          certain issues. When did you first become aware of  
25          that or was the need for that discussed with you? 16:04

26          A.   No. No. The need for that was not discussed with me.  
27          The first time I saw this screening report was just in  
28          advance of the Oversight Committee and Simon had said  
29          that he had been tasked with doing a screening report,

1           indeed he had given some recommendations in it as well.

2   546   Q.    Yes.

3           A.    So that's when I saw that.

4   547   Q.    Now obviously we'll get to the Oversight Committee, et

5                    cetera. 16:05

6           A.    Yes.

7   548   Q.    Now leaving aside the potential for having touched base

8                    with Toal and Wright, and you can't remember whether

9                    you did or you didn't, and that's your evidence.

10          A.    Yes. 16:05

11   549   Q.    Apart from that potential meeting to touch base, had

12                    you ever discussed the circumstances of Mr. O'Brien

13                    with, for example, the Medical Director in advance of

14                    the oversight meeting?

15          A.    No. 16:05

16   550   Q.    Now 12th September. If we could bring up TRU-257627

17                    and it's coming up to Close of business, I suppose, and

18                    Mr. Gibson is sending you the screening report for the

19                    oversight committee meeting which is to take place in

20                    the morning. 16:06

21          A.    Yes.

22   551   Q.    Let me just pull up what you've said about that in your

23                    witness statement. If we go to WIT-23409. And at

24                    paragraph 2 at the top of the page -- unfortunately,

25                    the questions that you're asked are in a separate 16:06

26                    place.

27          A.    I know.

28   552   Q.    But if I can tell you that you're being asked there

29                    when did you first become aware that there would be an

1 investigation into the performance of Mr. Aidan O'Brien  
2 and you say: "I became aware when Dr. O'Brien was  
3 listed on the agenda for a meeting of the Oversight  
4 Committee. I was not aware prior to attending that  
5 meeting. The agenda for the meeting was circulated 16:07  
6 one day before, but due to a busy work schedule, I had  
7 not had sight of the agenda in advance of the meeting."  
8

9 A. Yes.

10 553 Q. Can you help us with that? 16:07

11 A. Yes, it honestly -- you know, Emma would have been  
12 saying to me: "Esther, there's your papers", you know,  
13 and I would have literally been running down the hill  
14 to go to the Oversight Committee, which I think was in  
15 Dr. Wright's office in Headquarters. I think Vivienne 16:08  
16 somewhere else had said she had read the papers the  
17 night before. I didn't. I did not read them the night  
18 before, I read them sort of on the way and then during  
19 the meeting, it all started to unfurl and became --you  
20 know, I read it as the meeting went along. 16:08

21 554 Q. I asked you maybe at some length about whether you  
22 touched base in the week before.

23 A. Yes. Yes.

24 555 Q. It was perhaps with this answer in mind, because this  
25 answer that you've given here rather suggests that 16:08  
26 upon -- perhaps even upon arrival at the meeting it was  
27 almost a surprise or, certainly, a discovery that  
28 Mr. O'Brien was on the agenda. Whereas, you certainly  
29 received an e-mail?



1 A. I did.

2 556 Q. Or it appears you received an e-mail suggesting that an  
3 MHPS for Mr. O'Brien was at least a possibility.

4 A. A possibility, yes. And all I can say to you is  
5 I don't really remember touching base after the 16:09  
6 governance meeting. I can only tell the truth.

7 557 Q. Yes.

8 A. I can't remember -- I can remember when this whole  
9 thing, as they talk about, the alarm bells started to  
10 ring and they rang for me in this meeting. 16:09

11 558 Q. In what sense?

12 A. Because I read -- I started to read the screening  
13 report and everything that was on it and thinking to  
14 myself, gosh, you know, Heather and Eamon said they  
15 were going to be dealing with this in March. There was 16:09  
16 a lot of things went through my mind at that meeting,  
17 Mr. Wolfe, so...

18 559 Q. What were those alarm bells saying to you? Was it: We  
19 have failed to deal with this? Was it: This is more  
20 serious than I anticipated or can I put a third option 16:10  
21 to you: I don't like the way this meeting is going?

22 A. Well, I neither liked nor disliked it. It was  
23 a meeting, there was an agenda, and that was that. For  
24 me, it was really about the patients. For goodness  
25 sake, we need to get these -- that was it, patients -- 16:10  
26 you know, I didn't mind who wrote what and who -- you  
27 know I went to the school of very hard knocks in  
28 certain trusts, but it was the patients.

29 560 Q. Okay.

1 A. I'm okay, just keep going.

2 561 Q. Take your time.

3 A. You keep going, honestly, I'm fine.

4 562 Q. And we will take a break if you want.

5 A. No, no. We'll be here all night. Please keep going, 16:10

6 just ignore them, ignore the tears. Well, you go on

7 ahead!

8 563 Q. Before we get to the screening report and the meeting,

9 just another extract from your witness statement and

10 maybe you can help me understand it. I think it's -- 16:11

11 yes, just below, paragraph 11. It says:

12 "The concerns had been escalated to the CE". Is that

13 the Chief Executive?

14 A. That's the Chief Executive, yeah.

15 564 Q. Yes. "...before I knew the extent of the problem or 16:11

16 that Aidan O'Brien was going to be discussed at an

17 oversight meeting."

18 A. Yeah.

19 565 Q. "Simon Gibson had provided a screening report with

20 recommendations in the conclusion even before the 16:11

21 Oversight Committee met. The matter escalated formally

22 after the Oversight Committee meeting. The Chief

23 Executive would have been kept apprised of all matters

24 thereafter by the Oversight Committee generally and the

25 Director of HR." 16:12

26

27

28 A. Yes.

29 566 Q. So help me with this because I think we're a little

1           unsighted on the process here.

2           A.    Okay.

3   567   Q.    You say the concerns had gone to the CE, the Chief  
4           Executive, before you knew the extent of the problem.  
5           So if we can just maybe think about this in date terms. 16:12

6           A.    Yes.

7   568   Q.    13th September is the oversight meeting.

8           A.    Yes.

9   569   Q.    Francis Rice was the Chief Executive?

10          A.    Yes, he was. 16:12

11   570   Q.    What is your source of knowledge for thinking that this  
12           matter has reached the Chief Executive before it gets  
13           to the Oversight Committee?

14          A.    Well, at the Oversight Committee they were saying that  
15           the Chief Executive already knew about this and that he 16:12  
16           had -- I mean, I would need to see the minutes but that  
17           he had sort of tasked Richard Wright with taking it  
18           forward. That's why -- well, I'll tell you about that.  
19           I phoned Francis and Richard the next day, so I knew  
20           that Francis was aware of it. 16:13

21   571   Q.    Yes, okay. We'll look at perhaps the Trust guidelines,  
22           which has a provision for the Chief Executive becoming  
23           involved. We'll look at that in a moment. But you're  
24           saying that escalated to the CE before you knew the  
25           extent of the problem. Is it not fair to say that you 16:13  
26           knew the extent of the problem even before you got the  
27           screening report?

28          A.    I believe it's fair to say that I knew about the  
29           problem but not the extent of it.

1 572 Q. So if I could just then, before we formally enter the  
2 meeting, I suppose, look at the Trust guidelines. If  
3 you can -- the first page for them -- I'll just go to  
4 the first page so you can orientate yourself.  
5 TRU-83685. I think you told us earlier that they were 16:14  
6 available to you on the Trust Internet?

7 A. Yes, they would have been.

8 573 Q. If we go to TRU-83688. If we just scroll down a  
9 little, please, and stop there. It says that:  
10 16:15

11 "Concerns that may require management under the MHPS  
12 Framework must be registered with the Chief Executive.  
13 The Clinical Manager will be responsible for informing  
14 the relevant Operational Director."  
15 16:15

16 There's two points there. This might have been in the  
17 mind of whoever informed the Chief Executive.

18 A. Yes.

19 574 Q. There had been an issue raised which may require  
20 management under MHPS. 16:15

21 A. Yes.

22 575 Q. "The Clinical Manager would be responsible for  
23 informing it the relevant Operational Director."  
24 You were the relevant Operational Director, nobody  
25 informed you? 16:16

26 A. No.

27 576 Q. In fact, as we read on: "The Clinical Manager", at  
28 2.4, "will immediately undertake a initial verification  
29 of the issues raised. The Clinical Manager must seek

1           advice within Employment Engagement and Relations  
2           Department. "

3  
4           You received a screening report, and we'll look at  
5           that?

16:16

6           A.    With the agenda.   Yes.

7   577   Q.    Yes.   It was conducted by Mr. Gibson.

8           A.    That's right.

9   578   Q.    Plainly not a Clinical Manager.

10          A.    No.

16:16

11   579   Q.    Now you appreciated that he was the author of that  
12               report, acting under the instructions of the Medical  
13               Director?

14          A.    Mm-hmm.

15   580   Q.    Did anybody at any time point out to those gathered  
16               around the table at the Oversight Committee that; we've  
17               missed a stroke here.   The rules of the game, if you  
18               like, provide for clinical management input at this  
19               stage rather than being led by a nonclinical manager?

16:16

20          A.    The answer to that question is no, nobody did.   Plus  
21               also -- I mean, I've read this since, of course, in my  
22               pack, but I wouldn't have read that in advance of the  
23               meeting.   But it's just to say to you that,  
24               respectfully, Simon Gibson nearly ran the whole thing  
25               from the point of view of the Chief Executive's office.  
26               whether he did it under his guidance or whether he just  
27               took, respectfully, the ball and ran the whole way up  
28               the pitch with it, it seems that that's what he did.  
29               So nobody said round the table -- I always challenged

16:17

16:17

1           Simon, but then I got to the point where I didn't.

2   581   Q.    Okay. In terms of the absence of clinical management  
3           at this Oversight Committee meeting, looking back at  
4           the issue do you think that was a problem?

5           A.   Yes, I do. Very much so. It's why I contacted the AMD 16:18  
6           as soon as I went up, because one of the things that  
7           you'll find in Health and Social Care nowadays is that  
8           there's an awful lot of bureaucracy in it. There's an  
9           awful lot of people dish -- the way I looked at it, it  
10          was like those blind trying to lead those with 20-20 16:18  
11          vision. The people who really knew what should have  
12          been happening were the people on the ground. It was  
13          always the case with everything. They had the  
14          solutions. They always did. But there was a tendency  
15          for the bureaucracy in the organisation to just run 16:19  
16          away with the thing and come up with -- I mean at that  
17          meeting there was going to be another letter composed.

18   582   Q.    Yes.

19          A.   Here we go again now. Whereas, and I'm probably  
20          jumping on, so I'll wait. 16:19

21   583   Q.    Okay. The structure within the guidelines that  
22          you have up in front of you --

23          A.   Yes.

24   584   Q.    -- provide for a Clinical Manager to carry out  
25          a preliminary investigation if that's indicates that 16:19  
26          MHPS --

27          A.   Yes.

28   585   Q.    -- might be an issue. The Chief Executive is informed,  
29          and then the decision of the Clinical Manager is

1 notified to the Oversight Committee --

2 A. Yes.

3 586 Q. -- which has, as it describes in this document, as

4 a quality control function.

5 A. Yes. 16:20

6 587 Q. As opposed to a decision making function.

7 A. Yes.

8 588 Q. Did you appreciate that at the time? This Oversight

9 Committee made the decision, as we'll see, to have an

10 informal MHPS investigation as opposed to the Clinical 16:20

11 Manager.

12 A. Yes. But, again, that's why I tell you that I tried

13 very hard to bring it back to operational level to have

14 it sorted. Yes, I did appreciate it, is the answer to

15 your question. 16:20

16 589 Q. Okay. Let's look at the screening report then. You

17 said you read that at the meeting --

18 A. Yes. Well en route.

19 590 Q. As best you could?

20 A. Yes. 16:20

21 591 Q. It's to be found at TRU-257627. Sorry, it's not. It's

22 TRU-251423. It set out, under a series of issues,

23 Mrs. Gishkori, obviously we don't have the time to go

24 through it. Un-triaged patients, that problem is

25 described and the numbers given, 253 un-triaged 16:21

26 letters.

27 A. Yes.

28 592 Q. No plan received from Mr. O'Brien.

29 A. Mm-hmm.

1 593 Q. Some of those letters, 174, dating back 18 weeks.  
2 Alarm bells were starting to ring --  
3 A. Absolutely. Yes.  
4 594 Q. -- when you saw those figures?  
5 A. It did. 16:22  
6 595 Q. That was because of concerns about the impact on  
7 patients?  
8 A. Absolutely. And nothing else.  
9 596 Q. Outpatient review backlog.  
10 A. Yes. 16:22  
11 597 Q. Scrolling down. It's described -- you made the point  
12 earlier that the letter to Mr. O'Brien referred to  
13 a separate oncological review list that Mr. O'Brien  
14 seemed to retain.  
15 A. That's right. 16:22  
16 598 Q. That wasn't mentioned here. Was that your point?  
17 A. That's the point I was trying to make. I didn't see  
18 it. I could be wrong.  
19 599 Q. Did you think that significant when you picked up on  
20 that point? 16:22  
21 A. Well --  
22 600 Q. I take it you only picked up upon it in preparation for  
23 this?  
24 A. Of course. In preparation for this and I found it very  
25 significant. If you talk about oncology at all, you're 16:22  
26 talking about patients who have either a very small  
27 window of opportunity to be treated and, do you know,  
28 even if it's oncology and the patient has secondaries  
29 or on a terminal pathway, what about keeping them



1 comfortable? what about giving them the best option  
2 that there is? It just blows my mind to think that  
3 patients wouldn't be cared for. That's when I really  
4 do lose it, to tell you the truth. But I didn't see  
5 this oncology -- even though at a point Mr. O'Brien  
6 goes into some sort of big specific convoluted  
7 explanation of it, but anyway, for me, to be very  
8 simple, I just wanted this sorted as quick as possible.  
9 Really.

16:23

10 601 Q. Then it refers to patient notes at home. We needn't  
11 dwell on that. The fact that incident reporting had  
12 been used as a method of logging this in the past, that  
13 was no longer done. Do you have any view on whether  
14 notes at home and the discovery that notes are at home  
15 and can't be accessed within the hospital; is that  
16 something that should have been recorded as an  
17 incident?

16:23

18 A. Yes, of course, because, you know, it breaches the Data  
19 Protection Act, whatever other -- and Richard was the  
20 Responsible Officer for data protection. This is  
21 a problem that has been ongoing for a very, very, very  
22 many -- I would imagine it was custom and practice  
23 years ago. I can remember doctors taking charts home  
24 to write notes in and taking them back, long before the  
25 legislation came in. When I saw that, even though  
26 I was alarmed, I wasn't surprised. But on PAS -- it  
27 was hard to know until you'd lost a chart whether it  
28 was lost. Do you know what I mean? Until a chart came  
29 up that you couldn't find it. I'm not sure if I'm

16:24

16:24

16:24

1 putting that right or not.

2 602 Q. The fourth issue that's raised is in respect of the  
3 recording and the dictation of patient outcomes --

4 A. Yes.

5 603 Q. -- following clinical engagements. There had been no 16:25  
6 formal audit by this stage?

7 A. No.

8 604 Q. Together, I think you're saying, these issues caused  
9 you concern?

10 A. Yes. 16:25

11 605 Q. Just to scroll to the bottom of the page then. The  
12 conclusion reached by, as it appears, Mr. Gibson, is  
13 that there's a need for, or he recommends an NCAS  
14 supported external assessment of Dr. O'Brien's  
15 organisational practice, with Terms of Reference 16:25  
16 centred on whether there's a risk of patients coming to  
17 harm.

18

19 Did you pick up on that recommendation at any point in  
20 your thinking at that meeting? 16:26

21 A. I knew that Richard did make referral to NCAS, as you  
22 call it -- I just call it NCAS -- just previously or  
23 just after it. As far as I was -- I knew the NCAS  
24 flowchart fairly well. Normally what they say is try  
25 to resolve this at the lowest possible level. Don't 16:26  
26 start being convoluted about it if you can get it  
27 sorted there and then very quickly with good governance  
28 around it so that you can get it done. But Simon made  
29 whatever recommendations he wanted, really.

1 606 Q. It doesn't appear that that recommendation was accepted  
2 at the subsequent Oversight Meeting.

3 A. Right.

4 607 Q. Let's look at that now. The Oversight Meeting, as  
5 we know, took place on the 13th. If we go to 16:27  
6 TRU-00026. This is the record of the Aidan O'Brien  
7 discussion. By this stage Mr. Gibson had spoken to  
8 NCAS and he had received oral advice which was to be  
9 committed to writing, was received -- it was dated that  
10 day and it wasn't received before the meeting. 16:28

11 A. Okay.

12 608 Q. But it was subsequently shared with you and others.

13 A. Yes.

14 609 Q. Do you have a recollection of the NCAS advice being  
15 related to the meeting by Mr. Gibson? 16:28

16 A. Yes, I think so. Did they talk about audit? To audit  
17 his practice? I think they said, basically that, you  
18 know, we should work together with the clinician to  
19 produce the most positive outcome and as soon as  
20 possible, I think. More or less they were in that -- 16:28  
21 and to keep them informed. Yes, I remember seeing the  
22 letter, but just now I can't --

23 610 Q. Maybe if we get the chance we'll go to the advice  
24 letter.

25 A. Yes. 16:28

26 611 Q. You do have a firm memory of advice being related to  
27 the meeting?

28 A. Yes.

29 612 Q. The outcome of this --

1 CHAIR: Just to be clear, Mrs. Gishkori, I think there  
2 may be some confusion here. Do you remember the  
3 advice -- the telephone call being spoken about at the  
4 meeting before you saw the letter?

5 A. No, I don't remember the telephone call being talked 16:29  
6 about, but I remember seeing the e-mail when NCAS  
7 produced the e-mail. Sorry, that was my fault. Sorry.

8 613 Q. MR. WOLFE KC: what I was specifically putting to you  
9 was this. The written advice from  
10 Dr. Fitzpatrick didn't arrive before the meeting? 16:29

11 A. Yes.

12 614 Q. It was circulated some two weeks later by Mr. Gibson,  
13 on the 28th, I think, or 27th September.

14 A. Okay.

15 615 Q. Mr. Gibson has told the Inquiry that at the meeting on 16:29  
16 13th September he was able to tell you --

17 A. Me?

18 616 Q. Not you, the whole meeting. He was able to tell the  
19 meeting this is what NCAS have advised, and he took the  
20 meeting through, he believes, three or four points that 16:30  
21 NCAS had mentioned, including, as you point out, the  
22 need for an audit of an aspect of Mr. O'Brien's work.

23 A. Was it in the minutes? I didn't --

24 617 Q. It's not in the minutes, that's why I'm asking you. Do  
25 you have a memory of the advice or any reference to 16:30  
26 contact with NCAS being discussed at this meeting?

27 A. I'm sorry, I don't.

28 618 Q. You can't.

29 A. No.

- 1 619 Q. The upshot of the meeting, as we can see in the bullet  
2 points, is that Mr. Gibson got the letter which weir  
3 and Carroll would present to Mr. O'Brien at a meeting  
4 which would take place within the week or within the  
5 fortnight. The letter should inform Mr. O'Brien of 16:30  
6 the Trust's intention to proceed with an informal  
7 investigation under MHPS and it also include action  
8 plan with a four-week time scale to address the four  
9 main areas of his practice that are causing concern.  
10 You, Esther Gishkori, are to go through the letter with 16:31  
11 Colin Weir, Ronan Carroll and Simon Gibson prior to the  
12 meeting, and Mr. O'Brien should be informed that a  
13 formal investigation may be commenced if sufficient  
14 progress has not been made within the four weeks.  
15 16:31  
16 Is that a fair record of what was agreed at that  
17 meeting?  
18 A. That's what they said, but I thought it was an  
19 informal. I think Richard -- maybe I could be wrong.  
20 The very last point I felt -- 16:31  
21 620 Q. If you go up to the third bullet point. This letter  
22 should inform AOB of the Trust's intention to proceed  
23 with an informal.  
24 A. Informal, yes. Of course, I understand.  
25 621 Q. If he doesn't meet the target, a formal investigation 16:32  
26 would be contemplated?  
27 A. Yes. Sorry about that, yes.  
28 622 Q. Does that square with your memory?  
29 A. It does.

1 623 Q. Were you part of the consensus at that meeting that  
2 agreed that was the way to go forward?

3 A. Yes.

4 624 Q. You paused and thought long and hard about that?

5 A. Yes, it is a pause. Because I'm sitting there thinking 16:32  
6 to myself: what happened after the March letter? Where  
7 are we with that? Are these dictations still sitting  
8 somewhere, you know, from a clinic? Nobody else can do  
9 the dictation, only the person who saw the patient.  
10 I'm thinking here we are now going to send another 16:32  
11 letter. How are we going to do that? In my mind I'm  
12 thinking, 'but Charlie McAllister told me that he and  
13 Colin Weir, who was the CD, were considering ways to  
14 deal with it'. That's what I was thinking. But  
15 I wasn't brave enough at the meeting to say all of 16:33  
16 that. Because, I suppose in some ways I wanted to go  
17 up and check my e-mails to see had I had an e-mail  
18 saying, you know, between March and now. I just still  
19 felt that it should be informal as well. You can move  
20 on because it's the next bit, I suppose I'm going to 16:33  
21 say to you now.

22 625 Q. Just finish your answer as you wish to answer,  
23 Mrs. Gishkori. There's no structure to this  
24 particularly.

25 A. Okay. So I didn't really agree with this particular 16:34  
26 course of action because I still felt at this point  
27 there had been no indication that this man couldn't do  
28 his work. No indication of -- as we knew at this point  
29 of an incident, an accident, an SAI, any complaints

1 even. So I felt he should be made, just as his other  
2 colleagues do, I felt he should be made by the CD and  
3 the AMD to do it. And I felt it was their job to do.  
4 Yes, Martina could have helped, you know, but I wanted  
5 to get out of the room and go and find Charlie 16:34  
6 McAllister and find out what was going on. Honestly.  
7 626 Q. So what did you think was missing? I take your point  
8 that you didn't feel brave enough to articulate your  
9 real feelings about it. What did you think was missing  
10 from this plan of attack? 16:35  
11 A. So what was going to be in the letter that Simon was  
12 going to compose?  
13 627 Q. Sorry?  
14 A. So Mr. Gibson was going to write a letter. What was  
15 going to be in that letter? 16:35  
16 628 Q. Yes.  
17 A. Was it appropriate that he wrote the letter?  
18 629 Q. But he was going to be writing the letter and setting  
19 out detail on it and you were going to approve it?  
20 A. I just feel that informally -- 16:35  
21 630 Q. What was wrong with this approach?  
22 A. Well, there was still a big bit in relation to the  
23 informal process of MHPS. So the Clinical Manager, as  
24 you have already said, should be the one who  
25 establishes the facts. That didn't happen. Consider 16:36  
26 consultation with the Director HR NCAS, which they did.  
27 But then the next bit down is remedial action, i.e.  
28 local action plans, which I felt that a local action  
29 plan should be, and with the local team as opposed to

1 Mr. O'Brien getting another letter that now he knew  
2 everybody else knew and if he went off sick, what would  
3 we do? If he walked out the door, what would we do?  
4 How could we get all these dictated. So I wanted to  
5 sort it so that the solution involved him. 16:36

6 631 Q. The solution was going to involve him, was it not,  
7 under this approach?

8 A. Well....

9 632 Q. And we'll look at the letter in a moment.

10 A. Yeah, yeah. 16:36

11 633 Q. But was your problem with the decision that it was  
12 going to not only involve a time-tabled requirement for  
13 Mr. O'Brien to comply with the requisite standards and  
14 clear up the backlog, but was your concern that they  
15 were adding onto it an MHPS investigation? 16:37

16 A. I think my concern was that, clearly, it hadn't been  
17 dealt with by the CD and the AMD, and that's where  
18 I felt, before we start to send out an informal letter  
19 that says you may be excluded -- you know, what it said  
20 before, I just wanted it to be dealt with at the lowest 16:37  
21 possible --

22 634 Q. Let's pull up the letter that was sent to you.

23 A. Okay.

24 635 Q. TRU-251429. This is the e-mail that was sent to you,  
25 then we go to the letter. It's drafted very quickly 16:37  
26 after the meeting.

27 A. Yes, it is.

28 636 Q. You are specifically engaged by the content of this.

29 A. Yes.



1 637 Q. Mr. Gibson is saying that we've set a target of 70 per  
2 month. That is presumably 70 cases every month until  
3 the end of December with a view to dealing with the  
4 outpatient review backlog. He's saying to you,  
5 operationally this is your call. 16:38

6 A. Mm-hmm.

7 638 Q. First of all, let's go to the letter. Scroll down the  
8 page, please. Did you read the letter when it was sent  
9 to you?

10 A. This letter, yes. It was sent in a draft form. 16:38

11 639 Q. Yes.

12 A. Yes. Yes.

13 640 Q. Did you read it before you went out the next day to  
14 meet with Messrs McAllister and Weir?

15 A. Very possibly. 16:39

16 641 Q. Yes.

17 A. Although I don't know, but it came out very soon after  
18 the meeting.

19 642 Q. Yes. It's telling Mr. O'Brien, although, of course, it  
20 was never sent, that it's the Trust's intention to 16:39  
21 proceed with an investigation under MHPS. At this  
22 stage it will take an informal approach, as outlined  
23 within MHPS, but following the outcome of this they may  
24 proceed or we may proceed with a formal investigation.  
25 16:39

26 The informal approach -- skipping the next paragraph --  
27 will consider four areas of his practice and be time  
28 bound as indicated below. Each of the areas,  
29 un-triaged letters, outpatient review backlog, patient

1 notes at home, and recording of outcomes, which is to  
2 be the subject of 20 sets of notes per month audit.

3 A. Mm-hmm.

4 643 Q. He is then told in late October:

5  
6 "There would be an assessment of your progress against  
7 the targets and if there's insufficient progress, this  
8 may give rise to a formal investigation".

16:40

9  
10 The history of this, Mrs. Gishkori, was of informal  
11 efforts to address the problems with Mr. O'Brien. If  
12 you read the screening report, for example, you would  
13 have seen reference to those informal efforts which,  
14 over a period of several years, well before your time,  
15 had not worked. Here was a rigid time-tabled, targeted  
16 plan, but you did not want to use this?

16:40

17 A. Can I see the date of that letter, if you don't mind?

18 644 Q. It's dated 21st September but it was sent on the 13th  
19 with a view to it being sent in advance of the meeting  
20 with Mr. O'Brien, which was planned for week commencing  
21 19th September.

16:41

22 A. Okay. Yes. I still think that I'd said -- because  
23 we do know that Mr. O'Brien got wind of what Charlie  
24 and Colin were going to do and eventually started to  
25 go -- he went off sick in -- sorry, let me just go back  
26 to what you've asked me, then we'll move on.

16:41

27  
28 Again here we were with a letter that said, okay, this  
29 is informal. After a certain date we're going to make

1           it formal. You could be excluded. what I knew about  
2           him up until --

3   645   Q.    It doesn't mention that.

4           A.    No, it doesn't mention excluded. It said it could be  
5           formal. Sorry, can you put it back down? Sorry, 16:42  
6           I can't.

7   646   Q.    Do you want to go to the top of the letter?

8           A.    Yes, please. Sorry. Sorry. Thank you.

9   647   Q.    Okay. Is that good for you?

10          A.    Yes. Thank you. Yes. It says: 16:42

11

12                "We will be taking an informal approach as outlined  
13                within MHPS, but following the outcome of this we may  
14                proceed with a formal investigation. The investigation  
15                should be seen in the context of the letter written to 16:43  
16                you on the 23rd where a number of concerns were raised,  
17                no plan was provided at that time and concerns still  
18                exist".

19

20                Yes, those four areas. Yes, okay. That's fine. 16:43

21   648   Q.    Your concern about that letter was what?

22          A.    My concern about the letter was really just that if  
23                I now went by what everybody was saying about  
24                Mr. O'Brien, he wouldn't respond very well to someone  
25                saying, 'and if this doesn't go well, we're going to be 16:43  
26                taking a formal approach'. In my mind I was really  
27                very concerned about getting his dictations done,  
28                number one.

29   649   Q.    Yes.

1 A. And who was going to do these.

2 650 Q. Sorry to cut across you. If you start with the  
3 problem.

4 A. Yes.

5 651 Q. The problem is these four areas of practice. 16:43

6 A. Yes.

7 652 Q. You have indicated to us that as long ago as March you  
8 appreciated at least some of those problems as Patient  
9 Safety concerns.

10 A. Yes. 16:44

11 653 Q. That really rang as an alarm bell when you saw the  
12 granular detail --

13 A. Of it.

14 654 Q. -- in the screening report?

15 A. Yes. 16:44

16 655 Q. Those are the problems that you wish resolved?

17 A. Yes.

18 656 Q. Here is a letter which is going to be accompanied with  
19 a meeting with Mr. O'Brien setting out a time-tabled  
20 call to action. 16:44

21 A. Mm-hmm.

22 657 Q. You didn't like this. why not?

23 A. It's not that I didn't like it at all, it's just that  
24 I felt because I thought he would react better to his  
25 own clinical colleagues working with him without 16:44  
26 a letter going out to him. It just was the fact that  
27 we were sending another letter, basically. I really  
28 had hoped -- that's why I didn't say anything in the  
29 meeting, because I really had hoped it would be dealt

1 with at operational level still. In my mind, may be  
2 naive that I was, but I still felt.

3 658 Q. Notwithstanding the history, you thought it would be  
4 better with a clinical level or operational level,  
5 Mr. Weir or Mr. McAllister going to him? 16:45

6 A. Yes.

7 659 Q. Is that why you approached those two gentlemen the next  
8 day?

9 A. Yes.

10 660 Q. The next day, 14th September, did you take the 16:45  
11 initiative of approaching them?

12 A. Yes, I did. There must have been a meeting on my  
13 floor. You know, my Secretary would have phoned  
14 Charlie's secretary and she set Louise up with  
15 a meeting or whatever. I think Ronan might have been 16:46  
16 there too. I remember speaking to Colin at one point  
17 but I definitely, definitely spoke to Charlie  
18 McAllister who was my direct line that day, and  
19 I called him into my office.

20 661 Q. Yes. Within the Section 21 statement we've asked you 16:46  
21 about how you were to relate to certain people in the  
22 MHPS process, including the Medical Director?

23 A. Yes.

24 662 Q. You said at WIT-23408 that, as far as the Medical 16:46  
25 Director -- just at V here. So far as the Medical  
26 Director was concerned, your role was to support and  
27 respect his decisions on the Oversight Committee.

28 A. Yes.

29 663 Q. You were going to Mr. McAllister and Mr. Weir with

1 a view to obtaining an alternative view on what had  
2 been decided?

3 A. Yes, I still --

4 664 Q. -- by the Oversight Committee?

5 A. Yes, I still respected him and I still -- I mean you 16:47  
6 can challenge someone still respectfully, which is what  
7 I feel I did, both him and Richard -- sorry, Francis  
8 Rice.

9 665 Q. But you weren't supporting the decision of the  
10 Oversight Committee as you suggest is your obligation? 16:47

11 A. Well, I wasn't -- I respected it but I challenged it,  
12 let's just say, as I suppose was my right to do in the  
13 meeting. I told you before that for various reasons,  
14 I just wasn't that brave to do that and I wanted to  
15 check all my facts when I got back up to the office. 16:47  
16 But, you know, I phoned Richard and asked him  
17 respectfully, because Charlie and Colin felt it would  
18 take three calendar months to resolve the whole thing.  
19 That's what they felt. Although Simon felt it would  
20 take shorter times for some of the things, but that's, 16:48  
21 I suppose, neither here nor there.

22 666 Q. So your witness statement, let's go to WIT-23409 and  
23 just scroll down to (iii). Thank you. You say:

24  
25 "Following the Oversight Committee, I immediately spoke 16:48  
26 to Charlie McAllister and Colin Weir. Ronan Carroll  
27 was also present at the meeting. As both of these  
28 individuals were line managers to Aidan O'Brien,  
29 I wanted to confirm what information they held in

1 relation to the problems that I had just been informed  
2 of. Charlie informed me that he had received one  
3 e-mail from Simon."

4  
5 That was the request in August, wasn't it, as to 16:49  
6 whether Charlie had received any of the plans from  
7 O'Brien?

8 A. Any of the plans from Mr. O'Brien, yes.

9 667 Q. Charlie suggested a resolution to the problem, which  
10 you have outlined further at paragraph 8 above, and 16:49  
11 that solution was?

12 A. The solution was that Mr. O'Brien, who really loved  
13 theatre, his theatre sessions and liked being in  
14 theatre, Charlie said all that they would have to do to  
15 resolve it would be to remove him from his theatre 16:49  
16 sessions until such times as he had caught up with his  
17 admin duties. He said that he and Colin had already  
18 looked into it. I don't know if they had spoken to his  
19 colleagues, I'm not sure, but he said that it was  
20 perfectly doable and he felt that they could do it, it 16:50  
21 would be safe, effective, and they could do it within  
22 three calendar months, he told me.

23 668 Q. Did he see that as a sanction or did he see it as  
24 a form of assistance to Mr. O'Brien?

25 A. Gosh, I would have thought a form of assistance for me 16:50  
26 and Mr. O'Brien. Like, at the end of the day, it  
27 doesn't matter who it was, the patients were right in  
28 the middle of this.

29 669 Q. Yes.

1           A.    You know.  If Mr. O'Brien was assisted in the process,  
2                   that's fine, but for me, the patients came first and  
3                   I wanted this thing sorted just as soon as was possible  
4                   for the patients' sake.

5   670   Q.    Yes.  If we go to WIT-23373, please.  Just at the top       16:50  
6                   of the page.  Again, another perspective on why you  
7                   approached Weir and McAllister.

8           A.    Yes.

9   671   Q.    You say:  
10  
11                   "Sensing real and meaningful remedial action was  
12                   necessary."  
13

14          A.    Yes.

15   672   Q.    You spoke with them and asked if they could suggest an       16:51  
16                   official solution to address Mr. O'Brien's issues with  
17                   administration and:  
18

19                   "Being an anaesthetist and having worked in theatre for  
20                   a long time with Mr. O'Brien, Dr. McAllister said he       16:51  
21                   was almost certain that if Mr. O'Brien was relieved of  
22                   his theatre lists, until his administration was up to  
23                   date, he would soon catch up.  Mr. O'Brien loved the  
24                   operating theatre.  I understand that he would be  
25                   prepared to spend all day and into the evening there if       16:51  
26                   he could.  If someone else did his lists, he would  
27                   consider this intolerable and both clinicians thought  
28                   it would take three calendar months to rectify."  
29          A.    Yes



1 673 Q. So it was viewed as a form of assistance, he loved  
2 theatre so much, he would be unhappy being away from it  
3 and he would catch up quickly. Was that the thinking?  
4 A. Yes. You know, I think everybody believed that  
5 Mr. O'Brien could do this. I think everybody believed 16:52  
6 that, you know, he just chose not to do some of his  
7 admin. So, I mean, it wasn't a sanction per se but it  
8 was a step that was needed in order to resolve  
9 a problem.

10 674 Q. Yes. Now at this meeting with Weir and McAllister, did 16:52  
11 you tell them about what had been decided at Oversight?  
12 A. Yes, I did.

13 675 Q. Did you tell them that an informal MHPS  
14 investigation --  
15 A. Was going to be underway, and I told him there was 16:52  
16 going to be a letter and that, you know, they were  
17 going to set out a template for him to follow,  
18 etcetera, yes. I told them about it. Yes, they knew.

19 676 Q. Did you tell them that Dr. Wright wished to have  
20 Mr. O'Brien excluded? 16:53  
21 A. No, I don't think so. Gosh, no.

22 677 Q. A moment ago you thought that the letter could --  
23 A. Yes.

24 678 Q. -- for exclusion?  
25 A. That was -- 16:53

26 679 Q. Mr. McAllister, I think, has told the Inquiry that you  
27 told him that Dr. Wright wished to have or was prepared  
28 to have Mr. O'Brien excluded.  
29 A. It was probably discussed at the meeting but, you know,

1 just in a general terms of discussion, I think,  
2 although it's not in the minutes. But I don't know  
3 where else I would have got that from. I certainly,  
4 even though he was the excluded in the end, it must  
5 have been discussed at a point somewhere. Sorry,  
6 I don't know where. 16:54

7 680 Q. It wasn't any part of the Oversight Committee's  
8 decision to exclude him?

9 A. No. No, it wasn't.

10 681 Q. Apart from this plan that was being talked through to 16:54  
11 remove Mr. O'Brien from his theatre responsibilities,  
12 was there any other detail discussed at that meeting  
13 about how to carry this forward?

14 A. Yes. From what I remember, I think Mr. O'Brien's job  
15 plan was due. Yes, job plan. He hadn't had his job 16:55  
16 plan, and that this was a really good opportunity for  
17 Mr. Weir to do his job plan and to discuss the things  
18 that we had discussed. Because in a job plan it  
19 probably would have been accepted it was going to be --  
20 Colin said he would do it in a nonconfrontational, 16:55  
21 supportive way, and that they would reach, you know,  
22 a mutual decision. That was all part of the  
23 conversation. It wasn't just, we're going to exclude  
24 him from theatre, that's it, thanks, go. Colin said,  
25 I think it was in an e-mail a few days later from Colin 16:55  
26 that he was going to do it in a supportive way.

27 682 Q. Just finally with this meeting. Can you help us to  
28 understand why, emerging from that meeting, you took  
29 the view that you would be telling Dr. Wright, 'I don't

1 wish any longer to support the Oversight Group, the  
 2 Oversight Committee decision'?

3 A. I don't think I said I don't wish to support it. What  
 4 I did was I phoned Richard. I was to have a meeting  
 5 with Richard and Francis Rice about something else very 16:56  
 6 soon after that. I said to them, and then there was an  
 7 e-mail I sent, I sent as well. I said respectfully,  
 8 could we. I asked him if it would be possible for us  
 9 in Acute to deal with this issue at an operational  
 10 level. I've spoken to Charlie and Colin Weir, they 16:56  
 11 feel they could resolve the problem in three calendar  
 12 months and would you consider letting us have a go at  
 13 this? Then the Chief Executive, Francis Rice was  
 14 brought in as well. His opinion, he said, 'yes, I will  
 15 let you do this, but no more than three months. At the 16:57  
 16 end of three months, if no progress has been made, then  
 17 I suppose it was going to go to formal. I don't know.  
 18 He just said we in Acute would be given no more than  
 19 three calendar months to sort it.

20 683 Q. Just to summarise, the Oversight Group plan wanted 16:57  
 21 things resolved against a timetable?

22 A. Yes.

23 684 Q. He was going to be met with, there was going to be an  
 24 informal MHPS?

25 A. Yes. 16:57

26 685 Q. But you left the meeting with McAllister and Weir with  
 27 a plan to remove him from Theatre?

28 A. No, they weren't at the meeting, McAllister and Weir.

29 686 Q. No, the meeting you had with them?

1 A. Yes.

2 687 Q. You thought that was going to be a more efficacious and  
3 more likely to be fruitful in delivering a solution?

4 A. I honestly did. I honestly believed in my heart, you  
5 know, it made sense. 16:58

6 688 Q. Was any part of the thinking around this 'Mr. O'Brien  
7 and his reputation, and we need to protect him from  
8 adverse publicity, perhaps, associated with an MHPS  
9 investigation'? Was that part of what was driving  
10 this? 16:58

11 A. I wouldn't say protect him, no. I wouldn't have  
12 protected anybody where there was Patient Safety  
13 issues. I suppose it would have been a win -- the way  
14 I was looking at it, and bearing in mind I didn't know  
15 Mr. O'Brien from Adam. I didn't know the man at all, 16:59  
16 but everybody else had told me, even in somebody Neta  
17 Chada's report, the patients loved him, everybody  
18 thought he was great. He set up the Service himself.  
19 He was part of -- he set the Service up. So I'm  
20 thinking, well -- and he also was a viable part of the 16:59  
21 team, albeit in Theatre all day long. But, however, he  
22 was still very much needed and, don't forget, Urology  
23 was in an absolute dire straits in Northern Ireland.  
24 Mark Haynes one of our consultants had to go to Belfast  
25 on a Friday. Just so -- so all that was in my mind. 16:59

26 689 Q. Did you have a fear that if the informal MHPS group was  
27 adopted that Mr. O'Brien would walk away?

28 A. I did. I did. I honestly did.

29 690 Q. And that would impact the Service.

1           A.    Yes.

2           MR. WOLFE KC:  okay, it's coming up to five o'clock.

3           CHAIR:  I think that's where we'll call it quits for

4           today.

5           MR. WOLFE KC:  Yes. 17:00

6           CHAIR:  I'm sure Mrs. Gishkori will be glad of a break.

7           we will see her again but --.

8           MR. WOLFE KC:  Can we leave it that the Inquiry will

9           consider and liaise with Arthur Cox --

10          CHAIR:  Okay.  I'm sorry we can't give you a date 17:00

11          today, Mrs. Gishkori.

12          A.    That's okay.  Thank you very much.  I don't do very

13          much these days.

14          CHAIR:  we will get back to you before too long.

15 17:00

16

17          THE INQUIRY ADJOURNED TO TUESDAY, 28TH FEBRUARY 2023 AT

18          10:00

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