Urology Services Inquiry

Oral Hearing

Day 30 – Tuesday, 21st March 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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THE INQUIRY RESUMED ON TUESDAY, 21ST DAY OF MARCH, 2023
AS FOLLOWS:

CHAIR: Good morning, everyone. Ladies and gentlemen, forgive me for asking for a moment of your time to 10:06
mention the sudden death of an esteemed colleague at the Bar, Mr. Ivor McAteer. He died suddenly last night. On behalf of those of us who knew him both as a colleague and a friend, I want to express my sympathy, and all the members of the Bar working in 10:06
this inquiry, to his wife and family. Thank you.

Mr. Wolfe.

MR. WOLFE KC: Thank you, Chair. If I can briefly add that we all have our own fond memories of Ivor, but 10:06
your words faithfully capture the essence of the man and the relationship many of us had with him. I think I speak for many of us colleagues in the room when I say he will be much missed, and may he rest in peace.

CHAIR: Thank you, Mr. Wolfe. 10:07

MR. WOLFE KC: Good morning, Dr. Chada. Chair, your only witness today is Dr. Chada. I think she wishes to take the oath.

NETA CHADA, HAVING BEEN SWORN, WAS EXAMINED BY COUNSEL 10:07
AS FOLLOWS:

1 Q. MR. WOLFE KC: Dr. Chada, in advance of today, you provided the Inquiry with one substantive statement, an addendum, and something that's come in this morning

that's going to make its way into a further addendum statement. Let me just draw your attention to those and ask you to confirm whether you wish to adopt these materials as part of your evidence. Your substantial statement is in response to Section 21 notice 41 of '22; the first page is WIT-23759. Have we WIT-23759? 10:08

CHAIR: Another technical Tuesday, Mr. Wolfe.

MR. WOLFE KC: Is there a problem with the system, can I inquire?

MR LUNNY: [Inaudible] 10:09

MR. WOLFE KC: Thank you, Mr. Lunny, but I am more concerned about --

CHAIR: The witness does have her own copy I see before her, in any event.

A. With no annotations on it. 10:09

CHAIR: Do we have the WIT bundle in the system all right?

MR. WOLFE KC: Okay, we will see how we go. If we run into further problems, we might have to pause.

2 Q. So you recognise that document okay, I'm sure, Dr. Chada? 10:10

A. I do.

3 Q. And the last page containing your signature, I believe, is WIT-23788 and it's dated 24th June last year?

A. That's correct. 10:10

4 Q. And would you wish to adopt that statement as part of your evidence?

A. I do.

5 Q. Let's see if we have the addendum which would have been

added very recently. WIT-91937.
CHAIR: No joy? Might it be better just to try to resolve this at this stage before we get much further?
MR. WOLFE KC: We will run into difficulties because there's sections of Dr. Chada's evidence that we need to see on the screen. 10:11
CHAIR: We will --
MR. WOLFE KC: We will rise for five minutes?
CHAIR: Yes, we will rise for five minutes.
10:11
THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Right, everyone, let's hope that our technical difficulties are over for the week.
MR. WOLFE KC: Okay. So moving on to your addendum statement, then, let's bring it up on the screen, WIT-91937, please. You provided that addendum witness statement in the last few days or so to correct an issue at 8.4 of your original statement. So where you have previously said, "I had no direct contact with the Medical Director other than when I was asked to engage in the investigation process when the previous case Case Manager had to be replaced", you have reconsidered that in light of what Dr. Wright has said. If we scroll on down, you say that, on down to paragraph 3, you say: 10:16 10:16 10:17

"I do not recall the discussion that Dr. Wright alludes to", until you had read his statement and now you

recall that you had a brief informal conversation with Dr. Wright during the course of your investigation but it was, in essence -- as we scroll down -- he was asking you for a progress check and you were saying that progress was slow and outlined the reasons for that. That's the correction there. 10:17

Then, this morning, you have come in with two further corrections which you will, in due course, place into an addendum. If we go down to 11.3 of your statement, please. I will try and get the page number up for that, WIT-23778. At 11.3, you said in the penultimate sentence: 10:18

"I am not aware of the parameters under which Mr. O'Brien returned to work or whether they were adhered to." 10:18

And you wish to change that to say:

"I am not aware of the exact parameters under which Mr. O'Brien returned to work, but I was aware that there was an action plan in place relating to the areas of concern. I was told that the action plan was adhered to during my investigation. Monitoring adherence to the action plan was not under my role under MHPS." 10:18 10:19

That's a change you wish to make to that paragraph?

A. Yes.

6 Q. And then at paragraph 18.4, which we find at WIT-23787, the last sentence on that page reads:

"I am unaware of how he progressed on his return" -- that is Mr. O'Brien's return -- "as I was not advised of that" and you wish to change that to "I am unaware of how he progressed, after I completed my investigation as I was not advised of that." 10:20

10:20

That's the change you wish to make?

A. Yes. Yes.

7 Q. We can see from your statement, Dr. Chada, that you obtained a medical degree in June 1988, assumed membership of the Royal College of Psychiatrists in 1994, and appointed as consultant psychiatrist in the Southern Health and Social Care Trust, which is the name we now know it by, on the 1st February 1999. Is all of that correct? 10:20

A. Yes, that's correct. 10:21

8 Q. And you retired from your role as consultant psychiatrist in the Southern Trust on the 2nd March 2020. Is that also correct?

A. I retired from my permanent role on the 2nd March 2020, and was contacted about three weeks later because of Covid. I actually returned as a consultant then for a further 15 months or so to help out during Covid. 10:21

9 Q. Very well, thank you. Thanks for that clarification.

Those details, Chair, just for your note, can be found at WIT-23759 to 23760. We don't need to bring it up on the screen.

Now, in the course of your employment in the Trust, you've participated in a number of management roles. You were Clinical Director within your Directorate, which I understand was the Mental Health and Disability Directorate? 10:22

A. Yes, that's correct. 10:22

10 Q. After that, from 2011 you were Associate Medical Director within that Directorate?

A. Yes.

11 Q. Just to be clear, although you were asked to take up the role of Case Investigator for the purposes of an MHPS investigation concerning Mr. O'Brien in or about February of 2017, you had no prior knowledge of any concerns relating to his clinical practice or how he carried out his job as a Consultant Urologist? 10:22

A. No, I did not. 10:23

12 Q. Did you have any prior dealings or knowledge of him at all?

A. Mr. O'Brien was a consultant in the Trust when I was a junior doctor. I would have been aware of him. He was a very senior consultant and so I would have been aware of the name, I would have been aware that he was a urologist but I had no direct dealings with him at all. He was a manager at one point and I did wonder whether I might have come across him at management 10:23

meetings but I have no memory of doing so. I'm not sure if he was a manager and my management overlapped, but I had no direct dealings or contact with him whatsoever.

13 Q. As we will hear in a few moments, you had some experience of operating the MHPS and Trust guidelines prior to taking up the particular role of investigator in the case of Mr. O'Brien and we will hear about that in a moment. Clearly, your evidence today, in light of that experience, will hopefully assist the Inquiry on two levels. First of all, obviously and specifically the Mr. O'Brien investigation and your experience of that, and some issues arising out of that which I will need to tease out with you. But over and above that, the Inquiry is charged generally with looking at the MHPS process and any lessons that can be learnt from both the Aidan O'Brien investigation but, more generally, from witnesses in terms of their experience will no doubt be very helpful. I will have some questions on that at a second level for you. 10:24 10:24 10:24 10:25

You have told us in your witness statement that in terms of training prior to taking up this role as investigator, you attended a medical leadership forum for NCAS training on the 24th September 2010. Let's just have that up on the screen, WIT-23790. 10:25

We have heard already from Mrs. Toal, Chair, you will recall, that this was training introduced shortly after

the development of Trust guidelines in 2010. If you just scroll through that briefly, we can remind ourselves of it. The objectives of the training were to understand the Trust's guidance of handling concerns, to discuss the internal and external support 10:26
available for Clinical Directors and Associate Medical Directors and to clarify for them their roles in applying the guidance.

Scrolling down, please, we can see that Dr. Fitzpatrick 10:26
of NCAS, amongst others, was one of the people delivering the training, and also the Panel will recall Mrs. Toal's evidence in that respect.

Any particular memories of that training and how it 10:26
assisted you in the work that you were to undertake over the next few years?

A. Dr. Fitzpatrick was the most senior NCAS representative in Northern Ireland at the time, and having his training on that day was excellent. I have had the 10:27
benefit of further training from Dr. Fitzpatrick at a later stage. I was still a Clinical Director at this point, but I thought the training on that day was very helpful in terms of understanding the relationship. Maintaining High Professional Standards is the 10:27
overarching document and procedures that we would follow in the Trust. Then this was really, I suppose, the Trust guidelines were a derivation of that, but really Maintaining High Professional Standards was the

overarching thing and Dr. Fitzpatrick talked to that.

14 Q. You also trained on the 7th and 8th March 2017 shortly after you had been appointed to the role of Case Investigator. I suppose before you got in too deep into that investigation -- let's just bring that training up, WIT-23794 -- it is described as Case Investigator training workshop and it's a two-day workshop. Is this the one that you attended? 10:28

A. It is, indeed. Yes.

15 Q. Yes. If you just scroll down. Learning objectives are set out. Was this training attended by you because you had recently taken appointment as a case investigator or was it planned? 10:28

A. I believe it was already planned and I was invited to attend. It was fortuitous that it happened to be at this time. I was very grateful that I was getting an update at this stage. 10:29

16 Q. In general terms, do you think training in the operation of NCAS and the local Trust guidelines is essential, or do you derive more from familiarising yourself with the documents and doing the job of Case Investigator or Case Manager? 10:29

A. I think the training is very important because there would have been case studies and there would have been examples, so an opportunity to understand how the process is worked through, which, I mean Maintaining High Professional Standards as a document is reasonably lengthy. You will be aware, Chair, that the section on Case Investigator is about a page, which isn't really 10:29

terribly detailed. Therefore, this type of training -- this was a two-day training programme -- really expanded a lot on that, which I thought was very helpful.

17 Q. Is there anything in particular about your training experience -- or your experience of training, I should say -- that has caused you to reflect that things could be improved in any way in the training that you receive, or were you basically content with it? 10:30

A. I thought the training was very good, and there was a mixture of people who attended this training which I thought was helpful as well. I think Maintaining High Professional Standards leaves a lot to be desired as a document. But the training, I thought, was very good. I thought it was well put together and I thought it covered a number of relevant areas. 10:30 10:31

18 Q. You have reflected in your statement that as an Associate Medical Director perhaps in particular, you had significant experience, perhaps, of managing performance amongst colleagues. You say in specific terms, if we can go to WIT-23773, that you have been involved in some six cases using the MHPS format. If you just scroll down. What you are setting out here is an e-mail that you received from Zoe Parks when compiling your witness statement. She says: 10:31 10:32

"To the best of my knowledge I have you down for the following six cases. There are also a few other investigations that I know you were involved with but

they weren't managed or investigated under MHPS as such."

And she gives an example. Then if you scroll down slightly, we can see the six cases. I take it, and you can perhaps help me with this, if we work from the bottom, number 6 where it says "2013", that those three cases, 4, 5 and 6, were handled by you as Case Investigator in that year, or the issue arose in that year? 10:32

A. In 2013?

19 Q. Is that right?

A. Yes, that's correct.

20 Q. Then there was a matter in 2016. So, in all of those four matters you were Case Investigator? 10:33

A. Yes.

21 Q. Then there was a matter number 2 where you were Case Manager?

A. Yes, that's correct.

22 Q. And then another matter more recently in 2021 where you were Case Investigator? 10:33

A. Yes. Just for clarification, Madam Chair, the case in 2016 is not this case. That was a different case.

23 Q. It's, in essence, six cases plus Mr. O'Brien's case?

A. Yes. 10:33

24 Q. Yes.

A. Yes, that's correct.

25 Q. Looking at those four cases before you came to deal with Mr. O'Brien's case, can you help us in terms of

the kinds of experiences or learning that you took from your involvement in those cases before grappling with the Mr. O'Brien investigation?

A. All four cases were very significant cases, I suppose, so my experience of Maintaining High Professional Standards was of its use in situations which were complex and significant issues being raised. I found Maintaining High Professional Standards difficult to use in terms of time scales where -- and so I knew that from even before being asked in relation to Mr. O'Brien. Time scales were not met in any of those cases, I remember that vividly. I think that's one of the biggest issues for me in terms of learning, was that Maintaining High Professional Standards really very difficult to keep to the time scales. Very clear in terms of what the Case Investigator role is but again not a lot of additional information in relation to guiding that role. I suppose that's... 10:34 10:34 10:35 10:35

26 Q. You seem to highlight that one of the main things you take from those experience is managing the time scale. I suppose by the time it gets to a formal MHPS investigation, it involves a degree of seriousness or gravity and, perhaps in very many cases, complexity. We will look in due course at how time moved on in the O'Brien investigation. 10:35 10:36

But at this stage of our discussion this morning, can you see anything in terms of learning from those experiences that either yourself, as the Case

Investigator, can do better, or is it a case of Trusts who own these processes building a better infrastructure and support network around the investigations?

A. One of the things that I am minded of on reflecting on those cases was the impact on the subject of the investigation. I do think that that probably influenced me in terms of the investigation into Mr. O'Brien. You know, there's a difference between being told you are being managed under the Trust guidelines, which tends to be at an informal level, although that is part of Maintaining High Professional Standards still, and then being told that you are being investigated under the auspices of Maintaining High Professional Standards. 10:36 10:36 10:37

My memory of all four of those prior to Mr. O'Brien was how anxiety-provoking it was for people. They were afraid of the process and anxious about the outcome. 10:37

I'm so sorry, I have lost the track of your question, Mr. Wolfe.

27 Q. Yes. I asked the question from the angle of whether you, as the practitioner leading the investigation, or the Trust who owns the process, if there is impact on the practitioner as you describe, whether the delays that seem to punctuate the process -- perhaps inevitably because of complexity or whatever else -- can that be better managed by the investigator or is 10:37

there a need for better support by the Trust for the investigation in order to move it along with greater efficiency?

A. I think Maintaining High Professional Standards is not fit for purpose. The reason I say that is because Maintaining High Professional Standards requires really that it should be a medic that undertakes the investigation for, I think, very good reason. However, medics have other responsibilities, either clinical responsibilities or, in my case, both clinical and management responsibilities. There's an onus on the Case Investigator being somebody who is, I suppose, of a reasonably -- in a reasonably responsible position because you don't want an investigation carried out by somebody who is, you know, at a lower level or the same level in terms of perception. The difficulty with that is that people in that position are people who have additional responsibilities. As a consequence, you are trying to undertake a complex investigation, maybe interviewing lots of different witnesses, as was the case in some of these other investigations as well, who are very anxious. At the same time, you are running -- you are doing your clinical job, which, in my case -- I am not sure if this is helpful to the Panel -- but I ran an acute service, so I essentially ran an emergency service. I was the consultant for Home Treatment Crisis Response Services. That is an alternative to hospital admission. So, all my clinical work is not work that can be put off to another time.

10:38 10:38 10:39 10:39 10:39

I can't cancel Outpatient clinics, I can't cancel theatre lists, not that I would anyway. I have to be honest and say I wouldn't do that anyway for an investigation because I don't think putting other patients' quality of service, impacting on that is appropriate. 10:40

But all my work in any respect, in any way, in any event, was acute work, and these are things that can't be put aside. These are people who are acutely mentally ill, who, if it wasn't for my service, would have to be admitted to hospital. There aren't enough beds in hospital and therefore it's very important that we can safely manage those people who are acutely ill, presenting with some risk, in the community. So, you are doing that. 10:40

I was also the Associate Medical Director. Just to put that in context, you are responsible for performance of the biggest number of consultants, bar anaesthetists, in the Trust. Mental health and disability has the most significant number of consultants bar anaesthetists, so it's a big consultant body, along with junior doctors. Then there's the governance issues that you are directly responsible for. In the 15 months that this investigation took, there were also 30 ongoing Serious Adverse Incidents in mental health and disability, which I would have been aware of. 10:40 10:41

I chaired one SAI in mental health and disability. For me to chair -- for the Associate Medical Director to

chair an SAI within the Directorate suggests that there was something quite complex about it, maybe involving outside agencies.

I also chaired an SAI in the Acute Hospital across, I believe, ED and Children's Services, and Medicine was involved in that as well. Again, for someone from outside Acute Services to be asked to chair that suggests a very significant degree of complexity. On top of all of that, we had a double homicide in the Trust in this period. I suppose the reason I'm explaining this is that in terms of Maintaining High Professional Standards, it's my belief that the investigation is done to the best of your ability within time constraints that are available, and I'm not sure that that's the correct way to carry out an investigation if you want a more robust outcome. 10:41 10:42 10:42

I'm not sure how much time this Inquiry has but I suspect that time has been set aside -- in fact, I know that time is set aside specifically for it. No time is set aside for Maintaining High Professional Standards investigations in terms of my job plan, or in anybody else's. I mean, I was assisted by Mrs. Hynds, and no additional time was set aside for her either. 10:42 10:43

28 Q. Mm-hmm. So, the picture emerging from your evidence so far is that you, a senior practitioner, with perhaps more experience than most in the role of an MHPS investigator -- you have gone through four

investigations -- you are asked to do this; can you refuse, in real terms --

A. Yes.

29 Q. -- or is it part of your nature perhaps to assist the employer where you can, despite the pressures? 10:43

A. You can refuse. This is done as a voluntary additional activity. It's not my nature to assist the employer. It is, however, my nature to ensure that patient service, patient care, quality of service to patients, is considered and regarded with seriousness. 10:44

I felt that given my experience to date, and the fact that I had very little contact with the Acute side, so I was outside of a lot of these issues, I felt that probably did lend to me being able to carry out an 10:44 in-depth and reasonably robust investigation. You want to be helpful, and I suppose you want to be helpful also because you feel that if an issue arises within your own directorate that requires somebody from outside it to come in and take an independent hands-off 10:44 look at it, that they will do that. You know, if everybody said no, then we would never get anywhere. Nowhere is that appropriate, you know. Complaints and issues of concern need to be investigated and addressed, so I felt a moral obligation to do so. 10:45

30 Q. If the likely candidate for Case Investigator is a person like you, can one assume that the experience that you face of other responsibilities, the need to progress an investigation and the risk that, as you

have just pointed out, of a less than robust investigation or less robust than you would like it to be, if that's the experience of others, what is to be done, in your view? You have described MHPS as not being fit for purpose but assuming we need some form of framework to look at matters of this nature, what is to be done to avoid a situation where you aren't able to devote all of your energies in a consistent way to the investigation, risking delay and risking less than robust outcomes? 10:46

A. I think to the Panel, I suppose I have a number of comments in relation to this. An investigation which takes 15 months is not helpful to the person under investigation or to the Trust. I was aware that there was an action plan in place, which I suppose lent some degree of assurance that things weren't being allowed to continue in the previous manner. That helped to some extent. However, I think there's no doubt that, having a shorter timeframe for an investigation, where issues are looked at very quickly, recommendations are made quickly and that the Trust can implement those quickly is what's required.

In terms of how that happens, I don't believe that anybody can be a Case Investigator -- and, as you have indicated, Mr. Wolfe, I have some experience in this -- I don't think you can be a Case Investigator without time set aside for it. Further, I also think -- and I have reflected a lot on this through this experience

and coming here today -- I also think that not only do you need time set aside, but I think identifying specific people to be Case Investigators is helpful for a number of reasons. I think building up expertise is important. So, being familiar with guidelines, frameworks, protocols, whatever it is that's in place, is helpful so you are not constantly having to refer to them. I think you develop learning from being involved on a regular basis. I also think that it takes away from this issue of, well, you know, maybe I particularly like investigating other doctors and being irritable and annoyed with other doctors. I think if there's a pool of Case Investigators who are specifically trained, who have time set aside, maybe one day a week or whatever that is. 10:48 10:48 10:48

When I started in medicine, for example, I was the Northern Ireland Medical and Dental Training Agency Regional Adviser for psychiatry. That meant that I was responsible for all postgraduate training in Northern Ireland for five years. I resigned from that post when I was made Associate Medical Director because I felt that there was the potential for those two roles to have a conflict. However, the reason I raise this is because that role was also done under my usual clinical responsibilities and being a clinical director at the time. Now that's changed, so now if you have a college role, there's time specifically dedicated for your college role, which I think is absolutely correct 10:49 10:49

because you can't expect consultants to be doing all of these other things. I mean, part of my consultant role is teaching and training, for example. I have junior doctors working with me; it's very important that I ensure that they are appropriately trained. You have that role, you have your clinical role, you have your governance role and so on, and that's just as a consultant, not including the management role. 10:50

Time set aside to ensure that things that are very important -- teaching and training, governance, this type of investigation -- I think is very important. I have probably rambled, I do apologise. 10:50

31 Q. Don't apologise. A moment or two ago you used the word "robust", a robustness. This is what I took from your answer. I can't bring it up on front of me as I stand here, but what I took from your answer is that these pressures on your time often led to a lack of continuity in the investigation process, leading you to be concerned as to the robustness of this investigation; is that right? Is that what you were wishing to convey? 10:50 10:51

A. Yes. I think as doctors and lawyers, one of the things that's difficult is setting things down and then picking them up and then setting things down. None of us, for example, like to be involved in proceedings which, you know, go on for a week and then they disappear and then you come back and in the middle of that, maybe the next day, you are doing something else. 10:51

That made it very difficult. There were some delays in this investigation which were of my own making because, I was, as I have explained earlier, very busy through this year. It was an unusual -- unusually busy year. Some of it was of my making. Some of it was of other people's making. But in the sum of it, you are looking at something, something comes to mind, you think oh, yes, I must look at that again but then you are not looking at it again for maybe another month. I think that isn't helpful, which is one of the reasons why I think if there was, for example, a day a week set aside, you would always be coming back to, right, how far have we got, what are we doing with that? It would help with time scales, it would help with prompts. Whereas, for example, when you are waiting for witness statements to come in and so you are sort of, well, I can't do anything further until those come in, I have got all these 101 other things to do so I will go and do those, you don't keep things to the forefront of your mind in the same way, which I think is unhelpful. 10:51 10:52 10:52 10:52

32 Q. Within your witness statement -- I needn't bring it up on the screen, I will read it to you -- it's at paragraph 15.4 at WIT-23784, you say:

"I believe the processes and findings on this occasion were robust, balanced and led to clear conclusions which then generated and informed a clear action plan." 10:53

We will come, in due course, and look in some detail at

your report and the conclusions you reached. Do you still stand over that view, that the process and findings were robust, balanced and led to clear conclusions?

A. I think the process was robust, balanced and fair within the timeframe that we had. Perhaps I could have added that clarification. But I do think that we -- I think I did as much as I could in the timeframe that I had with the information that I had. I thought the conclusions, therefore, were reflective of the information gathered. From those points of view, I did feel it was robust. 10:53 10:53

I feel it could have been done better if I had more time, if I had freed up time. I think you reflect on these things, and I suppose -- I suppose everybody thinks things could have been done better. You know, I would be very concerned about most doctors if they said that they didn't think things could be done better because I think that's the nature of our work. So, I do think things could have been done better but I'm satisfied that the findings from the report were robust and reasonable on the information that we had, and that we progressed, we progressed the report to the Case Manager to make his decision. 10:54 10:54 10:54

33 Q. We will come and look at some of the minutiae of that later. You have earlier pointed out that the very concise description of the Case Investigator role which is to be found in the MHPS document -- let's just pull

that up. WIT-18503. At the bottom of that page you can see this is the description, I think, you were alluding to earlier, that:

"The Case Investigator must formally on the advice of the Medical Director involve a member of the medical or dental staff with relevant clinical experience in cases where the question of clinical judgment is raised during the investigation process". 10:55

We will come on to look at the role of Mr. Young in this investigation in a short time, but it's fair to say that he wasn't appointed to your investigation as a clinical adviser?

A. He wasn't appointed to the investigation as a clinical adviser, but I was aware that he -- sorry, he came to the investigation as a witness, and I was aware that Mr. Young had been asked to look at some of the evidence, along with some of the other urologists, that was trying to be gathered for the investigation. So I was satisfied that there was someone with the correct clinical expertise who was looking into the evidence that was being gathered. 10:56 10:56

34 Q. Yes. I don't want to go very much into that at the moment. Is this a case that might have benefitted from the involvement of somebody at your side or perhaps in place of you with expertise in urology, given the kinds of issues that were being raised? 10:56

A. The terms of reference that were raised were issues in

relation to, in my view, more administrative processes which had the potential to lead -- certainly had potential to lead to patient outcomes. However, I didn't feel, looking through the terms of reference, that there was a question of clinical judgment being raised, so that wasn't an area that I had concerns about. Therefore, I didn't feel that I needed either to be replaced by somebody with specific experience in urology or to be assisted directly by somebody with specific experience in urology. My view was that any consultant who has to carry out clinical administration, which we all do, should have been able to address some of those terms of reference -- terms of reference 1, 2 and 3. I felt any consultant should be able to look at whether private patients were being jumped up the queue, to put it in that way. Therefore, it was not my view that this required specific urology guidance or advice or input. 10:57 10:57 10:57

35 Q. We will look at that. Just going through this job description as such. 10:58

"Must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided. Patient confidentiality needs to be maintained. It's the responsibility of the Case Investigator to judge what information needs to be gathered and how". 10:58

Again, did you feel well-equipped to discharge that

element of your role?

A. Well, the terms of reference were very specific. The terms of reference with which I was provided by the Case Manager were very specific. I felt that the process of gathering information in relation to those Terms of Reference was being carried out and, therefore, I was content that that information was being gathered as required.

36 Q. There's then reference to the need to ensure sufficient written statements are collected and this was, as we will see, a process that you oversaw gathering witness statements, or drafting witness statements maybe is the right way to put it, after interviewing witnesses.

Could I just pick up on the last bullet point there? 10:59

"Must assist the Designated Board Member in reviewing the progress of the case".

The Designated Board Member was a Mr. Wilkinson. Had you direct dealings with him at any time?

A. No, I didn't. Mr. Wilkinson contacted Dr. Khan, who was the Case Manager, directly, rather than me. Because that relationship had already been established before I was appointed Case Investigator, I felt that that relationship could continue rather than directly be involved in it, although I'm aware that these guidelines suggest that it should be the Case Investigator.

37 Q. What did you perceive, not only in this investigation perhaps but from your experience. What did you perceive to be the proper role for the board member?
A. My understanding is that the board member in some ways is almost like a conduit between the investigation that's being carried out and the subject of the investigation; to provide support, to ensure that the investigation is progressing as it should. So, to provide support, sorry, to the subject of the investigation I mean, and to ensure that the investigation is progressing as it should. I believe Mr. Wilkinson did carry out that function, though, as indicated, through Dr. Khan rather than through me because both Mr. Wilkinson and Dr. Khan had been appointed prior to my involvement, as far as I'm aware. 11:00 11:01 11:01
38 Q. Paragraph 33. I suppose paragraph 32 first of all is important but it's perhaps stating the obvious, that you do not make the decision on what actions should or should not be taken. But you, as paragraph 33 emphasises, have a wide discretion on how the investigation is carried out, but in all cases the purpose of the investigation is to ascertain the facts in a unbiased manner. 11:01

In terms of the role that you were performing, did you consider yourself to be independent of the person, that is the Medical Director, who was in essence giving you the instruction to perform this task? 11:02
A. Completely.

39 Q. Could you, had you seen fit, have required the Medical Director to attend upon you as a witness?
A. Yes, the Medical Director can be required to attend as a witness, if required.
40 Q. In terms then -- just scroll down -- of the Case Manager's role, were you clear in the distinction between your role and his, that was Dr. Khan's? 11:03
A. I was.
41 Q. Where was the division of labour as you saw it?
A. Dr. Khan had no role in the investigation. I would have had meetings with Dr. Khan to discuss how the investigation was going but not really to discuss the detail of the investigation. Dr. Khan would have asked about timeframes. Dr. Khan was an Associate Medical Director, I was an Associate Medical Director. I would have met him at monthly meetings and, you know, he would have approached and said, look, how are things going, how long is this going to take? So I would have kept him up to date. But most of -- most of the, I suppose, more formal/informal contact with Dr. Khan would have been carried out by Siobhán Hynds, Mrs. Hynds, who was assisting me in the investigation, Mrs. Hynds is the head of Employee Relations, and so she would have been the person who would have been doing a lot of the e-mailing between me and Dr. Khan, or copying me into e-mails that Dr. Khan had received or Dr. Khan may have copied me into e-mails. So, some of that sort of more formal, I suppose, on paper contact would have been through that. But Dr. Khan had 11:03 11:03 11:04 11:04

no role in the investigation whatsoever.

42 Q. Yes. You have already indicated that you didn't see the need for clinical input as such or a clinical expert to assist you in any way. Paragraph 36 provides that: 11:05

"If, during the course of an investigation, it transpires the case involves more complex clinical issues, the Case Manager could consider whether an independent practitioner from another HSS body or 11:05 elsewhere would be invited to assist".

Did that ever arise for you or for the Case Manager at any point?

A. During this investigation we had no clinical concerns 11:05 raised with us bar one. I think fairly early in the witness statements, one of the witnesses, and I'm afraid I don't recall which one but it was one of the non-medical managers, indicated to us that one of the difficulties with Mr. O'Brien is that, for example, 11:05 Mr. O'Brien contacted patients to put them on a theatre list, he phoned them himself. So he put together his theatre list. He wouldn't indicate the urgency of patients on the theatre list. As a consequence a theatre list would go ahead, say for Tuesday, and if 11:06 something urgent came in the night before, the nursing staff and the staff who operated theatres and ran theatres had no idea if there were patients on this list who were urgent or could be moved off the list to

allow the urgent surgery to be carried out.

So, I raised -- I raised that with Mrs. Hynds because it was raised at one of these interviews. I asked Mrs. Hynds if she would contact Dr. Khan to let him know that so it could be brought to the attention of people who were supervising the action plan and supervising Mr. O'Brien's return to work, because I felt that was an issue that required some attention. But other than that, everybody we spoke to went -- well, most people we spoke to went to great lengths to say that this was a good doctor, who, in fact, was overinvolved with his patients and spent long periods of time with them, wrote -- when he did write -- letters and notes, that they were very complex. So, at no point did I have -- at no point did I feel there were complex clinical issues to raise with Dr. Khan so that he could have -- 11:06 11:06 11:07

43 Q. I am going to explore that with you in the context of Dr. Young in a moment, particularly around the private patient debate that you had to resolve. I will be asking you, just to flag it now, whether Dr. Young was the appropriate person or whether other people should have been involved to help you resolve that issue. I just want to flag that now. 11:07 11:07

Before we reach that, if we could just scroll down to paragraph 37, please.

"Time scale in decision: The Case Investigator should, other than in exceptional circumstances, complete the investigation within four weeks of appointment and submit their report to the Case Manager within a further five working days."

You have touched on the difficulty around that already, and I want to explore that again in greater detail as we go on.

Just in terms of the Case Manager's role, that's Dr. Khan, did he at any point suggest to you any methodology or assistance that could be brought to bear to move this matter on quicker or more efficiently? I know that he was kept in the loop in terms of the timeframe and he asked questions about the timeframe. My question is more specific: Did he make any suggestion to you in terms of how this ought to be progressed?

A. No, Dr. Khan did not. I think, in terms of time span, there was discussion with Dr. Khan about some of the things that were taking longer. For example, the numbers of triage, those numbers were already identified by the time my investigation started. However, the lookback in terms of their notes and records that were brought back from Mr. O'Brien's house, that was taking a lot of time for the consultant urologists. I did inquire through Mrs. Hynds whether additionality could be used to try and get through that

process a bit quicker, but Dr. Khan didn't make any specific suggestions. I think he shared that, I believe he shared that suggestion but I am not sure about that.

44 Q. If we just scroll back, I just want to underscore an issue that we will come back to later. If we go back to paragraph 35. You will note that it says halfway down that paragraph: 11:10

"The practitioner must be given the opportunity to see any correspondence relating to the case, together with a list of the people whom the Case Investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the Case Investigator and given the opportunity to be accompanied." 11:10

Again, in due course we will look at how that played out during this investigation, and in particular the fact that you, when you first interviewed Mr. O'Brien, he hadn't been provided with any witness statements; isn't that correct? 11:11

A. Yes. Yes, that is correct. However, we had a lot of discussion about the timing of interviewing Mr. O'Brien; Mrs. Hynds and I did. Maintaining High Professional Standards actually suggests that the subject of the investigation should be interviewed first. I knew that, I was aware of that. Having had sight of a lot of the documentation from prior to my 11:11

involvement, I felt that it wouldn't be fair to Mr. O'Brien for me not to at least be aware of some of the things that other witnesses had to say, because I felt that needed to be -- to be fair and equitable, I felt that needed to be put to Mr. O'Brien. I mean, I realised, of course, that we could always bring him back again. So, for that reason -- so this issue of not seeing the witness statements, absolutely, Mr. O'Brien hadn't the benefit of seeing those. At that time a lot of them weren't back -- 11:12

45 Q. I think we will come to that in some detail and we will explore -- sorry, I didn't mean to cut you off rudely.

In terms of your approach to this role, given your experience and your training, did you feel yourself well-equipped for it? 11:12

A. Yes.

46 Q. But that has to be set in the context of the strains, I suppose, of your everyday professional life in terms of fitting it in and doing it efficiently? 11:13

A. Yes. I mean, I think I had the appropriate training and the appropriate approach and appropriate seniority. If you are including in the appropriately equipped whether I had the appropriate time and resource, then no. I felt I was an appropriate person to do the investigation and, if I was doing it again, I suppose the issue would be of support. 11:13

47 Q. In terms of your, I suppose, initial briefing about the issues that have given rise to the investigation, that

came from Dr. Wright, is that right? Is that correct?

A. Yes, that's correct.

48 Q. Your witness statement, if we just turn that up, please, WIT-23760. You say at 1.5, if we can just move through this fairly swiftly, that you were approached by Dr. Wright in late February 2017. I should ask you, there's no such thing as a formal letter of appointment or letter of instruction setting out what you were -- I see you smiling as if that's pie in the sky. Why is it pie in the sky? 11:14

A. No, no. It's not that it's pie in the sky but I would bring you back to what I said earlier. This is a voluntary role, this is a "Dear Neta, will you please", and I think that's how that happens or at least has happened to date. I am not saying that's ideal. To date you get a phone call completely out of the blue saying we really need somebody get senior and away from the main hospital to deal with something. I mean, all of the cases in which I was either Case Investigator or Case Manager were outside of my Directorate, so they are all cases where I'm felt to be very independent. So this is a phone call. This is usually a lengthy phone call but a phone call nonetheless. 11:14 11:15

49 Q. Yes. I'm not sure we need to go through it all. You summarise in 1.6, 1.7 into 1.8, the kinds of things that you were told. You were advised that issues had been first raised by clinical and non-clinical managers with Mr. O'Brien in March 2016 in relation to his areas 11:15

of practice, or areas of his practice.

Were you clear at an early stage that, in fact, the issues of concern predated March 2016, went back some several years? 11:16

A. I was aware that -- well, I don't know if it was an assumption or that I was told -- but I believed that issues had arisen or had been brought to the attention of managers in 2015 such that there was a more formal approach to Mr. O'Brien in 2016. That was the first more formal approach. Prior to that, I was told that there had been issues through 2015 which were raised informally. I wasn't aware of it being raised or an issue prior to '14, '15 maybe; certainly '15. I was aware issues had arisen, you know, clearly had arisen in 2015 and possibly before that. 11:16

50 Q. Mm-hmm. You were provided with paperwork and we will come on and look at that paperwork in a moment. You were told about an ongoing or a recently concluded, probably, Serious Adverse Incident? 11:17

A. Yes. I'm not sure if that was concluded when I started. I don't believe it was. I think it was started in December '16.

51 Q. I think perhaps you are unsighted on the facts but it was to be signed off in March 2017, having been investigated through 2016? 11:17

A. I wasn't aware it had been completely signed off at that stage. I was aware Mr. O'Brien wasn't formally aware of the outcome of it.

52 Q. Yes. You were informed that Mr. Weir had been the previous holder of the Case Investigator role but you were being asked to come in in his stead?
A. Yes.
53 Q. In terms of that, you have explained -- I think it's at 1.11. Yes, on down the page -- over the page, I should say -- that there was a concern that he might have been required to be interviewed and, therefore, that was the reason he should step aside. Who told you that, can you recall? 11:18
A. Dr. Wright told me that in a phone call, and then Dr. Wright had directed me to speak to Dr. Khan and to Mrs. Hynds. I did so and they also advised me of the same, that Mr. Weir -- and Mr. Weir was a clinical director and was Mr. O'Brien's clinical director at the time. 11:18
54 Q. You were also advised -- this is paragraph 1.10 -- that Mr. O'Brien had been the subject of an immediate exclusion from work, that it was felt that there was a case to answer but that the immediate exclusion was lifted, it being felt that a clear management plan put in place might address the difficulties? 11:19
A. Yes, I was aware of that.
55 Q. In terms of the actual issues that were to make up the terms of reference, did you get the detail of that from Dr. Wright? 11:19
A. I believe in the phone call, Dr. Wright may not have -- I don't believe he went through the terms of reference and the sort of A, B, C sections of them, but I believe

he outlined in general there were four terms of reference and what they related to. I was told that in the phone call, yes.

56 Q. Your appointment towards the end of February is the suggestion, you haven't given us a precise date for that, but your appointment was, if we factor in the normal time scales as suggested by the MHPS arrangements, was coming almost eight weeks after a decision had been taken to pursue a formal MHPS investigation. Did you appreciate that? Did you appreciate that, if you like, the normal time scales had already expired by the date of your appointment? 11:20 11:20

A. Well, I appreciated that there had been a delay in the decision-making in terms of replacing Mr. Weir with me. I was aware that that decision, that the decision to progress an investigation, had been made sometime earlier. I was aware of that and I knew that from the e-mails as well that then subsequently arrived. 11:21

57 Q. Is there any discussion in your experience at the point where you are appointed as an investigator, that this four-week time limit - save in exceptional circumstances to give it its full read-out - is there any discussion of the importance of trying to meet that expectation or, if the expectation can't be met to the letter, that we really have to try to do this within the shortest time possible, or does that discussion simply not happen in your experience? 11:21

A. I don't believe Dr. Wright mentioned timeframes in the phone call. I did have telephone contact with Dr. Khan

and I believe I may have said, look, there's no way we are doing this in four weeks because it was perfectly clear from the information by e-mail that I had been provided with that this was a far-reaching, complex investigation. I think I was provided with a list of sort of six or seven witnesses that Mr. Weir, I think, had maybe put together. It was perfectly clear to me that that was just a small portion of people who would need to be interviewed. So I believe, and I do apologise but it may have been a flippant comment to Dr. Khan, that there was just no way that this timeframe was -- I mean, I felt the timeframe was ridiculous. 11:22 11:22

58 Q. Yes. I suppose my question is, and it's a general question, it goes even beyond this case and it's something the Inquiry will be thinking about, I suppose, this MHPS process inserts four weeks, save in exceptional circumstances, into its code, and yet you, as a relatively experienced investigator, are saying none of my investigations could have been done in that period of time. So, I suppose when you think about it, the draftsperson of that MHPS code is no doubt thinking there are good policy reasons - whether it's Patient Safety, whether it's the clinician's interests itself, the interests of the organisation - to get these things done in an expedited form, but you are saying just not possible? 11:23 11:23

A. I think, as I have said earlier, Mr. Wolfe, if there are patient safety concerns and if you are aware that

those are the subject of the investigation, well, then you raise those immediately and say look, hold on, you know, we need to address that immediately. I suppose the analogy that I might use is that if we have a Serious Adverse Incident in home treatment, for example, that Serious Adverse Incident will go through a review process, quite rightly, but we don't wait for the review process. If something happens at a weekend, at the next ward round on Monday or Tuesday I will bring the team together and I will say - excuse my language - what the hell happened, is there something we have missed? What can we do differently? What needs to happen here, what needs to change, even before the SAI Review happens. The SAI Review is a formal process undertaken by somebody else and that will take a process and a period of time. But we need to fix -- if we think there's an obvious glaring issue, that needs to be fixed now. 11:24 11:24 11:25

I think the same applies to Maintaining High Professional Standards. If there's clear clinical issues, then those need to be addressed. I was told -- I understood that there was a period of exclusion; that, you know, patient issues/safety issues were looked at; it was felt appropriate for Mr. O'Brien to return to work after the four-week exclusion period; and I was told that the main issues were in relation to administrative processes, albeit that has an impact on patient outcome, but there's an action plan in place. 11:25 11:25

So, whilst ideally these investigations should be done over a short period of time to ensure patient safety, if those are being managed anyway, and you are trying to make sure that you are fair to the subject of the investigation and trying to get interviews with witnesses who have -- I mean, I am saying I had competing demands; Mrs. Hynds had very many, probably more, competing demands. Other people being interviewed had all sorts of competing demands. I mean these are senior managers who have 101 other things going on. So, it was very difficult to get people together, and not just difficult, I think I have said in my statement impossible to do it in that time frame. 11:26 11:26

59 Q. What you are describing, whatever the rationale is for the four weeks, and it may be in most cases, patient harm is removed as being an issue because structures and safeguards are put in place. But the interests of Mr. O'Brien, he is a practitioner who is concerned, no doubt, and emotionally involved in this process and it's hanging over his head, for various reasons, for 15 months, 18 months or whatever the precise timeframe is. What you are describing is an acceptance on the part of the Trust that it will just take however long it will take. There is actually nobody sitting and having a discussion with you, saying, right, how are we going to get this done in three months? 11:26 11:27 11:27

A. No.

60 Q. On the 2nd March, it appears, certainly from my reading of the material, that you receive a large number of

documents. This is your first, I suppose, detailed briefing of what all of this is involved. Can we just bring up that e-mail, please, TRU-283049. This is Mrs. Hynds sending you -- if you could just look at the attachments. If you look at the attachments, you can see that you received this document - I don't mean that pejoratively - of a lot of the background material. It seems on my reading that, about two-thirds of the way down, letter to A O'Brien from Eamon Mackle, 23rd of March 2016, that's the earliest document in the sequence. But you can see that many of the relevant documents are provided to you, particularly those documents that have been generated as a result of the Oversight Committee decision on the 22nd December to go with a formal investigation. 11:28 11:28 11:29

Were you left to read that material yourself without further orientation as to the issues?

A. I spoke to Mrs. Hynds. I think I spoke to Mrs. Hynds before this e-mail arrived, who advised me that she'd be sending me lots of different things to read and if I needed any more sort of information about it, to contact her. So I spoke to her before this and then I spoke to her in a more lengthy conversation after this. I mean, I had many meetings with Mrs. Hynds, both in person and by -- and lots and lots of conversations on the phone. 11:29 11:30

61 Q. Mm-hmm. In terms of Mrs. Hynds, she was appointed to the process before your involvement; isn't that right?

A. Yes, that's correct.

62 Q. How did you see her role and your relationship with her in terms of the division of labour for the conducting of this investigation?

A. With no disrespect intended, my view was I was the Case Investigator, Mrs. Hynds was there to assist. In terms of gathering information, taking notes through interviews, maybe pointing out if there were any areas that I had missed, for example, but the interviews, for example, and the pulling together. -- for example, Mrs. Hynds, you know -- I undertook the interviews; Mrs. Hynds would have typed them up, for example, a first draft, and then she would have sent them to me and then I would have corrected or made changes or whatever and sent them back to her. She would have done all the administrative stuff in relation to sharing them with witnesses and gathering them together and things like that. Mrs. Hynds would have done all the sort of e-mailing people about audits and information and those sorts of things, so she did a lot of that administrative stuff that is imperative to an investigation as complex as this. 11:30 11:31 11:31 11:31

I was the Case Investigator, she was my -- when I say assistant, that sounds terrible but she was there to assist me as Case Investigator. That's how the relationship was. And she had carried out that role previously. 11:31

63 Q. So unequivocally you led the investigation. You were

the investigator and she was in the support role?

A. Yes, yes.

64 Q. Just going back to this document, is that again typical -- perhaps there's no typical MHPS investigation but in your experience is that the way it's done, you received the background documents and are invited to get on with reading them and orientate yourself, perhaps with some input from HR, and is that necessarily a helpful way to do it? 11:32

A. I suppose investigations I have been involved with before, I have been the Case Investigator from the beginning. I suppose some of this information I wouldn't have been provided with in previous investigations because I started, you know, at a different point. I prefer personally to read what's happened before and orientate myself and then have a meeting to discuss. So I would have met with Mrs. Hynds and with Dr. Khan after I had sort of understood what had happened to date because I think rather than -- you know, this is - certainly for Dr. Khan and myself - this is eating into clinical time. This is the sort of thing that I would read outside of work hours, you know, this is not something you read inside of work hours because you don't have time. But the meeting with Dr. Khan, for example, is something that does happen generally within work hours. You divide out the work that you can do that doesn't eat into work hours and then the work you need to do within work hours. My preference is to read it first 11:32 11:33 11:33

and then have an understanding of what it is I am being asked to do and then meet with Mrs. Hynds and Dr. Khan. Although I have to say, most of my telephone conversations with Mrs. Hynds were probably outside work hours, hers and mine. 11:33

65 Q. Just before we perhaps take a short break this morning, I just want to ask you about something that appears obviously missing from this list of documents. The 23rd March 2016 letter is clearly briefed to you. We can bring that up on the screen. If we go to 11:34 AOB-00979. You will have read that letter as part of your preparations. Were you advised at any point as to the background to this letter?

A. I spoke to Mrs. Hynds, and I think Dr. Khan may have been present for that as well, but I am not sure 11:35 because this was a meeting and it wouldn't have -- sorry, I can't be sure about that, who explained the background to that letter and some of the difficulties in relationships in terms of management with Mr. O'Brien. 11:35

66 Q. Would you have been aware, for example, that the Medical Director, Dr. Wright, had been approached by Mrs. Trouton and Mr. Mackle to alert him in January 2017 that there were problems with Mr. O'Brien's practice, and this led to the meeting and the 11:36 production of this letter?

A. January '16?

67 Q. January '16, sorry, yes.

A. I was aware that there had been meetings with senior

managers and I think I probably assumed with the Medical Director, because if it's an issue which involves a very senior doctor, the Medical Director is usually involved. So I would have been aware that there had been meetings which had led to this was an outcome from a previous meeting. 11:36

68 Q. Yes. You comment upon this in your report, about this letter not then generating any further action so far as you were aware. You have described that, and we will look at it later, as being a missed opportunity. When we look at that list of documents that you received as part of your briefing from Siobhán Hynds, there doesn't appear to be any reference to the oversight meetings that took place during 2016, of course until the 22nd December meeting that led to the decision to have a formal investigation. Nor, for that matter, do you see in what is briefed to you the advice that NCAS provided to the Trust in September 2016. Is it fair to say that you didn't spot that as an issue at the time? 11:36 11:37

A. I didn't spot it as an issue at the time, that's correct. I was aware that NCAS had been approached and that that was one of the reasons why the investigation was to be progressed under Maintaining High Professional Standards as opposed to a more informal route. But I was not provided with any written correspondence or advice from NCAS. 11:37 11:38

69 Q. If we just briefly look at the NCAS advice that came in in September 2016, AOB-01049. Again, conscious that you have never seen that document; is that fair?

A. That document was included in the bundle that I was provided for the purposes of this Inquiry --

70 Q. Yes, of course.

A. -- but I have not seen it prior to that.

71 Q. You didn't see it as part of your investigation? 11:38

A. No.

72 Q. Just scrolling down the page, this is the first advice the Trust received in the context of Mr. O'Brien's alleged shortcomings and what was to be done about that. Just going over the page, the Trust is advised 11:39 that:

"The problems with the review patients and the triage could just be addressed by meeting with the doctor and agreeing a way forward. We have discussed the 11:39 possibility of relieving him of theatre duties in order to allow him the time to clear this backlog. Such a significant backlog will be difficult to clear and he will require significant support."

11:39

In terms of your approach to your investigation, did you know or have any appreciation that NCAS was advising the Trust that, in terms of dealing with some of the issues that were of concern, Mr. O'Brien would require, and NCAS was endorsing, the need to provide 11:40 him with appropriate support?

A. No, I wasn't aware of this NCAS letter or of the recommendations. I was aware that NCAS had been approached. I have thoughts on providing additional

support. I am not sure if it's appropriate for the Panel to hear.

73 Q. What I want to ask you is now that you see this kind of thing - and we will come on to look at why you included paragraph 5 in your terms of reference in just a short time - but given that you did include paragraph 5, was it not important that you had a full understanding of what transpired during 2016? 11:41

A. I felt I had been provided with enough information. I mean, terms of reference number 5 is about what management did in terms of if they knew that there were problems and how they tried to deal with them. So, I suppose I was looking specifically at that. I wasn't aware of this letter from NCAS. My understanding was that NCAS had suggested that -- 11:41

74 Q. There was, and this Inquiry knows, a sequence of events in or around the period between August and the end of the year when the decision was taken in December to have a formal investigation. I suppose what I wish to look at with you in the course of this is, having regard to the term of reference which you included at 5, should you have been able to investigate what happened during those six months, there was a series of oversight meetings, there was NCAS advice, there was a conversation between the Medical Director and the Chief Executive, the Medical Director and the Director of Acute Services, Mrs. Gishkori, and none of that seems to have featured as part of your investigation? 11:42 11:42

A. To my mind, term of reference number 5 was added by me

or suggested by me to the Case Manager. Really, what I believed I was looking -- the reason I raised it is because what I wanted to know is what had happened prior to sort of 2016 or the first half of 2016, I suppose. And I had no knowledge of what happened between August and December so I was really -- to my mind, I added that as well, what happened earlier in 2016, were there attempts to try and deal with it; what happened prior to 2016, were there attempts to deal with it? So I had no knowledge of what happened towards the end of 2016. 11:43 11:43

75 Q. Yes. Okay, we will come back and that will be one of the first areas we will look at.

CHAIR: 12 o'clock.

MR. WOLFE KC: 12 o'clock. 11:44

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

76 Q. MR. WOLFE KC: In terms of the e-mail we just looked at from Mrs. Hynds to yourself, 2nd March, there's just a brief point I want to draw your attention to. If we could have it back up, TRU-283049, and scrolling down. She suggests to you you should give Mr. O'Brien a call to introduce yourself, as the Case Investigator and to reassure him "we are moving forward with the investigation". 12:01 12:02

Did you speak to Mr. O'Brien?

A. I believe I did so but I can't completely recall.

I expect I did so because it would normally be my -- that's a normal thing that I would do in this case of events. I believe I did so but I can't be entirely sure of that.

77 Q. Have you any record of it? 12:02

A. No, I haven't. I haven't retained diaries, for example, from my time in the Trust.

78 Q. Have you any memory of what was discussed?

A. No. I believe I did and I would have just said, look, my name is Neta Chada, I have taken over as the Case 12:03 Investigator and we will be arranging to meet you and I just wanted to touch base and say hello. Literally, it wouldn't have been any discussion about the procedure or about the investigation as such, it would literally have been a courtesy sort of introduction 12:03 type call, so it wouldn't have been in any great detail at all.

79 Q. So you don't recall a discussion of substance, more an introduction?

A. Yes. I don't recall -- no, I mean, I know there 12:03 wouldn't have been any detailed discussion. The normal thing I would do in this situation is introduce myself out of courtesy and say, look, I have been asked to take over, I am sure I'll meet you in due course and I do appreciate this is difficult. You know, that type 12:04 of conversation but a very brief conversation.

80 Q. We know that you wrote to him through I think Mrs. Hynds in June, suggesting a meeting, a substantive meeting for the end of June, before the holidays. Are

you sure that that wasn't your first contact with him?
A. I don't believe so. I mean, I think if Mrs. Hynds had suggested that I make a phone call, I think I probably would have. I believe I would have. I know it's other circumstances that would have been my normal course of events, I believe I would have. I say by means of an introduction but I absolutely can't be categorical about that.
81 Q. Yes. You have said in your witness statement, dealing with the terms of reference, that when you were appointed - this is paragraph 1.12 of your statement, if we could have it up on the screen. WIT-23761. Bottom of the page, please: 12:04 12:05

"The Terms of Reference had already been formulated and were shared with me". 12:05

And you go on at paragraph 120:

"When I took over as Case Investigator I believed I was advised of four Terms of Reference as outlined in the Trust's discovery documents. However as the information was being gathered, it became clear to me that a further term of reference needed to be considered. ToR5 was to determine to what extent any of the above matters" - that's the first four elements of the terms of reference - "were known to managers within the Trust prior to December 2016 when the outcome of the SAI was shared and to determine what 12:05 12:06

actions were taken to manage any concerns".

I just want to look at the terms of reference for a moment in this context. Let's look at the NCAS case on this issue, WIT-41394. Scroll down, please. If we go to 41407, sorry. It's understood that the Trust guidelines are to be read in the context of this NCAS document. Just if we scroll to the bottom of the page, thank you. It says that: 12:06 12:07

"In terms of finalising the terms of reference, these will have been agreed in outline at the time of the decision that was made to carry out the investigation but some final drafting may be needed. The Terms of Reference as finally drafted should be agreed by the organisation's relevant decision-makers. The Case Manager and investigators appointed to carry out the investigation would not normally be involved in this process". 12:07 12:07

If we just scroll down and go over the page, please. It says:

"It may be that as the investigation progresses, the Terms of Reference are found to be too narrow or that new issues emerge that warrant further investigation. In such cases the investigator should inform the Case Manager who should seek the agreement of the responsible manager or the decision-making group to 12:08

a widening of the terms. Such requests should be decided on promptly so that the investigation is not delayed", et cetera.

I want to ask you about the process by which ToR5 was added. Is it fair to say that it started with you? 12:08

A. That's my memory of it. I believe it went through the information that I was provided with and felt that for fairness and for an understanding of what had happened to date, that a review or some information from people about what had happened prior to this, should be considered. 12:09

82 Q. We will come on to the rationale in a moment. I just want to look at some e-mails in this context. TRU-283121. Highlight the bottom, please. I will check the reference. So, if we just go back a page, please, and TRU-283121. This is the 3rd March, shortly after your appointment. Siobhán Hynds is sending to Dr. Khan, the Case Manager, copying you into draft: 12:09

"Terms of Reference for your agreement. These need to be issued to Mr. O'Brien when agreed". 12:11

The last line is irrelevant for present purposes. If we go to the next page, please, 283122, and so we can see there are four matters to be investigated. Term of reference 1 concerns the issue of triage. ToR 2 concerns the issue of patient notes being stored at Mr. O'Brien's home. 3 is in relation to delay in 12:11

dictating outpatient clinics. 4 is to determine if Mr. O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their clinical priority.

12:12

That appears what you were sent at the outset. Then, on the 15th March, if we could look at TRU-283129, Siobhán Hynds writes to Ahmed Khan and copies you in.

"Please find attached final draft of ToR for the AOB investigation. Please also find the proposed witness list to date although it is likely Dr. Chada will need to speak to others. Once we have others determined, we will update Mr. O'Brien. If you are in agreement with the draft at ToR, can you please share with Mr. O'Brien. Dr. Chada and are starting the first of our meetings with witnesses this week."

12:12

12:13

If we scroll down again, we can see that that's the witnesses that have been agreed at that point. Then the terms of reference - scroll down through them, please - they have been expanded and they now add number 5. So, taking into account the e-mail that has been sent, there seems to have been some process undertaken perhaps between yourself and Mrs. Hynds to add a fifth, and that is being sent through to Dr. Khan for his agreement. Now, can you recall the process that was undertaken to come up with the fifth?

12:13

12:13

A. I would have -- after I had received the background

information and had read through it, I met with Mrs. Hynds over a period of time, I'm sure over that week. I felt that one of the things we needed to look at is what management were aware of. So I suggested that this fifth term of reference should be added if Dr. Khan and the decision-makers were in agreement with it. So I asked Mrs. Hynds to share that with Dr. Khan to see. This was essentially a draft to see if he was happy enough to progress with that.

83 Q. What was your understanding of the process for agreeing any revisions or amendments to the terms of reference at that time? 12:14

A. Normally, terms of reference are passed down to a Case Investigator, and it's not up to the Case Investigator to agree or to outline terms of reference. I think there's good reason for that. I mean, as the NCAS document outlines, you can't go on a fishing exercise. But, however, having read through the information that I had been provided with, I felt that it was important that we understood what had taken so long to get to this point. I felt that that term of reference was relevant and fair to Mr. O'Brien as well. 12:15 12:15

84 Q. What did you understand Dr. Khan should be doing with your suggestion?

A. Well, I mean, I don't think -- the Case Manager is not really supposed to set the terms of reference either, but my understanding is that Dr. Khan either takes that to the people who did set the terms of reference, which would have been the decision-making group, or, if it 12:15

was in his remit to agree that, then it was up to him to agree it. I mean I asked for permission to add it and that's what I felt my role was.

85 Q. The e-mail was asking for his agreement, whereas, in fact, the advice seems to suggest that it's within the remit of the Trust decision-making group, which, in local parlance, would have been the Oversight group. 12:16

Did you have an understanding that an Oversight group had been in command of this case and that that's where the issue of the terms of reference should have gone? 12:16

A. I knew that there was an Oversight group in command, in charge in overseeing this, and that there had been a scoping exercise done and that the terms of reference had been set by that decision-making group. I suppose I didn't consider whether the Oversight Group should specifically have agreed this term of reference. I suppose my view was my chain of command, if you like. My line of communication was with Dr. Khan rather than anybody outside of that, and therefore I shared with Dr. Khan. 12:17 12:17

86 Q. In terms of the communication with Dr. Khan, did you discuss this with him or did you get a green light back from him?

A. I believe that -- I believe that there was a green light back because the term of reference was adopted and shared with Mr. O'Brien, as far as I'm aware. I don't formally -- I don't remember specifically being told yes or no. I think the e-mail was sent with, 12:17

look, if you agree with this, then go ahead and do something with it and if you don't, well, I think -- I didn't say if you don't but the implication was to my mind, if you don't, come back and tell me.

87 Q. Yes. So you got nothing affirmative but you got nothing to the contrary back from him? 12:18

A. Yes, so I felt that that was an indication that it was an appropriate term of reference to consider.

88 Q. In terms of the terms of reference, the term that you have added and you took to be approved by Dr. Khan, what was the spark for that? What did you see in your documents that you had been provided with or in the briefing that you had received that caused you to think this is an important issue to look at? 12:18

A. I think originally there was the letter from Mr. Mackle back, who was, I think, the Associate Medical Director at the time for this Service in March 2016. I suppose I sort of thought, look, somebody has tried to do something. Prior to that letter being sent, there must have been things happening before that, you know. The implication was that we have tried to raise these things informally was my understanding, and I sort of thought well look, what has been done? So that was really the start of it, was that letter from Mr. Mackle which I felt this seems to suggest that the Trust knew that there was something not quite right with administrative processes at that stage. 12:19 12:19

89 Q. Just looking at how the term has been framed, it takes as its lookback date December 2016, that being the date

when there was a formal MHPS investigation decision made by Oversight. It's asking, I suppose, what was known by line managers prior to that date and what did they do about the concerns that they were aware of. It's as simple as that, really? 12:20

A. Yes.

90 Q. Was the spark for that a concern perhaps that things might have been done differently or better in terms of the management of these issues?

A. Yes. 12:20

91 Q. Had you, in how you imagined this might be investigated, a view that you would want to understand the management knowledge and the decision-making that they took in light of the knowledge of the concerns?

A. Yes. I suppose I wanted to understand what it was that 12:21 managers were aware of; what they had done to try and manage that. From Mr. O'Brien's point of view, I wanted to understand what support or assistance he had been given to manage concerns. Or how I suspected that, from the correspondence that I'd seen - I knew, 12:21 not suspected - I knew Mr. O'Brien wasn't happy that this had been progressed to a more formal investigation on the Maintaining High Professional Standards, and I wanted to make sure that, you know, there weren't earlier opportunities to have acted and to have done 12:22 something maybe in a more informal way. So, some of it was about trying to gather that information in terms of understanding what the Trust knew, what they did, and what Mr. O'Brien's view about how he was managed was.

92 Q. In terms of your approach overall, you've indicated, I suppose, that because of the pressures on yourself with other commitments, you would worry about, I suppose, the overall robustness or the overall quality that you would be able to bring to this exercise. 12:22
Notwithstanding that, did you have it in mind that you would need to adopt a fairly forensic approach in terms of working through, perhaps on a chronological basis, perhaps by imagining what witnesses are at all relevant to each term of reference, how this would be done? 12:23

A. Well, you try and approach an investigation like this as transparently, as inclusively, as completely as you can. However, the use of the word "forensic" is interesting because did I bring a forensic approach to this? Doctors are not either lawyers or detectives. 12:23
You know, that's just not what we do and how we function and how we deal with people. You know, an example that I sometimes give in terms of medico-legal approaches is that if a patient goes to a GP and says I have a sore tummy, the GP doesn't say I don't believe 12:23
you; or my foot is still sore after an accident. The GP accepts that.

I don't believe that -- I don't believe I could say that I brought a forensic approach to this. I believe 12:24
I brought a transparent and inquiring approach. The nature of the questions and the nature of the investigation was an inquiring one rather than a forensic one.

93 Q. I suggested to you, and I will maybe come to this in another way later, but I have suggested to you already this morning that some of what might be regarded as important materials from 2016 didn't reach you - the screening report of Mr. Gibson, NCAS advice, minutes of Oversight Committee meetings during 2016 - which all speak, I would suggest, to the knowledge and understanding of managers around these concerns, and all speak to the actions that they did or didn't take. 12:24

12:25

When I tell you about the existence of those pieces of information in light of your development of term of reference 5, would you accept that either you didn't adequately investigate term of reference 5 to get to those materials and to get to those issues, or, alternatively, relevant managers were holding back? 12:25

A. I would disagree with both of those.

94 Q. Yes.

A. I don't think either of those apply. I think those issues were, as far as I was concerned, part of the investigation, I mean part of the process that led to this investigation. Term of reference 5 was actually looking at things that had happened more historically from that point of view. That was my reason for putting in term of reference number 5. Anything that was part of that, of the process that was started, was, in my view, part of the process. 12:25 12:26

By that point, by that point in late autumn 2016, this

process of what are we going to do, does this need an investigation, what's the level of investigation; as far as I'm concerned that's part of the process. I suppose my real interest in including term of reference number 5 was what had happened before that, really. My view was that was part of the process. I expected that the Case Manager would have knowledge of that, so I never had intended to include and never considered including anything that was already part of that process. 12:26

95 Q. What process?

A. Of moving towards a Maintaining High Professional Standards investigation and appointing a -- it being suggested that a Case Investigator was appointed and things like that. 12:27

96 Q. So you set the temporal provision, December 2016, you are looking back from there. Are you telling me that you had no interest, for the purposes of ToR 5, in understanding what flowed from the 23rd March letter; the advice that was given around next steps from NCAS; the decisions taken by managers, whether they were Mr. McAllister, Mr. Weir, Mrs. Gishkori, the Medical Director, the Chief Executive? None of that was of any interest to you for the purpose of ToR 5? 12:27

A. The gap between the letter in March 2016 and things that happened much later on that year was of interest to me for terms of reference number 5, but it was my view that once, if you like, the ball was rolling with information being sought from NCAS, decisions made to 12:27

exclude, I felt once those things were in process in the autumn of 2016, my interest for term of reference number 5 was what was done about this previously? Yes, I mean that's really what I was thinking of when I thought of term of reference number 5. I'm not saying they are not of interest, I'm saying that's not what I was considering when I suggested term of reference number 5.

97 Q. If Mr. O'Brien, in the view of NCAS, should be supported by his management team to address what management saw as shortcomings, and if they knew all of that and didn't act on it, is that not four-square within your ToR 5? 12:28

A. As I have said, Mr. Wolfe, when I wrote ToR 5 or when I considered ToR 5, it was really to look at what had been done prior to this process. When I say "this process", I do mean NCAS being involved and the Medical Director being involved and all of those things that sort of started a roll-on from the autumn, because I think once that roll-on started, things moved on. 12:29

So when I wrote this -- I mean you are asking me about did it fall within it. When I wrote it, I was really interested in what had been done prior to all of this to manage the situation before we got to this process. As I said, I knew that NCAS had recommended that things moved on to a Maintaining High Professional Standards investigation. I wasn't aware of any of the rest of the NCAS correspondence. I mean, I didn't know it and 12:29

therefore couldn't be referring to it, or...

98 Q. Well, the NCAS advice that you did receive, which was dated 28th December 2016, did refer to the fact that NCAS had been contacted before and had spoken to Mr. Gibson. 12:30

I suppose the point I reach with you on this issue is you are dismissing what I have just outlined as not being relevant to ToR 5 because that was part of the process. So, everything from March to the end of the 12:30 year, you are seeming to suggest, was not of direct interest to ToR 5 because it was part of that process. But is it not fair to suggest to you that you didn't even gather the information around the issues I have outlined, so it wasn't even known to you? So how could 12:31 you dismiss what was not known to you? Yes?

A. What I didn't know, I didn't know. As I say, my view was that was part of a process which had already started. I was much more interested in what supports and what actions had been taken prior to that. I 12:31 suppose not really March but what flowed from the March letter; did something happen after the March letter? Did somebody support Mr. O'Brien? Was an action plan put in place? I was interested in all those things. 12:31

Things that happened much later in the year, so from the autumn onwards, I felt was the beginning of what this investigation was about. Therefore, I didn't regard that as part of term of reference number 5.

99 Q. Did you know that there had been an Oversight meeting on the 13th September 2016?

A. I knew that there had been Oversight meetings and I knew there was a meeting in the autumn. Without referring to whether I was provided with information about that, Mr. Wolfe, I can't answer that question. 12:32

100 Q. I can't see where you were provided with any information in relation to events after March 2016. So, it rather begs the question why that information didn't come to you, or, in the alternative, why you didn't ask for a timeline of events after March 2016 so that you could begin to break down what was known to managers after that event, the issuing of the letter to Mr. O'Brien and what they knew? 12:33

A. I think I was given -- I mean, I stand to be corrected but I believe I was given an overview timeline of things that had happened -- of some of the things, by the sound of it, that had happened in the autumn of 2016. I believe that I was given some information about that. 12:33

101 Q. If we go to your report, there will be set out a timeline. The report is to be found at TRU-00661. If you turn to TRU-00666 and you refer to the March meeting at the bottom of the page, you say that: 12:34

"Eamon Mackle and Heather Trouton met with Mr. O'Brien to outline their concerns in respect of his clinical practice."

It was, in fact, Mrs. Corrigan and Mr. Mackle who met with him.

Over the page, TRU-00667, you outline the concerns that were identified. Then in respect of the period April to October 2016, you say: 12:35

"During the period April to October 2016, considerations were ongoing about how to best to manage the concerns raised with Mr. O'Brien in the letter of the 23rd March 2016. It was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally. Mr. O'Brien advised the Review Team he did not reply to the letter but did respond to the concerns raised in the letter by making changes to his practice." 12:35 12:36

In November you detail that he was on sick leave or was going on sick leave. Then you refer to the ongoing SAI investigation before December when the formal decision was reached to have a formal MHPS. 12:36

The point I am asking you comes down to this, in essence: You have charged yourself with the task of investigating the knowledge of managers in the period before December 2016 and the actions that they took. Nowhere in this report is there to be found a description of what managers knew within that period and what action they took. We don't find out how the 12:36

Oversight Group grappled with the events with the events after March 2016; we don't find out how they might have grappled with NCAS advice. Is that not a shortcoming in your report?

A. I don't believe so, Mr. Wolfe. As I have indicated, you know, I added -- my understanding is that I added term of reference 5 and it was really about how things were managed before things gathered apace and started to happen. So, perhaps an error on my part is that it shouldn't have said December '16, it should have said before the summer of 2016. You asked me why did I add that term of reference; I added that term of reference because it seemed apparent to me that people spoke to Mr. O'Brien in March '16, and what wasn't apparent to me was what was done as a result of that letter. So that's why I added the term of reference. It was about that period where I felt maybe something else could have been done, both by the Trust and by Mr. O'Brien, to address those issues. So anything that happened beyond the summer of '16 was, to my mind - and I mean perhaps I haven't been explicit enough and clearly I haven't in the report - was to my mind out with that. Once the process started, it started. 12:38 12:38 12:38 12:38

102 Q. Okay.

A. And that's not up to me to -- I didn't feel that that was -- that wasn't my remit to have a look at that. I felt it was about understanding what happened at an early stage, and maybe I should have said that. 12:39

103 Q. In fairness to you, and I will put it out there now so

that you can address it, your report does, of course, go on to say that the failure to address matters after March was a missed opportunity. I will just find the reference. If we go to TRU-00703, you say at the top of the page: 12:40

"The above issues" - and that was dictation and triage - "were raised in the correspondence in March 2016. However, there appears to have been no management plan put in place at that time and Mr. O'Brien seems to have been expected to sort this out himself with no arrangements for monitoring or changes to practice were being made and sustained." 12:41

But is it fair to say it's no more than that; you don't identify the managers concerned with this shortcoming. You feel you didn't need to go to the NCAS advice or ask questions around what was happening in September and October, even if you didn't know directly about the NCAS advice? 12:41

A. I mean, as you have indicated, Mr. Wolfe, I do later in the conclusions indicate that management could have taken action at an earlier stage. The investigation was in relation to Mr. O'Brien rather than specifically about the managers. I added that term of reference because I felt that it was a fair, equitable, reasonable thing to do. But NCAS advice and Maintaining High Professional Standards advices around doctors as opposed to, you know, shortcomings or 12:42

failings of other people, so I felt that it was important that I highlighted this and then it would be up to somebody else to have a look to see, you know, what else needed to be done.

12:42

I still -- I mean, I accept everything you have said and I still don't think I would have done it differently. I still think I was looking for what assistance was given to Mr. O'Brien after March, you know; who did what in relation to that, and even prior to that. That's what I was interested in and that's the area that I covered.

12:42

104 Q. But it's about more than being equitable and fair to Mr. O'Brien, isn't it? This term of reference was formulated by you, assumedly with the approval of Dr. Khan, in order to get to grips with whether things could have been done better by Trust management in light of the concerns that were identified?

12:43

A. Yes. And I think my report does highlight that things could have been done better and there were missed opportunities. I believe I concluded that.

12:43

105 Q. Although you have said I am looking back from December 2016, you, in fact, only looked back so far?

A. Yes. I mean, in effect - and I say that and I do absolutely accept, I have said December '16 - I really only looked back from -- anything that happened from the autumn time to my view was part of this, and I only looked back from before that. Absolutely.

12:43

106 Q. In terms of setting terms of reference, can I broaden

this out as I think it's probably an important issue. The Trust has told the Inquiry through its witnesses that, in 2020, a range of issues relevant to Mr. O'Brien's practice were discovered; the Trust considers those matters to be shortcomings of practice. 12:44
This was investigated through a number of processes, including nine SAIs.

Now, the MHPS investigation set off in 2017 and didn't identify the kinds of issues that were discovered in 12:45
2020. The question, I suppose, that arises is should other aspects of Mr. O'Brien's practice have been the subject of MHPS investigation when you took up the reins? In light of your experience across a number of MHPS processes, can you help us at all in terms of the 12:45
development of terms of reference; how is that done; could it be done better? The public will want to know why an investigation that took so long under your watch didn't get to find what was there perhaps to be found, and was only found two or three years later? 12:46

A. First of all, Mr. Wolfe, I didn't know about the additional issues raised in 2020, I'd already left the Trust by that point. I suppose what I would say is that terms of reference -- so, how this process works is that there is an initial screening process, and then 12:46
terms of reference are drawn up and then a Case Manager is appointed and then a Case Investigator is appointed. I have used the phrase earlier but I think it is relevant, this is not a fishing exercise. You know,

terms of reference are clearly and specifically and very often precisely written. Really, the Maintaining High Professional Standards document indicates that actually - and I think the NCAS document actually takes that even further, makes it more clear - that you are not there to start looking at every aspect of a doctor's work, you are there to look at areas which have been specifically raised as an issue. 12:47

However, during the process, if somebody comes along and says something to you which rings bells, well then, of course it's your responsibility as an investigator to raise that with the Case Manager. I have identified, I have highlighted already that on one occasion that occurred and we raised it. But I was quite shocked by the findings that came out in 2020 because we had no inkling through the investigation - and I understand you will get evidence, you will receive evidence from Mrs. Hynds as well, I expect she will say the same - but I had absolutely no inkling. In fact, quite the opposite. The information that I was being given by almost everybody was that this was a good clinician who, in fact, was overinvolved; spent too much time with patients; wanted to do advanced triage, you know, look up blood results, look up imaging, send people off for other investigations, you know, before, you know, progressing to seeing the people, the patients. The information I was receiving was that there were no clinical concerns. 12:47 12:47 12:48 12:48

I mean, the patient outcome concern was to do with administration. You know, if you are not properly, you know, reading triages and putting them into a filing cabinet drawer, well, that has the potential to impact on patient outcomes. So of course patient outcome was something that we considered in this and we looked at those, at the five cases that were highlighted. But nobody at any point suggested that either there had been any previous or other concerns or that there were any clinical concerns in relation to how Mr. O'Brien was performing as a clinician. 12:49 12:49

107 Q. I'm not suggesting to you, Dr. Chada, that at the point that you entered the process as an investigator you should have free rein to go wherever you want with the investigation. I'm talking about the stage before that. You call that stage, quite properly, screening. 12:49

Let's start with the proposition, would you agree with me that what was known to the Trust was that Mr. O'Brien had shortcomings on the administrative side of his practice which had a clinical or a patient safety dimension? 12:50

A. Yes.

108 Q. I mean that covers the triage issue; it covers the dictation issue, doesn't it? 12:50

A. Yes.

109 Q. Now, as part of screening, is it not within the gift of the Trust - and it is the people who instruct you so

it's the people in the Oversight Group, perhaps, or it's clinical managers - depending on how it's done and the Trust may have done it in a way that wasn't entirely consistent with the process written down. However it's done, would you agree with me that there is an opportunity, indeed a responsibility, at that point to sit down and effectively screen the practitioner's practice to see what it is that should be investigated? 12:51

A. Yes, I think it's part of the screening role to decide what areas of practice need to be addressed or need to be investigated. 12:51

110 Q. Let's just look at what the NCAS guide says about this. If we go to WIT-41400. It asks:

12:51

"What should be considered in making a decision to investigate? Before deciding whether a performance investigation is necessary, consider what other relevant information is available."

12:52

Just before that, I beg your pardon, it says at the top of the page:

"The purpose of screening is to identify whether there are prima facie grounds for an investigation and if there are, to set Terms of Reference which are sufficiently detailed for an investigation to proceed. It is essential that managers sets aside dedicated time to address initial screening so it can be completed 12:52

properly and quickly".

Then, at 1.3, it's essentially telling the Trust what could be taken into account as part of screening, what should form part of screening. 12:52

"This could include clinical or administrative records; serious untoward incident reports or complaints; earlier statements are introduced for people with first-hand knowledge of the concern; clinical audit and 12:53 clinical governance data; the views of professional advisers; earlier occupations health reports."

That's not an exhaustive list. It appears to be suggesting that relevant decision-makers should 12:53 carefully think through what it is that should come within the terms of reference of an investigation.

Would you agree with me that if there are administrative-type shortcomings in one area of 12:53 a clinician's practice, it would be within the obligations of a Trust and its decision-makers to set the terms of reference wide enough to enable you, as the investigator, to explore whether those administrative shortcomings exist elsewhere? 12:54

A. I suppose it's the balance between earlier things in NCAS, which is about not making this so wide that, number 1, the investigation is unmanageable, and number 2, that you are just saying I am going to look at all

practice and see if I can find something. I think it's about -- my view is that, yes, of course screening needs to be properly carried out, of course it does. But I think if there are specific areas of concern that have been raised by managers or by SAI reviews or by complaints or by patients, well then, those are the areas, and issues around those areas certainly. I don't think it's a well, let's look at everything. 12:54

I suppose, Mr. Wolfe, and I have said earlier, you know, Mr. O'Brien's colleagues and managers, certainly who gave evidence to -- who I was involved in interviewing, were certainly very clearly saying that they had no concerns about his clinical practice, you know, other than, you know, the potential for patient negative outcomes because he wasn't doing things like triage which he didn't agree with. You know, as I say, people seem to think that other areas he was spending lots of time on and those seemed to be clinical areas. 12:55

111 Q. They were answering questions within a particular framework, the framework being your terms of reference. 12:55

Let me test you with this example. We know that in 2020, Patient 5 and Patient 8 were the subject of Serious Adverse Incident Reviews because, at least in part with regard to Patient 5, it was alleged that Mr. O'Brien had failed to action a CT scan, the results of a CT scan. With Patient 8, he had failed to action the results of a pathology report. Now, I know this 12:56

is, in some respects, a foreign planet to you but that was what was revealed in 2020.

If we rewind the clock to 2010 and 2011, there was a never event; the never event involved a retained swab in the cavity of a patient in respect of which Mr. O'Brien was the surgeon. There was a scan produced which would have suggested there was a pathology there that needed further investigation, but the scan wasn't looked at. Now, when Mr. O'Brien, and others, in the urology team were told about the importance of actioning the results of scans or looking at scans as soon as they would be available, he responded in a particular way. I will ask you just to look at this; TRU-276805. 12:56 12:57 12:57

So, back in 2011 he is writing to his Head of Service and he asks a series of questions which reveal his concern that there may be an expectation that investigative results and reports are to be reviewed as soon as they become available. So, it's for others to judge, but that might suggest that he was oppositional to that notion that he should review investigative reports and results as soon as they become available. 12:58 12:58

Given what we know happened in 2020, but given also what we know about Mr. O'Brien's attitude to these matters in 2011, which you might accept is broadly within the sphere of administrative processing of

matters which could result in patient harm, would you agree that, as part of screening, this is the kind of thing that should have been considered by the Trust?

A. I suppose 2011 is a significant amount of time before the screening was carried out. I don't know what the people who were doing the screening would have been aware of. I know that at the end of our interviews with people -- you have made the point, Mr. Wolfe, that we specifically asked questions in relation to a very tight term of reference, which we did. However, at the end of each interview, I would have said to the person, you know, there will be a statement drawn up, if you have anything else to add, if you think there's anything else that is of relevance to this investigation, please add it. 12:59 13:00 13:00

I have never been involved in -- I have to be honest and say I have never been involved in a screening or a scoping issue. I have always only ever been the Case Investigator or a Case Manager, neither of which are involved in those processes, so how screening is carried out, I really can't give an informed opinion about that because I really don't know. 13:00

112 Q. Have you anything to suggest to the Inquiry in light of your experience about how a Trust operating within the rubric of MHPS can ensure that when issues such as those that were raised in 2016 and into '17, how they can be translated into Terms of Reference which encompass other areas of the practice that perhaps 13:01

aren't known?

A. I suppose, looking at this e-mail, which I've never seen before, but looking at this e-mail and the case that you have outlined in relation to the retained swab, I suppose I would have assumed that when one was screening, one would have looked at adverse incidents, never events, things like that that had occurred in the past, I would have made that assumption. But I do have to preface that by saying I have no experience of screening, I don't know if there are limitations to time frames. I really don't know how screening happens and, therefore, I really don't feel I am the best person to comment on that. 13:01 13:02

113 Q. Very well. I think I have taken that as far as I can with you. It's one o'clock? 13:02

CHAIR: Two o'clock, everyone.

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon, everyone. Mr. Wolfe.

114 Q. MR. WOLFE KC: Good afternoon, Dr. Chada. I want to spend the next few minutes just talking about your approach to the witnesses who you thought were important to speak to as part of your investigation. Just if we could pull it up briefly on to the screen, WIT-23762. It's the bottom of page 4 of the speaking note, Chair. 14:05 14:06

At paragraph 1.13, just scrolling up, you say:

"A list of witnesses was agreed by Mrs. Hynds and I after reviewing the terms of reference. I quickly realised this would only be a few of the people who would need to be interviewed. The list was shared with Mr. O'Brien with the information that this was an initial list and we may identify others in the course of the investigation as it progressed. I am unable to recollect exactly how the witness list was put together. Certainly I am aware of having input into the witness list in that I realised we needed to speak to the current managers of the Service to begin with, Ronan Carroll and Ms. Corrigan, as well as the Clinical Director, Mr. Young..." 14:06 14:07

I think that should be Clinical Lead in the interests of accuracy. The Clinical Director was Mr. Weir, as we understand the position. In any event: 14:07

"... to understand how the Service functioned and its account of the issues. Having read the investigation chronology to date, I felt it was important also to interview Mr. Eamon Mackle who had previously been the Clinical Director and whom I had understood had raised issues with Mr. O'Brien previously, as well as Mr. Weir, who also had clinical managerial responsibility more recently." 14:07 14:07

So, you don't have a clear recollection of how this evolved. Were you to some extent dependent upon what

Mrs. Hynds knew of the intricacies of the issues?

A. I believe, Mr. Wolfe, by the time I was parachuted in, if you like, there was some witness list had already been put together by Mr. Weir and --

115 Q. Yes. Indeed just to help you, maybe we can bring that up on the screen, TRU-283124. This is the first list that was being circulated. I cut across you, sorry. 14:08

A. No, I was going to say I thought there was some list that had already been sort of considered in terms of who were the managers responsible sort of at that time. And I think that was the point when it became apparent that Mr. Weir couldn't remain as a case investigator because he might be on this witness list or might be asked to be on the witness list. 14:08

14:09

I think I got those names and then whenever I got the information in terms of the background information and what we were -- the terms of reference and what we were tasked with investigating, I sat down with Mrs. Hynds and had a discussion about who else would need to be interviewed. Mrs. Hynds would have been very helpful in terms of -- because I didn't work on the Acute side, I probably had less knowledge of the sort of structures around medical records and things like that. In Mental Health and Disability we have our own medical records system, which is a little bit separate because of the nature of mental health notes which traditionally would have been almost prioritised in terms of confidentiality. Mental health notes are not included 14:09 14:09

with Acute notes, so they are two separate set of notes. I would have had a lot of familiarity with medical record staff within my own directorate but not so within the Acute Directorate. So Mrs. Hynds -- I would have said, well, we need to speak to somebody about, and we need to speak to Mr. O'Brien's secretary but I wouldn't have known who these people were, whereas Mrs. Hynds would have come back and said oh, you need to speak to, that's the name, and that's the name of that person that you have identified. 14:10

I would have identified probably roles rather than people. Then, Mrs. Hynds very kindly would have found out the answers to the questions and then come back to me and said, look, this is who you mean. 14:10

116 Q. Yes. We can see, just by way of example of how this is developing, TRU-283129, just. Scroll down six pages, maybe, it might be quicker. 283129. It's maybe over the other side. This is an e-mail -- back up again, sorry. 283129. Yes, we have seen this e-mail earlier. 14:11

You are adding at this point, as you mention, a proposed witness list. If we scroll down the page to 130, these are some additional names we now see. Mr. Mackle has been added, and Mr. Weir. Then as we are about to see, other names are added over time. Ultimately, including Mr. O'Brien, you speak to 14 witnesses. 14:11

I want to ask you about your approach to those witnesses in a moment. Before I do so, in fairness to you, Mr. McAllister gave evidence and he was asked whether he gave evidence or information to the MHPS process, and he said that he didn't. This is when he gave evidence to the Inquiry and the reference is TRA-02803. He said:

"I would expect that they would give the reason that I was on sick leave. However I wasn't on sick leave for 17 months and I wasn't asked. I presume they didn't want to hear what I had to say".

Now, just in fairness to you, dealing with what Mr. McAllister has said, did you ask to hear from Mr. McAllister, who, as you know, was Associate Medical Director covering Urology for a short period of time in 2016?

A. It's Dr. McAllister.

117 Q. Dr. McAllister.

A. But that's okay. Sorry, that's me. So Dr. McAllister, as you have indicated, Mr. Wolfe, was Associate Medical Director for quite a short period of time during 2016. When we considered witnesses, Dr. McAllister was off sick and I wasn't aware when he returned to work. Of course, this process did take quite a long time but I really felt that by the summertime, we needed to have those witnesses interviewed that we were going to interview. I wasn't aware that Dr. McAllister could

add anything more than what other medical managers had already told us so I didn't ask for Dr. McAllister to be present.

As I say, my understanding was that he was an Associate Medical Director for a short period of time, there was a matter of sickness, there was a matter of other things that he was dealing with, and I felt that I had enough information from the medical managers that I did interview. 14:14

118 Q. He may have had relevant evidence to give around ToR 5 again. Let me put it in this way: The Inquiry has seen from him an e-mail which he posted shortly after taking up the Associate Medical Director role. We can find that e-mail at TRU-14875. Rogue reference. Try 14877. Thank you, Mr. Lunny. Just wait until we see the date at the top. So he has written, that is Mr. McAllister, on the 9th May 2016, and Dr. Wright is replying. If we just scroll down to see the substance at 6, please. 14:14 14:16

"As regards Urology..."

He is writing to Dr. Wright to say there's issues of competencies, backlog, triage and referral letters, not writing outcomes in notes, taking notes homes, and questions being asked regarding inappropriate prioritisation of the NHS of patients seen privately. 14:16

So he has given evidence, it appears, that he, very early in his role as AMD, he had a good handle on the issues that were emerging in relation to Urology. You will recall this is in the close aftermath of Mr. O'Brien receiving a letter asking him to deal with four issues.

If your concern in ToR 5 is to understand what was known by line managers, and clearly Dr. McAllister was a line manager, is he somebody you should have sent inquiries out to on whether he was able to speak to you? 14:17

A. Yes. I think Mrs. Hynds and I did have a discussion about Dr. McAllister and, as I said, I think that he was either on sick leave or just returning from sick leave, and I felt that the issues that Dr. McAllister would have been aware of at that time were similar to the issues that were already outlined in the letters from -- in the letter written by Mr. Mackle. So, I wasn't sure if he had anything else to bring along. 14:17

But I absolutely accept that, in terms of considering what the Trust did beyond or what -- beyond that letter of March '16, it would have been helpful to have ... I haven't seen this e-mail before but it would have been helpful for Dr. McAllister to have been one of the witnesses. 14:18

119 Q. Because plainly he took over from Mr. Mackle?

A. Yes.

120 Q. And if part of your interest is to see whether Mr. O'Brien was supported to make changes in his practice, a key person, arguably, the senior line manager on the medical side or on the clinical side, is Mr. McAllister? 14:18

A. Well, I did ask whether there was any action taken by Trust managers in relation to that letter from Mr. Mackle and I was told that there wasn't, that there was no formal action that came out of it, or action plan or further correspondence or contact with 14:19 Mr. O'Brien. That's what I was told. And I don't know if Dr. McAllister gave evidence to the contrary.

121 Q. No, but what there was was a series of events through Oversight Committee and the NCAS advice leading to a decision to have an informal investigation, that 14:19 decision being set aside and a decision being taken to approach it in a different way. But none of this is being drawn to the attention of Mr. O'Brien; no support being provided to Mr. O'Brien to enable him perhaps to avoid the formal MHPS, which came in December. It 14:19 appears from what you are saying that you were unsighted at least in terms of the fine detail of that, although you were sighted on the fact that nothing was done essentially?

A. Yes, I was aware that nothing had been followed from 14:20 the meeting in March 2016.

122 Q. Yes.

A. And I wasn't aware that Dr. McAllister had made any plans or had taken any action. I wasn't aware of that.

123 Q. Now, in terms of the witnesses you spoke to, 13 interviews were conducted between the 15th March and the 5th June. If we just have up on the screen, please, the timeline for that, TRU-00671. You started with Ms. Corrigan and, just over a week later, Mr. Young, and then a gap of just over a week, Mrs. Graham and so on. 14:21

Would it have been ideal, Dr. Chada, to have had, I suppose, less gaps in terms of gathering information/evidence from witnesses rather than spreading it over a three-month period? 14:21

A. In terms of the overall timeframe, clearly it would have been preferable to see people fairly close together in terms of comparing what different people have to say. That would have been helpful. The timings relate to me providing dates to Mrs. Hynds about when I was available; people were providing dates to Mrs. Hynds about when they would be available. Taking into account all of that, and I have to absolutely acknowledge that one of the things that I believe I advised Mrs. Hynds was that this investigation would not impact on patient care, so I tried very hard to facilitate timings around -- I didn't want outpatient clinics cancelled, I didn't want theatre lists cancelled, so things like that had an impact. On reflection and in terms of the time that it took, you know, perhaps that was a foolish aspiration that I had, but -- but, look, that's what we did. Yes, 14:22 14:22 14:22

is the short version, I am so sorry. Yes, it would have been preferential to have them all closer together, of course.

124 Q. Yes. The format or the process that you adopted when speaking to witnesses, was it essentially to interview them, you leading the interview, both you and Mrs. Hynds taking notes, Mrs. Hynds perhaps intervening to ask for clarification on certain points, and then Mrs. Hynds going away and producing a draft statement to be considered by the witness out of the notes that you and her had jointly assembled? 14:23 14:24

A. Yes. Mrs. Hynds would have written to the witness and explained that this was an investigation under Maintaining High Professional Standards, that this was a confidential issue that they shouldn't discuss, and that they would be asked questions in relation to the terms of reference which were sent to them. Then when the person identified -- when the witness attended, sorry, we both would have taken notes. I am a prolific note-taker, I write very quickly. I expect Mrs. Hynds will give you evidence that I probably had twice the amount of notes that she had because I tend to do that. At the end of the interview, witnesses would have been asked if they had anything else that they felt was relevant, anything that we hadn't asked about. They would have been reassured that a statement will be drawn up that they would have sight of, and that if they wanted to make corrections or additions, that they could contact either Mrs. Hynds or me. Then, 14:24 14:24 14:24

Mrs. Hynds would have gone away with her set of notes and would have drawn up a statement. She would have sent it to me; I would have gone through my handwritten notes and compared it to the statement and if there's anything else that I felt was relevant, I added that, it went back to Mrs. Hynds and she shared it with the witness, who, if they had changes, then they got back to Mrs. Hynds and those were made. Then that was how the witnesses -- and then they were asked to sign them.

125 Q. Could we just look at the chronology around this. If we turn to TRU-283629. Let's try TRU-283635. So, this is an e-mail to Martina Corrigan on the 15th August from Siobhán Hynds, and you are copied in. It's telling her: 14:25 14:25

"Please see attached statement from our meeting on the 15th March. I would be grateful if you could review and sign and return a copy to me if you are happy with the content. If you wish to make any changes, please highlight them on the attached document and return them for consideration." 14:27 14:27

So, as appears from the chronology, several other e-mails go out to witnesses on the same date. Mrs. Corrigan was the first witness to be interviewed, five months earlier? 14:27

A. Mm-hmm.

126 Q. What explains what I think you might accept was a very significant delay before the witness gets to see what

you have interpreted from the interview as being her evidence?

A. I'm not sure when the original draft from Mrs. Hynds came to me. I may have been responsible for some of this delay. In fact, I suspect I was responsible for some of this delay. For example, I know July there was a lot of holidays. There was annual leave, for example, Mr. O'Brien, myself, Mrs. Hynds. So, I know July was difficult. 14:28

I do know that, and I have mentioned earlier, we had a very serious event in the Trust in May, late May -- well, May 2017, so that may have delayed my input into this. I'm not sure what other delays were caused and whether those were Mrs. Hynds' responsibility or my responsibility. I apologise, I don't know. But I absolutely accept that that's a long period of time. 14:29

127 Q. All of those witnesses were interviewed in that three-month period ending in June?

A. Mm-hmm. 14:29

128 Q. And even by the 31st October - if we just bring up AOB-01766 - this is now the 31st October. Mr. O'Brien had been first interviewed with you on the 3rd August, more than two months earlier. We will look at that interview in a moment, which, as we now know, went ahead without the provision of any statements to him. By the 31st October, three witness statements are still outstanding to him in terms of sharing them with him. 14:30

Again, the delay in the process, was it simply down to resources between you and Mrs. Hynds to get them in a fit state to be disclosed to the witness in the first place for agreement and then out, or were there other factors at play? 14:31

A. I am not aware of other factors. As I explained, the process was Mrs. Hynds would type it up the statement, she would send it to me, I would compare it to my notes, I would make changes, I sent it back to her. All of that was being done without, for example, admin 14:31 support. You know, Mrs. Hynds, I'm aware, was typing these herself, which I think I highlighted in my Section 21 notice, that here was a very senior person within the Trust who was spending evenings typing up things, which I felt wasn't a good use of either her 14:31 time or my time.

Perhaps what wasn't helped was Mrs. Hynds doing it, sending it to me, me adding bits to it because that, of course, causes delays with every person that needs to 14:31 sort of look at it, and then it went back to the person and then they had to check it and send it back with any amendments. So, it was a slow process. I absolutely accept that at least some of those delays were down to me and some of those delays were down to lack of 14:32 administrative support.

129 Q. Would you agree that the longer you get away from the date of the witness interview, the more difficult it is, at least for the witness, to try to remember and

capture in a pure and consistent form what they have told you?

A. Yes. Yes, of course I would. Yes.

130 Q. It comprises -- it potentially at least comprises the quality of the evidence? 14:32

A. Yes, I absolutely accept that the longer it takes. I would also say, I suppose, that Mrs. Hynds had handwritten notes, I had handwritten notes. Mine certainly, as I have said, were really very comprehensive. But yes, I absolutely accept that 14:33 asking somebody to remember what they said five months earlier is not particularly helpful.

131 Q. Did any witnesses express concern about Mr. O'Brien seeing their statement or were they otherwise reluctant at any point to come back to you? 14:33

A. I mean, witnesses in general -- I think witnesses in general who were non-medical witnesses find this process quite difficult and I dare say intimidating. I mean, we did our absolute best to reassure people but I felt that they felt it was intimidating. I felt 14:33 non-medical managers, non-medics generally found it difficult to be giving what they felt was evidence or giving a witness statement about a doctor. I think they found that difficult.

14:34

Some of the witnesses, I mean at least one of the witnesses was shaking as she walked into the room and I spent a significant amount of time trying to reassure her that this wasn't about her and that nothing she

said was going to get back to Mr. O'Brien in detail, but that obviously we were taking a statement and that the information that she gave us for that statement, he would have to have sight of. So, trying to --

132 Q. Who was that witness? 14:34

A. Mr. O'Brien's secretary was really very anxious about the whole process, and I think had felt that she was in a difficult position in terms of divided loyalties and those type of things. Doctors and secretaries tend to have a very special relationship, and I think it is 14:35 difficult for secretaries that feel in some way their -- I don't know, just not being loyal. Certainly the secretary found it difficult.

Some of the managers, I felt -- I mean I couldn't tell 14:35 you off the top of my head but I felt some of the managers found the whole process very anxiety-provoking.

133 Q. Is there any work, do you think, to be done around the culture that creates that kind of, I suppose, fear that 14:35 you are describing, or sense of foreboding? I mean, is there a need for colleagues in this context come witnesses to better understand and better buy into the idea that performance issues need to be properly investigated? 14:35

A. I think a lot of progress was made, I hope a lot of progress was made after the Mid-Staff Inquiry because I think it addressed exactly this type of thing, that you have these very senior consultants who tell you how

it's going to be and that's how it's going to be. I think in medicine we have moved well towards working in teams and having a team responsibility for a caseload. In psychiatry we have done that much sooner, I suppose, than some of the others because of the nature of the work. I do think that helping people from the ground up to understand that this is not -- this is not an awful experience and that it's very important to raise concerns, and that anything that you say will be taken seriously, and that actually you have a responsibility. I mean, I have been involved in governance work in the Trust beyond this where we did governance teaching in a multidisciplinary way. 14:36 14:36

It was very interesting, as doctors, watching how difficult it was for secretarial staff and admin staff and even nurses to some extent to feel that they had a role in raising concerns. You know, it was very interesting to go along to some of those meetings where we were encouraging people from every level to raise concerns and to be aware of their responsibilities in doing so. 14:37 14:37

134 Q. Thank you for that. Your witness statement helps us to understand the extent to which your investigation was dependent upon progress being made by the Trust in what might be regarded as a parallel process. That is, a process of urologists in the Service working through the triage or the non-triage cases and the non-dictated cases and then producing results that were, I suppose, 14:37

fed through to your investigation and, in addition and perhaps subsequently, Mr. Young's work on the private patients.

I want to ask you about that. In your witness statement at WIT-23762 - just scroll down to 1 of 16 - you say that you realised that this work was creating a lot of additional work for the urologists, and you suggested via Mrs. Hynds that Dr. Khan should approach Dr. Wright and discuss the possibility and discuss further assistance to move that part of the investigation on more quickly. 14:38 14:39

"I felt it was important we had as much information as possible before we met Mr. O'Brien so that he would know the extent of the issues and have an opportunity to address those concerns. This information is all included in e-mails from Mrs. Hynds to Dr. Khan". 14:39

Just on that, were you concerned that, in essence, the process of looking at the dictation and non-triaged cases was slowing up your work? 14:39

A. It was more that I felt that -- I suppose some of the issues about patient outcome and whether there was an impact on patient outcome. One of the things that I wanted to be able to put to Mr. O'Brien in relation to the terms of reference was not only did this happen but was there an impact on patient outcome or a potential impact on patient outcome. So, I was keen 14:40

to have that information.

I suppose, in retrospect, and again this is something I have reflected over, you know, whether the exact numbers made any difference, you know, now I look back and realise that it probably didn't. If it was anything more than a handful, it didn't matter whether it was 400 or 200. No disrespect intended to those patients, of course, but the fact is, if it was more than a handful, then that was enough for me to have been concerned and to put that to Mr. O'Brien. Now I look back and think, you know, the fact that there was an issue and that there was hundreds of people involved was probably all that I needed to know. 14:40 14:40

What was helpful, as I said, was to know whether there were actually any adverse outcomes that we could then put that to him as well. That's what I thought was important at the time. As I say, you look back and you think, well, maybe I could have done it a different way. 14:41 14:41

135 Q. Yes. Well, thank you for answering that. I will go on in due course to look at your report and look at the information that Mr. O'Brien gave you around, for example, numbers around the issue of the 13 sets of notes that weren't ever recovered and issues like that. Would you be in a position, Dr. Chada, correct me if I am wrong, if you were wholly dependent on information coming to you from the operational and clinical side of 14:41

the Trust that was fed in to you and you had no means to independently interrogate that information?

A. No.

136 Q. Is that --

A. Yes, yes, I was wholly dependent. And no, I had no means to interrogate that. 14:42

137 Q. You drew our attention this morning to the situation that occurred, you say, early in your investigation whereby a witness drew your attention to a clinical-type issue concerning the failure, as the witness saw it, or the refusal as he saw it, on the part of Mr. O'Brien to assign clinical priorities to patients coming through theatre; is that the nub of it? 14:42

A. Yes.

138 Q. Just for the Panel's eye, let's just look at this briefly. I think you fully explained it this morning, your point being that the MHPS process allowed witnesses to raise other concerns that were maybe outside of the terms of reference which you would then, in turn, communicate back into the system for remedial action to be taken, if appropriate? 14:43 14:43

A. Yes.

139 Q. TRU-283201. Scrolling down, please. The witness concerned was Mr. Carroll. He had been interviewed by you and Mrs. Hynds the day before, on the 6th April. He's writing to you to say: 14:44

"Please see attached the operating the theatre lists for all urology consultants this week. In summary all

but Aidan O'Brien reference the clinical status on their lists".

If we scroll down, I hope to the next page to illustrate that. Perhaps not. 14:44

A. I am sorry, was that e-mail sent to me?

140 Q. It was. If you want to go back up again. So yes, he is addressing both you and Siobhán Hynds.

A. Sorry, I am not Neeta Gupta.

141 Q. Sorry? 14:45

A. What I can see on my screen is Siobhán Hynds and Neeta Gupta.

142 Q. You are right.

A. I don't know who that is.

143 Q. Yes, it's a later e-mail I had in mind. 14:45

I just want to illustrate to the Inquiry how this filters through the system. If we go to TRU-268080. Just before we leave this page, scroll up, please.

A. There I am there. 14:46

144 Q. That's what I had in mind, I beg your pardon. I think it's the case that Siobhán Hynds copies you and Dr. Khan in on the 11th May?

A. Yes.

145 Q. Could I ask you about another issue that was raised with you. If we go to TRU-0787. TRU-7787? Thank you. This is part of Mr. Haynes' statement which was prepared for your investigation. If we scroll down to paragraph 27, he says: 14:46

"I am aware the previous AMD, Mr. Mackle, raised issues with Mr. O'Brien and that this had become very difficult. Operationally Martina Corrigan knew of the issues and I anticipate he escalated these concerns. The problem were well known in medical records. Other people must have known, such as anaesthetists, and he says he was taking people to theatre without clear notes and at times with no pre-op done." 14:47 14:48

So, that's an issue out with your terms of reference, another potentially serious problem. Did you do anything with that information; did that go back to Dr. Chada or the Medical Director?

A. The issue about not having clear notes and notes not being available was one of the terms of reference in the Inquiry, so that was something that I felt people already knew. 14:48

146 Q. Mm-hmm.

A. The issue about no pre-op done, I, perhaps wrongly, assumed that that meant that the pre-op was done on the day of surgery. So, there was a period when I was a very junior doctor where pre-ops were done on the day of surgery or when somebody was admitted the day before surgery. Things had moved on since then, and perhaps my lack of knowledge about this, I assumed that what was being said here by Mr. Haynes was that pre-ops were done on the day of surgery, so somebody comes in for surgery, the anaesthetist comes and see them before 14:48 14:49

they go into theatre. So, the clear notes issue, I felt was already one of the terms of reference. The other issue, I didn't understand the relevance of that.

I look back now and I realise with hindsight with the information that came forward in 2020, but at the time I didn't realise the relevance of that at all. 14:49

147 Q. Did you seek to clarify it with Mr. Haynes?

A. If I had, it would have been in that statement. I think I made an assumption about what that meant and that's what was said and that's what was documented. 14:49

148 Q. You would agree that there's a particular onus on Case Investigators to be vigilant when speaking to witnesses, particularly clinical witnesses, where they are drawing your attention to issues of concern about the clinician's practice that maybe don't fall within the terms of reference but, as we have seen with what Mr. Carroll told you, are potentially significant for the Service and potentially significant for patient safety? 14:50 14:50

A. Yes, of course, and that's what the Case Investigator is tasked to do. I understood that an IR1 had been raised in relation to this so that the Trust was aware of it, but ...

149 Q. Do you know the name of the case? 14:50

A. No.

150 Q. When did that information come to your attention?

A. I think at the time. I thought Mr. Haynes mentioned that he had put in an IR1. Perhaps it wasn't about

that. I thought he had mentioned in his statement that he had put in an IR1.

151 Q. Certainly an IR1 was raised in respect of Patient 90, you will see mentioned in your cipher list beside you. But that was a case that came into theatre on the 9th May 2018, after your investigation. In that case, we can see -- just if we look at the SEA case for that case, TRU-161137. The date of the incident was 9th May 2018. If we scroll down to the bottom of 43, page 43 in this series. I am very conscious, Dr. Chada, that you won't have heard of this case, but Dr. 1 in this case was Mr. O'Brien, and the patient was seen by Mr. O'Brien and he was the surgeon. It records that the patient was pre-admitted for surgery on Thursday the 3rd May, and the Review Team noted that the patient did not have a formal outpatient pre-operative assessment as per Trust and NICE guidance. If we scroll down the page, please, and go to the bottom of the page and on to the top of page 44. 14:51 14:52 14:53 14:54

"The Review Team concluded, particularly in view of his co-morbidities, that Patient 90 should have had a formal pre-admission pre-operative assessment with optimisation of his clinical condition prior to surgery. This assessment should have been organised sufficiently in advance of the surgery to allow for all appropriate investigations to be completed". 14:54

Mr. Haynes was drawing your attention to a pre-op

assessment issue just about a year before --

A. Mm-hmm.

152 Q. -- this incident took place, which, unfortunately, after surgery, led to the death of the patient. Obviously there were a multiplicity of factors involved in that death, which were discussed in the SEA. When you look at what Mr. Haynes said in his statement - if I can bring that back up - was it simply a case of not appreciating the significance of that because it was outside your terms of reference, or did it just pass you by as something that he wasn't raising as a particular concern? 14:55 14:55

A. I don't think it was because it was outside the terms of reference, because if a clinical issue is raised outside the terms of reference, then it's a Case Investigator's responsibility to raise that. I think, as I said earlier, I genuinely didn't understand or missed the significance of it and I absolutely accept that that's because I don't work in surgery and, therefore, I'm afraid, 30 years ago when I was a junior doctor, pre-op assessments were done on the day of surgery or the day before surgery. So, I just missed the significance of it. You know, that's simply all I can say on that matter. 14:55 14:56

153 Q. Yes. Could I bring you to the process of engaging with Mr. O'Brien for the purposes of your investigation. It's plain from the e-mails that are available to the Inquiry, and we can bring those up at any point if you wish, that there was some difficulty in trying to find 14:56

an agreeable date to sit down and discuss this. Suggestions were made that you would meet at the end of June 2017; Saturday the 1st July was suggested by him; you agreed with that and then it seemed to fall away as a date that could work, but it was agreed then that 3rd August 2017 would be the date to meet. Have you any reflections upon the difficulties associated with meeting with him? Was that just one of those things, trying to marry diaries? 14:57

A. Yes. I think at the time I thought, well, this is a man who is under a lot of pressure. He wasn't well the previous year. I knew Mr. O'Brien had had surgery; I didn't know what was the reason for surgery. It wasn't appropriate information for me to know. I knew that he hadn't been well, and someone had mentioned to me - I think it may have been Mrs. Hynds - that Mr. O'Brien had reportedly lost ten pounds in weight, so I was conscious that this was a man who was under some pressure. So, at the time I felt that I was trying to be accommodating. 14:57 14:58 14:58

On reflection and as things progressed, and as a psychiatrist, I felt that there was a bit of passive aggressive behaviour evident from Mr. O'Brien. I felt that he -- on reflection, I felt he was trying to manage the timeframe; there was a level of control trying to be exerted. I didn't think about those things in the initial period at all, I have to say, I didn't really know Mr. O'Brien that well. But as the 14:58

situation progressed and as the year progressed, and as things weren't returned on time or e-mails weren't responded to, and then the situation worsened the following -- the beginning of the following year, I really felt that there was an element of control that was trying to be exerted by Mr. O'Brien in the whole process. At the same time, he was complaining about the length of time the process was taking, so it was -- it was difficult.

154 Q. You have said quite a lot there and hopefully we will come to much of it in the course of working through this. In terms of -- I mean, if we look at some of the e-mails, perhaps, because you have suggested that there was a degree of passive aggression on his part, or controlling behaviour when I asked you about the issue of the dates. If we go to AOB 03942, so just at the bottom of the page, please. Work backwards.

Evidently, Siobhán Hynds has written to Mr. O'Brien, perhaps the day before. I think it was the 14th. I can't at this point locate the starter e-mail but it's not terribly important. So, it had been suggested Wednesday the 28th as a meeting date. He is saying:

"It wouldn't be suitable for me to meet for two reasons: Firstly, I would wish to be accompanied by my son, Michael; however, he is in court that day, a commitment he can't avoid. Technically he has scheduled" -- that is Mr. O'Brien has scheduled --

"operating that day and is already committed to a number of patients".

He has asked Siobhán Hynds, politely it seems, to contact her to consider other dates. There's nothing controversial about that?

A. No.

155 Q. Then if we scroll up to the next e-mail, please. Siobhán Hynds tells Mr. O'Brien:

15:01

"There's no difficulty with rescheduling. Dr. Chada has told me the 29th also and the 30th may be possible. Would either of these dates suit you in the morning?"

Scrolling up, we see his response. On up, please, thank you. He is explaining that he becomes Urologist of the Week from 9 a.m. on Thursday the 29th June for the whole week; talks about the handover and the importance of that. He says:

15:02

"I do not know how important it is that I meet with Dr. Chada around that time rather than later. If it is, then most suitable day to have the meeting would be on Saturday the 1st July as one of my colleagues would probably be available to cover my absence, particularly with regard to operating, but I have not asked any of them yet. Would that be possible?"

Otherwise, he will be on leave from beginning the 10th

July. So, other dates not suiting him because of his professional commitments, he puts forward the 1st July, a Saturday, giving up a weekend day, it might be said. Again, is there anything passive aggressive in that or objectionable in that? 15:03

A. I did wonder whether Saturday might have been suggested because it was felt that I might not agree to that. It did cross my mind. However, I was keen to progress this and decided that Saturday would do, so I said to Siobhán, if she didn't mind - because of course it's not just my time on a weekend, and I was aware that Mrs. Hynds has younger children and I wasn't sure if it would suit her - but I think I went back to Mrs. Hynds and said that's okay with me. I believe I had appointments on the Saturday morning, I said if necessary I would rearrange them. 15:03 15:04

156 Q. Mm-hmm. You hadn't met Mr. O'Brien before?

A. Not -- no, no. Yes.

157 Q. Except in a kind of vague circumstances you describe.

A. Yes. I was aware of him, yes. 15:04

158 Q. On what basis would it enter your head that he is playing a bit of cat and mouse with you - my phrase - by suggesting the 1st July? Why wouldn't you take that at face value?

A. Well, it did cross my mind that it was a very generous offer to meet at a time that suited me, yes. It also crossed my mind that it might not be. It wandered across my mind. It wasn't until a bit later that I was more concerned about some of the cat and mouse, if you 15:04

like.

159 Q. It's very honest of you to say that it crossed your mind but what I'm asking you is why would it cross your mind, never having had any dealings with him before, that this might be a bit of a trick or on his part to suggest the 1st July, thinking that you may disagree with it? 15:05

A. Mr. O'Brien was a consultant psychiatrist when I was a junior -- sorry, a consultant urologist when I was a junior doctor. I suppose I knew of Mr. O'Brien, I knew he was a very formal man and I knew he was a very senior colleague. I suppose I did wonder how he would -- these investigations are supposed to be undertaken by somebody of a reasonable seniority in terms of Associate Medical Director, or a Clinical Director if you are investigating a consultant. I did wonder whether he might feel that I was a bit of a whippersnapper. I did wonder whether he might feel that because of the fact that he was really quite senior to me in terms of experience and years. So, I did wonder about that. As I say, knowing that he was quite a formal, proper gentleman, I did wonder whether he -- it did cross my mind. I mean it really was as simple as that. It crossed my mind, I dismissed it and said yes, Saturday will do. 15:05 15:05 15:06 15:06

160 Q. I am sorry to press you on this, Dr. Chada. You had no basis at all upon which to be suspicious of Mr. O'Brien's motivations in suggesting this date?

A. No, no, not at that time. As I have said, it crossed

my mind but I had no real concerns at that time that there were any other factors.

161 Q. If we just scroll on up, please, so that I can see the start of the e-mail and I can read down.

15:06

So, Siobhán Hynds has been in contact with you. In terms of when Dr. Chada can meet, he is passing on your view that you would rather meet later in July when both yourself and -- sorry, you are asking if you would rather meet later in July when both you, Dr. Chada, and 15:07 Mr. O'Brien are back from leave. Alternatively --

A. Yes. I think the e-mail says if that was his preference.

162 Q. Okay. Okay. The alternative is that you would be happy to facilitate Saturday the 1st July if that is 15:07 Mr. O'Brien's preference. You have a number of preplanned appointments on Saturday morning and if you are unable to change these, you would be happy to meet in the afternoon.

15:08

So, is there a degree of giving up to his preferences around this?

A. Well, I felt so. I felt if it suited Mr. O'Brien to meet at this time. Of course, I was mindful of how long this whole process is taking. I really wanted to 15:08 meet Mr. O'Brien before the summer recess because people do go on holiday. So I thought, look, if it suits Mr. O'Brien, then I will try and facilitate that.

163 Q. Then if we scroll up the page. He says that he

appreciates your flexibility and he says he feels it would be better to defer the meeting to later in July; says the only date prior to the end of July when he could have attended would be Thursday the 27th but his son cannot, and therefore he proposed to meet with you on Monday, during the week beginning Monday 31st July. He is suggesting Monday itself because he has a clinic which could be rescheduled. Ultimately, the date that's finally arranged is the 3rd August. 15:09

But just going back to how you introduced your view of the difficulties fixing dates, did you mean to say that you observed from your psychiatric expertise, or perspective, passive aggressiveness on his part around the fixing of the date? 15:10

A. I said at the time I didn't. I said subsequently when I reflected on this and as the investigation progressed, I felt that there was -- I felt there was a degree of wanting to control the process. Yes, I felt there was a degree, at a later stage. At that time, as I think I said earlier, at that time I didn't reflect on that. At that time it crossed my mind that maybe this date had been suggested on purpose thinking I would say no. But I wanted to get moved on with it, I dismissed that thought, I thought, look, you know this is a very busy man, he has a number of other commitments, he does need to make sure that his son is available, that's fair enough. At that time I was happy with this arrangement, I thought, well look, 15:10 15:10

that's okay. It was really at a later stage where I started to wonder if perhaps there was some element of trying to control. As I say, that was a later stage.

164 Q. Did you ever give consideration to whether there was an element of Mr. O'Brien simply trying to protect his rights within the process; that he felt perhaps a need to ensure that he was going to be fairly treated within a process which, by this stage in June, looking towards the July or an August meeting, hadn't facilitated him with the provision of a full witness list, any of the materials which you had been sent in respect of dictation, in respect of triage and that kind of thing, and no witness statements? 15:11 15:11

A. I think, as I said earlier, normally, in the normal course of events, for a case investigation and in cases where I've previously investigated, the subject of the investigation is usually the first person to be interviewed, so they don't have access to all those other things. 15:12 15:12

In this case, I felt things needed to be done slightly differently. That was more about feeling that, you know, I needed to come from a more informed position because the terms of reference were there. They were there for a reason. You know, obviously the background work or a certain extent of background work had been done to produce these terms of reference. So, the terms of reference were there; there were some detail 15:12

in the terms of reference. So I was very mindful, as I have said earlier, that Mr. O'Brien was clearly under a significant amount of stress; I was very mindful that this Maintaining High Professional Standards is a very distressing process for doctors. Nobody wants to get 15:13
a letter to say that they are a subject of this. The concern is it progresses and you get another letter to say you are the subject of a GMC Inquiry. These things are anxiety-provoking, and as a psychiatrist of course I am aware of that. 15:13

I felt that, you know, I was trying to be as fair as I could. Some of these witness statements weren't fully completed and so... I would have to say that I didn't realise at the time of that initial interview in 15:13
August the extent of some of the documents that Mr. O'Brien hadn't received. I actually hadn't realised that until we started the interview and, for example, Mr. O'Brien said well look, I don't have a full witness list. I was quite taken aback by that. 15:14
Not only did he not have the witness statements, he didn't have the full list. I didn't know that and I did apologise to him and said look, I'm so sorry, I wasn't aware of that, we will make sure you get that. Anything else that he asked for, I said we would make 15:14
sure he got it. I also said to him that if he had any other comments to make or any other issues to raise once he got those, that he could of course do that and we could certainly -- we would have to meet again

anyway but that we could do that. So look, I didn't realise the extent of the information he didn't have.

165 Q. Yes. It is possible, isn't it, and Mr. O'Brien can speak for himself, in terms of his engagement with you, which you have at least, looking back on it, judged to have been controlling, passive aggressive and the words that you have used, that he was perhaps just looking out for himself in a process that was both emotionally difficult, no doubt, and professionally difficult? 15:15

A. Yes. I would absolutely accept that, yes. 15:15

166 Q. Could I ask you to look at AOB-01690. Just scroll down the page, please. This is the 31st July, three days before he's coming in to see you. He says to Siobhán Hynds: 15:15

"In addition to my earlier request, could you please add the details of the nine private patients included in the investigation and the names or names of those who identified them". 15:16

Scrolling up the page, please. Two e-mails that day. The first is:

"In preparation for the interview on the 3rd August I would be grateful if you could provide me with the following." 15:16

The last of the items is:

"A list of the witnesses and their statements."

So, you say you went to the 3rd August meeting not knowing that he hadn't received items such as that?

A. Yes. 15:17

167 Q. Was there good communication between you and Siobhán Hynds?

A. There was a lot of communication between me and Mrs. Hynds but I wasn't aware that -- I wasn't aware that he hadn't received that. I'm not entirely sure 15:17 that Mrs. Hynds, although Mrs. Hynds can speak for herself, I'm not sure that she realised. I think she may have believed that she had sent that but I'm afraid you will have to ask Mrs. Hynds. But I know I was surprised that -- and I think the statement might 15:17 reflect that but I'm afraid I just don't remember.

168 Q. The issue concerning a list of witnesses and their statements was also fed into a complaint letter which you sent to Dr. Khan on that day, the 31st July. Just for the Panel's reference, it's AOB-01675. I don't 15:18 need to open it to the Inquiry but it draws attention in its last couple of pages to these very same issues.

Did Dr. Khan not draw that to your attention?

A. Dr. Khan was on holiday at the time but that e-mail was 15:18 shared with me, maybe the day of investigation or the day before the investigation. I can't quite remember. It was a lengthy e-mail addressed to Dr. Khan; a number of the issues related to Mr. O'Brien's concerns about

the process which had started back in 2016 and how we'd ever got to this point.

169 Q. Yes.

A. So it was quite a lengthy e-mail, and I may have just missed the fact that he hadn't been provided with some of these things. But it was in the letter and I was copied that letter prior to that meeting on the 3rd August. I think I saw it but Dr. Khan didn't see it, if you see what I mean. 15:19

170 Q. Yes, yes. You didn't pick up on the fact that he hadn't been supplied with a witness list? 15:19

A. Yes. I didn't pick up on it on the letter, and then he mentioned it in the interview and I apologised. I wouldn't have delayed the interview anyhow. I mean, I would have to be upfront and say that. It had waited long enough, we needed to get moved on, and I really felt that whatever documents weren't available, if Mr. O'Brien had comments to make, I encouraged him to do that either in written response or that that could be raised at -- you know, if he wanted other meetings, that we could arrange that but I really felt that we needed to move on. I know it was in that -- I know I got that letter, I know I saw that letter, I definitely remember seeing that letter but I've maybe just missed that. 15:19 15:20 15:20

171 Q. As you know, the meeting with Mr. O'Brien on the 3rd August was covertly recorded. I take it to be covertly recorded; you didn't know that it was being recorded?

A. I did not.

172 Q. We can see AOB-56226. Just scroll to the bottom of the previous page, please. So, Michael O'Brien asked:

"Have you spoken to all of the other witnesses now that you will be speaking to, that you have said you were going to be speaking to?" 15:21

You say:

"I think it's really important that we are clear about what this process is about. Okay. I am very happy for you to be here to support your dad but really a lot of this is for your dad and for Mr. O'Brien to raise queries or to raise concerns. You are here primarily for support really". 15:21

He says:

"If you prefer my dad to ask you the question, he will". 15:22

So, you weren't prepared to hear from Michael O'Brien, is that fair, or you wanted to control that?

A. Well, I felt -- I think the issue was complicated by Michael O'Brien's -- about Michael O'Brien's qualifications. You know, the MHPS allows for people to be supported by somebody and it says that they can be legally qualified, of course, but that really they are not there in a legal environment. I felt this was 15:22

a question that if Mr. O'Brien wanted to raise, then look, it could come from Mr. O'Brien. It didn't take somebody else to be raising this. But ...

173 Q. Okay. So, you were concerned about what you might describe as the thin line between him coming here in a representative capacity and coming there to support his father? 15:22

A. Yes.

174 Q. Leaving that point aside and looking at the point that he is working up to. At the bottom of the page, he said: 15:23

"Would you not have provided what day the evidence, all the points that he wants, that is to respond to in detail beyond the points in the Terms of Reference before he would date his witness" -- I think that should say "make" perhaps his witness statement -- "if you like"? 15:23

You say: 15:23

"There will be an opportunity to do both so we will provide -- we are in the process of agreeing all of those statements and our -- so there is a volume of paperwork going back and forth in terms of the agreement of those", et cetera. 15:23

A. I didn't say that, Mrs. Hynds said that.

175 Q. Sorry, Mrs. Hynds. Do you agree with what Mrs. Hynds was saying?

Why did you get to the stage of convening a meeting with Mr. O'Brien when he hasn't been provided with the witness statements containing reference to some of the issues he will have to address? 15:24

A. Well, as I have indicated previously, most case investigations, the person who is the subject is usually the first person. We didn't do that in that case, and it was more about me feeling that I was adequately informed. If there were issues that arose 15:24 in that, then I could certainly raise them with Mr. O'Brien. I was happy for Mr. O'Brien to come back and to discuss those again at a different stage. The intention had always been for those witness statements to be shared with Mr. O'Brien beforehand. Time was 15:24 moving on. I just decided, I'm afraid, that look, we have to get on with this because the terms of reference are there, they are very specific, a lot of them already have numbers and figures attached to them. As I said, you know, whether it was 400 records in your 15:25 house or 200 records in your house, you know, does that really matter? I really felt in the interests of progressing things that we needed to move on.

176 Q. What was the point of gathering witness evidence; directing, in some cases, allegations and providing 15:25 information in support of allegations about Mr. O'Brien if he is not going to be given an opportunity at this meeting to deal with it?

A. Mr. O'Brien was given the opportunity to deal with the

witness statements, and indeed did so. I mean, Mr. O'Brien responded with very specific points to a number of the witness statements, and I saw those. In fact, I believe they were appended in full so that the Case Manager would be aware of that. 15:26

As I say, my view was that I was putting to Mr. O'Brien some of the areas that had been raised. But most of the areas raised, in any event, were included in the terms of reference already. The point of the witness 15:26 statements was for me to get an understanding of the extent of the issue, how it had been managed to date, what attempts had been made to try and manage the situation, what assistance had been given to Mr. O'Brien to try and manage the situation. All of 15:26 those things, whilst not directly -- this came from witness whoever, weren't put to Mr. O'Brien in that format, but if there was anything additional to the terms of reference that had come up from witness statements, I did try to put them in that. And then he 15:26 was provided with all the witness statements and encouraged to put any response that he had back to us for us to consider.

177 Q. Of course that's right but my question was directed at this meeting. This meeting was set up so that 15:27 Mr. O'Brien could be interviewed with a view to providing a witness statement on each of the four ToR issues. Now, you allowed him a dispensation of not commenting on ToR 4, but he was being drawn into that

meeting, as it appears from the common correspondence, under some degree of protest that he hadn't been supplied with the material that you had in your mind and were able to address through questions; he hadn't had the preparation time to look at that to see what he was up against. Do you think that fair? 15:27

A. Mr. O'Brien was a witness.

178 Q. Yes.

A. Like everybody else.

179 Q. Okay. Was he not also primarily the respondent in a process which was directed at his professional performance? 15:27

A. Yes, of course. He was both; he was both the witness and he was the subject of the investigation. I felt there was enough information in the terms of reference. Ideally, I would have very much liked Mr. O'Brien to have copies of the witness statement before we spoke to him. That wasn't possible because of the timeframe to date, and, rightly or wrongly, I felt look, we need to push on and we will give you the opportunity to see these as soon as we can. 15:28

180 Q. You were in charge of the process?

A. Yes.

181 Q. As the investigator?

A. Yes. 15:28

182 Q. You had a degree of control or power in relation to the processing of witness statements. It was you who decided to push for a meeting before those witness statements could be disclosed to Mr. O'Brien?

A. Yes. I thought Mr. O'Brien needed to be given -- I think I felt he had waited long enough and I felt he needed to be given an opportunity to respond to the terms of reference. As I say he was both a witness and he was the subject. I felt time was moving on. I was aware that Mr. O'Brien was very unhappy about timeframes and I felt duty-bound to try and move things on. 15:29

I wasn't trying to be unfair to Mr. O'Brien or to blind-side him in any way, if that's perhaps an implication. I really felt he waited a long time and this was pressing on and he was unhappy about the timeframe as it was. 15:29

183 Q. You may not have been intended that. The question, I suppose, is whether it was a fair process. 15:29

A. Yes.

184 Q. And you believe it was?

A. Yes.

185 Q. You are quite content that he was required to come to this meeting in the absence of witness statements? 15:30

A. I think it wasn't ideal but I don't think that it was -- I don't think it was going to cause significant harm or affect the things that he had to say significantly. I think it was a very lengthy meeting, I think it went on for nearly three hours, so I felt Mr. O'Brien had an opportunity to answer the issues raised. I'm not sure that there were significant additionality from the witness statements, in any event. 15:30

MR. WOLFE KC: Chair, it appears unlikely that we will finish Dr. Chada's evidence today. I am in your hands in terms of whether you wish to take a break, sit to 4.30, or whether you wish to proceed until 4:00 or shortly thereafter and rise? 15:30

CHAIR: Just allow me to consult with my colleagues to see which they would prefer. I think we will take a quick break, Mr. Wolfe, and come back again at 3.45.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 15:38

CHAIR: Welcome back, everyone.

186 Q. MR. WOLFE KC: Thank you.

Good afternoon, Dr. Chada. We will probably sit until 15:48 4.30, if that's okay.

A. Yes.

MR. WOLFE KC: We are in discussions about the possibility of Dr. Chada coming back next Wednesday but we will finalise that after the hearing today. 15:48

CHAIR: It's becoming a feature unfortunately, Dr. Chada, that a witness gets a date to come and speak to us and has to come back, I'm afraid.

MR. WOLFE KC: Perhaps a feature of my advocacy.

CHAIR: I wouldn't go that far. 15:49

A. I probably talked too much.

187 Q. MR. WOLFE KC: It was agreed that Mr. O'Brien could speak to the private patients issue at a subsequent meeting with you, isn't that right? In other words,

you didn't draw him into detailed discussion about term of reference 4, the private patients term, because he was unsighted at that point in relation to the detail of the allegations that he faced?

A. Yes. He hadn't received that information and I didn't feel it was fair to expect him to comment on specific patients and specific examples without sight of -- without having an opportunity to look at them. 15:49

188 Q. On the 13th September that year, Mrs. Hynds writes on your behalf to Martina Corrigan in relation to the private patients matter. I just want to have a look at that and the role of Mr. Young in the time that's available today. TRU-283681. I said the 13th September, the 14th September. Sorry, scroll down the page. 15:50 15:50

Mrs. Hynds is writing, asking on your behalf for clarity around the process undertaken to address the clinical priority of the TURP private patients.

15:51

"Who assessed the clinical priority and what was this based upon? Can you please provide me with a copy of the information pertaining to each private patient assessed. Could I please have this information as a matter of urgency? If you have any queries, please come back to me". 15:51

So, eight months into the investigation, you don't even have the basis for the allegation around private

patients; is that fair?

A. Yes. I think -- I think, and I can be corrected on this, Mrs. Hynds may be able to inform you better, but I think we actually got the information on the private patients, or some information on the private patients, at the beginning of August. I think I said to Mr. O'Brien, look, we only got this today and I'm sorry, I don't expect you to answer on this point. 15:51

I think one of the issues that Mr. O'Brien raised at that first meeting might have been - or maybe it was Siobhán and I discussing it - was this issue of the fact that it wasn't just TURP patients that were looked at. I never really understood that it was just to be TURP patients but there was this issue of where does this list come from? Who made this list? I felt Siobhán and I needed some information about that that we could share with Mr. O'Brien before we met with him again. 15:52

189 Q. Mm-hmm. The assumption - and we will look at this just in a slightly different context later - the information conveyed to Mr. O'Brien on I think it was the 24th January 2017, when he met with the then investigator, Mr. Weir, was that they had concerns about nine private patients who had undergone a TURP? 15:52 15:53

A. Mm-hmm.

190 Q. And he proceeded on the basis of an understanding that that was the allegation to be faced. And as you are pointing out to us now, in fact, the nine patients

became eleven patients that were scrutinised?

A. Mm-hmm.

191 Q. Only three of which were TURP patients?

A. Yes.

192 Q. If we scroll up the page then, please, and see what Mrs. Corrigan has to say by way of return. 15:53

The process undertaken was that Ronan "had requested Wendy Clayton, op lead to request a report to be run on all Mr. O'Brien's surgery during 2016. Any patient that had a short wait between being added to the waiting list and being operated on had their records checked on the NIECR to see if they had a private patient letter i.e. a Hermitage letter. Out of this list that were eleven patients for which all the letters were printed off. I" -- that is Mrs. Corrigan -- "then asked Mr. Young if he could look at these letters and gauge from his clinical opinion could they have been as soon as they had been or should they have been added to the NHS waiting list to wait and be picked chronologically. Mr. Young agreed. He took the letters away and, using NIECR i.e. checking lab results, imagining and any other diagnostics available, made his decision on whether, in his opinion, they were sooner than they should have been." 15:53 15:54 15:54 15:54

She is attaching letters with Mr. Young's comments, "which he went through with me and advised which he felt was reasonable or not".

So, what did you take from that e-mail? Did you understand, firstly, that Mr. Young had been asked to conduct an evaluation of eleven patients against a particular standard, which seems to be a time standard; which doesn't have any other particular definition? But this was all being done without reference to you?

A. Yes.

193 Q. You didn't know that it was Mr. Young, the witness, who spoke to you earlier in the year about his knowledge of Mr. O'Brien? 15:55

A. I didn't know at the time that this was undertaken that it was Mr. Young that was undertaking this, no. But obviously I knew subsequently. 15:56

194 Q. There were no instructions or directions given by you in respect of this private patients issue?

A. No. The private patient issue was term of reference 4, which was provided to me.

195 Q. Mm-hmm. 15:56

A. And it was a wide -- you know, it was private patients whose wait times appear to have been shorter than they might otherwise have been. I think it was quite vague in those terms. I don't recall mentioning it being specifically TURP patients. But I mean, I had no input 15:56 into developing term of reference 4 or how it was worded. It was just one of the terms of reference I was provided with.

196 Q. Did you give any thought as to whether a practitioner

colleague of Mr. O'Brien within the Service, within Urology Service, was an appropriate person to be giving, I suppose, expert evidence to you or evidence involving an expertise around these matters in these circumstances? 15:57

A. I considered that Mr. O'Brien was a very senior colleague along with -- sorry, Mr. Young was a very senior colleague of Mr. O'Brien's. I thought, therefore, that he would have a good knowledge of waiting lists. I knew that his practice in terms of 15:58 waiting times and waiting lists and the length of time he had been in the Trust was lengthy; not as long as Mr. O'Brien but certainly longer than some of the newer consultants. And I feel there's an obligation on all of us to act as independent practitioners in this 15:58 situation so I expected that he would do a fair analysis. So, I didn't feel that it was inappropriate for Mr. O'Brien -- or, sorry, for Mr. Young to do that. I felt he would give a fair and balanced account. I believed that he would give a fair and balanced 15:58 account. I felt because his practice and his length of time and so on was similar, that that would be helpful.

197 Q. Is it fair to say that at no point did you speak to him about his analysis on the private patients issue?

A. Yes, that's a fair comment. 15:59

198 Q. We will look at his product in a moment but he produced a table. Or he produced, first of all, notes; then he spoke to Mrs. Corrigan about what his notes meant; she sent the product across to you?

A. Yes.

199 Q. Mr. O'Brien, as we will see in due course, challenged the conclusions which were reached by Mr. Young across nine of the cases, that there were eleven cases in total but Mr. Young felt two of them were appropriately 15:59
dealt with -- two of the patients were appropriately treated at the time they were treated, but there was conflict or dispute around the nine.

You accepted Mr. Young's view on that and didn't put to 16:00
Mr. Young -- didn't ask questions of Mr. Young in respect of what Mr. O'Brien was saying. Have I got that right?

A. Yes, that's correct. So, Mr. Young -- I was produced a list of patients. Mr. Young had made comments on it 16:00
and whether he was felt it was appropriate or not for them to be placed on a waiting list when they were. I put that to Mr. O'Brien and asked Mr. O'Brien, once he had a chance to see these, to look at them and to see if he had an explanation for that. I included both 16:00
Mr. Young's opinion and Mr. O'Brien's opinion in the investigation report.

200 Q. In terms of Mr. Young's product on this, could we just bring up on the screen, please, TRU-01069. That's a table showing eleven patients who had been seen by 16:01
Mr. O'Brien privately, who were then treated on the NHS, or received diagnostics on the NHS. Those are the days since they were added to the waiting list in the view of Mr. Young. Isn't that right?

A. Yes, that's correct, yes.

201 Q. As I have said, he found that two of the cases were reasonable. Or in the case perhaps of the second one down, perhaps "mandatory" is the word that Mr. O'Brien uses, mandatory, treats that patient having regard to cancer access times. 16:02

If we just scroll down, please. The main document, just to orientate the Inquiry, is a letter in the hand of Mr. O'Brien to a general practitioner. Then what Mr. Young appears to have done, although we have no direct evidence on this, it's not contained in any statement from him, is his Post-it note setting out what he thinks of the case. It would require translation from him, perhaps. It sets out a series of dates and then it ends with a query "urgent", and he repeats that exercise across eleven cases? 16:02 16:03

A. Yes.

202 Q. That's what you were getting through the Trust from Mr. Young? 16:03

A. Yes.

203 Q. Not a report, not a statement, a series of Post-it notes produced into a table summarising his views.

Did you think that was an entirely satisfactory way to deal with this issue in circumstances where you didn't have access or you didn't seek to achieve access to Mr. Young to further discuss these issues? 16:04

A. I think it was -- I felt that it was a very senior

clinician considering this, with a lot of experience behind him to know what the waiting times were. It was perfectly clear from every witness that we spoke to that waiting times for Urology were -- well, I mean, they were just, I suppose, unacceptable but of course they were unacceptable but they were very lengthy. And waiting times for Outpatients appointments were lengthy, waiting times for surgery were lengthy, and therefore it was clear to me that waiting times which appeared short, therefore, were outside what one would have expected, but I didn't interrogate this any further. It was put to Mr. O'Brien and Mr. O'Brien gave a full response to each one of these. 16:04 16:05

204 Q. One of the things that Mr. O'Brien said to you was where is the comparative analysis? In other words, if you looked at patients who had not been treated privately, would you see cases treated by him with similar conditions treated in a similarly short timeframe? Do you recall he made that point to you? 16:05

A. Yes -- 16:06

205 Q. He also made the point that if you look at his private patients in total, or patients that had been treated by him privately before going on to the NHS list, you will see lots of private patients sitting on the list for a lengthy period of time. The question becomes, in trying to assess this issue and where the proper conclusions could be drawn, could you have done more by way of investigation to effectively bottom this out? 16:06

A. I think we could have done more and I think that

applies to most things when you are investigating. It was difficult because interrogating waiting lists, I was told, was difficult because if patients were formerly private and then went on to the NHS waiting list, at times it was difficult to identify that they had been formerly private. I think that was one of the questions I asked Mr. O'Brien. I said would I, if I went along and looked at a waiting list, know that easily? So, I think there were a lot of matters that complicated the situation. 16:07

The comparator for this -- the comparator that was used was an average NHS patient. Not an average Mr. O'Brien patient but an average NHS patient. Was Mr. O'Brien putting private patients -- were private patients waiting a shorter period of time for surgery than one might expect for an average NHS patient. I understand that was the term of reference and that's the comparator that was used. Rightly or wrongly, that's the comparator that was used. I do accept that Mr. O'Brien felt that that isn't the comparator that should have been used. But, as I say, the issue of trying to establish who was a private patient who then becomes an NHS patient and at what point that happens and so on became very complex. So these were put to Mr. O'Brien. As I said, he provided a full response to this and, you know, that's what we took and we progressed with that. 16:07 16:07 16:08

206 Q. I may want to come back to this issue just to tidy some

threads of it up, but I suppose I'm asking you about the role of Mr. Young primarily. He was a consultant and a manager; he was the Clinical Lead; he was a witness to your investigation who may - certainly it was open for to you determine whether any criticism should be visited him upon, particularly around ToR 5 and what management knew about these issues and what they did or didn't do.

I introduced this morning the NHS Framework and drew your attention to whether there was any need in this case to involve someone with clinical expertise. It appears from Mr. Young's work in this particular issue that he was being asked to apply his clinical expertise in respect of whether patients should have been seen at the time they were seen.

A. Mm-hmm.

207 Q. He was giving that information to you in a circuitous route. He wasn't putting it into his statement, he was putting it in through Mrs. Corrigan, and you didn't have access to him or didn't seek to have access to him, and you didn't instruct him in the alternative as an expert. This was a case where expertise independent of the Service should have been brought in; is that fair?

A. At the time I felt that Mr. Young was an appropriate person to do this. I felt he understood how the waiting lists in the Trust -- how long waiting lists were; what the process was for adding people; what the

processes that the Trust adopted were. At the time I felt that he was an appropriate person. On reflection, I think if I was doing it again, I would do it differently.

208 Q. As we know, you met with Mr. O'Brien again on 6th November and, by that time, he had been provided with this information that Mr. Young had developed and he was able to comment on the ToR 4 issue. As I say, there's some threads in association with that that I want to come back to you with. We can see that there's a transcript again of that meeting. For the Inquiry's note, it's to be found at AOB-56285. 16:11 16:11

At that meeting, at the very outset Mr. O'Brien advised that his priority after the meeting would be to deal with his appraisal in the remaining weeks and months of the year. Is it fair to say that you agreed with him, that he was entitled to focus on that, notwithstanding that there were other elements of the investigation-related work that he needed to fulfil and complete? 16:12 16:12

A. Yes. He was saying it had been a very difficult year for him and that he felt that he needed to focus on his appraisal as a matter of priority. I had raised with him at the meeting in August that, in my view, issues that needed to be carried out at certain times needed to be carried out. You know, the GMC just didn't allow you not to do your appraisal or not to do CPD or whatever. He felt that this was weighing heavily on 16:12

him. Bearing in mind how long this process had taken to date, the fact that information hadn't been given to him in a timely manner, I felt it was appropriate to allow him some time to gather his thoughts on his appraisal and on the things that had been provided to him.

209 Q. I suppose you did that fully realising that this might add some further time to what was already a lengthy process?

A. Again, you know on reflection, you think, you know, maybe I shouldn't have done that, but I really felt that he made a heartfelt plea that this was not his priority just now and he had had a very difficult time. I was very conscious that that was indeed the case and he was making that point. And it is a fine balance between trying to be fair and accommodating and understanding and trying to get a process completed.

Mr. O'Brien was the single-most vociferous voice in terms of the timeframe of all of this, so he was asking for this delay. I kind of felt, well, do you know, we have taken a long time to get all this information so in fairness to him, if he's asking for this delay, that doesn't seem unreasonable.

210 Q. His purpose in seeking time, after completing his appraisal, was to allow him to comment on witness statements which you had gathered and sent to him, and also to provide comments in respect of the witness statements that he was providing. Is that right?

A. Yes. Well, the request for the delay was to do with his appraisal --

211 Q. Yes.

A. -- primarily. He said, look, I want to spend the next couple of months focusing on getting my appraisal information and CPD information gathered and getting my appraisal sorted out and then I will turn my attention to this. The first, I suppose, couple of months of that, November/December, the rest of the year I think he said were for appraisal, and then my view was that he was to put things together in January was, I suppose, the time I had in my head. 16:15 16:15

212 Q. Yes. There was a job for yourself and Mrs. Hynds to do and that was to compile his witness statement, isn't that right, and to send it off to him for approval or amendment arising out of the meeting on 6th November? 16:15

A. Yes.

213 Q. Let's just turn our attention to events in February 2018. TRU-269358. At the bottom of the page, please, Siobhán Hynds is writing, commenting: 16:16

"It has been some weeks since we last engaged about the ongoing investigation. When we last met with you, Dr. Chada and I advised that we were at the conclusions stage of our investigations and the meeting with you in November was the last meeting we felt was required". 16:16

And ultimately she is telling him:

"I have the notes of our meeting in November to share which will also require your agreement. We do however have your written statement on those issues in full so that was a small matter to be finalised".

16:17

The statement hadn't been sent to him at that stage; isn't that right?

A. Yes, that's correct.

214 Q. Yes. If you scroll up the page, after being reminded on the 22nd February to reply to the 15th February e-mail, he says: 16:17

"It would appear that I have misunderstood the arrangements and commitments agreed at our last meeting. I was of the understanding that I would next receive the note of that meeting in November '17 and that then I would reply with suggested amendments to both notes and comments upon witness statements". 16:17

He says he had been checking e-mails to ensure he had not overlooked a further communication and had been wondering why there had been such a long delay. 16:17

"I have not had time to attend to the process since November '17", and he would be grateful if he could be provided with a note of the meeting and any other documentation. 16:17

From there, a statement is compiled and then sent to

Mr. O'Brien for signing off?

A. Yes.

215 Q. That was sent to him on the 4th March; isn't that right?

A. Yes, I believe so. 16:18

216 Q. Why had it taken from the November meeting to the 4th March to provide Mr. O'Brien with his statement for checking and signing off?

A. I don't know the answer to that. I am not sure what led to that delay. I am not sure if it was 16:18 a combination of delays with Mrs. Hynds and with myself and with Christmas. So, I really -- I can't even speculate. I am not sure of the reasons for that delay. As far as I was aware, that was the only outstanding piece of information for Mr. O'Brien. 16:19

217 Q. It is the case that that provision of the statement or an outline statement to him or a draft statement, however we describe it, was an essential part of the process. That ball was in your court and the process couldn't be completed until he saw that and agreed it? 16:19

A. I absolutely accept that. As I have said, I think he had everything else that he needed. I think, as that e-mail outlines, Mr. O'Brien has said he hadn't had the time to attend to the process since November '17. I am not sure whether he had looked at the other things but 16:19 certainly that statement should have been provided at an earlier stage and I absolutely accept that.

May I add it does appear that Mr. O'Brien had

transcripts anyway, so although he didn't have the statement from us, the information from that day was available to Mr. O'Brien. That's not taking away from the fact that we should have provided that statement at an earlier stage, and that was a deficit. 16:20

218 Q. It's part of the picture that you weren't aware of, obviously, but --

A. Yes.

219 Q. -- I think you agree with me that until he had a statement set out, as you understood his position to be in the November meeting, commenting on each of the eleven private patients - that was the statement that was produced for him arising out of that meeting. Until he had that, you couldn't complete -- until he had that and approved it, you couldn't complete your process? 16:20 16:21

A. No, we couldn't complete our process and he couldn't -- and I absolutely accept that he couldn't progress his side of it either. So I mean, I absolutely accept that that was a deficit and that was an warranted delay. 16:21

220 Q. He wrote to you then on the 2nd April to complete his engagement with the process in terms of his written work; isn't that right?

A. Yes, that's correct.

221 Q. Is it fair to say that by this stage, you thought Mr. O'Brien was deliberately delaying? 16:21

A. I was concerned about that at this stage. I felt when -- I mean, you will see from the e-mail correspondence that we would provide a date, he would go past it,

suggest a different date. So, I was concerned that he was deciding when this was going to finish. I didn't think that we were being -- whilst the delay was entirely our fault in terms of the witness statement that needed to be got to Mr. O'Brien, and I absolutely hold my hands up to that, I felt that there didn't need to be this period of time to draw things together because a lot of the information was already available; the appraisal time in November and December had gone past. So I was starting to worry that we needed to get this pushed on and that maybe Mr. O'Brien wasn't being as accommodating as he could. However, having said that it, you know, I acknowledge the comment that you made earlier about, you know, perhaps Mr. O'Brien felt that we were trying to push on without him being provided with things, you know. So, I expect there were issues on both sides. 16:22 16:22 16:23

222 Q. Yes. Certainly he replied to you on the 2nd April, which was roughly a calendar month after you had sent him his statement for consideration? 16:23

A. Yes. Well, I went back and said look, we were trying to get this completed before the end of the month and so -- I think he had suggested the 31st and I think that's right, actually and I said look, if we get it finished say the 29th or 30th, let's try and do that, let's set a deadline. That was a day or two ahead of what he had suggested. I only suggested that because I think I was doing something, or there was some reason why I sort of said let's try and get it done for then. 16:23

That was with a couple of weeks of warning, maybe more than that. We said look, this is -- we are just going to have to draw a line under this at this point. And the lines kept being moved. So, originally I think we said the 9th March and then I think we said the 26th May and then the 29th May. Actually, on reflection, that wasn't a good idea because perhaps Mr. O'Brien took from that that we would continuously move the lines. I do accept that the lines moved and that wasn't ideal either. 16:24

I also would say that I don't know if Mr. O'Brien felt that there was a hidden agenda. I certainly had absolutely no hidden agenda. I wanted this done, I felt it had gone on far too long. 16:24

223 Q. Could I draw your attention to some remarks that were made by the grievance adjudicators that had considered the complaint registered by Mr. O'Brien when it came on for the first stage grievance hearing in 2020. If we could bring up on the screen, please, AOB-02804. In terms of the delay in the process, the Grievance Panel at first instance found: 16:25

"It is our finding that Mr. O'Brien was not inclined to progress and he controlled this by his inaction. We observed with the benefit of hindsight now in 2020 that there ought to have been a more assertive management of Mr. O'Brien, even though he would have been unlikely to have welcomed that. If he considered he had no time 16:26

and valued faster progression of the matter with the certainty he expressed his grievance, he ought to have asked if space could be create to allow him to progress his inputs".

16:26

In light of what you have said in the short period of time before I drew attention to this, would you accept that any delay in this process was more the fault of the investigating team, including yourself, than it was Mr. O'Brien, because - and let me just illustrate that - you couldn't meet with him until late June, which didn't suit him for reasons you agreed were reasonable, but you met quickly at the start of August when both of you were available. Then the meeting in November wasn't progressed until he had all available material, and it was within your gift to supply him with that material. Then we had the period of time which you agreed he could take to complete his professional work that he had to do during December. The investigation team then, it seems, forget to send him the statement that he needed signed off before you could complete your process.

16:27

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16:28

So, if there was any delay, would you agree that it wasn't his fault at all?

16:28

A. I wouldn't agree that it wasn't his fault at all. I think there were many factors which led to delays. There was delays in getting information, delays in arranging witnesses, delays in not having appropriate

support to get witness statements typed up and things. So, I think there was a multitude of factors for delay.

I think Mr. O'Brien contributed to those delays, I absolutely accept that I significantly contributed to 16:28
those delays. In retrospect, and having reflected on this, I think I would have been wiser to have considered having more time to be able to do this in a timely fashion. I certainly wouldn't go through this process again, I don't think any consultant would. 16:29
This is actually one of the reasons consultants don't volunteer for investigations like this any more, Mr. Wolfe, and I don't blame them. That's why, because we are expected to do this in the middle of everything else. 16:29

In fairness to Mr. O'Brien, Mr. O'Brien worked solidly through this. You know, he was seeing patients, he was doing Outpatients, he was doing extra theatre lists. In fairness to everybody involved, I think there was 16:29
a multitude of reasons. But if you are asking me was he not responsible for any of them, I'm sorry, I couldn't agree with that, no.

224 Q. Which part do you think he could have responded with greater expedition? 16:30

A. I think if Mr. O'Brien didn't want this to be dragged into the following year, he could have said well, actually, do you know what, I will put my -- I mean, his appraisal was already ten months late, you know.

Really, delaying it for another two months wouldn't have made a huge difference. As I say, I was mindful that this was something that he was indicating that he was very stressed about. If I was doing it again, I would say no, actually, I'm sorry, but your appraisal is ten months late already, another couple of months isn't going to matter. I do think that he contributed to delays.

I think whilst we didn't get the statement to him in time, and that is entirely our fault, you know, I absolutely accept that, we had those notes and that statement should have been got to him, and probably my fault - clarifying that very specifically - but the fact is other information was available by that time to him, and he could have had a lot of his responses prepared and drawn up and ready to go, waiting for that statement. The statement was sent to him and there was still a period of delay. So, I don't think it's entirely fair to say that none of it was Mr. O'Brien's fault. I don't think that is a fair comment.

225 Q. Do you agree with the opinion of the Grievance Panel, and it's repeated, I suppose, a similar sentiment in the review of the grievance -- maybe just in fairness I will bring this up for your attention, AOB-50034. There was a Grievance Panel and then that grievance decision was reviewed. At 5.8 to 5.9, this is the decision of the Review Panel. It comments on what the Grievance Panel has said. It says [it]:

"... recognised that there's a contribution to the delay by both the Trust and Mr. O'Brien in relation to concluding the MHPS investigation. We find that this should have been concluded in a timelier manner. If this investigation were as serious as it was reported to be, the investigator should have been given time out of her normal commitments to carry out the interviews necessary and have the reports completed. This did not happen. It is not referenced. There was no one pressing the completion of these matters, irrespective of the breach of the published timeframes. While Mr. O'Brien complains about the timescale of these matters, he too contributed to this, and while some delays are understandable and acceptable, others simply are not. The Trust has contributed to this. While one might argue that the parties are equally culpable, the Trust, as the employer, has the responsibility to take control of the process in the timescale for completion. Its general acceptance of the slow pace and failure to seek to have" -- this is the grievance closed out at an earlier position deserves mention so perhaps that moves on into the grievance issue?

16:32
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16:32
16:33

But in terms of the analysis at 5.8 - just scroll back so we can see it again - in terms of the progressing of the MHPS bit, they are, I suppose, putting the blame, as you have, across a number of factors and suggested that a significant factor here was that you were not

16:33

relieved of your professional duties to enable you to go about this more efficiently. Is that an analysis you would have some agreement with?

A. Yes.

MR. WOLFE KC: Thank you for your evidence today. It's just after 4.30. The Inquiry will speak to your legal team with a view to having you back next week. Sorry about that, but that concludes our business today. 16:34

CHAIR: Thank you. 10:00 tomorrow, ladies and gentlemen. 16:34

THE INQUIRY WAS THEN ADJOURNED TO WEDNESDAY, 22ND OF MARCH 2023 AT 10:00 A.M.