



Oral Hearing

Day 32 – Thursday, 23rd March 2023

Being heard before: Ms Christine Smith KC (Chair)
Dr Sonia Swart (Panel Member)
Mr Damian Hanbury (Assessor)

Held at: Bradford Court, Belfast

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

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Dr. Ahmed Khan (via videolink)

Examined by Mr. Wolfe KC

4

Lunch adjournment

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1 CHAIR: Good morning, everyone. I see some people have
 2 changed location to get a better view of Dr. Khan.
 3 Mr. Wolfe.
 4 MR. WOLFE KC: Good morning, Dr. Khan.
 5 A. Good morning. 10:07
 6 1 Q. Sound and vision all okay?
 7 A. Yes, it's fine.
 8 2 Q. As you know, my name is Martin Wolfe and I'm counsel to
 9 the Inquiry. Thank you for joining us this morning.
 10 10:07
 11 Could I ask you, just before you take the oath, a
 12 couple of logistical-type questions. Are you by
 13 yourself?
 14 A. I am.
 15 3 Q. And where are you located? 10:07
 16 A. I'm at home.
 17 4 Q. And do you have access to the witness disclosure bundle
 18 and the core bundle?
 19 A. I do. I have access on my laptop.
 20 CHAIR: I think, Dr. Khan, there is an issue with the 10:08
 21 sound with the stenographer who has to record what
 22 you're telling us. We're just getting that sorted out.
 23 If you bear with us a moment or two.
 24 A. Okay. I apologise not being there in person; just with
 25 the clinical commitments yesterday and tomorrow. 10:10
 26 CHAIR: Mr. McInnes, would it be better if we rose for
 27 a short period to get this sorted?
 28
 29 Dr. Khan, I'm afraid we're going to have to rise for a

1 short period to sort out the sound difficulties.

2
3 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

4 CHAIR: Everyone. Hopefully we're now ready to go,
5 Dr. Khan, and we'll not have any further technical
6 issues. 10:21

7 MR. WOLFE KC: Obviously, Dr. Khan, perhaps obviously
8 the person speaking to you is Ms. Christine Smith, who
9 is Chair of the Inquiry. Sitting alongside her is
10 Dr. Sonia Swart and Mr. Damian Hanbury. If at any time 10:21
11 during our communication today you can't hear me, it
12 will probably be obvious to us, but just raise your
13 hand.

14
15 As you know, you have two bundles. One is your 10:22
16 personal bundle, and I'll refer to it as that. The
17 other is the core bundle. I understand you can access
18 those relatively quickly, albeit we appreciate there
19 might be some delay. We'll work through that.
20 I understand, also, that you have your holy book beside 10:22
21 you. Our secretary will administer the oath.

22
23 DR. AHMED KHAN, HAVING BEEN SWORN, WAS EXAMINED BY MR.
24 WOLFE KC AS FOLLOWS:

25 10:23
26 MR. WOLFE KC: I should have mentioned to you also,
27 Dr. Khan, that within the recent short period of time,
28 the Inquiry secretariat have sent you an email
29 containing a designation list of patients with their

1 cipher or, if you like, code name, because we try to
2 keep anonymous the names or details of patients.
3 I think it unlikely we will refer to that in any great
4 detail but it should be in your inbox in the event it
5 becomes necessary.

10:23

6
7 The first thing we need to do is refer you to your
8 witness statements that you have kindly forwarded to
9 the Inquiry in advance of today. There are three
10 documents I need to refer you to. First of all, we can 10:24
11 find at page 35 of your personal bundle, this is
12 WIT-31069. You'll be familiar with that, Dr. Khan,
13 that's the first page of your statement, your
14 Section 21 response dated 29th April 2022. If we could
15 scroll forward, please, to the last page. It is 10:24
16 page 91 for you, Dr. Khan, WIT-31125.

17 A. Yes.

18 5 Q. Subject to the correction document I'm going to refer
19 you to in a short period of time, are you content to
20 adopt that statement as part of your evidence?

10:25

21 A. I do.

22 6 Q. Thank you.

23
24 The second statement is to be found at page 864 of your
25 bundle. The last page is 906. If we could have up on 10:25
26 the screen, please, WIT-31960. You recognise that
27 document, Dr. Khan?

28 A. Yes, I do.

29 7 Q. And the signature is, as I say at page 906, WIT-32002.

1 A. Yes. That's mine.

2 8 Q. Again, are you content to adopt that statement as part
3 of your evidence today?

4 A. I do.

5 9 Q. Then the third document is an addendum statement 10:25
6 recently received by the Inquiry. Your reference is
7 page 2093. If I could have up on the screen, please,
8 WIT-9124. The last page, WIT-91930. It is page 2099
9 for you, Dr. Khan. Again, that deals with a series of
10 corrections or clarifications particularly around the 10:26
11 issue of the terms of reference. We'll look at that
12 presently. Again, are you content to adopt that
13 statement as part of your evidence today?

14 A. Yes, I am.

15 10 Q. I'm obliged. 10:27
16

17 Now, you, as we can see from your statement, graduated
18 as a Bachelor of Medicine and Surgery from a university
19 in Pakistan in 1993; isn't that correct?

20 A. That's correct. 10:27

21 11 Q. And we can see at WIT-31070 -- your personal reference,
22 I believe, is page 93.

23 A. Yes, I can see that.

24 12 Q. We can see your qualifications. If we just scroll down
25 in this room, please. Your qualifications are set out 10:27
26 there at 4.1. If we go over the page, please, para
27 5.1, we can see your various post holdings. You first
28 came to the Southern Trust in June 2008 as a locum
29 consultant paediatrician. You obtained a consultant's

1 post from 1st June 2009 as a general paediatrician with
2 a special interest in Community Child Health, based at
3 Daisy Hill Hospital. Then, in November 2012 you took
4 up a medical management role, is that correct, as a
5 clinical director? 10:28

6 A. Clinical director.

7 13 Q. Subsequently, from 1st June 2013 through to 31st April
8 2018, Associate Medical Director within your
9 directorate, which is the Children and Young People
10 Directorate? 10:29

11 A. Yes.

12 14 Q. There was then a short interlude when you were Acting
13 Medical Director, isn't that correct, from 1st April
14 2018 until December 2018?

15 A. That's correct. 10:29

16 15 Q. That period of time coincided with your role as Case
17 Manager for the MHPS process which we're going to
18 discuss in some detail today; isn't that correct?

19 A. That's right.

20 16 Q. Then you, from 1st January 2019, resumed your role as 10:29
21 Associate Medical Director; isn't that correct?

22 A. Yes.

23 17 Q. The Inquiry understands that you have a particular
24 interest or had a particular interest in the whole area
25 of medical leadership, and in September 2018 you were 10:30
26 the author of a report dealing with medical leadership
27 and medical leadership review; isn't that correct?

28 A. That's correct, yes. It was part of one of my
29 ambitions to complete my doing my Interim Medical

1 Director role, so yes.

2 18 Q. You will find that at page 498 of your bundle. I'm not
3 going to open that now. If we have time later,
4 perhaps, we will look at aspects of that. I understand
5 that the Inquiry may have questions as well for you in 10:30
6 relation to your interest and perhaps your concerns
7 about medical leadership and how that function was
8 performed in the Trust. For the Inquiry's reference,
9 Dr. Khan's report is WIT-31352.

10
11 what is your current position, Dr. Khan? 10:31

12 A. So I was on a career break from Southern Trust
13 from July 2021 until September 2022, whilst I wanted to
14 do further skills and other things in my subspecialty
15 in children with genetic disabilities. So I was 10:31
16 working in Cork, I'm still working in Cork with a
17 special interest in children with disabilities.
18 In October, when my period of career break finished,
19 then I resigned from Southern Trust, and I'm currently
20 working as a substantive consultant paediatrician 10:32
21 from July 2021 onwards in Cork University Hospital.

22 19 Q. Thank you. So, you have no present links on the
23 professional side with the Southern Trust?

24 A. No.

25 20 Q. I'm obliged. Thank you. 10:32

26
27 Now, you were appointed Case Manager for the purposes
28 of the MHPS formal investigation into the practice, or
29 aspects of the practice, of Mr. Aidan O'Brien from in

1 or about December 2016 or January 2017. That is
2 obviously the main focus of your evidence with us
3 today.

4
5 I want to ask you some questions about your 10:33
6 understanding of MHPS at or about the time that
7 Dr. Wright approached you to ask you to take on this
8 role. So, if you look at 877 of your bundle, and we'll
9 turn up in this room WIT-31973. You tell us that prior
10 to the MHPS investigation, you had no experience of 10:33
11 implementing or applying formal MHPS investigations; is
12 that correct?

13 A. That is correct. I had no previous experience of
14 applying or implementing formal MHPS investigations in
15 that investigation. Although I was aware this 10:34
16 framework is available as part of my medical management
17 learning and understanding, but I had no role in the
18 previous implementation of this.

19 21 Q. Was that awareness or that knowledge just part of your
20 general familiarity with the area of managing 10:34
21 colleagues as an Associate Medical Director, but no
22 active involvement in applying the framework prior to
23 Dr. Wright's call to you?

24 A. That's correct. One of my interests, obviously, is the
25 governance arrangement, the clinician governance and 10:35
26 professional governance. As part of my AMD work, I
27 made myself familiarised with the current policies and
28 procedures in the Trust --

29 22 Q. Dr. Khan, not your fault at all. If we can just slow

1 down the pace of your delivery. The stenographer has
2 some issues of hearing which we'll probably try to iron
3 out over the course of the day, and your pace. Just
4 recap on that, please.

5 A. So, as part of my medical management role as Associate 10:36
6 Medical Director and my interest in medical management
7 and clinician governance, including the professional
8 governance, I made myself aware of the -- the current
9 policies and procedures, which included the current
10 policy of The Trust of addressing doctors' 10:36
11 performance, which was 2010. And I was aware there was
12 a MHPS Framework there to look, if I require to.

13 23 Q. You've told us again in your witness statement - it's
14 page 875 for you and WIT-31971 for us - that you
15 received MHPS training on 7th to 8th March. It was a 10:36
16 two-day course, listed at 4.4. If we pull up on the
17 screen just briefly to observe it, page 1040 for you,
18 WIT-32210, the certificate of your attendance at Case
19 Investigator training; self-evidently not case
20 management training. Obviously you will have 10:37
21 appreciated the distinction between what was your role
22 and what was initially Dr. Weir's role and then became
23 Dr. Chada's role. The Inquiry will look at the content
24 of the training you received, but can you reflect upon
25 us, thinking back on matters now, whether you were 10:38
26 sufficiently equipped in your view -- having regard to
27 your lack of experience and the nature of the training
28 you received, how well equipped were you for taking on
29 this role?

1 A. So, this had started with my discussion with the
2 Medical Director, when he approached me for MHPS Case
3 Manager's role. I have indicated that I have no
4 previous experience or training in this regard,
5 therefore Dr. Wright asked me to go for the March 10:38
6 training, which is the next training coming up. I did
7 attend that training and I found it useful in the
8 regard of general understanding of the MHPS Framework
9 various roles. But the training was a workshop
10 training specifically for case investigators. 10:39

11
12 I did reflect on that afterwards and subsequent to that
13 as well. So, that training was directed towards the
14 roles and responsibilities and the actions for a case
15 investigator. Although I must say the training was 10:39
16 very useful to me to understand the wider framework,
17 how it should work, but the training -- I understood
18 that there's another training after that for a case, or
19 something for case investigator, but this training was
20 mainly related to case investigator's training. I did 10:39
21 gain knowledge and understanding of MHPS investigations
22 and the current framework which was at that time.
23 However, I felt that as the training was directed to
24 case investigator, I felt that I did not receive what
25 I was hoping or intending to do. I did discuss this 10:40
26 afterwards and I've reflected on since then as well.

27 24 Q. When you think about it now -- let me ask you first:
28 Have you had a subsequent MHPS role, whether in your
29 current location or in the Southern Trust?

1 A. No.

2 25 Q. How useful do you think training is; how important is
3 it for people taking on roles such as the role you took
4 on? And have you any reflections to offer the Inquiry
5 about how medical managers - because it is typically 10:41
6 medical managers who take on these roles - how should
7 they be prepared by way of training or familiarity with
8 the processes? How should that be done if the Inquiry
9 were thinking about making recommendations around that?

10 A. I think we need to understand the different process 10:41
11 which we are going to train people. In case of MHPS,
12 the training should be part of a suite of other things.
13 The training was very useful but I don't believe that
14 only going to a training will equip you to go through a
15 complex, or even simple, case manager's or case 10:41
16 investigator's role.

17
18 Training, in a way, is also very important but I think
19 that developing skills, developing peers, developing
20 competencies, and developing the expertise in this role 10:42
21 requires more than just training. Training is one part
22 of the expertise but there should be further elements
23 to this whole, I say, a suite of tools available to
24 people who are going to do the MHPS role.

25 10:42
26 No doubt training is very important, and the right
27 training for the right time. Like, doing a training
28 three or four years ago and if you are asked to do
29 someone now, it is hard to remember or retain the

1 knowledge. So it's the ongoing training, it's the
2 ongoing peership, it's the ongoing support, it is the
3 ongoing elements of expertise development. And not
4 necessarily a large pool of people because we know from
5 clinical practice, the more you do something, you'll 10:43
6 get more and more expert in that way. So it is one of
7 those things.

8
9 I don't know whether I answered your question but
10 that's what my view was, and still is. 10:43

11 26 Q. Thank you. That's helpful.

12
13 If we can drill down into that a little bit further.
14 You talked about training being important but you also
15 talked about the need to develop competencies. What 10:43
16 are you thinking about in particular? So, for example,
17 the Case Manager, you will recall, had a role, a
18 significant role in terms of receiving the
19 investigation report. Then the next step was to
20 receive a statement from Mr. O'Brien, outlining, in his 10:44
21 case, his concerns about the process. Then, you had to
22 make a determination which contained three steps or
23 three recommendations. Is there any particular
24 competency or competence required around that that
25 should be developed for case managers for the future 10:44
26 that you thought might have been lacking in your case?

27 A. I think it's also important to have the background
28 knowledge and expertise, clinical expertise in that
29 particular area. Not necessarily specific in that

1 particular area, but an understanding of how the
2 clinical, you know, clinical domains were developed and
3 delivered would be useful having that competency within
4 that kind of case training suite or tools.

5 27 Q. So in direct answer to my question, is there anything 10:45
6 in particular about that part of the process where you
7 as Case Manager have to do work around the
8 investigation report and make determinations?

9 A. Yes.

10 28 Q. Do you think the bit that's missing in your case is a 10:45
11 lack of direct knowledge of the area; is that the
12 problem?

13 A. I don't see a problem there but I think that would be a
14 useful add-on for a competency point of view, to have a
15 greater understanding of the whole system or the 10:46
16 service, or how the initial service was developed and
17 delivered -- supposed to deliver. But I believe the
18 understanding of GMC Good Medical Practice is the core
19 principle which is available and which should be part
20 of this development or expertise development tool. A 10:46
21 lot of those performance or conduct-related issues are
22 late to the GMC Good Medical Practice guidance.

23 I believe I implemented, I addressed those. But having
24 a greater knowledge of that particular team or services
25 would be useful. 10:46

26 29 Q. You've told us in your witness statement -- this is
27 page 40 of your bundle, and WIT-31704 of ours. At
28 paragraph 7.1, you say:
29

1 "During your role as consultant paediatrician and
 2 Clinical Director and Associate Medical Director in
 3 Children and Young People Directorate from 2013 until
 4 2018 you had no operational governance and line
 5 management responsibilities for Urology Services or
 6 staff".

10:47

7
 8 So that was a part of the hospital or a part of
 9 The Trust that was totally foreign to you; is that
 10 fair?

10:47

11 A. So Urology Services sits within the Acute Directorate.
 12 I was the Associate Medical Director for Children's
 13 Service. Because my directorate also had a part in
 14 Craigavon Area Hospital, so although I was based
 15 clinically in Daisy Hill Hospital, my role was mainly
 16 to do with clinical -- for Children's Services, not to
 17 the Urology Services. I must say I would have had some
 18 understanding of the challenges within the AMD forum,
 19 various items discussed at the AMD forum and not
 20 specifically for the urology, but the likes of staffing
 21 shortages and challenges and the waiting lists are
 22 discussed at the AMD forum.

10:48

10:48

23
 24 But to answer your question, I wasn't aware or I wasn't
 25 having any role in governance or line management or
 26 medical professional governance within Urology before
 27 this.

10:48

28 30 Q. Do you consider your lack of familiarity with Acute
 29 Directorate and how it operated as being something of a

1 disadvantage in terms of how you did your work as Case
2 Manager?

3 A. I think there are elements of I felt that I was not
4 disadvantaged but not knowing I had to look for some of
5 the procedures and policies -- not policies, procedures 10:49
6 and how it's done. But I felt it was also useful
7 because I was coming with an independent mindset which
8 was, again, very useful in drafting the MHPS.
9 I believe that was the reason that I was approached by
10 the Medical Director to act as a case manager. 10:49

11 31 Q. Very well. Thank you.

12
13 Could we just look at what the MHPS Framework and the
14 Trust Guidelines then say about the role of Case
15 Manager. I'm going to ask you to have a think and 10:49
16 reflect to the Inquiry whether the understanding of the
17 role set out on paper matched your experience of
18 performing the role, so if we look at it from that
19 perspective. If we go to the MHPS document in the
20 first instance. It's the core bundle now I'm referring 10:50
21 to, not your own personal bundle. So it's page 16 of
22 the core, and WIT-18504. There you can find, at the
23 bottom of page 16, a description of the case manager 's
24 role.

25 10:50
26 "He or she is the individual who will lead the formal
27 investigation. The Medical Director will normally act
28 as the Case Manager but he or she may delegate this
29 role to a senior medically qualified manager in

1 appropriate cases".

2
3 So it was delegated to you, Dr. Khan.

4
5 what do you take from the description of you being the 10:51
6 lead for the formal investigation? what was the
7 distinction between that role and the role of, as it
8 became, Dr. Chada?

9 A. So I reflected upon this a lot of times since. I think
10 I have a number of reflections on this. First, I would 10:51
11 like to go to the framework document itself. In the
12 first line it says the case manager is the individual
13 who will lead the formal investigation full stop. what
14 my understanding was at that point in time was that I'm
15 the person who is leading the formal investigation, and 10:52
16 that's my role. when the formal investigation
17 finishes, by role ceased.

18
19 Now, the second reflection I have is that when
20 I started this role, I wasn't leading, it was already 10:52
21 led by the Oversight Committee. I had previous
22 experience of involving medical professionals
23 performance-related issues on the basis of Trust
24 Guidelines of 2010, where the Oversight Committee has a
25 role and they were actively making decisions. So, 10:52
26 I presumed at that stage that the Oversight Committee
27 in this MHPS Framework was also leading because of
28 that. There are a number of decisions which were made
29 before and since I was appointed as a case manager.

1 I did reflect on that part as well. So, that's the
2 framework and how it practically was happening.

3
4 My own reflection afterwards was that I wasn't leading
5 at the beginning of the case, of the MHPS
6 investigation. 10:53

7 32 Q. We'll come -- sorry to cut across you. We'll come to
8 some examples of that in just a moment, but if I could
9 ask you to perhaps focus at this time in terms of your
10 relationship with the actual case investigator and how 10:53
11 that description of your function as leading the formal
12 investigation, how did that work in practice with
13 Dr. Chada? Did you see yourself as having a role to
14 manage the formal investigation, albeit that Dr. Chada
15 was carrying out the actual investigation, or did 10:54
16 you see yourself as having a role to, if you like, sit
17 back more passively and await her outcome?

18 A. So, Dr. Chada came into the role after Dr. Weir was --
19 first it was Mr. Colin Weir and then Dr. Chada.
20 I would have known Dr. Chada before from the AMD roles. 10:54
21 We were both AMDs. I would have met and discussed
22 various issues in relation to other -- not necessarily
23 this, before that. So I would have known her before
24 already and I would have a good professional working
25 relationship with her previously as well. 10:55

26
27 In this particular case, we would have met, spoken over
28 the phone, discussed on numerous occasions, especially
29 in the later part of 2017 when things were slipping

1 away in terms of the timeframe and everything. So
2 I had, I would say, quite a good understanding and
3 working relationship with her during the course of
4 this. However, I did not feel that I need to or
5 I should be interfering about an actual investigation, 10:56
6 purely for the purpose of independence, letting the
7 investigator do the job, and then I will take ownership
8 of that investigation as my role of Case Manager,
9 perhaps.

10
11 On reflection, I may have or I should have done a
12 little bit more prompting. I did some. I spoke to
13 Medical Director, I discussed with Dr. Chada, I spoke
14 to Ms. Siobhán Hynds on a number of occasions.
15 However, we know now it took up quite a lengthy period 10:56
16 of time.

17 33 Q. Looking at paragraph 35, for example. It says:

18
19 "The practitioner must be given the opportunity to see
20 any correspondence relating to the case, together with 10:57
21 a list of the people whom the case investigator will
22 interview".

23
24 We'll go on and look at some detail in terms of
25 Mr. O'Brien's complaints about the process. He wrote 10:57
26 to you, for example, on 30th July setting out some
27 concerns. I don't wish at this point to go into the
28 detail of those but when concerns arise in a process
29 such as this, do you think the Case Manager has a role

1 to intervene and try to resolve those concerns, or do
2 you think it's the role of the Case Investigator to
3 simply address them so that the Case Manager, if you
4 like, sits back?

5 A. I believe there are a number of reflections on that and 10:58
6 there are a number of ways we can improve things.
7 I believe that there has to be a clear understanding
8 and distinction of supporting the doctor who is going
9 through this process which was, in a way, not very
10 clear in the framework and the implementation. On 10:58
11 reflection to this case and among also a lot of
12 learnings, I believe there had to be much clearer roles
13 and responsibilities in terms of addressing those
14 issues. For instance, the example you quoted there, I,
15 as a Case Manager, wasn't aware actually that the 10:58
16 doctor hasn't received all those information until he
17 wrote to me, which I forwarded to the Oversight
18 Committee and admin support from Siobhán Hynds to
19 address that.

20 10:59
21 But I believe there is an element of lack of clarity
22 within the framework but also lack of clarity within
23 the roles and responsibilities among various peoples.
24 There is a designated director, nonexecutive director,
25 as well, and there is a Case Manager, and then there's 10:59
26 a Case Investigator who is doing the case, who is
27 trying to explore what's happening. I believe there
28 needs to be much more clarity in roles and
29 responsibilities.

1 34 Q. Thank you.

2
3 Paragraph 36 at the bottom of that page refers to the
4 potential to involve an independent practitioner. It
5 says:

11:00

6
7 "If, during the course of the investigation, it
8 transpires that the case involves more complex clinical
9 issues which cannot be addressed in the Trust, the Case
10 Manager should consider whether an independent
11 practitioner from another health and social services
12 body or elsewhere be invited to assist".

11:00

13
14 Now, as this case developed, a question had to be
15 answered or a series of questions had to be answered
16 about clinical aspects. For example, Mr. Young was
17 charged with the duty of reporting on whether there was
18 a clinical justification for the treatment of a group
19 of 11 patients who had previously seen Mr. O'Brien as
20 private patients. Just to take that as an example of a
21 clinical issue that couldn't be resolved by the
22 investigator herself.

11:00

11:01

23
24 First of all, any reflections around that, whether by
25 reference to this particular case or in general, about
26 the clarity in relation to the use of clinical advisers
27 or clinical experts?

11:01

28 A. I think I go back to the point of very kind of fading
29 or in line of interfering into the investigation of

1 Case Manager's or Case Investigator's role. For
2 instance, I was getting updates from the Case
3 Investigator and from the admin in terms of the
4 timeframe and other things, but in the content or
5 what's coming up on the investigation, I wasn't getting 11:02
6 all of those informations, which I believe I will be
7 receiving the investigation report when the
8 investigation completed and I will make my
9 determination.

10
11 I think there is a missing link there now, on
12 reflection, that if clinical concerns are coming up,
13 then escalation or discussion with the Oversight Group,
14 Oversight Committee or the Case Manager may be a useful
15 opportunity to manage or to mediate those risks. 11:03

16 35 Q. You have reflected in your statement - I don't need to
17 draw your attention to the particular page - but you
18 have reflected in your statement that no one in this
19 process, least of all you, was granted any additional
20 or dedicated time to the fulfilment of your 11:03
21 responsibilities. We can see that that applied to the
22 Case Investigator; it also applied to Mr. O'Brien who
23 had to commit some significant time to preparing his
24 responses and participating in interviews and what have
25 you. 11:03

26
27 when you think about it now, in terms of the role of
28 the Case Manager and the Case Investigator, do
29 you consider that the Case Manager's role should be

1 more proactive in terms of understanding what the
2 investigator is doing, at what time and in what period
3 he or she is doing it, the particular challenges faced
4 in terms of gathering evidence and receiving evidence
5 and, to some extent directing, not necessarily the 11:04
6 minutiae of the investigation but directing in broad
7 terms where the investigation should go?

8 A. There are a couple of points in your question that
9 I would like to address in sequence. I think the first
10 thing is that resource allocation, the time, the 11:04
11 protected time. I'm now aware that nobody has received
12 any protected time for doing this MHPS investigation.
13 I had a busy caseload. I was also a medical management
14 role in my directorate. We were going through a major
15 reconfiguration for Children. We were going through 11:05
16 some other important pieces of work, which I can expand
17 on, if you like, at some stage. But no protected time
18 in my job plan or in my working day. I feel that was
19 one of the important factors.

20 11:05
21 I believe that I did try to address that as a Case
22 Manager. I believe I wrote to -- I asked, actually,
23 this question from the Case Investigator and I did
24 discuss with the Medical Director. I think we need to
25 understand the line management structures of all those 11:06
26 people are different. So, for instance, my line
27 manager was Medical Director but my appraisal line
28 manager was my Operational Director. The same as for
29 the Case Investigator, she had her own operational line

1 manager and then professional line manager. The same
2 works for the HR. I had no authority or responsibility
3 in terms of providing that. All I was trying to do is
4 to raise that issue with the Medical Director and the
5 Oversight Committee to address this lack of
6 understanding that this is a complex investigation and
7 it takes more time than you think initially. Initially
8 I was told that it would take three months and then it
9 should be finished, and we know it took much longer
10 than that. So, that the first point.

11:06

11:07

11
12 The second point you made about the proactiveness.
13 I think there's a balance to be made there in terms of
14 how much involved the Case Manager should be, or could
15 be in my case at that time. I think I reflected on
16 that, and I reflected in my statement as well, that
17 I could have or should have been more proactive in
18 terms of pushing this investigation through the process
19 and getting it finished. I did try that, and I've put
20 a number of elements in my statement what I tried in
21 doing that, but not interfering with the investigator's
22 role and not letting the investigator feel that the
23 Case Manager is nearly taking over or addressing some
24 of those. So, there is a distinction between those.
25 And those fine lines between those balanced approaches,
26 I believe, comes with experience and expertise. Also,
27 developing competencies and training and understanding.

11:07

11:07

11:08

28
29 That is my reflection in terms of not knowing when you

1 should be addressing some of the issues coming up but
2 not stepping into someone else's role.

3 36 Q. The Trust Guidelines, which you had some familiarity
4 with, the 2010 document, just take a brief look at the
5 definition of Case Manager, the description of Case
6 Manager to be found there. It is page 99 of the core
7 bundle at your end, and for us it is TRU-83702 at the
8 top of the page. So, the role will usually be
9 delegated by the Medical Director. We've seen that
10 already in the MHPS document. It says:

11:08

11
12 "The Case Manager coordinates the investigation,
13 ensures adequate support to those involved and that the
14 investigation runs to the appropriate timeframe. The
15 Case Manager keeps all parties informed of the process
16 and also determines the action to be taken once the
17 formal investigation has been presented in a report".

11:09

18
19 Is that a description of your role which met the
20 reality of it? Did you provide support; did you ensure
21 that it ran to an appropriate timeframe? Or with the
22 benefit of experience, do you think - and perhaps
23 resources, most importantly - that that is a goal or an
24 objective that the process should aim for but wasn't
25 deliverable for you?

11:10

26 A. I think we need to look at, for any task or activity,
27 what are we trying to achieve, when are we trying to
28 achieve and what quality we are trying to achieve.
29 I think in this case there were some resources but not

1 appropriate, not adequate. In addition to that, I feel
2 that the appropriate timeframe and what should be the
3 appropriate timeframe for an investigation; you cannot
4 have a generalised rule of one week or two weeks or
5 10 weeks, it has to be on the basis of what the 11:11
6 investigation looks like from the beginning and then
7 how it is progressing. But having that clarity that
8 this is important from the organisational point of
9 view. It is an important piece of work which we are
10 doing, and we will put resources into that, whatever 11:11
11 required resources are, in order to achieve the
12 timeframe, the quality, the outcome which we are hoping
13 to achieve, rather than doing it on add-on jobs, add-on
14 roles, and then on people who are already very busy in
15 other roles as well, and trying to complete these 11:12
16 things within a timeframe that is unrealistic, and
17 trying to do it in a way that there's not only -- so we
18 are talking about a complex piece of work. We need to
19 understand it - we can do it quickly or we can do it
20 right. There is a balance between those two things. 11:12
21 If you put a resource, if you put an expertise, if you
22 put all those sorts of required elements into that
23 process, we should get a good outcome.

24
25 In my case I believe that it was an add-on on many, 11:12
26 many people's job plans, roles and responsibilities.
27 I also believe there's this element of still lack of
28 clarity at many levels, including myself; I take the
29 responsibility for that. But I believe that it's even

1 more senior people than me at that period of time had a
 2 lack of understanding of their roles. I think we are
 3 learning, and that this is the one learning we should
 4 be taking forward, the clarity of roles and
 5 responsibilities; who escalates it; who should be 11:13
 6 acting when. At the centre of all that - I think we're
 7 talking about so many other elements - but the centre
 8 of all this is our patients; people, you know, our
 9 community. So we need to work around that and the
 10 process has to be right, the system has to be right, 11:13
 11 the support, the organisation -- and I'm not talking
 12 about, I think this is not about Southern Trust, it's
 13 about our whole system. We need to work to improve our
 14 system. We need to see an improvement going forward.
 15 That's my impression. 11:14

16 37 Q. Thank you for that.

17
 18 If you could pick one or two learnings from your
 19 experience and from your observations of the
 20 experiences of others who were participants in this 11:14
 21 MHPS journey, what would those learnings be? would
 22 they be resources, for example?

23 A. Well, as I alluded earlier, I think there are multiple
 24 factors. My experience was everybody was trying their
 25 best but not working as a team. I don't think we were 11:14
 26 working as a team; which should be. Again, team not
 27 necessarily means one team has roles and
 28 responsibilities, who is the leader, who is taking
 29 ownership, and where it goes next. There's a system,

1 and processes weren't there to support us. When I say
2 about the systems and processes, it's about the
3 resources, it is about the environment; all of them
4 were not there at that point of time.

5 38 Q. Very well. Thank you for that.

11:15

6
7 I want to ask you about two specific aspects of your
8 role by reference to the guidelines and the MHPS
9 Framework, which we will touch upon in greater detail
10 in the course of today. The first role concerns the
11 issue of exclusion and how the Case Manager had a
12 significant role in that, at least according to the
13 guidelines. If we can bring up page 97 of your core
14 bundle, and for us in this room it is TRU-83700.

11:15

15 A. It is my bundle?

11:16

16 39 Q. Sorry, it is the core bundle at your end. Page 97 and
17 you should see Appendix 5 at the top. This is Appendix
18 5 of The Trust's 2010 guidelines. It concerns an issue
19 we'll come on to look at in greater detail later this
20 morning but since we're in this document now, it's
21 convenient to look at it.

11:16

22
23 You can see that the context here is whether the
24 clinician should be the subject of formal exclusion.
25 We know that following a case conference concerning
26 Mr. O'Brien, the decision was that formal exclusion was
27 not necessary. But in terms of your role, you can see
28 that in the process is that the Case Investigator, that
29 was Mr. Weir, produces a preliminary report - this is

11:17

1 the left-hand box - for the case conference to enable
2 the Case Manager to decide on the appropriate next
3 steps. Then across the page, the report should include
4 sufficient information for the Case Manager to
5 determine if the allegation appears to be unfounded at 11:17
6 one level or whether the case requires further detailed
7 investigation. Then the next step is, again, a case
8 conference to be convened by the Case Manager and
9 others to determine if it is reasonable and proper to
10 formally exclude the practitioner, to include the chief 11:18
11 executive when the practitioner is at consultant level.
12 This should usually be where -- that is "exclusion
13 should usually be where, and it sets out some
14 circumstances and further detail about the exclusion.

15
16 First of all, did you appreciate when you went to the
17 case conference in January that this was the process
18 that you were following?

19 A. Yes, I did. Just I think a day or two before that
20 I looked at the framework, and I was also advised by 11:19
21 Ms. Siobhan Hynds in relation to that as well, that it
22 is your role to make two decisions at that point in
23 time. The first one is going to be looking at
24 preliminary investigation and about the formal
25 investigation decision. The second role, I understood, 11:19
26 was in relation to the formal exclusion after the
27 period of interim or preliminary exclusion. So,
28 I understood a couple of days before that.

29 40 Q. Yes. Plainly, as we saw earlier, you are entering into

1 this area of your role when you didn't have training.
2 The training that you ultimately received was in
3 relation to the Case Investigator's role, although it
4 had some general application as you have described; the
5 issues that you had to grapple with at that meeting, 11:20
6 whether there was sufficient, if you like, material or
7 evidence to justify a formal investigation and,
8 secondly, whether exclusion, formal exclusion, was
9 merited.

10
11 were those issues easy to grapple with on the basis of
12 your perhaps wider medical management experience, or
13 did you find this junction troubling and difficult in
14 the absence of training and the absence of experience?

15 A. I think I have reflected on that. At that point in 11:21
16 time, it was challenging for me to make that decision.
17 I did not make that decision on the basis of just my
18 assumptions, I took the advice, and I can go through
19 that. I did indicate in my statement what elements
20 I took in consideration in relation to that decision. 11:21
21 But there were two decisions to be made on that day.

22 41 Q. we'll come to the detail of those perhaps a bit later
23 but the question at this point, I suppose, is just in
24 terms of this part of your job description, in the
25 absence of training, you found these issues 11:21
26 challenging?

27 A. I did. Also, I felt that it was on the day, it should
28 be given an appropriate time consideration in terms of
29 knowing the report in advance, getting the report in

1 distance, considering that. I felt it was -- I still
2 believe the outcome would not be different but it was
3 challenging for me coming in to assist in this process,
4 first time, really first formal meeting about this
5 process, and being asked to make the call for the two 11:22
6 more decisions.

7 42 Q. Yes. The second part -- and this is really just draw
8 your attention at this point in the evidence to what
9 the rule book says, what the guidance of the Framework
10 says, if you like. The second aspect to bookend the 11:22
11 process is the determination role that you held.
12 I just want to draw out some aspects of that. This is
13 going back to page 17 of the bundle you're in, the core
14 bundle, WIT-18505. At the top of the page, it talks
15 about time scale. We've had your reflections upon some 11:23
16 of the reasons why four weeks wasn't possible, it being
17 a complex investigation. Your view is that it should
18 be done properly as opposed to be done at a certain
19 fixed time.

20 11:23
21 Moving on, it says that the report, that is the
22 investigation report, should give the manager
23 sufficient information to make a decision on whether no
24 further action is needed or whether some other action
25 should be taken, including a misconduct or a conduct 11:24
26 panel, reference to Occupational Health, NCAS
27 performance assessment, referral to the GMC, etcetera.

28
29 I'm just interested to hear from you, Dr. Khan, on

1 this. In your role as Case Manager receiving the
2 investigator's report, is it simply your role to accept
3 the investigation's findings or is it part of your role
4 to interrogate those findings and, if you like, assess
5 whether there are any flaws or weaknesses within the 11:25
6 analysis, any gaps in the evidence, anything not taken
7 into account? Do you understand the difference?

8 A. Yes. So, we're talking about the quality of
9 determination, I suppose. Part of the Case Manager's
10 role at the time of determination, which I understood 11:25
11 and I reflected upon, is not necessarily taking all
12 that evidence provided only in consideration. So,
13 making sure that factual accuracy is being consulted
14 upon, which we did in this case by receiving some
15 comments - I made a long list of comments back from 11:26
16 Mr. O'Brien - but ensuring that the evidence provided
17 is also -- there's no discrepancies between the
18 evidence provided in the report, the statements or
19 appendices which are also included in that as well. If
20 there are significant discrepancies coming up or 11:26
21 identified, then further explore that.

22
23 I must say it's not very clear in the framework
24 document, if you were to go as a Case Manager, how to
25 do that. But the Case Manager is taking all that 11:26
26 information and processing all that information in
27 addition to including the standards required through
28 the GMC, through the contractual agreements, through
29 the policies and procedures available in the Trust, and

1 making sure the other information is also included in
2 that as well, in that final outcome of that
3 determination. We're talking about the investigation
4 which is going through a lengthy period of a number of
5 interviews and statements, and also interview of the 11:27
6 doctor, and collecting all that information. So yes,
7 that was my understanding.

8 43 Q. If you had taken the view that there were discrepancies
9 in the investigation report or issues not effectively
10 covered, did you consider that a Case Manager has the 11:28
11 power to send the report back for further work to the
12 investigator, or is that something that didn't cross
13 your mind?

14 A. I must say in this case, other than one of the terms of
15 reference, which was the fifth term of reference - this 11:28
16 was about, you know, the management role and the
17 understanding of the issue, long-standing issue - that
18 wasn't coming across to me that there's sufficient
19 information available in order for me to make a
20 judgment on that basis. Therefore, I have asked the 11:28
21 further independent investigation to look at it
22 individually.

23
24 I also felt that that requires independence, that
25 requires a different set of skills, competencies, in 11:29
26 order to gain what we are trying to achieve. In this
27 case, it did not come across as a significant
28 discrepancy to me. There was some comments back from
29 Mr. O'Brien, and he was commenting about the number of

1 clinics and details, but I compared that standard, the
2 expected standard, with GMC Good Medical Practice, the
3 expected standards from the contractual agreement, from
4 the policies and procedures, and I made my
5 determination on the basis of that.

11:29

6 44 Q. I wonder could you help me with this particular point?
7 The Case Investigator's report led you to the view that
8 there should be a conduct hearing. Is that report the
9 subject of any further comment or consideration at the
10 conduct stage? Forgive me, I haven't asked this
11 question particularly clearly. What I'm anxious to
12 learn from you is, at the conduct stage, is there a
13 further investigation or does Dr. Chada's report serve
14 as the basis for the prosecution of the clinician in
15 the conduct context?

11:30

16 A. Yes. So, in drafting my determination, I applied all
17 those guidelines and standards and considered all
18 those. But I also received advice from key people
19 within the Trust and from NCAS. I would have received
20 advice and shared the investigation and the draft
21 report with three key people - the Chief Executive, the
22 Director of HR, and NCAS.

11:30

23
24 I was already aware of the fact that this case is
25 already known by the GMC Liaison Officer because I was
26 involved in my other role as a medical director. The
27 intention was that once the report is released, then
28 the report will be shared with the GMC and discussed in
29 the next GMC liaison meeting, which is coming up in a

11:31

11:31

1 couple of months' time, or before. I was also aware
2 that at conduct level, there are various avenues
3 available to the conduct panel. You know, there are
4 options available at the conduct level which includes
5 GMC referral, NCAS, if you feel there's a further 11:32
6 inquiry or investigation. So, I was aware of those.
7 But at the point of when I was making the
8 determination, I was satisfied that I have fulfilled
9 the requirements as per the MHPS guidance, what
10 I needed to do for the options available to me. 11:32

11 45 Q. Thank you.

12
13 Now let's look specifically at the circumstances of
14 your appointment. If we bring up page 238 of your core
15 bundle, and if we go to AOB-01280. We have here the -- 11:33

16 A. Sorry, what's the number you said?

17 46 Q. I beg your pardon. It's 238 of your core bundle. Not
18 your personal bundle, but core bundle. It's the
19 Oversight Committee meeting of 22nd December 2016.
20 We find that at that meeting a decision was made by the 11:34
21 Oversight Committee. Can we just scroll down, please.
22 The context is set out and the issues of concern are
23 described. Keep scrolling, please. Various action is
24 directed to various people. Keep going, please. So,
25 it is said: 11:34

26
27 "In light of the above issues, it was agreed by the
28 Oversight Committee that Dr. O'Brien's administrative
29 practices have led to a strong possibility that

1 patients may have come to harm. Should Dr. O'Brien
 2 return to work, the potential that his continuing
 3 administrative practices could continue to harm
 4 patients would still exist. Therefore, it was agreed
 5 to exclude Dr. O'Brien for the duration of a formal
 6 investigation under the MHPS guidelines using an NCAS
 7 approach.

11:34

8
 9 It was agreed for Dr. Wright to make contact with NCAS
 10 to seek confirmation of this approach and aim to meet
 11 Dr. O'Brien on 30th December... "

11:35

12
 13 On the exclusion issue, clearly by this date, 22nd
 14 December, you knew nothing about this case. Is that
 15 fair?

11:35

16 A. Yes. The first time I was contacted was, I think,
 17 after Christmas. I think it was 28th or 29th December.

18 47 Q. We've heard evidence from the Medical Director,
 19 Dr. Wright - we don't need to bring up the reference -
 20 but he said, "It would be the Case Manager's decision
 21 ultimately on exclusion but he would have been aware of
 22 our view. The final decision to do this has to be the
 23 Case Manager". The suggestion through his evidence,
 24 perhaps - it is for the Panel to assess - the exclusion
 25 decision was somehow your decision. Do you understand
 26 that?

11:35

27 A. I do. I don't see how it could be my decision when the
 28 exclusion was already decided. If it wasn't, which
 29 appears to be, before somebody is contacting me even to

11:36

say that you are Case Manager. So I don't see that --
so when I came to know more after New Year, when
I spoke to Dr. Wright about the case on a number of
occasions during the early part of January 2017,
exclusion was already in place.

11:37

48 Q. We will come to that discussion in a moment but just
one question in relation to it. During that
discussion, did he set out to you the fact that
Mr. O'Brien had been excluded, and did he seek your
view on whether it was merited?

11:37

A. Obviously Dr. Wright has indicated that Mr. O'Brien has
been excluded. I don't recall any discussion in
relation to my view on that. It was more about
providing information that Mr. O'Brien has been
excluded and there is further preliminary investigation
ongoing.

11:37

49 Q. Plainly, as we will see in a moment, at the case
conference, the case meeting on 26th January, you did
have a specific role in terms of the continuation of
the exclusion, if you like, and we'll come to that.
But certainly what you are saying to the Inquiry in
clear terms is this decision of the 22nd December had
nothing whatever to do with you and you weren't
consulted upon it?

11:38

A. No.

11:38

50 Q. Now, if we scroll down then. May be back up, I beg
your pardon. Pause there. This committee meeting also
took the decision - I'm struggling to find the
reference but we know it's there - that there would be

1 a formal investigation under MHPS. So, when it came to
 2 your discussion with Dr. Wright, was that something you
 3 were told?

4 A. I was told that Mr. O'Brien has been excluded from
 5 practice for a period of time; there is an 11:39
 6 investigation going, an ongoing investigation which has
 7 to finish within a few weeks, and there will be a case
 8 conference at the end of that before the exclusion
 9 period is over. I don't recall the specifics of those
 10 discussions but I can recall that Dr. Wright was 11:39
 11 indicating that it is highly likely there's going to be
 12 a formal MHPS investigation.

13 51 Q. We know from what you said in your statement that,
 14 following this meeting on 22nd December, Dr. Wright
 15 wrote to you saying - by email: 11:40

16
 17 "It's a tricky situation. There has been an SAI which
 18 has highlighted serious potential issues and would you
 19 be prepared to act as Case Manager under the MHPS
 20 framework". 11:40

21
 22 And I think you replied and suggested a meeting after
 23 the holiday period. At that meeting, as well as being
 24 told about exclusion and the process as envisaged going
 25 forward, to what extent were you briefed about the 11:40
 26 background to all of this?

27 A. I think we need to understand that the first time that
 28 I was contacted, I had no understanding or information
 29 what was going in the background. I had no clinical

1 contact or wasn't actually aware -- I had never met
2 with Mr. O'Brien before. I had no knowledge what was
3 going on the previous year or years. When I was
4 approached at that time, I thought about that, I said I
5 thought there's the request by my Medical Director, 11:41
6 we need to meet and discuss it after the holiday
7 period, which we did. I must say information was
8 drip-fed in a way. There was some information on the
9 first meeting, and then there was further information.
10 But I don't think I have received the extent of 11:41
11 background information before this Inquiry.

12 52 Q. Let me take, for example, the events of 2016. At some
13 point you did discover that Mr. O'Brien had met with
14 Mr. Mackle and Mrs. Trouton and received a letter dated
15 the 23rd March setting out some concerns and inviting 11:42
16 him to provide a plan. Were you told about that, do
17 you think, at an early stage?

18 A. I was told about the summary of what has happened in
19 2016, that there's some concerns, and then the clinical
20 managers met with the doctor and provided some action 11:42
21 plan and follow-up. Then it fell out of follow-up then
22 and the SAI has raised concerns, and now we are going
23 into the formal MHPS process.

24 53 Q. I think we know from events in late 2018 that at that
25 point you discovered that NCAS had an involvement in 11:43
26 this case from November 2016; that is several months
27 after the March letter. Is that the earliest point you
28 would have heard about that?

29 A. I would have heard about the NCAS December contact by

1 the Medical Director. Dr. Wright indicated to me, in
2 fact on a number of occasions, that we had discussed
3 with NCAS - and this is the December discussion with
4 NCAS - and they are also suggesting about the formal
5 investigation. I considered that as part of my role on 11:43
6 the day as a Case Manager in a case conference day, but
7 I wasn't clearly -- I had no clear knowledge or
8 understanding about previous NCAS meetings or
9 consultations.

10 54 Q. Yes. Perhaps it was fortuitous or coincidence that 11:44
11 term of reference 5 was entered into the investigation
12 because it, on the face of it, was supposed to look at
13 the events pre-2016 and all of that. We've heard from
14 you already that you were unhappy, to some extent, as
15 to the content of that aspect of the report. When 11:44
16 you look back at matters now, knowing that there were,
17 for example, exchanges with NCAS in September 2016,
18 knowing that they endorsed an approach which would have
19 been supportive of Mr. O'Brien in terms of addressing
20 the shortcomings in his administrative practice, do you 11:45
21 feel that you were in any way disadvantaged as Case
22 Manager by not having a better and more detailed
23 briefing of all of the events that predated the
24 decision to formally investigate?

25 A. I think the complexity of this investigation has a lot 11:45
26 of learnings. A learning for me was that I wasn't
27 aware of so many events or happenings happening before
28 I came into this process. It may not be intended for
29 that, but I gradually gained knowledge as I went

1 through the process. Maybe one of the learnings should
2 be that the Case Manager and the Case Investigator
3 should be briefed in a more formal way, providing the
4 information not only through verbal information but
5 having a more formal structure that a Case Manager, 11:46
6 Case Investigator, and others in that particular role,
7 should receive.

8 55 Q. Just one final question before the break, Dr. Khan.
9 Dr. Wright described this as a "tricky case". Perhaps
10 all MHPS cases are complex and tricky. You were new to 11:46
11 the world of MHPS, no experience and no training, as
12 you described, albeit you were familiar with the
13 documents. Did you feel that you had any option but to
14 accept the brief from the Medical Director or could you
15 have refused? 11:47

16 A. On reflection, it's actually I could have refused, yes.
17 I could have said no, but I felt that I needed to -- at
18 that point in time I needed to discuss more with
19 Dr. Wright to understand better, and as a medical
20 manager in the Trust, I have roles and responsibilities 11:47
21 as part of my medical governance roles. My main
22 purpose of my medical governance was in the CYP, in the
23 Children's Directorate, but I was also part of the
24 Trust part of the system, so I felt that I needed to be
25 part of understanding more and knowing more and then 11:47
26 taking it from there.

27
28 Obviously, in hindsight, I could have refused. Should
29 I have? I don't know. I would have liked a better

supported environment and training and time, and protected time. But that was my thinking behind that at that point in time.

MR. WOLFE KC: Very well. Is now a suitable time for a break?

11:48

CHAIR: Yes. We'll come back again at 12.05, ladies and gentlemen.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

12:05

56 Q. MR. WOLFE KC: Hello again, Dr. Khan. Are we loud and clear?

A. Yes, yes. Thank you.

57 Q. Just before the break you were reflecting on the fact that based on your experience, a greater formality and a greater level of detail, in your view, should accompany the briefing of the Case Manager at the commencement of an MHPS investigation. I can see from your statement that you recall having perhaps two meetings with Dr. Wright during January, but still and all, you, upon reflection, seems to be dissatisfied, knowing what you know now, about the briefing that you received.

12:06

12:06

A. I suppose at that point in time, I had no further knowledge of what I have gained since, and at that point in time I felt that -- I perceived that I was getting all adequate information, but in hindsight, with the information available to me now, there's a much greater knowledge I acquired, you know, now rather

12:07

1 than at that point in time. Yes, that's correct.
2 I feel that if there was an element of more structure,
3 standardised formal approach of hand-over or giving
4 information would be very useful in providing adequate,
5 sufficient, appropriate information for the people who 12:07
6 are going to lead this further.

7 58 Q. Yes. I mean, obviously, by its very nature an
8 investigation will reveal to you as Case Manager, and
9 the Case Investigator, facts that you wouldn't know at
10 the start. But can you think of any particular example 12:08
11 of the kind of information that Dr. Wright should have
12 been sharing with you, notwithstanding that an
13 investigation was to take place, which would have put
14 the investigation on a better footing, perhaps, from
15 the start? 12:08

16 A. I suppose there are a number of elements to the
17 information which would have been very useful.
18 I suppose the greater detail of what has happened in
19 March 2016 in terms of around that period when some
20 sort of a letter or explanation or action plan was 12:08
21 given without any follow-up. I did not see that. Then
22 the screening exercise, or -- I don't know whether I'm
23 calling it the right term. There was a screening
24 exercise happened, I think, in around September time,
25 2016. I did not receive the details of that. I was 12:09
26 aware that there was a screening done but I wasn't
27 aware of the details of that, by whom, by what extent,
28 where they're screening, what it led to. That would be
29 something I would have reflected upon and I thought

1 would be very useful. Those are the elements that
2 maybe different in another case, I think, but it is
3 having that structured information available that these
4 are the documents, these are the minutes, this is the
5 information which have been already happened before you 12:09
6 joined. You need to take control of that or being
7 aware of this would be very useful, and that's my view
8 on that.

9 59 Q. I want to ask you another question that builds on that
10 about, if you like, the nature of the communication and 12:10
11 understanding across the team generally. By that
12 I mean yourself, at that stage Mr. Weir, and
13 Siobhán Hynds, who was allocated to the investigation
14 wearing a human resources hat. We can see that
15 Mr. Weir emailed yourself and Hynds and Gibson on the 12:10
16 12th January 2017. This is at page 353 of your core
17 bundle, TRU-267243.

18
19 Against the background where the MHPS Framework
20 provides a four-week completion period from the date of 12:11
21 the appointment of the investigator, save in
22 exceptional circumstances to complete the formula, he
23 is writing on 12th January saying that he's the lead
24 investigator; "I know an Oversight Committee met this
25 week", they met on 10th January, "to discuss the 12:11
26 issues". He said:

27
28 "I have not yet received any official confirmation to
29 commence the investigation but I have been forwarded

several emails explaining the issues.

My understanding is the process should be completed within four weeks of the suspension of the consultant concerned" -- I'm not sure that's entirely correct but there's a four-week period I think from the date of appointment. 12:12

"I also understand I would have assistance from Employee Relations". 12:12

Is it fair to say, Dr. Khan, that there was a slow and uncertain start to this process with key actors such as yourself and such as Mr. Weir not quite knowing what was to happen next? 12:12

A. I think that indicates the lack of clarity in terms of roles and responsibilities at that point in time. I had very little understanding of my role personally and what I am supposed to do at that point in time. I was aware of a number of Oversight Committee meetings happening in somewhere, and I wondered afterwards and now on reflection why I wasn't involved in those information or meetings. Perhaps there was a reason behind that as well. That also made the roles and responsibilities less clear because there is a group of senior professionals in the Oversight Committee making those judgments and decisions whilst I'm being appointed as a Case Manager. I'm going through the framework, I have no prior experience or understanding 12:13

1 of the MHPS, I have no training.

2
3 I understood since afterwards and since then that there
4 was a lot of -- a lot of work was going on in the
5 background. So, the preliminary investigations were 12:13
6 going on and other things were happening but I wasn't
7 aware of that. I had no knowledge of that. It's fair
8 to say it may be intended at that point in time,
9 I wasn't sure, but it should be better communication
10 among the whole team which was appointed. 12:14

11 60 Q. If we take the team to be yourself, Weir, and Hynds,
12 did the three of you sit down at any point prior to the
13 case conference on 26th January to discuss "how are
14 we going to do this?"

15 A. I think the first time the three of us met was in case 12:14
16 conference, but I would have met with Siobhán Hynds
17 before that. I would have received a number of
18 communication, emails, phone calls, discussion with
19 Siobhán Hynds. But I don't recall; I may have spoken
20 to Mr. Colin Weir but I don't recall meeting him 12:15
21 face-to-face with Siobhán Hynds before the case
22 conference.

23 61 Q. Reflecting upon that important stage - the three of you
24 have just received your appointments, I suppose, in
25 January, sometime early January - do you think upon 12:15
26 reflection if you were doing this again that there's a
27 need for the three in the team to sit down and chart a
28 course, bearing in mind the imperative of the timeframe
29 set out in the framework; if we can't do it in four

1 weeks, perhaps how quickly can we do it; what are the
2 stages to go through; that kind of charting the way?

3 A. I believe there is an element of everybody is busy with
4 doing different things, but I believe there is to be a
5 formal meeting of the team appointed to discuss where 12:16
6 we are. I also believe this is not at the beginning;
7 like I believe there has to be a formal discussion at
8 various points in investigation to discuss face-to-face
9 how are we keeping a track of where we are, how we're
10 going, when we get there. 12:16

11
12 I don't think we had that at that particular time, but
13 yes, that should be something which I would like to do.
14 If I do it again, I would like to do it that way.

15 62 Q. Let's move to the case conference. The case conference 12:16
16 took place on 26th January 2017. We looked earlier
17 this morning at the flowchart in terms of the decisions
18 etcetera that have to be taken at that meeting and who
19 should take them. Feeding into that meeting is a
20 professional or preliminary report from Mr. Weir. If 12:17
21 we could have up on the screen, please, TRU-284981.
22 For you, Dr. Khan, it's 1617 of your personal bundle.
23 Your personal bundle, not the core.

24 A. Is that the email from Siobhán Hynds?

25 63 Q. It is, yes. Sorry, I should have said that. 12:17

26
27 Siobhán Hynds is writing to you at 11.25 on 26th
28 January attaching a report from Dr. Weir, telling you
29 that in line with MHPS the report is required to give

1 you sufficient detail to enable you to determine,
2 firstly, if there's a case to answer, and also to
3 enable you to decide on the next appropriate steps,
4 including whether formal exclusion is required or
5 whether there are alternatives to exclusion pending
6 conclusion of the investigation. 12:18

7
8 "It is also a requirement to consult with NCAS where a
9 formal exclusion is being considered", and you are
10 provided with a phone number for Dr. Lynn. 12:18

11
12 Have you any recollection of when this meeting took
13 place?

14 A. So, this email is important because I was doing clinic
15 in Daisy Hill; I was with a complex patient. This 12:18
16 email arrived in my inbox, which I didn't get to see
17 until I finished the clinic at 1.30. I had to be in
18 Craigavon, driving, and the meeting was at two o'clock.
19 So I did indicate that I'm not going to be able to see
20 the investigation report before the meeting and I will 12:19
21 discuss it at the time.

22
23 That's what was happening in my life at that moment in
24 time. I was seeing a patient, I had no time outside of
25 clinic activity to see the report which is going to 12:19
26 happen in a couple of hours' time, and then I had to
27 reach that meeting. So the first time I saw that
28 preliminary report was in that case conference.

29 64 Q. The Panel is familiar with the report and I suspect

1 we don't need to open it.

2
3 Plainly, as this email suggests and as the process
4 we looked at earlier this morning suggests, plainly
5 this meeting is focused on a number of potentially 12:20
6 pivotal decisions: (A) is there a case to answer and,
7 if there is a case to answer, then a range of
8 possibilities including a formal MHPS investigation.
9 And, secondly, again I think you'll agree with me, a
10 pivotal decision in relation to whether exclusion is 12:20
11 necessary. You agree with that, do you?

12 A. I do. I do.

13 65 Q. I suspect you would also agree, from what you've just
14 said earlier, that receiving this report when you're in
15 clinic an hour and a half or so, or two and a half 12:20
16 hours prior to the start of the meeting, was far from
17 ideal?

18 A. Yes.

19 66 Q. The suggestion that you might contact NCAS, was that
20 something you thought you should do prior to the 12:21
21 meeting?

22 A. I don't think so. I saw that email actually in
23 practical terms until I reached to the venue of the
24 meeting. My focus obviously was, first of all, to
25 attend that important meeting which was happening. The 12:21
26 two key elements of those meetings, I see that meeting
27 was an important point in time, which was to decide two
28 important elements. First of all, is a formal
29 investigation under the MHPS Framework going to happen.

1 The second important element on that meeting, the
2 outcome or the aim of that meeting was to decide
3 whether formal exclusion was necessary.

4 67 Q. If I could just ask you to pause and we'll bring up the
5 minute of the meeting. It's in your core bundle now, 12:22
6 going back to the other bundle, as 403. We can find it
7 at TRU-00037. That's the first page. You're in
8 attendance, obviously as the Case Manager, with
9 Mr. Weir also present and Siobhán Hynds. You've said
10 earlier - I don't know if it was just based on that 12:22
11 email that you received from Siobhán Hynds - that you
12 had an understanding of your role at that meeting?

13 A. I had a discussion with Siobhán Hynds before that
14 meeting on a couple of occasions. She would have
15 explained to me my role at that point in time, so I had 12:23
16 some understanding of my role before going into that
17 meeting.

18 68 Q. Yes. If we just scroll down through the document,
19 maybe end up at your page 405, the third page of the
20 document. We can see from the format, this is a 12:23
21 document the Inquiry is fairly familiar with at this
22 stage, that Mr. Weir outlined what his preliminary
23 investigation had established. He had previously met
24 with Mr. O'Brien, I think two days previously. Yes,
25 the 24th January, as we can see at the bottom. He was 12:23
26 putting into the mix various factors, including the
27 extent of his concern around the four issues. He was
28 also putting into the mix at the meeting his view on
29 whether exclusion would be appropriate.

1
2 Just back to the top of page 05, please. The
3 historical attempts to address concerns was discussed.
4 Did you get any sense -- it uses the word "advocacy" in
5 association with Mr. Weir. Mr. Weir was an 12:25
6 investigator. Was he putting a case on behalf of
7 Mr. O'Brien in an inappropriate way in your view, or is
8 the word "advocacy" used advisedly simply to say tat he
9 was trying to put forward a balanced approach to these
10 matters? 12:25

11 A. If you allow me, I'd just like to make a few comments
12 on that day, on that minute.

13 69 Q. Yes.

14 A. I think it was an important meeting and we need to take
15 account of the importance of that meeting, which was 12:25
16 planned well ahead, whatever timeframe. From the
17 Oversight point of view, Oversight Committee point of
18 view, Mrs. Toal was there and she chaired the meeting
19 because Dr. Wright was on the phone call.

20 Mrs. Gishkori wasn't available, so she designated or 12:26
21 she nominated Assistant Director, Ann McVey, came
22 along. At that point in time I clearly remember she
23 had been apprised of but not very much aware of the
24 information or background. Then in the meeting,
25 Simon Gibson was there, who provided quite a lot of 12:26
26 background, historical background in that meeting.

27 I don't think the minutes really reflect on what
28 discussion was happening because there was a lot of
29 discussion happening on that point in time and the

1 minutes were not -- I don't think they are called
2 minutes, probably action plan in some shape or form
3 summary discussion.
4

5 My role, as part of the first element of my role, was 12:26
6 to decide, as Case Manager, whether there is a case to
7 answer. How I was going to reach to that point was a
8 number of factors. The main factor was the preliminary
9 investigation report which was still preliminary, which
10 wasn't obviously completed because there was a lot of 12:27
11 elements to be completed afterwards, and it took nearly
12 four, five, six months before we got to know the extent
13 of the untriaged letter sent, all those things. So,
14 that was the evidence provided.

15 12:27
16 I was also made aware in that meeting that Mr. O'Brien
17 had successfully completed appraisals. He was
18 successfully revalidated. I queried that element of
19 the appraisal and revalidation and the role of that in
20 the medical -- professional medical governance, with my 12:27
21 experience in my directorate. I was informed that
22 these were important, these were important but they
23 will be looked at.

24
25 Then Mr. Weir, after presenting the report, the 12:28
26 discussion happened clearly in terms of the standards
27 from the GMC Good Medical Practice. I was aware of
28 that and I had read before, a couple of days before
29 that, to freshen my memory.

1
2 So, we got a report, we have the GMC standards, we have
3 an understanding or awareness of there's an SAI, which
4 was not reported but there was highlighted concerns in
5 December 2016. Then I was provided some, obviously 12:28
6 again historical background, about going on for some
7 time and the extent of all that information in the
8 preliminary report, which I don't need to go through
9 that. There was large number of untriaged letters,
10 large number of undictated letters, large number of 12:29
11 notes were sitting somewhere. And then a discussion
12 about whether there was a case to answer.

13
14 So, with all that evidence available in front of me,
15 I asked a simple question from the team, from the 12:29
16 available people in that meeting, what everybody thinks
17 what I am thinking, that this is a case to answer; what
18 the steering committee, the three people there, thinks.
19 I'd like advice. I would also like advice from a
20 clinical director, who was Mr. Weir as well. He was 12:29
21 the investigator; he had a greater knowledge and a
22 greater understanding of the extent of the problem,
23 which he investigated along with other people. On the
24 basis of all that information, the decision was
25 reached, and it was my decision, that there is a case 12:30
26 to answer. I reached that decision on all the elements
27 that I have explained there.

1 Then the discussion started to happen whether
2 Mr. O'Brien can be brought back.

3 70 Q. Yes. Dr. Khan, you're saying an awful lot, and I don't
4 wish to stop you. Can we deal with these issues in
5 part? Before going to the exclusion, let me just come 12:30
6 back on some aspects of what you've just said around
7 case to answer.

8
9 I asked you a question about Mr. Weir's role.
10 Obviously he is the Case Investigator but he was also 12:31
11 at that time somebody who knew Mr. O'Brien quite well.
12 He was the Clinical Director with some responsibility
13 for Urology. The record, the minute, talks of his
14 advocacy for Mr. O'Brien or in respect of Mr. O'Brien.
15 Did you see that as appropriate, given that he was the 12:31
16 investigator?

17 A. I didn't comment at that particular time. The term
18 "advocacy" wasn't used as the advocacy. Mr. Weir did
19 indicate that, in his view, Mr. O'Brien is a good,
20 caring surgeon who put a lot of effort in patient care. 12:32
21 He also indicated at a later part of the discussion
22 that he is not aware of any clinical concerns of
23 Mr. O'Brien.

24 71 Q. Is that part and parcel of taking a balanced approach
25 to his role which is entirely appropriate in your view, 12:32
26 or did you see anything amiss with it?

27 A. I suppose, on reflection, again that goes back to the
28 understanding of roles and responsibilities; when
29 we are in a role which is relevant to that point in

1 time that we need to act on that role. But I can see
2 from Mr. Weir's point of view that he was giving his
3 view or his opinion in that way. On reflection,
4 perhaps maybe it would have been, you know, better if
5 the advocacy role wasn't introduced at that point in 12:33
6 time. I can only say on hindsight and on reflection,
7 I must say I did not question, or I did not challenge
8 at that point in time. Neither anyone else.

9 72 Q. Thank you. If we scroll down just to see the decision
10 that you make on the next page. You have said that 12:33
11 you're a person who likes to take advice, you took
12 advice at this meeting, but the decision that there was
13 a case to answer was yours. Now, you've also said in
14 your witness statement that -- I'll just read it out to
15 you. If you need to bring it up, we can. You say: 12:34

16
17 "As this was my first experience of being involved in
18 an MHPS investigation, it wasn't very clear to me at
19 the beginning what my role as Case Manager would
20 involve. The Oversight Committee was comprised of the 12:34
21 Medical Director, Director of HR, and Director of Acute
22 Services. This committee was already involved and made
23 some decisions for this case, so this blurred roles and
24 responsibilities for me".

25 12:34
26 In terms of your autonomy and authority at this meeting
27 to take a decision that there was a case to answer and
28 a formal investigation should ensue, was that in your
29 mind a decision that had already been taken by

1 Oversight in December, so that you were influenced by
 2 that? Or was this an entirely independent and
 3 different stage of the process where you were simply
 4 informed by what Mr. Weir was reporting and the advice
 5 that you were taking around the table?

12:35

6 A. I think there's a lot of information come to my
 7 knowledge since. At that point in time when I went to
 8 the case conference and I made that decision on the
 9 basis of information and evidence provided to me, in
 10 addition to the advice I received on at that point in
 11 time. I still believe that that was my decision as a
 12 Case Manager for exclusion, with the advice from the
 13 Oversight Committee which was present there. I was
 14 aware of some indication/discussion with Dr. Wright
 15 that this was potential or likely - I don't exactly
 16 remember the term - but there was some discussion
 17 already has happened, and this is a potential or likely
 18 case for formal MHPS investigation, for various reasons
 19 which we have already discussed. But I still believe
 20 that was my decision at that point in time in the case.

12:35

12:36

12:36

21 73 Q. Help us if you can with this. The notion that there
 22 was a case to answer is legalistic language. The
 23 Framework document and the Guideline document produced
 24 by the Trust isn't very helpful in allowing the reader
 25 to take a grip of what is meant by that phrase. What
 26 was the task, as you understood it, and what factors
 27 did you take into account? Was there, in your own
 28 mind, an alternative to an MHPS investigation in all of
 29 the circumstances, even if there were concerns about

12:37

1 Mr. O'Brien's practice?

2 A. I think the first point I would like to make is the
3 MHPS Framework document is not easy to navigate, it is
4 not easy to understand. You have to go through several
5 times to understand the terms and the analogy and 12:38
6 pathways on that. I did go through several times to
7 understand various things. But at that point in time
8 when I went into the case conference, that was the
9 framework in front of us; it was the MHPS Framework we
10 were working from. So that point in time there was 12:38
11 no -- I must say there was no alternative framework or
12 the policy. The Trust Guideline 2010 for managing
13 performance and doctors and dentists was alongside with
14 MHPS, but we were on the MHPS Framework document and we
15 were keep referring back to that in that discussion as 12:39
16 well.

17 74 Q. I can maybe push on this. What test did you think you
18 were applying? What did those words, "case to answer",
19 mean to you?

20 A. "Case to answer" meant to me at that point in time 12:39
21 we need to do a further investigation, a formal
22 investigation, to understand; to allow for the doctor
23 as well to make their comments, case, statements,
24 representation. But also we need to look at in a
25 formal investigation way by approaching, by gathering 12:39
26 information, by taking the statements, by doing the
27 interviews. That was my understanding a case to answer
28 means in MHPS terms.

29 75 Q. Having taken a view at that point that there was a case

1 to answer, does that inevitably colour your view at the
2 other end of the procedure when you receive the
3 investigation report from Dr. Chada and have to make a
4 determination?

5 A. I would say no, because the case to answer was a 12:40
6 beginning of investigation, and when I received the
7 investigation and making a determination, that is
8 another point in time, and I have got details of the
9 statements -- apologies, I just.

10 CHAIR: Just for the benefit of the transcript, 12:40
11 Dr. Khan had to step away from the witness box briefly.

12 MR. WOLFE KC: Exit stage right.

13
14 Thank you, Dr. Khan, are you settled?

15 A. Yes. 12:41

16
17 So at two different points in time, I was making
18 judgment but they were at the different types, levels;
19 different information available to me. So I don't
20 think that my judgment at the time of determination was 12:41
21 in any way influenced by the time of the initial
22 decision.

23 76 Q. Some other issues arising out of the meeting, then. On
24 exclusion - if we just scroll down, please - the
25 discussion was whether Mr. O'Brien could be brought 12:42
26 back with either restrictive duties or robust
27 monitoring arrangements. As we can see as we scroll
28 down, the case conference members noted the detail of
29 what this monitoring would look like were not then

1 available, but it was agreed that the operational team
2 would provide this detail to the Case Investigator,
3 Case Manager, and members of the Oversight Committee.
4 So this monitoring arrangement, we've otherwise called
5 it an action plan, was to be the responsibility, in 12:42
6 it's formulation, of the operational members of
7 management.

8
9 Did it niggle with you at all that there wasn't any
10 clinical input into the formulation of this plan? 12:43

11 A. I think at that point in time we discussed what the
12 action plan or what the monitoring arrangements should
13 look like. There were various elements to that, that
14 obviously the monitoring should focus on elements of
15 preliminary investigation findings, and how and who is 12:43
16 going to do it and the practicalities of the monitoring
17 arrangements. There was no clear -- I suppose it was
18 building up on various decisions at that point in time.
19 So, the decision was made to make that monitoring
20 arrangement within the Acute Directorate who knows the 12:43
21 processes the systems and how to monitor those, along
22 with, obviously, from the HR admin manager
23 Siobhán Hynds, with the support of Siobhán Hynds, them
24 together monitoring arrangement which they feel that
25 they should be able to monitor. So, that was decided 12:44
26 at that point in time.

27 77 Q. we'll come on and look at your views of how effective
28 the monitoring arrangements and the action plan was
29 later this afternoon. I know you have reflected some

1 concerns around that.

2
3 Just staying with exclusion, you were satisfied then
4 that it was unnecessary, going forward, if a
5 satisfactorily robust plan was put in place? 12:44

6 A. Again, on the basis of information I was provided at
7 that point in time, with the assurance from both
8 operational and I must say clinical, because Mr. Weir
9 was a clinical director at that point in time. He felt
10 in his view that Mr. O'Brien could be brought back with 12:45
11 the monitoring and support arrangements. So yes, it
12 was -- with also -- actually there was information a
13 couple of days before. I think number of professionals
14 met with Mr. Weir about the process, I think, 24th -
15 the 23rd or 24th - and he provided assurance that he 12:45
16 will follow whatever monitoring arrangements or he will
17 adhere to the monitoring arrangements which will be put
18 in place.

19
20 So yes, I was satisfied that a robust monitoring 12:45
21 arrangement can be put in place for that.

22 78 Q. And it was agreed that should the monitoring processes
23 identify any further concerns, then an Oversight
24 Committee would be convened to consider formal
25 exclusion. 12:46

26
27 were you the person charged with the responsibility of
28 highlighting to the Oversight Committee if there were
29 to be any further concerns?

- 1 A. I don't recall that I was charged to do that. Again,
2 that goes back to the point of lack of clarity in terms
3 of roles and responsibilities. There was a lot of
4 links happening outside of the normal -- or I should
5 say formal arrangements. There was lots of discussions 12:46
6 and lots of emails from Ms. Siobhán Hynds to this
7 Oversight Committee which, for various reasons, were
8 happening. Then there was a lot of discussions
9 happening through me, Case Investigator, and the
10 Oversight Committee. So again it was back to the point 12:47
11 that certainly it wasn't clear to me am I supposed to
12 escalate to Oversight Committee if there is a formal
13 exclusion required.
- 14 79 Q. What did you understand would be, I suppose, the
15 trigger for bringing something back to Oversight 12:47
16 Committee?
- 17 A. I suppose my understanding at that point in time would
18 be that if -- a number of things, I suppose. The first
19 element is if there are series of or major deviation
20 from the action plan; if there are any other concerns, 12:47
21 a patient safety concern or clinical concern arising
22 from the investigation; or if there is anything else
23 coming from the overall Clinical Governance system,
24 such as complaints, such as, you know, SAIs, such as MM
25 incidents. All of those would feed in the decision of 12:48
26 do we need to meet as an Oversight Group or Oversight
27 Committee and discuss again in terms of further formal
28 exclusion.
- 29 80 Q. Did any issue come across your desk or to your

1 knowledge in the period between this meeting in
2 January 2017 and the conclusion of your involvement
3 with Mr. O'Brien that would have merited referral back
4 to the Oversight Committee?

5 A. There were a number of occasions there was some 12:49
6 deviation or departure from the action plan. We know
7 now -- certainly I know more now, because on a number
8 of occasions it wasn't escalated directly to the Case
9 Manager in my case. But most of them were immediately
10 addressed, immediately dealt with, immediately managed, 12:49
11 immediately rectified. And it wasn't for a period of
12 time or anything else.

13
14 Apart from that, as a Case Manager, I wasn't receiving
15 any other figures from the Clinical Governance or 12:49
16 Operational Governance point of view. As a Case
17 Manager, obviously I wasn't receiving any other
18 triggers from the Clinical Governance meetings or SAIs,
19 so I wasn't aware of any of those.

20 81 Q. In one of your earlier answers when I rudely cut across 12:50
21 you, you mentioned the issue of appraisal. We can see
22 in the minutes of this meeting how that issue arose.
23 If you go back to page 404 of your bundle and if we go
24 back to TRU-00038, just a few pages back. It says just
25 below the middle of the page, Dr. Khan: 12:50

26
27 "It was noted that Mr. O'Brien was successfully
28 revalidated in May 2014 and that he had also completed
29 satisfactory annual appraisals. Dr. Khan reflected a

1 concern that the appraisal process did not address
2 concerns which were clearly known to the organisation.
3 It was agreed that there may be merit in considering
4 his last appraisal".

12:51

6 Now, you are probably familiar enough with the MHPS
7 process which sets the MHPS arrangements in the context
8 of other quality assurance, quality improvement and
9 safety mechanisms, including appraisal. Just for the
10 Inquiry's note, we can see that at WIT-18495. We don't
11 need to turn it up. 12:51

13 why were you raising this appraisal issue at this
14 meeting? What was your interest in it?

15 A. Well, as part of my medical services role in Children's 12:52
16 Services, I was actively and heavily involved in the
17 professional medical governance. Appraisal,
18 revalidation, job planning, are the cornerstones of
19 medical professional governance. My instinct is the
20 appraisal system, the revalidation system, the job 12:52
21 planning system should indicate the need for further
22 look at things if we join these systems together and
23 look at them logically. That was my reasoning behind,
24 when I heard that this is going on for a number of
25 years but the doctor simultaneously is successfully 12:52
26 revalidated, and a successful appraisal has been
27 completed, I was a little surprised in a way that the
28 system is there to identify, to pick, to address those
29 things.

1
2 we know that the Southern Trust appraisal system over
3 the last number of years has been improving and it's
4 very proactive in that way. We also know that the
5 appraisal system not only just brings the doctor's 12:53
6 view, the appraisal system has a number of elements for
7 addressing the concern. So, the doctor has to bring
8 updated training passport, which is done by the Trust,
9 which is updated by the Trust. The doctor also has to
10 bring the previous year's PDP, which is discussed at 12:53
11 the appraisal. Then there's a new year's or next
12 year's PDP discussed. There is an element of the
13 doctor has to provide the CPD details, the Continuous
14 Professional Development details in the appraisal, but
15 they also have to provide the clinical activity, so 12:54
16 this comes from the Trust systems. The clinical
17 activity of individual doctors are provided as part of
18 the appraisal. Then there is a CLIP record, which is
19 Consultant Level Indication of Performance, which is
20 all provided by all the consultants -- 12:54

- 21 82 Q. If I could just slow you down, Dr. Khan. This is
22 important evidence, I think, and we just want to get a
23 careful note of it. You're talking about the CLIP.
24 A. So the CLIP report is provided to all doctors and it is
25 an independent tool, in a way, which is produced by the 12:54
26 Trust through an external agency and provided to all
27 medical staff - not all medical staff, consultant level
28 medical staff - and it is part of the appraisal.
29

1 As part of the revalidation, we are also aware that the
 2 doctors, in every five-year cycle, have to complete an
 3 anonymous feedback from our colleagues and an anonymous
 4 feedback from the patients. This is the requirement
 5 from the revalidation point of view. So, if a doctor 12:55
 6 who has successfully completed revalidation, he must
 7 have had all of these elements. The final year of the
 8 revalidation, the final year of appraisal which leads
 9 to the revalidation, has in a way enhanced appraisal
 10 which has some other elements to that as well. So, 12:55
 11 revalidation was an important point in time in 2014.
 12 Then there is 2015, '16 and '17 appraisals.

13
 14 So, I was a little surprised about having all those and
 15 not linking the dots there and finding out what's going 12:56
 16 on.

17 83 Q. I know that this issue comes up again and I'll look at
 18 it a little later in the context of the terms of
 19 reference. You come back on this issue in a slightly
 20 different way. These being your concerns, that the 12:56
 21 appraisal tool is part and parcel of this debate about
 22 Mr. O'Brien and his performance that's going to be
 23 formally investigated, did you see to it that these
 24 appraisals were brought in to, if you like, the pool of
 25 evidence or the pool of issues that had to be 12:56
 26 considered?

27 A. So as I put it in my statement, before getting to the
 28 evidence, I had requested or asked that why should we
 29 not involve, or include, the appraisal into the terms

1 of reference or in some shape or form. I was very much
2 hopeful that we will look into in more detail about not
3 only the administrative practices which were coming to
4 light, but looking in a little bit broader way of other
5 tools available to us as an organisation, but also for 12:57
6 the doctor as well. It is important that the doctor
7 represents that evidence provided, that he was
8 successfully revalidated in appraisals. I definitely
9 asked for that to be included and I was assured at that
10 point in time that this will be looked at as part of 12:57
11 the investigation.

12 84 Q. Okay. we'll park that issue and we will come to it.
13 Just I don't want to take it out of sequence from the
14 terms of reference, and we'll see what you did at that
15 point. 12:58

16
17 Just a couple of other points before our break. In
18 terms of the work that was to be done after this
19 meeting, Mrs. Gishkori and Mr. Carroll had to go away
20 and come up with a monitoring action plan. In 12:58
21 association with that, if we go to page something in
22 front of you and we scroll down to TRU-00040.

23
24 It was noted at the meeting that Mr. O'Brien had
25 identified workload pressures. They were articulated 12:59
26 to Mr. Weir when he met with him on the 24th. It was
27 highlighted that there had to be consideration given to
28 a review of Mr. O'Brien's job plan as a matter of
29 urgency. Secondly, the case conference members

1 considered it appropriate that there be a comparable
 2 workload activity exercise performed. Can you give us
 3 some indication as to the rationale for those steps?

4 A. I suppose the discussion around the point of fairness
 5 and supporting the doctor was ensuring that his job
 6 plan is comparative to his work colleague within the
 7 team, and ensuring that if there needs to be further
 8 support or other measures to put in place, that can be
 9 done. So looking at the job plan, not in isolation but
 10 looking in a more comparative way, that this should be
 11 done in a broader way, that was the indication or the
 12 discussion that happened at that time.

12:59

13:00

13 85 Q. Do you know whether, first of all, the comparable
 14 exercise was carried out, the workload activity
 15 exercise?

13:00

16 A. I'm not aware that it happened or not. I wasn't aware
 17 of that at that point in time, and I'm still not.

18 86 Q. Should you have sought assurances, the Case Manager,
 19 that it had been done?

20 A. I did discuss the job plan issue with the Medical
 21 Director on a number of occasions. I also discussed
 22 the job plan difficulties or challenges to sign off the
 23 job plan with his Clinical Director, which was
 24 Mr. Weir, Colin Weir. I also discussed the job plan
 25 issue with Esther Gishkori when I became the Interim
 26 Medical Director and we had established a one-to-one
 27 with her. This is the later part in 2018, essentially.

13:01

13:01

28 87 Q. You didn't follow-up, it seems, on the comparable
 29 exercise on the job plan. Presumably the thinking was

1 that if Mr. O'Brien is to be in a position to comply
 2 with the action plan, his job plan has to be
 3 appropriately balanced. [I see we may lose this in less
 4 than a minute].

5 A. Yes, yes. That was the reason, I must say. I did 13:02
 6 not -- can you hear me?

7 MR. WOLFE KC: He can see the panic in my eyes. We're
 8 going to lose you unless somebody presses the Sky
 9 button.

10 CHAIR: We have 24 seconds. Thank you. 13:02

11 88 Q. MR. WOLFE KC: what was intractable about the job plan,
 12 to the best of your understanding?

13 A. What my understanding was was that the job plan was
 14 discussed at various times and various occasions but it
 15 did not get signed off or agreed by the doctor, by 13:03
 16 Mr. O'Brien. That was on various discussions with
 17 various levels, as I indicated - with Medical Director,
 18 Clinical Director, and with the Director of Acute
 19 Services later on. I must say, and I accept, I did not
 20 personally follow up on the comparative exercise that 13:03
 21 was to happen. Again, that did not come to my mind,
 22 that I have to address that or follow that up. Perhaps
 23 on reflection that would be done by -- you know, at
 24 some point in time I should have reviewed that
 25 situation. 13:03

26 MR. WOLFE KC: Thank you, Dr. Khan. It is now just
 27 shortly after 1:00. We normally take a one-hour break.

28 CHAIR: Yes. If we come back at 2.05, ladies and
 29 gentlemen.

1 MR. WOLFE KC: Is that convenient Dr. Khan?

2 A. Thank you.

3 CHAIR: Thank you.

4

5 THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS: 13:05

6

7 CHAIR: Good afternoon, everyone. Dr. Khan.

8 MR. WOLFE KC: Good afternoon.

9 89 Q. Good afternoon, Dr. Khan.

10 A. Afternoon. 14:06

11 90 Q. It was your task after the case conference to make
12 contact with Mr. O'Brien and to tell him the decisions
13 that had been reached; isn't that right?

14 A. That's correct, yes.

15 91 Q. As we can see from a letter dated 6th February 2017, 14:07

16 you followed that up with a letter, which is at
17 page 417 of the core bundle at TRU-00730. In simple
18 terms you tell him about the outcome of the case
19 conference, that four concerns previously notified to
20 him would be the subject of a formal investigation and 14:07

21 that the question of immediate exclusion had been
22 resolved in favour of a clear management plan,
23 described in the second page of the letter overleaf.
24 On that basis, on the basis of the implementation of
25 this clear management plan, he could return to work and 14:08
26 that there would be a meeting with him to discuss the
27 monitoring arrangements on 9th February.

28

29

1 That prompted a letter from Mr. O'Brien which was
2 directed to Mr. Wilkinson. First of all, just before
3 reaching that, was that your first contact with
4 Mr. O'Brien, the telephone call, and then the letter?

5 A. As far as I remember, yes, that was my first contact. 14:08

6 92 Q. How did he receive the news from you?

7 A. Over the phone.

8 93 Q. Sorry, yes, that was my fault for asking such a loose
9 question. What was his response to the information
10 that you were giving him on the phone? 14:09

11 A. I don't think the phone call lasted more than a couple
12 of minutes. I informed him of the decision -- I first
13 of all introduced myself, because we never met before.
14 I discussed the outcomes basically in summary, and
15 I did say I will be sending out a letter and then 14:09
16 we will be meeting soon. I think as far as I can
17 remember, that was really the essence of our
18 discussion.

19 94 Q. Yes.

20 14:09

21 If you go to 420 of your core bundle, of the core
22 bundle, and if we can pull up TRU-01248. These are
23 concerns that were directed to Mr. Wilkinson but it
24 appears from -- if you just take a peek at page 441,
25 AOB-01446 for us. 14:10

26 A. Sorry, what's the number for me?

27 95 Q. 441, please, for you. This tells us that the Trust
28 legal advice from June Turkington was that the response
29 should be issued by you and assumedly not

1 Mr. wilkinson. Did you understand what was going on
2 there?

3 A. At that point in time I had limited understanding.
4 I understood Mr. O'Brien had met with Mr. wilkinson and
5 raised a number of objections or queries or concerns, 14:11
6 and then it's also about the case investigator's role.
7 So I was apprised afterwards by Dr. Wright and
8 Siobhán Hynds.

9 96 Q. What was your understanding of the role of
10 Mr. wilkinson if he could not be permitted to respond 14:11
11 to this correspondence?

12 A. I wasn't part of the discussion with the Trust legal
13 advice, but my understanding, looking at the MHPS
14 Framework document, was Mr. wilkinson was point of
15 contact from the doctor's point of view, and he was to, 14:12
16 I suppose, address or respond in whatever is
17 appropriate at that point in time. That was my
18 understanding. But I was asked, and appraised -- first
19 of all, informed about the details of the discussion
20 and then I was appraised -- also I was informed that 14:12
21 the letter has to go from you.

22 97 Q. Did you have any input into the drafting of the letter
23 or was it simply a case of you putting your name to it?

24 A. I looked at the draft letter and I had a brief
25 discussion with Siobhán Hynds about the content. 14:12
26 I wasn't involved in a lot of other discussions so
27 I wasn't aware of what else is going on. I did
28 indicate that, obviously, this is a letter going from
29 me so I would like to know a little bit more. I was

1 appraised by Siobhán Hynds and then also by Dr. Wright
 2 as well. So, yes, it's a matter of -- so Siobhán Hynds
 3 drafted it from the HR point of view. I did look at
 4 that as a draft letter. All the factual information
 5 I was told was obviously coming from the discussion and 14:13
 6 the previous elements to that as well, so I agreed to
 7 that.

8 98 Q. Just before looking at the letter - we'll look at the
 9 letter in just a moment or two - in terms of
 10 Mr. Wilkinson's role, we can see in the Trust 14:13
 11 Guidelines and the MHPS that the role of the
 12 nonexecutive director is described. If we take, first
 13 of all -- if you go to page 99 of the core bundle and
 14 if we pull up TRU-83702. Just scroll down, please.
 15 This is the description of the nonexecutive director 14:14
 16 which we find in Appendix 6 of the Trust's guidelines.

17
 18 "The nonexecutive director is appointed by the Trust
 19 chair and he must ensure that the investigation is
 20 completed in a fair and transparent way in line with 14:15
 21 the Trust procedures and the MHPS framework. The
 22 nonexecutive director reports back findings to
 23 the Trust Board".

24
 25 Then if we could look at WIT-18499. That's page 11 of 14:15
 26 your core, Dr. Khan. Definition of roles. Here, the
 27 designated board member is described in perhaps less
 28 elaborate terms than the Trust Guidelines, as being:
 29

"Responsible for overseeing the case to ensure that momentum is maintained and consider any representations from the practitioner about his or her exclusion, or any representations about the investigation".

14:16

In terms of your relationship or interaction with Mr. wilkinson, one can see from a flurry of emails over the period of the investigation that there's an effort to update him by you or on your behalf, and sometimes by Mrs. Hynds on behalf of Dr. Chada about the progress of the investigation.

14:16

were you being challenged by Mr. wilkinson at any time to move things along or to address particular issues or any concerns?

14:17

A. Yes, I had a number of communications with Mr. wilkinson. On the other hand, he also approached me on various occasions inquiring about the current progress of the investigations. I don't think that there was an element of challenging but I believe there was more about keeping up-to-date and also to encourage, to move along and finish the investigations. But I wouldn't consider that as a challenge to me or to the Case Investigator.

14:17

14:18

99 Q. I don't mean that in any antagonistic way. Was he, if you like, a friendly challenger to the process? If you like, in answer to his job description as I've read it out from the two documents, is that what he was, in

1 essence, doing?

2 A. In fairness to Mr. Wilkinson, he was asking about and
3 he was requesting the updates on regular intervals, and
4 I was providing the information to him as well. That
5 was the bulk, really, of what these communications 14:18
6 were. I had some sideline meetings with him - well,
7 not meetings, discussions or chat - when I became the
8 Interim Medical Director and attended the Trust Board
9 meetings and things. But apart from that, that was
10 really what our discussions were. 14:19

11 100 Q. Yes.

12
13 In terms of the role, perhaps more generally, of the
14 nonexecutive director within an MHPS process, are they
15 well-equipped? Do they have any, I suppose, weapons at 14:19
16 their disposal to ensure momentum in an investigation
17 that's perhaps going slowly, or is it simply, as you
18 have described, asking questions on a regular basis?

19 A. I think in my experience, in my view, the biggest
20 weapon they have is the Trust Board. They are expected 14:19
21 to update the Trust Board and the Trust Board can ask
22 the Trust to update in terms of the follow-up or the
23 update of the MHPS or any such investigation. So,
24 I believe the biggest tool they would have is going
25 through the Trust Board and the Trust Board is 14:20
26 requiring further information. But in my experience,
27 both as a Case Manager and with an addition to Interim
28 Managing Director when I was a Trust Board member,
29 I didn't see many ways of requesting other than that,

1 really.

2 101 Q. You became an attendee at the Trust Board upon assuming
3 the Interim Managing Director's role. I'm not sure
4 what might have been your first board meeting;
5 presumably some time around February, March, April 14:21
6 time - is that fair - 2018?

7 A. It was a little after that, I think. I started in
8 April, so I think either it was end of April or May,
9 the next board meeting I attended.

10 102 Q. Was the subject matter of the MHPS investigation 14:21
11 brought to the attention of the board or was it the
12 subject of any discussion, whether through
13 Mr. wilkinson or through you?

14 A. I'm afraid I can't provide that information. It's just 14:21
15 I don't recall, and I don't want to be saying something
16 which is not correct. Without looking at the minutes,
17 because I did attend a number of board meetings,
18 I can't recall at present time, no.

19 103 Q. Thank you. Now, the letter that you signed off, which
20 went back to Mr. O'Brien, is to be found at your 443, 14:22
21 that is the core, core 443, and TRU-01252. This is the
22 letter going out to Mr. O'Brien.

23
24 He raised a number of issues. I don't need to deal
25 with this letter in any particular detail, the Inquiry 14:22
26 can read it for itself. Just go over the page, please.
27 One issue that was raised in his correspondence -- just
28 pause there, please. One of the issues he raised in
29 his letter - and we'll just deal with this if we can

1 simply through your letter rather than jumping
 2 backwards and forwards awkwardly through two pieces of
 3 correspondence - but one of the issues he raised was
 4 the person who met with him on 23rd March 2016 and who
 5 provided him with the letter, and who, in Mr. O'Brien's 14:23
 6 view, didn't provide any support for dealing with the
 7 shortcomings identified in that March letter was
 8 Mr. Mackle. Mr. O'Brien, to some extent, protested, if
 9 that's the right word, that Mr. Mackle and him had had
 10 a run-in historically, and Mrs. Rankin, or Dr. Rankin, 14:23
 11 had decided that Mr. Mackle shouldn't be dealing with
 12 Mr. O'Brien any further. That was an issue drawn to
 13 your attention; do you remember that?

14 A. I was informed about this issue. It was historical and
 15 I wasn't involved. I did indicate in my letter that 14:24
 16 I wasn't a party to that discussion and I'm unable to
 17 provide my opinion or view on that. But the facts were
 18 provided to me and I put that into the letter. But
 19 yes, I was informed about that issue. Not in greater
 20 detail but as an overall summary. 14:24

21 104 Q. Obviously the issue was touched upon in the
 22 investigation report; Dr. Chada subsequently.

23
 24 When you saw that issue being raised, did that help to
 25 inform your concern that, historically, issues around 14:25
 26 the management of Mr. O'Brien and, indeed, the attitude
 27 of managers towards Mr. O'Brien and the decisions that
 28 they reached was something that was worthy of
 29 investigation or consideration as part of the

1 investigation?

2 A. I think that was the first time I -- well, one of

3 the -- I was aware of some of this background talking

4 to Dr. Wright initially in January, but this came to my

5 attention more, in greater detail at that particular 14:26

6 time, and I was, let's say, mindful of the fact that

7 this has been in the history and addressed but not

8 possibly the right way or the completion of the whole

9 process. So, I was mindful of that, yes.

10 105 Q. If we scroll down, please. Another issue that you have 14:26

11 to come back to him on is that the role of Mr. Weir had

12 now changed. He was coming out of the investigation

13 and Dr. Chada is coming in. The explanation that you

14 give there is that it's likely that Mr. Weir may be

15 required to provide information to the investigation on 14:27

16 this issue.

17

18 Sorry, Chair, I'm going to have to go and clear my

19 throat. It is just I have a cold today.

20 CHAIR: Can we take 5 minutes? 14:27

21

22 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

23

24 CHAIR: Everyone?

25 MR. WOLFE KC: Thank you, Chair. 14:31

26 CHAIR: Just before we start again, Mr. Wolfe, just to

27 say we probably won't sit past 4.30 today.

28 106 Q. MR. WOLFE KC: very well. Thank you for the break and

29 apologies for the interruption, Dr. Khan.

1
2 Just coming back to the letter, your page 444, can we
3 have up on the screen TRU-01253. Second part. In
4 terms of what you're telling Mr. O'Brien, you're saying
5 in respect of Mr. Weir that you think it likely that 14:32
6 Mr. Weir may be required to provide information on the
7 issue, therefore you have asked Mr. Weir to step down
8 from his role as Case Manager and ask Dr. Chada to take
9 up the role of Case Investigator. Is the reality of
10 that that you agreed with those decisions but somebody 14:32
11 else had taken the decision and somebody else had asked
12 Dr. Chada?

13 A. For that element, Dr. Wright had written to me.
14 I think he wrote an email and then we also spoke over
15 the phone as well. He indicated that due to these 14:32
16 issues and Mr. Weir's inclusion into the possible
17 witness list, then Mr. Weir has to come off, and he has
18 already discussed with Dr. Chada. And he did ask if
19 you are happy with that, I'll go ahead with that, and
20 I was agreeing on that. I had no issue with this. 14:33

21 107 Q. There are obviously other issues addressed in
22 Mr. O'Brien's letter and the Inquiry can look at those.
23 One particular issue on the next page, if you go across
24 and we go down, is the time scale of the investigation.
25 It is notes that he - that is Mr. O'Brien - has raised 14:33
26 those issues of the time scale with Mr. Wilkinson, and
27 that the issue was raised also with Colin Weir on 24th
28 January.
29

1 You have said to him:

2
3 "Given the vast scale of the concerns, the numbers of
4 patients involved, the time period, the records that
5 require needing reviewing, etcetera, a four-week turn 14:34
6 around time is not practicable".
7

8 You say these are exceptional circumstances.
9

10 we will look at the reasons for the delay, perhaps, in 14:34
11 a short period of time. Is it fair to say that there
12 was no attempt to plot out in advance how the time
13 scale required by the framework could be achieved or,
14 if not achieved, how much greater time would be
15 required? 14:34

16 A. I think at that point in time, the time scale was
17 already thought to be unrealistic, the time scale which
18 is prescribed within the MHPS framework. However,
19 nobody at that point in time anticipated how long it's
20 going to take. It took a greater length of time 14:35
21 compared to initially anticipated. But at this point
22 in time, what the intention was was to inform or to
23 warn Mr. O'Brien just it may take a little longer than
24 initially -- which is prescribed as per the MHPS
25 Framework. That's what I was only referring to in this 14:35
26 letter.

27 108 Q. You know - we don't need to bring it up - that the MHPS
28 Framework talks about the need to provide an audit of
29 the process, which assumedly is designed or included so

1 that those who need to know have an idea of what's
 2 going on; next steps; are we meeting reasonable
 3 timeframes. Was there anybody formally carrying out
 4 that role? We know, for example, that you were keeping
 5 an eye on things, writing regular emails, but there was 14:36
 6 nobody formally auditing the process to ensure that
 7 next steps were given some momentum?

8 A. I don't think there was a formal audit process in
 9 place. However, there was, especially in the beginning
 10 of the investigations I'm talking about - the first six 14:36
 11 months of 2017, from April onwards - there was an
 12 attempt to track or to chase or to make the completion
 13 as soon as possible. However, when there was
 14 nonengagement or whatever from Mr. O'Brien at that
 15 point in time, it was hard to know how long it's going 14:37
 16 to take. But there was no formal audit or process in
 17 place for to track the time.

18 109 Q. Let me move on to the terms of reference. Could
 19 I start by asking you to consider what NCAS say about
 20 that. If we pull up their document How to Conduct 14:37
 21 a Local Performance Investigation, which you can find
 22 at page 63 of your core bundle. That's the relevant
 23 page; obviously the document begins some pages before
 24 that. In terms of finalising terms of reference, the
 25 Inquiry is now familiar with this document, but it 14:38
 26 says:

27
 28 "The terms of reference as finally drafted should be
 29 agreed by the organisation's relevant decision-makers.

1 The Case Manager and investigators appointed to manage
2 and carry out the investigation would not normally be
3 involved in that process".

4
5 I take it to be the process of finalising the terms of 14:38
6 reference.

7
8 Over the page, Dr. Khan - 41408 for our purposes and
9 page 64 for yours, it provides... As you can see from
10 the first main paragraph on that page, Dr. Khan: 14:39

11
12 "It may be that as the investigation progresses the
13 terms of reference are found to be too narrow or that
14 new issues emerge that warrant further investigation.
15 In such cases, the investigators should inform the Case 14:39
16 Manager, who should seek the agreement of the
17 responsible manager or decision-making group to
18 a widening of the terms".

19
20 Now, in the context of this investigation, there was no 14:40
21 need to -- or at least nobody saw the need to widen the
22 terms midflow. But did you have an understanding when
23 you took up the reins of Case Manager or as a result of
24 your training in early March that the procedural route
25 or signing off or finalising terms of reference was not 14:40
26 the Case Investigator and not the Case Manager but the
27 decision-makers within the organisation?

28 A. As part of my understanding and looking at MHPS
29 Framework and doing the MHPS training, I was aware that

1 Case Manager had some role, but I was also aware that
 2 in most cases it's a collective decision between the
 3 Case Manager and the decision-makers, which could be
 4 Oversight Committee, it could be other similar type of
 5 groups. So, I was aware of that option, yes. Sorry, 14:41
 6 I missed your second part.

7 110 Q. I suppose the thrust of my question is the finalisation
 8 of terms of reference before the investigation starts
 9 is not the role of the Case Manager or the investigator
 10 taking that NCAS guide into account, but is the role 14:42
 11 for the relevant decision-makers in the Trust. That's
 12 not defined but it might mean the Oversight Group, for
 13 example.

14 A. Yes. To my understanding it was, obviously in this
 15 particular case, the Oversight Group was making the 14:42
 16 decisions in terms of the terms of reference. However,
 17 my input, and I understand Case Investigator's input,
 18 was there as well.

19 111 Q. On 7th February 2017 you are sent the terms of
 20 reference as they had been drafted at that point. If 14:42
 21 we just look at those. It's page 2080 of your personal
 22 bundle. If we could have up, please, TRU-267637. If
 23 we start at the bottom of the page and work up.
 24 Siobhán Hynds is writing to you and copying Toal,
 25 Gishkori, Wright and Weir. By this point Dr. Chada 14:43
 26 hasn't been appointed.

27
 28 "Please see attached draft terms of reference for the
 29 AOB investigation for your comment/agreement. Once

1 agreed, we can share these with AOB at our meeting this
2 week.

3
4 "Oversight Committee for your comment and agreement".

14:44

5
6 scroll up the page, please. You reply:

7
8 "As discussed previously, should completing successful
9 appraisals while these ongoing issues be part of
10 investigation terms of reference".

14:44

11
12 So this, as we saw this morning, has hung over in your
13 mind from the discussion at the case conference. Let's
14 just see her response.

14:44

15
16 "The issue of how a successful appraisal has been
17 signed off will certainly be part of the queries
18 needing to be answered by some we interview. However,
19 in respect of the terms of reference for this
20 investigation, it is not a matter of concern for Aidan
21 O'Brien to answer necessarily, which is what the terms
22 of reference for this investigation need to focus on".

14:44

23
24 Were you satisfied with that answer?

25 A. I suppose I started this conversation in the case
26 conference and subsequent to that with Siobhán -
27 Siobhán Hynds - but also with the Medical Director.

14:45

28
29 In relation to the appraisal, I believed and I still

believe that is a significant amount -- an important, let's put it this way, an important, vital piece of information and tool available for professional medical governance. I would need to use this tool appropriately in order to gain and understand more.

14:45

That was the reason when I received this terms of reference, the draft terms of reference, the only query I had at that point in time was why not include the appraisal into this? And I received the reply from Siobhán saying this will be -- essentially this will be part of the investigation. And I was -- in a way I was -- I wasn't satisfied completely, I must say, on reflection, I should have pushed more, but I was satisfied in a way that this is going to be looked at as part of the investigation.

14:46

112 Q. Because if you look back at it and think about the content of Dr. Chada's report, I think I'm right in saying - I can stand corrected on this - but there's precious little mention, and perhaps no mention, of appraisal at all; isn't that correct?

14:46

A. I think you're right.

113 Q. Yes.

In a sentence or two, if you had been asked to draft a term of reference around the issue of appraisal, what would have been the general focus of what you were saying?

14:46

A. In my mind, I suppose, I wasn't thinking of me drafting that. I was thinking of starting this discussion among

1 the relevant people, the decision-makers and others, to
 2 think about how we go about looking at appraisal in
 3 a wider term, in a professional governance tool term.

4
 5 In simple terms, it would be a matter of reviewing the 14:47
 6 past four or five years' appraisals and coming up with
 7 what were the themes, how the organisation can miss
 8 some of the issues which were raised in the appraisal
 9 and how we can address those going forward in the
 10 investigation and beyond that as well. So, that was 14:47
 11 essentially my thinking of the appraisal part coming
 12 into this.

13 114 Q. Could I put it into these words and you can tell me
 14 whether you agree? You were seeing a situation where
 15 operational and clinical managers were alleging 14:48
 16 shortcomings on Mr. O'Brien's part. You were also
 17 seeing or hearing about successful appraisal, if I can
 18 put it in those terms, and revalidation. Your
 19 questions, presumably, were in circumstances where this
 20 clinician is said to have significant shortcomings in 14:48
 21 his practice, is our system of appraisal working
 22 appropriately or effectively. Is that what you wanted
 23 to look at?

24 A. I suppose it's even before that. The link of appraisal
 25 into the job planning and also beyond that, of linking 14:49
 26 appraisal into performance, management, clinical
 27 governance, all of that needed to be looked at. There
 28 was kind of joined-up working between the so many
 29 elements of professional governance and clinical

governance which we are aware now were not as robust as they should be. I was trying to indicate that although it's not an immediate issue which is obvious now, but in my experience -- I was heavily involved in appraisal and revalidation and job planning in my directorate, and I found it a very useful tool to be able to identify, to support, to make sure that the safety element is there. That was the thinking in my mind at that point in time.

14:49

115 Q. You received that response from Siobhán Hynds, which was, in essence, the focus of our terms of reference are on the clinician but we will raise, or these queries can be raised, with appropriate witnesses as we proceed.

14:49

If you were less than, I suppose, assured by that, did you take the issue to Dr. Chada to ensure that this matter was on her agenda when she sat down to interview relevant witnesses?

14:50

A. The simple answer is I didn't, purely because I didn't want to interfere in Dr. Chada's investigation. I was assured by Siobhán Hynds, who was supporting that investigation, that this will be part of the investigation in some shape or form. So I took that assurance and I didn't go to Dr. Chada.

14:50

14:51

116 Q. We know that the early iterations of the terms of reference contained four elements. On 15th March, if you can go to 2085, and if we go to TRU-267981. It says, to you:

1
2 "Please find attached final draft of terms of reference
3 of Aidan O'Brien investigation. Please also find the
4 proposed witness list to date although it is likely
5 Dr. Chada will need to speak to others. Once we have 14:51
6 others determined, we will update Mr. O'Brien.

7
8 If you are in agreement with the draft terms of
9 reference, can you please share with Mr. O'Brien
10 Dr. Chada and I are beginning the first of our meetings 14:52
11 with witnesses this week".

12
13 So if we scroll down, please, and just take a look at
14 the terms of reference. Just scroll on down, number 5.
15 This number 5 is the addition. You were obviously 14:52
16 asked to express your contentness or otherwise with
17 that addition. Did you discuss this proposal for
18 addition with Dr. Chada?

19 A. I don't think so. I can't recall talking to Dr. Chada
20 about this specific term of reference. I do remember 14:53
21 that there was some discussion. I think it was
22 between -- not discussion as specifically for this term
23 of reference but around the terms of reference
24 discussion with Siobhán Hynds, saying this is known
25 to -- this issue is known to the organisation before 14:53
26 and Dr. Chada is also aware of that.

27
28 I was aware this issue in the background -- awareness
29 of this issue in the background by Dr. Chada and

1 Siobhán Hynds. I must say I don't recall discussing
 2 this with any of the Oversight Group or Oversight
 3 Committee.

4 117 Q. You say you had an awareness of it being discussed in
 5 the background. Have you any understanding of whether 14:54
 6 the Oversight Group approved this element of the terms
 7 of reference or do you think that stage in the process
 8 was missed?

9 A. My understanding from the beginning of this process of
 10 terms of reference was that they were coming to me 14:54
 11 after the approval of Oversight Group, or the same time
 12 at least. So every time I was getting -- I got about
 13 two or three communication emails from Siobhán Hynds
 14 about this, and every time initially it was asking
 15 Oversight Group -- initially, actually, it was saying 14:54
 16 the Oversight Group to approve or comment. Then it
 17 came to me has a final version of that terms of
 18 reference. I am not aware that it was or it wasn't,
 19 but my understanding at that point in time was it was
 20 looked at and approved by the Oversight Group. 14:55

21 118 Q. We don't need to bring it up on the screen but we have
 22 at TRU-285787 you saying back to Siobhán, "I am happy
 23 with the attached terms of reference, can this be
 24 shared with Mr. O'Brien". So you expressed the view
 25 that you were content. 14:55

26
 27 If Dr. Chada hadn't come up with this, is this
 28 something you might have come up with anyway? To put
 29 it another way or a slightly different way, is this

1 something that you embraced as being a valuable thing
2 to explore during this investigation?

3 A. At the time of the case conference I was surprised by
4 the fact that this issue was known to the organisation
5 for a period of time, at least for 2016. I was also a 14:56
6 little surprised about the appraisal and revalidation
7 and all other things as well. So, yes, in my mind
8 I don't think at that point in time I was thinking of
9 admin or admin review or looking at this as a terms of
10 reference, but there was something in my mind around 14:56
11 that issue of organisational awareness of the issue for
12 a period of time. When this final terms of reference
13 came to me, I was satisfied. I agreed to that and
14 I was satisfied this was part of the investigation now.

15 119 Q. Is this part of, I suppose, the inherent flexibility of 14:57
16 the MHPS process in that issues like this - number 5 -
17 not directly focused on the clinician's actions or
18 conduct but forming part of the context in which he is
19 working, including his relationships with management
20 and their knowledge, is this part of the advantage of 14:57
21 the MHPS process, that this kind of thing can be looked
22 at alongside the actions of the clinician?

23 A. I'm afraid I'm not able to answer that because I don't
24 have much of expertise. This was the only MHPS I was
25 involved in in terms of looking at. In that instance, 14:57
26 I felt it was useful to include that terms of
27 reference.

28 120 Q. Yes. Because self-evidently, perhaps, it is important
29 that if the clinician is struggling to perform to the

1 standard expected of him by his or her employer, it's
 2 necessary, isn't it, to understand that in its fullest
 3 context, including, amongst other things perhaps,
 4 whether adequate support is provided or has been
 5 provided, whether the job plan is perhaps too heavy, 14:58
 6 whether the expectations are too much. would you agree
 7 with that?

8 A. I think it's a joint responsibility for the
 9 organisation and the doctor or the healthcare worker in
 10 the situation that both brings their responsibility 14:59
 11 together. Without one or the other taking their own
 12 responsibility, there are high risks of failure and, as
 13 a result, potential or severe harm. So in my view,
 14 both parties, organisation and the staff or the
 15 employee or the healthcare worker, need to take their 14:59
 16 responsibility. That's why I felt, when I was happy
 17 with the terms of reference, I agreed with that, that
 18 this part is in the terms of reference.

19 121 Q. we'll look a little later, perhaps, at whether you were
 20 satisfied that this element of the terms of the terms 14:59
 21 of reference was exploited, if you like, to its fullest
 22 potential during the investigation and the conclusions
 23 that emerged from it.

24
 25 Just one other aspect of the terms of reference, and 15:00
 26 I quite take your point that you're not expert in this
 27 and not particularly experienced in this. An element
 28 of what the Inquiry is seeking to grapple with is
 29 whether the terms of reference were sufficiently broad

1 to look at other aspects of Mr. O'Brien's practice,
2 issues that came to light some couple of years later.

3
4 The first thing that has to be done, I think you would
5 understand, is a screening process. You referred to 15:00
6 that earlier. The screening process has to be defined
7 or have some parameters. Then what emerges from
8 screening feeds into the terms of reference. Were
9 there any clues in the evidence before you - or the
10 information before you, I should say - at the early 15:01
11 stage that would have led you to take the view that
12 perhaps we need to look beyond what we already know?

13 A. So, at any point during the investigations there was no
14 indication of clinical performance/Patient Safety
15 issues, even at the part of investigation completion. 15:01
16 I do believe in hindsight, with a lot of information
17 since then available, it's my view that the terms of
18 reference was narrow, quite narrow, and we would have
19 gone to a wider terms of reference. However, at that
20 point in time, the terms of reference was mainly 15:02
21 dictated by the preliminary investigations and the
22 screening process which happened before that as well.
23 So that was leading to the formation and drafting of
24 the terms of reference in a way.

25 122 Q. But if you have information before you which shows that 15:02
26 a clinician's approach to administration is of concern
27 in area X, Y and Z, should that not inspire some
28 curiosity on the part of the decision-makers to open
29 the drawer and see whether there might be concerns on

1 the administrative side, perhaps - or perhaps only
 2 limited to that - in other areas of his practice that
 3 have not yet been looked at?

4 A. Again, going back to the point of at that point in time
 5 there was only the administrative issues which were 15:03
 6 highlighted in the preliminary report and the screening
 7 process there. I was aware that as part of going
 8 forward in investigations, other elements can be
 9 included into the part of investigation. However,
 10 I can only reflect on now that we should have gone a 15:04
 11 little bit wider in terms of terms of reference. But
 12 this is with the benefit of a lot of information
 13 available to us now at this point in time.

14
 15 However, I believe that the decision-makers, in our 15:04
 16 case the Oversight Committee, must have and should have
 17 thought about all those elements in agreeing to the
 18 final terms of reference. I can only say that at this
 19 point in time, it is quite obvious, but it wasn't at
 20 that point in time. 15:04

21 123 Q. I want to move on now and look at, I suppose, how you
 22 were viewing the investigation as it proceeded, and to
 23 an extent try to establish the extent of your awareness
 24 of some of the issues that were perhaps holding up
 25 progress. It's fair to say, isn't it, that there was 15:05
 26 a parallel information-gathering process being
 27 undertaken by clinicians in Urology Service in that
 28 they were working through the files of patients who had
 29 not been triaged where there were concerns there hadn't

1 been dictation, and that information was coming back
2 into the system to assist Dr. Chada with her
3 investigation. You understood that to be the scenario?

4 A. I was aware of that exercise going on by the clinicians
5 and that's feeding into the investigation, but I wasn't 15:06
6 very close to what exactly the information was coming
7 through.

8 124 Q. Your document is 480 of the core. If we look at
9 TRU-268080. Scroll down slightly so that i can see the
10 address. Siobhán Hynds is writing to you on 12th 15:06
11 April, Dr. Chada copied in. By 12th April, they had
12 met with four witnesses, taken comprehensive
13 statements, these are being typed for agreement;
14 identified another 11 witnesses they are arranging to
15 meet. 15:07

16
17 "We have established that all untriaged referrals have
18 now been looked at and we've been made aware of
19 a number of referrals which, in the opinion of other
20 consultant urologists, designed to have been triaged at 15:07
21 red flag or urgent but were dealt with as routine.
22 We currently understand this number to be 24, and of
23 those, three have been identified as SAI issues.
24 A further five still unknown at present. 13 files
25 remain unaccounted for". 15:08
26

27 Then: "There has been slower progress with the
28 undictated clinics as the work required in the review
29 of these cases is significant. We have asked for an

1 update on a sample of the patients to allow us to
2 progress our investigation. As this work is slow, it
3 may be prudent to discuss further with Dr. Wright the
4 possibility of getting further assistance with this
5 work to move it forward. Dr. Chada and I are happy to 15:08
6 discuss further with you if it is required. It is
7 unlikely we will have completed our investigation in
8 the next four weeks, therefore you will be updated
9 within that timeframe".

10 15:08
11 This issue of slow progress in this parallel
12 investigation - no doubt understandable because the
13 clinicians performing it have their clinical duties to
14 pursue as well - but here was, if you like, a cry for
15 help or a suggestion of your intervention to secure, 15:09
16 through Dr. Wright, some further assistance with that.
17 Was that an issue you pursued with Dr. Wright, can you
18 remember?

19 A. I think I don't have any email trail. I can't find
20 that. But I think I discussed with Dr. Wright two 15:09
21 issues. One was about a protected time or additional
22 time for the investigator, and also do we need to --
23 obviously we need to look at what other elements are
24 coming out from the other clinicians looking at other
25 referrals and triage, and is there anything which can 15:10
26 be done in relation to further fast-tracking the
27 process.

28 125 Q. Let me just assist you with an email you sent on 14th
29 April, just a couple of days after this. You'll find

1 it at 1385 of your bundle. We have it at TRU-264370.
2 Just scroll down to see if there's anything. You're
3 being asked to meet with Mr. O'Brien to tell him of
4 further SAIs. You respond by saying:

5
6 "I have spoken to Mr. O'Brien yesterday over the phone
7 and informed him regarding the SAIs. He did raise
8 concern regarding the time taken for the case so far".
9

15:11

10
11 You have also updated Mr. Wilkinson.
12

15:11

13 "Is there a possibility for some more dedicated
14 resource for this case especially as it is becoming
15 more complex".
16

15:11

17 So, relatively early stage in relation to the
18 investigation in that only several interviews of
19 witnesses had taken place, but you could see already
20 from what you were told on 12th April that the clinical
21 aspect was slowing things up and that Dr. Chada had
22 identified another potentially 11 witnesses to speak
23 to. So, was this all in your thinking as you were
24 writing to Dr. Wright?

15:11

25 A. I think I spoke to him as well. I think I did add into
26 to my communication with -- to Richard, I suppose, in
27 terms of follow-up from our discussion, was there
28 anything then. I don't remember really that there was
29 something came back in a more substantive way in terms

15:12

1 of doing. What my recollection is a verbal discussion,
 2 myself and Dr. Wright, that the clinicians are doing
 3 it, they are doing their best; this is additional work,
 4 they are doing it, and they are doing outside of their
 5 usual time frame and their job plans, and they are 15:12
 6 doing it as fast as they can; so we will get through
 7 these and I can assure you, you know, I have spoken --
 8 or I'm aware of this. Something in relation to that.
 9 But I haven't received anything -- I don't think I have
 10 received anything more than that after this discussion. 15:13

11 126 Q. I think we spoke earlier about the issue of dedicated
 12 time and just to perhaps go back on that again. Is it
 13 your view that an MHPS investigation of any complexity
 14 does require dedicated and focused resource, both in
 15 terms of the Case Manager and the Case Investigator, 15:13
 16 and perhaps also the HR support, in order to ensure
 17 that the process works itself through in the most
 18 efficient manner?

19 A. Yes. I have reflected on the whole MHPS process and
 20 I think this is one of the improvements we should make 15:14
 21 as a healthier system. These type of investigations
 22 require quite a lot of input both from the clinicians
 23 and from the HR point of view, and requires
 24 additionality. Therefore, it has to be recognised as
 25 an additional piece of work, and additional time and 15:14
 26 resources should be put in place, yes.

27 127 Q. Now, we know, if you look at page 512 of your core
 28 bundle and if we pull up TRU-66814, that
 29 Martina Corrigan, on 7th June, is able to tell

1 Siobhán Hynds that, I suppose, what we take to be the
2 final outcome on the work on the undictated clinics is
3 now known. Within a period of two months, you'll
4 recall I showed you the document of 12th April, where
5 it was said that the review of undictated clinics was 15:15
6 a mountain of work and it hadn't yet started, it
7 seemed. But by 7th June, the clinicians had obviously
8 got through what they thought was necessary to get
9 through, and they set the details out here.

10
11 It's worth considering, isn't it, Dr. Khan, that from
12 this date, it takes a further 12 months, with all the
13 clinical information have been collected and with Dr.
14 Chada, it takes a further 12 months to get this report
15 to the finishing line. What's your reflections on the 15:16
16 reasons for that?

17 A. I think there are a number of factors. I suppose as we
18 were going through the investigations, there were new
19 emerging challenges. There were a lot of witnesses to
20 interview, to type their reports, to confirm their 15:16
21 statements, then to engage with Mr. O'Brien and get his
22 statement on multiple meetings. I think there are
23 a number of factors and I think the time was not --
24 I don't think we had a process or system in place to
25 track the time. It wasn't going to be a quick run of 15:17
26 investigation, it was going to be thorough and detailed
27 and it will take longer time. I believe we were
28 progressing at a fairly good pace in the first six
29 months of the investigation until August/September time

1 2017. Then there were multiple attempts to engage with
2 Mr. O'Brien and, for various reasons, the delay was
3 happening to meet him and to get his statement, or the
4 representation, or the comments back. The time was
5 ticking and it looks like we lost track of time at that 15:18
6 point in time. I take personal responsibility to that
7 as well, that I should have been more proactive in
8 terms of making sure that the investigation is pacing
9 according to what it was initially intended to be.
10 However, for various reasons it did not happen. 15:18

11 128 Q. It may be correct to say, just to clarify, that the
12 private patient issue was a process that was still
13 ongoing, it seems, at that time. When I suggested that
14 all of the clinical information was with the
15 investigators, it is with that caveat. We'll look, 15:19
16 perhaps, at how that information was generated and when
17 it was available.

18
19 You received correspondence from Mr. O'Brien, or at
20 least it was sent to you on 30th July. You can find 15:19
21 that at page 550 of your core, and it's AOB-01675. The
22 letter is wide ranging in its nature. The inquiry is
23 familiar with it.

24
25 A couple of questions. You didn't reply to this letter 15:20
26 to Mr. O'Brien?

27 A. No. When I received this letter, I forwarded it to the
28 Medical Director and the Oversight Committee and
29 Siobhán Hynds to address because there were a number of

1 elements in the letter which were historic and previous
 2 elements to that. So, I wanted the Oversight Committee
 3 and the Medical Director to address those. I was happy
 4 to be part of that but I did not feel that - although
 5 it was addressed to me - I have sufficient knowledge of 15:21
 6 historic background to address from my letter. So
 7 I forwarded this letter -- sent this letter to the
 8 Medical Director and Siobhán Hynds and the Oversight
 9 Group.

10 129 Q. Mr. O'Brien had written you a letter. From his 15:21
 11 perspective, the absence of a response might have the
 12 absence of a response might have appeared concerning,
 13 not only discourteous, perhaps, but in the midst of an
 14 investigation which was obviously of concern for him
 15 given the nature of the issues he was raising, some of 15:22
 16 which touched directly upon the quality of the
 17 investigation itself and the fairness of the
 18 investigation, should you not at least have dealt with
 19 those aspects?

20 A. I think on reflection there were some elements of that 15:22
 21 letter which I could have addressed but I wanted,
 22 I think my thinking of sending it to the Medical
 23 Director and the Oversight Group was not just to
 24 forward it to someone else to deal with it, but more so
 25 getting advice and support in terms of addressing some 15:22
 26 of the issues raised in the letter and to reply for
 27 that. I am afraid I think it slipped out of the radar
 28 from many people and I certainly didn't reply to
 29 Mr. O'Brien.

1
2 If you turn to page 559 of your copy, and if we go to
3 AOB-01684. You will know because the letter was
4 telling you that Mr. O'Brien was due to be interviewed
5 by Dr. Chada three or four days later on 3rd August and 15:23
6 he's making a couple of points. He's saying, at the
7 bottom of page 559. For your purposes, the bottom of
8 this page. On the private patient issue he was
9 previously advised that he would be told of the source
10 of this concern or complaint and six months later he 15:24
11 has still not been advised. He has requested the
12 identity of the nine patients concerned. He's still
13 not being advised of their identity. Now, when
14 you read that, were you concerned for the fairness of
15 the process? 15:25

16 A. I think it's a point he was making and I wanted to know
17 more about the background of that issue which he was
18 raising which I wasn't aware of or I wasn't informed of
19 at that point in time. My thinking behind that was
20 sending it to Siobhan Hynds and the Medical Director 15:25
21 either to come up with, you know, some sort of factual
22 information for me to reply back to him, to
23 Mr. O'Brien, or else give me some information so that
24 I can start drafting some part of my reply back to him.

25 15:25
26 As I said, on reflection, I don't really know why
27 I didn't reply to that. I know I was on annual leave
28 around that time. But to there was something because
29 I do remember sending it, making sure that someone in

1 the Oversight Group and the HR Team knows about this
2 issue and we need to address it. But there may be
3 a reason that I didn't get to reply to that and it went
4 out of my radar.

5 130 Q. Yes.

15:26

6
7 Over the next page it's our AOB-01685, your page 560.
8 Right in the middle of the page Mr. O'Brien expresses
9 concern that he had been previously advised that
10 he would receive a witness list. In other words, the
11 witnesses who had been interviewed by the investigation
12 and he hadn't received that, and nor on the eve of his
13 interview with Dr. Chada had he received any of the
14 testimonies of the witnesses so that he could
15 adequately prepare for the interview and understand.
16 I suspect he is thinking what people are saying about
17 him in relation to the issues of concern.

15:26

15:27

18
19 Did you appreciate, Dr. Khan, that this investigation
20 was being, I suppose, run this way for whatever reason.
21 You knew that interviews had been taking place since
22 March. No doubt you knew that the last interview of
23 a witness took place in the first or second week
24 of June. It was now the end of July and yet none of
25 these statements had made their way to Mr. O'Brien.
26 Did you know that?

15:27

15:28

27 A. I wasn't aware of that. In fact I wasn't aware that he
28 did not receive the witness list. Because that was one
29 of the things, one of the documents, he should have

1 received it at the beginning of the investigation,
2 formal investigation from Dr. Chada and Siobhan Hynds.
3 And I believe that he would have received it. I wasn't
4 aware that he did not receive the witness list.

15:28

5
6 But I was aware that some of the statements, or a lot
7 of statements in fact, were going through factual
8 accuracy and correction and drafting and typing at that
9 point in time. I was aware of that fact but I was not
10 aware that he did not receive the witness list.

15:29

11
12 So there were a number of elements in this letter which
13 I wasn't aware of, or I would have liked to address
14 that but I had no background information or knowledge
15 of those and, therefore, I thought the two best people
16 to inform about the issues which are raised in this was
17 the Medical Director who was also the Oversight
18 Committee member, and Siobhán Hynds, who is the HR Case
19 Manager.

15:29

20
21 Now, I do not wish to take off the responsibility what
22 I had and I don't understand, I usually address these
23 issues, I don't understand why I did not reply to him
24 or; I must have done something about it. And I think
25 all I can think about right now is I have forwarded
26 this to the two people I mention to be addressed.

15:29

27 131 Q. we know and we have observed this week already with Dr.
28 Chada that there was a drip-feed of information through
29 to Mr. O'Brien over the next several months before he

1 was invited on 4th November to be interviewed again, it
2 not having been possible to address all issues at the
3 first meeting because the information around private
4 patients had not been disclosed to him. But even as
5 late as, I think it was 29th October, four or five days 15:31
6 before he was due to be interviewed for the second
7 time, he has had to take the initiative with Mrs. Hynds
8 and Dr. Chada to say 'I am still outstanding four
9 witness statements which you haven't disclosed to me'.

10
11 I hear you when you say "I accept some responsibility
12 for this", but was there not a concerted effort on your
13 part, rather than pass the message across, to actually
14 try to inject some a greater efficiency or momentum
15 into the disclosure process? 15:31

16 A. So, in October time, I can't recall that I had received
17 something again from Mr. O'Brien. I may have. I can't
18 recall that I had received again asking for the
19 same information, or similar type or more information.
20 I would have imagined at that point in time that this 15:32
21 matter has been dealt with or its in the process of
22 being addressed, you know, in a way of information or
23 otherwise. I wasn't aware of the witness list until
24 that point in time that Dr. Chada, obviously she had to
25 apologise from the investigation team that 15:32
26 Mr. O'Brien didn't get the witness list initially and
27 then the statements.

28
29 But I think, again, coming back to the point that the

1 information or the communication within the team could
 2 be better on hindsight and on reflection, both ways,
 3 from Case Manager to case investigation, and
 4 vice-á-versa, and we can, I suppose learn from that
 5 element to that.

15:33

6 132 Q. You wrote to Mrs. Hynds on 7 February 2018. To be
 7 entirely fair to you, you are communicating with the
 8 investigative team to establish progress. This is page
 9 581 of your core, TRU-269355, you say:

10
 11 "I haven't heard any updates for this case in the last
 12 couple of months. Kindly let me know the progress".

15:33

13
 14 We know that Mr. O'Brien was interviewed in
 15 early October and Dr. Chada saying:

15:34

16
 17 "The last we spoke to the doctor he was to get back to
 18 us. He explained he wanted time out to sort out his
 19 appraisal. We are waiting for him to get back to us
 20 rather than any delay on our part".

15:34

21
 22 Did you know between Dr. Chada and Mrs. Hynds that they
 23 had allowed or agreed a period of time out for
 24 Mr. O'Brien to turn his attention to appraisal, rather
 25 than concentrate on finishing the MHPS process and his
 26 role in it?

15:35

27 A. I became aware of that issue, not at that point in time
 28 but afterwards, so I think in, I think it's after
 29 Christmas, after New Year, I became aware that he was

1 allowed, Mr. O'Brien was allowed to focus on the
2 appraisal in the meantime and to provide the statements
3 afterwards. And then within a couple of weeks later
4 I asked another update afterwards, I think
5 in February-time.

15:35

6 133 Q. Now, the impression to be borne from this email is that
7 the investigative team is waiting on Mr. O'Brien, and
8 that is perhaps true in part, but as appears from
9 emails that the Inquiry has looked at already this
10 week, on 22nd February Mr. O'Brien replied to Mrs.
11 Hynds, who was obviously chasing Mr. O'Brien to
12 follow-up. But he was able to tell her that he had not
13 received from the investigative team in the
14 three months since November, getting on for
15 four months, the Draft Witness Statement which was the
16 responsibility of the investigative team to produce.

15:36

15:36

17
18 So interview early November, sitting then on 22
19 February, and Mr. O'Brien still hasn't received that
20 draft statement for his consideration and approval.
21 Again, did you know that?

15:37

22 A. I don't think so. I was aware of that at that
23 particular time. I was aware that the investigation
24 team is waiting for the statement or the representation
25 or the comments back from Mr. O'Brien. But I don't
26 recall knowing that issue that he has with this
27 statement from the team.

15:37

28 134 Q. Then eventually it is sent to him on, do you recall,
29 the 4th March and he takes a further four weeks to

1 sign-off on his works. So can you accept from that
2 description, Dr. Khan, that the responsibility for the
3 delay in this process was certainly not by any stretch
4 of the imagination wholly Mr. O'Brien's, but
5 a significant responsibility for the delay rests with 15:38
6 the investigative team. And I think you'll probably
7 accept yourself for not effectively managing that team
8 to ensure that greater expedition was brought to bear?

9 A. I think on reflection there are a number of issues
10 there. The most important thing was going through the 15:39
11 process well into end of 2017. I was getting quite
12 regular updates in the investigation, how it is
13 progressing, and then in the later part, after Autumn
14 2017, around that time, there was a little pause or it
15 was something about getting through Mr. O'Brien's 15:39
16 statement. On reflection, maybe he shouldn't have been
17 allowed to go for a further two months for the
18 appraisal, which was already, now you know, quite
19 delayed and this is an important part of the
20 investigations, so on reflection, he shouldn't. But at 15:40
21 the same time I think that the responsibilities lies
22 across.

23
24 A lot of people, and I take my responsibility,
25 absolutely, in terms of managing and keeping the 15:40
26 momentum going, I was also providing updates to
27 Mr. wilkinson as we were going along in the
28 investigation, in fact, in the second part of 2017.
29 I was also requesting some updates from the

1 investigator and Siobhan Hynds in terms of how it
2 was progressing.

3
4 But I think there are a number of factors which led to
5 further delay and could have been avoided if we acted 15:41
6 upon at that point in time.

7 135 Q. It is fair to reflect I think, isn't it, Dr. Khan, that
8 this has to be viewed in the context of your day job
9 and the duties and responsibilities that you had as
10 a clinician, as well as an Associate Medical Director 15:41
11 at that time, shortly to take up the reins as Interim
12 Medical Director. Delays are almost an occupational
13 hazard perhaps as a scheme such as this which doesn't,
14 at least in terms of how the Southern Trust, and no
15 doubt, other Trusts operated, provide for dedicated 15:41
16 time and that's across both, yourself, Dr. Chada, and
17 indeed Mr. O'Brien who obviously had others things in
18 his in-tray, most obviously of all a busy clinical
19 practice. No doubt the Inquiry will reflect upon those
20 structural issues when it is looking at this. 15:42

21
22 I'm going to suggest a short break, perhaps, for
23 comfort purposes and the stenographer and no doubt the
24 witness.

25 CHAIR: Can we come back at five-to-four and finish by 15:42
26 half?

27 MR. WOLFE KC: Yes.

28 CHAIR: Thank you.

(Short adjournment - 3:54 p.m.)

CHAIR: Thank you, everyone. Mr. Wolfe.

MR. WOLFE: Good afternoon again, Dr. Khan. We aim to finish at about four-thirty today. Regrettably, and I say this to almost every witness, you will have to come back to us on Tuesday, hopefully Tuesday morning is suitable. 15:54

Before we finish this afternoon there are just two discrete issues: The first is your engagement with the General Medical Council's Employer Liaison Officer. If we go to document 596 of your core to start with, we'll scroll down to 597. It is TRU-264001. 15:55

We can see that you, "AK", are meeting on 6th June 2018. At this point you are meeting because you're the Interim Medical Director. The MHPS report is about to arrive on your desk any day now. The GMC are aware of that and they're aware of an SAI, or a series of connected SAI reviews arising out of the triage issue. 15:56

One issue arising out of this engagement that I would ask you to deal with. At the bottom of the page you say you will update "JD", that is Joanne Donnelly, isn't it, on the MHPS investigation as soon as you can and on the SAI investigation as soon as you can. In the meantime you are assured that there are no Patient 15:56

1 safety risks:

2
3 "...subject to the doctor providing a written
4 undertaking that he will not work from his home, his
5 own home or do any other private work which you will 15:57
6 seek as soon as practicable."

7
8 You are asked to confirm to Ms. Donnelly that the
9 undertaking is going to be provided and that you're
10 confident that you can rely on it. That issue was the 15:57
11 subject of a follow-up letter too. If you just glance
12 at that, it is 601 of your core, and if we go down to
13 251519. She's reflecting on or summarising the meeting
14 of 6th June. She sets out the fact that there are no
15 clinical concerns and describes that the concerns 15:58
16 relate to administrative delays, et cetera. Then you
17 set out, it is set out on your behalf what was done
18 when the problem was identified.

19
20 Then the next paragraph you also confirmed that: 15:59

21
22 "While the doctor does not work for any private
23 organisation, he does do some private work from his own
24 home involving triaging and referring urology patients
25 referred by their general practitioner." 15:59
26

27 Ms. Donnelly advised that in their view, GMC view, it
28 would be prudent for you to secure an undertaking. So
29 he is repeating what was said at the meeting. Just by

1 way of orientation then, so what, if you can elaborate,
2 was the concern here, can you recall?

3 A. I suppose at this stage I would be Interim Medical
4 Director and have had contact with Joanne Donnelly as
5 part of the ELA Trust meetings. GMC was already aware 16:00
6 of this case. It was in the list of ongoing issues
7 within Joanne Donnelly's emails and minutes before
8 that. Dr. Wright would have been already updating
9 her. So from the time, I understood from the time the
10 MHPS investigation started the previous year, which was 16:00
11 2017, that there was some discussion between her and
12 Dr. Wright in relation to private practice and
13 undertaking of not doing private practice.

14
15 The reason behind this is, if there is an MHPS 16:01
16 investigation and also an SAI which is still ongoing,
17 until that is concluded and the report is available and
18 discussed and assured, until then he should stop doing
19 private practice at his home. We did indicate to
20 Joanne Donnelly that he is, obviously Mr. O'Brien is 16:01
21 being monitored under the action plan on the Trust, but
22 there is obviously no monitoring arrangements at his
23 home. So she requested an undertaking that Mr. O'Brien
24 will not do a private practice, so that was the
25 background of this issue. 16:01
26

27 Now, that would be my first-time meeting with Joanne
28 Donnelly in the GMC ELA Southern Trust liaison meeting.
29 I would have gone through the minutes before and

1 afterwards and then when this, again this request came,
2 I discussed this issue with Mrs. Toal as HR Director,
3 asking her advice and opinion in that regard. I also,
4 obviously, discussed this with Simon Gibson who was the
5 Assistant Director in the Medical Director's office and 16:02
6 assisting me in those meetings.

7
8 So I think there is also another chain of communication
9 which I have added in to my addendums as well in terms
10 of how my reflection was at that point in time. 16:03

11 I wanted to, obviously, understand better from the
12 Trust point of view and position what we have to do and
13 therefore I discussed this with Mrs. Toal. There was
14 some lack of clarity in terms of what we are expected
15 to do or what we are supposed to do from The Trust 16:03
16 point of view and my personal view at that stage, I was
17 leaning towards obviously to get the undertaking, but
18 how we are going to do that.

19 136 Q. Yes, just to interrupt you by way of assistance,
20 hopefully. If you go to page 621 of your core bundle 16:04
21 and if we go to TRU-263996. So you've already alluded
22 to your engagement with Vivienne Toal on this issue.
23 This is 22 June. This is some two weeks after your
24 meeting with the GMC ELA. You explained to Mrs. Toal
25 that: 16:04

26
27 "JD is clearly requesting an undertaking from A0' B on
28 the basis of Patient Safety risks. I know Trust
29 haven't demanded this before from Mr. O'Brien, however,

1 on reflection, I would also be concerned and reluctant
2 to provide assurance without an undertaking from him.
3 Can we discuss this again early next week before I can
4 go back to her?."

5
6 So it is framed as a Patient Safety concern against the
7 background of what had triggered the MHPS investigation
8 presumably?

9 A. Yes.

10 137 Q. Yes. The issue, as you say, had been raised with Dr.
11 Wright before you, and we have seen that already
12 through the records of engagement with the GMC. You're
13 expressing your view that you're uncomfortable in the
14 absence of an undertaking and you're inviting Mrs. Toal
15 to discuss this with you.

16
17 Now, just before I ask you a question about that,
18 we can see from the advice that you took from Grainne
19 Lynn of NCAS in September following your determination,
20 or in the run-up to your determination on the MHPS
21 report, if we just pull this up to complete the
22 picture. AOB-01902. If you can go to page 898 of your
23 core, Dr. Khan. If we go down towards the bottom of
24 the page, the penultimate paragraph. Thank you. She
25 records, and we'll look at this document for other
26 purposes later, this follows a telephone conversation
27 between you and her on 20th September 2018, and she
28 says:
29

1
2 "We discussed the current situation and the overriding
3 need to ensure patients are protected. I note that
4 you have a system in place within the Trust to
5 safeguard patients."

16:07

6
7 which is the monitoring arrangements:

8
9 "But we discussed that this needs to be mirrored in the
10 private sector."

16:07

11
12 You explained that the doctor saw private patients at
13 his home and did not have a private sector employer.
14 She would suggest that as per paragraph 22 of section 2
15 which states that:

16:07

16
17 "Where a HPSS employer has placed restrictions on
18 practice, the practitioner should agree not to
19 undertake any work in that area of practice with any
20 other employer."

16:07

21
22 Dr. O'Brien should not currently be working privately
23 was their advice.

24
25 How was this managed within the Trust? I think we know 16:07
26 that by the date of his retirement an undertaking had
27 not been obtained, his retirement period coming
28 in June 2020?

29 A. I was reflecting on this issue. I think I added

1 another communication in my addendum as well. I had to
2 go on urgent leave just after that week. I don't know
3 whether; it should be in my addendum which I submitted,
4 that email communication. I asked Simon Gibson to
5 discuss with Vivienne Toal and Richard Wright and
6 inform Joanne Donnelly the outcome of that discussion.

16:08

7 138 Q. If we pull up page 2104 of your bundle, not the core
8 bundle, your witness bundle, and if we could have up
9 WIT-91935. So does that assist you, Doctor?

10 A. Mh-mmm.

16:09

11 139 Q. You were explaining, and as you can see in the top
12 email that you hadn't got to speak to Vivienne Toal
13 before she left for annual leave, but you make clear
14 your view that you were personally leaning towards
15 Joanne Donnelly's advice to request an undertaking. So
16 what's your understanding of what steps were taken?

16:10

17 A. My understanding at that point in time was I made it
18 clear that this requires further discussion. I did
19 discuss with Mrs. Toal and I was to discuss again
20 before she goes on leave and it didn't happen. And
21 I had to go on leave for some family reasons soon after
22 that, I think within a few days, or a couple of days
23 after that. So I delegated this to Simon Gibson in
24 order to close the loop and to address this issue
25 because I knew I was going to be away for a number of
26 weeks, to draw this and to inform Joanne Donnelly in
27 relation to that.

16:10

16:10

1 Now, when I came back I understood this was completed.
 2 It never came back to us again until quite later in
 3 terms of that undertaking, but that was my
 4 understanding at that point in time.

5 140 Q. It came back to you, obviously, in the NCAS
 6 correspondence.

16:11

7 A. Yes.

8 141 Q. In September. Do you know whether a decision was ever
 9 reached to approach Mr. O'Brien to ask for an
 10 undertaking, or did this issue, was this issue avoided
 11 and the view of GMC and NCAS effectively disregarded?

16:12

12 A. I'm not sure whether I was aware after that that this
 13 issue was either resolved or still outstanding. And
 14 I can't recall any further discussions in relation to
 15 this undertaking until the end of the year when my
 16 interim Medical Director role ceased. But I must say,
 17 was trying to figure out and I was trying to reflect on
 18 this, whether this issue kind of stayed or left after
 19 I left it with Simon Gibson and to discuss with this.

16:12

20 142 Q. Can you explain why you were synthetic to the view
 21 expressed by Ms. Donnelly that an undertaking should be
 22 obtained?

16:13

23 A. Purely for the reason that we, at this point in time,
 24 we had very little information in terms of any further,
 25 obviously we knew that there were other SAIs started
 26 ongoing, they haven't finished. I was on the view that
 27 we should take an undertaking that Mr. O'Brien should
 28 not work until we know the investigation, the SAI and
 29 the MHPS investigations are concluded.

16:13

- 1 143 Q. From a validation perspective was it important?
 2 A. For the revalidation?
- 3 144 Q. Yes. Did you need to have in your own mind, I'm not
 4 quite sure what the date was for the revalidation, but
 5 from your own perspective, if you were entering into 16:14
 6 the process of revalidating, is this something you
 7 would need to have assurance on?
- 8 A. Absolutely. You need to have assurance for many
 9 reasons but revalidation is one, yes. But even for the
 10 basic element of ensuring that you have a system in 16:14
 11 place for assurance in all areas of his practice.
- 12 145 Q. Can I move then to the issue we touched upon just this
 13 morning about the monitoring plan, its implementation
 14 and your role in superintending it. Overall
 15 reflections, first of all: How, looking back at this 16:15
 16 area, how well do you think the action plan with its
 17 monitoring arrangements worked, taking into account
 18 that the alternative that was under consideration was
 19 exclusion?
- 20 A. The monitoring arrangement was designed and drafted by 16:15
 21 the Acute Directorate to ensure robust monitoring in
 22 terms of the elements which needs to be monitored. And
 23 it was clear, elements to be monitored according to the
 24 action plan. I was getting regular updates and I was
 25 also requesting assurances at various points in time. 16:16
 26 On reflection, I suppose, the monitoring arrangement
 27 was not as robust as it should have been, purely
 28 because it was reliant on possibly one or two people
 29 and also the lack of any clinical monitoring, clinical

1 managers monitoring in that action plan. And
2 I reflected on that issue when I was drafting the
3 determination. And that was one reason I wanted to get
4 the monitoring arrangements renewed or updated.

5
6 I feel that monitoring arrangement was started with
7 a robust process but it did fall down on a number of
8 occasions, purely because it was reliant on Head of
9 Service to monitor it on various elements and when she
10 was away, she was off, then it didn't, it wasn't picked 16:16
11 up by a replacement or there was no alternative
12 arrangements in terms of how the monitoring should go
13 along and the escalation.

14 146 Q. Could I just ask you about that element of it, the
15 actual work of doing the monitoring, the escalation 16:17
16 requirement to you through the Assistant Director
17 Mr. Carroll. You pointed up the absence of a clinical
18 involvement on that role. Now, we do know, for
19 example, that in the summer of 2017 Mr. Weir attended
20 at a meeting which focused on the issue of case notes 16:18
21 being retained in Mr. O'Brien's office, and Mr. O'Brien
22 proffered an innocent explanation around that. He said
23 that his secretaries were responsible for putting files
24 into his office. He didn't need them and it wasn't his
25 system, but the secretaries' system. 16:18

26
27 So Mr. Weir was involved to an extent, but did you see,
28 looking back on it or reflecting on it, that there was
29 a greater role that should have been enshrined in the

1 process for the Clinical Director and perhaps,
 2 ultimately, for the Associate Medical Director?

3 A. I think reflecting on that action plan and monitoring
 4 arrangements I see there was a role for clinical line
 5 management structure in there, purely for the reasons 16:19
 6 of understanding better the clinical ins and outs of
 7 Mr. O'Brien's working and also the line management
 8 structure was already there. I was the aware that Mr.
 9 Colin Weir is also aware of the arrangement but not
 10 necessarily actively involved in the monitoring. 16:19

11 147 Q. Do I take it from your answer that you're suggesting
 12 that it's not sufficient to have simply operational
 13 managers looking at this area, that he needs either the
 14 support or the cajoling, in certain circumstances if
 15 there's divergence of his peers who are managers? 16:20

16 A. I think that is one of the elements in my mind I was
 17 thinking about when I was drafting my determination in
 18 terms of going forward action plan, that the role of
 19 Clinical Manager into the monitoring of all that.

20 148 Q. Can I ask you about a discrete issue and see if we can 16:20
 21 follow it through a little. The monitoring plan is to
 22 be found at your core 429. If we go to TRU-00732.
 23 We can see at the top, just look at some of these
 24 elements, we'll come back at it with questions perhaps
 25 on the next occasion. It is explaining the background, 16:21
 26 first of all, of the decision to have such a plan and
 27 it is saying that this action plan will be in place
 28 pending conclusion of the formal investigation process
 29 under MHPS. Now that's explicit. I think you say

1 something in your statement that it wasn't made
2 explicit in the plan. Maybe that was an oversight on
3 your part, but you accept that it is seeming to say
4 that the action plan is alive for the duration of the
5 investigation.

16:21

6
7 Certainly from a Trust perspective it was to remain
8 alive after the investigation, indeed after your
9 determination; is that fair?

10 A. I think it's fair to say there is a variability in
11 terms of understanding from what it should be in my
12 mind and many other people in the Trust. We were of
13 the opinion that this is alive and it's ongoing until
14 the new action plan is in place. However, I understand
15 there are other understandings or views in relation to
16 that as well.

16:22

17 149 Q. Yes.

18
19 Did you, for instance, ever communicate directly to
20 Mr. O'Brien your view that this plan remains alive?

16:22

21 A. I think I did at the October 28 communication. I think
22 in one of the letters I asked him -- or one of the
23 communications I asked him to make sure that, you know,
24 you are still adhering to the action plan.

25 150 Q. Yes, I've seen that. We'll perhaps bring that up at
26 another time.

16:23

27
28 The one issue I wanted to ask you about in this
29 particular plan is, if we scroll down to the issue

1 concerning dictation concern, I think Concern 3. It
2 says:

3
4 "All clinics must be dictated at the end of each clinic
5 theatre session via digital dictation. This is already 16:23
6 set up in the Thorndale Unit. This dictation must be
7 done at the end of every theatre and a report by via
8 digital dictation will be provided on a weekly basis to
9 the Assistant Director of Acute Services to ensure all
10 outcomes are dictated. An outcome plan record of each 16:24
11 clinical attendance must be recorded for each
12 individual patient and this should include a letter for
13 any patient that did not attend as there must be
14 a record of this back to the GP".

15 16:24
16 Now, just on the issue of the ability of the Trust to
17 effectively monitor dictation and ensure that clinics
18 are followed up with dictation, it was pointed out in
19 December 2016 that the system depended upon the reports
20 coming back from the medical secretary. Let's just 16:25
21 look at that. If we go to your core 207 and if I could
22 have up TRU-288967. If you go to 207 and scroll down
23 to what Katherine Robinson has to say to Anita Carroll.
24 This is 20th December 2016. She's telling Anita
25 Carroll: 16:26

26
27 "This is a list of clinics that Mr. O'Brien has not
28 dictated on and hence no outcome for some of these
29 patients. There is a risk that something could be

1 missed so I am escalating to you although a lot of time
2 I know Mr. O'Brien knows himself what is to happen with
3 patients. Unfortunately, this was not highlighted on
4 the backlog report. The secretary assumed we knew
5 because there have always been issues with this 16:26
6 particular consultant's admin work from our
7 perspective. As I learning from this discovery, I've
8 asked all secretaries to provide this information on
9 the backlog report so that we fully understand the
10 whole picture of what is outstanding in each 16:26
11 speciality. The secretary also advises that
12 Mr. O'Brien is presently working on some of this
13 backlog admin work as he is off sick recovering".
14

15 This seems to suggest, Dr. Khan, that this system 16:26
16 depends on reports coming back from the secretary that
17 the dictation work is all present and correct. Now,
18 did you know at the time of the construction of the
19 action plan and its attendant monitoring arrangements
20 that this was the system in place for checking for 16:27
21 compliance?

- 22 A. I suppose I wasn't aware of the specific issue, but
23 working in the Trust I would have known that there is
24 a system in place for secretaries to report back in
25 terms of compliance of the digital dictation. 16:27
26 Historically, it was analogue dictation but then most
27 of the places were converting into digital dictation.
28 I understood as part of the action plan, Mr. O'Brien's
29 on his computer in his office should have the digital

1 dictation, and monitoring arrangement through his
 2 secretary by completing the backlog report.

3 151 Q. If we could then turn very briefly - we'll just finish
 4 this issue - to page 513 of your core bundle. If we go
 5 to WIT-55743. Here you'll find, several months after 16:28
 6 the introduction of the monitoring action plan, an
 7 email from Mark Haynes, 17th June 2017. He's thanking
 8 members of the support team for circulating a backlog
 9 report. But he's saying:

10
 11 "I'm concerned regarding the robustness of this data,
 12 particularly in relation to 'results to be dictated'".

13
 14 Then he asks:

15
 16 "Could you advise me of the process whereby this data
 17 is collected. From recent experiences I would suggest
 18 that the date presented in this column is inaccurate.
 19 My concerns relates to how this information would be
 20 used in the event of a significant issue arising due to 16:29
 21 a delayed or not acted on result. Corporately are
 22 we kidding ourselves that all results are acted on,
 23 dictated on in a timely manner? That is the conclusion
 24 you could draw from the information, particularly in
 25 relation to some consultants. If a backlog were 16:30
 26 identified after an issue were to arise, are the staff
 27 who collect the data (I presume our secretaries) liable
 28 to be found culpable for not highlighting the backlog
 29 through this process? One could argue that the

1 information presented whereby some consultants seem to
2 barely ever have any results to dictate is not untrue -
3 not all of us dictate letters on results. An
4 illustration of the inaccuracy of the data may be seen
5 in last year's data in relation to a number of clinics 16:30
6 to be dictated, which has been proven to be
7 inaccurate".

8
9 I seem to recall Mr Haynes, when giving evidence on
10 that issue, was directing attention to what he knew in 16:30
11 respect of Mr. O'Brien.

12
13 Unfortunately, we have to leave this issue a little bit
14 in the air but it is the case, Dr. Khan, that
15 by October 2019, the Trust is still grappling with the 16:31
16 issue of dictation in the context of Mr. O'Brien and,
17 indeed it might be said, generally, and there was
18 a meeting convened in January to 2020 to try to address
19 this issue.

20 A. I think this is a long-standing issue in terms of 16:31
21 dictations and how the dictations are typed and
22 monitored. Various departments have various ways in
23 terms of addressing those issues. But I think in the
24 Acute Directorate, this was still quiet active and
25 alive in terms of an ongoing challenge in terms of how 16:31
26 to address the dictations backlog typing, printing out
27 or sending it to the GPS or to the charts.

28
29 I think you are right, you are correct to say it was

still -- until quite recently, it was an alive and
challenging issue.

152 Q. Very well.

MR. WOLFE KC: I think we'll leave it there for today.
Maybe take up on the next occasion and finish the area
of monitoring. Then we'll move into your determination
in respect of Dr Chada's report.

So 10 o'clock, I think, on Tuesday?

CHAIR: Yes.

Thank you, Dr. Khan. We'll see you at ten o'clock next
week.

10 o'clock next week, ladies and gentlemen.

THE INQUIRY ADJOURNED TO 10:00 A.M. ON TUESDAY 28TH
MARCH 2023