Urology Services Inquiry

Oral Hearing

Day 33 – Tuesday, 28th 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.

Gwen Malone Stenography Services

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THE INQUIRY RESUMED ON TUESDAY, 28TH MARCH 2023, AT 10:00 A.M. AS FOLLOWS:

CHAIR: Good morning, everyone. I know my colleagues are on the Zoom call with Dr. Khan. You can't see them this morning but they are both present.

Good morning, Dr. Khan. I'm sure you're rather relieved you were joining us remotely last week when we had all to test for COVID. I'm fit and well, my two colleagues thankfully, although positive, have mild symptoms so they're certainly fit to get on with the work. So that's what we're going to do.

Mr. Wolfe.

MR. WOLFE KC: Good morning, doctor, and welcome back and thank you for joining us. You remain under oath, of course. You still have your bundles available to you?

A. I do, yes.

Q. Very well.

You'll recall that at the conclusion of the last day of hearing with you, I was exploring with you the action plan and the monitoring arrangements attached to that. Through the lens of the dictation issue, I was examining with you how robust or reliable was the information available to managers in order to supervise that issue as part of the plan. I brought you,

I think, to a meeting on 20th January, if you like, several years after the plan had been introduced, and you were explaining to me at the end that within the Acute Directorate there always seemed to be a problem - I hope I'm not overstating it - but there seemed to be a problem which was never fully resolved in relation to the dictation issue. Is that fair? 10:03

A. I suppose, just to further expand on that, I never worked in the Acute Directorate so I wasn't going to be part of a clinician's experience in that way, that I would have seen a patient and dictated in Acute Directorate. I was aware there was an implementation of the digital dictation process across the Trust, including the Acute Directorate. Some parts were already implemented and other parts were going through the implementation of the digital dictation process. But other parts - various parts, actually - had challenges in terms of managing the dictations, not necessarily just in Acute Directorate, there other directorates would also be in that position. So it was a process going through the digital dictation which gives a more robust monitoring recording arrangements for the dictations. That was obviously my impression in that way, that the Acute Directorate was also going through the implementation of the digital dictations. 10:03 10:04 10:04

2 Q. Yes. I just want to explore with you then the process by which this action plan with its monitoring element was put on paper and agreed in February 2017 so that we can better understand how the various elements came

together.

Let's start by looking at something you said in an email -- sorry, in your witness statement, I should say:

"I attended the return-to-work action plan meeting along with Mrs. Siobhán Hynds, Ronan Carroll and Mr. Colin Weir".

Let me just put up an email from Siobhán Hynds in relation to this, 22nd February 2017, your core 414 and TRU-267574. At the bottom of the page, please. Siobhán Hynds is writing to Esther Gishkori and Ronan Carroll is copied in. It is explained that Siobhán Hynds and yourself hope to meet with Mr. O'Brien this week to outline the monitoring arrangements, however Ronan's on leave, and you notified Mr. O'Brien that you do not have the detail as yet but will inform him as soon as possible. It's important that this is done as early as next week because he intends to return to work if passed fit.

Siobhán explains:

"Colin Weir is fully aware of this and it will be necessary, I assume, to inform the other clinical directors to ensure the monitoring is robust and doable", and a meeting is suggested.

Can you help us, Dr. Khan, in terms of where was the action plan developed and who developed it, and was it in fact brought to a meeting of the several people mentioned here to discuss its robustness? 10:07

A. The action plan was developed after the case conference. At the case conference, one of the actions were to develop an action plan by the Director of Acute Services and her team. Ms. Esther Gishkori and Ronan Carroll, or her team, was to develop an action 10:08 plan. Purely it was felt at the time of the case conference that this is necessary in order to make sure that the monitoring and the action plan and follow-up and monitoring is robust within the Acute Directorate, purely because they know the system within the Acute 10:08 Directorate in terms of the operational management and how it best can be managed. So, that was the background at the time of the case conference at the end of January.

10:08

Subsequent to that, I understood there was a number of discussions within the Acute Directorate. Now, I wasn't party to that or I wasn't involved in those discussions. Talking to Siobhán Hynds and looking at other communication, I was aware that there was some 10:08 discussion happening within Acute Directorate in terms of putting that action plan together. We were to come together and meet before I and Siobhán Hynds would be meeting with Mr. O'Brien in order to inform him and get

his agreement to that. So yes, it was devised, developed and obviously drafted by the Acute Directorate team.

Now, I understood at that time as well that Siobhán Hynds was helping in supporting them in order to put that together in more kind of a document format. 10:09

3 Q. We know that you met with Mr. O'Brien and you discussed the action plan with him, and we'll come to that in a moment. But before you reached that stage of meeting Mr. O'Brien, did you sit down and meet with these other people, study the action plan, and give your approval for it? 10:09

A. I did give my approval for that. My recollection is that a small group of people met. Now, I'm uncertain who was -- I know it was myself and Siobhán, and there was Ronan Carroll possibly. My recollection is that a small group of people met to go through the action plan before I met with Mr. O'Brien. 10:10

4 Q. You say in your witness statement - I don't need to bring it up to the screen but if you need to look at it, it's at your bundle at page 84 - where you say that the return to work action plan monitoring arrangement was drafted by the Acute Directorate Management and agreed by the Oversight Committee meeting on 3rd February 2017. Now, I'm not aware of a record of any such meeting. Are you saying the Oversight Committee met on that date? 10:10 10:11

A. Now, I suppose on reflection this may be that the small

group of people when they met rather than the Oversight Committee, as such. I was aware that the Oversight Committee was aware of this action plan. I'm not sure if this is the correct reflection what it was at that stage. Maybe it was just that a small group of people met, including myself and Siobhán Hynds and Ronan Carroll. I'm just trying to think about whether the whole Oversight Committee met. Maybe not. It was this small group of people who met and then, obviously, the Oversight Committee was aware of this action plan. That was my understanding. 10:11 10:12

Q. So when this small group met, did you have it in mind, for example, to discuss - take the example of the dictation issue that we have gone through - how are we going to be able to establish that Mr. O'Brien has performed all of the dictation that we require him to perform? 10:12

A. I think there was -- I don't recall that there was a specific dictation issue was discussed at that point in time. The understanding was it will be monitored by the arrangement which is already in place, such as -- it wasn't actually mentioned about that, the secretary or who else, but my understanding was that it would be monitored within the Acute directorate Management system, which is already in place for any other clinician and tracking back and all those things as well. 10:13 10:13

So, my experience in my department would be that my

secretary would be, you know, informing me or keeping me appraised of where the dictations are, or what we need to do if there is obviously a further clinical dictation or something required. That was my understanding at that point in time. As I said, 10:13
I wasn't very close to Acute Directorate or especially with Urology Services at that point in time. In fact, I wasn't clearly appraised at that point in time about the lack of escalation of the dictation. So, it was felt that that would be the system which is already in 10:14
place.

6 Q. Are you saying, in other words, that you were assured by what Acute managers were telling you about their ability to robustly manage this?

A. I suppose the assurance was not only just for the 10:14
dictations, the assurance was for the whole action plan --

7 Q. Of course.

A. -- that this is drafted, this is performed and drafted by the Acute Directorate, a team who knows their 10:14
system, and they will provide the assurance monitoring and escalation.

8 Q. If we can then just look at the action plan which also serves, it appears, as a record of your meeting with Mr. O'Brien. Page 429 of the core bundle, Dr. Khan. 10:15
If we could have up TRU-00732.

A. Page 49?

9 Q. Page 429 of the core.

Could you explain to us the format of the meeting which you held with Mr. O'Brien on the 9th February? Did you lead the meeting with him?

A. Yes. It was a meeting with Mr. O'Brien and it was myself, Siobhán Hynds. I led that meeting, explaining the purpose of that meeting. Essentially the main purpose of that meeting with Mr. O'Brien was to share the action plan and get his agreement in order to proceed to the return-to-work arrangement which was already agreed in the previous month. So, we did go in the details of the action plan with him, essentially going in terms of what are the main elements of the action plan and what is required from Mr. O'Brien's point of view, and then how they are going to be monitored. 10:15 10:16 10:16

10 Q. Just on this record, it doesn't appear to make any reference to any contribution from Mr. O'Brien at the meeting. Can one assume that he did contribute a viewpoint at the meeting?

A. The action plan was already established and we shared that action plan. I must say he did not contribute into the formation of action plan. However -- 10:17

11 Q. Sorry, just to cut across you. Did he contribute at the meeting to your explanations of what was required of him? 10:17

A. I don't recall the exact details of the meeting but he did show his agreement that he will adhere to the action plan. I was also aware that in another previous meeting, I think end of January - I didn't meet him but

he met with a number of other people - he said, or he agreed, that he will adhere to any monitoring or action plan arrangements in order for him to come back to work. So, in my meeting he agreed on the action plan, that 'I will stick to or I will adhere to the action plan'.

12 Q. If we just look through it. As it appears from the top section, it is made clear that a condition of his return to work would be monitoring around the four main issues under investigation as well as an urgent job plan review to consider any workload pressures. We've heard evidence from you in relation to the delays and the difficulties around that. 10:18

If we just scroll down then. His immediate workload upon returning to work is set out there. Then in specific terms under Concern 1, the issue for investigation is highlighted at the first bullet point, and then the action required of Mr. O'Brien going forward, including the completion of red flags daily when urologist of the week. Scrolling down, please. Then it provides that a report will be shared with the Assistant Director at the end of each period to ensure all targets are met. 10:19 10:19

On that, were you satisfied that that met the difficulty and provided adequate assurance in relation to the triage issue?

A. I guess different elements of the action plan are

monitored by various peoples but they're all providing report to the Assistant Director of Surgical Services at that point in time. So, in this instance it was the central booking system who was monitoring and providing assurance to the Assistant Director, who obviously was to escalate or to inform other people if there is a deviation or otherwise. So in this case that was, again, established that this is going to be the monitoring arrangement for the triage part, yes. 10:20

13 Q. Then, with regard to the issue of notes being removed From Trust premises, it's made clear that that's not to be done at all. Notes tracked out to Mr. O'Brien's office must be tracked out for the shortest period of time possible for the management of a patient. How was that to be determined, Dr. Khan? Was there any particular thinking given to the issue of what is the shortest period of time, or was that to be on a case-by-case basis? 10:20 10:21

A. I don't recall the specific discussion around the period of time the notes can be kept in the office or outside. It was depending on the situation at that point in time, but there was no specific discussion happened in relation to that. 10:21

14 Q. Do you think there was clarity of thinking around that issue? 10:22

A. I think in hindsight we see some challenges there. However, at that point in time, that was felt to be appropriate and monitored by various people, yes.

15 Q. Then Concern 3 in relation to the issue of dictation

we've spoken about that at some length already. We know, I think I pointed out on the last occasion, that late in 2016 the issue of the frailty or the weaknesses in relying upon the secretary to report whether dictation had been done or not had been exposed in an email from, I think, Katherine Robinson -- between Katherine Robinson and Anita Carroll copying Mr. Ronan Carroll in. 10:22

Did he raise that issue with you at all as part of this? 10:23

A. I don't recall that I was informed or appraised about the issues. In fact I didn't know until much, much later. In fact, I wasn't aware of those issues which were happening in terms of monitoring and escalation about the dictations through the secretarial services, the secretarial team. 10:23

16 Q. We know, and we'll look at it in a few minutes, that come January 2020 - you referred to this meeting already - that you attended, convened at the direction of the Medical Director at that time, Mrs. O'Kane, and chaired by Mr. Gibson, that issues were raised at that meeting about the lack of clarity in relation to dictation generally across the Trust, whether there was a set standard, whether it was known, when should issues be escalated. 10:23 10:24

In terms of Mr. O'Brien and this specific action plan, is it fair to say that the expectations of him,

regardless of the rest of the Trust, the expectations of him were made very clear?

A. In the action plan there are obviously four elements and one of them was dictation. Therefore, the action plan was agreed by Mr. O'Brien, and it was expected that he will -- that that's the standard which he is expected to deliver and that was until there is some change. So yes, you are right in saying that and that was my understanding, that the action plan provides the standard form for Mr. O'Brien, which he already agreed to, in relation to the dictation and for other three elements. 10:24 10:25

17 Q. Specifically it provides that dictation must be done at the end of every clinic, and a report via digital dictation will be provided on a weekly basis to the Assistant Director to ensure all outcomes are dictated. Then, it provides that an outcome, plan or record of each clinical attendance must be recorded for each individual patient, and this should include a letter for any patient that did not attend as there must be a record of this back to the GP. 10:25 10:25

So, it was designed to be specific in those terms; is that fair?

A. I think it was going in much more detail in terms of the dictation than other elements. I believed that the specific reason of having that action plan in place, and specifically for the dictations, is to ensure that the multi-disciplinary way of working and making sure 10:26

the patient management plan is shared with the multi-disciplinary team, both in hospital and in the primary care team, for the main reason that some of these patients attend multiple occasions by the primary care team, including the GPs, in between when they are attending the hospital services. So, I believe that is a robust arrangement in order for that to achieve that element of standards.

18 Q. Then, scrolling down, please, private patients is addressed. I needn't go into the detail but specific reference made To Trust policies, a guide to paying patients and a specific reference to referral of private patients to NHS lists. 10:27

Again scrolling down, it's made clear that, in conclusion, any deviation from compliance with the action plan must be referred to you immediately, and the referral to you would come through the Assistant Director. Was that your understanding? 10:27

A. That's correct, that's my understanding. In the vast majority of cases or occasions, it did happen that way, yes. 10:27

19 Q. Now, after this meeting there was some discussion, it appears, within the Trust as to whether NCAS should be advised of this plan. If I could just draw your attention to your bundle at 2082. If we could have up on the screen, please, TRU-267906. Siobhán Hynds is writing to you, copying in Dr. Chada, attaching the draft terms of reference for agreement. That's in 10:28

relation to the MHPS investigation. Then asking you, Dr. Khan, "Did you get speaking with Grainne Lynn, NCAS, about the action plan"? That precedes an email earlier in the month which suggested that the legal advice from DLS was that the action plan should necessarily be shared and discussed with NCAS.

Did you get an opportunity to discuss that with Dr. Lynn at NCAS?

A. My recollection is that I did try to speak to her and I didn't get through to her. There was a training coming up in a couple of weeks' time and there was an indication that I could discuss with Ms. Grainne Lynn in the sidelines of the training as well or around that time. However, in the meantime I discussed -- I met actually with Dr. Wright, the Medical Director, and he indicated that he was going to. Subsequent to that, I understood that he did discuss with Grainne Lynn from NCAS. I don't recall seeing a correspondence in relation to that, but my understanding was that Dr. Wright discussed with Grainne Lynn.

20 Q. Did Dr. Wright feed back to you what NCAS had said in relation to the action plan?

A. I don't recall that we had any such discussion, but what he suggested that he did speak to Grainne Lynn. But I tried to -- even afterwards as part of the preparation of my statements, I was trying to identify or find a communication in relation to that but I couldn't find any communication.

21 Q. So are you saying that you made contact with Dr. Lynn, it was agreed that you could discuss this issue on the edges of the training that was coming up but in the meantime Dr. Wright took over the issue, and it's your understanding that he talked to her about it? 10:31

A. That's my understanding. I tried to speak to Ms. Grainne Lynn on one occasion after this and I couldn't get through to her. Something that I couldn't get through to her. Then there was some -- I think Siobhán Hynds possibly suggested that you are 10:31 attending that meeting which Grainne Lynn is going to be -- not that meeting, the training day, which is Grainne Lynn going to be at, so if you wish to discuss it at that point of time, which was in a couple of weeks' time. However, Dr. Wright, when I met with 10:32 Dr. Wright, he indicated that he's going to speak to her, and my understanding afterwards is he did get speaking to Grainne Lynn.

22 Q. If you just go to 1498 of your bundle. If we could have up TRU-268026. Mrs. Hynds is obviously persistent 10:32 on this issue and she's writing to you now at the end of March, four weeks after her first email. The training was the start of March as well, I think the 7th and 8th. Dr. Wright is absent. "Is there any update for Dr. Lynn, NCAS, at this point"? 10:33

Can you help us on that, Dr. Khan?

A. I don't seem to remember this communication, looking at any communication. I can see in this email there was

some sort of a communication came back because I know the NCAS communication usually comes with encrypted message. So, there must be an email communication came back from NCAS at that point in time. I don't recall seeing any letter or communication at that point in time. I know this must be that Dr. Wright must be off for a day or two and it was sent to me. But you need -- to decrypt that email, you need another password and other information as well, so everybody can't open that. I don't recall seeing a communication or a letter from Grainne Lynn. 10:34 10:34

23 Q. No. If I can preempt what we anticipate she might say, drawing from her contact with the Inquiry to date through statements. She has indicated that she wrote several emails to the Trust after December 2016 when her advice was sought. Her repeated emails didn't receive any response from the Trust and ultimately NCAS closed the file. 10:35

Is it possible, Dr. Khan, that this request or direction that you should contact NCAS was either missed by you or avoided by you for any reason? 10:35

A. I remember contacting her first when the first request was made, I think at the beginning of March, and I didn't get through to Grainne Lynn. I think I wrote back to Siobhán Hynds asking is there another number or something that I can contact her. However, in the meantime, Dr. Wright indicated that he is going to, or he is going to meet or talk or discuss with Grainne 10:35

Lynn. So certainly it wasn't intended to be avoidance. It was possibly that I remember clearly Dr. Wright suggesting -- he said, "I'm going to discuss with Grainne Lynn anyway". I can't recall an email coming back. Now, necessarily all those emails or communications back from NCAS comes to the case manager, they usually come to the Medical Director. I presume this email was sent to me because Dr. Wright was maybe off for a day or two. But you can't access these encrypted messages without having your login details and everything; you have to have that. I don't remember trying to open it or maybe I didn't even try to get to it. 10:36 10:36

24 Q. So you can't recall responding to this email?

A. No. 10:37

25 Q. Very well.

Now, I just want to look at some of the alleged departures from the action plan and examine your participation in the supervision and escalation of that. 10:37

First of all, it appears that on 12th April 2017 you had to write to Mrs. Esther Gishkori and Mr. Carroll asking for an update. If you go to core 489, and if we could have up on the screen WIT-40828. This is at an early stage in the plan you find yourself writing, asking for an update. Had it not been, I suppose nailed down, at an early stage, how the process of 10:37

keeping you informed would be acted out?

A. I suppose I did write to the Acute Directorate just to get assurance, in order to get the assurance for the action plan. However, if you look at the action plan, at the end of the action plan it suggests "any deviation should be referred to should be escalated to case manager". So on reflection, I don't know, that may be the reason if there is any deviation, then it will be escalated to case manager. 10:38

I must say, I did receive a number of assurances for the action plan during the year and on occasions I also requested some, but the action plan document actually suggested for escalation rather than a regular update. So, there may be this understanding in the Acute Directorate. 10:39

26 Q. Yes. If you go two further pages on in your bundle to 491, and if we could have up on the screen TRU-251847. If we just go down to the middle email, please. So you're suggesting that - reading between the lines here - that you want monthly updates; is that fair? 10:40

A. Yes, absolutely. What it says there, it's very clear that I was requesting monthly updates. Now, this is very early on in the investigations. I was trying to get a more regular update if I wasn't receiving any. But I must say in between, in some months I was receiving twice a month and some months I wasn't receiving. So, I was requesting I get a monthly assurance report. And I was getting it; I was getting 10:40

it, initial investigations.

27 Q. I needn't bring this up on the screen but it appears that the team on the ground, that is Mrs. Corrigan and then the Assistant Director, they had set out a plan to look at matters weekly and draw to your attention any difficulty but, in any event, provide you with a monthly report. Is that the understanding of how things were to work? 10:41

A. I think that was the understanding, yes. I wasn't aware of how they're working, on a weekly or monthly, but I was getting it at least monthly, yes. 10:41

28 Q. Shortly after this email on 15th May, your attention is drawn to what you might have suspected was a first deviation or perhaps a first problem with compliance with the plan. I want to ask you how you bottomed that out. If you go to 118 of your bundle and if we can have TRU-251855. If we scroll down, please. The issue is in respect of Concern 2, that's charts in the office. It is reported that -- it says apart from the 13 already identified missing notes - and that goes back to the start of the investigation, if you like - Mr. O'Brien has 68 further charts in his office which are all recent and are waiting for results. 10:41 10:42

Then just scroll up, please. Just keep going. You are, it seems, copied into this. By 23rd June, it's reported by Mrs. Corrigan to Mr. Carroll that Mr. O'Brien has 85 charts in his office. If you go to 1519 and if we go to TRU-268972, Siobhán Hynds is 10:43

advising you of this issue. If we scroll on down. You can see that -- just on down, please. It is flagging that there are 85 further charts in his office.

Can you help us just in terms of what you were thinking at that time and what actions you took, or whether you were content that these issues being drawn to your attention by the team on the ground, that they had it under control? 10:44

A. I think at that point in time there was some indication of the charts coming in his office and also returning back to the secretaries or the other admin staff. I suppose what I was assured by that at the same time the charts are coming in and going out from Mr. O'Brien's office, that there is a management arrangement, or how to deal with this issue is also coming through. They were saying we will deal with this by 30th June or returning to the previous position. 10:45 10:45

So, I was assured with the arrangements already in place and I wanted to ensure that we return to the position. I did discuss this with Siobhán Hynds on one occasion around that time when we were meeting for something else, not necessarily specifically for this issue. But there appears to be action plan, monitoring arrangements were there and a management plan was there when the charted were not returned on time, so follow-up arrangements were already made. So, I was 10:46

satisfied at this point in time.

29 Q. I just want to tease that out with you. On 11th July -- and I'm conscious you've sent in an email to us with your amended statement or your addendum to your statement to indicate that you were on holiday when this email was sent. On 11th July, Ronan Carroll was writing to you. 523 of your core bundle and we could look at TRU-251860. Just scroll down. On Concern 2, which again is notes in the office, 90 further charts. 10:46 10:47

"This amount has been increasing each week and while some are moving on, there are now quite a few that haven't been actioned. I have emailed Mr. O'Brien today and I again reminded him that as part of the action plan, notes should never be stored offsite and should only be tracked out and in of his office for the shortest time possible", etcetera. 10:47

While there's some suggestion there that some notes are moving out, as you've suggested in your last answer, the picture is emerging of an increased volume of notes in his office at that point in time. I want to ask you why, in advance of going on holiday - and obviously this email was sent while you were away or on the day you went - why you hadn't taken any specific steps to meet with Mr. O'Brien and nip this issue in the bud? 10:48 10:48

A. I think before, the previous emails and the communication obviously suggest there was plans around

that to manage this. This escalation, when it came to my attention, obviously I was off on annual leave. When I came back from annual leave, I was assured that the issue of charts had been resolved.

10:49

Now, on reflection, possibly it was going up from June, end of May/June time, and on reflection and hindsight with all that information available, I could have taken a more robust arrangement, or meeting with the team or even indeed meeting with Mr. O'Brien. But every time 10:49 with these issues were raised, it appears to be before this email came that there was an arrangement in place to address those.

30 Q. In fairness to the team, a meeting was arranged by them with Mr. O'Brien in your absence. If you could look at 10:50 page 531 of the core, and if we could have up on the screen AOB-56210. That's the first page after a recording or a transcript of a recording made by Mr. O'Brien of this meeting attended by the persons named there, Weir, Corrigan and Carroll. 10:51

As appears from the content of this meeting, if you go through to 533 of your core, and if we could go down to AOB-56212, another couple of pages down. Just scroll down. At this meeting, in fairness to Mr. O'Brien, 10:51 he's explaining that, if you just read that page, that the notes that are in his office from his perspective do not need to be there, that they are being brought there by secretarial staff. He says at the top of the

page or about a third of the way down that page:

"I don't ask for them. I'm not the person responsible for storing them. There's no need for them. It is an obsolete system". 10:52

It seems, if you read the full account, and the Inquiry can read the full account, that he's making the case that notes are being brought to his office by members of the secretarial team to draw his attention, for 10:52 example, to results relevant to the case, the results are placed on the file and the file is left in his office and multiple files are generated, but he doesn't see the need for that kind of system. 10:53

Was that drawn to your attention up your return from holiday or not?

A. When I returned from my annual leave, I was assured by Ronan Carroll just that the issue of notes had been resolved. I must say, I wasn't aware that they met 10:53 with Mr. O'Brien and the issue of the charts brought to his office had been discussed in detail. But I was assured that the issues had been resolved, you know, in agreement with Mr. O'Brien and the team which is on the ground. 10:53

31 Q. Now, I think it's fair to say that no other issue of concern regarding the action plan was drawn to your attention during 2017. I want to ask you about an issue that arose in 2018. If you go to page 1389 of

your bundle. Your bundle, not the core. If we could have TRU-264481. Just start at the bottom of the page, please. Martina Corrigan is updating Siobhán Hynds, assumedly for the purposes of the MHPS investigation report that comments on Mr. O'Brien's compliance with the action plan. She indicates that apart from one deviation on 1st February 2018 when Mr. O'Brien had to be spoken to regarding a delay in red flag triage, and he immediately addressed it, she can confirm that he has adhered to his return-to-work action plan, which she monitors on a weekly basis. 10:54 10:55

Was your attention drawn to the February deviation, as it's described there?

A. Not until -- I wasn't informed until Vivienne Toal emailed me. I wasn't involved in any escalation or communication prior to that. 10:55

32 Q. Yes. If we just scroll up the page. Vivienne Toal is being advised in respect of this and Vivienne Toal asks you: 10:56

"See below regarding Aidan O'Brien. Have you been getting these updates on a regular basis in terms of assurance?" 10:56

You say at the top of the page:

"I have been receiving it until earlier this year from Ronan Carroll. Haven't received it in a few months

now. Have spoken to him recently and he will forward this to me. Is the report ready", and that's a reference to the MHPS investigation report.

Is this explaining then that you hadn't been advised of the triage issue in February which, on Mrs. Corrigan's description, seems to have been relatively quickly resolved, is that right? You didn't know about that? 10:56

A. That's correct. I wasn't aware of that, no.

33 Q. Plainly, as it's explained here, you had been receiving updates from Mr. Carroll but hadn't been receiving them recently. How did that happen; was that outside of your expectations from him? 10:56

A. So at that point in time there were a couple of things happening. I was preoccupied with my appointment to the Interim Medical Director. I was appointed after the recruitment and selection process in April of 2018. I was also talking or discussing the issues of the progress of the MHPS investigation report with Siobhán Hynds, with Dr. Neta Chada. I would have spoken to Ronan Carroll about the understanding and the management of action plan. So, I was assured by talking to various peoples that the action plan is monitored and the investigation is coming to -- the formal investigation is coming to an end. So I was assured on those bases. 10:57 10:57 10:58

But I must say I didn't go looking for a report, an assurance report. I was under the impression that

I will be informed, and I have been previous to that. So I was assured on my experience in that.

34 Q. Did you interpret, if you like, the failure to send you updates as being an indication that everything was okay? 10:58

A. My understanding was that if there was an issue, it was addressed immediately, and I will receive an escalation if there are further issues, yes. That was my understanding.

35 Q. Later that year shortly after the publication of your determination, this is the autumn of 2018, you became aware, I suppose, of a more significant issue in that, as you will recall, Mrs. Corrigan, who was, if you like, the person primarily responsible for the monitoring and gathering the information in for 10:59 monitoring purposes, she was absent from work on sick leave and monitoring of Mr. O'Brien's compliance with the action plan did not happen for a period of months; isn't that right?

A. I wasn't aware of Martina Corrigan being off for that 10:59 period of time. My understanding was that the action plan has been monitored as it has been before, purely because it was not only my - well, let's call it my perception or understanding - it is not just based on Martina Corrigan but it is the team. If someone is off 11:00 sick or off, then someone else takes on that responsibility, and the Assistant Director was there. So, my understanding was it was monitored. I wasn't aware of Martina being off for that period of time

until much, much later, and I became involved when it was escalated to me.

36 Q. Your previous answer regarding the start of the year when you weren't receiving updates contained an explanation that you were satisfied, perhaps through word of mouth, that nothing was going wrong, things were being monitored, and the absence of an update was interpreted by you at the start of the year as an indication that things were okay. Mrs. Corrigan, I understand, was off from June until October 2018. Did you seek assurances, word of mouth or otherwise, during that period that monitoring was continuing to be done? 11:00 11:01

A. I didn't seek actively any assurances at that period of time but I was assured on a number of other elements. After becoming the Interim Medical Director, I would have some one-to-one with the Director of Acute Services. I would have also had some discussions with other people as well. For instance, my discussion with the Director of Acute Services, it wasn't an established meeting but I established it after becoming the Interim Medical Director. One of the discussions happening in that short period of time before Esther Gishkori was off on sick leave, I think in June or July 2018, one of the important elements were the assurance of the action plan. I was assured that the whole action plan was being monitored closely. 11:01 11:02 11:02

37 Q. We will hear from Mr. Carroll in relation to this today. He seems to have been under the impression,

perhaps, that others in the team were doing the monitoring but, for whatever reason, the issue or the task was not performed. Who was giving you assurance that it was? Was it Mrs. Gishkori?

A. At that point in time I remember there were a number of discussions with Esther Gishkori. Not in October; I'm talking about in June. When I started Interim Medical Director in April, I realised there was no one-to-one discussion with the Medical Director and the Direct of Acute Service in terms of a predicted or dedicated time to discuss issues, so I approached Mrs. Gishkori and we established an informal discussion time, either after the Trust SMT or another time. During the period of from May until June -- May and June, certainly, I was getting assurances this was monitored. 11:03

Now, I must say she was off, I knew she was off in the summertime on sick leave. I had, I think, one meeting with Ann McVey, but I was getting -- my impression was that I will be informed of any deviation, and I was in October, but I wasn't informed of any deviation before that. 11:04

38 Q. If I could ask you to look at page 919 of the core bundle, and if we could have up on the screen, please, TRU-251526. At the bottom of that page, Dr. Khan, you can see that Mr. Weir is writing to you. 11:04

"Please for your urgent consideration and action. See email correspondence below. Please see attached

Excel spreadsheet and go to the October tab or see below in email trail".

If you go over the page then, please, to TRU-251527. It explains to you that Mr. O'Brien has accumulated a large backlog of dictated letters and a large number of charts in his office. Mr. Weir explains "I'm his clinical director", and he asks for instructions on how to proceed. 11:05

If you just scroll down a couple of pages, please. I'll tell you when to stop. If you go over a couple of pages, You can see the details. Stop there, just put it back slightly. This is all copied to you. 11:05

You are told, if you read through all this, Dr. Khan, if you go through another couple of pages, you can see that you're being told there are approximately 82 charts in his office. Scrolling down. By this stage you can see across from Mr. O'Brien's name, 91 clinic letters to be dictated, the oldest of which is dated back to 15th June 2018, if you look at the right-hand column. 11:06

If we could go back up the email trail in the direction we have just come. Thank you. A number of people contribute to these emails, I hope you are familiar with them, Dr. Khan. Ultimately, if we just go on up and see your input. Sorry, on up. Thank you. You say 11:06

this is clearly unacceptable practice from the clinician and responsible managers; you're meeting with Siobhán tomorrow regarding MHPS, and you're asking a number of members of the team can they attend.

11:07

Did you get to the bottom of what had happened here, and what steps did you take?

A. So, this is the time when I received this and I felt it was clearly a departure from the action plan, so therefore I did a number of steps. In fact, I first of 11:08 all informed the Chief Executive. I also approached the Director of Acute Services in order to get assurance or information. I also started discussing with Siobhán Hynds and Ronan Carroll, asking where's the break in all that; where was this, kind of as call 11:08 it, breakdown in terms of monitoring. I still wasn't aware at that point in time, I think, that Martina Corrigan was off for that period of time and it had kind of fallen in between various people's understanding and responsibilities. 11:09

Then I thought it be useful to have a face-to-face discussion in order to understand better what's happening. Unfortunately, Ronan Carroll couldn't meet because he was out of the Trust for some other 11:09 commitment, but he did reply back and he informed about the issues or what was the main issue in terms of monitoring. I think there was an issue of initially about 90 plus dictations and then, within 24/48 hours,

it was identified that it was much less, it was about 16 or 18 dictations left from the previous few weeks. I was still wasn't clear how it happened, so I asked that question. I think it's in the communication chain somewhere that I asked the question about what exactly that means, that you're giving me assurance that it has been addressed and it's going to be monitored, but exactly where it is? So I received the assurance, again from Ronan Carroll, who was obviously the Assistant Director and providing the assurance throughout, that this has been addressed and it's monitored. 11:10 11:10

39 Q. A meeting did take place - I think maybe just to assist your answer with that - or it appears to have taken place. If you go to 939 of your core, and if we look at TRU-251531. Go to 940. Just scroll on down, please. Ronan Carroll, 23rd October, a week or so later, says: 11:10

"Regarding the outcome of today's meeting, can I ask are we to continue monitoring Aidan O'Brien against the four elements of the action plan"? 11:11

If we scroll up, please. Simon Gibson says that's a matter for the case manager. Then you come in very specifically saying: 11:11

"The action plan must be closely monitored with weekly report collected as per the action plan. Can you also

clarify that yesterday, 22nd October, there were 91 outstanding dictations and today only 16"?

A couple of things there. One, you've had a meeting. There was some clarification that the amount of outstanding dictations is reduced. There seems to be some uncertainty in the team about whether the action plan should continue.

How could they have left the meeting with that uncertainty? 11:12

A. Now, I was very clear at the time of this -- this happened just after the determination report was published. So I was very clear after that meeting, even after that -- in that meeting and after discussion with relevant professionals that the action plan should closely be monitored. I was certainly very clear in my mind that this action plan is still in place, and I was conveying this information to the relevant professionals who are supposed to monitor and escalate that action plan is in place, and they should clearly see that the monitoring arrangement should be in place as well. I'm unsure why the uncertainty came but I was, again in that communication, back to the relevant professionals. I concluded actually in that email Esther Gishkori, Siobhán Hynds, Vivienne Toal, that this action plan is still in place and we need to continue to monitor it. 11:12 11:13 11:13

40 Q. You have said, and we've seen your email which says,

this is clearly unacceptable practice, and you point the finger at both management and the clinician. While in any walk of life accidents and omissions can happen, from the managerial perspective, given the concerns that the Trust said that it had in respect of Mr. O'Brien, at a time when the MHPS investigation had reached a conclusion and there was a determination issued, this doesn't reflect well on how seriously the Acute team were taking the issue of monitoring? 11:14

A. I think at that point in time, the determination was out; it was shared with the Chief Executive, with the Director of HR. However, I must say that the monitoring arrangements were fairly robust until that point in time. There were a few elements of some possible deviation but it was addressed, it was managed, it was rectified immediately until this information came to me. I was clearly mostly disappointed and frustrated at that point in time, that we have achieved such reasonably good compliance until now, why can't we do it more? That was my frustration and disappointment in terms coming out, that I was saying it is unacceptable from both parties. 11:14 11:15 11:15

I recall, I think, also I wrote to Mr. O'Brien as well for his responsibility to continue to adhere to the action plan. 11:15

41 Q. Let's just come to Mr. O'Brien in a moment. In terms of management, Dr. Khan, if I can ask you this: Who do you think bears the lion's share of responsibility for

this omission to effective monitor over a period of months?

A. I suppose it falls to many people. On reflection, the action plan was heavily reliant on one person and that should be a broader, much more robust monitoring of arrangement for the action plan. I believe without anyone's intention, it fell through the system in terms of monitoring when one person who was mainly responsible was off sick for a period of time. I do believe as a system there would be an opportunity at that point in time when Martina Corrigan was off, that was someone else delegated or allocated this responsibility. I don't believe that it was something which was really appreciated, let's put it, at that point in time. But what I was trying to say is that we still need to keep this robust, and including the key people into that, like the director of acute service, the HR Director, just to make sure that everybody is aware of their responsibilities. 11:16 11:16 11:17

42 Q. In terms of reports to you, on 23rd November we see that you wrote to Martina Corrigan to say that you only need monthly reports, or earlier only if issues arise. So, notwithstanding the difficulties over the summer months in October, you were still content to get monthly reports? 11:17 11:17

A. I was content to get information if there is a deviation in between. I wanted the deviation to be escalated to the case manager at that point in time. However, as regular monthly reports, now at this point

in time I would have completed the determination; it was published, released, sent to the relevant people. Now I was also kind of doing a transition, call it, from the medical director's point of view to Dr. O'Kane. At this time I wanted this to be any deviation, but not regularly as monthly would be fine.

43 Q. In terms of Mr. O'Brien's behaviour and the concerns that were expressed about the dictation issue and the notes, how grave was that, in your view? Was it serious or not serious when you got to the bottom of it? 11:18 11:19

A. In relation to the investigation or this --

44 Q. In relation to what was reported to you in October about the number of outstanding dictations, 91, and the number of notes retained in the office. Was that a serious issue or not? 11:19

A. I was concerned, yes. I felt it was a significant deviation again. I was also concerned about the patient outcomes and the sharing of information to the Primary Care Team and other multi-professional teams. I felt it was a grave or significant issue which I needed to address in relation to that. 11:19

Now, we know that afterwards, within a couple of days, I was informed at that point in time it wasn't that, it was 16 or 18 dictations rather than 90 or 92 which was previously reported. But at that point in time I was concerned that this was significant and it can lead to major issues with the patient care. 11:20

45 Q. We can see that you wrote to Mr. O'Brien. If you go to page 926 of the core bundle and if we could have TRU-261997. You're writing to Mr. O'Brien in respect of an information request that was generated out of issues he became aware of through NCAS and as a result of the MHPS process. Much of this is irrelevant for the purposes of the question.

If you go to the very bottom of this page, please. You take the opportunity, you say in the last line, to ask if he is adherent to the agreed MHPS action plan, which you attach. This is 23rd October. Is that the only step you took in respect of Mr. O'Brien's deviation from the plan?

A. That was the step I took to Mr. O'Brien but I took other steps, as I already alluded, in terms of how I addressed that deviation, to informing the Chief Executive, making sure that everybody in the team is aware; addressing the understanding of the monitoring of action plan after the determination report is released and making sure that everybody is aware that we need to still monitor.

However, on reflection, perhaps I should have tried to meet with Mr. O'Brien, or maybe going through a further discussion with him. That's on reflection, I suppose, yes.

46 Q. He wasn't told at any time by anyone that the deviation from the plan which was placed before you in October

was unacceptable; is that right?

A. Certainly I didn't speak to him but my understanding was that he was -- the team in the Acute Directorate would have spoken to him in relation to the deviation, the charts, the dictations, and there was a management plan around that. My understanding was that he was spoken to but I didn't personally speak to him, no. 11:23

47 Q. As case manager, should you have been the one speaking to him?

A. On reflection, yes, I could have just arranged a meeting with him. Obviously, on reflection, it is important that I could have. I didn't at that point in time. 11:23

48 Q. Why, Dr. Khan, do you have to caveat your answer with "on reflection"? Should it not have been blatantly obvious that you were the person with the responsibility to address this with him? 11:23

A. Just what happened at that point in time, I didn't. It didn't come across to my mind.

49 Q. Now into 2019, roughly the same time of year, September 2019, Martina Corrigan forwards information to you to suggest that triage and dictation have slipped in respect to Mr. O'Brien. If you go to 1031 of your core bundle and if we go to TRU-275344. She's telling you, Concern 1, which is triage, not adhered to. She's referring you to escalated emails. 11:24 11:24

"As of today, Monday 16th September, Mr. O'Brien has 26 paper referrals outstanding, and on E-triage 19 routine

and 8 urgent".

Then, scrolling down, she draws your attention to a digital dictation issue as well, and she sets out the details.

Why, Dr. Khan, you, having presented your determination in MHPS a year previously, are you still engaged in the escalation process around the action plan?

A. At the end of 2018, when my determination was released and I completed that formal investigation process, call it, with the release of the report, my personal understanding was that my role as a case manager ceased at that point in time. Obviously, the MHPS Framework does not assist you in relation to when the case manager role finishes and who is responsible for implementation of the recommendations. My understanding, my personal understanding, was that my role ceased at that point in time. The rest of the couple of months until end of December 2018, I was involved as an Acting Medical Director. In the later part of 2019, in fact, I do not recall receiving regular updates in 2019, but the deviation, this came to light. My understanding at that point in time is my involvement is on the advice or request from the Medical Director as previous case manager. At that point in time I received this and I discussed with Dr. O'Kane, the Medical Director, about what action should be taken.

I think simultaneously there was another process, was more information was coming from the GMC, and Dr. O'Kane was involved in that process as well, finding out and extracting information for GMC. But this information came and I discussed this with Dr. O'Kane. But my understanding is my role has finished a year ago nearly.

50 Q. What was your role then? Why was this being brought to your attention? 11:27 11:28

A. I'm unsure why it was brought to my attention.

51 Q. We know, if you take a brief look at -- if you go to 1037 of the core bundle. If we can have TRU-275588. We know that an attempt was made within the Directorate itself to manage this. As you can see from this email from Martina Corrigan to Mr. O'Brien, it was proposed to Mr. McNaboe, who had become Clinical Director, I think succeeding Mr. Weir at some point that year, or perhaps the year before, they wished to meet with Mr. O'Brien to discuss a deviation when he was on-call in September. That's where we started this part of the conversation with the email to you in September. 11:28 11:29

If we just scroll down to the next page, please. Go to TRU-275595. You can find this letter at page 1038 of the core bundle. It's a letter, 7th November 2019. Do you have that, Dr. Khan? 11:29

A. Yes.

52 Q. Mr. O'Brien is writing to Martina Corrigan in respect

of the meeting that had been proposed with Mr. McNaboe and Mr. O'Brien for that week. He is explaining here that when he met with you on 9th February 2017, he was advised in writing of the action plan. The case manager explained that this plan remained in place pending conclusion of the formal investigation, and that concluded in September when you presented him with the report or the determination which provided for a further action plan. He says at the last line of the third paragraph: 11:30 11:31

"The Trust has failed to implement this recommendation to date".

He goes on to say: 11:31

"It is evidence that the issues you wish to discuss cannot be considered deviations from a Return to Work Plan which expired in September 2018". 11:31

We'll obviously have to ask Mr. O'Brien about his thinking around that, but he's seeming to say that he can't be held to an action plan that was now out of date or no longer in force. 11:31

Did you, in any of your conversations with him, after you published the determination, tell him that the action plan from 2017 remained in force?

A. I met with Mr. O'Brien - Mr. O'Brien, and I suppose

there were other people there in that meeting - after the determination to share the report. I must say it was not an easy discussion. It went on on multiple strands, and keeping the meeting focused on the determination was challenging. I'm aware later on that 11:32
meeting was recorded, which I wasn't aware at that point in time. However, I think we went into the details of the determination and what came out of as a report. I do not recall discussing the action plan at that point in time. 11:33

This is happening just in October 2018, and the anticipation was that three elements of the determination will take place as soon as possible straightaway, essentially, purely for the purpose of 11:33
getting the action plan, the Conduct Panel hearing and the admin review. We know now it didn't happen for a significant period of time, purely because the grievance came in straightaway in November and everything was put to hold, including the action plan 11:33
as well. But at that point in time when I discussed with him the determination, I don't think that we went into the continuation of action plan or there was even any discussion around that. I think that was more focused around the determination. 11:34

53 Q. We know, and we've just seen how you ended a letter to him on 23rd October 2018, asking him whether he remained compliant with the plan. When you think about it now, by 2019 when he's writing this letter, do you

think Mr. O'Brien has every entitlement to consider that he was no longer bound by the plan?

A. I think there is a variation in terms of the understanding on various people from the Trust and Mr. O'Brien as well. 11:35

First of all, I don't think anyone was anticipating that the action plan wasn't put in place until then on the basis of grievance and other related issues. My, I suppose understanding, was that the action plan was 11:35 in place and is being monitored. When I received this at that point in time, this information, I was surprised, I was shocked that, first of all, the action plan wasn't in place. I wasn't aware of that at that point in time that that action plan hasn't been put in 11:35 place. In a way I was out of the loop of information or awareness of what's happening around this case.

However, when I received this information, I had a discussion with the Medical Director, Dr. O'Kane, 11:36 around the action plan and monitoring arrangements and various other things, including the GMC referral and the information. I was obviously told at that point in time that the grievance hasn't been completed and all the elements of the determination report is on hold. 11:36

54 Q. In direct answer to my question, Dr. Kane, do you think that there's an understandable belief on Mr. O'Brien's part, because the communication wasn't as clear as it should have been, that he was no longer bound by this?

A. Well again, I can go by what my understanding was. I can appreciate what Mr. O'Brien was thinking. Coming back to the point, I did write even after the determination that you are adherent to the action plan. In that way I was indicating that the action plan is in place. Perhaps if I could have met, or during that meeting that happened after the determination if the action plan was also discussed, would have been a better understanding. But at that point in time, everybody was thinking that this is going to proceed now with action plan information. I did actually put in the determination how the action plan should be done in terms of all the details of the action plan, what should be included, what style the action plan should be formed, including the inclusion of Mr. O'Brien and NCAS. I was very clear in my mind that this determination is out now, the action plan should immediately be put in place or updated on the basis of a number of elements in the report. 11:37 11:37 11:37

55 Q. Just in order to bring this issue of the action plan to a conclusion, I want to bring you to the meeting you've briefly touched upon already in January 2020. I just want to highlight the lead-in to that meeting. If you go to page 101 of core, and if we could have up on the screen, please, WIT-55824. We can see in the middle of the page that Siobhán Hynds is writing to Dr. O'Kane, copying you and others in, expressing the view that Mr. O'Brien is clearly deviating from the action plan that was put in place as a safeguard to avoid this type 11:38 11:38

of backlog. She is asking has there been any direct discussion, and she suggests a meeting to decide on the necessary next steps.

That then is taken up by Dr. O'Kane, if we scroll up the page, please. If we go to WIT-55823, two pages up. At the bottom of the page, please. Dr. O'Kane is asking Simon Gibson to coordinate a meeting, which should be minuted to describe in detail the management plan around this, the expectation regarding compliance, and the escalation. 11:39 11:40

"It will be important before all of you meet with Mr. O'Brien that you have this process well-described and documented. Process mapping this might be the most useful approach". 11:40

If I can stop you there, Dr. Khan. If we look at the action plan and the specific requirements around the dictation of clinical encounters, Dr. O'Kane is saying it is important before you meet Mr. O'Brien that you have this process well-described and documented. Was it not well-described and documented already by reference to this specific action plan that Mr. O'Brien, in your view, remained obliged to comply with? 11:40 11:40

A. It appears to be that Dr. O'Kane wanted to explore further, possibly, the management or escalation of the action plan. But you're right, the action plan was

already describing all the elements of the monitoring arrangements and the points. Obviously, she has asked Simon Gibson to chair that meeting, coordinate and chair. Simon Gibson did chair that meeting a couple of months later to discuss the system or the arrangements behind that. 11:41

56 Q. Yes. Then, just in fairness to the author of the email, she writes another couple of lines at the end, just in case it's not -- it doesn't change the meaning or the direction of travel. So, there is to be a meeting, and if you go to page 1039, Dr. Khan, you can see the record of the meeting as set out by Simon Gibson. If we scroll up the page, please. Keep going. Keep going. Thank you. 11:42

11:42

So, this meeting focuses on the issue of the backlog report and the area of dictation and, as you can see from the agenda items at the top, expectation around compliance and escalation. And it's to assist in a meeting with Mr. O'Brien to discuss his deviation from the action plan. It appears, and this is a broad summary of what the meeting appeared to focus on, there appears to have been a discussion more broadly about the problems faced by Acute Service or Acute Directorate in managing these issues of dictation. So, for example, it said that as regards the backlog report there was scepticism amongst some at the meeting about the accuracy of the data regarding compliance. The view was expressed that no one was aware of any written 11:43 11:43

standards in relation to what was considered reasonable for dictation of results or letters.

As regards escalation, again the word "cynicism" is used, along with the view that there was no agreed process for escalating any concerns regarding non-compliance. 11:44

It goes on to say at the top of the next page, just scrolling down, please: 11:44

"It should be noted that those present agreed that the weaknesses identified in the current process described above may cause challenges in taking forward this issue with Mr. O'Brien". 11:44

Then a series of conclusions are set out.

Can you help us, Dr. Khan, in terms of how you viewed these discussions at this meeting? This suggestion that there was an uncertainty or a vagueness around these aspects when compared with, as I've described it, and you may disagree, the certainty and the specificity of what was set out in Mr. O'Brien's own action plan. How did the meeting get into this description of a vague process when the O'Brien plan was anything but vague? 11:45

A. I recall the meeting started with the issue of deviation from the action plan. You can see the

meeting was attended by both operational and clinical or medical leadership. So, Ronan Carroll, Martina and Mark Haynes. Mark Haynes was AMD (Associate Medical Director) at that time. Simon Gibson was chairing that meeting. I attended that meeting, and my thinking behind going into that meeting was that we are going to discuss, in more detail, about the robustness of the current action plan and monitoring and arrangements and escalation. However, within that meeting it kind of went into more broad discussion within the Surgical Services or the Acute Directorate or the Urology Services of monitoring, recording, escalation, of any dictations or triage, and all those elements. So, it was quite technical in a way and it ended up, the meeting kind of ended up with a lot of discussion around the wider elements of the system-wide challenges. 11:46 11:46 11:47

I did indicate in that meeting that we have to focus again on the current action plan and the deviation and monitoring. I think I have -- I recall I have sent a -- when I was shared the minutes I sent some sort of communication back to the -- 11:47

57 Q. If you want to pull that up, it's your own bundle, 1147. If we could have up TRU-251809. Do you have that at 1147? 11:47

A. Yes.

58 Q. You do. So, you are writing back to Simon Gibson, having received his record of the meeting. Just

explain what you have in mind here.

A. So, I was, again, trying to focus back to the issue which was initially raised and this meeting was called in for that purpose. And bringing my previous experience of the Case Manager role, I was trying to bring back to the focus this is about we have all the challenges and all the issues but we have to focus on the action plan and monitoring and escalation for this specific issue. And that's what I was bringing back to everyone's mind that, yes, there are challenges, but the action plan is very clear. The monitoring arrangement has been there before, so why can't we continue to do that and focus on it? I know in that meeting there was discussion about should we make changes in terms of wider arrangements. That's why I said I don't need to be part of the Acute Directorate internal discussions about the wider arrangements, but I was bringing back to the focus of action plan and this monitoring and that was my discussion in the meeting and afterwards as well. 11:48 11:48 11:49 11:49

59 Q. Can you explain to us why the meeting was seemingly tying itself up in knots in relation to these broader issue when there was a specific plan in place for Mr. O'Brien, was it because he - in the correspondence that I've shown you - was pushing back against the current applicability of that plan? 11:49

A. I wasn't aware of that letter back from Mr. O'Brien. I wasn't shared any information that he has even written a letter back to. So I went into that meeting

being kind of nearly out of the loop for a good period of time and then I was asked about to contribute into that meeting. I wanted to bring focus to the action plan and its monitoring arrangement, however it did go into a lot of discussion about the wider challenges in the Acute Directorate in terms of monitoring and escalation and other almost to that. But I was still trying to bring that back to the point that this is the purpose of this discussion. 11:50

60 Q. Is it fair to say then, Dr. Khan, that was your last input in relation to the action plan and monitoring of Mr. O'Brien? 11:50

A. That's correct. Yes.

CHAIR: I think then if we can sit again at 12.05 and hopefully conclude Mr. Khan before lunch. Is that likely to be possible? 11:51

MR. WOLFE KC: It's very unlikely to be possible.

CHAIR: Perhaps we can talk in the break as to what is possible. Okay. Five past 12, everyone.

11:51

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Mr. Wolfe.

61 Q. MR. WOLFE KC: Dr. Khan, I want to move to that part of the chronology where you have received Dr. Chada's investigation report and you received a submission from Mr. O'Brien. Just as a lead into that, the Inquiry is, of course, aware that by the summer -- by early 2018, but as you're commencing the process of looking at 12:09

Dr. Chada's report, you're also wearing interim Medical Director hat at the same time. We can see from what you've said in your witness statement at WIT-32000, this is 904 of your own bundle, at paragraph 24.2(b) you say:

"After my appointment as Acting Medical Director I was very mindful of my competing demands as Senior Management Team and Trust Board member and its responsibilities, therefore, I requested to step down by from the Case Manager role. However, this wasn't accepted by the Oversight Committee".

Do you mean the Oversight Committee or do you mean particular people?

A. Yeah, I suppose at that point in time I was working as an Interim Medical Director and I can go through some background on that in order to understand better. I suppose I started this Interim Medical Director role in April with no formal hand-over. My predecessor was off sick for a period of time, so I ended up in that role with a significant amount of outstanding matters to be addressed in the Medical Director's Office. I think I had the formal induction of the senior management team or the Board member a couple of months later. So I ended up in a situation when I was also a Case Manager but also now wearing the interim Medical Director role and with significant demand in the Senior Management Team with very little understanding or

awareness of a lot of background information, with no hand-over. So, I was aware of that and mindful of that issue, therefore I discussed my inability to be available for Case Manager role completely with the Chief Executive who was my line manager. I did also discuss with the Director of HR, Mrs. Vivienne Toal. So, I suppose -- so that's what I probably meant by saying "Oversight Committee". It wasn't really an Oversight Committee to discuss at that point. 12:12

62 Q. You say in an email that you're not comfortable having both roles, but was that purely down to your capacity, the number of hours in the day to get things done? Is that why you weren't comfortable or were you not comfortable because you didn't regard the dual roles as being compatible for other reasons? 12:12 12:13

A. No, it's to do with the capacity. So, I didn't feel that I have enough hours in my day to competing demands in terms of Medical Director and also the Case Manager role.

63 Q. We can also see - this is TRU-288510, your core page 618 - that you in an email to Siobhan Hynds says: 12:13

"I've agreed to continue as a Case Manager for this MHPS case on condition that I will not be in a position to go through this report until after you've returned from annual leave". 12:13

So, you basically said I'm taking my annual leave before I'll be able to deal with this; is that fair?

A. Yes, that's correct. And I suppose I reluctantly agreed to continue because I had a number of discussions with the Chief Executive and the Director of HR and Mrs. Toal, obviously, was encouraging me to continue because it's too late in the process and for various other reasons. I had my own limitations in that way, for the capacity reasons. I was also aware that this investigation is significantly delayed in terms of the timeframe and I'm going to be away for another nearly month or over that, and I will not be able to address this until I come back, and then I will have to do a number of other elements in order to compile and draft the report. So, for that particular reasons I suggested that. 12:14 12:14 12:15

And when I reluctantly agreed, I did agree to continue on and finish this work, however I made it very clear that on what grounds, really, I can do that.

64 Q. Yes. We will now look at the steps that you had to take prior to issuing your determination. Amongst those steps included a telephone meeting with Dr. Lynn of NCAS as well as consideration of a submission that Mr. O'Brien put before you. 12:15

Before we look at that submission, can we bring on to the screen please, it's your core at page 17, WIT-18505? 12:15

A. 17?

65 Q. 17. This is the stage of the process we have reached.

So, the report is submitted to you. It says:

"The Case Manager must give the practitioner the opportunity to comment, in writing, on the factual content of the report produced by the case investigator. Comments in writing from the practitioner, including any mitigation must normally be submitted to the Case Manager within 10 working days of the date of receipt". 12:16

Then it says: 12:17

"The report [that is the investigation report] should give the Case Manager sufficient information to make a decision on whether...", and then there's a list of options. 12:17

Now, can I try to gain an understanding of your thinking at this point? The role of Case Manager at this stage is what? Is it to read the investigation report in the light of the clinician's comments around fact finding and to reach a conclusion taking the two documents into account? 12:17

A. I suppose my understanding was the role of Case Manager at that point in time was not necessarily just looking at the investigation report which was provided by the Case Investigation Team but looking in the statements, all the appendices which were the statements from various witnesses statements, the case investigator 12:17

report, getting the factual accuracy statement by the doctor, in this case Mr. O'Brien, but also to discuss all that investigations with the relevant professionals. In my case I shared the investigation report with the Chief Executive, also with the Director of HR, and then I had a lengthy discussion with Mrs. Grainne Lynn from NCAS. So, my determination was coming from all that elements into coming together, and then I also consulted the GMC's Good Medical Practice and the MHPS Framework which gives me what options are available as a Case Manager. So, I had took all those elements in line together in order to compile my report. 12:18 12:18

66 Q. Can you remember whether you read the report and the appendices before you considered Mr. O'Brien's submission on fact finding? 12:19

A. I think I read the reports at the same time as I read Mr. O'Brien's statement. So it was around the same time I read both of those, and the statements as well.

67 Q. Yes. We can see, if we turn to AOB-01879, it's your core 878 - this is Mr. O'Brien's response to the formal investigation. Did you recognise this at the time, Dr. Khan, as falling within that part of the process that I've just read out as being a response to issues of fact finding? 12:19 12:20

A. So I received Mr. O'Brien's statement, which I read as the part of the investigation. And it was a detailed account of his involvement and understanding during previous years. Yes, I did.

68 Q. But this document here, as distinct from the statements he gave to Dr. Chada, did you realise that this document here was his challenge, if you like, or his analysis of the fact finding contained in Dr. Chada's report? 12:21

A. Yes, I appreciated the number of challenges or number of points he raised in that statement in relation to the report and also in relation to the historical context of his involvement during previous years. Yes.

69 Q. And I want to explore with you the extent to which you took into account the points that he was raising. Could I ask you that as a general question first off. He raises a number of points in this document. What was your approach to that? Where you saw, for example - and I'll give you some examples - were you saw that he was taking a different view of the facts to Dr. Chada, what did you see as being your responsibility or your methodology to try to bridge that gap, if there was a gap? 12:21 12:22

A. So, there were a number of variation or differences in both statements. I obviously shared the investigation report with the Chief Executive and the Director of HR and I was advised to take the evidence as provided by the Investigation Team, because they have gone through the whole investigation. I did appreciate it at that point in time Mr. O'Brien was making comments on various elements of the investigation. For instance, he was making comment about the dictations or the undictated clinic numbers and so on. So I took 12:22 12:22

consideration on that. And I took close observations of his statement. However, my conclusion was based on the broader element of the investigation but taking in account of his statements as well.

70 Q. But your advice from the Chief Executive was to go with the evidence gathered by Dr. Chada and not try to address the challenge to that coming from Mr. O'Brien. 12:23

A. The advice from the Chief Executive and the Director of HR, was to go by the evidence but as a Case Manager I felt I have to look at the both elements of the statements. So, I did consider Dr. Chada's investigation report but also looked closely and considered Mr. O'Brien's statement as well. 12:24

71 Q. Okay, so --

A. Now, I must say the Chief Executive never said not to look at or consider. He did advise me to take evidence from -- as provided by the investigation report, which I did. 12:24

72 Q. I'm not sure I'm following the distinction you're making. If we think about it in terms of what's written down in the MHPS process, Mr. O'Brien, the clinician, is entitled to make a submission on fact finding. If you are faced with a scenario where he considers that the facts as written up by the investigation are wrong and he can demonstrate that to you, what are you to do about that? 12:24 12:24

A. So, I'm going back to the point of the terms of reference of the investigation. So, the terms of reference was set for the investigation and for this

process. So I looked at the specific -- in fact, if you look at my Case Manager's determination, I started putting together in a format that what's the Case Manager's role in this part of the case, MHPS Framework, then I put together the terms of reference of the investigations, and then I further expanded on what the investigations was reported to me. And then, obviously, what are the options available as part of the MHPS Framework. I also included in my own determination about the advice I have received from the Chief Executive, from the Director of HR, but also from my discussion and advice from Mrs. Grainne Lynn from NCAS. 12:25 12:26

73 Q. But what did you regard as the purpose of a submission by the clinician in relation to the factual content of the report? What was the purpose of that? 12:26

A. Obviously, Mr. O'Brien got an opportunity to provide his view on the investigation, which I considered. However, on the balance of what information was available to me as a Case Manager, I decided on the evidence provided by the investigation report. 12:26

74 Q. Okay. Let's explore aspects of that. If you go to AOB-01889 at your core 888. If we scroll down a little, Mr. O'Brien explains that on 3rd August, he submitted to Dr. Chada's and Ms. Hynds detailed documentation of all additional in-patient and day case operating during the years 2012 to 2016; all additional outpatient clinics during 2012 to 2016, in addition to all additional time spent in the role of lead clinician 12:27

of Urology MDT and of Chair of Urology MDM in that period. He refers to the appendix. He says:

"None of this documentation has been included in the report of the investigation". 12:28

Plainly, his introduction of this issue to Dr. Chada, and indeed to yourself, is to set out the full context and circumstances in which he was required to work, so it may at least in part being put forward as mitigation 12:28 for any shortcomings on his part. Whatever the reason for putting it forward, he's making the plain point that the investigator hasn't taken this into account, hasn't mentioned it, hasn't even appended it to her investigation. 12:28

First of all, did you recognise the thrust of what he was saying? Did you appreciate it?

A. I did. I understood what he was making as the point. However, I go back to the point of the investigation 12:29 was carried out for a period of time and he was provided opportunity to make a statement, but also provide all the documentation. When I received the investigation report, there was obviously all the statements, including Mr. O'Brien's information and his 12:29 statement and his account of his discussion with the investigation team. So, I had all that information. But he's making in that case some of the other information which wasn't included, no.

75 Q. Did you think it your obligation to go back to Dr. Chada and say, where is this appendix; why haven't you mentioned it; why have you apparently not taken it into account?

A. No, I don't -- I don't think I went back to Dr. Chada. 12:30

76 Q. I know you didn't, Dr. Khan. I'm asking did you see it as part of your obligation during this fact-finding aspect of your role?

A. I must say I did not think that it's my role now to go back to the investigation team for more information. 12:30 I did obviously share the investigation and discussed with the Chief Executive and Director of HR, and clearly I was advised that you have to take the evidence provided by the investigation team. That was my point and context for making the determination. But 12:30 I did not go back and challenge Dr. Chada or challenge the investigation team.

77 Q. Is it fair to say then that you didn't go back and look at Appendix 11 or try to get Appendix 11 and see whether it would have made any difference to your 12:31 determination?

A. No, I didn't go looking for Appendix 11 from this letter.

78 Q. Could I ask you about the issue of undictated clinics. If you go forward to core 889 and if we pull up 12:31 AOB-01890. He explains here that also on 6th November he provided a spreadsheet addressing the issue of term of reference 3, the dictated clinics issue. He said:

"This clearly established that not all the patients who had attended 51 clinics had not letters dictated, not 61 clinics as the case investigator had been advised".

He goes on to explain: 12:32

"The total number of patients who attended those 51 clinics had been 450 patients. 261 had had letters dictated. These 261 were those who were more clinically urgent. This left a total of 189 patients 12:32 and not the 668 as had been advised by those who had informed the case investigator and whose the data the Medical Director found no need to validate. This detailed information submitted on 6th November was not included in the report of the investigation". 12:33

So, again he's making the point that Dr. Chada has failed to take into account relevant information which goes to the quantity of the outstanding dictation. Again when you saw this, did you not consider that this 12:33 was an important factual issue that needed to be resolved?

A. When I looked at this, I suppose that goes back to the point of what I put together as part of my determination. GMC Good Medical Practice is one of the 12:33 elements which I studied and applied in going through the determination report. In either account, there appeared to be a sufficient number of undictated clinics. If you look at even Dr. Chada's investigation

or even Mr. O'Brien's, he himself agreed or accepted that he didn't dictate any letters on every consultation. He agreed that he would have done it on the completion of the care. Whereas if you compare that with the standard set by the GMC, that when 12:34
a patient is managed by a multi-disciplinary team, the other healthcare professionals should be able to rely on the information provided to them. Now, the whole care could take weeks, months or years. In between the
patients are attending other clinicians, they are also 12:35
attending Primary Care Team, they are attending GPS or other elements, and not having availability of clinical information or the clinical management plan will make the patients more prone to get adverse outcomes in
their care. This is about the GMC Good Medical 12:35
Practice. The GMC Good Medical Practice is based on four elements, and three of them are --

79 Q. Sorry to cut across you, Dr. Khan. We understand perfectly well the importance of dictation. The point
that I'm arrowing in on is simply this: Mr. O'Brien 12:35
challenged the factfinding of Dr. Chada by saying it wasn't 666 clinics, or whatever the number was, or it wasn't that number of outstanding dictation, it was 189. Yet when you write this up -- if you go to
page 906 and if we go to AOB-01917. Scroll down a 12:36
little, please. So when you're writing up the findings of the investigation, what you say is:

"It was found that there were 66 undictated clinics by

Mr. O'Brien during that period. Mr. O'Brien accepts this".

But, in fact, he had written to you in the document we've just been looking at, saying I don't accept this, and, what's more, I've told Dr. Chada in a particular document that I don't accept it. 12:37

Is your answer the same - I was advised to take into account the evidence received by Dr. Chada and, does it appear, nothing else? 12:37

A. I think there are multiple elements to that but the most important things are the GMC Good Medical Practice. There appear to be a sufficient number of undictated clinics on either version of the events by Dr. Chada or Mr. O'Brien. However, going back to the point of I was obviously advised that the evidence is provided by the investigation team after going through the whole investigation and this is in front of you, you need to make determination on the basis of that, yes. 12:37 12:38

80 Q. Private patients again, I needn't turn up the detail because I suspect I'm going to receive the same answer. Mr. O'Brien told you in this paper that he had prepared a comparative analysis of TURP patients which showed that the suggestion that he was giving advantageous treatment to private patients, private TURP patients, was wrong or inaccurate. He makes that point to you. 12:38

Again, do you simply follow the evidence and the findings of Dr. Chada's report rather than take into account any aspect of what Mr. O'Brien is saying to you?

A. I believe that we need to understand the bigger impact of these to the patients, both of the undictated letters and the private patients, and how it impacted upon the systems put in place, the waiting list, the theatre lift, and impact on other patients. I believe at that point in time as well, going back for both the undictated letters, no matter if it is 600 or 162, every patient counts. It is important to understand that, yes, it is less than what is reported in 600 or 642, but 150 or 160, every patient has a right to be trusted by the doctor. That's again by the GMC Good Medical Practice, that patients should be able to trust the doctors. In order for that to achieve, doctors must show the good medical practice as per the GMC Good Medical Practice guidance. That includes not only the compliance or the clinical ability, but also the safety and quality, the interaction, the communication, the team working, the partnership and the trust that other professionals put in place for us as doctors to provide our reports. 12:39 12:39 12:40 12:40

Going back to the point, yes, he was challenging the number 600 and he is suggesting he is probably 100 and something, but every patient is as important. It is not about the numbers. There are sufficient numbers to

suggest he was failing in providing all that information to the multi-disciplinary team, both in the hospital and in the community in the Primary Care Team. But it is also important to understand the impact it had for each individual patient.

81 Q. Sticking with your example of the numbers of undictated; we'll move to the private patients issue then. But surely in terms of an investigation which took into account the numbers of patients involved, there is a factual significance to how many patients were involved; would you agree, Dr. Khan? If Mr. O'Brien is saying and putting evidence before you which he says wasn't taken into account by the investigator, why didn't you reflect that in your report? 12:41 12:42

A. Yes, perhaps I could have added the reflection in my report. However, I was provided, I was presented a clear evidence of all those elements of the terms of reference in the investigation.

82 Q. But with respect, Dr. Khan, this is the stage of the process which you read and you understood that Mr. O'Brien has a right to challenge the facts. And in relation to the dictation issue, while you may have read it, you didn't include in your report any reference to the factual dispute or to the fact that Dr. Chada had seemingly received evidence with respect to this factual issue and apparently had not taken it into account. Why did you fail to take those basic steps? 12:42 12:42

A. I suppose I'm going back to the point of the evidence presented to me in the investigations. So, I took that investigation report information of the -- my determination. Perhaps it would be good if I included some of the elements which Mr. O'Brien has indicated. I still believe that it wouldn't have changed the outcome but it would be good to have included that, yes.

83 Q. Is it fair to say that this element of the process, allowing Mr. O'Brien to contribute in respect of the factual aspects was simply removed from the process by the approach that you took?

A. I believe that Mr. O'Brien received opportunity at the time of investigation as well. He provided information and he did respond to his statement to the investigation team. So he already was provided at the time of investigation. He did provide further information to me as well.

84 Q. This is a wholly different stage. You are the Case Manager, you're performing a different role to Dr. Chada. You are expected, by the process, to take into account his submission and if there are gaps in the investigator's factual analysis, are you not supposed to take some steps to address that?

A. Yes, I suppose I could have included his comments into my determination, that he did not agree to the numbers. It was reflected in the investigation. However, I believe that there was sufficient grounds, the sufficient numbers of undictated clinic letters on

either version.

85 Q. Did you seek specific advice on how you were to handle and approach this submission from Mr. O'Brien?

A. I took the advice from the Chief Executive. I did discuss with the Chief Executive about the report and shared the report. I also shared my draft determination with the Chief Executive as well. Then I took advice from Mrs. Grainne Lynn from NCAS, and I shared the investigation report with her. 12:45

86 Q. Yes. 12:46

A. And I asked the specific advice on how to draft or compile the determination of the investigation and, simultaneously I did with the Director of HR.

87 Q. But did you say to anybody: 'I've received this submission from Mr. O'Brien. He's taken issue with the facts. He's provided me with information which suggests that Dr. Chada hasn't adequately taken into, account or at all, on occasions his evidence. What do I do about that?' Did you ever present that scenario to an adviser and did you ever receive advice? 12:46 12:46

A. No. I don't recall that I have basically asked about that particular element of the report.

88 Q. You can recall meeting with Mr. O'Brien, his wife and his son to discuss the determination that you produced. Let me refer you to the transcript of that. If you go to 2067 of your bundle, not the core, your bundle, and if we could have up on the screen, please, AOB-56441. If we scroll down please. Michael O'Brien interjects at the meeting and he says: 12:47

"Your position is you've read the investigator's report and then you read my father's report and then you weigh up and then the decision on which one you find to be more persuasive on certain points. Is that what you're saying? 12:48

Well, I considered both in making my final determination".

12:48

Michael O'Brien says:

"I understand. But do you weigh up both, is that your process?"

12:48

You say:

"There is a process behind that as part of the MHPS. You know, I have Mr. O'Brien's, you know, his report and also the investigation report. 12:48

Michael O'Brien: I understand that you have them both.
Dr. Khan: Yes.

I just wondered, is it your process then that you weigh them up?" 12:48

And you say "yes". But in fact, Dr. Khan, you didn't weigh them up, you did the opposite of that. You

failed to take into account Mr. O'Brien's submissions, albeit that you read them and you preferred, based on an element of the advice that you received, to simply adopt the findings of the investigation report. Is that fair? 12:49

A. I think it's important to keep that in mind that I did consider the report. I did weigh up the information provided by the statement. However, on the report on my determination I put more emphasis on the investigation report. 12:49

89 Q. Just finally on this point. If you think, again, about the approach that you adopted while no doubt, as it says in your report, you have received this document from Mr. O'Brien, no doubt you've taken it into account, you've taken Mr. O'Brien's statements to 12:50 Dr. Chada into account, but where you face a scenario such as Mr. O'Brien put before you, where he says: 'I did not agree with Dr. Chada's calculation of the number of outstanding dictations. The number is this, and she says it's that.' And you then write into your 12:50 report "he agreed with Dr. Chada" when he's telling you in black and white that he didn't agree. When you have your time on this, would you agree that a better approach to this, a different approach to this, was appropriate? 12:51

A. I think it's important that we -- certainly there's a lot of learning for me, personally, as a Case Manager. There's a lot of learning for the system, the organisation. I was in this investigation with very

little training or expertise. I did develop my experience during the investigation. I think the learning for me is that we, you know, ensure that the whole element is included, the expertise are developed, the training and support is there. I must say there has been a lot of learning for me personally as well. I have learned a huge amount of elements into this process. But at that point in time when I was making that determination, with all that investigation available to me, the MHPS Framework was providing limited assistance in that regard as well. So, yes, there is reflection and learning for me as well. 12:51 12:52

90 Q. You sought advice from NCAS in respect of your determination and if we could bring up on the screen, please, AOB-01901. It's your core 897, Dr. Khan. And you spoke to her on the 20th and she's writing to you, I think it says the 21st. Scroll down slightly. The 21st, yes, thank you. So your purpose in speaking to NCAS and Dr. Lynn was to seek advice from NCAS. 12:52

A. Yes. 12:53

91 Q. As appears from her summary - if just go further down the letter, please - you explained that there were five terms of reference for investigation, and those are set out, as well as the considerations that you took into account. She provided you with two broad aspects to her advice. First of all, she explained that as regards the GMC -- if we just scroll down to the top of the next page. As regards the GMC, you explained that the GMC is aware of the issue and she advised: 12:54

"You may wish to update the GMC ELA but in the majority of cases the GMC prefers the Trust to conclude their own procedures before considering referral".

12:55

Is that advice that you took into account when you were making your determination?

A. So as part of my determination I was aware that the GMC ELA is aware of this case and it has been discussed in previous Trust and GMC ELA meetings. I was also aware that we will be providing an updated position with the determination report to the GMC ELA meeting, which is coming up in a couple of months. 12:55

So, yes, I took an account of all that information and the advice. In my report also I put together that currently or at present there is no requirement for the referral, however, I was aware that we are going to discuss at the GMC ELA meeting about the threshold in the next couple of weeks or couple of months. 12:55 12:56

92 Q. Yes. The second broad issue that you discussed with her was in relation to Mr. O'Brien's work. Now, we saw on the last occasion that she gave you advice in relation to Mr. O'Brien's working privately. If you go to page 898 of your bundle and if we could just scroll back please to AOB-01902. Stop there. We can see in the middle paragraph that she is saying to you that Mr. O'Brien should not currently be working privately. I think you accepted on the last occasion that that 12:56

issue wasn't particularly well handled. You thought it was being dealt with by somebody else in the system but in fact would you accept that as Interim Medical Director that was an issue that really rested with you to resolve? 12:57

A. Yes, it was -- part of my role was to address that. As I previously informed the Inquiry, I did try to address it by discussing with the Director of HR; by also leaving this issue to be discussed with the previous Medical Director and then the handing over to the 12:57 upcoming Medical Director. This point is between October and December, so two months I would have done a number of elements to ensure that this is addressed. Unfortunately, it wasn't addressed until much later in -- well, it wasn't addressed until a 12:58 long, long time, I suppose. I wasn't aware afterwards.

93 Q. Associated with Mr. O'Brien's working, albeit in his Trust role, you were provided with advice. If we just scroll down. If you go to page 899 of your bundle; AOB-01903. 12:58

You were advised by Dr. Lynn that NCAS could offer support, that that support would come from the SPSR, the Professional Support and Remediation Team, and that they could assist by drafting a robust action plan 12:59 which would involve input both from the doctor and the Trust, and that the purpose of the plan would be to ensure oversight and supervision of the doctor's work, that the Trust could be satisfied that there would be

no risk to patients, and it would afford the doctor sufficient support to enable him to meet the objectives of the plan. She has spoken with the SPRS team and they arrange and, in fact, do send the forms to you. Is that right? 13:00

A. At the time of my discussion, I had a lengthy discussion. Part of that discussion was what the action plan can look like and how NCAS can support that. I was previously unaware of NCAS can provide an assistance in that regard. However, I was very much 13:00 encouraged, actually, by talking to Grainne Lynn that there is a service available for the Trust to ensure the independence or the expertise comes into the formation of action plan. Therefore, I put specific elements into my determination for that action plan. 13:00

To me, there were four elements actually on that action plan. The first one was who should be involved updating that or informing the action plan, which will 13:00 include the NCAS, this practitioner performance advice team from the NCAS; the doctor, which is Mr. O'Brien; and then the Trust coming together and making sure everyone on board and in formation of this, drafting the action plan going forward. 13:01

But the action plan, I have also gone into more detail in the action plan in my determination. I just didn't want the action plan to be just updated by three

people -- three parties, but having that action plan much more broader, going into further elements of the patient administration duties, perhaps looking at how it can impact the clinical outcomes, and involving the medical and clinical leaders in the team and this organisation to ensure the performance and also the monitoring of that. I indicated that this action plan should include all that. Perhaps you are going to come to that, I suppose, at some stage. 13:01

94 Q. Yes, just after lunch we'll look at that. But just on the role of NCAS, did you find that Dr. Lynn's input was helpful and - a second element to the question - were you, in a sense, of the same mind with regard to the particular importance of an action plan? 13:02

A. I did, I did. At that point in time I discussed with Grainne about how it can be challenging in terms of having a right kind of a balanced action plan, and how can we ensure -- therefore, she indicated we have a team where we can help you, we can advise you, the Trust, in terms of putting together the action plan. So I must say I was very much encouraged to involve NCAS in forming the action plan. 13:02

95 Q. We can also see from her advice that she recognised in what you were saying the fact that a conduct issue had arisen and that a formal conduct process was likely. I know that ultimately Mr. O'Brien disagreed with that and presented a different analysis for the purposes of his grievance. Just to be clear, did you interpret Dr. Lynn's advice as indicating to you that a conduct 13:03

approach in lightly of the findings of the investigation that you were reporting to her could be recorded as appropriate?

A. As part of putting together my determination, yes, I did obviously receive the advice and I considered that. That was my own conclusion anyway. But as part of that, yes, NCAS advice was very comprehensive and it was very useful in that regard. 13:03

MR. WOLFE KC: Okay. If we could break now for lunch.

CHAIR: We will sit again at 2.05. Thank you, Dr. Khan. 13:04

THE INQUIRY THEN ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

14:09

CHAIR: Good afternoon, everyone. It's not getting any less lonely up here!

96 Q. MR. WOLFE KC: Good afternoon, Dr. Khan. I'm going to bring you to your determination just now but just one point I think in fairness you might wish to comment on. 14:09 The Stage 1 Grievance Panel which considered the grievance raised by Mr. O'Brien at a hearing in 2020 produced a decision which looked at delays in the MHPS process. If I could bring up at -- if you go to Core 1107 and if we can have up AOB-02803? 2.4.6 on down 14:09 the page, please. Allow me a moment, Chair, just to find the reference. At 2.4.6, Dr. Khan, it says that:

"In speaking to you, the Panel consider that you

clearly reflected on the report and the MHPS options. However, they find that the 21 weeks you took to do so unnecessarily protracted the process. After such lengthy investigations, Dr. Khan's response, where no exchanges with Mr. O'Brien were required, should have been expedited. It required Dr. Khan's analysis and reflection on the facts in the report and how it fitted with MHPS decision-making. They say the time scale is not explained sufficiently, but Mr. O'Brien's grievance is not upheld in that respect". 14:11

A little clunkily worded, but you can take from it that they feel that you could have expedited the process and that the time you took was unnecessarily protracted.

Now, we've heard from you earlier in respect of the condition you imposed, that you couldn't deal with this until after your leave; you were acting Medical Director at the time. Do you feel that this criticism is warranted? 14:12

A. I don't necessarily agree with this. I did what my role as case manager as per the MHPS Framework advised me to do. I felt I needed to complete the process in accordance with the MHPS Framework. I understand this grievance panel commented on that. I don't necessarily agree what the comments are, and I believe that subsequent to that there was a further re-look of the grievance panel report, and that did agree with my conclusion as well. 14:12

97 Q. Very well. Could I bring you to your determination, then, just to orient ourselves. The covering page is at page 903 of your core bundle. AOB-10194. We can see the structure of your report over the early pages. If we scroll down through it, you set out your responsibility as case manager, set out the terms of reference, and then you set out in your own language the investigation findings. Or partly in your own language. You set out other findings or context at your page 907. Scrolling down to 918, please. Then over the page at AOB-01919 you set out your determination. 14:13 14:14

You highlight in the first bullet point, Dr. Khan, there's no evidence of concern about Mr. O'Brien's clinical ability with patients. Plainly, the investigation wasn't focused on clinical ability. Why are you drawing that point out? Does it imply that the shortcomings that had been identified were somewhat less serious because they didn't concern clinical ability? 14:14 14:15

A. I suppose my determination was based on the evidence provided to me. In fact, in the report and the statements provided with the report, if there was anything it was the compliments rather than any criticism in his clinical ability. So, there was no evidence -- I was presented to indicate there is a clinical ability issue. In fact, in some statements and in the report, it was that the patients who did 14:15

attend Mr. O'Brien provided a clinical ability of his level as a consultant. There was no indication of any clinical ability issues at that point in time.

98 Q. Yes, I understand that but my question is somewhat different. While your bullet points go on to develop an analysis or a report on Mr. O'Brien's way of working on the administrative side, how is one to read the first bullet point? Is it to suggest that the concerns about administrative aspects are somewhat less important because he is sound clinically, or how are we to read that? 14:16 14:17

A. I suppose in forming that report, I wanted to make sure that all elements of the evidence which is provided to me is presented in my determination. By no means that was undermining in any shape or form the shortcomings of the administrative practices and its impact. It's merely just adding up to the fact that I did not find any evidence in the report suggesting that there is a clinical ability issue identified at that point in time. 14:17 14:17

99 Q. Of course you do go on, as we can see here, to highlight the potential harm to patients because of Mr. O'Brien's administrative processes and what you describe as "actual harm" to at least five patients. 14:18

Could we go down to the next page please, 01920. You make a remark at the first bullet point, where it says:

"Mr. O'Brien did not adhere to the requirements of the GMC's Good Medical Practice specifically in terms of recording his work clearly and accurately, recording clinical events at the same time of occurrence or as soon as possible afterwards".

Just on that, Dr. Khan, the concern that is expressed in the investigation report involves Mr. O'Brien's failure to dictate following certain clinical encounters. It doesn't make a criticism that he was failing all together to record clearly and accurately clinical events at the same time as occurrence. Do you understand the distinction?

A. Yes, and it's important that the distinction sometimes is very fine in terms of recording and providing that information to the wider healthcare system. That is going back to the point of the Good Medical Practice standards from the GMC. Having that unavailability of that recording or the clinical events in the notes and then having that supplied to the wider healthcare providers, the clinical encounters are important, and every aspect of clinical care provision by the multi-professional team. That's what I was referring to in terms of unable to provide the full standards of Good Medical Practice in terms of communication, partnership, and team working.

100 Q. Yes, but it is one thing to fail to dictate a letter as a general practitioner which may well also be kept on the patient's file, but it is quite a different thing

to suggest that Mr. O'Brien wasn't clearly and accurately writing a note into the patient's record following the encounter. They are two different things, are they not?

A. Yes. They are two separate things but they are interlinked in a way. 14:21

101 Q. You, with respect, have suggested that the offence or the shortcoming is the latter when, in fact, it was a dictation issue that was front and central of the investigation. Do you accept that? 14:21

A. Yes, that's the terms of reference. That's correct.

102 Q. Looking then at your determination, you have set out the advice that you have received. Let's just deal with the misconduct issue. If we go over the page, page 910 for you. If we scroll down, thank you. You 14:21 decided that you don't consider an exclusion from work to be necessary. Let's deal with that, sorry, a restriction on practice. The top of the page.

You set out the purpose of the action plan. As you 14:22 were reflecting just before lunch, you considered that a fresh action plan was necessary; isn't that's right?

A. That's correct, yes. So as part of adding this into my determination, I was very clear in my mind what part would be necessary in terms of having a continuous and 14:22 ongoing assurance. The action plan would have a number of elements. The first element is how the action plan should be developed in consultation with NCAS, Mr. O'Brien, and the Trust coming together, putting

together an action business plan which is, in essence, a combination of, you know, minds and brain coming together forming this action plan which will be owned by the consultant as well, and the Trust in terms of monitoring. That was the first element. 14:23

But then the monitoring of that action plan was not necessarily an operational line manager's, but I wish to add that into -- the clinical and the line management structure to the monitoring support and 14:23 escalation. Then at the same time, I wanted to include an agreed job plan, an enhanced appraisal element into part of the action plan as well.

103 Q. In terms of the scope of the action plan, you've described a need, in this second paragraph at the top 14:24 of the page, for continuing assurance about Mr. O'Brien's administrative practice and management of his workload. Did you anticipate that this action plan, if it had been developed at this time, would have scrutinised any other aspects of his practice, whether 14:24 other administrative issues or even clinical issues, or did you think in the alternative that you would be repeating the same issues that were the subject of the existing action plan?

A. So my thinking of developing the action plan in 14:25 consultation with NCAS, and Mr. O'Brien as well, to expand the action plan more a little bit wider to include the administrative practice but which can lead to poor clinical performance or poor clinical outcomes.

So, expanding that in a way that it will cover broader elements of Mr. O'Brien's practice into the action plan.

104 Q. The role of NCAS in providing professional support, how did you anticipate that that might work? They had sent you the forms, as we saw. They can be found at page 900 of your bundle. I needn't bring them up on this screen. Did you think that that element was going to be important? 14:25

A. I felt that inclusion of NCAS into the action plan formation and putting together would be very useful. I had no previous experience of putting together an action plan with NCAS, and I had no previous understanding or experience of involving NCAS in relation to that. It wasn't very explicit or clear in my mind how, but I felt it would be necessary to involve NCAS into the formation of a further going-forward action plan. 14:26 14:26

105 Q. In terms of the ownership of this issue, who did you understand would be responsible for taking this forward? 14:27

A. So, as for the implementation of action plan, I suppose the three elements in my determination were presented and I provided this to the Chief Executive, the Director of HR and the Medical Director. So, I suppose, it was in combination with the Acute Directorate with the Medical Director and the Director of HR because the action plan included the appraisal which is Medical Director's responsibilities, but it 14:27

also included the job plan would be the Director of HR in combination with Medical Director's responsibility. So, I felt that would be a combined effort by the Director of Acute Services, by Director of HR and Medical Director, I suppose, in -- and the Chief Executive as the overall, you know, in charge of the organisation.

106 Q. What is your understanding as to why this aspect of the action plan wasn't implemented?

A. Soon after the determination came out we had some brief discussions, not formally, but we wanted to get things moving. But soon afterwards we were informed that the grievance request has came in and everything is on hold until the grievance will be completed. Nobody, I don't think anyone contemplated how long it took eventually to complete that, but at that point in time the general advice coming back was we have to wait until the grievance is completed before we can take on further anything. 14:28 14:28 14:29 14:29

107 Q. And was that the view of HR? Whose view was it?

A. Mainly from HR, yes.

108 Q. So, it was your understanding that the grievance provided the obstacle to moving this forward?

A. That's correct. That was my understanding, yes.

109 Q. At that time there was concern, as we saw this morning, or there was to be concern within a number of weeks about aspects of Mr. O'Brien's compliance with the existing action plan, and mainly the investigation report from the Trust perspective, and accepted by you, 14:29

pointed up concerns, albeit historic, in relation to Mr. O'Brien's practise. Was any conversation given to whether, notwithstanding the introduction of this grievance, that it would be necessary, nevertheless, to develop a better action plan in light of your determination to address what remained as concerns for The Trust?

A. I suppose that was the intention when the determination came out, that we would move on and form this action plan and other elements of the determination. But at that point in time my understanding was that everything was to be put on hold until the grievance is completed.

110 Q. Yes. And you didn't challenge that view?

A. I suppose I didn't challenge it but it was coming from -- obviously it was coming from the HR Department and obviously it was coming with a view that this has to be put on hold. But I must say I had some discussions around that but I did not challenge that.

111 Q. In relation to misconduct, we can see at the bottom of page 910 for you - AOB-01921 for us - that you found that there was a case of misconduct that should be put to the Conduct Panel. Again, can you help us with your analysis around that? Why did you see the issues in relation to your findings or Dr. Chada's findings. Why did you see them in terms of misconduct as opposed to simply a clinician being unable to perform the tasks that were required of him because of, as he explained it, job pressures, particularly in theatre but also around the demands in other aspects of his practice?

14:30 14:31 14:31 14:32 14:32

A. So, if you look at my determination, I put together a number of points there. Essentially, what it means is that going back to the point of terms of reference and looking at the investigation report, there were failings from The Trust, yes, but Mr. O'Brien as a senior clinician had an obligation to ensure there is a proper -- and that this was properly known and understood by his line managers. Obviously, there was elements of failure to triage off red flags which led to a number of -- we know from afterwards, failing to take his other elements of his administrative duties. So, there were a number of elements which was clearly indicating that he was failing in regards of his administrative duties, known, standardised practices, policies and procedures, and also failed to maybe not recognise or not, you know, inform the wider system in relation to that. 14:33 14:33 14:34

112 Q. Yes. Before we get to the bullet points, you make the point that - this is at the top of page 911 for you, 1922 for us - you make the point that at this time there's no requirement for formal consideration, IPPA or referral to GMC. 14:34

Again, just on the GMC issue, why do you think the threshold for referral had not been met? 14:35

A. At that point in time I was aware that this case is already known at the GMC ELA. We were going to discuss the threshold meeting, and we did afterwards. But at that point in time, taking the advice from NCAS, I was

satisfied that this is to proceed as a Conduct Panel. I was also aware that a Conduct Panel, if required, this can be referred to the GMC. So, GMC referral was -- in my determination I said at that point in time the GMC referral wasn't required. I wasn't saying it's not required at all. Having that discussion with the GMC ELA, we discussed that and seems to be meeting the threshold, so he was referred.

113 Q. We'll look at that in just a moment. But the -- you then set out the conduct concerns by Mr. O'Brien. You say that they include the following. You don't mention in that list his retention of multiple patient notes at home. Did you decide that that was not worthy of a conduct hearing? 14:35 14:36

A. I suppose I put a number of elements there. I did not include all of them. But I included -- for example, as a summary of some of the elements which are there but in the report, if you look at previously in my report, I did indicate these are the failings in Mr. O'Brien's case and it was included previous to that. But this was a list of some of the elements which were already included in the report. 14:36 14:37

114 Q. Notably, if you look at the fourth bullet point, I took you up on the issue of how you had formulated your GMC concern around record-keeping and here you're - can I suggest to you - more precise about the actual alleged shortcoming of Mr. O'Brien, which was dictation, a contemporaneous dictation issue as opposed to record-keeping more generally; would you accept 14:37

that?

A. Yes. Yes.

115 Q. You then, then if we scroll over the page, in your conclusion section you insert a fourth decision or a fourth aspect of your determination, and that relates to the actions of management - both clinical and operational. 14:38

Tell us about that. Why did you formulate a binding or a decision around that? 14:38

A. So, by looking through and reading through and considering all the evidence presented to me in the investigation report but also in the statements, it was becoming quite clear that these issues were known by many in the operational and clinical and medical leadership roles. It was also becoming clear that they were not addressed, they were not escalated, they were not addressed to the full extent. They were partially addressed, they were partially dealt with, and then there was gaps. So, becoming very clear to me that this issue requires more in-depth analysis investigation by independent team. I also was trying to find in the report, in terms of whether I can reach to any conclusion in that part of the terms of reference, and I wasn't able to reach to any specific conclusion. Therefore, my determination was that this area of the terms of reference required further investigation by the independent team. 14:39 14:39

116 Q. The terms of reference of the investigation report at

number 5, as we recall, was directed to the knowledge of management in the period before 2016 and their actions. Did you find the report unhelpful in terms of its coverage of those issues?

A. The investigation report, you mean? 14:40

117 Q. Yes.

A. The investigation report was comprehensive in many areas, however, I felt that perhaps the investigation team or the investigation report did not provide the adequacy of the details of the report which I need to 14:40 do make some conclusion on that basis. Therefore, I wasn't satisfied that this is just to finish the whole fifth element of the terms of reference. Therefore, I asked for further -- I requested for further investigation by the independent panel. 14:41

118 Q. You say in your conclusions towards the bottom of 912 for you, 01923 for us, that these are what you regarded as systemic failures by managers at all levels, both clinical and operational, to deal with those matters. What did you mean by "systemic" in that context? 14:41

A. I suppose the operational team and clinical teams -- the operational and clinical management teams provide the governance, the professional governance assurances. So, what I meant was that there must be failings at many levels in order to reach to this stage, both 14:42 operationally and professional governance point of view. I was aware that these issues were raised at multiple times and they were not addressed by professional, clinical, medical and operational teams.

So there must be -- I was trying to explore there must be other reasons and I wasn't finding that in the report. Therefore, I requested that there needs to be a further in-depth analysis investigation by the team which is independent, and they can do independent assessment and they should provide for learning for the organisation to go forward. That was my thinking, I suppose.

119 Q. Can I trouble you for an example of what you might have been thinking about, perhaps, for example, triage. You would have observed from your reading of Dr. Chada's report over a period of time, going back several years, triage was an issue being raised both clinically and operationally by management, but the issue was never resolved to the satisfaction of management so that a default arrangement was put in place whereby if triage wasn't performed, then the patient was placed on a waiting list in accordance with the general practitioner's designation. If that's a useful example, or pick another example of what you would seek to communicate in identifying this concern.

A. I suppose there were many examples, but more troublesome for me at that point in time was I could not find a valid reason that these issues were raised on multiple occasions and they were not addressed, so there might be a system-wide failure to get to that point. I was really troubled by thinking what's going wrong? Why is the system not working? There is a professional governance structure, there's a clinical

governance structure, there are operational managers. There are so many levels of safety netting, so why we are not able to protect patients. That was troubling me quite a lot at that time, and still is.

120 Q. You were obviously a medical manager yourself. You were sitting with the Interim Medical Director's hat on your head at that point in time. Obviously you were an Associate Medical Director (AMD) at that time. I suppose that was in abeyance while you were Interim but you had that in the background. What, from your perspective, were you seeing when reading this about the shortcomings of medical management? What should they have been doing but weren't doing? 14:44 14:45

A. I suppose my experience as Associate Medical Director before and as part of the Interim Medical Director, I was mindful of the shortcomings in the succession planning, the resources, the roles and responsibilities of all of that. That was the reason why one of the three key priorities I took as part of the Interim Medical Director was to start a process of looking at the professional governance structures in the Trust and the whole medical leadership structure. As part of my role as Interim Medical Director, we produced a paper to the Senior Management Team, SMT, for reviewing medical management or medical leadership structure. 14:45 14:46 14:46

The other element was about the whole Clinical Governance and how it fits into the bigger picture of governance structures and supporting the clinicians and

managers. But also highlighting and raising and providing the assurance to the system was also something I was mindful of and entrusted at that point in time. Therefore, I started another piece of work which I put in the statement report. 14:47

121 Q. Yes, and that's your report on medical leadership review, which the Inquiry can find at WIT-31532. We're not going to have the time to deal with it today, Dr. Khan.

14:47

Just again glancing back at your conclusions in this respect, you had it in mind and, indeed, you recommended the Trust would carry out an independent review of the relevant administrative processes, with clarity on roles at all levels within the Acute 14:47 Directorate and appropriate escalation processes.

"The review should look at the full system-wide problems to understand and learn from the findings".

14:48

So, a number of elements there. It was to be independent; does that mean out with the Trust or simply out with the Acute Directorate?

A. I suppose in my mind it was to be independent to the organisation. 14:48

122 Q. Why did you think that important?

A. It was important because whilst the learnings are mainly from the Acute Directorate, they were previously escalated to the corporate level as well. I felt that

it would be necessary to bring in a fresh pair of eyes. An independent view of finding out and learning from those findings are going to be more useful.

123 Q. Now, presumably you saw this matter as being of some significance to go to the bother of making such a recommendation. Was there any urgency about it in your mind? 14:49

A. I suppose the determination was to be implemented immediately. We know it did not happen. However, the intention or -- certainly in my mind when I was writing the determination, it was very clear to me that these should be implemented - all three of them - should be implemented immediately. So there was an emergency, not only the administrative review but also the action plan and the conduct panel, all three were to be reviewed immediately. 14:49 14:50

124 Q. Was any reason associated with the grievance given to you as an explanation for the failure to carry out the administrative review immediately?

A. I suppose the advice I received, that everything was to be on hold until the grievance is completed, I suppose in hindsight perhaps it would have been useful if some elements of the recommendations or the determination could be proceeded, and this is probably one of them which would easily be proceeded. Unfortunately it did not happen until much, much later. 14:50 14:50

125 Q. Did you understand then that the administrative review wasn't going to be taken forward until after the grievance, or did you assume it would be?

A. Well, at the time of determination, my understanding would be all three -- all of the determination recommendations will take place. But at the point of grievance, we were advised that everything is on hold now until the grievance is completed.

126 Q. You were approached in July 2020 by Mr. Stephen Wallace, prior to the completion of the grievance, to seek your views on a term of reference for an administrative review. Can you remember that?

A. I do, yes. That was the time -- it was much later, I was approached by Mr. Stephen Wallace from the Medical Director's office for my view on the terms of reference, and I did provide my views on that.

127 Q. I'll assist you with the e-mail. If you could look at page 865 of your bundle. Not the core, of your bundle. If we could bring you WIT-32073. Just at the bottom of the page, please.

This presumably comes out of the blue to you, if I may use that expression?

A. Yes.

128 Q. He sets outs over several paragraphs the terms of reference he is considering you should consider. First of all, he sets out your recommendation. Then if we scroll down, the purpose of the review, its objectives, output, scope and timing, governance and methodology. Various headings.

You write back to him. Just if we go back up the direction we came. You say:

"It was clear during this investigation, system-wide failure happened at many levels within Acute Directorate. Therefore, my recommendation was to provide for" - I am not sure the word "recommendation" should be there - "for system-wide problems in Acute Director and not just only focus on Urology Department". 14:53 14:54

So, you wanted a broader examination across Acute, as you say in the last few lines of your determination.

Let's just look at how this is handled by the Trust. So you are presumably expecting, on the basis of that, if they were to honour your recommendations, they would broaden it out to consider an Acute Directorate investigation or view, not just urology. Were you contacted by Mr. Wallace beyond that? 14:54 14:54

A. I don't recall being contacted afterwards.

129 Q. Two days later he emails those terms of reference round. You can go to 1043, and if we could look at TRU-292694. If we go to the bottom of the page, please. Mr. Wallace is copying that group in. You're not part of the group. He says: 14:55

"Please see below terms of reference for the review of administration processes as per MHPS recommendation.

These have been reviewed by Dr. Khan...".

We'll obviously ask Mr. Wallace about that, but is it fair to say you had not reviewed the terms of reference and approved them? You had reviewed the terms of reference and suggested how they could be improved to meet your recommendation? 14:56

A. That's correct, exactly. I was provided initial terms of reference; I provided my opinion, my view on those terms of reference. However, unfortunately I was not being approached afterwards. 14:56

130 Q. It appears that after your intervention on 27th, Ms. O'Kane - that's Dr. Maria O'Kane - commented. If we look at WIT-91392. This is an annex to your addendum statement. You can find it at 2101, Dr. Khan, of you're bundle, not the Core. And so -- have you highlighted it in yellow? 14:57

A. I didn't. I don't remember highlighting it myself.

131 Q. Okay. So, it appears that Dr. O'Kane will have seen your observation as regards the terms of reference and she says: 14:58

"For the purposes of what I require currently for the GMC, Stephen please ask Mary and Rose to review the new patient referral to urology process only and the remainder then sits with Acute Services." 14:58

Again, we can ask Dr. O'Kane about that but she seems to be limiting the scope of the review to be conducted

by Mary and Rose to what she describes was the new patient referral to urology process. It's possibly stating the obvious, Dr. Khan, but that's much narrower a scope than you had conceived of?

A. I suppose my determination was to review the whole Acute Directorate System in terms of the system-wide failure and the learning from that. Potentially, this information came to light to me, obviously, as part of the preparation of the hearing. I did not obviously highlight it or anything but I can see Dr. O'Kane must be making it in two distinct parts and completing the first part before the other. So that may be the reason behind that. But I obviously was provided the terms of reference and I advised on terms of reference to Stephen Wallace. 14:59 14:59 15:00

132 Q. Did you anticipate that the independent reviewer would look at each aspect of the administrative arrangements governing Mr. O'Brien's work and provide a critical appraisal, not just of those administrative processes but of the management, whether individual or as a general managerial entity, such as AMD or CD or on the operational side, the Assistant Director or the Director. Did you anticipate that all of those things across Acute Services but with particular reference to Mr. O'Brien's activities and alleged shortcomings would all be looked at as part of a review? 15:00 15:01

A. So, my thinking behind putting that recommendation was to -- I wasn't, at that point of time, going to put together a specific terms of reference for that

investigation or for that review. Perhaps, I was keeping it open for that team or people or decision makers to think and come up with appropriate terms of reference for the review. I was providing at that point in time really the direction or the guidance in terms of what should be done in order to achieve the understanding of why the operational team and whole professional governance were failing in terms of addressing this issue for a long period of time. So, not providing specifics about what but I provided the general guidance in terms of what it should be, who it should be done by, by the independent reviewers, it should look at the system-wide failures, it should look at, obviously, in context of this case but learning for the organisation going forward. 15:01 15:02 15:02

133 Q. On 5th October you were sent the draft findings from the review. You can see those in your bundle at 1033. If we could have up on the screen WIT-32141. That's the email sent to you. You're being invited to read this. As Siobhán Hynds says, it's only two pages. 15:03

"If you get a chance, take a quick read for discussion at 1.30."

So, if we scroll down the page, please. Do you remember getting this? 15:03

A. I do, yes.

134 Q. Do you remember meeting to discuss it?

A. Yes. I recall a short meeting with a number of

professionals discussing that. Certainly Siobhán Hynds was there, I was there. I think there were possibly a few other professionals discussing the outcomes. Certainly, I was surprised or shocked to see the so limited amount of outcome and whether there was really any learning from this activity. And I did voice my view on that, that it doesn't appear to be what I anticipated as part of my determination.

135 Q. Thank you for that.

15:03 15:04

Just before we finish, a couple of threads, just to tidy up. We know, and we saw a glimpse of your meeting with Mr. O'Brien after your determination was released, you met with him, and his wife and son. He sought assistance from NCAS as well and I just want to ask you about that. If we look -- if you go to page 961 of the core bundle and if we could have up WIT-53469. That's a letter to you from Dr. Lynn. And if we go to the last paragraph on this page. Clearly, Mr. O'Brien is explaining from his perspective what he thinks of the determination. He indicates in the last paragraph that notwithstanding advice provided to The Trust in September 2016, he wasn't afforded any opportunity to address the concerns which had been raised with him. And his view is that had this been done, it might have avoided a formal investigation. And over the page, please. It is suggested at the bottom of the page that -- at the bottom of the page. Thank you. Just up a bit. In your discussion with Dr. Lynn, the issue had

15:04 15:05 15:06

been raised whether a meeting with all parties should be convened. You took some time to think about this and you say you were unsure of the purpose of any meeting and in the circumstances it was difficult to see what a meeting would add. And she was to inform Mr. O'Brien of this.

Can you recall your thinking there in terms of refusing, if that's not too strong a word, an opportunity to meet with Mr. O'Brien, with NCAS input. Why did you think that meeting would not be useful? 15:07

A. I suppose when this letter came in I sought advice from the HR. I also put together a reply back to Mrs. Grainne Lynn. The reasons behind -- we did, actually, offer to meet with Mrs. Grainne Lynn to explore further what the meeting between The Trust professionals, Mr. O'Brien and NCAS would bring to the whole process. And because, the fact that the determination and the formal investigation, MHPS investigation was completed already with the determination report out, we were not clear in our mind what that meeting will bring, therefore I wrote back -- I think I wrote back to Mrs. Lynn requesting a purpose and what the expectation from that meeting would be. 15:07 15:08

136 Q. Would it not have been useful to meet to see whether, for example, Mr. O'Brien could benefit from further support or to see whether issues around an action plan in respect of his work could be advanced, notwithstanding the grievance which was to be issued? 15:08

A. Yes. So, this letter came in early November, 2018, which is just a few weeks after the determination was out. The intention was, at that point in time, that the action plan will be formed. Three elements of the determination will proceed in terms of the action plan, the admin review and the Conduct Panel hearing. In fact I did write to Mr. O'Brien advising that we will be in the process of putting together a Conduct Panel hearing in January, which is in a few months' time. 15:09 15:10

For the purpose of getting more information, I asked Mrs. Grainne Lynn that we are happy to meet and explore further what that meeting, if that goes ahead, what it brings, what it looks like. So putting that -- requesting a little bit more information. 15:10

137 Q. You had to write to Mr. O'Brien on 17th November - this is 971 of your Core, TRU-279201 - to caution him in respect of members of his family, as it says here, being in contact with Trust employees to discuss the ongoing case involving him. Which members of his family are you thinking about? 15:10

A. So, number of Trust staff were approached by his family members, including his wife and his son. And it came to my attention so I wrote to Mr. O'Brien to cease that -- you know, to immediately cease this type of behaviour. 15:11

138 Q. Why did you consider it inappropriate?

A. I suppose, it was mainly to protect the staff but also to protect Mr. O'Brien's view as well. That was

inappropriate, in approaching Mr. O'Brien's family members to a number of staff. And they were -- they felt vulnerable in that way. So, it was important that this was to be addressed.

139 Q. Into the following year a decision was made to make a referral to the General Medical Council; was that your decision or was it Dr. O'Kane's decision? 15:12

A. Dr. O'Kane took over the Medical Director role in December. So, in December 2018 we were together. She was coming in as a substantive medical director. I was transitioning out, I was finishing my role. We had a period of 2018, December, when both were there. At that point in time, the MHPS report was shared with GMC ELA and it was discussed around the same time. The ELA has indicated that all that information appears to be meeting the threshold. Therefore, Dr. O'Kane was in the Medical Director's role and responsible officer role at that point in time, so she provided all that information and made a referral. I think it was in March or April 2019. 15:12 15:13 15:13

140 Q. You were despatched to communicate this to Mr. O'Brien?

A. That's correct, yes. So I was informed by Dr. O'Kane and I was advised to inform Mr. O'Brien about that.

141 Q. Was that in your role as case manager?

A. I presumed it was as my previous role as case manager. 15:13

142 Q. Just finally from my perspective. You've offered some reflections on the MHPS process generally and your role in it. One of the things you've said in your witness statement -- this is at page 903 of your bundle, not

the core. WIT-31999. You say at 23.1 that on reflection in your view, the MHPS process could have been more proactive. Proactive in that context means what? Proceed with greater expedition or efficiency?

A. I suppose I was thinking on my experience and my reflection since then. The MHPS process was implemented and there were a number of elements. My reflection was that all of them or most of them contributed into the MHPS process; the framework document itself, then how it was implemented in the informal stages, the formal investigation, and post determination, but also how the resources were allocated, what was provided, what was the training element, the experience, the expertise going forward, the interaction or the interface of the Trust own going into the MHPS Framework, that was all part of my thinking. In terms of proactive more towards clarity of the framework or the document or the policy, but also clarity of roles and responsibilities, clarity of entry and exit points in the process, and clarity of taking it forward. That's what I meant by proactive. 15:14 15:15 15:15 15:16

143 Q. I'm glad I asked because there was more to it than simple efficiency. It's a wide-ranging concern you have. You go on to point out the absence of dedicated resources, and you give the example of your own role as case manager being an add-on to your other day jobs, which were more than one, as we know. 15:16

Anything further you wish to add to that?
A. I think the dedicated time or protected time is vital in terms of doing these investigations. We know now it took much, much longer and it's still was going on and on. It was initially thought to be for a few months. I was already doing a busy clinical practice but also in a managerial role. Then I took over the Interim Medical Director role, which was also very busy, without any proper induction or hand-over. So, I felt that in my particular role as case manager, it took a significant amount of my time, not only just the time but also it had a greater impact on other elements going into the clinical and my managerial roles. So, I felt that what needs to be put in place if this is to be done in a correct way. 15:17 15:17 15:18
MR. WOLFE KC: Thank you very much for your evidence, Dr. Khan. I understand that the Panel will have some questions for you. The Chair, Ms. Smith, will speak to you about the arrangement for that. There may be a short break. 15:18
CHAIR: Thank you, Mr. Wolfe.

Dr. Khan, thank you for your evidence. As you're aware, my co-panelists and assessor are not in the room with me today, but I understand we can switch. They are actually on the Zoom call with you. If we can switch to them, I'm going to ask them first of all to ask questions. I think it can be done relatively quickly and we could see them on our screens in the 15:18

chamber. They are going blank so let's just hope that happens. I'm hoping you can see both of them, Dr. Khan, on your screen.

A. I can see.

CHAIR: I'm going to invite, first of all, Mr. Hanbury, who hopefully will have his voice operational by this stage, and he can ask some questions. Thank you very much. 15:19

AHMED KHAN WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS: 15:19

MR. HANBURY: Thank you very much, Dr. Khan, for your evidence. I hope you can hear me?

A. Yes, I can. 15:19

144 Q. I just have a couple of clinical things I just want to run past you, in no particular order.

You said you were interested in appraisal and job planning. Out of interest, one of the delays of 15:19 Mr. O'Brien's -- of the investigation was when he took two months out for appraisal. Do you remember that?

CHAIR: Mr. Hanbury, can I just ask you to make sure the microphone on your headset is at your mouth, because your voice is dropping slightly. 15:19

MR. HANBURY: Is that better?

CHAIR: Hopefully.

MR. HANBURY: I'll just repeat that. When Mr. O'Brien took those two months out to do his appraisal during

the investigation, did you ask to see the appraisal, as a matter of interest, which was happening in the middle of the investigation? It might have been quite enlightening.

A. No, I didn't ask for appraisal to be seen. I was interested in the appraisal and revalidation purely because when it come to me -- this information came to me essentially at the beginning of the investigation, that Mr. O'Brien was successfully revalidated and had appraisals. I was interested to know what was the process behind it and how was that not linked, why it wasn't linking to his job plan and other elements. I was interested in the bigger picture of the appraisal feeding into the professional governance, the revalidation, and also the job planning going into the whole process of not necessarily identifying just the identification of concerns but also supporting the doctor, making sure these are professional governance arrangements, and why they have not been coming together. 15:20 15:20 15:21 15:21

145 Q. Then there was a delay in the job plan as well. That never came through, I think; is that correct?

A. Unfortunately, I understand it never came through. It was progressed to the level to Mr. O'Brien for agreement but I don't think it was completely agreed and signed off from both parties. 15:21

146 Q. Thank you. This may be slightly unfair on you in contrast to Dr. Chada, I may ask her the same thing. When the colleagues did the dictation reviews as part

of her investigation, I think that took two or three colleagues a couple of months to do, it was a good deal of work. From my notes, there were about 35 patients not added to the waiting list and about three who needed urgent follow-ups. Did the report look at those cases in a bit more detail because that looks a bit like potential patient harm at that point. I'm not sure if that got the weight it possibly deserved. Can you comment on that? 15:22

A. I'm not aware of any specifics on those patients, but I knew that there was a, call it a lookback exercise or reviewing the triage was done, was completed and appropriately escalated or managed. A number of patients were to be escalated. So I was aware of that point but I'm not aware of any specifics more than that. 15:22 15:23

147 Q. All right. Okay. I'll just move on.

The next thing was the private practice review. Mr. O'Brien came back to you about the way that was done, with one of the urologists at Southern Trust looking at old letters and just making an off-the-cuff analysis in contrast to comparing that group with a similar group of, if you like, pure NHS TURP or other cases of similar priority. Did that not ring alarm bells? Is it fair, in a way, to compare the one group with a nonexistent other group in the way that it was presented to you? 15:23 15:23

A. I must say, it didn't come to my mind at that point in

time. Again, that may be due to the fact that I am not a surgeon, I suppose, and at that point in time it was done by the surgeons, his colleagues. Also, I was assured this was going to be looked at, you know, robustly, and it didn't come across my mind that I needed to challenge that. 15:24

148 Q. I have one final question. I appreciate you're not a surgeon but this should link in with your physician background. It is the charts in the office thing, which was obviously part of the Inquiry. Secretaries don't just put charts or notes in the consultant's office for no reason. When the numbers went up, did no one think, well, what was it about those charts or notes that meant they went into the office? Was it a patient or a GP query, or investigations, radiology to be answered? It seemed the analysis was just on numbers, not how or why they were there, which might have actually answered a lot of questions and in fact raised a few clinical concerns. Again, thinking back, do you think that was maybe an opportunity lost? 15:24 15:25 15:25

A. Yes, absolutely. I think among the other elements of our reflection, I think that was a learning for us that we could have looked at a little bit more deeper at that point in time. Absolutely. That was something we could have picked up if we looked at. Secretaries are usually bringing that information, and there is a reason behind that and it happens in all departments. So yes, I would agree with that. Yes. 15:25

MR. HANBURY: Thank you, Ms. Smith. That's all the

questions I have.

CHAIR: Thank you, Mr. Hanbury.

Dr. Swart? Again, move to Dr. Swart. If we can see her on the screen, please. I don't think we can hear you, Dr. Swart. I am not sure if you are muted. No we can't hear you at all at the moment. We still can't hear you.

I'm just wondering, we maybe should take a five-minute break just to see if we can get the sound issues sorted. I don't know if it's at our end or Dr. Swart's, but we'll take five minutes and try to get her in sound as well as vision. 15:26

15:27

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: We have resolved the issue. Dr. Swart, can you speak so we can make sure we can hear me?

DR. SWART: Hello, can everybody hear me now? 15:31

CHAIR: Yes, we can. Thank you.

DR. SWART: Sorry about that. It was working fine before, but there you are.

149 Q. Good afternoon, Dr. Khan. I just want to ask you a few things. Just to start with, I do fully appreciate that your first big case as a case manager was a complex one. Taking on acting Acting Medical Director role without induction is a difficult gig. I've been there in these things and I do understand that. It is just 15:31

important to help understand a bit more from your perspective on a few other issues.

One of the most important aspects of your case manager determination was the failing of managerial processes. 15:31
Your account of that this afternoon has been quite clear, I think. But the terms of reference was then translated into a review of administrative failings. Now, I don't think that quite covers it, really. Were you under any pressure to adjust the terminology, or 15:32
why do you think that happened, that it got translated into that particular phraseology?

A. So at the time of my determination, I was very clear in my mind, I had no pressure in terms of how do I put my determination. I did receive advices but it was my 15:32
decision. I felt, as I alluded earlier, that to understand better what exactly happened at many levels on both operational and medical professional governance line management structures, I was puzzled, basically, to understand what really went wrong there and how can 15:32
we learn and improve our systems in order to --

150 Q. I understand that but did you think further in terms of what was it saying about the way the Trust was managed and led in terms of its structures and development? Now, you came from a different directorate, 15:33
I understand that, but clearly from the evidence we've heard, the lines of demarcation between operational, clinician, professional were not all working correctly. Do you feel now that that's adequately expressed by the

term "administrative review"? I'm saying that because of they way it was interpreted when it actually happened.

A. At the time of determination, I was hoping to make it clear that this is not about just the administrative duties or the responsibilities, it is the overall responsibility of the whole system. I must say I was disappointed to see the administrative part just taking in that way and not necessarily learning from that. I am aware that a lot has been done since in the Trust in terms of improving the professional governance structure but also the Clinical Governance, and combining all that together, bringing it together in more learning format. Since then, in fact, I was reflecting on that as well. There were elements, environmental elements such as the processes, the policies, the overarching -- the frameworks which were not working together. So, there were competing demands on various elements. The targets or the waiting lists are always in the forefront of all that, but are we making sure that the quality of care is there? Are we making sure that the succession planning is there? We know now the senior management team was going through the turnover and how it impacted on various elements of the Trust, so the leadership, the medical leadership and the no succession planning -- well, I must say less focus on that. But also the culture, the culture of both of --

151 Q. I think you're quite right and we've heard that. All

I'm trying to ask you is would you agree now that the term "administrative review" perhaps doesn't do justice to the extensive thinking that you did around it and that we can now see. It was just to make that point because it is much more than that, isn't it? 15:35

A. Yes, it is.

152 Q. On another aspect, this lack of dictation of letters, have you ever come across this particular degree of problem in relation to that with any other clinician?

A. No, I'm not aware of any -- I am not aware of any other clinic who would leave that length. The extent of that was remarkable. It was unbelievable. 15:35

153 Q. There was a monitoring plan put in; we talked about that extensively. But it is my perception, and you can correct me if I'm wrong, that there wasn't any regular standard or data presented in that regard for the department. I can't see any evidence to the length of time dictation was taking for the other consultants, for example, or any regular report of that; is that correct? 15:36

A. That was my understanding as well, yes.

154 Q. In that context, is it entirely equitable to monitor only one consultant in a department and not put it into the context of how their colleagues are performing?

A. I suppose if you take it in the count of this case, there was a clear action plan around one consultant, and that was to have -- that would be the standard for that particular consultant's monitoring arrangements. I appreciate your point is it was kind of not taking 15:36

broadly for the whole team or the whole system rather than just one.

155 Q. I'm really asking you what your view on that is, because I can see that from the point of fairness, individual practitioners have a right to be treated, in terms of standards, the same as other people. 15:37

A. Absolutely.

156 Q. Would you agree? Yes.

The other thing is in all of this, because of the length of time the letters were taking, at various times we've touched on the need to copy letters to patients, patients being a key partner in the multi-disciplinary decision-making process. Did you consider that at all in any of this, and is it your view that there are such standards at the Southern Healthcare Trust? 15:37

A. There are such standards, and certainly in my Directorate, I personally would have copied my letters to the patients. That would be quite standard practice in some teams, not all of the teams. But that would be -- my view on that is that patients and carers are the key player in managing patients, actually. So, we should be keeping them informed and I do tend to. 15:38

15:38

So in the Trust, I'm going to give you an example: Some teams would be doing it regularly, perhaps other teams are not doing it.

157 Q. What's your view? You spent a period as Acting Medical

Director, what's your view on the role of the Medical Director in setting the tone for this type of thing?

A. I think the Medical Director has a key role in the quality of care and provision of the services across the Trust. But the Medical Director is part of the senior management team. I felt, when I was in the Interim Medical Director role, I was the lone medical voice in the senior management table and, in fact, on the Trust board as well. Having that robust structure, I'm aware that Southern Trust have it now and I'm glad that they took the initial paper which I produced when I was Interim Medical Director and further developed on that paper. Having the right kind of structures around you is vital as a medical director as well. I felt at times very overwhelmed and lonely in that capacity and not, you know, not the support which I would require to do that. I understand it has improved since then. I have gone through that, yes. 15:38 15:39 15:39

158 Q. When you were Acting Medical Director, do you think there was an effective way of the Medical Director being assured - not reassured - assured about the quality of clinical services? Did you see enough information as Medical Director to give you that assurance? 15:39

A. When I was Interim Medical Director, I wasn't getting assurance as I would have hoped, maybe because I had no previous experience but I was coming into that role thinking I should get more robust assurance. When I wasn't getting that, the second key priority I took 15:40

in my role was to look at the Clinical Governance structures. Not the structures, necessarily; it was an exercise to understand better and I put my role in that. We looked at the understanding of the assurances, processes, the learning process behind that, and how we can improve our provision of care to the patients. One element we did was to establish a lessons learned forum. That was bringing together quite a lot of learning from complaints, from SAIs, from M&M, and bringing together to the people which are really the decision-makers, and perhaps taking it back to the clinical floor as well so that the clinicians are involved. 15:40 15:41

159 Q. I agree with all that and we've heard some of that. That's definitely a positive development. 15:41

When you were appointed as Acting Medical Director, do you think you really at that point understood the full scope of the role?

A. When I was appointed to the Acting Medical Director, I was already in the Associate Medical Director MD role for a period of time. Before that I was Clinical Director and before that I was Lead Clinician. From the time I joined the Trust, I was always interested about making positive change in the role of medical leadership and how it can impact the positive outcomes and the experience and the patients. It was my first exposure into the Medical Director hot seat, I would call it, and it was so much learning for me. I think 15:41 15:41

these roles require succession planning. Although I did complete, previous to that, a number of medical leadership training courses and other things, but I think this requires more succession planning and development. 15:42

160 Q. So, my experience is that nothing really prepares you for absolutely being in the hot seat, unless it's a very exceptional Trust. But once you were there, you will quickly have realised the scale of the problems, as you will have done with the Case Manager role. Who 15:42 was there to support you and mentor you? What senior advice did you have, maybe outside The Trust? Were you signposted to anyone or did you seek any additional help?

A. So, I did reach out to other Medical Directors in the 15:43 region. So we had a Medical Directors' forum. So I attended those. I had informal discussions with other Medical Directors in the region. I did receive some advices and discussions on similar issues. But there was no, call it a support mechanism in The Trust. 15:43 I suppose the Medical Director is thought to be leading all that but not having the support sometimes could be really daunting.

161 Q. So, what I'm trying to get at is were you formally signposted to a specific mentor outside The Trust or 15:43 did you have someone you could ring, for example, when you had the challenge from Mr. O'Brien about the case management determination and he gave you a lot of information. Did you think then, 'I need to ask

somebody what to do with this.' And was there anybody to ask?

A. To answer your first question, no, I wasn't signposted to any resources or mentorship outside. But I suppose, unfortunately, when I started the Medical Director's role there was no Medical Director so I had no link to a Medical Director -- 15:44

162 Q. I realise that.

A. -- which would be very useful advisory role in terms of knowing what to and how to approach others. So, I had -- I was disadvantaged in that way of that having -- so I started with a vacant office with a lot of stuff to complete. 15:44

163 Q. I get it. Yes. But did you not think: 'This is a difficult issue, I need to ask advice on that particular issue.' The letter from Mr. O'Brien, it was a very, very comprehensive letter full of information. What stopped you from thinking: 'Hang on a minute.' Was it just you thought you should be able to do it? Were you not sure who to ask? 15:44 15:45

A. I actually -- I don't actually know why I didn't. I just -- it just didn't cross my mind. Probably there was a lot else going on, a lot of competing priorities in The Trust and I wasn't -- I suppose on reflection I was thinking maybe if I was just the Case Manager and had the Medical Director there at that point in time I could have reached out to the Medical Director. Unfortunately I was or whatever at that point in time I was in both roles. And I didn't reach out. 15:45

164 Q. Aligned to that, during the investigation, which was very prolonged, there were Patient Safety issues coming up. You know, additional SAIs, various things to do with prioritisation of lists, the whole private patient thing. Whether or not that was properly investigated, 15:46
it was an issue about policies and things which was disadvantaging, possibly, some patients. What did you think about those as they came along? Did you feel you needed to take any more action because, really, as Medical Director, patient safety has to be the biggest 15:46
thing. There is a Medical Director to talk to at the beginning, as Case Manager you'd got the same responsibility. What worries did that give you?

A. I was -- yes, I was mindful of that and I was concerned about purely for the patient safety perspective. I was 15:46
aware of this SAI is ongoing and I think it did not conclude until much later. What I was assured by was that there was an action plan, there is an assurance coming from various parts of the system to me.
I wasn't -- I wasn't getting -- I wasn't hearing -- 15:47
let's put it this way -- I wasn't hearing the patient safety risk to me coming through the Medical Director's office.

165 Q. Okay. So, I think the learning from that is probably one always has to look further. I think we've all 15:47
learnt that over the years.

One thing that's come through with you and with many of the other managers, clinical and operational is, there

seemed to have been a reluctance to sit down with Mr. O'Brien and just say: 'Tell me how it is for you. What is going on behind this? Why are you behaving in this way?' Is that fair; was there a reluctance to do that? 15:47

A. I think it's a fair comment. There was reluctance, in fact, from quite a long period of time by his senior colleagues, even by his colleagues or his own immediate line managers to sit down and talk about that as well. So, I think it's a fair point, yes. 15:48

166 Q. And were you fearful of it? Did you feel vulnerable?

A. I didn't feel vulnerable but I thought that there is a process going and I will make my determination when I receive these. I did address those if I felt that I needed to intervene. However, I think the learning 15:48 for me, personally, is that maybe we could have been more reaching out in that way to Mr. O'Brien as well. Even for his -- for the support to him as well. I was assured that the support has been provided within the teams, but in my role as Interim Medical Director 15:48 I possibly would have been more going out to him as well, yeah.

167 Q. I think you were reassured rather than assured, weren't you?

A. Yes. 15:49

168 Q. That he had the right sort of support from what I can see so far. Would you agree with that, that it was people telling you?

A. That's right.

169 Q. That you didn't see it for yourself?
A. Yes.
170 Q. If you had to do the whole Case Manager thing again from the beginning, what one thing would you do differently yourself? Never mind the process and The Trust, and all of that, but you as an individual, what's the biggest learning for you? 15:49
A. I think the biggest learning for me is that I wanted to make sure that I am properly equipped with myself, my training, my experience. I wanted to make sure am I in this role being properly supported? What are the processes we are following? Are we clear in our roles and responsibilities? Am I clear? Are others clear for their roles and responsibilities? And also making sure that this is an important process for one doctor or others, or something. But is The Trust taking the responsibility in terms of supporting all this, all these processes. So there was a lot of learning for me as well, but I think as a system we need to understand this better and learn more. 15:49 15:50 15:50
DR. SWART: Thank you very much. That's all from me. Thank you.
171 Q. CHAIR: Thank you, Dr. Swart. Dr. Khan, just a couple of questions from me. 15:50
It's clear that you were drafted into this role without any experience, expertise or training. On reflection do you think - aside from the all the other skills you may have - do you think you were the right person to be

asked to do this?

A. I think I wasn't equipped, I wasn't ready at that point in time. Obviously I had no experience, no training. So looking back perhaps it's -- I could have just said no. Sometimes the clinicians, they don't take -- in my 15:51
experience as AMD and Interim Medical Director it's very, very challenging to ask or to get the doctor or senior clinician to do such investigation, purely for the reasons which we know now, there are the add-ons, there are the -- you need to start with something, and 15:51
it's something else, and at the end of all that you look back and you thought you could have done a number of things differently. So, yes.

172 Q. So, one of things that we have to do is obviously to make recommendations about the whole MHPS process. 15:51
Would I be right in thing, and correct me if I've got this wrong, but do you think that there needs to be greater clarity within the Framework itself as regards the roles and responsibilities that each individual who's asked to operate that Framework has? 15:52

A. That's right. That's correct. I think the Framework requires update and the Framework document itself is very difficult to navigate. You just need to read it multiple times to understand the extent of it. I think it requires a little bit of easier language as well and 15:52
maybe FAQs and perhaps further explanation on various things as well. So the whole Framework requires an update, I say, yeah.

173 Q. So, perhaps a simplified document with more clarity in

it, but what about the actual operation of the Framework itself. Is it appropriate for an individual Trust to operate the MHPS process in isolation or would it be better to have, perhaps, a regional team with experience and expertise coming in for these complex cases at least? Would that have been beneficial? 15:53

A. I think, as we know now, complexity usually comes halfway or as a process going into the formal investigations. But I believe that there needs to be a capacity building. I believe there has to be an expertise which would be supported with other elements of the system. But also having a peer support. I would have experience of peer support in terms of SAI or M&M. So in my Interim Medical Director role I would have created an M&M peer support role in The Trust. So, yes, there needs to be an expertise -- build-up of capacity and expertise in that role, yes. Whether it would be central or Trust-wide, it really depends on how many, really, in a year or in a timeframe is going to be carried out. 15:53 15:53 15:54

174 Q. So, it would be useful to have an analysis of the number of MHPS investigations there are across the regions, say, to inform that?

A. That would give us a good indication. Yes. 15:54

175 Q. Just in terms of, if I've got this right, the initial decision to go for an MHPS investigation in respect of Mr. O'Brien, as I understand it, to put it maybe in laymen's terms as well, here we've got a problem,

there's a problem with this particular practitioner not doing all of these things and we need to look at that in some detail, and that that problem essentially dictated the terms of reference. Would that be fair?

A. I think the initial screening or initial preliminary investigation provided some context to that. But maybe it wasn't providing the greater clarity or greater visibility didn't which was not clear at that point in time. So, the importance of an initial screening and initial preliminary investigations would be very useful to have a greater understanding and then to develop the terms of reference. 15:55 15:55

176 Q. How do you feel that they need to maintain the confidentiality of any such screening process to protect the practitioner, apart from anything else? How do you feel that affects what then subsequently happens? 15:55

A. As we know, it's a fine, very fine line between the confidentiality and patient safety. So there has to be a balance maintained in order to protect the confidentiality of the individual. But at the heart of that is our patients. So we need to keep a balance right there. Not by protecting and too much protection or going one way or other. So, there has to be a clear balance on that which in the practice it's very, very challenging and we know in this case it has created a lot of challenges for The Trust. But I think we should aim to keep a balance right. And I think the Framework should give us more advice and assistance in 15:56 15:56

relation to that as well.

177 Q. So, it would be useful if the Framework set out, as you described it, some frequently asked questions as to where maybe the line should be drawn between protecting a practitioner's confidentiality or the confidentiality of the process per se versus patient safety? 15:56

A. That's correct. Yes. That's right.

178 Q. Thank you.

I'm just checking through my notes. If you bear with me one moment, to make sure I've nothing else that I want to ask you. 15:57

Yes, just one thing. In terms of this particular case, you knew that there was an ongoing SAI in the background, obviously we know it didn't conclude until much later, but that seemed to trigger the formal MHPS process in this case. At that point in time ought there to have been a greater involvement of the clinician at that stage, do you feel, when the two processes are running in parallel lines, if you like? Should they have been linked up more? 15:57

A. In my view, I think the clinicians should have been involved, really from the very beginning. I think there was a missed opportunity at that point in time when the initial screening wasn't completed by the clinician, per se, or part of that screening process. I think there was a missed opportunity there. 15:57

The clinician should be part of this process, I suppose, in terms of immediate line management, the Clinical Director, the Associate Medical Director, and the same thing for the operational line management. I believe that the inclusion of clinicians at the earlier stage would have given us maybe an earlier indication of some of the facts which we come to know at a later part. 15:58

CHAIR: Thank you very much, Dr. Khan. I think Mr. Wolfe might have something that he wants to ask you before we allow you to go today. 15:58

MR. WOLFE KC: It is not questions, it is just a reference for you.

You'll recall that I was asking Dr. Khan about his interaction with Dr. Grainne Lynn of NCAS. You saw her letter to Dr. Khan of 6th November 2018 which was reference WIT-53469. It was an email from Dr. Khan to Grainne Lynn the day before, which explains his thinking around whether he should meet with Mr. O'Brien. That reference is TRU-251539. In essence, he says in the email: 15:58 15:59

"We remain unclear as to the purpose of a meeting with Mr. O'Brien at this stage. We're happy to be guided by NCAS and if you feel it is useful to meet, we're happy to do so". 15:59

I maybe didn't put it as fairly as that in my question.

That ties that up.

Thank you again, Dr. Khan.

CHAIR: Thank you, Dr. Khan. I think that concludes your evidence. We appreciate you giving up the time to speak to us on two occasions. Hopefully we won't need you back. Thank you. 16:00

Ladies and gentlemen, it is now four o'clock. We'll start again at 10 o'clock in the morning. I think we have both witnesses tomorrow scheduled in person; isn't that correct? 16:00

MR. WOLFE KC: That's right. We start with Dr. Chada in the morning.

CHAIR: Thank you. 16:00

THE INQUIRY ADJOURNED UNTIL 10:00 A.M. ON WEDNESDAY 29TH MARCH 2023