



Oral Hearing

Day 35 – Thursday, 30th 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

INDEXPAGE

Dr. Colin Fitzpatrick	
Examined by Mr. Wolfe KC	3
Questioned by the Inquiry Panel	116
Lunch adjournment	127
Dr. Gráinne Lynn, sworn	
Examined by Mr. Beech BL	127

1 THE INQUIRY RESUMED ON THURSDAY, 30TH MARCH 2023,
2 AT 8:00 A.M.

3
4 CHAIR: Good morning, everyone. Glad to see everyone's
5 alarm clocks were working well. 08:01

6
7 Mr. Wolfe, good morning.

8 MR. WOLFE KC: Good morning, Chair. Your witness this
9 morning and for the evening is Dr. Colin Fitzpatrick.
10 I understand he wishes to take the oath, although, as 08:01
11 I say, I'm not sure. He wishes to affirm. Thank,
12 you, doctor.

13
14 COLIN FITZPATRICK, HAVING BEEN AFFIRMED, WAS QUESTIONED
15 BY MR. WOLFE KC AS FOLLOWS: 08:02

16
17 1 Q. Thank you, Dr. Fitzpatrick. Thank you for joining us
18 late into the evening for you, bright and early for us.
19 We appreciate that you probably had a long working day
20 prior to joining us, but given the state of Inquiry 08:02
21 expenses, you've at least saved us the bus fare all the
22 way to New Zealand.

23
24 A couple of introductions. You should have alongside
25 you three documents, a designation list setting out 08:02
26 patients and their anonymity code, which I doubt very
27 much we'll need to refer to. Then you've two bundles.
28 One is our core bundle.

29 A. Yes.

1 2 Q. The first document in that is the MHPS Framework, if
 2 I need to call that up, as I will, I'll refer to that
 3 as core. Then the other bundle which commences with
 4 the Inquiry's notice to you of 4th May, I'll refer to
 5 that simply as your bundle, your personal bundle. 08:03
 6
 7 Now, the first thing I need to do then is to refer you
 8 to your witness statements.
 9 A. Yes.
 10 3 Q. Our screen has gone a little bit fuzzy here to say the 08:03
 11 least. There, you're back with us, that's fine.
 12 A. Sorry about that.
 13 4 Q. The first document which I'll bring up is your bundle
 14 at page 45, and we have it as WIT-53474.
 15 A. Got it. 08:04
 16 5 Q. The last page of that document is page 49.
 17 A. Correct, yes.
 18 6 Q. That is a statement that you signed off anticipating
 19 that the Inquiry would need to hear from you, but you
 20 were leaving the services of NCAS at that point. It 08:04
 21 was signed off prior to the Inquiry serving a notice on
 22 NCAS; isn't that right?
 23 A. That's correct. As you rightly say, we anticipated
 24 you'd probably want to hear from us so Gráinne and
 25 I prepared these in advance. 08:05
 26 7 Q. Can I ask whether you wish to adopt that document as
 27 part of your evidence?
 28 A. Absolutely. One very, very minor correction, which is
 29 at paragraph 12 where I refer to Simon Gibson as

1 Dr. Simon Gibson, I think that be should be Mr.

2 8 Q. I anticipated that, thank you. We can see at paragraph
3 13 you go on to refer to him as Mr. It's a small issue
4 I'll raise with you in the course of your evidence in
5 any event. 08:05

6

7 The next document is a supplementary statement which
8 we find at page 65 for you.

9 A. Yes. Got it.

10 9 Q. WIT-53789 for us. 08:05

11 A. Yes.

12 10 Q. The last page of that we'll find at page 70 for you?
13 A. Yes, correct.

14 11 Q. We're experiencing another screen issue here, so let
15 me... 08:06

16 A. Well, I can see you.

17 12 Q. It's just with our documents. Here we go, I think
18 we're sorted now.

19

20 We have up here the first page of your supplementary 08:06
21 statement. Could we go to the last page. Page 70 for
22 you, doctor, WIT-53794 for us.

23 A. Correct.

24 13 Q. I'm told that all of the documents are not loaded and
25 we need five minutes to resolve that. 08:06

26 CHAIR: Okay. Then we'll take a five-minute break.
27 Sorry, Dr. Fitzpatrick. It's technical difficulties at
28 our end but we'll get it sorted quickly.

29 A. No problem, I'll hang on here.

1 CHAIR: Thank you.

2

3 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

4

5 CHAIR: Hopefully our technical issues are resolved. 08:13

6 I should tell Dr. Fitzpatrick that this is not unusual.

7 We've had a series of technical difficulties but

8 hopefully it will be more straightforward from now on.

9

10 MR. WOLFE KC: Dr. Fitzpatrick, let's go back to 08:13

11 page 65 at your end and we have WIT-53789. It will be

12 typical for there to be a slight pause after I give out

13 the references so that we get the document up on this

14 screen at our end, just so that you're aware of that.

15

08:14

16 This is your supplementary witness statement. It is

17 dated 6th July 2022. We find the last page at page 70.

18 If we could have that up, please, at WIT-53794. Again,

19 you recognise that document, Dr. Fitzpatrick, and you

20 would wish to adopt that as part of your evidence; is 08:14

21 that right?

22 A. Yes, that's correct.

23 14 Q. Thank you. Then finally you provide a response to

24 a Section 21 notice. It's at page 105 your end.

25 A. Yes.

08:14

26 15 Q. It's WIT-62805. You'll recognise that. It's signed at
27 page 109?

28 A. Yes.

29 16 Q. WIT-62809 at our end. 20th October 2022. Again, same

1 question, doctor, would you wish to adopt that as part
 2 of your evidence?

3 A. Yes. Yes, please.

4 17 Q. Okay. Then let's go to page 45 of your bundle, and
 5 we'll have up on the screen WIT-53474. 08:15

6 A. Yes.

7 18 Q. This is back to your witness statement. You are, by
 8 profession, a general medical practitioner, doctor?

9 A. That's correct, yes.

10 19 Q. You qualified, as we can see here, in 1992. You 08:15
 11 describe some additional professional activities
 12 outwith the normal role, I suppose, of a general
 13 practitioner.

14 A. Yes.

15 20 Q. You've had roles in medical management, first as 08:16
 16 a medical adviser with the Eastern Health and Social
 17 Services Board, as it then was?

18 A. Yes.

19 21 Q. Then in the South Eastern Health and Social Care Trust
 20 where you were a Clinical Director until early 2021? 08:16

21 A. Correct.

22 22 Q. I suppose you're here primarily to speak to us about
 23 your role as a senior adviser in NCAS. I know the name
 24 of the organisation has changed a couple of times over
 25 the years but I understand that for all relevant points 08:16
 26 in our timeline, NCAS is the appropriate term to use.

27 A. Yes. Yes.

28 23 Q. So, that's the nomenclature.

29

1 29 Q. Secondly then, the role that you provided or the
 2 services that you provided and your organisation
 3 provided in the context of the Southern Trust's work
 4 with Mr. O'Brien.

5 A. Right. 08:18

6 30 Q. That broadly is the framework this morning.

7 A. Okay.

8 31 Q. NCAS Northern Ireland, it has a base and an office in
 9 Belfast; is that right?

10 A. Not any more. We did have but that was got rid of 08:19
 11 a few years back. We did have a base in -- actually
 12 first in Belfast, then in Lisburn.

13 32 Q. And we know about Dr. Lynn, who we'll hear from later
 14 today?

15 A. Yes. 08:19

16 33 Q. Were you essentially the advisers dealing with Northern
 17 Ireland Trust issues?

18 A. Yes, absolutely. The two of us, broadly speaking, at
 19 the time when we were both working for NCAS, dealt with
 20 just about all of the Northern Ireland issues, with 08:19
 21 a very, very small number of exceptions where there was
 22 conflicts of interest or something like that. Gráinne
 23 was full-time working for the organisation, so she had
 24 a fair number of Trusts in England that she also was
 25 responsible for. I largely dealt with Northern Ireland 08:20
 26 with a small caseload in England, usually cases that
 27 I had particular skills with or whatever.

28 34 Q. Help us with this. How do you, a medically qualified
 29 person, adapt yourself or train yourself to come into

1 a senior adviser role which, as we will see this
2 morning, carries with it a number of components, and it
3 probably - I don't know if you would agree with this -
4 brings you into a quasi-legal field, employment issues,
5 human resources issues; all, of course, focused on the 08:20
6 medical arena?

7 A. Yes.

8 35 Q. Was there training or additional qualifications
9 required as you came into this role over and above your
10 medical qualifications? 08:21

11 A. Well, yes. Yes, yes. Basically, in order to be
12 selected, you didn't just need to be a doctor. In
13 fact, many of our advisers were not doctors and had
14 other backgrounds - HR, legal, etcetera.

15 08:21
16 Maybe if I take you back to the original concept of the
17 NCAA as it was originally, and that might help to
18 explain things. When NCAA was set up by Alastair
19 Scott, way back in 2001 I think it was. His idea was
20 he would get a calendar of senior medical managers and 08:21
21 people with experience of managing doctors who had
22 a lot of experience and who understood the nuances of
23 dealing with doctors as opposed to dealing with other
24 members of staff. And that we would have high-level
25 discussions, usually with medical directors and chief 08:22
26 executives, about how to manage difficult situations.

27
28 NCAS, in its various names, always had workshops for
29 all the advisers from across the UK, usually three or

1 four times a year, talking about and addressing the
2 sorts of issues, you know, what the policies are, what
3 the protocols are, how do I apply MHPS, and some other
4 general training about performance and under
5 performance, etcetera. So, there was a fair bit of
6 training. 08:22

7
8 Gráinne - you'll speak to Gráinne later - she went
9 above and beyond that and did a degree in employment
10 law. I did various other programmes. Over the years 08:23
11 I've also had a fair degree of management training
12 because I suppose I went into the management business
13 fairly early in my career, three or four years anyway
14 in the Eastern Health Board, and there's a fair bit of
15 training involved there as well. So I was coming in to 08:23
16 NCAS with a fair bit of experience managing doctors --

17 36 Q. Could I stop you? Sorry to cut across you,
18 Dr. Fitzpatrick. I'm trying to check in this room and
19 with the stenographer. I get the impression you're
20 speaking a little fast, but I also get the impression 08:23
21 that there's a problem with the quality of the line.
22 I'm not sure whether we're going to be able to address
23 that. I first want to check with the stenographer that
24 we're getting a reasonable note.

25
26 Chair, it's a matter for you. I'm struggling a little
27 bit. 08:23

28 CHAIR: Yes, there is... I think we have the connection
29 issue fixed. Let's continue. If we encounter further

- 1 difficulties, we'll stop.
- 2 A. I will try to speak slower. If I get too fast again,
3 please just slow me down.
- 4 37 Q. MR. WOLFE KC: Thank you for you that. You were
5 helping us understand the background of NCAS, as it 08:24
6 became known, and how you and Dr. Lynn equipped
7 yourselves with the necessary skills, I suppose, to do
8 your job.
- 9 A. Yes. So, as I say, we would have had regular training
10 programmes internal within the organisation. We would 08:24
11 also have had access to various external training.
12 I mentioned Gráinne's degree in employment law. I, for
13 example, did several training programmes in mediation
14 which is, obviously, extremely useful in this business.
15 I had previously done a course in leadership in 08:25
16 Harvard. So, we had a fair range of experience and
17 training. I can safely say that any training need that
18 I identified to, my managers in NCAS, they were quite
19 happy to look at what we needed to fill that gap.
- 20 38 Q. Yes. We're going to go now and look at the kinds of 08:25
21 services your organisation through yourself and Dr.
22 Lynn, and presumably others where specific expertise is
23 required, was able to deliver to, I suppose, the Trusts
24 in Northern Ireland.
- 25 A. Yes. 08:25
- 26 39 Q. Just before we look at that, do you think that the
27 services offered by your organisation are well-known
28 and sufficiently well-publicised amongst those who
29 might need them in Northern Ireland, which is primarily

1 the Health and Social Care Trusts?

2 A. Well there are five -- well, six Trusts in Northern
3 Ireland. Certainly with the exception of the Ambulance
4 Trusts, which only employs, I think, one or two doctors
5 we would have -- I would personally have touched base 08:26
6 with each Trust one or two times a year through their
7 Medical Director or other senior people in HR who were
8 all, I think, very aware of us. I'm not absolutely
9 convinced that everybody at a lower level in the
10 organisation, such as even clinical directors and 08:26
11 below, would have been aware of us to the same degree.
12 Certainly at the higher levels there was a very clear
13 awareness, and I would have been on first name terms
14 with all of the medical directors and most of the
15 senior HR people who were dedicated to work being with 08:27
16 medics and dentists.

17
18 I think yes, we were well-enough known certainly at
19 a high level. I'm not completely convinced that
20 everybody who got involved in a performance procedure 08:27
21 with a doctor would have known as much about us as we
22 would have liked. We certainly did do a fair bit of
23 awareness raising, and we did our best to promote our
24 services.

25 40 Q. Yes. We can see and we will see as we just move 08:27
26 through this this morning that you specifically have
27 been involved in the provision of training to medical
28 managers. We'll look at that in due course.

29

1 Now, you say in your statement - this is at page 46 for
 2 your purposes. WIT-53475 - that the advice service, as
 3 you call it, this is paragraph 7:

4
 5 "Provides a range of core services to NHS organisations 08:28
 6 and other bodies in England and Wales and Northern
 7 Ireland such as advice, assessment and intervention,
 8 training courses and other expert services".

9
 10 Now, you refer us to a service level agreement that's 08:28
 11 signed off between our local Department of Health and
 12 the NHS Litigation Authority in 2017. Let's just bring
 13 that up, please. It's page 71 at your end and for us
 14 WIT-53795. The Inquiry obviously has this document to
 15 read and digest so I don't need to go through it in 08:28
 16 granular detail this morning. It's signed off, as
 17 we can see, at page 78 your end, 53802 for us, on
 18 10th October and 17th October '17. What was in place
 19 before that? Was it more of an ad hoc arrangement?

20 A. No, no, no, no. This was a three-yearly -- I think 08:29
 21 there had been SLA since we started in 2004 or
 22 thereabouts. It was a three-yearly SLA so this was the
 23 version applicable at that time. Broadly speaking,
 24 there wasn't much difference. I mean the previous ones
 25 would have been broadly similar with subtle changes, 08:29
 26 such as every time we changed our name, we had to
 27 change the SLA.

28 41 Q. If we just glance at the first page proper of this.
 29 This is a legal agreement between the two

1 organisations. Page 72 your end, 53796 for us.

2 A. Yes.

3 42 Q. We can see that the Department and NHS Litigation
 4 Authority wish to enter into an agreement under
 5 Section 28 of the Northern Ireland Act whereby NCAS 08:30
 6 will provide support to the Department and its
 7 arms-length bodies. Those bodies include, of course,
 8 the Southern Trust, which we're primarily interested
 9 in.

10 A. Yes. 08:30

11 43 Q. It sets out, at paragraph 3 at the bottom of that page,
 12 the functions of NCAS. Notably, over the page, at
 13 page 73 your end --

14 A. Yes. Yes.

15 44 Q. -- an advisory service; an assessment in intervention 08:31
 16 service; a service which are provides support to local
 17 efforts to improve good practice which provides support
 18 in relation to the resolution of difficulties and
 19 concerns, etcetera, and a provision of support for
 20 reporting at a local level. I suppose that's more 08:31
 21 fully set out across Schedule 2 of the document which
 22 we see at your end, page 81. For us WIT-53805.

23
 24 I just want to pick up on three aspects of the service
 25 that was provided. We can see at the bottom then of 08:31
 26 page 81, the reference to a case management service.
 27 In that respect, the requirement is to provide expert
 28 support to local resolution of concerns about the
 29 performance of a practitioner. That's particularly

1 germane to the work that was done with the
2 Southern Trust; isn't that right?

3 A. Yes.

4 45 Q. It's elaborated upon over the page where it says:

5
6 "The NCAS adviser" - in other words yourself or Dr.
7 Lynn - "will provide expert advice and support and will
8 be responsible for directing the management of NCAS's
9 input to the case".

08:32

10 A. Yes.

11 46 Q.

12 "The level of support will depend on the nature of the
13 case. The progress of all active NCAS cases are
14 reviewed at monthly meetings between the adviser and
15 a senior colleague. NCAS lead and senior advisers
16 provide senior support in quality assurance for the
17 work undertaken by the adviser".

08:33

18 A. Yes.

19 47 Q. I suppose that that advice work takes place in
20 circumstances where the MHPS Framework is relevant and
21 deployed, but it can be broader than that, can it?

08:33

22 A. That's right. I mean, we advertise ourselves as
23 providing advice whenever anybody had a difficulty with
24 a practitioner. So sometimes that was minor and
25 trivial, sometimes it was much more serious and
26 required much more input. MHPS was often involved
27 because we referred to them on several points of MHPS,
28 but not always. It didn't have to go through the MHPS
29 Framework. Some of the stuff wasn't relevant to MHPS.

08:34

- 1 48 Q. I suppose the primary method by which this expert
2 advice and support role is provided is simply through
3 telephone calls, and perhaps frequent telephone calls,
4 depending on the case, every case being different,
5 followed up generally, as we have seen in the O'Brien 08:34
6 case, usually very quickly with a summary of the
7 telephone call and the advice that you think is
8 relevant and pertinent?
- 9 A. That's pretty much it. We would have a fairly,
10 hopefully a reasonably in-depth, discussion on the 08:35
11 telephone and then the salient points would be
12 summarised in the letter. Yes.
- 13 49 Q. We can see a description of the work on this page. I'm
14 just trying to see if I can see the words. Yes, at the
15 very bottom of the page. It's described as providing 08:35
16 a constructive challenge to the local management of
17 concerns and support. Would you unpack that for us?
18 Is it a case of --
- 19 A. Absolutely. Very frequently people will have phoned us
20 with a preconceived notion as to how they're going to 08:36
21 do it, how they're going to solve this problem. We
22 would frequently say is that the only way of doing it?
23 Is there a better way to do this? Sometimes we'll come
24 back to the conclusion that what they thought in the
25 first place was the right way, but often we would 08:36
26 change.
- 27
28 A really good example is when somebody has phoned us
29 and they have decided they are going to exclude this

1 doctor or suspend them, you know. we would be saying
 2 is there another way we could do this; could we
 3 restrict his practice to ensure Patient Safety? Could
 4 we supervise a bit more closely and come up with other
 5 ideas. Because the whole point of the NCAS advice 08:36
 6 service was not that we have superb training and
 7 we're -- it's just that we're very experienced. well,
 8 when I was working in the job, I was dealing with
 9 underperforming doctors several times a week, and the
 10 full-time advisers much more frequently than that. The 08:37
 11 average medical manager or manager in a Trust encounters
 12 these issues once or twice a year if they are unlucky.
 13 So, we had a lot of experience.

14
 15 Not only that, we also then, if it got too -- if you 08:37
 16 like, too tricky for the adviser on the telephone,
 17 we then had the resource of another 20-odd advisers.
 18 So, very frequently there would an email going around
 19 saying here is a problem I've come across, anybody have
 20 any ideas? That usually dragged up a couple of good 08:37
 21 ideas.

22 50 Q. I skipped past a little hurriedly the reference to the
 23 internal monthly reviews of cases, if they're live. Is
 24 that a feature of the work in relation to Mr. O'Brien's
 25 case? So, for example, you were brought into the mix 08:37
 26 in September 2016. we'll look at that in some fine
 27 detail later. It was one phone call followed up by
 28 a letter, and then nothing more until Dr. Lynn was
 29 engaged in December '16?

- 1 A. Yes. That was still technically an open case.
2 Probably a few weeks after the discussion that I had
3 with Simon Gibson, I'll have had a chat, probably -
4 now I can't swear because I don't remember it and
5 we didn't keep detailed notes of these meetings - but 08:38
6 I think I probably spoke to Karen Wadham, who's my line
7 manager, we'd run through the case, I'd say there's
8 this one about a urologist in the Southern Trust,
9 here's what I've got, here's what I suggested, and she
10 probably would have said, well, that sounds reasonable. 08:38
11 That's the sort of level of review it was. Then when
12 we got into more tricky ones, we'll have had more of
13 a discussion about them, you know, if we were hitting
14 problems.
15 08:39
16 I know certainly I had various conversations with
17 Gráinne - I won't pretend it was monthly - when she was
18 running the case. We had a chat about it every now and
19 then.
- 20 51 Q. So it's really a health check on the state of the case? 08:39
21 A. Pretty much. Pretty much.
- 22 52 Q. Where are we at with that? Do we need to go back?
23 Those kinds of questions?
- 24 A. Yes, exactly. The letters would, generally speaking,
25 have been quality assured as well before they went out. 08:39
26 Somebody else would have cast their eye over a letter
27 before it went out to make sure it made sense, it was
28 written in English and the advice was sensible.
- 29 53 Q. You say in your witness statement - I needn't bring it

1 up on the screen, it is page 46 your end if you want to
 2 look at it, paragraph 8 - you refer to the fact that
 3 your advice service doesn't rest upon a statutory
 4 power.

5 A. Yes. 08:39

6 54 Q. You're unable to require people to follow advice or
 7 cooperate with assessment functions?

8 A. So the only -- sorry, I interrupted you there.

9 55 Q. I was going to ask, the voluntary basis of the
 10 encounters, the reality is that's the only way to do 08:40
 11 it, do you think?

12 A. There's only one place, if you like, in the guidance
 13 where we have, if you like, a statutory function, and
 14 that is when somebody is considering a formal exclusion
 15 under MHPS, they are required to contact us. Other 08:40
 16 than that, it is all a bit voluntary. When that works,
 17 it works very well. But you're absolutely right,
 18 there's nothing to stop a Trust completely ignoring us
 19 and just carrying on doing what they want to do.

20 56 Q. I'm not suggesting you were ignored but there's 08:40
 21 a series of emails that Dr. Lynn wrote to the
 22 Southern Trust after her engagement in December '16.
 23 The evidence before the Inquiry isn't entirely
 24 straightforward in relation to that but I think from
 25 her perspective, and perhaps your understanding as 08:41
 26 well, those emails were not the subject of reply from
 27 The Trust, and there may not, from NCAS's perspective,
 28 have been any contact from The Trust in response
 29 to those.

- 1 A. That would be my understanding.
- 2 57 Q. Yes.
- 3 A. If you like, that is the downside of the voluntary
4 nature of the thing, that we can't make them answer us.
5 But on the other hand then, if we had statutory 08:41
6 footing, that brings with it other issues and
7 responsibilities as well.
- 8 58 Q. Just your reflections around that, if I can press you.
9 If there was a requirement, statutory or with stronger
10 guidance to oblige the Trust to follow-up, to address 08:42
11 correspondence from NCAS, across your broad experience
12 of dealing with cases like this, would this make for
13 better outcomes, perhaps?
- 14 A. I think it probably would, to be honest with you.
15 I suppose when you don't get a reply, you're forced 08:42
16 into one of two conclusions. Either they are sorting
17 it out and they really don't need our advice and they
18 are carrying on; or they are not sorting it out and
19 nothing much is happening. Really good -- apart from
20 anything else we would know, well, if it's all sorted, 08:42
21 we can close the file. If it's not sorted, then maybe
22 we need to be a bit more bullish about providing
23 advice.
- 24 59 Q. Have you finished? I didn't mean to cut across you.
- 25 A. Apologies. I'm finished. Apologies. No, I cut across 08:43
26 you.
- 27 60 Q. You also make the point, paragraph 9, that you're
28 dependent on the NHS bodies who you are dealing with
29 providing the relevant information about the case?

1 A. Yes.

2 61 Q. Again, I suppose in one of these telephone calls you're
3 entirely dependent upon getting a clear history,
4 a reliable history, so that you can tailor accurate and
5 appropriate advice. Again, any reflections upon that 08:43
6 dependency and whether it could be improved in any way?
7 We're going to look at the specific points you raise in
8 relation to your engagement with Mr. Gibson in 2016.
9 More generally, is there room for improvement around
10 that or what can be done to secure improvement? 08:44

11 A. The straight answer is, yes, there have been a number
12 of occasions over the years where I have been given an
13 account of an event by whoever phones me and at a later
14 stage -- often the practitioner, when they get -- what
15 happens is they then put in a subject access request 08:44
16 and they come back to us and say that's not what
17 happened, or there may be other sources of information
18 which come up with a different story. Bearing in mind
19 that our advice depends entirely on the story that we
20 are told, it would be quite possible to craft a story 08:44
21 to get a particular piece of advice. So yes, that is
22 a flaw.

23
24 On the other hand, if we were then obliged to gather
25 evidence from both the practitioner and the Trust, for 08:45
26 example, we're then left in the situation where we've
27 effectively got to run an investigation to find out
28 what happened, and that's not something we would have
29 been resourced to do. So, you know, it cuts both ways.

1 we are absolutely dependent on an honest and balanced
 2 account.

3
 4 Now, often when people phone me, I'll be able to ask
 5 a question to -- I'll be able to probe a bit more, as 08:45
 6 I did to a degree with Simon Gibson and find out a
 7 little bit more about what's going on because I know
 8 the sorts of questions to ask because I have done this
 9 before. So you can do a bit of probing, but again at
 10 the end of the day, you are still completely reliant on 08:45
 11 what they tell you.

12 62 Q. I think it's the case that when Mr. O'Brien spoke to
 13 you in July 2020, he made the point that the advice
 14 that you provided in 2016 - indeed, I suppose going
 15 back even further than that - the fact of your 08:46
 16 engagement with the Trust and the Trust's engagement
 17 with you, let alone the advice that was provided, was
 18 never shared with him. He was completely in the dark
 19 about your involvement. He made the suggestion to
 20 you -- it's at page 61 for you, WIT-53490 for us. 08:46

21 A. Yes.

22 63 Q. At the bottom of the page, please. You write:
 23 "You and your wife met [made] a helpful suggestion that
 24 our organisation should have an early discussion with
 25 practitioners who have been referred to us. Whilst 08:47
 26 there are some practical difficulties with this, I can
 27 see that it has benefits. In particular in your case,
 28 I suggested that had I spoken to you early in the
 29 process, I would probably have advised you to contact

1 the MPS early".

2

3 That is if I had spoken to you early in the process,
4 you would probably have advised this?

5 A. Yes.

08:47

6 64 Q. would you accept this as a broadly correct proposition
7 - you'll take a view from management, whether that's
8 the Medical Director phoning you or, as in this case
9 Mr. Gibson, and they will provide a diagnosis or
10 account of the problem which could be analysed in
11 a wholly different way by the clinician concerned?

08:48

12 A. Yes, yes. They're going to give a completely
13 different -- in almost every case they are going to
14 give a different story to the clinician concerned.
15 There were a few things when I spoke to Mr. O'Brien in
16 2020, I was a little bit surprised and shocked at. I
17 mean, for example, the fact that he had never heard of
18 my discussion with Simon Gibson was shocking to me.
19 That was something over the years we realised was
20 happening, these letters and the fact of our
21 involvement was not being shared with practitioners.
22 If you look at Gráinne's final letter in this chain of
23 letters, you'll have noticed that I think she does say
24 we advise that this letter be shared with the
25 practitioner, or words to that effect. Because
26 we started to add that as a standard phrase in our
27 letters to try to make sure that the practitioners knew
28 what was going on.

08:48

08:48

08:48

29 65 Q. Yes. I can see that it isn't in your 2016 letter, but

- 1 that was a development or a learning --
- 2 A. That was a learning point. We pretty much -- well,
- 3 I started doing it fairly early. I think by the time
- 4 I left, everybody was doing it.
- 5 66 Q. Yes. 08:49
- 6 A. Yes.
- 7 67 Q. Getting back to, I suppose, the thrust of my point,
- 8 just reflections on this again, if you could. You're
- 9 speaking to management, you're dependent upon them
- 10 giving you a reliable history and I suppose an accurate 08:49
- 11 diagnosis of the problem, but you're not speaking to
- 12 the clinician at that point, and sometimes -- and
- 13 perhaps rarely are you speaking to the clinician. Does
- 14 it really then depend upon the intelligence and
- 15 sometimes the good faith of the Trust organisation in 08:50
- 16 terms of taking your advice and ensuring that in their
- 17 dealings with the clinician, a proper and accurate
- 18 understanding is achieved of the issue and that,
- 19 really, NCAS can do very little about that?
- 20 A. Yes. I mean, you have to take somebody's word for what 08:50
- 21 had happened. I suppose we have traditionally always
- 22 taken the word of the management person who has
- 23 contacted us. On the occasions where we also get
- 24 involved and speak to the practitioner, we often --
- 25 sometimes we get the same story; that has happened, 08:50
- 26 believe it or not. But often we get subtly different
- 27 story and you sort of have to make a judgment call in
- 28 terms of your advice as to what way you couch that
- 29 advice, given those two differing accounts.

- 1 68 Q. Just to maybe go close to dealing with the particular
2 facts of the Mr. O'Brien scenario --
- 3 A. Yes, go ahead.
- 4 69 Q. -- but in broad terms, a Trust is saying to you, he is
5 just not doing the work that's expected of him, triage, 08:51
6 validation of reviews, he's bringing notes home, he's
7 failing to dictate.
- 8 A. Yep.
- 9 70 Q. From his perspective it's "I'm running to standstill in
10 theatre. I'm not being given the support I need". Do 08:51
11 you see how that becomes slightly black and white?
- 12 A. Well, it does and it doesn't. Actually that's a really
13 good example, because if you look at my letter of
14 September 16th, I suggest that Mr. O'Brien requires
15 fairly significant support. Because I got an 08:52
16 impression, just even from what Simon told me -- Simon
17 may not have spotted this himself but I got the
18 impression this was a man who was struggling. You
19 know, the sort of behaviours that were being described,
20 somebody with a huge backlog. How he got the backlog 08:52
21 was irrelevant, the fact is he has a backlog and he has
22 to clear that and that's a huge piece of work. Simon
23 mightn't have quite comprehended what that involved.
- 24
- 25 So actually, I think if I had spoken to Aidan O'Brien 08:52
26 at that time, I mightn't have changed my advice. I'd
27 have probably -- I might have been a bit stronger on
28 the "he needs more support" line of things.
- 29 71 Q. I think, if I can interpret that and complement you to

1 some extent, that was your sixth sense and experience
 2 as an adviser saying "I wonder if there's some systems
 3 issue or support issue here in that he's not doing the
 4 work but it may not be just as simple as that". Is
 5 that fair?

08:53

6 A. Exactly. I mean I've dealt with hundreds, at least, of
 7 doctors in difficulty. Most of them are well-meaning,
 8 they have the best interests of their patients at heart
 9 but they are struggling for whatever reason. I have
 10 met a small number of people where that's not true, but
 11 that's a small number. Generally if somebody is
 12 struggling in that way it's not because they are a bad
 13 person, for lack of a better term, it is because they
 14 are struggling, so they need support. Most of us go
 15 into medicine to help people, not to harm them.

08:53

08:53

16 72 Q. Mr. O'Brien suggestion, which you comment upon here at
 17 the bottom of your page 61, you think it's a helpful
 18 suggestion but you could foresee practical difficulties
 19 around that. Is that something that might be worth
 20 thinking about from the Inquiry's perspective - they
 21 have to make recommendations - what are the practical
 22 difficulties? Is it simply resources in terms of
 23 getting involved with the clinicians at the point or
 24 shortly after the point when the Trust contacts you?

08:54

25 A. I think so long as it is reasonable -- so long as
 26 there's a clear understanding, for want of a better
 27 term, whose side you're on; that you're there to
 28 provide advice to try to progress the case and you're
 29 not there to adjudicate between a practitioner's

08:54

- 1 version of events and the Trust's version of events.
2 There's no way we have resources to do that. Certainly
3 looking at the practitioner's viewpoint is not an
4 unreasonable suggestion. I think that's probably
5 a good idea. You'd need to apply a bit of thought as 08:55
6 to how it was done.
- 7 73 Q. Yes. I think you are accepting that you don't have
8 a fact-checking mechanism?
- 9 A. No, we don't. We never pretended we did.
- 10 74 Q. Yes. It might be interesting to put to you some of the 08:55
11 perspectives that we've received already in terms of
12 how NCAS is perceived by the organisation you are
13 trying to assist. Mrs. Toal has given evidence; she's
14 the Human Resource Director. I think she has a fuller
15 title than that but she's the Head of Human Resources 08:55
16 now in the organisation, having taken up that role in
17 September 2016, coincident in time with when your
18 advice was first sought. She reflects that the NCAS
19 advice service is a useful sounding board. She said
20 probably back then, that's 2016/'17, maybe we weren't 08:56
21 as an organisation availing of their advice as much as
22 we should have. Does that resonate with you?
- 23 A. Yes, they weren't -- the Southern Trust weren't --
- 24 75 Q. Is it more or less than what you would like to think
25 you were regarded as? 08:56
- 26 A. No. Sounding board, I think, is reasonable. That's
27 very much as I say, we would bounce ideas around with
28 whoever phones us. To a degree, one of the problems
29 that happened over the years was when our organisation

1 was first set up, I largely spoke to medical directors,
2 chief executives, people who were very senior in the
3 organisation, as organisations got bigger and things
4 changed, we wound up being phoned by less senior
5 people. Now, Simon Gibson is a very sound man but he's 08:57
6 not very, very -- he's not senior enough to take
7 decisions off his own bat. It is much easier to bounce
8 these things around when you are talking to someone who
9 can take a decision at a high level. I suppose that
10 was one thing that was a bit of a problem. If you talk 08:57
11 to somebody that's senior enough to actually decide,
12 well, that's what we're going to do, it was much easier
13 to bounce ideas around. But the sounding board thing,
14 yes, I can accept that. That's fine.

15 76 Q. would you like to see a return to that time when it was 08:57
16 the senior decision-maker who made the call --

17 A. Yes.

18 77 Q. -- for the good reasons you explain?

19 A. In a word, yes. I don't want to sound like an old
20 fogey, talking about the old days. But yes, you got 08:58
21 further in those days; you could take a decision.
22 Because otherwise you are having a discussion with
23 somebody who is going to go off, talk to a committee or
24 somebody senior. That's an extra stage in the process
25 which makes it more difficult. It is much easier to 08:58
26 talk to someone who is actually senior enough to take
27 a decision and also understands the clinical
28 background. So, that's the advantage of talking to
29 a clinician, they actually understand the clinical

1 background. If I was to have been speaking to the
 2 Medical Director, well, he's probably had backlogs in
 3 the past so he knows what it's like, if you see what
 4 I mean. So yes, that, I think, was better. I think
 5 the move where we've had less senior people phoning us 08:58
 6 has not been a good thing.

7 78 Q. Indeed when you think about it, a senior clinician and
 8 perhaps a senior person from the HR side who has an
 9 experience of what's doable in terms of process?

10 A. Absolutely. I would totally agree. Senior HR 08:59
 11 professionals are excellent; they are generally
 12 speaking excellent. As you say, the senior ones who
 13 have dealt with doctors over the years understand what
 14 it's like, and they know the nuances of managing senior
 15 clinicians. 08:59

16 79 Q. Dr. Wright offered a reflection. He was the Medical
 17 Director at the relevant time in 2016 and he directed
 18 Mr. Gibson to you and then Mr. Gibson was reporting
 19 back to Dr. Wright and others. He told us that his
 20 experience of NCAS would be that: 08:59

21
 22 "They often want us to conclude" - I think conclude on
 23 a formal MHPS process is the context - "to go through
 24 the MHPS process. And they would want to be informed
 25 at the end of the process what the recollections were. 09:00
 26 They would often be prepared to then help with possible
 27 solutions to an issue, if that was appropriate".

28
 29 I think that takes a little bit of interpretation.

1 I think the point he was driving at was from an NCAS
 2 perspective, yes, there would be some initial advice
 3 but his sense of it was that you would want the Trust
 4 to get on with it and then come back in at the end.

5 A. No. I think that's a misunderstanding. That certainly 09:00
 6 would not have been my impression, and I suspect
 7 Gráinne would say something similar. Because we would
 8 like to be there whenever they hit difficulties.
 9 You've seen this MHPS process here. You know,
 10 difficulties will emerge and we want to be there to 09:01
 11 help them through whatever difficulties there are.
 12 We'd much rather get an update every month on a case
 13 than, you know, them go away and do a MHPS process and
 14 come back to us a year later. We'd much rather know
 15 what's going on; we feel much more comfortable that 09:01
 16 way. Even if they're struggling, I'd rather know about
 17 it.

18 80 Q. Do you think that's reflected in the level of attempted
 19 activity on the part of Dr. Lynn in the early months of
 20 2017? She heard in December '16 and provided advice 09:01
 21 around whether there was a need for exclusion and
 22 whether there should be a formal investigation. Then,
 23 as we'll see later, a number of attempts on her part to
 24 come back in to the process and, for whatever reason,
 25 appears to have been thwarted around that. 09:02
 26
 27 Does that, in part, explain your view that your
 28 advisory service wanted to be active at the start of
 29 the process and not just at the end?

1 A. Yes. Gráinne's activity -- Gráinne is very efficient.
2 She obviously diarised that and chased them every month
3 or so. That was sort of what we expected to do, was to
4 chase them and see what -- just keep up to date what
5 was going on so we have something on the file. So if 09:02
6 somebody asks me what's going on with the Mr. O'Brien
7 case, I could answer that question. Because we liked
8 to know what was happening with all of our things.
9
10 I don't know, have I just disappeared off your picture? 09:02
11 81 Q. You have, indeed, yes.
12 A. If I reset my camera, that will help. There we are.
13 82 Q. Okay. That's all I want to ask you in relation to the
14 advisory service at that theoretical as well as
15 practical level. 09:03
16
17 If we go back to the Service Level Agreement, your
18 page 83, our WIT-53807. This run-through this morning
19 doesn't pretend to be an exhaustive examination of all
20 the services provided by NCAS. Another service as well 09:03
21 as advisory is a performance assessment. Now, we saw
22 at the end of this MHPS investigation a determination
23 reached on the part of Dr. Khan, who was the Case
24 Manager, that there being no clinical concerns in
25 association with Mr. O'Brien's practice as revealed by 09:04
26 the investigation, it was unnecessary to have an NCAS
27 performance assessment. That's just part of the
28 specific context here.
29

1 Help us, if you can. The document says:

2

3 "In a small proportion of cases NCAS will advise the
4 use of a performance ascertainment".

5

6 Is that specifically in the context of cases where
7 there are clinical concerns?

8 A. Largely speaking, it was -- the performance assessment,

9 I suppose, assessed people's performance as a doctor.

10 So, yes, you're absolutely right. It would largely 09:05

11 have been where there were capability concerns about

12 somebody's ability to practise. It wasn't really

13 designed to look at conduct issues. I mean, I'm happy

14 to talk to you a little bit about performance

15 assessments if you want me to. 09:05

16 83 Q. Yes. If you can, just help us with that.

17 A. Okay.

18 84 Q. Where does that typically come in? Can it come in
19 without an MHPS investigation?

20 A. Oh, yes. Yes, absolutely. 09:05

21

22 I mean, we would have -- right. The performance

23 assessment, the original performance assessment as it

24 was away back in the early 2000s, was a very big affair

25 where we assessed everybody's -- we would do 09:05

26 a psychological assessment; we would do an occupational

27 health assessment; we would observe their practice; we

28 would do a case note review; we would do a patient and

29 colleague feedback; we would speak to their patients.

1 The actual visit took several days, and the report
2 would take some weeks to write and would be quite
3 a thick report with some fairly significant proposals.
4

5 Over the years we discovered that certain elements of 09:06
6 that were more valuable than others, so we actually
7 started to offer what is described here as modular
8 assessments where you simply take single modules of
9 that and provide that alone, because if we'd looked at
10 the issue and we say actually if we do an occupational 09:06
11 health assessment alone or a psychological
12 ascertainment alone, that will probably answer the
13 question. The whole idea was the performance
14 assessment is a diagnostic process; we are trying to
15 make a diagnosis about what's going on with this 09:06
16 doctor's practice, so we would pick the tool we thought
17 would give us the right diagnosis. Yes, typically it
18 was doctors who appeared to not be performing as well
19 as they could.

20 09:07
21 I'll give you an example of a radiologist whose error
22 rate had crept away above his colleagues and had been
23 involved in some significant high-profile missed
24 diagnoses. We then did a full assessment on him and we
25 were able to identify what it was about his practice 09:07
26 that was causing this difficulty, and able to make some
27 recommendations and, as far as I know, that radiologist
28 is still in practice and is having no difficulties.

29 85 Q. I suppose more specifically - I just want to see where

1 this sits in the services outlined here - we know that,
2 obviously as distinct from a performance assessment,
3 very much distinct from a performance assessment, you
4 offered the potential for an intervention in
5 September 2016 in the context of a notes review? 09:08

6 A. Yes.

7 86 Q. It was being suggested to you that there was a problem
8 with Mr. O'Brien's record-keeping; I put it in those
9 general terms. There's some difficulty, perhaps,
10 around how that was expressed to you, and we'll look at 09:08
11 that. But that kind of service, that kind of bespoke
12 service, where does that sit? Does that just
13 suggest to you --

14 A. Well, I mentioned the modular assessments. That's one
15 of the modules, basically. That would have been part 09:08
16 of what would have been in the big performance
17 assessment, and we just say, well, we'll just do that
18 bit because that's the issue that's being addressed
19 here. We would have put in -- obviously there would
20 have been a certain amount of bespoke-ness to it, we 09:08
21 would have tailored it to the situation. But, largely
22 speaking, we'd have got an assessor who would have
23 reviewed the notes according to a standard template and
24 given us a report as to their quality.

25 87 Q. That suggests as an organisation it's perhaps an 09:09
26 infinitely flexible approach. You can manage --

27 A. Yeah, we were pretty flexible. I mean, I remember, for
28 example, doing an assessment on a doctor who worked in
29 the GP Out-of-Hours Service, a very, very different

1 scenario where all the work is done by telephone. So,
 2 we had to design a bespoke assessment for that doctor.

3 88 Q. Another feature of your services as set out at the
 4 bottom of your page 83 is professional support and
 5 remediation services? 09:09

6 A. Yes.

7 89 Q. That's where action plans may be developed following
 8 a review in a case?

9 A. Yes.

10 90 Q. We know that that was a service offered by Dr. Lynn 09:09
 11 after the MHPS investigation had reached its
 12 determination stage. Again, is that a service that's
 13 regularly deployed by your organisation?

14 A. Yes. It was one of our more frequently used services.
 15 We had a team who had got good at developing these 09:10
 16 action plans and they had a range of tools at their
 17 disposal, if you like; things we could put into our
 18 action plans. Our action plans were very different
 19 from the action plan Southern Trust developed for
 20 Mr. O'Brien. Their action plan was just a list of 09:10
 21 things he was to do, more or less, for want of a better
 22 term. Our action plans would have included support,
 23 training, retraining. Often somebody, for example, who
 24 had been out of practice for an extended period of
 25 time, we would have a structured process of getting 09:10
 26 them back into practice. They'd start off with doing
 27 observing practice and then start doing a little bit
 28 under supervision, and the level of supervision would
 29 be reduced as the time went on. So, a very structured

1 approach; very supportive. The whole idea -- and
 2 milestones that each doctor would have to pass before
 3 they moved on to the next stage of the process, with
 4 a clear understanding if you fail your milestones,
 5 we went back to the last stage and redid that last
 6 stage because, you know, you obviously hadn't
 7 progressed through it.

09:11

8
 9 But the idea was that it was a very supportive process
 10 and intended not to set unachievable goals but usually
 11 to steer people back into practice. It usually
 12 required quite a fair bit of resource from the employer
 13 but, on the other hand, these are expensive members of
 14 staff, they're very hard to replace, it is worthwhile
 15 investing in them.

09:11

09:11

16 91 Q. We'll maybe have a moment later just to look at the
 17 Trust's action plan that you refer to. Perhaps in more
 18 general terms is what you are describing -- say, for
 19 example, a clinician was found to have a shortcoming in
 20 a particular area, whether that was clinical or whether
 21 it was an administrative type task or skill associated
 22 with the clinical, does NCAS have the wherewithal to
 23 provide, I suppose, a retraining element or an
 24 upskilling element, or would it simply work with the
 25 Trust to focus on that and --

09:12

09:12

26 A. We would have developed the action plan and worked with
 27 The Trust and the practitioner - generally speaking,
 28 the practitioners are very involved - to develop what
 29 we suggested was the way to deal with it. We didn't

1 deliver the content of the actual plan, that he was
 2 down to the Trust. We would often help, say we know
 3 somebody -- for example, one of the big things was
 4 coaching and we had a list of people who would help us
 5 with that. So, we would do things like that, do what 09:13
 6 we could to assist. But we didn't take the
 7 responsibility for delivering it, we just designed it
 8 in conjunction with the Trust and the practitioner.

9 92 Q. Yes. Over the page then, this is the last aspect of
 10 the services I wanted to touch on. It's education 09:13
 11 services, workshops and conferences. We can see
 12 through the evidence of several witnesses that they've
 13 attended training at which you have been a person
 14 delivering workshops or what have you.

15 A. Yes. 09:13

16 93 Q. 2010, I think September 2010, you delivered a training
 17 in the context of management leadership for the
 18 Southern Trust.

19 A. Yes.

20 94 Q. We've heard from Mr. Gibson that in August 2016, he 09:14
 21 attended MHPS case investigator training; is that not
 22 right? Perhaps I've picked it up wrong.

23 A. No, that was case manager training.

24 95 Q. Case manager training. I beg your pardon, you're
 25 absolutely right. 09:14
 26

27 Then in March 2017, I think we've heard from Dr. Chada
 28 and Dr. Khan that they attended case investigator
 29 training in which you were the deliverer or the

1 teacher, I suppose. So, training is a not
2 insignificant part of your role; is that right?

3 A. That was -- that's absolutely true. We had a suite of
4 training programmes. We had one which we called - what
5 was it called - Recognising Concerns. It was, if you 09:15
6 like, the introductory programme. Usually we ended at
7 newly appointed Clinical Directors and folk like that
8 who were new to the idea of managing doctors. That was
9 to teach them how to identify issues and what were the
10 sorts of factors that affected doctors' performance. 09:15
11 We then moved on to case investigator training, which
12 was a two-day programme that won various awards,
13 actually. It was a standard programme delivered right
14 across the UK with subtle changes in different
15 territories because the rules were slightly different. 09:15
16 But broadly speaking, it was a two-day programme
17 centring on a dysfunctional surgeon called Dr. Purple.
18 We would walk the candidates through how would they
19 recognise that Dr. Purple had a problem; how would they
20 go about investigate it; how would they gather 09:15
21 evidence. We had lots of material which we would
22 provide to them as their evidence. They did role-play
23 in terms of how to interview a witness. Then we had
24 a session where we asked them to draft part of the
25 report. So, they had a very hands-on experience how to 09:16
26 investigate. So that was a two-day programme.

27

28 Then the third, the other one was the case manager
29 training, which was a one-day programme. That was the

1 one that Simon Gibson went to on 30 August.

2

3 we delivered these programmes in two ways. We had
4 a series of public workshops - for want of a better
5 term, public workshops - which were open to anybody 09:16
6 working in Northern Ireland in the Health Service who
7 could attend. The one that Simon went to in August was
8 one of those. The others are where the Trust
9 commissioned us to provide the training. The
10 Southern Trust commissioned us to provide a training in 09:16
11 March of '17, I think it was. So we went down and
12 delivered a programme to their people.

13

14 We were sort of hoping -- I think we did go round all
15 of the Trusts in Northern Ireland. The idea was that 09:17
16 each Trust would have a group of people who were
17 trained as case investigators so that they would have
18 that resource available when they needed something.
19 And I think we went round -- yeah, we did, we went
20 round all of the Trusts in Northern Ireland at various 09:17
21 points over the sort of few years around that time.

22 96 Q. Yes.

23 A. The case investigator training, actually I was just
24 counting there, I delivered it six times in the year
25 prior to the Southern Trust one. 09:17

26 97 Q. Yes. Helpfully, Dr. Fitzpatrick, you've supplied us
27 with the slides for the training that you have
28 provided. They're at WIT-62815, page 115 at your end.
29 I don't need to work through them, they're there for

1 the consideration of the Panel.

2
3 In broad terms can you help us with this: In terms of
4 MHPS, how well do you think the Trusts in Northern
5 Ireland are served by the training provision that's 09:18
6 available? Is there room for improvement around that,
7 or can training be over-emphasised in terms of its
8 importance to the safe conduct and the safe operation
9 of the MHPS arrangements?

10 A. I think training is critical. Training is very 09:18
11 important, and it needs to be the right training.
12 A lot of it is even just around allowing medical
13 managers and others to discuss how they would implement
14 MHPS and what would they do. We use a lot of case
15 studies to say, well, what would you do in this 09:19
16 situation? That was always very interesting and people
17 learned a lot from that. So yes, training is critical.

18
19 Another thing is just because you went through
20 a training in whatever it was, March '17, doesn't mean 09:19
21 that in March 2023 you are still up-to-date and sorted
22 in terms of conducting an investigation. There needs
23 to be -- and that's probably an area where we don't do
24 enough of, is coming back and reviewing it. It's okay
25 if you have been doing investigations constantly since 09:19
26 2017, you probably reasonably up to speed, but quite
27 frequently people do this course and three years later
28 someone asks them to do something and they have
29 forgotten everything they learned.

- 1 98 Q. In terms of those who have attended your training
 2 workshops, what have you, do you receive any feedback
 3 from those attendees, particularly amongst those who
 4 have conducted MHPS investigations or have acted as
 5 case manager? Do you receive any feedback in terms of 09:20
 6 how comfortable or how adequate they perform their
 7 duties, or in relation to the kinds of difficulties
 8 that they face when trying to operate the framework?
- 9 A. Well, we do, as you do in every course, have feedback
 10 forms at the end of the course which are handed out. 09:20
 11 Of course, the candidates are all on a high because
 12 they've just had a great few days and they've enjoyed
 13 it. They write very nice things about us. Gráinne and
 14 I, generally speaking, had very good feedback. But
 15 you're absolutely right, probably we should be doing is 09:20
 16 go back a year later after they tried it out a bit and
 17 getting more feedback. NCAS nationally have done a
 18 little bit of that work. I'm not totally up to speed
 19 myself but I know they have done a little bit of work.
 20 You might want to ask them. Certainly that would be an 09:21
 21 area, how useful was this training, not when you were
 22 leaving and you were saying what a nice fella Colin is,
 23 but when you actually used it in practice, you know.
- 24 99 Q. One of the issues that I suppose we've heard from
 25 the Trust they grappled with in 2010 when they were 09:21
 26 developing their own guidelines to sit as, I suppose,
 27 a sister piece on an accompaniment to the MHPS
 28 Framework proper was in relation to something that they
 29 decided to call the Oversight Group. I suppose the

1 development of those guidelines put the onus on
 2 a clinical manager to identify the problem with the
 3 clinician, follow that through and present his or her
 4 view of the world in the next steps to this Oversight
 5 Group who would then, in the language of the guideline, 09:22
 6 quality assure that. So the Oversight Group wasn't the
 7 decision-maker, it was made up of the Medical Director,
 8 the director for the service, operational director for
 9 the service, and an HR component.

10 A. Yes. 09:22

11 100 Q. As it happened in Mr. O'Brien's case, the clinical
 12 manager wasn't brought into this process, as it appears
 13 from the evidence we received. The decisions were
 14 taken and led by the Oversight Group.

15 A. Yes. 09:23

16 101 Q. First of all, did The Trust ever seek your view when it
 17 was developing the guidelines around any aspect of the
 18 guidelines?

19 A. I have no recollection of them asking my views. I know
 20 this was suggested, we had been involved. I have no 09:23
 21 recollection. I have find no documentary evidence, nor
 22 apparently can the Trust, found any documentary
 23 evidence that we were asked. My memory, the first time
 24 I saw these guidelines was when I presented the meeting
 25 in 2010. We then had a discussion about the 09:23
 26 application of them and I participated in some of the
 27 discussions. They used case studies. I had given my
 28 presentation, which was about MHPS and NCAS and all
 29 that stuff, and then they presented on their new

1 policy. I was still there so I had a bit of a chat.
 2 But I think my memory is that is the first time I saw
 3 it; I suspect the only time I've seen it, apart from in
 4 the witness bundle.

5 102 Q. Certainly by the time you came to the September 09:24
 6 leadership training, the Trust's local guidelines had
 7 been finalised and Mrs. Toal came to the same training
 8 as you and delivered a workshop around that?

9 A. That's right. I remember that.

10 103 Q. This is at page 22 of your bundle. WIT-41278. Let me 09:24
 11 just have that up, please.

12
 13 She says in the first paragraph:

14
 15 "When you're talking to Kieran, can you ensure he is 09:25
 16 happy with the role of Oversight Group in that they are
 17 endorsing the decision of the clinical manager as to
 18 the action to be taken. In light of NCAS formal
 19 advice, I think this is safe enough and they can have
 20 a sufficient challenge function". 09:25

21
 22 So, that's where we derive the suggestion that NCAS had
 23 some role in advising around that.

24 A. As I've said, this obviously was some years ago.
 25 I have absolutely no memory of it and I was unable to 09:25
 26 find any documentation of it. That's all I can say,
 27 I'm sorry.

28 104 Q. Thank you for that.

29

- 1 Can I ask you about one specific aspect of the message
2 that is given out at training. It concerns the issue
3 of terms of reference and who within the organisation
4 should be responsible for developing them and
5 finalising them. 09:26
- 6 A. Yes.
- 7 105 Q. My question will derive from the evidence that this
8 Inquiry has received to date which suggests that
9 aspects and significant aspects of the terms of
10 reference were developed within the Medical Director's 09:26
11 office with perhaps some contribution from the HR side.
- 12 A. Yes.
- 13 106 Q. Those terms of reference are then handed to the case
14 manager and case investigator.
- 15 A. Yes. 09:26
- 16 107 Q. Before the investigation commences but after some
17 consideration of the documentary material that had been
18 supplied to the case investigator, she added a further
19 element to the terms of reference which she sent
20 through to the case manager for his approval. 09:27
- 21 A. Yes.
- 22 108 Q. It doesn't appear on the evidence so far received that
23 that addition proposed by the case investigator made it
24 as far as the Oversight Group, the Medical Director and
25 what have you. 09:27
- 26 A. Yes.
- 27 109 Q. We wondered whether it's an issue that its problematic
28 for the case investigator to be adding to the terms of
29 reference without it going back to the key

1 decision-makers within the organisation. I'm anxious
2 to take your views on that.

3
4 Before I ask you the questions around that, can I just
5 take you to what the training says in relation to this. 09:28

6 A. Go ahead.

7 110 Q. Page 208 your end, and if we could have WIT-62908,
8 please.

9 A. Terms of reference, I see that. Yes. Sorry, I need to
10 turn it round. Go ahead. 09:28

11 111 Q. The terms of reference are agreed by the case manager
12 and issued to the case investigator to define the
13 issues to be investigated, boundaries of the
14 investigation, etcetera.

15 A. Yes. 09:29

16 112 Q. It appears from Mrs. Toal's evidence that that remains
17 the training that is provided to Trusts when they come
18 to NCAS training.

19
20 Could I ask you to look at page 50 of your core, your 09:29
21 other bundle.

22 A. Yes, 50. Hold on a second.

23 113 Q. Page 50, at our end it is WIT-41394.

24 A. Yes. Page 50 is the cover sheet for how to conduct an
25 performance investigation. 09:30

26 114 Q. That's your orientation, that's the document you're in.
27 If we could just look at page 63 of that. If your
28 bundle is anything like mine, the pagination disappears
29 into some blue ink.

1 A. It disappears and I can't actually see it. what's the
2 WIT-number you want?

3 115 Q. WIT-41407. If we could have that up here, please. It
4 is chapter 3 of the document Managing an Investigation.

5 A. I see it, yes. 09:30

6 116 Q. At the top of the page, it says:

7

8 "The investigation starts once its terms of reference
9 are finalised and when a case manager and investigators
10 have been appointed. Once the decision is taken to 09:30
11 hold an investigation, there should normally be
12 a discussion about with the practitioner to secure as
13 much engagement as possible. The practitioner should
14 be made aware of the terms of reference and who the
15 proposed case manager and investigators are so any 09:31
16 objections can be raised".

17

18 A. Yes.

19 117 Q. Then in terms of finalising terms of reference down the
20 page: 09:31

21

22 "There will have been agreed an outline at the time
23 a decision was made to carry out the investigation, but
24 some final drafting may be needed. The terms of
25 reference as finally drafted should be agreed by the 09:31
26 organisation's relevant decision-makers. The case
27 manager and investigators appointed to manage and carry
28 out the investigation would not normally be involved in
29 this process".

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

- A. That's a contradiction.
- 118 Q. I'm wondering whether in terms of the training that's provided by NCAS which seems to say that it's a matter for the case manager and investigator to deal with terms of reference, whether there's some disconnect or inconsistency with the document and the passage I just read with you? 09:32
- A. I can tell you what our training says. I was not involved in developing this, the other document, and know very little about it. It predates the training, I think. I'm pretty certain it is a much older document than training. But the training was quite clear. The final response -- the person who signed off on terms of reference would be the case manager, because they are responsible for managing the process and making the process move forward. 09:32
- Now, generally speaking, I would expect if the case manager isn't the Medical Director that, they go have a chat with the Medical Director and the Medical Director has an input there. That's what I would expect to happen in practice. Occasionally the Medical Director is the case manager, but not so much in the large Trusts that we have these days. That would be the process. 09:33
- But, finally, if you like, in our teaching it was always the case manager. For the case investigator to

- 1 draft, they might make suggestions, as you've just
 2 described, but they wouldn't be responsible for signing
 3 off on the case terms of reference, that would be
 4 clearly for the case manager to do. That was the
 5 teaching that we did when we were doing it. The other 09:33
 6 document, I can't answer to why it contradicts because
 7 I had nothing to do with it.
- 8 119 Q. First of all, you could readily see dangers in an
 9 overeager case investigator suggesting or perhaps
 10 making changes to the terms of reference without 09:33
 11 approval. That would be wrong?
- 12 A. That would be wrong, you're absolutely rightly. That's
 13 why we say the case manager, who has the overarching
 14 responsibility for organising the thing, would do it.
 15 As I say, from a practical point of view, I would 09:33
 16 expect them to keep the Medical Director updated on
 17 that.
- 18 120 Q. Just in terms of the document that I've read from where
 19 it suggests that the case manager and investigator
 20 appointed to manage would not normally be involved in 09:34
 21 the process, as I understand this document remains
 22 extant. It was certainly shared with us on that basis.
 23 That line within it is worthy of some attention, would
 24 you agree, in terms of clarifying --
- 25 A. I hadn't spotted that line until you pointed it out to 09:34
 26 me, and it concerns me because I think -- my personal
 27 view is it disagrees with what we have been teaching
 28 for years.
- 29 121 Q. Yes. Thank you.

1

2 If we could turn specifically then to the MHPS

3 Framework and the Trust Guidance. Again, the Inquiry

4 is obviously familiar with this document. It suggests

5 that the role of NCAS is integral to the working 09:35

6 through of various aspects of the MHPS process.

7 A. Yes.

8 122 Q. If we go then to page 10 of your core bundle.

9 A. Core bundle. Yes.

10 123 Q. Yes. 09:35

11 A. Page 10. That's MHPS Action When a Concern First

12 Arises. Yes.

13 124 Q. Yes.

14 A. Go ahead.

15 125 Q. Just allow me a moment. 09:36

16

17 It states that one of the key actions needed at the

18 outset is to consider discussing the case with NCAS.

19 This is paragraph 10.

20 09:36

21 You, I think I'm right in saying, when you contributed

22 to the Department's review in 2011, had some difficulty

23 with how the role of NCAS was described there. Is that

24 right?

25 A. I did send an email to Paddy woods. Off the top of my 09:37

26 head, I can't remember exactly what I said.

27 126 Q. Let me see if I can help you with that. Just allow me

28 a moment, please.

29 A. Take your time.

1 127 Q. Page 44 of your bundle, not the core. Sorry, we're
 2 jumping in between bundles.

3 A. You're all right. Not a problem.

4 128 Q. For our purposes WIT-43152.

5 A. Yes. I remember send being sent this email. I think 09:38
 6 it was my sole contribution to the various reviews of
 7 MHPS.

8 129 Q. Yes. You've said, it is the penultimate contribution
 9 before the line saying:
 10
 11 "Finally, the description of NCAS and its services
 12 would also benefit from revision".
 13
 14 It's a case, was it, that by 2011, the MHPS document
 15 being six or seven years old, that NCAS services had 09:38
 16 developed.

17 A. Basically, I think I was probably referring to
 18 paragraph 9, Lists of Services. It was really just
 19 that we had moved on and we were doing slightly
 20 different things, and that could benefit from 09:39
 21 rewording.

22 130 Q. Thirteen years further on, we're still sitting with --
 23 12 years further on, we're still sitting with the same
 24 description.

25 A. Exactly. The same document. 09:39

26 131 Q. What needs changed there by reference to the services
 27 provided by NCAS?

28 A. Well, obviously I no longer work for NCAS but certainly
 29 at the time I left, I would have added in a little bit

- 1 more about -- a little bit more detail with performance
2 assessments and a little bit more about what was
3 available, and emphasise perhaps the flexibility which
4 we referred to earlier in terms of how we can design
5 services, almost bespoke services for individual 09:39
6 situations. I'm not quite sure how I would have
7 written it but I would have rewritten it in those broad
8 terms, you know.
- 9 132 Q. Paragraph 11, does that accurately capture the sense of
10 NCAS's involvement in the opportunity which is 09:40
11 available for Trusts at an early stage?
- 12 A. Yes. Actually yes, to be honest that paragraph has
13 worn well. It is probably still applicable, yes.
- 14 133 Q. Although, as we discussed earlier, you do see 09:40
15 opportunity, perhaps, to think through whether at this
16 initial stage, perhaps after the contact with the
17 Trust, whether there would be room for some engagement
18 between NCAS and the practitioner. Would that require
19 some thought?
- 20 A. Yes. Again, if you were rewriting MHPS, you might want 09:40
21 to put something to that effect in.
- 22 134 Q. Paragraph 15, again the role of NCAS is mentioned.
23 Informal approach is being discussed.
- 24 A. Yes.
- 25 135 Q. We need to bring this up on the screen. WIT-18501. 09:41
26 A. Yes. I don't like the word "informal" in this context
27 because it is interpreted as meaning, well, a bit too
28 informal. I would have said "preliminary assessments"
29 on something like that, or "preliminary work", which

1 maybe gives it a better feel. My experience has been
 2 "informal" sometimes means not recorded and very, very
 3 informal. If you look back at my understanding -- I'll
 4 give you an example. My understanding is that,
 5 according to what I've been told, Mr. O'Brien was 09:42
 6 spoken to about some of the issues way back in 2014.
 7 In fact, Simon Gibson told me this, he had been spoken
 8 to before but nothing had been written down. Well,
 9 that's just a bit too informal for my liking, you know.
 10 136 Q. Yes. In fact, if you just glance back at your email to 09:42
 11 Mr. Woods in 2011. It is too cumbersome to bring it up
 12 on the screen again here but just for the Inquiry's
 13 note, we're back at WIT-43152. If I could just read it
 14 out. You say that:
 15
 16 "We feel that the word 'informal' in the flow diagram 09:42
 17 at page 43 of the process to be counterproductive.
 18 We have found this encourages an overly relaxed
 19 attitude to process and could be replaced by another
 20 term such as at 'preliminary' ". 09:43
 21
 22 That captures your point.
 23 A. It continues to be my view.
 24 137 Q. If we go to page 48 of your document. For us it is
 25 WIT-18536. 09:43
 26 A. Oh, sorry, 43 of the main bundle?
 27 138 Q. Sorry, page 48 of your core bundle. I beg your pardon.
 28 Core bundle.
 29 A. Core bundle. The big bundle.

1 139 Q. Yes. It's internal 43. That's the point you were
 2 making to Mr. Woods perhaps --

3 A. Yes, the flow diagram.

4 140 Q. The flow diagram, you said, is titled "Informal
 5 Process". That's unhelpful, it carries with it the 09:44
 6 risk that it encourages an overly relaxed attitude and
 7 "preliminary" is the better word?

8 A. That would be my view. I mean, it doesn't matter
 9 whether you are at that stage or what is subsequently
 10 called a formal process, this is serious stuff and 09:44
 11 we need to do it properly; we need to record it
 12 properly. Sometimes informal is interpreted as meaning
 13 you bump into somebody in a corridor and you say, "You
 14 really need to pull up your socks". There still has to
 15 be a process. 09:44

16 141 Q. Yes. What we see in Mr. O'Brien's case is that after
 17 advice from you in September 2016, the Oversight
 18 Committee met and they developed the idea of pursuing
 19 an informal MHPS investigation, a term that a witness
 20 has said wasn't all together helpful. "What is an 09:45
 21 informal MHPS investigation" was the question to him,
 22 and it was recognised that it doesn't exist within the
 23 process. But that might be supportive of your view
 24 that informality can be dangerous --

25 A. Yes. 09:45

26 142 Q. -- and that there's a need to recognise that although
 27 the process might be called "informal", it is serious
 28 business that requires proper organisation and
 29 record-keeping?

- 1 A. Absolutely. That's absolutely my view.
- 2 143 Q. If we go to paragraph 20, it says:
- 3 "NCAS must, where possible, be informed prior to the
- 4 implementation of an immediate exclusion. Such
- 5 exclusion will allow a more measured consideration to 09:46
- 6 be undertaken. This period should be used to carry out
- 7 a preliminary situation analysis... ", etcetera.
- 8
- 9 I just want to, because it's an issue, go back to
- 10 WIT-18502 for the screen. Just the timing of advice 09:46
- 11 being sought from NCAS, in your experience do Trusts
- 12 sometimes make decisions and then come looking for
- 13 advice to reinforce their decisions, or sometimes take
- 14 decisions in principle subject to NCAS advice, and is
- 15 that an altogether helpful way of doing it, in your 09:47
- 16 view?
- 17 A. Yes. It would not have been uncommon for me to get
- 18 a phone call - and I think my colleagues would have
- 19 echoed this - more or less saying 'we've decided to
- 20 exclude this bloke but we need to contact you first', 09:47
- 21 and they had made up their mind. Now, that wasn't
- 22 universally true and there were a number of instances
- 23 where that didn't happen, quite a lot of instances
- 24 where that didn't happen, but there were occasions
- 25 where they quite clearly had made up their mind before 09:47
- 26 they phoned us. You know, apart from being a bit
- 27 irritated being, you know, being asked to act like
- 28 a rubber stamp, we felt that we weren't getting the
- 29 opportunity to offer the alternatives as we often

1 would. If somebody phones me and says 'sort of
2 thinking about excluding or suspending this chap, what
3 do you think are the alternatives', because we had
4 a fair bit of experience, we could run through the
5 alternatives. Sometimes people hadn't thought of 09:48
6 simple things, like, for example, we have concerns
7 about this surgeon's ability to take out gall bladders
8 so we're going to suspend him. I went, why are you
9 doing that, why don't you just stop him doing gall
10 bladders until you've sorted this problem out and get 09:48
11 him to do other things. So sometimes they hadn't even
12 thought through the simple things. We were often able
13 to produce alternatives because we were coming to this
14 afresh from the outside, with a different viewpoint,
15 and lots of experience of having done this before. 09:48

16 144 Q. Yes. We know, and perhaps it is more for Dr. Lynn to
17 comment upon, that the Oversight Group made a decision
18 at its meeting on 22 December to exclude for the
19 duration of the investigation, as it was described in
20 their decision. That was to be subsequently revised. 09:49
21 The second part of their decision was to have a formal
22 MHPS investigation. But then the advice was sought;
23 the advice was then sought from her on 28th December.
24

25 In general, while there's nothing to prevent that 09:49
26 approach, you consider that to be the wrong way round
27 and unhelpful?

28 A. I would agree. It is the wrong way around, it is
29 unhelpful. What's the point ringing us if you want us

1 to rubber-stamp a decision you have already taken.

2
3 Just take that example, and I'm not going to
4 second-guess Gráinne's advice here but I'll just give
5 you an example of the sorts of discussions you could 09:50
6 have had. I don't know what discussions she had. You
7 could have said why are you excluding him when you
8 could restrict him to administrative jobs or work only.
9 You could put all sorts of restrictions on him which
10 would avoid the problems that you're trying to avoid. 09:50

11 It may well have been that the only answer was
12 exclusion, and I'm assuming that's the conclusion they
13 came to, but we would have a discussion about what are
14 all the alternatives. One of the founding principles
15 of NCAA, as it was in the old days, was that we were 09:50
16 there to get rid of some of the scandals that happened
17 in the '90s where we had doctors suspended -
18 particularly in England, but also in Northern Ireland -
19 for extended periods of time; what we would refer to as
20 'suspend and forget'. We have a problem with a doctor, 09:50
21 we'll suspend him and then we'll forget about it. The
22 whole point OF MHPS and our organisation was to keep
23 that stuff under review to make sure that you didn't
24 suspend the most expensive member of staff in your
25 organisation and forget about him; that you were 09:51
26 actively managing the case.

27
28 So we were there to try and -- I wouldn't say one of
29 our performance indicators but certainly something

- 1 we measured was the number of active suspensions in
2 place across the UK. A lower number was better, as far
3 as we were concerned.
- 4 145 Q. Just picking up on a few further threads relevant to
5 NCAS's role within the MHPS document. We can see then, 09:51
6 if you turn to your page 17, or core 17 I should say,
7 and if we go through to WIT-18505. It says that one of
8 the determinations that a case manager might make is
9 where there are concerns about the practitioner's
10 clinical performance which require further 09:52
11 consideration by NCAS.
- 12
- 13 Is that the junction at which consideration ought to be
14 given to an NCAS-led performance assessment?
- 15 A. It's one of the places you could consider that. Many 09:52
16 assessments were done where the practitioner
17 volunteered to take part in them because they wanted
18 the answer as much as the rest of us did, so you didn't
19 have to go through this extensive MHPS process because
20 everybody was in agreement that this was what we were 09:52
21 going to do. There were a number of other situations
22 where people got into assessment. Obviously, the
23 assessment doesn't work if the practitioner doesn't
24 agree to it because if they don't participate and
25 participate fully, it won't work. It is hard work for 09:53
26 a practitioner to be assessed. But, on the other hand,
27 very often they came out of it with a plan which got
28 them back on track and got them into safe and effective
29 practice. So, there was a good outcome for many

1 practitioners in assessments. Not always, there were
 2 a few that weren't just so good.

3 146 Q. At page 26, this is WIT-18514. Another role for NCAS
 4 is in misconduct cases. Paragraph 4 on that page tells
 5 us:

09:53

6
 7 "Employers are strongly advised to seek advice from
 8 NCAS in misconduct cases, particularly in cases of
 9 professional misconduct".

09:53

10
 11 As we saw here, in this case Dr. Khan was thinking
 12 along the lines of misconduct and a conduct hearing,
 13 and he sought advice from NCAS and Dr. Lynn advised.
 14 What is the importance of NCAS input at that point? Is
 15 there sometimes conclusion, for example around the
 16 proper categorisation of the shortcoming?

09:54

17 A. Yes. I mean I suppose from the point of view of my
 18 job, those were the easier ones because, to a large
 19 degree, what we were saying is, first of all, we need
 20 to be satisfied that it is a conduct issue and not
 21 a capability issue, and you would have that discussion.
 22 But once we had agreed it was a conduct issue, the
 23 advice was relatively straightforward, which was, well,
 24 what would you do if this was another member of staff?
 25 Well, whatever that is, do it, follow your own conduct
 26 procedures. Because there was always -- to a degree
 27 there was a bit of confusion, and maybe MHPS
 28 contributed to this confusion, that things were
 29 different for doctors. But at the end of the day,

09:54

09:54

1 conduct is conduct, and if you have a misconduct case,
2 you deal with it under your conduct procedures. To
3 a large degree, the advice referred to in that
4 paragraph would basically be that, you know.

5 147 Q. As we can see from this document, plenty of roles for 09:55
6 NCAS across the MHPS journey. Only one, I think you
7 said, is obligatory; that's returning to NCAS in the
8 context of extended exclusion.

9 A. Formal exclusions, we were supposed to be contacted in
10 advance. If you remember -- if you think through the 09:55
11 process, the organisation has immediate exclusion for
12 the emergency. It is Friday afternoon, this guy is
13 on-call over the weekend, we need to do something now.

14 So, they have immediate exclusion available to them.
15 They don't have to contact us for that, although 09:56
16 usually they did because the Friday afternoon phone
17 call was a fairly common feature of our lives. But
18 then they've got four weeks to think about what they
19 were going to do next, and that's where they would
20 bring in the formal exclusion and that's where they 09:56
21 would have to speak to us.

22 148 Q. Has NCAS done any work around the extent to which there
23 is, if you like, good compliance by the Trusts in
24 Northern Ireland with, if I can put it in these terms,
25 the suggestions made in the MHPS document as to when 09:56
26 NCAS should be contacted, or are you in that position
27 of being in the dark because you may only know about
28 the organisations that contact you and you don't know
29 what you can't know?

1 statement you provided to the Inquiry which I omitted
2 to refer to this morning. I'm not sure it's on the
3 bundle we sent you. If we can put it up on the screen
4 here, WIT-91049. It's a further supplementary from you
5 dated 10th December last year. If I can just ask you 10:22
6 to recall that in substantial part, it concerns the
7 contribution you made -- or your comments on whether
8 you made a contribution to the 2010 Trust Guidelines.
9 If I could just scroll down to the bottom of that,
10 please. Apologies you don't have it in front of you. 10:22
11 I assume you don't have it in front of you?

12 A. No.

13 151 Q. If we go to paragraph 5, and you already dealt with
14 this in evidence this morning, it said:

15 10:22
16 "If I had been asked to provide formal advice on the
17 2010 guidelines, I would have expected a formal request
18 to comments on a draft or to be part of the group
19 developing the guidance. I have no memory of either
20 and cannot find any documentation to suggest that 10:23
21 either happened".

22
23 I think that's in keeping with what you said earlier in
24 your evidence. That's dated 10th December. Are you
25 content to adopt that as part of your evidence as well? 10:23

26 A. Yes. Yes, I am. I must have actually made that when
27 I was in New Zealand. Yes, of course. Of course, yes.

28 152 Q. Apologies for how that was handled.

29 A. No problem.

- 1 153 Q. We looked this morning already, I suppose, at part one
 2 of your evidence. That was the NCAS services and how
 3 they fit within the MHPS structure. I now want to turn
 4 to the second part of your evidence, which was your
 5 involvement in providing advice to the Southern Trust 10:23
 6 in respect of Mr. O'Brien's case.
- 7 A. Yes.
- 8 154 Q. If you could turn to page 50 of your bundle, not the
 9 core bundle, your bundle. It is WIT-53479.
- 10 A. Yes. 10:24
- 11 155 Q. I think you are familiar with this document. Is this
 12 a typical pro forma used by Jill Devenney within your
 13 organisation alerting you to the fact that you've had
 14 a contact that requires followed up from the
 15 Southern Trust? 10:24
- 16 A. That's the standard process. So, Jill would probably
 17 have telephoned me earlier in the day and said 'I've
 18 got one for you, are you available'. Then she would
 19 have followed up with that, yes.
- 20 156 Q. We can see then two pages further along -- page 52 for 10:24
 21 you, 53481 for us. Scroll down two pages, please.
 22 This is your advice encapsulating, I suppose, your
 23 record of the telephone discussion with Mr. Gibson.
 24 Mr. Gibson was somebody you knew from your professional
 25 past; is that right? 10:25
- 26 A. Yes. I'd met Simon in a previous life when he was in
 27 a different job and so was I.
- 28 157 Q. Could you - whether you need to rely on this document
 29 or otherwise - just take us through your memory of what

1 you were told during this encounter, what advice you
2 provided and, generally, the thinking that underpinned
3 that advice?

4 A. Okay. So, consultant urologist. It was explained to
5 me that he was experienced. I think it may have been 10:26
6 pointed out he was the most senior urologists, or
7 oldest in the service - I remember getting the
8 impression he had been around a long time - but there
9 had been a number of issues. Simon mentioned this
10 thing about a backlog of 700 patients, which was 10:26
11 different to everybody else. We discussed the issue
12 around triaging referrals, and it was mentioned up to
13 18 weeks of triage a referral, whereas this is
14 something that's expected to be done there and then --
15 you know, very, very quickly. So he was way behind, 10:26
16 very different to his colleagues.

17
18 This thing about taking charts home was mentioned.
19 I distinctly remember that. There was a suspicion that
20 he had a large number of charts at home because there 10:26
21 were large numbers of charts missing. Then he
22 mentioned this about note-keeping not being terribly
23 good. He clearly said there were occasions where there
24 was no record of a consultation, which of course --

25 158 Q. Just on that, I think that the shortcoming there, as 10:27
26 the Inquiry understands it from the evidence received
27 to date, is that it's not so much the notes as it's
28 described there, not a case of the note-taking being
29 poor, it's more a case of a failure to dictate on some

1 outpatient encounters. In other words, the follow-up
 2 letter for the general practitioner or for the patient
 3 and for the file.

4 A. Yes.

5 159 Q. But it's not a criticism per se of the absence of 10:27
 6 a note. That's how you've recorded it.

7 A. Well, no, sorry, that nuance didn't come across to me.
 8 I'm fairly certain that I understood him to be saying
 9 that the notes were not very good.

10 160 Q. In ease of yourself and the record that you have made, 10:28
 11 can I just put before you for your observation, jumping
 12 across to the other bundle 158.

13 A. There we go. Yes, 158. Yes, I see that.

14 161 Q. We can have it up on the screen, TRU-251424.

15 A. That's the second page of Simon's screening report. 10:28

16 162 Q. Yes. He would, in his evidence, say that he had that
 17 in front of him as he is speaking to you. No
 18 suggestion that you would have seen that at the time or
 19 at any time prior to the Inquiry knew it.

20 A. I didn't see it. 10:29

21 163 Q. How he has recorded it, he has said:
 22
 23 "Mr. O'Brien may not always record his actions or
 24 decisions regarding a patient following a period of
 25 in-patient care or outpatient consultation", albeit he 10:29
 26 was working without a formal audit at that stage. If
 27 he spoke in those terms to you, not mentioning
 28 dictation it might appear, do you think your record is
 29 broadly fair?

1 I might probe a little bit around some of the things,
2 the statements, that the caller is making. We would
3 then look at what are the options open to us. Well,
4 I suppose the other thing is, and one of the first
5 questions I tend to ask, particularly of more senior 10:32
6 callers, is what is it you want to be the outcome with
7 this? Where are you going with this? We would then
8 talk about what were the realistic options available to
9 us and how would we ensure.

10
11 I mean, there's a number of set points in any of these 10:32
12 calls. One of them is the Patient Safety issue. Does
13 this represent a threat to Patient Safety? That's the
14 sort of question I would ask in, well, all but the most
15 trivial of cases. There are a number of set questions 10:32
16 you would always ask. But yes, it's around take the
17 history, explore, check there's no Patient Safety
18 issues, what are the options open to us, come to an
19 agreement as to what it is we're going to do.

20
21 As I said earlier in earlier evidence, that discussion 10:32
22 is much easier when you have somebody who is of the
23 seniority where they can actually take a decision there
24 and then.

25 165 Q. Okay. In terms of your description then, you're at 10:32
26 that part of your process where you are taking the
27 history. Part of the history is the inadequate
28 note-keeping or note provision, if we can put it in
29 those more neutral terms. As you say, it may not have

1 mattered too much to the advice that you would give,
 2 both issues, if you like, being serious.

3 A. Both are serious. Obviously, if you haven't written
 4 the primary notes, you have nothing on which to dictate
 5 a letter. I suppose you might say that's more serious. 10:33
 6 But as a GP, I tend to think that the letter to the GP
 7 is quite important.

8 166 Q. Yes. It is maybe stating the obvious, if it had been
 9 presented in that way to you as a failure of dictation,
 10 what does that failure do to the primary carer such as 10:33
 11 the general practitioner?

12 A. First of all, obviously the GP, who is looking after
 13 the patient on a day-to-day basis, doesn't know what is
 14 going on. He doesn't know what the plan is. When the
 15 patient comes in and says 'that consultant up in the 10:34
 16 hospital, he was awfully nice but I didn't understand
 17 anything he said, can you explain it to me', you have
 18 nowhere to go.

19

20 The other fact is generally often the other consultants 10:34
 21 will use the letter as being their primary -- that's
 22 the thing they look at when they are taking over care.
 23 Or the patient comes in the Outpatients clinic and they
 24 have previously been seeing Mr. O'Brien, they will look
 25 at the letter because, quite bluntly, it is easier to 10:34
 26 read. It is a primary method of communication. With
 27 electronic record these days, the bit that is kept on
 28 the electronic record is the letter, so if there is no
 29 letter there will be nothing on the electronic care

1 record. Handwritten notes don't get uploaded to that.
2
3 So, yes, the letter is important; it's an important
4 part of the process. So yes, if I had been told, well,
5 he writes handwritten notes but he doesn't dictate 10:35
6 letters, it wouldn't have made an awful lot of
7 difference, maybe a subtle change to the advice but not
8 much.

9 167 Q. Okay. I'm just glancing at your page 52.
10 A. Yes. 10:35

11 168 Q. You've dealt with note-taking just now. An issue at
12 the bottom of the page --
13 A. Yes, that's the --

14 169 Q. You say:
15 10:35
16 "It is a standard question to ask about harm to
17 patients".
18 A. Yes, and that's why that's in there. Simon said to me
19 that he wasn't aware of any patient harm although he
20 mentioned some anecdote about a delayed referral but it 10:35
21 all seemed awfully vague. If it was one incident, one
22 incident isn't enough to say a doctor is
23 underperforming. So, that was there.

24
25 Again, if I'd been talking to a senior clinician, 10:35
26 I might have had a more in-depth analysis of
27 Mr. O'Brien's performance, but Simon was a layperson
28 who probably wouldn't have had a lot of knowledge on
29 that.

- 1 170 Q. That line about anecdotal evidence of delayed referral
2 to oncology, did it in any way spook you or concern you
3 in terms of that sounds particularly serious? If it
4 did, was there any follow-up around that?
- 5 A. Well, in judging the seriousness of something like that 10:36
6 you have a balance of if this was true, how serious
7 would it be, and what is the evidence that it might
8 actually be true? On this basis, I had a sort of very,
9 very vague reference to, well, more or less there was
10 a rumour about a delayed referral to oncology, so the 10:36
11 level of evidence was pretty low.
12
- 13 Yes, a delayed referral to oncology might be very, very
14 serious or it might not be. It might not actually have
15 made much difference to the patient's outcome. If it 10:37
16 was one single incident of a delayed referral, we all
17 make mistakes. Every single doctor in the country
18 makes mistakes and one mistake isn't enough to say you
19 have an underperforming doctor.
- 20 171 Q. In terms of the substance of what that might mean, are 10:37
21 you able to help us beyond what you have written there?
22 A. No memory of it other than that, I'm sorry. I can't
23 help you.
- 24 172 Q. Over the page then, if that assists your memory in
25 terms of how the conversation continued. 10:37
26 A. Looking at that, I then recount a little bit of what's
27 been done so far. He has been spoken to a few times
28 but nobody kept a record, which goes back to what
29 I said about informal processes.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

"He was written to in March of this year seeking an action plan to remedy these deficiencies but to date there has been no obvious improvement".

173 Q. I've been told to slow you down, Dr. Fitzpatrick, just for the stenographer. 10:38

A. As I said, he had been spoken to on a number of occasions about the behaviour but no records were kept. That goes back to what I said earlier about informal processes. He was written to seeking an action plan to remedy these deficiencies but no obvious improvement to date. That, I suppose, concerned me, that he had been warned. We're now six months later and he hasn't really made any difference. To me that implies a doctor who really isn't taking the process seriously. 10:38

You know, if I had been warned in that way and not having read -- now having read the letter in March, if I had been on the wrong end of that letter, if I'd received that letter, I would have been assiduously trying to improve my practice. But I got the impression from that that this was somebody who wasn't taking the process seriously, which sort of leads into a later part of my letter. 10:39

174 Q. I suppose, Dr. Fitzpatrick, one can interpret what is written there in the way that you have, the doctor isn't taking it seriously. I suspect if the doctor was in front of you, he would offer the perspective that in the six months since that letter was handed to me, 10:39

1 no Trust manager has approached me to further discuss
 2 that letter; I've been offered no support against
 3 a background of overwhelming work and pressures.
 4

5 Now, I'm not sure what you can say by way of response 10:40
 6 but is it incumbent upon you, perhaps, to keep an open
 7 mind that there's perhaps at least two sides to the
 8 coin when the history is being revealed?

9 A. Absolutely. As you will see later on, I do say that
 10 this doctor will require some support. 10:40

11 175 Q. Yes.

12 A. And, absolutely, that was there -- okay, maybe I was
 13 being a bit trite there saying he wasn't taking it
 14 seriously, but certainly he wasn't doing anything, or
 15 there was no evidence he was doing anything about it. 10:40
 16 Maybe to say he wasn't taking it seriously was
 17 inappropriate.

18 176 Q. The reasons for that were unknown to you, I suppose, is
 19 the fairest way of putting it?

20 A. But nothing was happening, so we need to do something 10:40
 21 to move this along.

22 177 Q. This then brings you to, I suppose, the analysis and
 23 advice part of the conversation; is that right?

24 A. That's where we're going here. So, I talked about it.
 25 The policy on removing charts from the premises, to me 10:41
 26 that seemed a pretty straightforward one. You know,
 27 there's a clear policy which says what you do with
 28 charts, it is being breached. My understanding was the
 29 letter in March was a warning and we can debate whether

1 it counts as a warning or not, but he had certainly
2 been told that it wasn't appropriate to do way back in
3 March. Nothing had happened.

4
5 Now, that's not a difficult thing to solve. You have 10:41
6 a whole pile of charts sitting on your dining room
7 table, you just put them in the boot of your car and
8 bring them in. That's not a huge piece of work. That
9 puzzled me why nothing had been done there, you know.

10 10:41
11 As I said, that's a straightforward disciplinary
12 process. If you recall, when we were talking about
13 MHPS and the conduct bit of MHPS, I said that my advice
14 tends to be what would you do if this was a nurse or a
15 porter or somebody, you know somebody else, and that's 10:42
16 what you do. Effectively what I'm saying here is just
17 apply the disciplinary policy, you know, because that's
18 a straightforward disciplinary issue.

19 178 Q. Yes.

20 A. That's that bit. 10:42

21
22 The poor note-taking. With regard to the poor
23 note-taking, I suggested an audit. It all sounded a
24 little bit anecdotal, the note-taking issues. As you
25 said, Simon didn't have an audit available. He was 10:42
26 dealing with what other people told him about the notes
27 so to do an audit would give us a bit of evidence as to
28 how good the practitioner's note-keeping was and we
29 could then decide what to do after that. If the

1 quality of the notes was poor, I suggest that we could
 2 do a notes review and come up with suggestions as to
 3 how the practitioner could improve the quality of his
 4 notes. So, I thought that was a reasonable suggestion.

10:43

6 The triage thing, new patients to triage, I suggested
 7 meeting with him and agreeing a way forward because,
 8 again, this is a backlog of 700 patients. That's
 9 a phenomenal backlog. You know, I don't know how many
 10 patients he sees in a clinic but if you say he sees 10
 11 patients in a clinic, that's a huge number of clinics
 12 that he's behind on. So, how you would clear that.

10:43

13 179 Q. I think in fairness the issue around the backlog in the
 14 clinics was around the issue of validation. There was
 15 an exercise to be performed around how these patients
 16 in the backlog stood in terms of the urgency of the
 17 care that they required. However it was defined, there
 18 was a piece of work to be done, and you saw it --

10:43

19 A. Absolutely, yes. You know, obviously I can only advise
 20 on the information I'm given and that was the
 21 information I was given. I absolutely agree there's
 22 lots and lots of issues around waiting lists and
 23 validation and things like that, but at the end of the
 24 day he still had a big piece of work to do. To ask him
 25 to do it on top of his day job and continue with the
 26 day job was a huge ask. It doesn't really matter how
 27 he got into the situation, that's something else we
 28 could address. But just to ask someone to clear that
 29 level of backlog was going to require some resource.

10:44

10:44

1 I believe I say that.

2

3 "Such a backlog would be difficult to clear and would
4 require significant support".

5

6 we talked about why don't we take him out of theatre.

7 That was just one possible suggestion, take him out of
8 theatre and that would free up a bit of time to clear
9 all this stuff.

10 180 Q. Just to be clear, you weren't being, I suppose,
11 prescriptive there?

12 A. No.

13 181 Q. It was a suggestion of the kind -- first of all, in
14 principle it was an indication that you thought some
15 support and assistance was required. This is an
16 example, not necessarily one that you would hold them
17 to?

18 A. Absolutely.

19 182 Q. But an illustration of what might be done?

20 A. That's exactly correct. That's exactly what I was
21 thinking. You know, let's think about this creatively,
22 there are different ways we can do this and here is one
23 possible way. I'm not saying that's one we have to do.

24

25 I then offered to attend a meeting. I would be a bit
26 of a fan of me going to meetings with practitioners
27 simply because my experience was that if an external
28 person such as myself came in, suddenly the
29 practitioner, who possibly wasn't taking this with the

1 seriousness he should have, starts to get serious,
 2 particularly if, as I normally would do, I insist that
 3 they bring their Protection Society representative with
 4 them. I find them to be immensely helpful in that
 5 situation, because they will also recognise we have 10:46
 6 a big problem here and we need to work together to
 7 solve it. That's the approach. I would have always
 8 had a very good relationship with the Protection
 9 Society representatives because as far as I was
 10 concerned, we were all on the same side, we were trying 10:46
 11 to get this practitioner into effective and safe
 12 practice, you know. Except he had the ear of the
 13 practitioner, I didn't.

14 183 Q. Can I offer the following summary then of what appears
 15 in this letter. First of all, you were suggesting an 10:46
 16 element of stick in the sense there's a disciplinary
 17 component to this?

18 A. Yes.

19 184 Q. But, at the same time, you recognised that there was
 20 a requirement for some element of support, whatever 10:46
 21 that might ultimately look like after a period of
 22 engagement, meeting or discussion with the
 23 practitioner, which isn't stick, it is more support.
 24 Is that fair?

25 A. I think that's a fair analysis, yes. 10:47

26 185 Q. You were also thinking, am I right in saying, that this
 27 was not only a conduct issue but there was an aspect of
 28 that. There was also an element, although you may not
 29 have been entirely clear as to the detail, there was

1 also an element of perhaps capability concerns?

2 A. Yes, I think so. I just had a feeling that, you know,

3 the level of backlog and some of the stuff we were

4 talking about, and also the poor note-keeping, you

5 could say it's conduct but at the end of the day people 10:47

6 don't do that willingly. They get themselves into

7 a situation. Quite frequently I've seen practitioners

8 get themselves into a hole where they don't know how to

9 dig themselves out and you have to help them.

10 186 Q. Yes. Can you remember whether Mr. Gibson was 10:48

11 presenting it as that mix of conduct and concern about

12 capability, or whether his view was less nuanced than

13 that?

14 A. I don't think he had done that analysis, to be honest

15 with you. I think he just had a problem and he wanted 10:48

16 me to come up with some answers.

17 187 Q. Now, there is a relatively complex evidential picture

18 in terms of what happened next. I don't particularly

19 need to go into that with you and it might be unfair to

20 ask you to comment, but it is the case that no contact 10:48

21 was made with Mr. O'Brien in respect of those issues

22 until December, and late December, 2016. I don't wish

23 to build in the complex ingredients to what was going

24 on on the ground but, in general terms, where there are

25 shortcomings or perceived shortcomings in 10:49

26 a practitioner's practice, whether that's a conduct

27 issue or a capacity or capability issue, and where the

28 Trust has sought advice from you, or NCAS in general,

29 it would be good practice, would it not, to advise the

1 practitioner that these engagements are happening so
 2 they are no longer behind the scenes, they're upfront
 3 and direct with him?

4 A. I absolutely agree. As I think I may have said
 5 earlier, in later years we actually wrote specifically 10:50
 6 in our letters, we put in a phrase which said 'please
 7 make sure you share this with the practitioner',
 8 because we were come to a realisation that that wasn't
 9 happening in many cases, and it clearly didn't happen
 10 in this case. It is a sort of fundamental principle of 10:50
 11 justice that if you are being accused of something, you
 12 have a right to know what it is and who is accusing
 13 you.

14

15 So yes, they should be involved early and informed and 10:50
 16 informed of their ability to phone us. Quite often
 17 we would find out that that had happened because the
 18 practitioner would phone us and we'd have a chat. Yes,
 19 it was disturbing to discover that Mr. O'Brien didn't
 20 know anything about this until quite sometime later. 10:51

21 188 Q. Now, just if I could pick up on one accuracy issue that
 22 you may wish to comment on.

23 A. Go ahead.

24 189 Q. You spoke to Mr. O'Brien in July 2020. We already
 25 opened the letter briefly this morning. It is your 10:51
 26 page 61, our WIT-53490.

27 A. Yes, got it.

28 190 Q. In the second paragraph, the second sentence is:
 29

1 "In particular you told me that my initial advice given
 2 in September 2016 had not been shared with the
 3 decision-making group when they decided how to address
 4 issues which were raised at that time".

10:51

6 You say you were disappointed to hear this.

7 A. Yes.

8 191 Q. As a matter of accuracy, your advice following your
 9 conversation on 7th September is dated 13th September
 10 and only arrived with the Trust after their meeting had
 11 taken place that morning. Why was your advice delayed
 12 by a week? Are you able to comment after this passage
 13 of time?

10:52

14 A. Administrative delay is the only excuse I can give you.
 15 The process after I wrote the letter; so I would have
 16 written the letter probably the following day or maybe
 17 the same day or not that long afterwards, bearing in
 18 mind that I only work two days a week for the
 19 organisation so I sometimes didn't have time for a few
 20 days to write. So, I don't know exactly when I wrote
 21 it. But then the next thing was it would go off to be
 22 QA'd by another adviser. Somebody would have a read of
 23 it, see that it made sense and it was a reasonable
 24 letter. Then it would go back to Jill for dispatch.
 25 By the time all that happened, you were going to build
 26 in a couple of day's delay. I assume there was
 27 a weekend in there somewhere. So that would all
 28 contribute to what was a five day delay or six days.

10:52

10:52

10:53

29 192 Q. In fairness to Mr. Gibson and the evidence he gave, he

1 told us that the advice you gave verbally was shared
 2 with Dr. Wright, the Medical Director, in the first
 3 instance, and then at the meeting of the Oversight
 4 Group on the 13th. That later that month he circulated
 5 your written advice to all members of the group, with 10:53
 6 the exception of the Director of HR who seemed to be
 7 missed out on the email. I suppose the point is that
 8 your advice was known to the decision-makers but wasn't
 9 implemented for reasons too detailed to go into?

10 A. The letter to Mr. O'Brien of July 2020 was based on 10:54
 11 what he had told me. I was quoting back to him what he
 12 told me and he said that it hadn't been shared, to
 13 which I said well, that sounds disappointing. Again,
 14 this is back to you take the word of the person who is
 15 speaking to you. 10:54

16 193 Q. That's fully understandable. I just wished to give you
 17 the opportunity to comment on it.

18 A. No, absolutely. It is unfortunate. I don't remember
 19 whether Simon told me there was an Oversight Group
 20 meeting, in which case I would have tried to make sure 10:54
 21 he had the letter in time because, as you know, you can
 22 always push things through.

23 194 Q. Could I move quickly on to some reflections that you've
 24 offered in your witness statement about the
 25 conversation and engagement with Mr. Gibson in 10:54
 26 September?

27 A. Go ahead. Yes.

28 195 Q. If you go to page 66 of your bundle, and if we could
 29 have up on the Screen, please, WIT-53790.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

"Anecdotally I understand that there were individuals who worked with Dr. O'Brien who had concerns about his capability for a long time. I do not have any documentary evidence that these concerns were ever raised formally".

10:57

In terms of capability, what were you thinking and capability as distinct from what?

A. Okay. When Dr. O'Kane spoke to me in 2020, July 2020 I think it was, she mentioned a review of, I think it was 300 cases in which there were 40 something percent, 46 percent, perhaps, where there were matters of concern about the management of the patient. That sounded to me like a significant capability issue. I mean, those are big numbers. Looking back, I just find it difficult -- and as somebody who has quite a few years of experience of managing doctors as well as working for NCAS, I just find it hard to believe that somebody could have that level of poor performance and somebody not know about it.

10:57

10:57

10:57

This is not the first time I've given evidence to this effect to an inquiry. I was involved in a neurology inquiry and I was similarly dumbfounded as to how these things could have gone on so long and nobody seemed to know about it, you know.

10:58

198 Q. We'll go on in a moment just to look at the screening stage which should take place before a formal

1 investigation and try to tease out whether there is
2 anything to be gained by better defining that stage of
3 a process. In terms of capability, just to be clear,
4 at the time when Mr. Gibson was speaking to you, and
5 you're saying that he mustn't have been aware or cannot 10:58
6 have been fully informed, again you're looking at that
7 with the benefit of some hindsight; you've had your
8 discussion with Dr. O'Kane by the time you have written
9 this. You refer also to anecdotal understandings
10 brought about from individuals who worked with 10:59
11 Dr. O'Brien. What did you have in mind there when you
12 wrote that and who had you been talking to?

13 A. Again, this was something that occurred long after my
14 discussions with Mr. Gibson and also long after my
15 discussions with Dr. O'Kane, by which time this was all 10:59
16 in the newspapers. The problems were all over the
17 newspapers and everybody knew about it. I had
18 a meeting with a doctor who happened to be a urologist
19 about an entirely unrelated issue, nothing to do with
20 this, and I suppose as part of the chit-chat in around 10:59
21 the meeting, I asked did other urologists have
22 concerns. This particular urologist described a number
23 of incidents which had occurred when he was a junior
24 doctor working in the same unit as Mr. O'Brien, and he
25 described some rather odd forms of treatment, which 11:00
26 I don't recall because I'm not a urologist and I didn't
27 go into it in any great detail. But it sounded odd to
28 me and he certainly thought it was odd. So that's,
29 I suppose, where that comes from.

1 199 Q. Just to be clear, who was that?

2 A. That was a urologist in Belfast, Mr. Hagan.

3 200 Q. Mr. Hagan?

4 A. Yes.

5 201 Q. What's his first name? 11:00

6 A. Chris.

7 202 Q. Chris Hagan. Thank you.

8 A. If you want more information about his views, you'd

9 have to talk to him.

10 203 Q. Of course, of course. That's very fair, you're not 11:00

11 a urologist. I suppose what you took from that, in

12 some respects, caused you to construct this paragraph

13 that more must have been known within the Trust.

14 A. I just find it hard to believe that somebody can have

15 gone off normal treatment to the level which I've seen, 11:01

16 not so much in this but also read in the newspapers and

17 in other places, and nobody really seemed to know about

18 it. I just find that hard to believe. This is not the

19 first -- as I just said, it is not the first time I've

20 come across this situation. As somebody who has for 11:01

21 many years managed quite a number of doctors, I like to

22 think I had a handle on who was good and who had

23 problems, and was able to intervene when I had somebody

24 with problems.

25 204 Q. You talk in your statement as well, if we go over the 11:01

26 page, to page 67 for you.

27 A. Yes, go ahead.

28 205 Q. And it's paragraph 13.

29 A. Yes.

- 1 206 Q. You talk, helpfully I think, that categorisation of the
2 initial concern can make a significant difference to
3 how a case progresses with the distinction between
4 capacity with options for assessment and remediation
5 and conduct which can lead to disciplinary. If 11:02
6 Simon Gibson, you say, did not know about any
7 capability, clinician capability concerns in
8 September 2016, that avenue under the MHPS Framework
9 effectively disappeared.
- 10
11 As I say, we're going to go on just in a moment to look
12 at the issue of screening and the availability of, if
13 you like, soft intelligence or soft information. What
14 you may not know is that Simon Gibson is asked to
15 perform this screening exercise effectively off the 11:03
16 back of the March 2016 letter which identified the four
17 issues that were rehearsed to you.
- 18 A. Yes.
- 19 207 Q. Is there a problem, or can you help us in trying to
20 assess whether there's a problem, in that he gathered 11:03
21 the information for that screening report --
- 22 A. Yes.
- 23 208 Q. -- by speaking to operational management. He was
24 feedings back to this group that I've called the
25 Oversight Committee, and there was no intervention, no 11:03
26 contribution from clinical colleagues of Mr. O'Brien,
27 I think it's fair to say. So, the Associate Medical
28 Director was not brought into that loop; the Clinical
29 Director wasn't brought into that loop; the Clinical

1 Lead was not brought into that loop; none of his
2 colleagues who don't hold managerial roles but are on
3 the medical side and are senior clinicians were spoken
4 to. Is that the kind of information that needs to
5 enter into the system at the earliest possible stage in 11:04
6 order to get the categorisation correct?

7 A. I think that's reasonable. Sorry, my camera has
8 frozen, I'm going to reset it.

9
10 Yes. Simon went to the operational managers because 11:04
11 that's Simon's world. Simon is an operational manager,
12 do he went along and he would have got the feedback
13 around delayed triage, the things causing bother to the
14 operational managers. You're absolutely right, if he
15 had gone along to the medical colleagues, he would have 11:05
16 probably got a different bit of feedback. He might
17 have got some of the same stuff but he would also have
18 got a more nuanced feedback on capability.

19
20 I suspect if a medical person had been asked to do the 11:05
21 screening report, it would have probably looked a
22 little bit different because they would have gone to
23 the medics. So, you're absolutely right, and I think
24 that's a reasonable observation, that, you know,
25 somebody should have asked his medical colleagues. 11:05

26 209 Q. On the face of the letter - and I don't need to open it
27 again unless you need me to - you refer to a review
28 date of 7th October 2016. I don't think you made
29 contact with The Trust and The Trust didn't make

1 contact with your organisation until December. what's
 2 the significance of a review date and in the particular
 3 circumstances of this case where your advice was being
 4 given to be digested by the Trust and applied, if
 5 appropriate? should there have been a review? 11:06

6 A. There should have been a review. The records aren't
 7 very good here. I have no access to my emails from
 8 that time. So I should have, if I hadn't heard from
 9 The Trust within, I don't know, six or eight weeks,
 10 chased them to find out what is going on. whether 11:06
 11 I did or not, I don't know. My system for
 12 record-keeping at that time usually involved
 13 spreadsheets which are no longer available to me.
 14 I actually don't know whether I tried to phone Simon or
 15 I emailed him, or what happened or whether I just 11:07
 16 dropped off the radar. I actually don't know the
 17 answer to that question.

18
 19 But in terms of what should have happened, I can tell
 20 you what should have happened, which is we should have 11:07
 21 tried to make contact with Simon and find out what had
 22 actually happened which would give us a chance to
 23 provide further advice.

24 210 Q. Okay. The next stage in this story brings in your
 25 colleague, Dr. Lynn. 11:07

26 A. Yes.

27 211 Q. As I've explained to you this morning, on the 22nd
 28 December, Oversight Committee met and decided that
 29 there would be a formal investigation, that there would

1 be exclusion, albeit that Dr. Wright would seek advice
 2 from NCAS. By that stage, the Trust was in receipt of
 3 the findings of a Serious Adverse Incident review that
 4 was to be signed off completely in the early months of
 5 the new year. The Trust had reached the view that on 11:08
 6 the basis of that primarily, there was now
 7 a significant Patient Safety concern from their
 8 perspective, and that the earlier advice from you,
 9 which hadn't of course been implemented, was no longer
 10 appropriate; they needed to move to a more formal 11:08
 11 approach. I think I have summarised that accurately.

12
 13 Do you understand or follow the rationale for the
 14 approach that's being suggested?

15 A. So, now there is a Patient Safety issue. I know when 11:09
 16 I looked at the case after Gráinne had given that
 17 advice, I actually thought the SAI related had happened
 18 something in between when I spoke to them in September
 19 and heard discussion with them in December. Turns out
 20 it actually predated that by quite some time. 11:09

21
 22 But yes, there's a Patient Safety issue now so we need
 23 to ensure Patient Safety. Now, whether exclusion was
 24 the only or the most appropriate thing, I wasn't
 25 involved in the discussion so I'm not going to comment 11:09
 26 on that. Certainly there are alternatives available.
 27 Sorry, my screen keeps freezing here.

28 212 Q. Yes.

29 A. So, you know, certainly the fact there's now a Patient

- 1 Safety issue does change the game. Whether that
2 automatically means exclusion is a different question.
- 3 213 Q. Is it not the case when you think about it or reflect
4 back on it, the fact that triage wasn't being done,
5 except for red flag referrals, that was known for some 11:10
6 time; that's what you were being told in September. To
7 the extent that a failure to triage raises the
8 potential for patient jeopardy, is that an issue that
9 ought to have been recognised and grappled with
10 earlier, even if it didn't lead to a formal 11:10
11 investigation?
- 12 A. On reflection, yes. On reflection when I think about
13 it now, failure to triage must involve some risk to
14 patients, and the fact of the subsequent SAIs and
15 things proved that. Perhaps I should have probed that 11:11
16 a little bit more with Simon when I spoke to him.
17 Whether that would have changed the advice is
18 a different question.
- 19 214 Q. Yes. You have offered some reflections on this
20 changing of the circumstances in your witness statement 11:11
21 at page 66.
- 22 A. Yes.
- 23 215 Q. We can bring up WIT-53790.
- 24 A. Okay. Go on ahead.
- 25 216 Q. Paragraph 10 at the bottom of the page, if we can start 11:11
26 there. You talk about what you describe as the
27 substantial shift between the initial call and the 28th
28 December engagement, by which stage there was a more
29 sizable problem as by that point a Serious Adverse

1 Incident had been identified and there was concern
 2 about patient harm.

3
 4 I want to jump to paragraph 12 because this brings in
 5 the issue of screening: 11:12

6
 7 "Upon being informed of a Serious Adverse Incident and
 8 patient harm, I would expect a medical director to
 9 carry out a soft investigation in relation to wider
 10 concerns around clinical capabilities, which would then 11:12
 11 inform the Terms of Reference of any subsequent
 12 investigation. This might be considered as another
 13 missed opportunity".

14
 15 You go on to say, and I think did I read this out 11:12
 16 earlier:

17
 18 "The categorisation of the initial concern can make
 19 a significant difference to how a case progresses... "

20 11:13
 21 I ask these questions, albeit with a degree of
 22 hindsight available to us arising out of the
 23 revelations which Dr. O'Kane brought to your attention
 24 in 2020. There were these clinical problems emerging
 25 at that time, and you got some of the detail of that. 11:13

26 A. Yes. Go ahead.

27 217 Q. What should be done, in your view, by, for example, the
 28 Medical Director if a decision has been made on the
 29 basis of certain information that an MHPS

1 investigation, a formal investigation, is necessary?
 2 How do you set adequate but fair terms of reference?
 3 Adequate in the sense that we need to get to the bottom
 4 of the practitioner's shortcomings and any attendant
 5 risk to Patient Safety. 11:14

6 A. Obviously we have the information in Simon's screening
 7 report which is going to form a core of the terms of
 8 reference. But then, I suppose probably what I'm
 9 talking about here in terms of a soft investigation is
 10 a look-around and see are there any other issues of 11:14
 11 other practitioner's practice we need to look at.
 12 Well, I can tell you what I would do if I was the
 13 director. I would maybe do a quick look at some notes;
 14 I would talk to some colleagues; I would say are there
 15 any other issues that we need to think about, and 11:14
 16 decide whether those justified putting in the terms of
 17 reference. That's what I mean by soft investigation;
 18 let's just see if there's any other issues here.
 19 Something might have emerged, I don't know.
 20 11:15

21 Again, yes, you would have spoken to admin people and
 22 secretaries and things like that but they would have
 23 come up with the issues Simon came up with. You are
 24 looking more at the quality of care. That's where you
 25 need to talk to medical colleagues about that. 11:15

26 218 Q. Do you think, on the basis of your experience, taking
 27 into account this case as well, is this important and,
 28 you might suggest, fundamental part of the process
 29 involving a good attempted or ensuring there's a good

1 attempt to categorise what the concerns are before you
 2 investigate fully; is guidance around that within the
 3 MHPS Framework somewhat lacking?

4 A. I think that's a fair statement, yes. It wouldn't be
 5 immensely helpful in drafting terms of reference. 11:16
 6 Certainly in our training, we would have emphasised
 7 quite a lot about terms of reference and how to draft
 8 them and how to make them fair and specific. We also
 9 had a process - and this often happens and has happened
 10 to me when I'm doing investigations - where halfway 11:16
 11 through an investigation, you suddenly discover another
 12 issue. I mean, I recall doing an investigation, which
 13 was a disciplinary issue, a conduct issue. About
 14 halfway through it, we discovered there was an enormous
 15 capability issue to do with this practitioner and 11:16
 16 we then had to have a discussion with the case manager
 17 as to whether to change the focus of my investigation
 18 to include the capability issue or commission a new
 19 investigation, which was actually what they decide to
 20 do because it was so far distant from what was 11:16
 21 I investigating.

22
 23 But, you know, there is a process where, if you find
 24 something in the course of an investigation, for
 25 changing and either commissioning a new investigation 11:17
 26 or changing the focus of your investigation. We do
 27 teach that in the case investigator training and case
 28 manager training.

29 219 Q. Because obviously, doctor, where we had in this case

1 a lengthy investigation, it took some 18 months to
2 bring it to a conclusion, and where it didn't identify
3 the kinds of shortcomings that were to come to life in
4 2020, the public will obviously be concerned about the
5 MHPS process and whether it is fit for purpose for 11:17
6 discovering these kind of things. Or perhaps the
7 reflection is the MHPS is only as good as the people
8 using it and if they don't take effective stock at the
9 beginning, then it's not going to deliver the kinds of
10 outcomes that are important from a Patient Safety 11:18
11 perspective.

12 A. Absolutely. MHPS is a flawed process; there are many
13 flaws in it. We could sit down and have a long
14 discussion about how it could be improved. At the end
15 of day, it is a process and if we don't follow it, it's 11:18
16 not much use at all. So, it's not rigorously followed.
17 It also doesn't replace common sense. You know, you
18 still need to apply common sense occasionally. You
19 know, yes, there are terms of reference and
20 investigators are expected to stick to the terms of 11:19
21 reference but that doesn't mean they can't listen to
22 anything that's told to them.

23
24 If I go back to my example of the conduct investigation
25 I conducted. During this, various witnesses said 11:19
26 'that's all very well, but I wouldn't let this guy
27 operate on me'. When people say things like that to
28 you, you have to go back to your case manager and say,
29 hold on, there's a whole different issue here which you

1 practitioners, you'll do that un -- well, not unfocused
 2 but you'll do that initial assessment and actually
 3 you'll say there's no other issues here, it is just
 4 about the things we already know about. But yes, again
 5 if you have terms of reference which encompass all the 11:21
 6 initial failings, it does make life a lot easier.

7 225 Q. Are you still at page 67 of --

8 A. Yes. Go ahead, yes.

9 226 Q. Thank you.

10 11:21

11 At paragraph 14 you said:

12
 13 "Even when the case was thought to involve clinical
 14 issues and apparent patient harm, there was a failure
 15 to progress a timely effective investigation within the 11:22
 16 Trust".

17
 18 "We sent three separate emails chasing progress to the
 19 Trust..." - and you set them out - "which were not
 20 responded to and as a result the file was closed." 11:22

21
 22 This goes back to what we were talking about this
 23 morning: You're a demand-led organisation, if the
 24 employer doesn't wish to respond, you can't make it
 25 respond. 11:22

26 A. That's correct, yes.

27 227 Q. Given that this investigation took the best part of
 28 a year and a half, and given that at the start of it
 29 there was a requirement on the part of the Trust to

1 develop an action plan and monitor Mr. O'Brien's
2 practice, do you see that there were opportunities
3 which the Trust could have used in order to improve
4 their approach to this?

5 A. Well, not taking 18 months to do an investigation would 11:23
6 be a good start. MHPS is largely, I think, to blame in
7 this because MHPS puts an entirely unrealistic target
8 of four weeks. I have rarely seen an investigation
9 completed in four weeks, and only the simplest
10 investigation is completed in four weeks. But what 11:23
11 that does, this unrealistic target, is everybody knows
12 they're not going to meet it, so it's worse than not
13 having a target at all. Nobody expects you to meet it
14 so the investigations just drag on. 18 months is,
15 I will confess, exceptional but certainly it's 11:24
16 certainly not the only one I've seen. So yes,
17 completing it on time would have been a good thing.

18
19 The action plan, perhaps providing a bit more support
20 to Mr. O'Brien at that stage, would have been helpful 11:24
21 as well. So yes, there was a number of things
22 that didn't go terribly well. The other thing is
23 because the investigation is ongoing, everybody sits
24 back and thinks well, this is all in hand, we're
25 investigating it. 11:24

26 228 Q. I think you've had an opportunity, you mentioned this
27 morning, to look at the action plan. It's at page 429
28 of the core bundle and TRU-02732 for us. I don't wish
29 to go through the fine detail of it. I think you

1 adequately described it this morning in terms of it's
 2 a plan that tells Mr. O'Brien what he has to do; this
 3 is what you are required to do.

4 A. Yes.

5 229 Q. It is prescriptive in that sense. But you think that 11:25
 6 had NCAS been brought in to provide some advice around
 7 this, a different and, perhaps I take it from what you
 8 are suggesting, a better or more appropriate action
 9 plan could have been developed. What did you mean by
 10 that suggestion? 11:25

11 A. Obviously, we would like to think it would be better.
 12 Yes, we would have almost certainly looked at what
 13 support was required to help him achieve these things
 14 and we would also have had a much more staged process.
 15 So, in the first so many weeks, you will do this; in 11:25
 16 the next few weeks you will do the following and in
 17 a very staged process. This was just sort of you will
 18 get on with it and do all this triage and clear your
 19 backlog, but no suggestions as to how to do that and no
 20 support for him in how to do that. 11:26

21
 22 I would suggest not setting up to fail -- well, it is
 23 setting up to fail, to be honest, it would be difficult
 24 to achieve these things. From what I've read in the
 25 bundle, he made a good go at it but failed on a number 11:26
 26 of occasions. He was able to keep up for a period of
 27 time, you know.

28 230 Q. Yes. Of course, the action plan itself is narrow in
 29 its scope.

1 A. Yes.

2 231 Q. It addresses the issues which are the subject of the
3 MHPS investigation but, for all of the reasons we just
4 discussed, it doesn't engage with the clinical concerns
5 which were perhaps hidden below the surface at that 11:27
6 time but which were to emerge in 2020.

7 A. Yes.

8 232 Q. Is there anything over and above what you've said
9 already in relation to screening that you wish to add
10 in terms of what NCAS could have provided had it been 11:27
11 involved?

12 A. Again, perhaps if we had been involved at that stage of
13 the process, we might have asked a little bit more in
14 terms of what do we know about his clinical practice,
15 his abilities, things like that. It's hard to 11:27
16 know/speculate what we would have done but I suspect we
17 would have asked more questions. I think you referred
18 to us as a sounding board - somebody did anyway - and
19 that would be bouncing ideas off us and we would be
20 challenging to a degree what the assumptions were, 11:28
21 because that's part of our role.

22 233 Q. Just a discrete point at paragraph 23 of your
23 statement. This is page 68 of your bundle; WIT-53792.
24 You say that an unusual feature of this case that
25 we might need to think about is the number of medical 11:28
26 directors or interim medical directors who had some
27 responsibility for the case over a short period of
28 time. Obviously Dr. Wright in 2016, he went off
29 unwell. At the start of '18, Dr. Khan came in as an

1 interim in '18, handing the reins over to Dr. O'Kane At
 2 the start of '18 start of '19.

3
 4 Is that a recipe, are you suggesting, for perhaps
 5 people taking their eye off the ball or a lack of -- or 11:29
 6 a less than optimal flow of information, or what are
 7 you suggesting?

8 A. I'm suggesting-- Richard Wright had come in, he had
 9 not previously worked in Belfast and had no experience
 10 in the Southern Trust, nor had Maria O'Kane. I think 11:29
 11 Dr. Khan had previously worked in the Southern Trust.
 12 So, there's a loss of organisational memory there. I
 13 mean, the Trust that I worked in, South Eastern Trust,
 14 in all the time I worked in the organisation, we had
 15 the same Medical Director, and he knows everybody. 11:29
 16 He's still there and still knows everybody, you know.
 17 Whereas if you are in post and move on very quickly,
 18 that memory isn't there and it's not written down. It
 19 should be all written down but it isn't. The turnover
 20 just means that you get into post, you start to get 11:30
 21 a feel for what are the issues, you start to address
 22 them and then you're gone.

23 234 Q. The remainder of that paragraph deals with - this is
 24 the top of your page 69 - it appears some of the gaps
 25 in communication were compounded by Dr. O'Brien's sick 11:30
 26 leave. His sick leave was a relatively short period of
 27 time between 15th November '16 and 3rd January '17. He
 28 was spoken to for the first time about these issues
 29 obviously in March but, after March, on the 28th

1 December 2016. I'm not sure I understand your point.
 2 I would ask you to just clarify, if you can, how
 3 his short period of sick leave --

4 A. On reflection, the word "extended" shouldn't be in
 5 there. That's an error on my part. Probably due to 11:31
 6 understanding.

7 235 Q. Thank you.

8 A. Having said that, the sick leave won't have helped
 9 matters. My understanding, and I could be wrong here,
 10 is that the issues -- that sort of was another thing 11:31
 11 that delayed raising the issues with him.

12 236 Q. I think you're right. Certainly what we've heard, what
 13 the Inquiry has heard in evidence is that following the
 14 advice that you provided in September 2016, there was
 15 an intervention on the part of the Director of 11:31
 16 Acute Services to, if you like, stay the process of
 17 dealing with this because Mr. O'Brien was going off on
 18 sick. From that perspective, you don't think that
 19 helpful?

20 A. No. No, I don't. I think you need to address these 11:32
 21 things. I mean, after I spoke to Simon Gibson in
 22 September, I was sort of expecting a phone call a week
 23 or two later saying 'can we get that meeting
 24 organised'. I was a little disappointed when
 25 that didn't happen. 11:32

26 237 Q. Now, we know that come the end of the MHPS process in
 27 September 2018, your colleague Dr. Lynn was contacted
 28 by Dr. Khan and further advice was sought.

29 A. Yes.

1 238 Q. Were you out of that loop at that point?

2 A. Well, I wasn't out of the loop in that I was Gráinne's
3 line manager so we would have probably discussed the
4 indicate at various points. But, largely speaking, she
5 was taking the lead. 11:33

6 239 Q. Yes. You were contacted by the Trust in 2020, not in
7 an MHPS context per se, albeit you did provide advice
8 that these new matters that Dr. O'Kane was raising with
9 you should be viewed through an MHPS lens; is that
10 fair? 11:33

11 A. I'm trying to find the letter in question. Hold on
12 a second. Do I have it here? Well, I mean, from
13 memory Maria phoned me and told me that there had been
14 further developments, that a review of a number --

15 240 Q. This is - just to assist you - your letter to 11:34
16 Dr. O'Kane is 9 July 2020.

17 A. Sounds right.

18 241 Q. Page 54 of your bundle. If we could have it up on the
19 screen, please, WIT-53483.

20 A. 9th July 2020, my birthday as a matter of interest. 11:34
21 Yes, we discussed him in the past and I recounted some
22 of the previous issues. She specifically said she was
23 concerned with the lack of insight. I remember her
24 saying that. The issue around private practice, and
25 she'd referred him. She told me a little bit about the 11:34
26 grievance, which appears to be another thing that
27 delayed everything. Then she told me about this review
28 they had done of 300 records where there were matters
29 of concern in 46 percent, which were things like

1 unusual treatment, scan -- well, I've mentioned scan
 2 results; not entirely on the matter but I vaguely
 3 remember unusual forms of treatment and things like
 4 that being mentioned, and a number of SAIs in the
 5 treatment of the things. So, at this point now alarm 11:35
 6 bells are starting to ring in my mind and I'm start to
 7 think this is a bigger issue because those figures are
 8 quite startling. At this point I said this is a big
 9 issue here.

10
 11 She was talking about doing on a preliminary inquiry,
 12 etcetera, etcetera, and I then said, well, we need to
 13 look at Patient Safety, and also then highlighted the
 14 fact that this was -- because it was clearly a bigger
 15 issue, I thing suggested that the Department of Health 11:35
 16 would want to be informed of it because it had
 17 significant potential to cause embarrassment.

18 242 Q. Yes. Well, the early alert to the Trust sent to the
 19 Department came at the end of that month. Are you
 20 suggesting in your answer that Dr. O'Kane, and perhaps 11:36
 21 the wider Trust, hadn't yet grasped the significance of
 22 this, or is the fact that she's calling you at this
 23 point indicative of a concern on her part that this has
 24 got exponentially more significant?

25 A. I may have misjudged Dr. O'Kane here, but my impression 11:36
 26 was that she hadn't actually thought through this
 27 issue, that this had a potential to be a huge issue and
 28 that she would need to inform the Department of Health.
 29 That was my impression. Again I can't read her mind so

1 I don't know exactly what her thinking was. But my
 2 impression was when I said that to her, it was sort of
 3 news to her. Well, the rest is history.

4 243 Q. Yes. Certainly we can see it at your page 55 and our
 5 53485, just scrolling down, that you said: 11:37
 6
 7 "If the patient numbers indicated by your initial
 8 inquiry of 300 cases are supported by further
 9 investigation, this has potential to cause significant
 10 public concern. I therefore suggest that you alert the 11:37
 11 Department of Health".

12 A. Yes.

13 244 Q. Did you raise the issue of private patients?
 14 A. I do mention it somewhere there, don't I? Concerned
 15 about the interface of health service and private 11:38
 16 practice. I then suggested:
 17
 18 "He will be asked to voluntarily refrain from seeing
 19 private patients which you believe he has previously
 20 done at home". 11:38
 21
 22 My understanding from this discussion was that
 23 he didn't function -- he didn't do his private work in
 24 the way many doctors do and see people in the
 25 Independent Clinic or wherever it happened to be, that 11:38
 26 he actually would have people come to his house and
 27 basically did outpatients private work; he didn't do
 28 any operative private work. I said I suggest you stop
 29 asking him to do that. If he then left employment,

- 1 she would no longer be his responsible officer so
2 she would then have to talk to the GMC about that. At
3 this stage, he was about to retire.
- 4 245 Q. You may have appreciated that in 2018, Dr. Lynn had 11:39
5 provided advice in respect of private patients, that he
6 should be asked to desist from private work. Have you
7 any understanding as to why the Trust hadn't been able,
8 to put it at its most neutral, to implement that
9 advice?
- 10 A. No, I've no idea why not. To be honest with you, 11:39
11 I didn't read Gráinne's letter in great detail before
12 speaking to Maria, so I didn't spot that at the time.
- 13 246 Q. You were able to close the case from an NCAS
14 perspective. We can see at page 382 of your bundle --
15 this is WIT-534746. 11:39
- 16 A. Oh yes, that's an email.
- 17 247 Q. Yes. Karen Wadman is --
- 18 A. Karen Wadman is my boss.
- 19 248 Q. Yes.
- 20 A. She's second-in-command at NCAS (inaudible). 11:40
- 21 249 Q. So there's nothing unusual around you closing the case
22 at this point; matters were in the hands of the GMC
23 and, as you were shortly to find out, there was to be
24 a public inquiry following announcements at Stormont.
- 25 A. Exactly. At this stage we're advising the Trust. 11:40
26 The Trust have no longer any action they can take so
27 there's not much point keeping the file open. The GMC
28 had it in hand. Generally speaking, once the GMC took
29 an active interest in a case, we would tend to close

- 1 it.
- 2 250 Q. At page 384 of your bundle, we find an internal note.
- 3 A. Yes.
- 4 251 Q. It's WIT-53754.
- 5 A. Yes. 11:41
- 6 252 Q. This is a chronology prepared for the Practitioner
7 Performance Advice Core Operational Group. Is that an
8 internal group or committee within NCAS?
- 9 A. That was basically our senior management team. I'm not
10 quite sure why it's called a core operational group but 11:41
11 it's basically a senior management team. After
12 a number of cases that we were involved in over the
13 years, Patterson, Watt and various others, there was an
14 awareness that there were certain cases that were
15 likely to achieve a higher profile, a higher public 11:42
16 profile. Basically we set up a system of flagging
17 those to the senior management, that here's one that
18 I think might go further.
- 19 253 Q. Yes. We can see -- just to cut across you but just to
20 assist you, over the page, if we can scroll down, that 11:42
21 what you are providing within this document is
22 a chronology to assist your senior management group?
- 23 A. Yes.
- 24 254 Q. The reason the chronology is ticked as being
25 significant concern and a high-profile case. 11:42
- 26 A. Yes.
- 27 255 Q. Is there any sense of this being a document, because
28 NCAS was concerned, that questions might be asked about
29 its role in all of this and that it might be the

1 subject of criticism around the services it provided?
 2 A. I don't think so. I think, certainly -- well, that's
 3 not the way I took it. Certainly you wanted to be
 4 prepared. If somebody is going to come along and ask
 5 you what you did about this case, senior management 11:43
 6 wants to know about it. I suspect there's also
 7 a certain amount of let's have a look at this
 8 chronology and see did we miss anything along the
 9 process here. Yes. But I was simply asked to prepare
 10 this chronology, which I did, and it was then put in 11:43
 11 this format and submitted to the COG.

12 256 Q. Thank you.

13
 14 In terms overall, your reflections on the NCAS role in
 15 this case, is it a case that you think between yourself 11:44
 16 and Dr. Lynn, the advice provided at the various
 17 interventions was appropriate, or do you reflect that
 18 this was a case that might have been done better from
 19 your perspective; we might have been more proactive or
 20 we may have touched on various other issues or 11:44
 21 methodologies that might have assisted the Trust to get
 22 to the bottom of all of this somewhat quicker?

23 A. Well, first of all, you have to remember that the
 24 responsibility for managing doctors doesn't rest with
 25 NCAS, it rests with the Trust. So, that's important. 11:44
 26 But could we have done it better? Just to analyse,
 27 I think actually my initial advice I would stand over
 28 and I would give the same advice today, more or less.
 29 There might be subtle difference but generally

1 speaking.

2

3 when Gráinne agreed with the suggestion to exclude,
4 that was a reasonable thing to do. There might have
5 been options there, I don't know, and I wasn't involved 11:45
6 in that discussion so I can't actually answer to that.
7 Then we chased them. Then you could question is our
8 policy - and this was our policy - that if we didn't
9 get any response, we didn't keep the file open, we just
10 closed, assuming that the Trust would get back to us if 11:45
11 they needed us again. That's back to the voluntary
12 involvement Trusts have with us. You know, if they
13 don't want to speak to us, we can't make them. Whether
14 that policy is correct or not, I think we could debate
15 that forever. Then you would have to ask if that 11:45
16 policy is not correct, what's the alternative. Do
17 we just keep the file open forever? Because we have
18 obviously got limited resources, like everybody else.

19

20 what else? The later part of involvement, I think my 11:46
21 involvement at the end - just to speak to my
22 involvement - with Dr. O'Kane, I think was reasonable
23 and appropriate. Again, I don't think I would advise
24 significantly differently now.

25

26 I can't really speak very much to the advice that
27 Gráinne gave Dr. Khan. I think you'd probably want to
28 talk to her about that.

29 257 Q. Yes, I think that's fair.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

MHPS generally then; I think you've offered up some thoughts already. Page 67 of your bundle, if we go to WIT-53791.

A. Of my bundle?

11:47

258 Q. Yes, page 67 of your bundle.

A. Got it.

259 Q. You will find at paragraph 16, if we scroll down, please, something I think you've said already. One of the problems which the Inquiry has heard through a number of witnesses is that those charged with the responsibility of taking MHPS investigations forward are, inevitably, busy practitioners in the main. Some take on a second role in senior medical management. In this case it was an Associate Medical Director investigating, and an Associate Medical Director soon to become an Interim Medical Director holding the case manager role. They are assisted by a human resources skill set but, again, she had her day job and all that that entailed. For whatever additional reasons, but that being a large part of it, the absence of preserved time to allow them to get on with it caused this matter to stretch over 15, 18 months.

11:47

11:47

11:48

You highlight that a four-week timeframe as set out in the framework is almost always unachievable. I think you are sympathetic to the view if it's almost always unachievable, it shouldn't be in the framework as that kind of aspiration?

11:48

1 A. Yes, absolutely. I would agree. I've said 12 weeks
2 here, which I think is probably pretty reasonable. If
3 you asked me to design the time scales, I would say
4 12 weeks with the possibility of extension but you have
5 to justify your extension every four weeks. That's 11:49
6 sort of the way I would do it, because you want some
7 pressure on to keep it down but you need to be
8 achievable.
9

10 Twelve weeks. The other problem - you referred to 11:49
11 this - the other problem with the process is they pick
12 the busiest person in the organisation and ask them to
13 do it. The best investigations I've seen done have been
14 done by externally commissioned investigators who come
15 into the organisation and worked full-time on it and 11:49
16 cleared it. That works well, that level of resourcing.
17 There are many -- I've seen, for example, retired
18 consultants, they're a pretty good resource, recently
19 retired consultants doing investigations. I've seen
20 independent -- there are companies out there who will 11:50
21 do these investigations for you and will do them very
22 well, and there are a number of independent consultants
23 who will do them. The advantage is, yes, it costs
24 a couple of thousands pounds to get the investigation
25 done but it is an awful lot cheaper than letting it go 11:50
26 on for 18 months, and the damage that does to the
27 service, to the practitioner, and just general overall
28 costs. Giving an external person is few thousand
29 pounds is nothing compared to the overall of these

1 processes. I would suggest that you need -- it is
 2 about putting proper resource in and making
 3 investigations happen.

4
 5 The same applies, if you look at the grievance, how 11:50
 6 long did it take? It took the best part of maybe two
 7 years to be cleared and the SAI took the best part of
 8 a year. Those things should have been done much, much
 9 quicker and that would have moved things forwards a lot
 10 better. 11:50

11 260 Q. Yes. I think many of those other examples, or those
 12 two other examples you referred to, are at least in
 13 part trapped by this requirement quite often to use
 14 medical management resource to progress them.

15 A. As somebody who has been a medical manager, it is not 11:51
 16 an easy job and we don't have a queue of people wanting
 17 to be medical managers, I'll tell you that. Most
 18 clinical director jobs basically -- well, one of my
 19 clinical director jobs, I was more or less bullied into
 20 taking because nobody else wanted it, you know? 11:51

21 261 Q. Just a couple of other points before we finish, doctor.
 22 Paragraph 25, if you scroll down or turn the page to
 23 page 69 for you. It is WIT-53793 for us. I think this
 24 is relevant to something you've said already. There's
 25 only one requirement and that's in the context of 11:52
 26 exclusion, or suspension as you've called it here, for
 27 NCAS to be contacted. You've made the point that
 28 there's no requirement for other notifications.

29 A. Yes. In this one, I think I'm actually referring to

1 the escalation -- at six months' suspension they're
 2 supposed to inform the Department, but also you are
 3 absolutely right, the other point is where they have to
 4 contact us before a formal exclusion. So those are two
 5 points in the system where things have to be done. 11:52
 6 Again, if I was rewriting MHPS, I'd put a few more of
 7 those points in because it is about holding to
 8 accounts.

9 262 Q. You go on to say and recognise at paragraph 26 that
 10 whether it is a grievance or whether it is sick leave, 11:53
 11 that has the potential to hold up the process.
 12 Sometimes from a Patient Safety perspective, perhaps,
 13 that isn't helpful. Sometimes from the perspective of
 14 the organisation being able to move on, I'm sure,
 15 that's not helpful. No doubt these matters, if they're 11:53
 16 still hanging in the air, aren't helpful for the
 17 clinician him or herself.

18
 19 Have you any particular or specific thoughts around
 20 that? You suggest that this needs to be looked at and 11:53
 21 greater guidance given.

22 A. I think there needs to be great guidance. One in
 23 particular is where you're in the middle of an
 24 investigation and the practitioner launches
 25 a grievance. And often investigations are halted and 11:53
 26 left sitting until the grievance is cleared. Sometimes
 27 that's appropriate. In this case, it probably was
 28 appropriate because the grievance was actually about
 29 the process of investigation and commissioning the

1 investigation, etcetera, but often the grievance is
2 unrelated and still the investigation process is
3 stopped. The only guidance out there that I'm aware of
4 really, there's ACAS guidance on this which is
5 reasonably good but that can probably be put into -- 11:54

6 263 Q. Did you say ACAS guidance?
7 A. ACAS, not NCAS. Another lot. The opposition.

8 264 Q. We'll perhaps look at that and thank you for pointing
9 that out.
10 11:54

11 You make the point at paragraph 33 - this is page 70 of
12 yours and 53794 of ours - that overall, the MHPS
13 Framework probably needs updating and recalibrating.
14 You say:
15 11:55

16 "However, of greater importance is the implementation
17 of the MHPS Framework by the Trusts themselves".
18

19 That's a little cryptic for me. What are you getting
20 at there with the latter part of that sentence? 11:55

21 A. Just that if you have a guidance, we need to be very
22 clear that it's definitely being followed, certainly in
23 spirit and preferably down to the letter. Sometimes
24 people -- that doesn't always happen.

25 265 Q. Yes. This particular trust, the Southern Trust, we can 11:55
26 see, perhaps by contrast with other Trusts in Northern
27 Ireland, developed a set of local guidelines in 2010,
28 held training around those for key managers, as we can
29 see taking steps to regularly use your services to

1 train staff; has developed a new set of local
 2 guidelines complement MHPS; adopting lessons, they tell
 3 us, from the experience of the O'Brien case. I'm not
 4 asking you to give them a score out of 10 but is that
 5 degree of proactivity around MHPS, is that by positive 11:56
 6 contrast to some other organisations?

7 A. Well, I suppose the first thing I'd say is that in the
 8 year or two prior to me leaving NCAS, things had
 9 improved significantly. Most Trusts now had basically
 10 followed more or less the process you've just 11:56
 11 described. We had provided training to, I think, all
 12 Trusts in Northern Ireland, bar the Ambulance Trust who
 13 don't really have any doctors. They had all, for
 14 example, acquired -- this is actually one of the things
 15 that's quite useful. They had all developed a role for 11:57
 16 an administrative person to make sure that all of these
 17 processes were being followed. You know, ticking all
 18 the boxes, here's this case, where is it in the process
 19 and what's the next step. That's an administrative
 20 task. You don't need a medic to do that, you need 11:57
 21 a good administrator to do that. I think all of the
 22 Trusts now have people in place to do that and that is
 23 really helpful, just to make sure things keep moving.
 24 Quite often we would have had discussions with whoever
 25 the person in the relevant Trust was about where a case 11:57
 26 was and what to do next. So yes, things have improved
 27 but that doesn't mean MHPS doesn't need some revision.

28 266 Q. As we saw earlier, we have your suggestions, albeit
 29 dating from 2011 to the Department. I don't need to

1 open those again. But do you consider that the failure
 2 on the part of the Department to bring revision through
 3 the MHPS arrangements, for whatever reason, is
 4 regrettable and something that does need to be
 5 addressed?

11:58

6 A. It is disappointing. MHPS was written in a different
 7 era when the health service was in a different place
 8 and was doing different things. It needs updated in
 9 many, many, many ways. I sat down and went through it
 10 last night - sad person that I am - and came up with
 11 about 20 areas where I think it could be improved.
 12 Even a simple thing: why is MHPS about doctors and
 13 dentists? When it was written, doctors and dentists
 14 were the major autonomous practitioners in the health
 15 service. Now we have nurse practitioners, we have
 16 paramedics who are practising autonomously, so should
 17 we be including them in this process? MHPS was about
 18 fundamentally about dealing with autonomous
 19 practitioners because managing them is different to
 20 managing people who follow protocols and guidelines.
 21 267 Q. Obviously, as you know, the Department is now engaged
 22 in the review of the framework.

11:58

11:59

11:59

23
 24 Just to finalise. We have it on the screen, just to go
 25 back to this line "greater importance is the
 26 implementation of the MHPS framework by the Trusts".
 27 Is that alerting us to any particular aspect of the
 28 framework which are the Trusts are not following? Are
 29 you saying that there are cases where they should

11:59

1 follow it but they don't, for whatever reason, follow
2 it?

3 A. Well, when I last worked in this field, which is
4 several years ago now, there were occasional cases
5 where, you know, you discovered that MHPS hadn't been 12:00
6 as rigorously followed. There were things like --
7 I think I mentioned earlier that notification to the
8 Department at six months' exclusion. I wouldn't be
9 convinced -- now, I don't know for certain because only
10 the Department could answer this question for you, but 12:00
11 I wouldn't be absolutely certain that that happens
12 without exception, you know. That's just an example,
13 just one example of something I just have a feeling
14 maybe isn't as rigorously done as it could be.

15 268 Q. Thank you. 12:00

16
17 Thank you again, doctor, for your answering my
18 questions this morning. The Chair will now speak to
19 you, and she and her Panel member and her assessor may
20 have some additional questions to you. But thank you 12:01
21 for taking the time to speak to us this morning.

22 CHAIR: Dr. Fitzpatrick, I appreciate it is midnight
23 with you; at this point it is well beyond the working
24 day for you. If you bear with us, hopefully we will
25 have a few short questions for you to answer. I'm 12:01
26 going to go, first of all, to Mr. Hanbury, who is the
27 Inquiry's urology assessor.

28
29 We just have to switch the screens here so that we can

1 see Mr. Hanbury and make sure we hear from him.

2 MR. HANBURY: Thank you. Are you hearing me?

3 CHAIR: Yes, we can.

4

5 THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL

12:01

6 AS FOLLOWS:

7

8 269 Q. MR. HANBURY: Thank you very much for your candid and
9 helpful evidence. I have three short questions,
10 I promise.

12:01

11

12 The first going right back to the March 2016 letter
13 with respect to your initial approach to the diagnosis
14 process of the problem. There were those four things
15 that the managers were concerned about . Do you think,
16 looking back, what you would have offered had you been
17 involved at that point is to have recommended things re
18 triage, dictation, notes at home, PPs, and sort of done
19 it in a sort of short, sharp fashion? I guess that's
20 my question.

12:02

21 A. You mean if I had been involved in March 2016, would
22 I have advised --

23 270 Q. Yes.

24 A. Okay. Yes, is the straight answer. I would again --
25 which reflects what I said in September, is this is
26 a massive piece of work, you can't just ask him to do
27 it. You need to provide him with the resources to do
28 because it would be very, very difficult to do it any
29 other way. Sorry, I'm going to reset my camera here.

12:02

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

Yes, I would have advised differently and more along the lines of providing resources and support, and probable more careful monitoring.

271 Q. In fact, with more support there may have been a better outcome at that point, I guess is where I'm driving at? 12:03

A. Yes, you'd like to think so. Yes.

272 Q. Just moving on, you made an off-the-cuff comment about - moving on to September 2016 - expecting a call back from Simon Gibson following your initial contact with him, rather hoping for a meeting. 12:03

A. Yes.

273 Q. We heard from other witnesses that there's this reluctance to actually engage with Mr. O'Brien face-to-face. Had a meeting been set up, would Mr. O'Brien have been there or would that have just been with Mr. Gibson and the Oversight Group? 12:03

A. No, no, no. The point I was trying to make is we need to meet with Aidan O'Brien and have the discussion with him. There would be no point me meeting with the Oversight Group. The idea of the meeting would be to get him engaged and get him on board and, you know, get him to realise that we have a shared problem here and we need to solve it. 12:04

274 Q. The third one. Yes. My other point is when you are speaking about your initial discussion with the senior decision-maker, i.e. preferably the Medical Director, once that had been done and you'd sorted out an action plan, do you think you would have had to have spoken 12:04

1 again with the Medical Director, or would someone like
 2 a clinical director who has more operation knowledge of
 3 the problems would be a good person to talk to?
 4 I suppose what I'm asking does it always have to be the
 5 most senior decision-maker or can you go down the sort 12:05
 6 of food chain later?

7 A. I think that's probably reasonable. Certainly at the
 8 beginning, we need to have a discussion, I think, with
 9 somebody who can take decisions and decide the way
 10 forward. Yes. When you are just monitoring progress, 12:05
 11 I suppose you could, as you say, speak to someone whose
 12 a bit more operational, with the proviso that if
 13 we say, hold on, there's a big decision to be taken
 14 here, it's not working, you can go back up the ladder.
 15 MR. HANBURY: Thank you very much. Those are all my 12:05
 16 questions.
 17 CHAIR: Thank you, Mr. Hanbury.
 18
 19 Dr. Swart then.
 20 DR. SWART: Can you hear me? 12:05
 21 CHAIR: Yes, we can.

22 275 Q. DR. SWART: Thank you. I can identify with a lot of
 23 your views and recommendations having had the privilege
 24 of multiple interactions on most of these things.
 25 12:06
 26 It is my observation, particularly in the Southern
 27 Health Care Trust, that there was a huge fear in
 28 relation to managing doctors, some of it because they
 29 had this view that everything had to be done under

1 MHPS; rather a lack of understanding about what I would
2 call normal medical management. Much like in the old
3 days, you just called someone into your office if you
4 were Clinical Director and said come on, we can't do
5 this, and if they don't do it you write them and email, 12:06
6 a letter and help them do it, you don't think you have
7 to go down a big framework. But it is still
8 management.

9
10 Now, I don't think there's a good understanding about 12:06
11 this, certainly at the Southern Healthcare Trust at the
12 time this happened and probably in other institutions.
13 whose role is it to deal with this in your view? where
14 does the responsibility lie and is it a combined one,
15 and is that something that NCAS could help with since 12:06
16 you see what happens when it goes wrong?

17 A. Yeah. I mean, one of the problems is the way we get
18 into medical management, which is usually by accident.
19 There's not really a lot of lot of -- in recent years,
20 the faculty of medical leadership, or whatever they're 12:07
21 called, and other people have provided a bit of
22 training, but there's precious little training out
23 there for people to be medical managers. You're
24 absolutely right, they sort of get scared by processes
25 like MHPS. It's not helped by defence organisations 12:07
26 who scare them as well. They don't realise, as you
27 say, you can apply common sense and just do it. Quite
28 often - I mean back to what I think I said earlier,
29 particularly with conduct issues - the best advice

1 I can give is just do what you would do if it was
2 someone else.

3
4 what can we do? There needs to be training. whether
5 that's for NCAS to provide or somebody else, I'm sure 12:08
6 NCAS, if you asked them nicely and paid them enough
7 money, they would do it.

8 276 Q. Do you think it would be helpful to have a warning in
9 the MHPS Framework to say 'by the way there is normal
10 medical management'? 12:08

11 A. That wouldn't go amiss. That wouldn't go amiss.

12 277 Q. Because actually the number of times people, in any
13 experience, would come to me and say we have doctors,
14 we have to use this, and I would say no, it's common
15 sense. 12:08

16 A. I agree with you.

17 278 Q. In this case, and I'm sure you found it in other
18 places, there clearly are multiple issues with the
19 whole investigation, with the whole interaction with
20 NCAS but it seems to me that they basically ignored 12:08
21 lots of things in terms of the NCAS advice. That's
22 what it appears to me. I don't know if it was entirely
23 deliberate or if part of it was accidental but it
24 indicates as a cultural problem, I think. In your
25 experience over the time you've been doing this, what 12:09
26 are the cultural issues at play that cause this sort of
27 attitude? Or do you not think there are any?

28 A. Oh, there are. First of all, I think you pointed this,
29 there's this fear of -- you know, they treat doctors

1 differently when they shouldn't. They're just
2 employees. And doctors, many of them often think they
3 should be treated differently, which doesn't help
4 matters. Doctors are senior people, they're well-paid.
5 Many of them, particularly surgeons, are fairly 12:09
6 dominant. So those are all issues that make it
7 difficult to manage doctors.

8
9 You're absolutely right, there are a number of cultures
10 around. I mean, there's a terror of MHPS. If you 12:09
11 look, for example, there's the formal and informal
12 processes in MHPS. Everybody is terrified to go to the
13 formal processes, whereas actually there's not that
14 much difference.

15 279 Q. would you agree all of that needs to be more clearly 12:10
16 defined, because people seem to have got their knickers
17 in a twist about it?

18 A. Yes, yes. They do. That's a reasonable suggestion.
19 Yes, they have. They've got really messed up with it.
20 They get terrified of going "formal", whatever that 12:10
21 means. As I say, I'm not entirely sure that there is
22 that much difference because you are still applying
23 common sense; you're defining the concerns, investigate
24 concerns, you're deciding what to do about it.

25 280 Q. Another thing I think it would be helpful for your 12:10
26 observation on this, the administrative issues, as they
27 were called in this, are really very extensive, yet
28 there was a blindness because people felt it was
29 totally unrelated to clinician capability. In your

1 experience is there quite often a link between very
 2 severe administrative issues, conduct and capability,
 3 or do you think it's possible to separate them like
 4 this, like they have done?

5 A. No. Actually, I suppose I have to confess, reading 12:11
 6 through this bundle I was getting increasingly
 7 irritated by referring to these issues as
 8 administrative because not writing notes, not triaging
 9 patients on time, not writing letters to GPS are not
 10 just administrative issues in sort of the way that -- 12:11
 11 you know, it's not the same as not having, you know,
 12 put your parking sticker up on the car. It is
 13 a different type. This goes to the core of clinical
 14 care. Because when you're a surgeon, only a little bit
 15 of your work is cutting, the rest is it is what has 12:11
 16 been referred to as administrative in this. There is
 17 an overlap. People who are bad at one area of their
 18 practice are often not terribly good in other areas as
 19 well. So, yes, there is a connection and an overlap.

20
 21 I suppose if I was to criticise myself, probably in
 22 that discussion about Simon Gibson I should have
 23 majored a little bit more on that.

24 281 Q. Finally, there's a little bit of hiding behind 'we
 25 can't do an unfocused trawl, therefore we can't look 12:12
 26 too widely'. But an unfocused trawl is different from
 27 no trawl. It would appear to me that in this case,
 28 there was very little objective information available
 29 about the quality of work in this department because

1 there's no audit, there's no metrics. Everybody just
2 said he's a very nice guy who works very hard, which
3 I'm sure is true.
4

5 Is this a common problem in Trusts, that they don't 12:12
6 know where to look because they don't have enough
7 automatic data and information?

8 A. It is less common than it used to be. It is actually,
9 interestingly, more common for them not to have data in
10 other specialties. In surgery, I've always found they 12:13
11 tend to have reasonable data because surgeons do things
12 like count the number of operations they have done and
13 how many patients have died, things like that. Try
14 doing that in psychiatry. So, it is a little unusual
15 for a surgical specialty not to have any decent data at 12:13
16 all. My experience is they generally do have. Whether
17 it is part of a national database - I have seen cardiac
18 surgeons who have been called up because their failures
19 on a national database went over a line - or be it
20 local data. But surgeons tend to have better data, so 12:13
21 this is unusual.

22 282 Q. Do you think the term "unfocused trawl" could be
23 qualified a bit in the various advices so that people
24 actually realise they do have to ask, they do have to
25 enquire, because not knowing is not an excuse, is it? 12:13

26 A. Again, when you are rewriting MHPS, we need to put in
27 something about we need to have a wider look, a wider
28 look at a practitioner's practice to see if there are
29 other issues which might require investigation.

- 1 283 Q. Okay. Thank you very much. Very helpful.
- 2 A. Thank you.
- 3 CHAIR: I won't be very long with you, Dr. Fitzpatrick,
4 but I was interested to hear you had received some
5 training yourself in the use of mediation. I just 12:14
6 wondered is that something that might have been of
7 assistance, certainly with regard to some of the
8 aspects of this case?
- 9 A. Yes. Well, I'd like to think so. That was sort of
10 part of my offer to meet because I felt that those 12:14
11 skills could be very useful in terms of coming to some
12 sort of common ground that would advance this case. My
13 mediation training was one of the most useful things
14 I've had, apart from doing pure mediations which I have
15 done on quite a number of occasions, usually with 12:14
16 warring practitioners. But even just the skills that
17 come with mediation make it easier to manage a meeting
18 and get a result.
- 19 284 Q. Do you think it would be a useful training for medical
20 managers generally? 12:15
- 21 A. Yes. Yes, I think so. I think some of the skills,
22 even if they don't want to go off and be mediators as
23 such, the skills acquired are very useful.
- 24 285 Q. One of the things that we have heard, you were saying
25 about -- you give the example of an investigation that 12:15
26 you were involved in where everyone was saying, 'well,
27 I wouldn't let that person operate on me', and that led
28 you to go back to the case manager and say there's
29 a wider issue here.

- 1 A. Yes.
- 2 286 Q. The opposite was true in this case. Everybody was
3 saying he is a great clinician, he's a great surgeon,
4 there's no problem there. That seems to have blinded
5 people to perhaps doing a more focused trawl. 12:15
6
- 7 Is that one of the problems that there are in terms of
8 carrying out these investigations? I think Dr. Wright
9 summed it up by saying it was -- I'm paraphrasing what
10 he said but basically it was an overreliance on 12:16
11 deference?
- 12 A. Yes, I think that's fair. I mean, this is somebody who
13 was very senior. He had obviously done great things in
14 the past and he had set up the service and run it and
15 there was significant deference to him. Certainty from 12:16
16 my experience, having spoken to Mr. O'Brien, he's an
17 awfully affable, pleasant fella. All of those things
18 would make it more difficult for people to suggest that
19 there was an issue with his practice, yes.
- 20 287 Q. Is that all the more reason then, where you do have 12:16
21 someone of that seniority and that reputation, that it
22 is important to bring in someone external to lead this
23 investigation?
- 24 A. Yes. Again, an external person won't be blinded by the
25 fact he's the most senior surgeon and he has been there 12:16
26 forever and everybody likes him. They will stick to --
27 they will actually do the investigating. I'm a great
28 fan of external investigators because they don't have
29 the baggage that comes with being part of the

1 organisation.

2

3 Also, if they are externally commissioned, they are on
4 a commission, they are going to do it on time, they are
5 going to do it in whatever timeframe you agreed with 12:17
6 them.

7 288 Q. Obviously with the budgetary constraints that Trusts
8 have, and we know that the Health Service have at the
9 moment, what would your view be on a regional resource
10 perhaps provided by the Department of Health where you 12:17
11 have a pool of people with requisite experience and
12 expertise who could be drafted in externally to
13 a Trust.

14 A. That would work, that would work. Interestingly
15 we have a similar sort of model in HSC at The Beaches 12:17
16 where they have a number of consultants. I'm actually
17 on their list of consultants of people who are
18 available to do things like SAI investigations,
19 etcetera. So they could expand their repertoire to
20 cover performance investigations, so that would work. 12:17
21 But yes, that's a good idea; externally commissioned
22 but available.

23 CHAIR: Thank you very much, Dr. Fitzpatrick. I'm
24 sorry that it's twenty past midnight and I'm sure you
25 want to get to your bed. The rest of us are going to 12:18
26 get some lunch before we start the afternoon session,
27 but thank you for attending remotely.

28 A. Thank you very much. Thank you for starting a couple
29 of hours early to facilitate me.

1 CHAIR: we did realise it would be very late when we
 2 were finishing.

3
 4 I think we're due to start at one o'clock but I'm going
 5 to say 1.20 before we start this afternoon. Yes, it's 12:18
 6 Dr. Lynn.

7
 8 THE INQUIRY THEN ADJOURNED FOR LUNCH AND RESUMED AS
 9 FOLLOWS:

10 13:20

11 CHAIR: Good afternoon, everyone. Mr. Beech.
 12 MR. BEECH BL: The witness wishes to take the oath.

13
 14 GRÁINNE LYNN, HAVING BEEN SWORN, WAS EXAMINED BY MR.
 15 BEECH BL AS FOLLOWS: 13:20

16
 17 289 Q. MR BEECH BL: Thank you very much, Dr. Lynn.
 18 You should have water on your table if you need it.
 19 Hopefully any documents needed for this afternoon
 20 should appear on the screen for you to consider. 13:21

21
 22 Before we start, a brief health warning. I'm well
 23 aware that NCAS has now become Practitioner Performance
 24 Advice. I suspect I'll end up using the two terms
 25 interchangeably. 13:21

26 A. That's absolutely fine.
 27 290 Q. Just to confirm then, but for the change of name from
 28 NCAS to PPA, has there been any substantive change to
 29 the role played?

1 A. No.

2 291 Q. Thank you very much.

3

4 If I could start by referring you to a copy of your

5 witness statement, then, which appears in the bundle at 13:21

6 WIT-53449, please. First and foremost, are you

7 familiar with this document?

8 A. I am, yes.

9 292 Q. I'm just going to ask you a quick question about the

10 formatting of that, perhaps. The top of it, it is 13:21

11 entitled Independent Inquiry Into Mr. Aidan O'Brien.

12 Now, there is correspondence from Field Fisher PPA

13 explaining the circumstances but can you explain how

14 and when this witness statement came into existence?

15 A. Well, the witness statement was undertaken before 13:22

16 I retired from NCAS. I think that it was realised that

17 there would be, obviously, questions asked but they

18 thought if I put a statement in, that that at least

19 would give the Inquiry some idea of what had happened.

20 293 Q. Just to clarify then, although it says on the top of 13:22

21 it, Independent Inquiry Into Mr. Aidan O'Brien, you're

22 well aware of the terms of reference of this Inquiry?

23 A. Yes.

24 294 Q. If we can jump to the very last page of that,

25 WIT-53454, please. Go down to the bottom where your 13:22

26 signature is. Do you confirm that that's your

27 signature?

28 A. Yes, that's my signature.

29 295 Q. As you've just indicated, this was dated and signed

1 23rd December 2020. That was maybe just after the
 2 Minister made an announcement about the Inquiry?
 3 A. That's correct, yes.
 4 296 Q. If having read that witness statement, are you content
 5 to adopt that witness statement as your evidence to the 13:23
 6 Inquiry today?
 7 A. Yes, I am.
 8 297 Q. On your reading of it, do you wish to make any changes,
 9 amendments or corrections?
 10 A. No, I don't. 13:23
 11 298 Q. Thank you very much.
 12
 13
 14 I know you have been sitting here this morning and
 15 perhaps followed a bit of Dr. Fitzpatrick's evidence. 13:23
 16 I intend to spend a bit of time on the actual practical
 17 advice that you were offering to the Southern Health
 18 and Social Care Trust. Before we get there I think it
 19 is important to understand a bit about the role you
 20 understand NCAS played. 13:23 Okay?
 21 A. Yes.
 22 299 Q. We refer back then to the first page of the statement.
 23 It is WIT-53449. Just the first paragraph there. You
 24 outline you qualified in dentistry in 1983, and in 1990
 25 you obtained Fellowship of the Faculty of Dentists. 13:24
 26 From that point on, could you just outline a bit of
 27 your background and experience up until you becoming
 28 involved in NCAS?
 29 A. I worked for a couple of years in Hospital Service

1 before I qualified, and then I moved into a post in
 2 Foyle Trust, or its predecessor, in the community.
 3 I also worked part-time in general practice. I was
 4 appointed as the Clinical Director in Foyle Trust and
 5 had been Clinical Director I would say, from 1996 until 13:24
 6 2005. I think that it's the Clinical Director
 7 experience that enabled me to be eligible to meet the
 8 essential criteria to work with NCAS. They required
 9 you to have management experience of working in the
 10 Health Service. 13:25

11 300 Q. You outline in paragraph 1 then that you started
 12 working for NCAS on a part-time basis in 2005. You've
 13 already confirmed today you've since retired. When did
 14 you retire from your role at NCAS?

15 A. 2021, January 2021. 13:25

16 301 Q. I'm afraid my maths is sketchy on my feet. would that
 17 be 17 years then perhaps?

18 A. 16, is it? I said 15 previously but I think it's 16.

19 302 Q. I'll take your word for it.

20 13:25

21 During your time, you were involved in NCAS for
 22 16 years, you mentioned you had a part-time
 23 involvement; is that correct?

24 A. I was part-time originally, yes. A group of us were
 25 appointed as advisers in 2005. As dental advisers. 13:25
 26 Originally we were only involved with dental cases but
 27 then the role became broader. I think they realised
 28 that if you had experience of working in the Health
 29 Service and you also had experience of management, then

1 the management of these problems was similar.

2 303 Q. Okay. You mentioned you started part-time; are you
3 implying that you then moved into a full-time position?

4 A. I did move into a full-time position but I did go
5 part-time again in the year or two before I retired. 13:26

6 304 Q. So perhaps your involvement with The Trust this time
7 was 2016, 2018, 2020, so at that time you were
8 full-time with NCAS?

9 A. I would have been full-time, yes.

10 305 Q. Can you just outline what training did you receive to 13:26
11 discharge your functions as an NCAS adviser?

12 A. We got quite a lot of training. There was a very
13 engaged Director of Clinical Services there who was
14 a dentist by background, and she recognised that even
15 though we had management experience within the Health 13:26
16 Service, that we would still need a comprehensive
17 induction programme. We did have that, you know.
18 I went to London for a week of induction. Then
19 we travelled over every week for some time, you know,
20 to address really what she felt would be any deficits 13:27
21 in our knowledge. I think that was very valuable.
22 I know you talked about this earlier, but when I was
23 appointed as a Clinical Director, there definitely were
24 significant deficits in my knowledge. I think, you
25 know, that that would be relevant in most people who 13:27
26 are appointed into management positions, certainly the
27 time in which I was appointed.

28 306 Q. I can see then from paragraph 1, which is still on the
29 screen, that you also obtained an LLM in Employment

1 Law. Was that primarily to assist with your role in
 2 NCAS?

3 A. Yes, it was.

4 307 Q. We'll come on to the specifics of the type of queries
 5 you were fielding from the Trust, but in general did 13:27
 6 you feel well-equipped in your role at NCAS to address
 7 often complicated and complex issues about
 8 a practitioner's performance?

9 A. I think initially it was a huge challenge when I was
 10 first appointed, but we had great support. There were 13:28
 11 other advisers there and there was a good network. So
 12 if I didn't feel I could answer a query or needed
 13 assistance, there were people you could ask.

14 308 Q. You've mentioned other advisers and you're well aware
 15 we spoke to your erstwhile colleague, Dr. Fitzpatrick, 13:28
 16 this morning. How many other advisers were there in
 17 Northern Ireland?

18 A. Just Colin and I in Northern Ireland.

19 309 Q. Would you and Colin, as the two advisers in Northern
 20 Ireland, been able to link in to a larger group of 13:28
 21 advisers?

22 A. Yes. There were about 20 advisers in England, not all
 23 of whom were full-time, but they had a range of
 24 backgrounds as well. So we had advisers from legal
 25 background, HR background, and who had been working in 13:28
 26 the Health Service as well. So they would have legal
 27 experience of working in management and Trusts as well.

28 310 Q. Just perhaps generally - we'll come on to Mr. O'Brien
 29 and the Trust in a minute - but your relationship with

1 Colin - Dr. Fitzpatrick, forgive me - would you have
 2 been sharing information, discussing complex cases,
 3 discussing best practice?
 4 A. Colin became my line manager when I was relatively late
 5 in my career in NCAS. I was managed within the dental 13:29
 6 team originally so I would have brought my queries to
 7 them, you know. If we needed the expertise from
 8 outside of that, we could have accessed it. I remember
 9 we would have had monthly reviews of cases and that
 10 would have been undertaken by other advisers, Stephen 13:29
 11 Peece, he was an adviser with a legal background.
 12 I would say I was mentored and supported by others and
 13 later by Colin.
 14 311 Q. You mention the monthly reviews. Perhaps if we could
 15 have a look at WIT-53769, please. This is an aspect of 13:29
 16 a larger document, which is a Service Level Agreement
 17 between the Department of Health and NCAS. Are you
 18 familiar with this document?
 19 A. I am familiar with this document, though not as
 20 familiar as Dr. Fitzpatrick, because he was the lead 13:30
 21 adviser and he would have been required to sign it off.
 22 312 Q. If we look at the second paragraph there. Perhaps I'll
 23 start halfway through and we'll come back. You
 24 mentioned there monthly reviews. This paragraph refers
 25 to: 13:30
 26
 27 "The progresses of all active NCAS cases are reviewed
 28 at monthly meetings between the adviser and a senior
 29 colleague".

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

whenever one reads that, it makes it sound like a relatively formal process. was it a formal process or more of a discussion between you and a colleague?

A. It wouldn't usually have been a formal process. You brought your list of cases. Certainly if any case, if any practitioner was subject to exclusion, that would have been a formal case. You know, that would have been managed more formally. But you would have discussed them, or you would have discussed anything you were concerned about. 13:30
13:31

313 Q. would these have been formal minuted discussions? would there be a paper trail of notes?

A. No, there wouldn't be a paper trail, except about the monitoring of exclusion. 13:31

314 Q. we'll just use this opportunity to discuss briefly your role and how you saw your role. If we go to the first sentence of that paragraph. we are still on the second paragraph here:

"An NCAS adviser will provide expert advice, and support will be responsible for directing the management of NCAS's input to the case. The level of the support will depend on the nature of the case". 13:31

A. Yes.

315 Q. we're going to open up a series of letters that you send to the Trust and Mr. O'Brien.

1 whenever it stays "The level of support will depend on
 2 the nature of the case", what does that mean? Is it
 3 always done by letter? Is there some type of other
 4 process?

5 A. I suppose it is the potential risk at the initial call 13:32
 6 would be what would determine how significant. If you
 7 have a practitioner excluded, that would have meant it
 8 was automatically considered a more serious case.
 9 We had responsibilities to monitor exclusions as well.

10 316 Q. If a case was considered particularly high-risk or 13:32
 11 particularly serious Patient Safety issues, how would
 12 that affect its management?

13 A. There was an operational group within NCAS and any
 14 significant issue had to be flagged through them.

15 317 Q. If we could just scroll down please to the bottom 13:32
 16 paragraph of this page. It starts:

17
 18 "As a competent advisory body in this work, a key
 19 feature of NCAS involvement is to bring constructive
 20 challenge to the local management of concerns and 13:33
 21 support the resolution of disputes between
 22 practitioners and their employing/contracting
 23 organisation".

24
 25 I really want to focus in on the constructive challenge 13:33
 26 aspect of that. How would you, as an NCAS adviser,
 27 bring constructive challenge?

28 A. Well, if I can use this case as an example. When
 29 Dr. Wright spoke to me in December of 2016, I think

1 we all know now, the decision really had been made in
 2 principle to exclude. When I spoke to Dr. Wright,
 3 we talked about the alternatives to exclusion and the
 4 ability to use an immediate time limit exclusion for
 5 four weeks if that was appropriate. In the end, 13:33
 6 I didn't actually know they had used the immediate
 7 exclusion because, obviously, we didn't have
 8 a follow-up call. But I can see that they used it
 9 instead of formal exclusion and then they moved to
 10 restrictions, although I only know that now with 13:34
 11 hindsight, I didn't know it at the time.

12 318 Q. I keep telling you we'll come to the specifics, and
 13 we will. Your way of constructive challenge would be
 14 via a discussion with the Medical Director, whoever is
 15 in the organisation. 13:34

16 A. Yes.

17 319 Q. That perhaps brings us then to a slightly different
 18 point. If we could go back to your witness statement
 19 at WIT-53450, please. Principally we're going to look
 20 at perhaps 9 and 10. I'm aware that you were present 13:34
 21 for much of Dr. Fitzpatrick's evidence this morning.
 22 The last sentence of paragraph 9:

23
 24 "In respect of its advisory functions, all of the
 25 assistance that we provide is based upon information 13:34
 26 we receive from NHS bodies and other parties, such as
 27 the practitioner concerned".

28
 29 In practice, would your ability to constructively

1 challenge a referring body, anyone who phoned NCAS, it
 2 is really, in fact, limited to what they are telling
 3 you about a situation.

4 A. That's correct. Although we do -- you know, in the
 5 letters that we sent out more recently we also 13:35
 6 encouraged the letter to be shared with the
 7 practitioner, and then we often talk to the
 8 practitioner as well.

9 320 Q. At the time in which, let's say -- again, we'll get on
 10 to specifics of Mr. O'Brien later this afternoon. But 13:35
 11 at the time in which a Trust phones or makes contact
 12 with NCAS, would it be standard procedure to contact
 13 the practitioner or reach out to the practitioner?

14 A. No, we don't do that. It originated, I think, because 13:35
 15 originally the calls were made to us in confidence, and
 16 there was some difficulty when we used to want to copy
 17 the letters to the Chief Executive of the Trusts.
 18 I think when it was set up originally, that was
 19 certainly our practice, to copy in the Chief Executive.
 20 The role sort of changed a little bit and it became 13:36
 21 is -- you know, the issue of keeping confidentiality
 22 the Trust changed in that you have to be open with
 23 practitioners, and we found that a lot of that wasn't
 24 happening. It sort of evolved.

25 321 Q. You then go on at paragraph 10 to say that: 13:36
 26
 27 "As a result the advice service is dependent on NCAS
 28 bodies providing the relevant information about
 29 a case".

1

2

In practice - again, we're talking generalities here - if a Trust phoned you, would you be sitting listening or would you be asking questions, providing some type of probing exercise?

13:36

4

5

6

A. Well, you would ask questions. If I didn't agree with what they were suggesting, you know, I would challenge that. You know like, if they wanted to exclude and

7

8

9

I didn't there were grounds, or if, for example, they were saying it isn't a clinical issue but there is the potential for harm, you know, I would challenge that too.

13:37

10

11

12

13

322 Q. Would that challenge or probing ever go so far as perhaps requesting documentation or evidence?

14

15

A. That's not something we have ever done. We're an advisory body, we're not a regulator. In our own organisation, I don't imagine -- we would have accepted information if they had wanted to send it to us, and they frequently did, but we would never force them to do anything because we're not a regulator. I don't know if that would be within our power.

13:37

16

17

18

19

20

21

22

323 Q. You're drawing a distinction here between NCAS as a regulator and NCAS as an impartial adviser?

23

24

A. Yes.

25

324 Q. Dr. Fitzpatrick this morning drew a different comparison this morning; he said we're not an investigator. Would you agree with that?

26

27

28

A. We don't do the investigation, no. We rely on the organisations doing their own investigation. But

29

13:38

1 I completely agreed with the suggestion that the
 2 investigation should be done externally.

3 325 Q. Just scroll down, please, to paragraph 11. It's at the
 4 very top of the screen there, you touched on it
 5 already: 13:38

6

7 "Letters to an NHS body are not routinely copied to
 8 practitioners but we advise the NHS bodies to share
 9 with the practitioner unless this is deemed
 10 inappropriate". 13:38

11

12 Has that always been NCAS's approach?

13 A. We would always have encouraged NHS Trusts to be open
 14 with the practitioner. I mean, the first person who
 15 should know about the concern is the practitioner. 13:39

16 Sometimes in the early days we would have been talking
 17 to employers who hadn't told the practitioner of the
 18 concern but they were on the phone talking to us. That
 19 would have become apparent when you say what does the
 20 practitioner say? 13:39

21 326 Q. In practice, does NCAS ever or has it ever received any
 22 information about whether or not these letters are
 23 routinely shared with practitioners?

24 A. Well, I think now we put it in our letters that they
 25 should be. I think we do know a lot of times they 13:39
 26 weren't, previously.

27 327 Q. Just so we're clear, what exactly do you think is the
 28 benefit or the importance of letters being shared with
 29 practitioners?

- 1 A. I think they know exactly what has been said and what
 2 has been negotiated, really, between the employer and
 3 NCAS. And it gives them then the opportunity, if they
 4 feel that there's a misrepresentation, to come to us
 5 themselves. 13:39
- 6 328 Q. You were an NCAS adviser for 16 years perhaps. During
 7 that time, what type of individuals were contacting the
 8 service.
- 9 A. There was a very big range of individuals contacting
 10 the service - HR Directors, Medical Directors. We did 13:40
 11 get a lot of calls from practitioners, especially more
 12 recently. More recently than when we did the case
 13 investigator training, we also told the case
 14 investigators we were happy to give them advice on
 15 investigations on sort of help, not on specifics but on 13:40
 16 generalities. If they had queries, we were happy to do
 17 that as well.
- 18 329 Q. And having delivered that training - again we're
 19 talking general - but did any case investigators during
 20 your time at NCAS phone the service? 13:40
- 21 A. Yes. Yes, they did. Just with general queries about
 22 what they could or couldn't do.
- 23 330 Q. In your mind, if a Trust or any type of healthcare body
 24 is contacting you, is it more helpful than not to be
 25 speaking to the decision-maker, i.e. the Medical 13:41
 26 Director or the person who is actually going to be
 27 making a call on a practitioner's practice?
- 28 A. I mean, I take Colin's point about the Medical Director
 29 having authority but I did have some very useful calls

1 with people who would not have been as senior as that.
 2 That would be my experience. They sometimes weren't --
 3 didn't have as definite a view about what should happen
 4 if they were more junior.

5 331 Q. We've discussed, really, this afternoon so far what 13:41
 6 would be called the advisory side of NCAS or PPA.
 7 There really appears to be two other kind of broad
 8 limbs then. There's the educational type services
 9 involved with NCAS. Would you have been involved in
 10 delivering workshops or training? 13:41

11 A. I was, yes. I was involved in one in the
 12 Southern Trust which took place just after the
 13 investigation was organised.

14 332 Q. Would that have been a case investigator training about 13:42
 15 March 2017?

16 A. That's it, yes. That was the one. I hadn't been
 17 involved in the case manager training, which was
 18 earlier than that. That was my first time in
 19 Southern Trust. It wasn't a Trust I would have been
 20 usually involved with because I used to live in Derry. 13:42

21 333 Q. Then there's what I'm going to call, forgive my rather
 22 loose language, the third limb of NCAS, which might be
 23 called performance assessments?

24 A. Yes.

25 334 Q. When and in what circumstances would that performance 13:42
 26 assessment limb kick into gear?

27 A. Performance assessments could be useful where there was
 28 a substantial concern about how a practitioner
 29 undertook their job. They're very expensive, as you

- 1 can imagine, so there were a limited number approved
2 but really we're talking about a capability concern.
3 Now, Colin did talk about assessment this morning in
4 some detail. He talked about the performance
5 assessment involving health and behaviour and 13:43
6 a clinical component. For some cases, we then moved on
7 to provide, you know, a break-up of that. We would
8 have found sometimes behavioural assessments very
9 useful, so they would have been undertaken in some
10 cases. 13:43
- 11 335 Q. In terms of that performance assessment limb, in your
12 experience how often is it utilised?
- 13 A. Well, there were several of them undertaken. I don't
14 have the figures, you know, but my impression was
15 possibly about 1 percent of the cases that we did. 1 13:43
16 to 3 percent maybe, but that's -- I don't know the
17 figures exactly.
- 18 336 Q. We'll come on to discuss more specifically, I suspect,
19 about -- is it the PSR scheme, Professional Support and
20 Remediation. Would that be under that performance 13:44
21 assessment?
- 22 A. That can be done after an assessment or without an
23 assessment. If it comes after an assessment, obviously
24 it will be based on the conclusions of the assessment
25 report, but it can be done. If you already know what 13:44
26 the problems are, you don't need an assessment. It's
27 really very useful, a performance assessment, if you
28 don't know the scope or the scale of the performance --
29 the alleged performance deficits.

- 1 337 Q. I'm going to ask you again, in your experience as an
2 NCAS adviser, are those, what I'm going to term PSR
3 type assessment, are they actually used in practice?
- 4 A. They were used a lot, I would say. They were used more
5 often in England; I don't know why that is. Certainly 13:44
6 I was involved with a lot of Trusts in England who were
7 undertaking PSR plans.
- 8 338 Q. I keep promising we'll come back to discuss some stuff
9 later this afternoon, but that's another one.
10 13:45
- 11 The Inquiry is obviously very interested in your
12 reflections. You're a very senior adviser in NCAS and
13 you had a number of years under your belt. Before
14 perhaps I move on to NCAS under MHPS, is there any
15 further reflections you wish to offer about the general 13:45
16 rule of NCAS, perhaps in light of anything
17 Dr. Fitzpatrick might have said? I want to give you an
18 opportunity to comment if you have any comments you
19 wish to make?
- 20 A. I can't think of any at this stage but if they come to 13:45
21 me, I'll let you know.
- 22 339 Q. Can you describe to me then what in your mind is the
23 relationship between NCAS and the MHPS framework?
- 24 A. It's very close. You know, everything that the
25 employing Trust does really should be done with the 13:45
26 knowledge of that in the background. Of course, their
27 local policies should be compliant. That was an issue,
28 you know, at the start, that local policies and MHPS
29 conflicted.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

You know, you talked today earlier about conduct hearings, and in the paragraph above which you discussed with Colin, I mean the conduct hearings in MHPS, professional misconduct, must have a professional member of the panel. If their local policy doesn't have that, then they'll be in conflict with MHPS, which will give them some trouble.

13:46

340 Q. I'm going to ask you a broad enough question. In what scenarios do you understand the Trust is required to seek advice and consult with NCAS?

13:46

A. They are required to seek advice if they are considering exclusion, a formal -- it is mandatory for formal exclusion. When we do our training as well, and I think this might conflict with evidence given earlier by some people from the Trust, we like to be contacted early. You know, we don't like to get intractable problems.

13:46

When NCAS started up in 2001 - I wasn't there at the time - but a number of issues which came to them, which were very long-standing and very difficult, therefore, to resolve. Our director, Alastair Scott at the time, was very keen that we would get problems at an early stage, then it might be potentially much more straightforward. I think that was what we found.

13:47

341 Q. I'll just unpack a couple of elements of that. If we could call up, please, WIT-18502 on the screen. Focus on paragraph 20. This is the section of MHPS on

13:47

1 immediate exclusion. As you described there, it says:

2
3 "The NCAS must, where possible, be informed prior to
4 the implementation of an immediate exclusion".

13:48

5
6 The "where possible" caveat on that, what is that
7 designed to cover?

8 A. Well, when NCAS first started, it was available
9 24 hours but that changed. I presume that something
10 can happen in a Trust that, you know, you want the
11 practitioner out of the site immediately and you may
12 not be able to make contact with NCAS. It might be
13 late on a Friday night, for example. whilst originally
14 we were a 24-hour service, that changed. So I suppose
15 it covers that.

13:48

16 342 Q. That's really covering perhaps a scenario where there's
17 something so urgent, but they can't get hold of you.

13:48

18
19 Then WIT-18500, please. I think it should help a
20 couple of points you were referring to. Down to
21 paragraph 10, please. It says:

13:48

22
23 "Employers or practitioners are at liberty to make use
24 of the services of NCAS at any time they see fit.
25 However, where an employing body is considering
26 exclusion or restrictions from practice, the NCAS must
27 be notified so that alternatives to exclusion can be
28 considered".

13:49

29

- 1 It is the thrust of these two paragraphs, isn't it,
2 that NCAS are consulted with before a decision to
3 exclude has been taken?
- 4 A. That's correct.
- 5 343 Q. Then you were talking about NCAS's ability to get 13:49
6 involved at an early stage. I think paragraph 11 might
7 help with that.
- 8
- 9 "The first stage of the NCAS's involvement in a case is
10 exploratory - an opportunity for local managers or 13:49
11 practitioners to discuss the problem with an impartial
12 outsider, to look afresh at a problem and possibly
13 recognise the problem as being more to do with work
14 systems than a doctor's performance, or see a wider
15 problem needing the involvement of an outside body." 13:49
- 16
- 17 Is that what you were describing there about NCAS
18 getting involved in an early stage?
- 19 A. Yes, that's what I would mean.
- 20 344 Q. In your opinion, does that paragraph accurately 13:49
21 summarise the benefits of NCAS getting involved at an
22 early stage?
- 23 A. Well, it could probably be expanded but since there --
24 you know, it has never been rewritten. There are a lot
25 of problems, as you know, with the document. This 13:50
26 wouldn't be one of the major ones, as I see it, but it
27 definitely could benefit from some rewriting.
- 28 345 Q. If I might then turn to some of the specifics then in
29 this case. My understanding is that your first

1 involvement was on 28th December 2016. There's an
 2 internal NCAS note as WIT-53523. This is, in fact, an
 3 internal NCAS note of a call from the Trust; is that
 4 correct?

5 A. That's right, yes. 13:50

6 346 Q. It says:

7

8 "Time taken: 11.30 on 28 December."

9

10 That was shared with you, I believe at 11.44. Is this 13:51
 11 all the information you would have had prior to
 12 contacting the Trust?

13 A. Yes.

14 347 Q. It says here "RB", I assume that's refers to referring 13:51
 15 body?

16 A. Yeah.

17 348 Q. "...had a serious adverse incident investigation that
 18 flagged up a problem with this doctor's review of
 19 a patient with cancer. The patient came to some harm.
 20 Due to delay they may have come to more harm. 13:51
 21 The review has highlighted some issues with the doctor's
 22 review system and lack of updating the system with
 23 patient notes, possibly taking the notes home and not
 24 returning."

25

26 You received this page at 11.44. You do then speak to
 27 Dr. Wright that day. Can you recall what time you
 28 spoke to Dr. Wright?

29 A. No, I don't recall the time. 13:51

1 349 Q. whenever you spoke to Dr. Wright and before you spoke
2 to Dr. Wright, were you aware that Dr. Fitzpatrick had
3 looked at this case some three months?
4 A. I can't remember that specifically.

5 350 Q. If we call up your advice letters, this is at 13:52
6 WIT-53455. I'm hoping this will assist. If you would
7 scroll down to the first substantive paragraph. This
8 is the following day. In this letter you refer to
9 advice which your colleague Dr. Fitzpatrick had
10 previously discussed with Mr. Gibson? 13:52
11 A. Yes, but it had then been flagged up to me that this
12 was already a case that we had. There was a mistake,
13 I think, with the number. I think that's on the file
14 somewhere. So we didn't automatically match them as we
15 would normally do. They're matched on case number when 13:52
16 a new case comes in. So I may well have done the call
17 without knowing that Dr. Fitzpatrick had -- but it's
18 not something I recall. I know by the time I did the
19 letter, obviously, which would have been fairly soon
20 afterwards, I would have thought, that I did know but 13:53
21 I can't be sure whether I knew or didn't know.

22 351 Q. Your letter goes out the following day. So, clearly
23 you gave this some urgent attention. Just so I'm
24 clear, you're saying that normally, in normal
25 circumstances if a case comes back to NCAS the system 13:53
26 in some way links it?

27 A. It links it, yeah.

28 352 Q. And in that scenario would you have the ability to
29 easily and quickly pull up previous advice?

1 A. Yes. Yes.

2 353 Q. You're saying there may have been an issue with
3 linkage, if I can use that term this case?

4 A. Yeah, that's right. If you don't have the right number
5 the case won't be linked. And we do link cases that 13:53
6 come from the same employer. It goes back to the same
7 number. If it's a new employer we would get a new
8 number linked to the case.

9 354 Q. So, this time you can't say whether or not you'd seen
10 Dr. Fitzpatrick's advice? 13:53

11 A. I don't know, really.

12 355 Q. In a perfect world would you --

13 A. Obviously, yes, in a perfect world I definitely would.

14 356 Q. On that note then, Dr. Fitzpatrick obviously had dealt
15 with this in September or at least taken the call. You 13:54
16 outlined in your witness statement that you believe
17 Dr. Fitzpatrick wasn't available as he works part time.
18 Would it have been preferable had this been kept with
19 Dr. Fitzpatrick do you think?

20 A. Well, we do try to make keep cases with the same 13:54
21 adviser. It makes for continuity of care. But it
22 wouldn't be uncommon for an adviser not to be available
23 and then it to be allocated to somebody else and then it
24 would be a judgement call about who keeps it.

25 357 Q. I don't particularly want to labour the point. If 13:54
26 we go to AOB-01049, please. This is a copy of
27 Dr. Fitzpatrick's initial advice. I fully accept what
28 you're saying, that you may not have seen this at the
29 time. Having reviewed this since, do you consider that

1 there's perhaps quite a lot of useful information which
 2 you could have used going into that phone call?

3 A. Yes.

4 358 Q. If we look at the very bottom of that page, there's
 5 reference to as well as perhaps a series of issues 13:55
 6 there's also reference to delayed referral to oncology.
 7 what you're told about the SAI subsequently is perhaps
 8 the outworkings of such a process; would you agree?

9 A. It could have been, yes.

10 359 Q. If we go over the page, Dr. Fitzpatrick offers a series 13:55
 11 of advices or suggestions about how to deal with the
 12 problem. He suggests that removal of charts could be
 13 dealt with via disciplinary action. That there could
 14 be a audit of what's described as poor note-keeping or
 15 note-taking. Then he says: 13:56
 16
 17 "The problems with the review patients and the triage
 18 can best be addressed by meeting with the doctor and
 19 agreeing a way forward.
 20
 21 We discussed the possibility of relieving him of
 22 theatre duties in order to allow him the time to clear
 23 his backlog. Such a significant backlog will be
 24 difficult to clear." 13:56
 25
 26 At the time you speak to Dr. Wright, so far as you can
 27 recall are you aware of these recommendations or
 28 advises from Dr. Fitzpatrick?
 29 A. I don't recall.

1 360 Q. I suppose if the system is working appropriately
2 you should have been linked to this and then in the
3 course of your call with Dr. Wright you could have
4 almost -- I don't want to use the term marked the
5 Trust's homework, but you could have ticked off, you 13:56
6 could have asked them what's been done about issues
7 about notes, issues about triage, whether or not
8 support was offered. You weren't able to do that on
9 your call?

10 A. Well, I'm presuming that's the case. 13:57

11 361 Q. Forgive me for the jumping around. We're going to go
12 back to WIT-53455, please, which is again your letter
13 of 29 December.
14

15 what can you recall Dr. Wright telling you in that 13:57
16 phone call?

17 A. I do recall that he seemed very concerned and I recall
18 that he was very keen on formal exclusion when he spoke
19 to me.

20 362 Q. The first thing you mentioned there was very concerned. 13:57
21 what was he very concerned about?

22 A. Well, the allegations, as he set them out to me,
23 sounded very concerning. You know, slowness of
24 triaging. The removing of a substantial number of
25 charts, that worried me a lot, as did the reappearance 13:58
26 of a chart.

27 363 Q. Just scroll down, please.
28
29

1 what was discussed with you about a Serious Adverse
 2 Incident?

3 A. Just that the patient a had come to harm. I didn't
 4 realise this was an historic event. I thought it was
 5 relevantly recent. That's how I described it, I think, 13:58
 6 "a recent Serious Adverse Incident."

7 364 Q. So, we're looking at the third paragraph. You say:
 8
 9 "A recent Serious Adverse Incident has caused concern
 10 that there is potential for patients to be harmed by 13:58
 11 the ongoing situation."

12
 13 As you say, your understanding of "recent" was that the
 14 incident itself had happened recently?

15 A. Yeah. That was my understanding, yes. 13:59

16 365 Q. Can you recall in any way what Dr. Wright said to you
 17 about the incident?

18 A. I can't recall.

19 366 Q. I do appreciate there's been quite some passage of
 20 time, okay? You're now aware that the failure to 13:59
 21 triage happened around late September 2014 and that
 22 this was picked up by another consultant urologist in
 23 January 2016. When did you become aware of the fact
 24 that the SAI perhaps wasn't as recent as you thought it
 25 was? 13:59

26 A. Only when I got the information recently for the
 27 Tribunal.

28 367 Q. Would you have expected Dr. Wright to make it clear to
 29 you that the SAI, although it was in the process of

- 1 reporting, in fact happened some time ago?
- 2 A. Well, yes. I suppose I would, really. I can't imagine
3 I categorised it as recent if -- but he might have said
4 the recent -- you know, it's hard to know now whether
5 he said a recent Serious Adverse Incident or maybe he 14:00
6 said the recent Serious Adverse Incident Report, and
7 I didn't make the designation, although the report you
8 would have expected to be concluded in a little bit
9 more timely fashion.
- 10 368 Q. Had you known that the SAI, in fact, was perhaps a bit 14:00
11 more, I don't want to use the word historic but a bit
12 further back in time, would that have changed your
13 advice to Dr. Wright in any way?
- 14 A. Well, I might have asked why he was so worried now.
15 But, again, if it was the report coming, presumably 14:00
16 there was something in the report that worried him
17 more.
- 18 369 Q. Can you recall if you were provided with any specific
19 details about the SAI and what it uncovered?
- 20 A. No. I can't remember. 14:00
- 21 370 Q. I think, given perhaps what we've discussed already
22 this afternoon, would you have asked?
- 23 A. I don't remember whether I would have asked or not.
- 24 371 Q. Thank you. We'll just keep working our way through
25 this letter. I think that's the bottom paragraph on 14:01
26 the page then, where it states:
27
28 "As you're aware, the concerns about Dr. 18665 should
29 be managed in line with local policy and the guidance

1 in MHPS. We discussed that as the information to date,
 2 no noted improvement, despite the matter having been
 3 raised with Dr. 18665 suggests that an informal
 4 approach is unlikely to resolve the situation, a more
 5 formal process is now warranted." 14:01

6
 7 I want to ask you some questions specifically about the
 8 phrase "no noted improvement, despite the matter having
 9 been raised with Dr. 182655."
 10 14:01

11 what did you understand had been going on in the Trust
 12 here with this doctor?

13 A. I understood that he had been made aware of the
 14 concerns but that there had been no improvement. He
 15 was still not keeping proper records, he was still slow 14:02
 16 to triage, he still was removing charts and not
 17 bringing them back.

18 372 Q. As we discussed, you may or may not have been aware at
 19 the time of your call about Dr. Fitzpatrick's advice,
 20 but at the time of drafting your letter you're 14:02
 21 definitely aware of Dr. Fitzpatrick having offered
 22 advice?

23 A. Yeah.

24 373 Q. When you say "no noted improvement, despite the matter
 25 having been raised with Dr. 18665", did you think the 14:02
 26 matter had been raised recently with Mr. O'Brien? Was
 27 that the impression that you were given?

28 A. That would have been the impression I had. I thought
 29 it was recent.

- 1 374 Q. while there was various, perhaps, attempts in the Trust
2 to start some type of informal process or engage with
3 Mr. O'Brien, for one reason or another Mr. O'Brien was
4 spoken to in March 2016 and then wasn't actually spoken
5 to again by senior management in the Trust about these 14:03
6 concerns until the day after this letter. What are
7 your reflections on that with regard to the advice you
8 offered to the Trust here? Would you have offered the
9 same advice that a formal process was now to follow had
10 you known no one had spoken to Mr. O'Brien for some 14:03
11 nine months at this stage?
- 12 A. That's a difficult question. I think it was very
13 regrettable that nothing substantial had been done but
14 I must say that the matter -- you know, he should have
15 had the opportunity to address these issues. And 14:04
16 I think had he been given the opportunity, things might
17 have been different but I still felt that the
18 allegations were quite serious on a first off. There
19 was the real potential for harm here. And if you
20 scroll down the letter further you'll see about a chart 14:04
21 appearing, that troubled me greatly. You know,
22 I was -- I thought, you know, that the allegation there
23 is that, you know, the unspoken allegation, I suppose,
24 is that that chart was brought back by him and
25 I thought there was something, you know -- well, 14:04
26 something unprofessional about that if, indeed, it had
27 been him that left the chart back.
- 28 375 Q. Again, the complicating factor here is whether you were
29 or were not aware of Dr. Fitzpatrick's advice. But

1 definitely in September 2016, Dr. Fitzpatrick, on
 2 looking at a very similar set of concerns, advises that
 3 the Trust, at least in part, should engage in some sort
 4 of informal process - he doesn't use these words, I'm
 5 paraphrasing - or a supportive process with 14:05
 6 Mr. O'Brien. Your advice here, at the end of December,
 7 is that a more formal process is now warranted. What
 8 exactly had changed?

9 A. Well, even with the benefit of hindsight the SAI is
 10 worrying the Medical Director enough that he wants to 14:05
 11 formally exclude him, you know. So, presumably his
 12 situation has changed between September and December
 13 and he's the one that's medically qualified and
 14 possibly better qualified to make that judgment than
 15 I am, in those circumstances, with the SAI. 14:05

16 376 Q. I might just ask you to expand on that. Is there any
 17 suggestion there that there was a bit of a power
 18 imbalance between you and Dr. Wright here?

19 A. I think we have different skills. I don't have any
 20 difficulty challenging people where I think it's 14:06
 21 inappropriate, but if they are worried about a clinical
 22 issue, a specific event - and I haven't seen this SAI
 23 myself, you know - I think that does make you reflect
 24 in the world in which we live. You know, if he's so
 25 worried that he wants to formally exclude him. You 14:06
 26 know, it would be easy for me to say now maybe
 27 you should have done an informal process, but I think
 28 if patients are being harmed, well then, you do have to
 29 bear that in mind as well.

- 1 377 Q. It's your evidence to this Inquiry that you really
2 didn't really have any further details on that SAI but
3 for the fact there had been an SAI and that Dr. Wright
4 was concerned?
- 5 A. Not that I can recall but we wouldn't have gone into -- 14:07
6 even if he had told me the details of it, I wouldn't
7 have necessarily put them in the letter because you
8 don't really envisage that, you know, that your letters
9 will be... Dr. Wright and I obviously had a fair idea,
10 we had the conversation, so it reflects where we got to 14:07
11 in that conversation but now, looking at it with the
12 benefit of hindsight, it's very difficult for me to
13 say.
- 14 378 Q. Dr. Lynn, I do appreciate that we are looking at
15 a number of years after the event. 14:07
- 16 A. Yes.
- 17 379 Q. My final question on this specific is whether you knew
18 at the time or not, the SAI really related on one level
19 - I think there is some dispute about this - to
20 a failure of triage or a missed triage. It was really 14:07
21 on one reading could be no more than the natural
22 outworkings of the types of concerns reported to Dr.
23 Fitzpatrick, i.e. patients might not have been triaged,
24 there might have been delayed in patients receiving
25 treatment. Looking at these two letters with the 14:08
26 benefit of hindsight, was there sufficient escalation,
27 perhaps, in the nature of concerns to justify a formal
28 investigation. To be clear, I'm asking you to reflect
29 with the benefit of hindsight. You couldn't know what

1 you didn't know at the time.

2 A. well, you know, I think you could have given an

3 informal process a try. Obviously that's something

4 that Dr. O'Brien was very upset about. So, it may

5 have -- you may have been able to work through it more 14:08

6 favourably if it had been an informal process. I don't

7 honestly.

8 380 Q. On the call, or what you can remember of the phone

9 call, can you remember Dr. Wright informing you that an

10 informal process had, in fact, been tried? 14:09

11 A. No, I don't recall.

12 381 Q. The last sentence there then is "a more formal process

13 is now warranted".

14 A. Yes. I suppose it was the "no noted improvement

15 despite the matter having been raised with him". They 14:09

16 haven't gone to a formal process without having spoken

17 to him and given him an opportunity to address it.

18 I agree that he wasn't supported to address it but he

19 certainly had an opportunity in March.

20 382 Q. I suppose what I would like to ask you about now is you 14:09

21 say there a more formal processes is now warranted. At

22 the time of your phone call with Dr. Wright, were you

23 aware that a decision, whether in principle or

24 otherwise, had already been taken to start a formal

25 investigation into Mr. O'Brien? 14:10

26 A. No.

27 383 Q. Where I'm getting that from is minutes from an

28 Oversight Committee which took place on 22nd December

29 2016. If we could have a look at TRU-251442, please.

1 Just down toward the very bottom under the heading
 2 "Consideration of the Oversight Committee". This is
 3 22nd December, the meeting attended by Dr. Wright, the
 4 HR Director Ms. Toal, and others.

5
 6 "In light of the above, combined with the issues
 7 previously identified to the Oversight Committee in
 8 September, it was agreed by the Oversight Committee
 9 that Dr. O'Brien's administrative practice had led to
 10 the strong possibility that patients may have come to 14:10
 11 harm. Should Mr. O'Brien return to work, the potential
 12 of his continuing administrative practices could
 13 continue to harm patients would still exist.
 14 Therefore, it was agreed to exclude Dr. O'Brien for the
 15 duration of a formal investigation under the MHPS 14:11
 16 guidelines using an NCAS approach".

17
 18 That's 22nd December. Were you aware at all of those?

19 A. No, not at all.

20 384 Q. Would you have been expected to be advised that the 14:11
 21 decision had already been made?

22 A. To be honest, no, because it flies in the face really
 23 of what's an MHPS. So, you know, I'm not surprised
 24 he didn't tell me that they'd made the decision
 25 already, although, as somebody pointed out, it might 14:11
 26 have been a decision in principle.

27 385 Q. In fairness to Dr. Wright, his evidence to this Inquiry
 28 was that had anything contradictory come back from
 29 NCAS, he would have considered that.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

But under the MHPS Framework, should NCAS have been advised there was to be a formal investigation or they were considering a formal investigation before that decision was made?

14:12

A. I think that would be better. D to be fair to Dr. Wright as well, he did change his mind in that it was an immediate exclusion and it only lasted for four weeks. Again, that's something I only discovered more recently, that the doctor returned to practise with restrictions then.

14:12

386 Q. I'll come on to the exclusion aspect of this in a moment. You mentioned it would have been preferable for Dr. Wright to have sought advice before making that decision. In your opinion, in what way would it have been preferable?

14:12

A. Well, I think it's just -- it may not have changed the outcome but I think, you know, it's better than that you can go back to your Oversight Committee with the information before they make the decision.

14:13

387 Q. If we look then, just the next sentence of that Oversight Committee meeting:

"It was agreed for Dr. Wright to make contact with NCAS to seek confirmation of this approach".

14:13

Then he goes on about a meeting of Dr. O'Brien -- Mr. O'Brien. On that call did you understand that Dr. Wright was seeking confirmation or was he seeking

1 advice?

2 A. I thought he was seeking advice, given I didn't know
3 the decision had been considered at Oversight
4 Committee.

5 388 Q. I would like now to just return to your letter of 14:13
6 29th December. We're making progress, we're on the
7 second page. WIT-43456 this time, please. Your final
8 comment on the previous page was a more formal process
9 is now warranted. At this stage you're offering the
10 Trust perhaps some information on how to set up that 14:14
11 process.

12
13 The first paragraph I'm particularly interested, about
14 four lines down where you offer the suggestion or
15 advice: 14:14

16
17 "The investigation should not be an unfocused trawl of
18 Dr. 18665's work...."

19
20 what was your thinking in offering that advice? 14:14

21 A. I think it's very important to have terms of reference
22 which reflect the allegations that have been raised.
23 I know this was discussed in some detail this morning
24 with my colleague, but the other thing that I did talk
25 about was a lookback, and I think that's something that 14:14
26 people don't think so much about. So, had the lookback
27 been done, probably the information would have been
28 found at that point which are supported adding to the
29 terms of reference. When we do our training, this is

1 something we talk about a lot, the investigation should
 2 be to a focused terms of reference. Patients coming to
 3 harm is obviously the main priority, so you don't want
 4 to have to investigate huge -- I mean, the
 5 investigation took them some 18 months. You don't want 14:15
 6 to make the job any more difficult than it already is.

7
 8 But the patient then lookback focuses on if there are
 9 any issues for Patient Safety. That might have flagged
 10 up that there were other issues that should come into 14:15
 11 an investigation and could properly have come into an
 12 investigation had there been a patient lookback.

13 389 Q. You do, quite rightly, point out that your advice
 14 doesn't stop at the words "unfocused trawl". If goes
 15 on to suggest that if there are concerns about adequate 14:16
 16 treatment or adequate records, this could be managed
 17 separately with an audit lookback to ensure that
 18 patients have the appropriate standard of care.

19
 20 Are you proposing, in fact, a separate process, 14:16
 21 a parallel process?

22 A. Parallel but separate, yes, absolutely. Because if you
 23 give that job to the case investigator, it would be far
 24 too broad. It's a priority, obviously, to identify any
 25 patients that have been inappropriately managed. 14:16

26 390 Q. On this comment about the unfocused trawl, Dr. Wright
 27 offered some evidence about this, and this appears at
 28 TRA-02622. This is Dr. Wright's evidence to this
 29 Inquiry. At the very top of that page he's here saying

1 "the investigation should not be an unfocused trawl",
 2 so that is in reference to your advice.

3
 4 "My experience is that it was virtually always their
 5 advice. They were very against a wide net because 14:17
 6 you're more likely to run aground in the investigation
 7 and it can be considered unfair, so you need really
 8 hard evidence for that".

9
 10 First of all, do you agree with Dr. Wright's statement 14:17
 11 there?

12 A. I do agree with it.

13 391 Q. This advice about unfocused trawls, is that standard
 14 advice from NCAS to a body such as a Trust?

15 A. It is certainly what we talk about in the case 14:17
 16 investigation training, so yes.

17 392 Q. If you expand to me what the thinking is underneath
 18 that advice. Is it to protect patients, is it to
 19 protect practitioners, or is it to protect Trusts?

20 A. As I mentioned earlier, the unfocused trawl is to 14:17
 21 concentrate on an investigation that can be done in
 22 a timely way. Its primary purpose is to establish
 23 facts. Protecting patients is more important but it is
 24 something which should be done separately, either with
 25 restriction of practice, should that be necessary, or 14:18
 26 exclusion, and then things like lookbacks that can be
 27 managed separately.

28 393 Q. In your opinion is the NCAS advice too conservative in
 29 these scenarios in advising --

- 1 A. Well, I'm not sure because if you investigate too
 2 widely, you know, you'll be criticised for that.
 3 I mean, we can see this investigation ran aground
 4 anyway. You know, it's very, very difficult for Trusts
 5 to get a balance. You could say with hindsight did 14:18
 6 they ignore things; was the unfocused trawl relied upon
 7 to make the investigation too narrow? But you have to
 8 bear in mind the investigation gave the case manager
 9 the ability to think the matter should go to a conduct
 10 hearing. It did get a result, albeit there were other 14:19
 11 things going on that should have been addressed. But
 12 I think, and I still think, that those should have been
 13 addressed with a lookback at that time. I think that's
 14 essentially what eventually happened. I wasn't
 15 involved in the case really more recently obviously, 14:19
 16 but my understanding just from what I've seen in the
 17 media, really, is that that's what eventually happened,
 18 there was a lookback.
- 19 394 Q. There's a definitely more formal perhaps lookback in
 20 2020. During the course of the investigation, 14:19
 21 I suppose clinics are looked at in terms of issues of
 22 dictation, stuff like that. Is that what you are
 23 referring to? Which of those two exercises are you
 24 referring to there?
- 25 A. Well, I don't know the detail of them, really. Either 14:19
 26 of them, I suppose.
- 27 395 Q. In this scenario you have a Trust coming to you with
 28 what you describe in your letter as increasing
 29 performance concerns. There's an escalating,

1 seemingly, concern here?

2 A. Yes.

3 396 Q. There's poor record-keeping, slowness of triage
4 referrals and arranging reviews, substantial number of
5 charts at home, and then you're being told about an SAI 14:20
6 where there's at least potential for patient harm,
7 presumably which could be repeated.

8
9 In this scenario would NCAS ever say to a Trust,
10 listen, I think perhaps a formal investigation is 14:20
11 merited but you need to go away and conduct a fuller
12 screening at this stage just to make sure all the
13 issues have been identified? would that ever form part
14 of NCAS's advice in this scenario?

15 A. I think it's a reasonable thing to suggest, that they 14:20
16 have done a screening. But I think my view in this
17 case was that the screening had been done but I think
18 it is a fair point, it's something that might need
19 addressed in more detail in future, that has the
20 screening been properly done at the start? 14:20

21 397 Q. I suppose this Inquiry and the circumstances which
22 directly led to the establishing of this Inquiry was
23 the uncovering of additional concerns in 2020.

24 A. Mm-hmm.

25 398 Q. And one question the Inquiry would have to consider is 14:21
26 why those concerns weren't uncovered earlier as part of
27 the MHPS investigation, which took place over
28 18 months. An angle which could be taken might be that
29 the parameters of that investigation, the terms of

1 reference were set too narrow from the start. That in
2 effect the Trust were only looking at what they knew,
3 as opposed to establishing or satisfying themselves
4 that there's no patient safety concerns or any further
5 patient safety concerns and NCAS advice may have played 14:21
6 into that. What do you say in response?

7 A. Well, I wouldn't really agree with that because I'm
8 still back to the point of, you know, they did come to
9 a conclusion that the matter should go to a conduct
10 hearing which would have given them an opportunity to 14:22
11 draw a line under it and presumably monitor
12 Dr. O'Brien's performance to ensure it didn't happen
13 again. I mean, if patients were still being harmed,
14 that's a completely separate issue and we need to look
15 at why the restrictions that were in place weren't 14:22
16 sufficient to prevent that. If you're saying to me
17 that patients continued to be harmed whilst this
18 investigation was going on and after it concluded,
19 obviously that's a huge problem. The biggest problem
20 is why were the restrictions removed? The problem had 14:22
21 never been addressed. They never got to a conduct
22 hearing. They never really got to an
23 acknowledgment that there was anything -- I mean
24 I don't think Dr. O'Brien acknowledged that he accepted
25 the findings. You know, in those circumstances, how 14:22
26 was he continuing to work without some sort of
27 supervision in place? That, for me, is the biggest
28 issue.

29 399 Q. We'll maybe get on to some issues of that nature.

1 I would just like to continue working through your
 2 advice from 29 December. If we call up on screen
 3 WIT-41394, please. Are you familiar with this
 4 document? This is produced by NCAS, it's entitled "How
 5 to conduct a local performance investigation"? 14:23

6 A. Yes. I know we discussed this document this morning
 7 with Colin. I thought this was a document that wasn't
 8 in use anymore. It's not a document I've seen. It
 9 wouldn't be on our website. But trust me, I have it.
 10 It definitely was a document that we used and that NCAS 14:23
 11 drafted. And it's very worrying that some of what's in
 12 it conflicts, obviously, with what we now are telling
 13 people to do.

14 400 Q. We're talking about 2016 here and I think at the time
 15 the Trust internal guidelines referred to this specific 14:24
 16 document as a useful source of guidance. Would you
 17 have ever relied on this?

18 A. I would have used it more when I was advising in
 19 primary care. So, I wouldn't really have used it in
 20 any secondary care setting. Primary care, you know, 14:24
 21 obviously the practitioners are independent contractors
 22 so, you know, they don't have the MHPS format.

23 401 Q. So it's your understanding -- are you saying this is
 24 primarily for primary care or are you saying just in
 25 your experience you used it for primary care? 14:24

26 A. In my experience I didn't use it really for secondary
 27 care and I haven't seen -- well, I'm retired since
 28 a few years but I haven't seen it in a number of years.
 29 Certainly, since we started the case investigator

1 training. So, I'm not sure -- obviously if it was
 2 never withdrawn -- I don't know whether documents get
 3 withdrawn once they're out of date. I can't see a date
 4 on that here. Is there a date on the document?
 5 402 Q. It's dated 2010. I do believe it's still available on 14:25
 6 the NCAS website. Perhaps that's a question more for
 7 PPAs as opposed to for you today, Dr. Lynn.
 8
 9 If we could look at WIT-41407, please. If we look at
 10 just above a rather large orange box. Scroll down. 14:25
 11 Yeah, perfect.
 12
 13 "Terms of reference should be tight enough to prevent
 14 an unfocused general investigation of everything
 15 concerning the practitioner." 14:25
 16
 17 So, that reflects the advice which you put in your
 18 letter. But if we move back, almost, into the
 19 document, to WIT-41399. Scroll down, please, to 1.1,
 20 the second paragraph. It says: 14:25
 21
 22 "Terms of reference have to be determined based on what
 23 is known at the time an investigation is set up. If,
 24 later, a substantial issue comes to light that is
 25 outside the initial terms of reference, the terms can 14:26
 26 be reviewed and, if necessary, changed to ensure that
 27 the investigation covers the new issue."
 28
 29 Now you've already gone into your discussion about

1 having some type of audit and lookback --

2 A. Mm-hmm.

3 403 Q. -- but that's almost sounded like a separate process?

4 A. It can feed into terms of reference, I certain am aware
5 of situations where it does and where practitioners 14:26
6 would have known that that was happening. And when
7 they expressed dissatisfaction about that, we said well
8 it's a very reasonable thing to do. You know, they're
9 not widely investigating, they're doing the lookback in
10 patient's best interests. But if something comes out 14:26
11 of that well then, of course you're entitled to adjust
12 your terms of reference to reflect that.

13 404 Q. would that have been the tenor of your advice on the
14 phone to Dr. wright do you think?

15 A. we didn't have that -- I don't think we had as detailed 14:26
16 a conversation about it as we've had today.

17 405 Q. I'm just going to take you to another section of this
18 document which is actually on the next page, so it's
19 41400. Now, I fully accept this is entitled: "what
20 should be considered in making a decision to 14:27
21 investigate?" It states there:

22

23 "Before deciding whether a performance investigation is
24 necessary, consider what other relevant information is
25 available. This could include: Clinical or admin 14:27
26 records; serious untoward incidents; earlier statements
27 or interviews; clinical audit; clinical data; the views
28 of appropriate professional advisers; and earlier
29 occupational health reports."

1
2 So, there does appear to be scope here for advice to be
3 offered for bodies to go and, in effect, have a bit of
4 a look.

5 A. Mm-hmm. 14:27

6 406 Q. Do you accept that?

7 A. Oh, yeah.

8 407 Q. But that didn't form the nature of your advice to
9 Dr. Wright on 28 December 2016?

10 A. No. 14:28

11 408 Q. We've covered some of this ground today but just again
12 can you explain why, specifically, you didn't advise
13 the Trust to engage in a slightly larger look or to
14 satisfy themselves?

15 A. Because I think I thought that the threshold had been 14:28
16 crossed.

17 409 Q. I'm going to bring you back to your letter now which is
18 at WIT-53456. I want to explore with you -- if you can
19 scroll down a couple of paragraphs, please. Thank you
20 very much. I want to explore with you what discussions 14:28
21 you had with Dr. Wright about exclusions. So, whenever
22 I took you to this letter first you were very clear to
23 me that you used the words that Dr. Wright was very
24 keen on a formal exclusion. Is that a fair summary of
25 what you told me earlier? 14:28

26 A. Yeah, that's a fair summary.

27 410 Q. What exactly did he tell you about a formal exclusion?

28 A. Well, he told me that they were considering exclusion
29 and I think that he felt that that would be a formal

1 exclusion. I don't know, so we talked about the
 2 criteria for formal exclusion, as set out in the
 3 document, and then we discussed whether an interim or
 4 immediately exclusion would be better because it would
 5 give them the window of opportunity to see whether 14:29
 6 there was really necessary to go ahead with.

7 411 Q. In terms of a formal exclusion, what do you understand
 8 the criteria to be to impose a formal exclusion under
 9 MHPS?

10 A. Well, there are three grounds, really. You know, that 14:29
 11 somebody might interfere with an investigation; patient
 12 safety of grounds or staff concerns about safety; or if
 13 there's a complete breakdown in relationships,
 14 sometimes in a team then it can be necessary as well.

15 412 Q. So, it's your recollection that Dr. Wright was very 14:29
 16 keen on a formal exclusion. What advice did you offer
 17 him?

18 A. Whether an interim exclusion would allow them to time
 19 to think about whether they could safeguard the
 20 situation with restrictions. That would be the line. 14:30
 21 I mean, I don't obviously specifically recall this
 22 telephone call, I'm just basing it on what I would
 23 normally have gone through.

24 413 Q. The paragraph which is reflected in your letter says
 25 you did discuss the criteria for formal exclusion and 14:30
 26 the option of an interim exclusion.

27
 28 "The latter would allow for further information to be
 29 collated and to take account of Dr. 18665's comments

1 about the allegations, before deciding whether there
2 are reasonable and proper grounds for formal
3 exclusion. "

4
5 At this time again, were you aware that a decision had 14:30
6 already been made to exclude?

7 A. No.

8 414 Q. When did you become aware that Mr. O'Brien had in fact
9 been excluded and that it was an immediate exclusion?

10 A. I don't think I knew that until relevantly recently 14:31
11 because he was -- obviously, I never was in discussion
12 with Dr. Wright again. And I think I've now

13 established that when I was in the case investigator
14 training, when we were doing it, in March I spoke to
15 the case investigator, because we were training people 14:31
16 and she told me she was doing an investigation and she
17 was aware of our involvement. So. I would have known
18 that - that would have been Dr. Chada, I think.

19 We certainly knew then that the practitioner was
20 working with restricted practise. So nobody had ever 14:31
21 told me that he had been immediately excluded.

22 415 Q. Would you have expected to have been told what was the
23 follow-up to this?

24 A. Well, to be fair to Dr. Wright, it's not a requirement 14:31
25 once you've had the discussion to notify -- we don't
26 have the requirement to monitor the way -- because it's
27 such a time-limited thing. You know, the conversation
28 that we'd had would probably satisfy that requirement.
29 But, obviously, because the concern was being viewed so

1 seriously, we did expect that we would have heard back.
 2 But I did know, because I did the case investigator
 3 training there, that there was an investigation and
 4 that the practitioner was restricted.

5 416 Q. The very bottom of your letter then lists a review date 14:32
 6 of 27 January 2017. What's the significance of the
 7 review dates in these letters?

8 A. Well, when you've a case that there are serious
 9 concerns about, such as, you know, exclusion is being
 10 considered, the case would be open and it would be 14:32
 11 reviewed every month. If there wasn't exclusion, it
 12 wouldn't be unusual for us to close cases to allow the
 13 investigation to continue with the proviso that they're
 14 welcome to contact us during, or the case investigator
 15 is welcome to contact us during the life of the 14:33
 16 investigation.

17 417 Q. You stated there that the case would be reviewed every
 18 month, whenever it's open. Are you referring to the
 19 that internal review process that we were discussing
 20 earlier this afternoon, or are you referring to 14:33
 21 intended communication with the Trust?

22 A. Intended communication with the Trust. The file
 23 remains open and the case is open on our system and we
 24 would review it usually monthly.

25 418 Q. Was it for you to contact the Trust or was it for the 14:33
 26 Trust to contact you? How was it left?

27 A. It was -- I would have usually called or emailed my
 28 contacts because it was less likely that the time scale
 29 would slip.

1 419 Q. That review date is 27 January 2017. I just want to
 2 check one matter. If we could have a look at
 3 TRU-285015 please. This is an email from Dr. Khan who
 4 had been appointed the Case Manager, it's dated 26
 5 January 2017, and it's at 18 minutes past one. The 14:34
 6 significance of that is I believe that that afternoon
 7 the Trust held a case conference in relation to
 8 Mr. O'Brien, both the investigation and the exclusion.
 9 Dr. Khan is saying here, "Siobhán", which is
 10 a reference to Mrs. Siobhán Hynds "I have tried to 14:34
 11 contact Dr. Gráinne Lynn, the NCAS adviser but couldn't
 12 get through. Is there any direct number we can try?
 13 I'm now leaving for Crai gavon Area Hospital."
 14
 15 Can you recall ever discussing this matter with 14:34
 16 Dr. Khan on 26 January, prior to that case conference?
 17 A. No.
 18 420 Q. So far as you're aware, is there any records from NCAS
 19 or anything which might show that he tried to --
 20 A. Nothing. We've no record. Although he would not have 14:35
 21 known my direct line. When I emailed Dr. Wright
 22 I would have been sending him my direct number as well.
 23 But Dr. Khan, I think, would not have known that, so...
 24 421 Q. If we can have a look then at you're witness statement,
 25 specifically at WIT-53451. Can we scroll down to 14:35
 26 paragraph 16, please? You state:
 27
 28 "I left it that given the possibly exclusion I would
 29 review the case with the Trust in about a month's

1 time", which is when any immediate exclusion which
2 would have been imposed would have been up".

3

4 Is that your thinking there?

5 A. Yes. 14:36

6 422 Q.

7 "I then sent follow-up emails in January, March and
8 May 2017, and in August 2017 our file was closed as
9 there was no response to my emails".

10 14:36

11 You then go on to repeat that NCAS don't really have
12 a proactive role.

13

14 If we have a look at your emails then. Is we start at
15 your email of 27th January 2017. If we go to 14:36
16 WIT-53537, please. This is an email from you yourself
17 to Dr. Wright.

18

19 "Good morning, Richard. I was hoping for an update on
20 this case. If there is anything you wish to discuss, 14:36
21 I am available today and on Wednesday, Thursday, Friday
22 of next week".

23

24 Can you recall receiving a response to this email?

25 A. No. 14:36

26 423 Q. Are you aware of anyone else in NCAS received
27 a response or an update from the Trust to this email?

28 A. No.

29 424 Q. As I pointed out, I think the date perhaps is

1 significant as the day before, on 26th January, the
 2 Trust held a case conference. If we look at the very
 3 last page of that minute, which is at TRU-00040,
 4 please. I think we're at the very bottom of the page
 5 again, please. While various things were agreed at 14:37
 6 that meeting, including to lift the exclusion and to
 7 bring Mr. O'Brien back on some form of restriction, the
 8 final action was it was agreed to update NCAS in
 9 relation to this case. The action is listed as for
 10 Dr. Wright. 14:37

11
 12 At that time did you receive any type of update from
 13 Dr. Wright?

14 A. No.

15 425 Q. Dr. Wright's evidence to this Inquiry can be found 14:38
 16 a number of places. He gave a response to a Section 21
 17 notice. If we look at WIT-7834, please. WIT-17834,
 18 please. If you could go down to the very bottom of the
 19 page again. This is Dr. Wright's written evidence to
 20 the Inquiry, where he states: 14:38

21
 22 "I informed NCAS of these developments by telephone
 23 over the next few days".

24
 25 If we just jump briefly to Dr. Wright's oral evidence 14:38
 26 to the Inquiry at TRA-03232. Look at line number 13,
 27 please. He says:

28
 29 "I do recall having a phone call and I think it may

1 have been with Gráinne Lynn. The reason I think
 2 I recall it is because we discussed conditions in which
 3 Mr. O'Brien would come back from work after his
 4 temporary exclusion."

14:39

6 Can you recall ever receiving a update from Dr. Wright?

7 A. No.

8 426 Q. I'm well aware you are retired but are you aware of any
 9 type of internal NCAS notes or correspondence which
 10 might indicate that Dr. Wright provided you with an
 11 update?

14:39

12 A. No.

13 427 Q. In response to the pieces of evidence I've shown you
 14 there from Dr. Wright, what do you say in response to
 15 that?

14:40

16 A. I think his wording at the bottom, which is why I'm
 17 pretty sure it happened, and then he talks about it
 18 could have been another case. Does he mention that or
 19 is that...

20 428 Q. He does say "I'm pretty sure that it happened". He is
 21 far from certain, perhaps.

14:40

23 Could we have a look then at WIT-53538, which is an
 24 email from yourself on 30th March 2017. Now, you're
 25 again here seeking an update. It is copied to
 26 a Ms. Thompson, who I believe was a revalidation
 27 manager in the Trust, as well as to Dr. Wright. Why
 28 would it have been sent to Ms. Thompson?

14:40

29 A. I think because I hadn't heard from Dr. Wright. That

1 would be I would normally try to copy it to somebody on
 2 the board in the hope they might come back to me.

3 429 Q. The email reads:

4
 5 "Hi Richard, I called for an update on the case but you 14:41
 6 were unavailable. As I understand it, there is to be
 7 an investigation and there are restrictions on the
 8 practitioner's practice".

9
 10 Perhaps this is referring back to a discussion you had 14:41
 11 with Dr. Chada?

12 A. Chada, yes, on her case investigator training. I know
 13 that, you know -- I've seen information in the file
 14 obviously that, you know, they decided they would need
 15 this training. So we were called in at fairly short 14:41
 16 notice in March to provide training. I know that the
 17 case investigator and the case manager, that's when
 18 I met them both for the first time. They were just,
 19 you know, were saying they had a case. But that isn't
 20 something I would have discussed obviously with the 14:41
 21 case investigator which is why then -- but obviously
 22 Dr. Wright would have known we were in. He wouldn't be
 23 at the training, he had done it before. As
 24 I understand it, because he would have known that I had
 25 probably spoken to the staff that were there. 14:42

26 430 Q. You weren't receiving perhaps a formal communication
 27 from the Trust but you did have information, if I may
 28 say, down informal channels perhaps from a discussion
 29 from Dr. Chada?

1 A. Yes. And Dr. Wright would know about this. Obviously
2 I copied him this email. Maybe that's where he thought
3 he had updated me. If I had received a call from
4 Dr. Wright, I would have recorded it, as in taken
5 notes, not overtly recorded him. 14:42

6 431 Q. I'm particularly interested by your reference here to
7 the word "restrictions".

8

9 "I'm aware there is to be an investigation and there
10 are restrictions on the practitioner's practice". 14:42

11

12 Could we call up TRU-77032, which is a copy of the
13 return-to-work monitoring arrangements for Dr. O'Brien.
14 Are you familiar with this document?

15 A. No. 14:43

16 432 Q. Can you recall if this document was shared with you at
17 the time?

18 A. No. If it was shared with us, it would be on our file.

19 433 Q. I'm not convinced there's much need to go into the
20 precise minutiae of what this says, but you were 14:43
21 understanding that Mr. O'Brien had been restricted.
22 I would suggest that this plan is perhaps much closer
23 to monitoring than a restriction on Mr. O'Brien's
24 practice. Would relevantly intense monitoring of this
25 nature, in your mind, be defined as a restriction for 14:44
26 the purposes of MHPS?

27 A. I think restriction and monitoring are different,
28 obviously. But I think, you know, I got the news from
29 the case investigator who would not have been as

1 familiar with terms, maybe, as Dr. Wright so, you know,
 2 may not have made that distinction. From my point of
 3 view, I was just happy that there was something in
 4 place so that it implied that the Trust had safeguarded
 5 the position. 14:44

6 434 Q. You refer to restrictions in that letter - or that
 7 email, rather, forgive me - to Dr. Wright on 30th
 8 March. We already discussed today the provisions of
 9 MHPS at paragraph 10 which says:

10 14:44

11 "Where an employing body is considering exclusion or
 12 restriction from practice, the NCAS must be notified".

13

14 whenever Dr. Chada told you that Mr. O'Brien had been
 15 restricted, were you shocked or surprised because NCAS 14:45
 16 had not been notified?

17 A. I think because it was an open case, I still thought
 18 that I would be getting -- that I would be hearing from
 19 Dr. Wright. I think our view would be if a case is
 20 open, very often we had covered the thought processes 14:45
 21 of the options of an informal exclusion, about what was
 22 available to them. From that point of view,
 23 restrictions would have been an option to him. So he
 24 may well have thought he met that criteria by the
 25 conversation we'd already had. 14:45

26 435 Q. Just go to TRU-267753, please. 267753, sorry. This is
 27 an internal Trust email between Ms. Siobhán Hynds again
 28 and Dr. Khan, who was the case manager of 22nd
 29 February.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

"It was noted that the action plan agreed for AOB's return to work requires to be shared and discussed with NCAS at this point. Can you please discuss with Dr. Lynn".

14:46

Can you recall the specifics of the plan ever being raised with you?

A. No, I can't. I wonder did it fall between the two stools of Dr. Khan and Dr. Wright, because the previous action was for Dr. Wright, yet Dr. Khan had tried to call me on 20 something of January. So, there does seem to have been a bit of confusion about who was taking it forward with me. I don't know. I don't want to say. You'll have to ask them.

14:46

436 Q. Finally, can we go to WIT-53539, which is your last chasing email to Dr. Wright at this stage, 30th May.

A. Because as far as I was aware, Dr. Wright was still in charge of it.

437 Q. You say:

14:47

"Hi Richard. I was hoping for an update in this case. If you don't need any further NCAS input, I can close the file; it can easily be reopened at any stage".

14:47

Quick question perhaps, what is the significance of a closure of a file within NCAS?

A. It means that we really stop, you know, following it up with them. So we don't know where the -- we don't know

- 1 exactly what is happening. I think it is not uncommon
2 in cases where they are doing an investigation because
3 they know they can contact us if they need to, but it
4 stops us ringing them every hour or emailing them, and
5 the problems of them potentially not coming back to us. 14:47
- 6 438 Q. In this case then you sent three chasers to the
7 Southern Trust. You never received any official
8 feedback or update, although you do accept that you had
9 some discussion with Dr. Chada, you believe. Would it
10 be normal for a Trust to go quiet on the official 14:48
11 channels? Would it be normal for NCAS to chase so much
12 and then have to close a file?
- 13 A. Reasonably normal.
- 14 439 Q. What does that say about the service; about NCAS? Or
15 is it simply a reflection of the realities that NCAS is 14:48
16 dependent on engagement from the Trust?
- 17 A. I think that's so. I think as well it tells you
18 something about the challenging conditions in which
19 they are working in the Health Service, and it is very
20 difficult for a busy medical director to find the time. 14:48
21 Sometimes in their investigation, they are inclined to
22 contact us if they have a problem but if the
23 investigation is continuing and there's nothing to
24 report, well then, they might go very silent.
- 25 440 Q. Silent this went until we get to September 2018; is 14:48
26 that --
- 27 A. Yes, that's correct.
- 28 441 Q. In fact, essentially, over 18 months passed from your
29 communication with Dr. Wright to your contact with

1 Dr. Khan. When this came across your desk were you
 2 shocked or surprised to hear the name again?

3 A. Well, I was very surprised that it had taken so long.
 4 I mean we're used to investigations taking a long time
 5 but this had obviously taken a very long time. So, 14:49
 6 yes, I was surprised that it had come back.

7 MR. WOLFE KC: If we could have a look then at
 8 TRU-251925. I think we're having slight technical
 9 difficulties. I have just jumped 18 months forward in
 10 time. I don't know if now's a good moment to have a 14:49
 11 brief five-minute break?

12 CHAIR: It's just after ten to three, we'll take until
 13 three o'clock then.

14 MR. WOLFE KC: I'm very much obliged. Thank you.
 15 International 3 o'clock. 14:50
 16

17 THE HEARING ADJOURNED SHORTLY AND RESUMED AS FOLLOWS:
 18

19 442 Q. MR. WOLFE KC: Dr. Lynn, thank you. Just before the
 20 break I jumped us forward a fair bit to September 2018. 15:00
 21 Could I just check one point? Obviously Dr. Wright's
 22 evidence is that he did discuss this with you, and by
 23 "this" I mean the MHPS investigation. Is there any
 24 possibility that Dr. Wright and you may have had
 25 a discussion on 7 or 8 March 2017, whenever you were in 15:00
 26 the trust, can you recall?

27 A. I don't recall that Dr. Wright was there, and that's
 28 Colin's recollection too.

29 443 Q. So although you were on Trust premises, you don't think

1 helpful for you?

2 A. It would be unusual enough that we would receive the

3 investigation or something as detailed as that, but...

4 448 Q. Do you recall being -- Dr. Khan sharing it with you.

5 Do you recall requesting it in any way from him? 15:02

6 A. No, I don't recall requesting it.

7 449 Q. Was this the only document you ever saw with regards to

8 this MHPS investigation? So for example, you never saw

9 Dr. Chada's investigation report or Mr. O'Brien's

10 rather detailed comments in response? 15:03

11 A. No, I don't recall that. Anything we have would be on

12 our file so I don't...

13 450 Q. I think in fairness to you, from a look at NCAS's

14 papers, I don't believe there's any copies of those two

15 documents. 15:03

16

17 Can I then turn to your letter at WIT-53458? This is

18 dated 21 September 2018. So, again, it's the next day

19 you're following up in writing. I don't propose to

20 spend as much time on this letter as I did the earlier 15:03

21 December letter.

22

23 If you scroll down, please. Interestingly, this letter

24 starts, the first paragraph is:

25 15:03

26 "PPA encourages transparency in the management of cases

27 and advises that practitioners should be informed when

28 their case has been discussed with us."

29

1 like if you see terms of reference in the completed
 2 investigation, there's not much point in saying you
 3 don't like the terms of reference, because that's what
 4 it is.

5 454 Q. I don't want to incorrectly paraphrase what you're 15:05
 6 saying or put words in your mouth, but really what
 7 you're saying is that you're advising the Trust going
 8 forward --

9 A. Exactly.

10 455 Q. -- that was, to a certain extent, in the past? 15:05

11 A. Exactly.

12 456 Q. Over the page please then. WIT-549. Your letter
 13 includes a relatively detailed list of issues or
 14 concerns, specifically fully detailed consideration,
 15 you noted that, and the list concerns (a) to (g) there. 15:05
 16 On being told of these concerns (a) to (g), can you
 17 recall your level of concern or intrigue?

18 A. Yes. I felt there was very real concern here but
 19 Dr. Khan also was very concerned.

20 457 Q. On that call then, what specifically can you remember 15:06
 21 Dr. Khan being concerned about?

22 A. The risk. Risk to patients and the risk of harm and
 23 the fact that they hadn't really been aware of it. He
 24 addressed some of the issues which he felt were
 25 important. They're set out there really, you know. 15:06
 26 Because Dr. Khan was such a senior member of staff,
 27 that he was in a very -- he should have ensured that
 28 the Trust were aware that he wasn't undertaking triage
 29 as expected. He was very concerned about the private

- 1 patients taking priority over NHS patients.
- 2 458 Q. We'll come on momentarily to the private patients. You
3 said that Dr. Khan was concerned. On reading those
4 list of issues, what were you concerned about?
- 5 A. I thought it was -- I thought it was a very concerning 15:07
6 report. You know, there were a lot of issues I was
7 concerned about.
- 8 459 Q. In terms of your experience as an NCAS adviser, by this
9 stage you had been well over 10 years, I suspect, did
10 you ever come across investigations perhaps with 15:07
11 seemingly so many headlines. We have paragraphs (a) to
12 (g) there?
- 13 A. It was very detailed. You know, it was unusually
14 detailed.
- 15 460 Q. You mentioned the private patients. I would be 15:07
16 grateful if we could scroll down, please. You say:
17
18 "We discussed the current situation and the overriding
19 need to ensure patients are protected. I note you have
20 a system in place within the Trust to safeguard 15:07
21 patients but we discussed that this needs to be
22 mirrored in the private sector. You explained that
23 Mr. O'Brien saw private patients at his home and did
24 not have a private sector employer. I would suggest
25 that as paragraph 22 of Section 2, MHPS states that 15:08
26 'whereas the HPSS employer has placed restrictions on
27 practice, the practitioner should not agree not to
28 undertake any work in that area of practice with any
29 other employer".

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

It was your view then that Dr. 18665 should not currently be working.

You said Dr. Khan -- on this phone call was Dr. Khan concerned about this aspect of the private patients or was this reflective of your advices and your concern? 15:08

A. That was reflective of my advice and my concern. I think Dr. Khan had plenty to worry about with the patients he was responsible for. 15:08

461 Q. From what you've seen of this case, what made it necessary in your mind to suggest or to advise that Mr. O'Brien needed to stop practising privately?

A. There was no ability to put in place any safeguards because there was nobody there. You know, if you are working in private practice where there is a medical director, well then, you know, the Medical Director can be informed of the concerns and take a view as to what restrictions or supervision they need. But Dr. O'Brien was working at home so there was no ability to do that. 15:09

462 Q. Perhaps, as a lawyer I'm conditioned to read things overly literally but it says:

"Where HPSS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer". 15:09

Mr. O'Brien didn't have an employer. He appears to

1 have operated a limited enough private practice in the
 2 sense that it was outpatient consultations from his own
 3 home. Does paragraph 22 of that section of MHPS
 4 actually apply or cover this situation?

5 A. Well, you know, it didn't really -- to be honest, 15:10
 6 I wasn't thinking about what the law might say, I was
 7 thinking about the risk to patients. But that's
 8 something we've come across before. I felt he
 9 shouldn't be working privately so I put it in the
 10 letter. 15:10

11 463 Q. I'm just curious about this little kind of quirk,
 12 perhaps, in the framework. If we go to WIT-53825 and
 13 what I'm going to take you to is an email which you
 14 prepared in December 2019, not in the context of Mr.
 15 O'Brien but you engage in a comparative exercise of the 15:10
 16 English and Wales framework and the Northern Irish
 17 framework. WIT-538125, please. So far as I'm aware,
 18 this is nothing to do with Mr. O'Brien; is that
 19 correct?

20 A. That's correct. 15:11

21 464 Q. Scroll down to where it says Section 2, please. You
 22 say:

23
 24 "The NI version would appear to suggest that the person
 25 could undertake paid or voluntary work when excluded in 15:11
 26 time not paid for by the employer, although they must
 27 not engage in any medical duties consistent with the
 28 terms of the exclusion. In England you must seek
 29 consent to work".

- 1
2 You've clearly done some type of comparative exercise.
- 3 A. Yes.
- 4 465 Q. In your opinion, I was going to say which is clear but
5 perhaps which is more effective of protecting Patient 15:11
6 Safety, if there are concerns?
- 7 A. I suppose when you point that out to me, in England
8 where you must seek consent to work, that seems to be
9 clearer.
- 10 466 Q. In your opinion, the current phrasing of paragraph 22 15:11
11 there, is that a regional, almost kind of kink or issue
12 in our system which could perhaps be ironed out?
- 13 A. It would be one of those that could be addressed.
- 14 467 Q. If you then look at TRU-292465, please. This is,
15 again, very much in the context of your advice 15:12
16 regarding the private patients. You were advising the
17 Trust then in September 2018 that Mr. O'Brien should
18 not be working privately. An undertaking or assurance
19 that Mr. O'Brien would not be working privately was, in
20 fact, secured, but it wasn't until 21st July 2020 when 15:12
21 further concerns had arisen. What's your reaction to
22 that, that action was taken but not perhaps for another
23 18 months plus?
- 24 A. Well, I mean I felt that it should have been taken at
25 the time. We don't have any authority. As you know, 15:13
26 the only people that would have had the authority to
27 stop Dr. O'Brien doing that was the GMC. I mean,
28 Dr. Khan wouldn't have any ability to stop him doing
29 that, especially after he retired.

- 1 468 Q. If we perhaps use that in a context of back to your
 2 advice in September 2018. You're advising the Trust
 3 that Mr. O'Brien should not be practising privately.
 4 At a very similar time the GMC ELA was offering perhaps
 5 similar enough advice to Dr. Khan. Would you have 15:13
 6 expected action to have been taken at that time? -
- 7 A. It would have been, I would have thought, up to the
 8 GMC. They're the regulator. They could have put
 9 conditions on his practice.
- 10 469 Q. But you are advising in September 2018 the Trust that 15:14
 11 Mr. O'Brien should not be practising privately. Whose
 12 responsibilities was it to deal with that?
- 13 A. Well, normally a Trust has a responsibility to contact
 14 the private employer. Of course here we don't have
 15 a private employer, which is a gap and was something, 15:14
 16 I think, was flagged. You know Joanne Donnelly, she's
 17 the GMC ELA, was to check with RQIA is that even
 18 possible. So I don't really feel -- I don't think
 19 really Dr. Khan can be criticised here. I think this
 20 was an issue beyond his -- there was nothing he could 15:14
 21 do. But I put it in black and white I felt he
 22 shouldn't be working.
- 23 470 Q. Thank you for that. Now if we go to WIT-53459 which is
 24 back from the letter we are currently discussing. Down
 25 towards the bottom of this page, please. 15:15
 26
 27 "We discussed that the issues identified in the report
 28 were serious, and whilst there are clearly systemic
 29 issues and failings for the Trust to address, it is

1 for example, if his treatment of patients on the
 2 operating table had been deficient, that would be
 3 a capability. I thought this was quite clearly
 4 a conduct matter, but they always argue about this
 5 because it's much, much easier to manage a conduct 15:16
 6 process than a capability process. So, challenge
 7 around this is inevitable, as far as we were concerned.

8 472 Q. If you could expand on your understanding there. Using
 9 your experience, you've said it is much easier to --
 10 what way did you put it - easier to argue a conduct? 15:17

11 A. It is much easier to manage a conduct process than
 12 a capability process. Clinical performance they call
 13 it in the Northern Ireland version.

14 473 Q. Just again, I'm relying on more your general experience
 15 as an NCAS adviser. Why is that the case that it is 15:17
 16 preferable for a Trust to go down conduct but
 17 practitioners wish to go down the clinical performance
 18 route?

19 A. Well, we had a court ruling in England that you
 20 couldn't go to capability without an NCAS performance 15:17
 21 assessment. I think it was a misunderstanding, really,
 22 around the process. That was eventually overturned and
 23 it was if the capabilities issues are clearly
 24 understood, then you can go directly to a clinical
 25 performance, but it's very -- that's quite difficult 15:18
 26 and much more difficult to prove.

27

28 A conduct issue is very straightforward. If somebody
 29 isn't doing what they have been asked to do, well,

1 that's misconduct. If you are taking charts home that
 2 you've been asked not to bring home, that's misconduct.

3 474 Q. This is you, as you've just said, summarising your
 4 advice to Dr. Khan. What was Dr. Khan's position on
 5 the call? 15:18

6 A. Dr. Khan's position was very, very much that he
 7 regarded it himself as a conduct issue. They
 8 considered him a capable clinician, he just wouldn't
 9 follow the Trust instructions.

10 475 Q. Scroll over to the next page. This is the perhaps the 15:18
 11 key issue I want to explore with you in this letter,
 12 please. The very top of this page.

13

14 "Dr. 18665 could also be offered support going forward
 15 to ensure that in the future he is able to meet and 15:19
 16 sustain the required and expected standards".

17 A. Yes.

18 476 Q. You quickly move on in the next paragraph to say:

19

20 "I told you that whilst there are no noted clinical 15:19
 21 performance concerns, practitioner performance advice
 22 could offer support via the professional support and
 23 remediation team by drafting a robust action plan with
 24 input both from Dr. 18665 and the Trust to address some
 25 of the deficiencies which have been identified". 15:19

26

27 You then state:

28

29 "The purpose of the plan would be to ensure oversight

1 and supervision so the Trust is satisfied there's no
 2 risk to patients, but also to provide support to
 3 Dr. 18665 to afford him the best opportunity of meeting
 4 the objectives of the plan. We know this might involve
 5 job planning and enhanced appraisal".

15:19

6
 7 what you are describing there is an invocation of the
 8 PSR service, which we discussed earlier.

9
 10 Is it standard advice in all cases for NCAS to suggest
 11 involvement of the PRS team, or was this specific
 12 advice and recommendation you made based on what you
 13 heard about this case?

15:20

14 A. This was specific really related to this case, but
 15 I had seen it in a couple of other cases. So the
 16 conduct issues. You're going to a conduct hearing,
 17 that was the open anticipation, but the conduct issues
 18 are not likely to lead to termination of employment.
 19 Therefore, you want to be sure you give the
 20 practitioner the best chance to come back to work. So
 21 that some of the objections, for example, that might
 22 have been open to the Panel would be a warning along
 23 with a requirement that he go through a plan. The
 24 plan, as was pointed out this morning, is very, very
 25 detailed so it is very well monitored, so there's a lot
 26 of evidence underpinning it. They either make it
 27 through the plan or they don't, in which case the
 28 options are much more straightforward.

15:20

15:20

15:20

29 477 Q. On reading the suggestion it appears to offer almost

1 the best of every world. It offers the Trust a chance
 2 to protect patients, to ensure Mr. O'Brien is working
 3 to required and expected goals and, as you said there,
 4 he is regarded as a very capable surgeon. It also
 5 offers Mr. O'Brien support in order to work through his 15:21
 6 issues. So, it would appear to be a pretty good
 7 potential solution to this?

8 A. Yeah. That's the thing, these were not -- given his
 9 track record and everything he'd done for the Trust,
 10 this was never going to be a dismissal kind of 15:21
 11 situation. But obviously they felt very strongly
 12 about -- Dr. O'Brien felt very strongly about not going
 13 to a conduct hearing.

14 478 Q. You mentioned there:
 15
 16 "Since we spoke, I've talked to the PSR team and will
 17 arrange for the forms, which must be completed to
 18 formally request the PSR support plan." 15:21

19
 20 Those forms were, in fact, sent out that day on 21 15:22
 21 September 2018. Did NCAS or PPA, as it was then, then
 22 ever receive a request from the Trust to engage that
 23 PSR process?

24 A. No.

25 479 Q. On the call -- you mentioned the suggestion on the call 15:22
 26 with Dr. Khan?

27 A. Yes. Yes.

28 480 Q. Did he appear to be supportive or interested?

29 A. I think he was, yeah.

- 1 481 Q. Did you have any further discussions with Dr. Khan
2 specifically about this PSR process? We're going to
3 come on shortly to you speaking to him on 31 October.
4 But did you ever speak to Dr. Khan again about using
5 this process? 15:22
- 6 A. Not that I recall.
- 7 482 Q. As I said there, you did end up speaking to him again
8 in October.
- 9 A. Mm-hmm.
- 10 483 Q. On that call did you say: 'Dr. Khan what about those 15:22
11 forms?' Did you raise it with him?
- 12 A. I can't remember. I'd need to see -- I don't remember
13 raising it with him again because I think there were so
14 many additional issues arising at that time. I mean,
15 to use the PSR forms to their best effect they would 15:23
16 have been combined with some sort of conduct process.
17 So, if they couldn't get him to a conduct hearing they
18 would probably -- I mean I can't second guess what they
19 were thinking, but possibly they wanted the two to go
20 together. 15:23
- 21 484 Q. Well, we know that the grievance only comes in, I
22 believe, at the end of November --
- 23 A. Mmm.
- 24 485 Q. -- so there is a period of time here before -- we'll 15:23
25 come on in a very brief moment to Dr. Khan's
26 determination, but is there anything stopping this PSR
27 process running alongside a wait for a grievance or a
28 conduct hearing, as in could the two processes, while
29 informing each other, run in parallel; i.e. we could

1 have started the PSR process but still just waiting on
 2 the conduct, and subsequently grievance hearings? Was
 3 there anything stopping that?

4 A. No, there's nothing to stop that.

5 486 Q. If we look at your advice letter again, we're still 15:24
 6 there actually so scroll down to the very bottom,
 7 please. You've a review date this time of 24 September
 8 2018. That's a very tight kind of time.

9 A. It's probably an error, I would say. What date's on
 10 the letter? 15:24

11 487 Q. 21 September?

12 A. To the 24th? That would be an error, I would imagine.
 13 We would usually review in a few days because it
 14 doesn't give them enough time. So I'm assuming that's
 15 an error. They are both September. 15:24

16 488 Q. So the fact that the review date says 24 September
 17 2018, it doesn't indicate some desire on your part to
 18 keep this under active review, it's more likely just an
 19 administrative error?

20 A. I think so, yeah. I'll see when I next spoke to him. 15:24

21 489 Q. Now, we discussed, very briefly there, Dr. Khan's
 22 approach to this on the call. You said he sounded
 23 relevantly interested, is that fair, or...

24 A. Yeah. I mean I found him very engaged and keen to
 25 resolve matters. 15:25

26 490 Q. If we look at TRU-251931, please. What this document
 27 is, this is Dr. Khan's draft determination or his notes
 28 which he shared with you before the meeting. Do
 29 you recall me referring you to that a couple of minutes

1 ago?
2 A. Yeah.
3 491 Q. If we look at point (b) there, it says:
4
5 "Possibly restrictions on action plan." 15:25
6
7 So, that's Dr. Khan's view before he speaks to you.
8
9 If we jump then to his final determination, which is at
10 AOB-01921. This is Dr. Khan's final version of the 15:25
11 determination. What he's recommending is:
12
13 "In order to ensure the Trust continues to have
14 assurance about Mr. O'Brien's administrative practices
15 and management of his workload, an action plan should 15:26
16 be put in place with the input of the PPA, the Trust
17 and Mr. O'Brien for a period of time agreed by the
18 parties."
19
20 If you scroll down. It then provides a bit more detail 15:26
21 about how that would be reviewed and monitored. That
22 sounds very similar to the PSR plan that you were
23 suggesting, doesn't it?
24 A. Yes.
25 492 Q. But just so you're clear, it was never followed up on 15:26
26 by the Trust?
27 A. No. We never got the forms back. Obviously for the
28 team to work on it they need to have all the
29 information.

- 1 493 Q. For the avoidance of all doubt, was any input from NCAS
 2 or PPA requested at that time or subsequently for an
 3 action plan with regards to Mr. O'Brien, even if it
 4 didn't formally tick the boxes of that PSR process
 5 we've been discussing? 15:27
- 6 A. Not that I'm aware of.
- 7 494 Q. We're going to come on to some discussions you had with
 8 Mr. O'Brien presently. You spoke to him on the 1st,
 9 11th and 30th October, so three times in a relatively
 10 short sequence. 15:27
- 11 A. Mm-hmm.
- 12 495 Q. Did you discuss with Mr. O'Brien taking an action plan
 13 of this kind forward?
- 14 A. I don't think so.
- 15 496 Q. Why would you have suggested to the Trust but not 15:27
 16 floated the idea with Mr. O'Brien?
- 17 A. Because Mr. O'Brien, when he was on the call, mostly he
 18 was talking to me. And I think I saw the action plan
 19 as something that would go hand in hand with the
 20 conduct process and Mr. O'Brien seemed to have some 15:27
 21 trouble with thinking about going to a conduct process
 22 at all.
- 23 497 Q. So, you never discussed it with Mr. O'Brien?
- 24 A. No.
- 25 498 Q. You can't recall if Mr. O'Brien was keen and willing to 15:28
 26 engage in such a monitoring process?
- 27 A. No.
- 28 499 Q. I'm just going to discuss a bit about your interaction
 29 with Mr. O'Brien. So, if we could look up your letter,

1 please of WIT-53461. This is a letter from you to
 2 Mr. O'Brien, on 17 October. Can you just scroll down
 3 please. It refers to discussions that you had with
 4 Mr. O'Brien on 1st and 11th October 2018. Was it
 5 unusual in any way to be contacted by practitioners? 15:29

6 A. No, it's not unusual.

7 500 Q. Was it usual to be contacted by a practitioner so late
 8 in the process, i.e. almost coming up two years since
 9 your first engagement in this?

10 A. That is quite late in the process. 15:29

11 501 Q. Before I dive into your letter, I think you've
 12 subsequently learnt throughout this Inquiry process
 13 that Mr. O'Brien actually recorded one of your
 14 discussions which I believe must have been your second
 15 discussion on 11 October 2018. At the time you were 15:29
 16 offering that advice, were you aware that the
 17 discussion was being recorded?

18 A. No.

19 502 Q. I would just like to give you an opportunity to
 20 perhaps, on finding out that that was recorded to offer 15:29
 21 some reflections to the Inquiry about how you felt
 22 about that?

23 A. I feel it was unprofessional. I feel it was --
 24 Mr. O'Brien was very concerned about the process. He
 25 felt that the process had been unfair and certainly the 15:29
 26 Trust had made a lot of mistakes but I felt that what
 27 he did was unfair. But, having said that, like I can
 28 stand over what I said. I said maybe I'd have done
 29 less humming and hawing. If I'd known I was on record

1 but, you know, I don't think it would have been
 2 substantially different from the conversation that
 3 we had. I mean, I had a great deal of sympathy for his
 4 position. I mean, I know that there was a risk to
 5 patients and all those things but I was aware of the 15:30
 6 background and how successfully he had worked for
 7 a long period of time. So, you know, I felt very sorry
 8 for Mr. O'Brien. But I also was beginning to feel
 9 frustrated in that he didn't -- whilst the Trust had
 10 made a lot of errors he really couldn't see the Trust 15:30
 11 point of view in any way.

12 503 Q. I do intend to move relatively quickly through these
 13 communications with Mr. O'Brien. The paragraph on
 14 screen, about halfway down it says 'specifically you
 15 allege' - this is Mr. O'Brien's instructions to you - 15:30
 16 "you allege that the Trust has misled PPA service
 17 (formerly NCAS) by implying that you were supported to
 18 address concerns in 2016."

19
 20 Is it normal for practitioners to raise allegations 15:31
 21 that NCAS have been misled?

22 A. That's reasonably normal.

23 504 Q. And what action do NCAS take on being informed that
 24 they've potentially been misled?

25 A. Well, we really -- it's not something we can adjudicate 15:31
 26 on so we always tell -- we keep, obviously, the records
 27 on file and then if we go to meetings with them, with
 28 all parties, we can sometimes get some sort of meeting
 29 of minds. But that didn't happen in this case.

- 1 505 Q. I think the letter goes on, and you direct Mr. O'Brien
2 towards making a subject access request --
- 3 A. Yeah.
- 4 506 Q. -- I think that's to NCAS, is that right?
- 5 A. Yes. Well, we would prefer the organisations to give 15:31
6 the practitioner the information to which they're
7 really entitled but the problem is a SAR is a lot of
8 work for the team in NCAS and we get a huge amount of
9 requests. I know the information team much prefer the
10 Trust to provide this information. But if they're not, 15:32
11 well, we usually will.
- 12 507 Q. You go on variously to advise Mr. O'Brien to exhaust
13 his internal options, i.e. speaking to a designated
14 Board member, the Chair of the Trust and the Chief
15 Executive. And the letter ends with you saying that 15:32
16 you will advise Dr. Khan of your conversations with
17 Mr. O'Brien. Did you speak to Dr. Khan at that stage?
- 18 A. I did go back to Dr. Khan and talk to him about it,
19 yes.
- 20 508 Q. Was that at that stage or was that on 31 October 2018? 15:32
21 I can bring up the letters in due course.
- 22 A. You'll need to, I couldn't recall the date without it.
- 23 509 Q. You ended up speaking to Mr. O'Brien again. If we look
24 at WIT-53463. I don't want to downplay at all what
25 Mr. O'Brien was telling you, but it's perhaps 15:33
26 information from a similar vein before any allegations
27 that NCAS had been misled by the Trust, but perhaps
28 further information provided. If you can scroll down,
29 please, and on to the next page.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

Again you advise him of his right to make a subject access request. Then the final sentence here:

"We discussed that it may be helpful, with the Trust's agreement, for all parties, including PPA, to meet. I told you that I would liaise with Dr. Khan to ascertain dates." 15:33

what was your thinking behind the suggestion of a meeting? 15:33

A. Well, I think the fact that the Trust and Mr. O'Brien were so far apart, really, it had the feel of a case that was going nowhere, you know. So we thought if we could get them around the table we might be able to achieve something. Now, we didn't talk about mediation. I have been trained as a mediator as well but we didn't offer that. I felt there was too much conflict at that stage, really, for mediation. 15:34

510 Q. So, your intention was not so much to mediate but to try and find some degree of common ground, is that it? 15:34

A. Yeah. Yeah. The Trust had admitted -- I mean obviously those allegations that they had misled us were worrying, but the Trust had admitted, I mean Dr. Khan -- from that point of view I commend the investigator and the Trust. They did, very unusually, say we weren't -- I mean they're on record as saying they weren't as proactive as they should have been. It's unusual to see that in an investigative report. 15:34

1 511 Q. Was any part of this meeting concerned with an action
 2 plan, the likes of which you and Dr. Khan had discussed
 3 previously?
 4 A. Well, if we'd got to the meeting, yes. But we didn't
 5 get there. 15:35

6 512 Q. Before we get on to why you didn't get there, on this
 7 phone call or these phone calls, was Mr. O'Brien
 8 supportive of having a meeting with The Trust?
 9 A. Very.

10 513 Q. So, he seemed to be keen? 15:35
 11 A. He wanted a meeting, yes. He wanted a round table
 12 conversation.

13 514 Q. This letter here I believe is dated 31 October and
 14 I understand that you spoke to Dr. Khan on that very
 15 same day. We can have a look at WIT-53467, please. If 15:35
 16 we scroll down to Dr. Khan's email, please. This is an
 17 email of 5 November from Dr. Khan to yourself. He is
 18 copying in Mrs. Hynds and Mr. Gibson, who I understand
 19 may also have been on your phone call. Do you have any
 20 recollection of that? 15:36
 21 A. Of talking to Dr. Khan?

22 515 Q. Of talking to Khan, Hynds and Gibson?
 23 A. Yes, yes. Absolutely.

24 516 Q. He says:
 25 15:36
 26 "Further to our telephone conversation on Wednesday 31
 27 October"
 28
 29 -- it is a relatively detailed email, I will not read

1 it out entirely verbatim. He has clearly been informed
 2 of your discussion with Mr. O'Brien, in particular the
 3 concerns the formal investigation was inappropriate.
 4 Sorry?

5 A. I don't think I have that in front of me, have I? Are 15:36
 6 we looking at two different things?

7 517 Q. It should be an email of 5th November. It's from Dr.
 8 Khan to you. Sorry about that if I caused any
 9 confusion.

10 15:36
 11 In this email, Dr. Khan is setting out the Trust stall
 12 really that a formal investigation had always been
 13 merited and they'd provided submissions to Mr. O'Brien
 14 addressing this issue in the past, and given the
 15 serious nature of the concerns it was considered 15:37
 16 appropriate to pursue a formal investigation.

17
 18 If you go to the next page, please. He says:

19
 20 "I was encouraged to hear from you that Mr. O'Brien and 15:37
 21 his son are not in dispute of the issues of concern.
 22 The findings from the formal investigation further
 23 outline that the concerns under investigation and which
 24 are now founded are very serious in nature."

25 15:37
 26 The final two paragraphs:

27
 28 "I appreciate your offer of a meeting between the Trust
 29 and Mr. O'Brien with you in attendance. Having

1 considered this, we remain unclear as to the purpose of
 2 this meeting at this stage. As always, we are happy to
 3 be guided by NCAS and if you feel it is useful to meet,
 4 we are happy to do so.

15:37

5
 6 "We would be very grateful for your advice on the best
 7 course of action in this regard and what you feel could
 8 be achieved by such a meeting".

9
 10 Now, on a reading of this, and while the Trust are
 11 robustly enough setting out their stall about what they
 12 understand the circumstances to be, Dr. Khan here isn't
 13 saying he's against a meeting, is he, he is saying
 14 we're just unclear about what a meeting will achieve.

15:37

15
 16 what's your reading of that email?

15:38

17 A. Yes, I agree he was unclear about what a meeting -- but
 18 the issue of concern to me was they were determined
 19 that the conduct hearing would go ahead and the
 20 practitioner was equally determined that it wouldn't.
 21 They didn't mind a meeting, but it was in the context
 22 that the conduct hearing would have to proceed.

15:38

23 518 Q. I suppose the key sentence which I didn't actually
 24 bring your attention to there is at the bottom of the
 25 first paragraph:

15:38

26
 27 "As previously discussed and agreed with you, the next
 28 step is this process to hold a conduct hearing
 29 following conclusion of the formal investigation."

1 A. That's right. So the next step had to be the conduct
 2 process. They would have seen the PSR, as I explained
 3 earlier, as probably coming after that but then
 4 we never got to the conduct hearing.

5 519 Q. Can we go back to 53467, please. It is just the first 15:39
 6 page, and Dr. Lynn's response. You do respond to
 7 Dr. Khan on 5th November 2018. You say:
 8
 9 "Thank you for this. In the circumstances I am not
 10 sure anything further could be achieved by a meeting". 15:39
 11
 12 So having considered the Trust's submissions, you're
 13 now completely off the notion of having a meeting?

14 A. Well, yes, at this stage.

15 520 Q. You're reasoning for that, just so that we're clear? 15:39
 16 A. The reasoning for that is they wanted the next step to
 17 be the conduct hearing, and Mr. O'Brien didn't want
 18 a conduct hearing. There was no process, really, of
 19 getting an action plan together without a conduct
 20 hearing. I think they weren't opposed to a performance 15:39
 21 improvement plan but they were determined that the
 22 matter was significant enough that it needed to go
 23 forward to a hearing.

24 521 Q. You subsequently write then to Dr. Khan that day, or on
 25 6th November, in fact confirming your position that no 15:40
 26 hearing will go ahead.
 27
 28 You write to Mr. O'Brien on 9th November. Can we have
 29 a look at that, WIT-53472. This isn't a letter you

1 write to Mr. O'Brien on 9th November. You say:

2
3 "Following our conversation I contacted the Trust to
4 explore further with them and to offer to meet".

5
6 You set out the Trust position. 15:40

7 A. Yes. So the last paragraph -- the second paragraph,
8 last sentence, you see:

9
10 "I note it is also likely as per earlier correspondence 15:40
11 with the Trust that they will want to support you
12 moving forward".

13
14 But it was in the realm of after a conduct hearing.

15 522 Q. Then the final paragraph of this page: 15:41

16
17 "These decisions made by the Trust are ultimately
18 matters for them as your employer and PPA cannot
19 arbitrate on these decisions or take on the role of
20 your advocate". 15:41

21
22 Did you consider that Mr. O'Brien or the Trust were
23 asking you to become an arbitrator here.

24 A. I thought that Mr. O'Brien certainly would have wanted
25 that. 15:41

26 523 Q. Did you consider that Mr. O'Brien or the Trust wanted
27 you to advocate for their position in any meeting?

28 A. Well, I got that impression.

29 524 Q. What was to be the NCAS follow-up to this? If we go

1 down, I believe there is a review date attached to this
 2 letter. There might not appear to be. What was to be
 3 the NCAS follow-up to this?

4 A. I can't remember. I mean, we do have follow-up,
 5 I know, but I can't remember. Specifically, I would 15:41
 6 have been waiting then for the conduct hearing but then
 7 the conduct hearing got derailed because of the
 8 grievance. That's what I recall, but I haven't got...

9 525 Q. In your opinion and perhaps your experience as an NCAS
 10 adviser, given the nature of the grievance did it mean 15:42
 11 that it was impossible for the conduct hearing to go
 12 ahead? Did everything have to grind to a halt?

13 A. It didn't really have to grind to a halt but, yes,
 14 I think the Trust were finding it all very difficult.
 15 I'm sure Mr. O'Brien was finding it very difficult too. 15:42
 16 In fact, I know he was because I was speaking to him on
 17 the phone.

18 526 Q. If we just look WIT-53453, please. Paragraphs 27 and
 19 28. You say you followed up with the Trust on 2nd
 20 January. You were asking if any process has come to 15:42
 21 a conclusion. Dr. Khan replied there was now a formal
 22 grievance which had to be dealt with. You say there at
 23 paragraph 28 you emailed again in February '19, emailed
 24 again June '19, emailed again September '19 before the
 25 file was formally closed in February 2020. 15:43
 26

27 Is that an accurate summary, you think, of the
 28 involvement?

29 A. It is an accurate summary.

1 527 Q. You'll be pleased to know I am almost done; do rest
2 assured I want to ask you one or two questions.

3
4 This case comes back before NCAS, or PPA as it was
5 then, around the summer of 2020. At that stage it goes 15:43
6 to Dr. Fitzpatrick primarily. Why again, had it
7 switched from initially Dr. Fitzpatrick to you and why
8 was it now switching from you back to Dr. Fitzpatrick?

9 A. I think I was probably on leave but I had also given
10 notice of my intention to retire so they were trying to 15:43
11 re-direct some of my caseload. So, the Northern
12 Ireland cases would have been heading to Colin.
13 I think I was on leave but I can't be sure.

14 528 Q. Then you did speak to Mr. O'Brien and his wife,
15 I think, on 15th July 2020. You followed this up with 15:44
16 a letter which can be found at WIT-53720. About
17 two-thirds of the way through this paragraph you
18 state -- this is again, I think, you're reflecting on
19 what Mr. O'Brien told you:

20
21 "You think that our organisation is being manipulated 15:44
22 with misleading information and that you have been
23 victimised whenever you have raised concerns".

24
25 Just on that, in a sense Mr. O'Brien is suggesting he 15:44
26 may have been some type of whistleblower and was being
27 punished or victimised. Is that a fair description of
28 what he was telling you at this time?

29 A. That's a fair description.

- 1 529 Q. what, if any, role does NCAS have whenever these type
 2 of whistleblowing issues are raised?
- 3 A. It's not uncommon for the practitioners to raise this.
 4 But his employment with The Trust had terminated, so,
 5 you know, I'm not really sure what we did with that, to 15:45
 6 be honest. Normally if people raise whistleblowing,
 7 then it escalates through our organisation. He felt
 8 that -- was this after the review, the lookback had
 9 started?
- 10 530 Q. I believe this was after the further concerns had been 15:45
 11 raised in July 2020, so we're relevantly far through
 12 the story at this point.
- 13 A. I think how we saw it, like we knew that there were
 14 these concerns. He'd agreed that there were -- he
 15 always had agreed that there were issues of concern. 15:45
 16 So, it didn't seem unreasonable for Dr. O'Kane to be
 17 doing a lookback. I wasn't sure that there was
 18 evidence to support what he was saying, that he was
 19 being victimised for doing that.
- 20 531 Q. would it be NCAS's job to investigate whether he was 15:46
 21 a whistleblower?
- 22 A. No, no. That would be for his defence organisation,
 23 you know, to raise.
- 24 532 Q. I promise you, I've got three questions left.
 25 Hopefully they're not the hardest you faced today but 15:46
 26 who knows.
 27
 28 You've more experience than most of dealing with the
 29 MHPS Framework given your unique enough position. You

1 obviously heard some of Dr. Fitzpatrick's reflections
 2 earlier. Does the process or does the framework work?
 3 Can it work? What might need to change in order to
 4 make it more effective?

5 A. I think there's a number of problems with MHPS. 15:46

6 I think there's great difficulties in Trusts in
 7 managing concerns. I mean, we've seen this a few times
 8 now. You know, you pointed out earlier -- and it is
 9 something that we address in case investigative
 10 training but it's not getting any better. They don't 15:47
 11 have people freed up really, they add it on to their
 12 day job. I think they're completely -- I think the
 13 situation in which the Health Service in isn't going to
 14 make it any easier any time in the near future. As you
 15 can see, this was taking up an enormous amount of time. 15:47

16 533 Q. Those issues you describe, I don't personally have
 17 a view on it and I'm not expressing the Inquiry's view
 18 by any stretch, are they issues with the framework
 19 itself, are they issues with almost the structures, the
 20 funding or the infrastructure around the framework in 15:47
 21 how it's implemented?

22 A. I think there are problems within MHPS but I think
 23 there are problems within organisations as well.
 24 I think there are difficulties -- there's a lot of tick
 25 boxing goes on in the Health Care system at the moment. 15:48
 26 I think there's a real nervousness around managing
 27 performance concerns. You're damned if you do and
 28 damned if you don't. There's real concern. I see it
 29 as people doing things just so that though can say they

1 did them. It has become increasingly bureaucratic, and
 2 that has an influence on patients as well in that the
 3 time taken to do everything is hugely extended because
 4 of the need you are making sure that you're adequately
 5 covered, that you're not exposing yourself to risk.

15:48

6
 7 I think there's a lot of -- there's a huge amount --
 8 I don't even know how you begin to fix it.

9 534 Q. That's probably not welcome news to the Inquiry at this
 10 stage.

15:48

11 A. I know but it's true.

12 535 Q. I'll ask you about your reflection on NCAS's role. Do
 13 you think NCAS's role was sufficiently clear in these
 14 processes?

15 A. I think it's reasonably clear but I think, you know,
 16 we don't have any authority. I think that's the
 17 problem. We have no ability, you know, to make
 18 organisations do anything. We rely on them engaging
 19 very much with us. Again, you know - and I'm not
 20 saying necessarily in this case - but people engage
 21 with us really so that they can say they engaged with
 22 us; you know, that they've met that requirement. I'm
 23 sure you will have seen in the bundle I saw that
 24 somebody even suggested 'we better get them down to
 25 train us so that we can say we're trained'. That is
 26 the prevailing atmosphere in the Health Service.

15:49

15:49

27 536 Q. A final question. Dr. Wright, in his oral evidence,
 28 offered a reflection that there wasn't a great
 29 awareness of the goal of NCAS and the potential it had

15:49

1 to assist and help with difficult cases. That
 2 reflection, I believe, is from his interpretation at
 3 the time, which was about 2015, 2016.

4
 5 In your view, is there sufficient -- let me ask you two 15:50
 6 questions. Was there sufficient knowledge of NCAS's
 7 services and ability to help back then, so let's say
 8 2016, whenever this process started?

9 A. I would have thought that there should have been.
 10 I think, you know, by 2016 they were already in very 15:50
 11 real difficulty. It turned into -- it was almost an
 12 intractable problem because it had preexisted.

13 537 Q. I suppose Dr. Wright's reflections may be a slightly
 14 broader one. Generally within the system, did you view
 15 that people knew who NCAS were, what they could offer 15:50
 16 and what assistance they could provide?

17 A. I don't know whether practitioners on the ground are
 18 very aware of it. I know the medical managers would
 19 all be aware of it. I know that the nonmedical
 20 managers would not. So, I think you would find teams 15:51
 21 within organisations where their HR departments would
 22 have a very sketchy idea of MHPS.

23 538 Q. And at the time you retired did you consider there had
 24 been any improvement in that situation?

25 A. I'm not sure that there was. 15:51

26 MR. BEECH BL: Thank you very much, Dr. Lynn. I've no
 27 further questions for you, I'm sure the Panel might
 28 have one or two. Thank you.

29 CHAIR: I know you've been here from early morning too,

1 Doctor, so we'll try to be quick but I'm going to go
 2 first of all to Mr. Hanbury and I'm sure he might have
 3 something he wants to ask you.

4

5 DR. LYNN WAS QUESTIONED BY THE PANEL AS FOLLOWS: 15:51

6

7 539 Q. MR. HANBURY: Thanks very much for your evidence.
 8 I hope you can hear me.

9

10 I've just have got two short questions, hopefully. I'm 15:51
 11 still struggling slightly with the classifications of
 12 shortcomings and just two things with respect to,
 13 firstly, the dictation and, secondly, the triage.

14 We know Mr. O'Brien could do it but he on
 15 occasion didn't do it. How do you classify that as 15:52
 16 capability or performance or something different and
 17 how do you work that out?

18 A. Well, I think if you have the ability to do something
 19 and you don't do it, that's a conduct issue. So, as
 20 I understand it, Mr. O'Brien didn't really agree with 15:52
 21 the triage that was a put in place but he was
 22 instructed that that was to happen but he didn't want
 23 to do it like that, so that led to the backlog. So it
 24 was as a direct result of decisions he was making about
 25 how he behaved. So I viewed that very much as conduct. 15:53

26 540 Q. What's the place of mitigation there, pressure of work,
 27 and things, would that change?

28 A. Yeah, I agree entirely with that. I think that was --
 29 you know, there were mistakes made there about not

1 freeing him up to do it. But I think even -- when it
 2 was drawn to his attention, you know, and it had become
 3 a big issue, that was the time that he could really
 4 have, even for himself he could have stopped --
 5 I imagine if he had told the Trust I'll stop doing X, Y 15:53
 6 and Z, to do that. There would have been very little
 7 they could do about that. But he didn't. So I think
 8 that had he -- you know, I realise he did a huge amount
 9 of work and a huge amount of hours but he wasn't
 10 following specific instructions and he didn't make 15:53
 11 any -- well, he used to get the better for a while and
 12 then slide back which sort of as well implies conduct.
 13 He could do it when he had to but he couldn't
 14 consistently do it, probably because he didn't believe
 15 in it. 15:54

16 541 Q. And do you say the same about the dictation issue?
 17 A. The dictation issue?

18 542 Q. That is dictating after patient contact?
 19 A. Well, I said, when he talked to me about that I didn't
 20 have an issue with whether it was dictated or not, as 15:54
 21 long as it was recorded in some way. So I'm not -- you
 22 know, I didn't say -- he had in our telephone
 23 conversation together, and that's on record, I said to
 24 him, you know, as far as I know there's no requirement
 25 either -- I don't know that the Trust had 15:54
 26 a requirement, there's certainly no requirement that
 27 you must dictate but you need to keep a note,
 28 a contemporaneous note because obviously at the end of
 29 the week you'll never remember what you did. Or at

1 least most of us wouldn't remember what we did.

2 543 Q. Thank you. Just harking back to the March '16 and the
3 first warning letter and could more have been done in
4 that case. We've heard from Dr. Fitzpatrick that if
5 he'd got a letter like that he would've taken it very 15:55
6 seriously and, in his words, pulled his socks up. I
7 mean is that something that you agree with or do you
8 think at least you would have raised it if that had
9 come to you? What would your comment be about that?

10 A. We didn't know about it in March 2016. But I think 15:55
11 when a concern is raised with a practitioner, usually
12 they try to do something about it. And the cases
13 we see that don't go well, it's usually when the
14 practitioner adopts a defensive position. Because
15 really, mostly what the Trust wants is that the problem 15:55
16 goes away, so that their concerns are addressed. But
17 I think Mr. O'Brien felt, you know, I think possibly
18 outraged, really, that with all his work, you know,
19 that he was -- his performance was being called into
20 question. And I think it would have been helpful if he 15:56
21 had shown a little bit more flexibility.

22 544 Q. In retrospect, if he felt he couldn't get anywhere at
23 his Trust, would NCAS have helped him then?

24 A. I'm not sure I followed that. Sorry.

25 545 Q. Well, if he felt he wasn't getting anywhere with his 15:56
26 local medical managers, what other options could he
27 have explored? Would there be a place for him to call
28 your services?

29 A. Well, as I say, we can't arbitrate. I mean that falls

1 to his defence organisation. I'm not sure if he was
2 a member of a defence organisation. I know he was --
3 he had access to legal support but I'm not sure that he
4 was a member of a defence organisation. We never --
5 I certainly never spoke to a member of a defence 15:57
6 organisation and I wonder was that an issue for him
7 because the defence organisations are used to trying to
8 meet trusts halfway, which might have been, you know,
9 might have been helpful in the circumstances.

10 MR. HANBURY: Thank you very much. I've got no further 15:57
11 questions. Thanks, Ms. Smith.

12 CHAIR: Thank you, Mr. Hanbury. Dr. Swart.

13 546 Q. DR. SWART: Thank you. Looking the evidence relating
14 to MHPS and this Trust and this practitioner, it's
15 clear that we had everybody trying to do the best they 15:57
16 could and somehow it didn't go well. Supposing that
17 the case investigator had contacted you personally
18 a few months in and said, 'look, this is quite
19 a complicated case, there's a number of issues that
20 I find quite difficult, I'm not sure how to balance 15:58
21 things,' would you have advised at that point, would
22 you have signposted them? Do you think it's clear to
23 people that that route is open?

24 A. Well, when we do our investigation training we do tell
25 them that. But I do think these investigations are 15:58
26 very complex and they are being delegated to people,
27 you know, with very little experience. They don't do
28 investigation often and I'm sure having done one NHS
29 investigation you'd probably never want to do another

1 training but in the documentation?

2 A. Yes, I agree it would be. I think it's an incredibly
3 difficult job to do and I think the people involved in
4 this investigation certainly did their best.

5 553 Q. Then there's an ongoing issue here which is around the 16:00
6 scope of the investigation, which you've talked about
7 and we asked Dr. Fitzpatrick about it this morning. If
8 you just look at dictating letters, for example. With
9 the benefit of hindsight we have someone who is unable
10 to dictate on large numbers of letters and doesn't see 16:00
11 it as his job. This means he's not communicating
12 people to the members of the multi-disciplinary team -
13 whether it's a GP or colleagues who pick up the notes -
14 and this is a risk to patient safety because it
15 indicates a uni-professional practice which is contrary 16:00
16 to modern safety and multi-professional theory. So, if
17 you look at that now and we look at the things that
18 eventually happened, surely we could specify a little
19 bit more, or MHPS could specify a little bit about the
20 scope and about what the warnings signals are? There 16:00
21 are a few here. There's a doctor who doesn't take note
22 of that letter, for whatever reason. That is unusual.
23 Large numbers of undictated letters, it is very
24 unusual. Difficulty in dealing with it is very
25 unusual. It's almost inconceivable that there's not 16:01
26 another problem. It may be a problem brought on by
27 pressure of work, there may be lots and lots of causes
28 of it, but with the benefit of hindsight what could
29 NCAS have done more in that situation, now that you

- 1 look back?
- 2 A. That's a very difficult question too. I think if we'd
 3 possibly gone out to meet at a very early stage it
 4 might have helped, if we'd gone out and -- at the very
 5 initial -- even back in September '16. But it's very 16:01
 6 difficult to call, at that stage, because obviously you
 7 only know how difficult it's going to be at the end
 8 when it didn't seem that unusual at the start.
- 9 554 Q. I think that's the theme that's gone through this.
 10 People sitting down with the practitioner, whether it's 16:02
 11 within the Trust or someone else, to actually try and
 12 determine the diagnosis, if you like: what is going on
 13 here? what is impacting on this person, cause this
 14 behaviour. So thank you for that.
- 15 A. Thank you. 16:02
- 16 DR. SWART: That's all from me.
- 17 555 Q. CHAIR: Doctor, just so that I'm clear in my own head,
 18 NCAS is a service which has the service agreement with
 19 the Department of Health. Presumably somebody pays
 20 your wages. Is it right that the Department of Health 16:02
 21 then pays NCAS for the service provided, is that it?
- 22 A. They pay a lump sum, as I understand it, and then
 23 separately -- the lump sum, as I understand it,
 24 includes a number of things. And then if they go over
 25 a certain number of assessments or -- for example -- 16:02
 26 then they would have to pay for those.
- 27 556 Q. would the Trust be asked to pay for those directly or
 28 is it just the Department of Health?
- 29 A. I imagine it would be the Department. It's normally

1 free to the Trust.

2 CHAIR: To the Trust at the point of usage.

3

4 Thank you. That's really very helpful. It has been
5 a very long day and I'm sure you'll be glad to get
6 home, as I'm sure everybody in this room will be glad
7 to get home.

16:03

8

9 Can I say to everybody, thank you for starting so
10 early. I think it was important that we did do that.
11 It is appreciated and I do appreciate how long a day
12 it's been for all of us. And can I just wish you all
13 a very healthy and happy Easter and I'll see you after
14 the break, such as it is, because we're straight back
15 in. Thank you very much.

16:03

16:03

16

17 THE INQUIRY WAS THEN ADJOURNED UNTIL TUESDAY, 18TH
18 APRIL 2023

19

20

21

22

23

24

25

26

27

28

29