Urology Services Inquiry

Oral Hearing

Day 77– Tuesday, 9th January 2024

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

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THE INQUIRY RESUMED ON TUESDAY, 9TH JANUARY 2024, AS FOLLOWS:

CHAIR: Morning everyone, happy new year and welcome back for another session.

MS. MCMAHON: Good morning. The witness this morning is Eileen Mullan and she is going to affirm.

MS. EILEEN MULLAN, HAVING BEEN AFFIRMED, WAS DIRECTLY EXAMINED BY MS. McMAHON AS FOLLOWS:

MS. MCMAHON: Good morning, Ms. Mullan. My name is Laura McMahon and I am junior counsel for the Inquiry, I'll be taking you through your evidence today. I know we have time tomorrow, if we need to move into tomorrow we will do so. But we'll see how we get on today.

1 Q. You have been called to give evidence as you are the Non-Executive Chair of the Southern Health and Social Care Trust and have been on the Board for a period of time as a member -- a director of the Board. You were sent a Section 21 notice dated 5th July 2023 and your reply to that can be found at WIT-100434. We'll see your name at the top of that, notice No. 15 of 2023, and, if we go to WIT-100568, you will see a signature there dated 25th September 2023 and do you recognise that as your signature?

A. I do.

2 Q. And do you wish to adopt that response to the Section 21 notice as your evidence?

A. I do.

3 Q. Thank you. Just at this point, is there anything you'd like to add or amend or indeed anything you'd like to say at this point before we move into the detail of your evidence? 10:04

A. There is nothing I would like to add or amend, but there is something I would like to say at this point. I would like to reiterate the apology that was given to the Inquiry on 10th November by our counsel, Donal Lunny KC. That apology was given on behalf of the 10:04 Trust. It was given on behalf of our Chief Executive, Dr. Maria O'Kane, and it was given on behalf of me as Chair of the Trust Board. The fullness of that apology is in the Inquiry dated 11th or 10th November for your records. Thank you. 10:04

4 Q. Thank you, Ms. Mullan. So just by way of general context as to the information you can bring to the Inquiry, you were a Non-Executive Director of the Southern Health and Social Care Trust from 15th February 2016 to 30th November 2020, and then you 10:05 became Chair of the Trust Board from 1st December 2020 and you're currently Chair?

A. That's correct.

5 Q. You've provided us with an extensive statement and exhibits attached to that. The Inquiry has received 10:05 all of that and it's in evidence now and they have your statement to consider within the context of other evidence they've heard and will hear. So the purpose of today, really, is for us to look at some of the key

aspects of your statement, for me to highlight some issues that may be of interest to the panel in looking at the evidence in the round and also informing their recommendations. So we'll dip in and out of your statement and I'll ask you to explain or give us a bigger context of some of the issues that the Panel have heard about and may yet hear about.

So the general outline of your evidence will be on three broad headings: First of all, your role and the general Board structure within that role; the functions of the Board, the way in which the Board received and processed information and gathered it and shared it up, the communication generally and decision making. We then look at Board knowledge of and involvement in issues generally and specifically within urology and also in relation to Mr. O'Brien; then, thirdly, the broad topic of the current position and the Board, the learning that has occurred, the reflections that you have included in your statement and any response to the learning and really what the position is now. The Panel will be keen to hear your views on what the current structures are and how they may be improved to inform any recommendations they may have. 10:05 10:06 10:06 10:06 10:06

So I'll just start with you generally, your background and role. If you go to your statement at WIT-100436, just paragraph 4.4 there, we'll see your qualifications, we'll start with those. You have a BA

Honours degree in Business Studies, a Postgraduate Certificate in Management and a Diploma in Management Practice. You also have a Masters in Management and Corporate Governance; the IOD - is that the Institute of Directors? 10:07

A. It is.

6 Q. Certification in Company Direction and, also from the IOD, a Diploma in Company Directions.

Then if we go back up to the previous page we'll see your employed roles. You've worked in Training Consortium, Training for Women Network, the Belfast Metropolitan College. Then I think currently you're the director of a company, Strictly Boardroom Limited. Could you give us just an outline of what that company does and the services provided by it? 10:07 10:08

A. Yep. In the early days, Strictly Boardroom is a website that I provide pro bono to offer information in relation to vacant board roles within the public and third sector primarily here in Northern Ireland. I have run that for a number of years, just to share information. Later, from 2020, I mobilised the company into a live company, it was shelf previously, and I use that as a mechanism for me in my self-employed work. So through that then it will be either me undertaking work with boards within the public or third sector, going in as a governance consultant, and also the work that I do in relation to Boardroom Apprentice, which is an initiative I founded in 2017, which provides 10:08 10:08

opportunities for people to prepare for board roles. I do that here in Northern Ireland and also in Great Britain.

7 Q. I think probably between us today we will be told off at some stage about the speed at which we deliver my questions and your answers, so if I promise to try and slow down would you do the same? 10:09

A. I will.

8 Q. People are taking a note as well, but I am forever being told off, so you won't be on your own. 10:09

So if we just go to the previous page, you have outlined your expertise in relation to boards. At paragraph 4.2 we'll have a look at some of the boards you have been on. You started in 2009 in the Northern Ireland Environment Agency and you were a Non-Executive 10:09 Director there; then Age NI, you were a Trustee, then you were the Chair of Age NI from December 2013 to March 2018. You were the Chair and Trustee of Audiences NI and then, in January 2015 to December 2020, you were Senior Council Member on the 10:10 Health and Care Professions Council.

Then, as we've said, in 2016 to 2020 you were in the Southern Health and Social Care Trust; 2014 to 2021 you were Committee Member in Northern Ireland for the 10:10 National Lottery Community Fund and then your current role is as Chair in the Southern Trust. So the Southern Trust role and perhaps the Health and Care Professions Council jump out slightly as being two

perhaps potentially related in some way in relation to health care provision, and they would be boards you have been on for quite a number of years.

Now we will go on to look at this later on in more detail about the level of expertise needed or would be helpful to be on the Board. But in relation to your particular experience on boards, what is your view or your experience of coming on to a Health Care Board and whether that particular expertise is helpful or is there a new skill set required and perhaps a new mindset? 10:10 10:11

A. Okay. Certainly there is a thread of health and social care through the Board roles, particularly Age NI through to the Health and Care Professions Council and then the Southern Trust. So for the mechanics of governance and being a Board Member then yes, but when you step into the realms of a Non-Executive Director role within the Health and Social Care Trust it's at a completely different level. So my view on it is that I had a set of skills that I was bringing to the table, a desire and a willingness to serve, but when I got to the table for the Health and Social Care Trust I was on a steep learning curve to understand the complexity and the vastness of the work within health and social care at that level. 10:11 10:11 10:12

9 Q. The difference, I suppose, as well is in the business of a trust where it is patient safety, issues about risk that have outcomes that you wouldn't expect from

other Board decision making, was that something that was new to you at that point?

A. It was at that scale. Age NI had a domiciliary care provision. It also had a care home dimension, focused care homes. So there was a patient safety and care aspect there but not at this level in relation to Health and Social Care Trust.

10 Q. You have provided some detail in your statement but just as a general proposition: Did you feel that the training or information provided to you at the start of your tenure as an NED, Non-Executive Director, in the Trust prepared you properly for the role?

A. No, and if I may give some context to that.

11 Q. Yes, please do.

A. The induction process, when I stepped in in 2016 there was a period of six to 12 months where you had an opportunity to meet with all the directors, to understand the nature of the work that goes on in their Directorate. That was very helpful: One, you got to meet the team that were leading the directors, you got to understand in part what they were there to do. In Northern Ireland, particularly for health and social care trusts, you are sent on a half day course called "On Board" to prepare you for the roles and responsibilities. That course was never going to -- that half day session was never going to prepare me for health and social care in a governance way.

Sitting here now looking back to 2016, that learning

curve was so steep that I say that it has taken quite a number of years to get to the knowledge base that I have today. I would be advising - and you may want to come on to this at another point - but I would be advising that certainly what is needed for Non-Executive Directors needs to be different. I have been having conversations with the Department of Health and with the Health and Social Care Leadership Centre to bring about a different focus of induction, training and development opportunities for Health and Social Care Non-Executives here. That needs to be bespoke for health and social care and not that it is grouped into a training session for Non-Execs, whether you're on the Housing Executive or you're on an infrastructure body or you're on a health trust. I think we need to contextualise the health trusts, we need to contextualise health and social care, and we need to equip Non-Executive Directors to understand the kind of business that comes before you as a Non-Executive Director. These reports are vast, they are complicated, they are not something that we would ever have experienced. So whilst I have had Board experience in the past, nothing would prepare me for the information that was going to flow my direction as a Non-Executive Director. So my advice to colleagues in the Department of Health and Leadership Centre is to develop a suite, and that's the work that is undergoing at the minute.

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12 Q. Thank you for that context. We will come on to look at

some of the information that is contained in Board packs to give the Panel and others an idea of the complexity of the information and the volume. But just as a general point, you mentioned there about the knowledge base that was required was something that was outside your remit at that stage and perhaps the remit of other board members, would you agree that in order for a board member to be sufficiently curious about information that either they need or they are provided with, that they have to have a knowledge base and the confidence to ask the right questions so the information and the training would be essential?

A. Absolutely.

Q. If we look your role as a Non-Executive Director first of all, WIT-100437, your Section 21. At 5.1, you say:

"I commenced my tenure as a member of the Southern Trust Board on 15th February 2016, was reappointed from 15th February 2020 and completed my tenure on 30th November 2020."

Just in relation to that, while we're on that particular point, the appointment and the reappointment of board members, is that something that has to be applied for or is the reappointment automatically if the Board Member wishes it to be so?

A. It's both. It depends on the department, but there is an approach in Northern Ireland from the Commissioner of Public Appointments Office that reappointments

should not be automatic. The Department did bring in a piece of work, going back to 2019 possibly, where current Non-Executive Directors would have to re-apply if they wanted a second term. That has happened sometimes but it hasn't been consistent.

14 Q. And the previous Chair, you took over from Mrs. Brownlee, do you have a recollection of her tenure, the length of time she was on the Board or as Chair, do you have an idea of that?

A. Chair for nine years with the Southern Health and Social Care Trust. I understand she was a Non-Executive Director previously on the Southern Health and Social Care Trust, she might have been there eight years. Then the legacy organisation, she was a Non-Executive Director in the legacy organisation as well.

15 Q. Are you currently appointed on a four year term?

A. At the moment, yes, and my term concludes in November.

16 Q. Do you have any view as to the appropriateness of reappointing individuals or people applying when you're looking perhaps to identify skill mix or skill set, do you have any view on whether it should be encouraged that people stay on Boards for long periods of time or do you feel that there should be a way of refreshing both the individuals the skill mix?

A. I would agree with you on that. Positions on Boards should always be based on what skills are needed at that point in time. If you think of any organisation, you have a strategy for a period of three years, there

is work to be done on that and then the lens may change. Your Non-Executive Directors and the skills that are required will change too. So longevity should not be about because you have been there, it should be about the skills that you have or the skills that are required at that point in time.

17 Q. Now if we look at the roles and responsibilities of the Non-Executive Director, just paragraph 5.2, we are just at that page, and you say:

"The main duties of the role and responsibilities of the Non-Executive Director, as detailed in my letter of appointment of 8th March 2016 and my letter of reappointment of 22nd October 2019 were as follows: Share in the independent Non-Executive oversight, scrutiny and stewardship of the HSC Trust work; hold executive directors to account, including assessing the performance of and appointing senior management; sit on Board Committees, such as the Governance and Audit Committee; participate in professional conduct and competency inquiries as well as staff disciplinary appeals; scrutinise decision making on major procurement issues and scrutinise the handling of complaints."

So the first, point (a) there mentions about oversight, scrutiny and stewardship, and I suppose that encompasses the entirety of governance generally as the role of the NED. Then if we look at your tenure and

role and responsibilities as Chair of the Governance Committee. Just can I ask you, you ended up on the Governance Committee, was that something that you volunteered for or was your appointment as Chair of the Governance Committee something that was given to you, if I can put it that way?

A. Yeah, I was appointed as Chair of the Governance Committee by our previous Chair Roberta Brownlee.

18 Q. And what year did you take that up?

A. That was 2016, later in 2016, later in the first year of appointment.

19 Q. If we go to WIT-100438, paragraph 6.1, you've given us the date:

"I commenced my tenure as Chair of the Governance Committee on 8th September 2016."

And you completed it on 30th November 2022. Do you know who the current Chair is?

A. Mr. Martin McDonald.

20 Q. Thank you.

A. Sorry, can I caveat that?

21 Q. Yes, of course.

A. Mr. Martin McDonald but is now moving to Pauline Leeson.

22 Q. When is that? Is that something that is imminent?

A. It's imminent, yes.

23 Q. If we look at paragraph 6.2, and you explain:

"There was to the best of my knowledge no specific role specification for the Chair of the Committee. The Committee is delegated its authority by the Trust Board through its terms of reference. My role, as I carried it out, was to ensure that the Committee fulfilled its remit as outlined in the terms of reference."

Now there was no role specification in relation to chair, was there any training in relation to that particular post given perhaps the significance of the Governance Committee when one considers patient safety and risk, was there anything specific to your induction to allow you to take up that role? 10:22

A. No, there was no training.

24 Q. Do you feel that if you had have had training it may have benefitted you taking up specifically in relation to governance, there might have been some assistance given to you at that time? 10:22

A. I would, but I would also say - and a thread runs through all of this in relation to the role of the Non-Exec within health and social care - there is something about creating a space for overlap between Non-Execs, that period of being able to shadow somebody so that you can transfer your skills, you can hand skills to the person that is coming behind you so that there is no gap and you are not asking somebody to start from afresh with nothing, there is no stabiliser sitting there. So, in my view, and it is what is happening currently, certainly with me to Martin 10:23 10:23

McDonald to take on that Chair's role and Pauline Leeson then taking on the Chair from Martin, there is a natural succession plan in there that has allowed each of us, well apart from myself, but allowed for Martin and Pauline to be able to have that support in stepping into that role. 10:23

25 Q. If we look at the terms of reference at 6.3 of the Governance Committee:

"The terms of reference detailed that the remit of the Committee is to ensure that: 10:24

(a) there are effective and regularly reviewed structures in place to support the effective implementation and continued development of integrated governance across the Trust; 10:24

(b) assessment of assurance systems for effective risk management which provide a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective; 10:24

(c) principal risks and significant gaps in controls and assurances are considered by the Committee and appropriately escalated to the Trust Board;

(d) timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed if there is an internal failing in systems or services; 10:24

(e) There is sufficient independent and objective assurance as to the robustness of key processes across

all areas of governance;
(f) recommendations considered appropriate by the Committee are made to the Trust Board, recognising that financial governance is primarily dealt with by the Audit Committee." 10:25

So if we just go back up and look at a couple of these. So point (a), that there are "effective and regularly reviewed structures in place to support the effective implementation and continued development of integrated 10:25
governance across the Trust"; and then (c), for example, "principal risks and significant gaps in controls and assurances are considered by the Committee and appropriately escalated to the Trust Board".

10:25

They are quite broad terms of reference, and keeping in mind that the Governance Committee deals with governance as does the Board and director level deals with operational aspects; sitting here today and knowing what you now know about the Inquiry and the 10:26
evidence, which I'm sure you've had the opportunity to listen to some of or read some of it, do you feel that the terms of reference were able to be fulfilled by the Governance Committee based on the information they were provided with or perhaps not? 10:26

A. I think the "perhaps not". The Governance Committee was not provided with the information in light of what we know now has come through the Inquiry.

26 Q. Now you said in your statement later on you can't know

what you don't know, and we'll look at some of the information that was coming to the Governance Committee and the Board and the confidential meetings. But it does seem as if there was perhaps inadequate information brought up, and I will come on and ask you later on about the position now --

A. Okay.

27 Q. -- and the way in which information makes its way, but if the terms of reference are the same for the Governance Committee now when Mrs. Leeson takes over, would you be content that those terms of reference are able to be satisfied by the way in which information is now brought to the Governance Committee?

A. I am. I suppose we're at a changeover in relation to what comes to the Governance Committee and how it is coming to the Governance Committee. I would say a lot of it is as a result of what's come through this Inquiry in terms of the approaches that are being deployed at an operational governance level then to feed through to our Governance Committee. So I'm not sure whether you want me to speak to that now or maybe we talk about it later. Because I can see it starting to happen in a more fruitful and meaningful way in respect to previously. If you even go back, the escalation piece to Trust Board, you can't escalate something unless you know there is something to escalate. What I put in place now is a requirement of Committee Chairs in their report to the Trust Board, there is a section there, they need to detail

escalation to Trust Board. So the Committee Chair needs to take ownership of what the committee are escalating up or not and be confident in that.

28 Q. So even the presence of that is a trigger --

A. Yes. 10:28

29 Q. -- that people then know that escalation is required?

A. Yeah.

30 Q. At paragraph 6.4, which we have on the screen - and for the transcript it's WIT-100439 - you set out what you attempted to do during your tenure as Chair of the 10:29 Governance Committee. You say:

"I endeavoured to ensure that the Committee fulfilled its remit by working with the Board Assurance Manager in preparation on agreeing the Committee agenda, annual 10:29 work plan and the contributors and attendees at the Committees' meetings. My role at the meetings was to ensure all agenda items were discussed and outcome actions reached and then to provide assurance on behalf of the Committee to the Trust Board. In practice this 10:29 was about providing structure to the meetings, ensuring appropriate time was allocated and being able to manage the flow of the meeting on the day and create the environment for those attending to be open and honest in their contributions." 10:29

Just by way of practicalities, were the Governance Committee meetings before or after Board meetings? What was the timetabling of those meetings?

A. Governance Committee meetings happen quarterly, but they won't sit naturally either before or after. There is a calendar of events for both the Board meetings and all the committees. So it isn't that it happens the day before or the morning of, it just happens in a cycle.

31 Q. What about the confidential meetings?

A. Confidential governance meetings happen just before the Governance Committee meetings. So it would start at 8.30 or quarter to nine in the morning with the Governance Committee meeting then starting at 9.30, depending on the agenda items.

32 Q. And so, if we look at your tenure as Chair of the Trust Board at WIT-100441, we will look at some of these issues in more detail, but I just want to set out the landscape of your involvement so far. At 7.1, you say:

"I commenced my tenure as Chair of the Board of the Southern Health and Social Care Trust on 1st December 2020 and I continue to hold this role currently. My tenure is due to complete on 30th November 2024."

Then, at 7.2, you set out the main duties. You say:

"The main duties and responsibilities of the role of the Non-Executive Chair, as detailed in the letter of appointment dated 18th November 2020 are: The Non-Executive Chair is responsible for leading the Board and for ensuring that it successfully discharges

its overall responsibility for the organisation as a whole."

At point (b):

10:31

"The Non-Executive Chair shall ensure that the SHSCT policies and actions support the wider strategic policies of the Minister and that the SHSCT affairs are conducted with probity."

10:32

Then, at 7.3:

"The Non-Executive Chair has particular leadership responsibility on:

(a) formulating the Board's strategy for discharging its duties; 10:32

(b) ensuring that the Board in reaching decisions takes proper account of guidance provided by the Minister, the sponsor department, the HSCB and/or the PHA;.

(c) ensuring that risk management is regularly and formally considered at Board meetings;. 10:32

(d) promoting the efficient, economic and effective use of staff and other resources;.

(e) encouraging and delivering high standards of regularity and propriety;. 10:32

(f) representing the views of the Board to the general public;

(g) ensuring that the Board meets at regular intervals throughout the year and that the minutes of meetings

accurately record the decisions taken and, where appropriate, the views of individual board members;(h) ensuring that all members of the Board, when taking up office, are fully briefed on the terms of their appointment and on their duties, rights and responsibilities and receive appropriate induction training;. 10:33

(i) advising the Department of the needs of the SHSCT when Board vacancies arise with a view to ensuring a proper balance of professional, financial or other expertise;. 10:33

(J) annually assessing the performance of individual board members;

(K) ensuring the completion of the Board governance self assessment tool on an annual basis; 10:33

(l) ensuring that board members are made aware of the code of conduct for board members of HSC bodies 2012, including the Nolan Seven Principles of Public Life, and the requirement for a comprehensive and publically available register of board members' interests; 10:33

(m) communications between the Board, Ministers and the Department shall normally be through the Non-Executive Chair who shall ensure that the other board members are kept informed of such communications on a timely basis;

(n) operating the Board and chairing all Board meetings when present, the Non-Executive Chair has certain delegated executive powers and must comply with the terms of appointment and with the SHSCT standing orders; and 10:34

(o) working closely with the Chief Executive and ensuring that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions." 10:34

It's quite a list, when you read it out like that you wonder what attracted you to that particular position. But just in relation to that, just for the Panel's information, is the Chair of the Board remunerated, is it a remunerated position? 10:34

A. It is indeed.

33 Q. What about the Non-Executive Directors?

A. They are remunerated also.

34 Q. Just give us a flavour of life as the Chair, I can't imagine you have much spare time if you are going to meet all of those requirements, but what is it like being the Chair and what are the demands on your time? 10:35

A. It's an absolute honour to be the Chair of the Southern Health and Social Care Trust. I didn't step into this role lightly. Whilst it is an extensive list, that is what is required. They say in the information booklet that goes with the application form that it's a three day per week post. It's not, it's seven days. You're thinking about it, you are responding to it or you're in it and that's what is required. We are in the business of health and social care that operates 24/7. My view is that at the senior leadership level then we need to be available and working at the same level we 10:35

are asking of our staff teams.

35 Q. In relation to your Board at the moment, give us a run down of the numbers and the areas of particular expertise or professionalism that those members bring to the Board? 10:36

A. Okay. So the Board of the Trust is made up of 13 individuals, eight of them are Non-Executive. So you have your Non-Executive Chair and then you have a financial Non-Executive and that's the person who is either qualified or highly experienced in financial 10:36 aspects. Then you have six further Non-Executive Directors who are all lay members. Five additional members are the executive directors, you have the Chief Executive Medical Director, the Nursing Midwifery and Allied Professions Director, the Executive Director of 10:36 Social Work and the Director of Finance Procurement and Estates. So those professional governance roles sit as part of the Board. So the Board is made up of 13 individuals.

10:37

In terms of the skills that are on our Board currently from our Non-Executive Directors, they range from social work to public sector leadership, management, financial, governance, community and voluntary sector work as well. Then the professional side is our 10:37 executive directors who are bringing to the table their extensive professional experience obviously in medicine, social work, nursing, allied professional, midwifery, financial, procurement and our Chief

Executive then across the piece.

36 Q. Now the service provision expertise comes from the executive directors, the senior leadership team --

A. Correct.

37 Q. -- and, as you have mentioned, the medics and other staff. We'll look later on at the potential for there to be more curiosity, perhaps, about the information that was brought and maybe the absence of curiosity and the working out of that, do you have any view as to whether it would be beneficial or useful to have previous service providers on the Board who perhaps know a bit more about the nuts and bolts and their experience might trigger particular questions from them that might allow the Board to be better informed on some issues that are brought to them? 10:38

A. I don't, I don't have that view. I currently sit with a Board where I have two doctors and one nurse who are executive directors. My expectation is they bring their professional role to the table. We have Operational Directors that attend our Board meetings and are part of our committee meetings. I have two further nurses in there. If I look back to 2016-2020, our former Chair was a nurse; Siobhán Rooney, another Non-Executive who is longer serving than ourselves there at that time was a nurse. So we had those, if you want to put it, that knowledge and skills sitting at the table than we do have now. My expectation is that they bring their curiosity too. The curiosity is not just down to the lay Non-Executive Directors, it

has to be across the piece of the Board. I invite our Operational Directors to be a part of the conversation as well, and I see that coming through over the last couple of years.

38 Q. We are going to look at Board training in a moment, but just on that point that you have mentioned about, you felt that the skill mix was sufficiently robust for curiosity to be generated, just as a broad point: Do you have any view as to why people perhaps weren't more curious about information that was brought then, if the skill mix would have allowed that, why perhaps more questions weren't asked when certain information was brought to the Board and it doesn't seem that there was any desire to interrogate it in any robust way, do you have any view on that? 10:39 10:40 10:40

A. I do. My observations, both as a Non-Exec and now in the position of Chair, there appears to be this view that when you get into the boardroom the questions only come from Non-Executive Directors, that the Board is Non-Executive Directors. That is not the case. The Board is made up of 13 individuals with other Operational Directors being a part of that discussion. So there's a long held way of working where the people responded to questions and didn't think they had a place to ask a question. What I have attempted to do in the time that I have been in post as Chair is to create that environment and allow our executive directors and Operational Directors to know that they have a voice at that table too and to use it. I'm 10:40 10:41

seeing that happening more and more over the recent years. So I think it boils down to a way of working that has been ingrained for a long period of time and the thought process that we are there to respond. Some of the language that was used, that is used actually in the terms of reference, you know we talk about scrutiny, we talk about challenge, that is interpreted as we sit and wait till we are asked a question rather than thinking I have a role to do that too. 10:41

39 Q. So can I take from your answer that it's two-fold really: Promoting and encouraging confidence and confidence building and also fostering the correct cultural environment that people feel able to ask and be curious without thinking that they are either inappropriately asking or asking a question that they shouldn't? 10:42 10:42

A. And if I may add a third one: Reminding executive directors that they are executive directors of the Board. So when we make a decision as a Board, it's making a decision, 13 people are saying this is the path, so they have to be involved in that discussion. 10:42

40 Q. Now, when we look at Board training and we go to your statement at WIT-100443, at paragraph 8.1 you say:

"The Non-Executive Chair is responsible for identifying and organising training for board members. Non-Executive Directors also have a personal responsibility to identify training needs at least annually through the appraisal process." 10:43

Now, before you became Chair was it your experience on the Board that training needs for NEDs were appropriately identified and met?

A. Not at the level it could have been. When I look at that period 2016 to 2020, I think we could have been doing so much more to enhance our knowledge and understanding than what we did. I certainly look from 2020 onwards and see the amount of opportunities we have taken to enhance our knowledge and understanding to help us do our jobs. As a Board this isn't just purely just about the Non-Executive Directors but as a Board collectively together. I think we could have done much more. There is an onus on us individually as Non-Execs to raise the flag and say 'I would like'. There are few opportunities each year within the world of health and social care in Northern Ireland to attend conferences and events. But they are not training opportunities, they are not about enhancing our skill set. I think we should get better at that. 10:43 10:44 10:44

I come back to the work with the Health and Social Care Leadership Centre, my vision of that is a very clear and robust induction process and then an offering of a suite of learning opportunities that all Non-Execs can select and access on a regular basis. And it shouldn't just be a once off. We shouldn't just be training people when they come into the role, we should be continuing their training every year to enhance so as long as they are with us then we are enhancing their 10:44 10:45

skills and knowledge across the piece.

41 Q. We'll look at some of the training that was provided so the Panel can get a flavour of the specific Board expertise and some of the issues that are relevant to the Inquiry, for example MHPS. Just before we do that, 10:45
if we look at some of the ways in which training is provided, you say at paragraph 8.2:

"Organisation of training for board members would be carried out through the office of the Chair and CEO. 10:45
This can be arranged as a result of discussions at Trust Board and Committees through discussions with Chair/CEO and/or all Board and Operational Directors. Currently as Chair, I discuss with the Board Assurance Manager training and how best to provide it. Training 10:46
can be provided in a number of ways. A provision of a training course such as "On Board", as was prescribed by the Department of Health for newly appointed members; (b) through Board workshops in developing the Board's understanding of a given area; and (c) 10:46
mandatory training provided by the Trust for all staff and board members."

Then if we go to WIT-100444, you have provided some examples of the Non-Executive Director Board Member 10:46
training and I just wanted to highlight a couple of those. If we move down we'll see dates on the left. 21st March, for example, 2016 there was a Trust Board induction, induction into Trust Board, committee

structure, what is expected of a Board Member.

Then if we move down to 19th September 2016, we'll see there was training in performance and reform induction, 10:47
information session on the performance and reform directorate. 27th March, again performance and reform induction, information session on performance and reform directorate.

10:47

If we could just pause there for a moment. We've looked with other witnesses at performance and reform and the information that is provided to the Board setting that out and there's been a bit of a tension between quantitative data and qualitative data and the 10:47
way in which the Board might be perhaps better informed on one argument of the information underlying the data. So, for example, why waiting lists are the way they are and actually looking down at the layers underneath and was the focus too much on numbers and meeting targets 10:48
and not on quality.

I'm just wondering, when we are looking at the induction, which presumably allows people to understand the information that is presented to them as an NED, 10:48
did you have any view on whether the data you received in relation to performance and target indicators was more numbers driven than quality driven?

A. I'll take the last part first. Yes, certainly target

driven about meeting targets. When I even recall the performance report which came to the Trust Board before we had a dedicated committee, it was, obviously, RAG rated, red, amber, green, so the reds got the focus. It was about what we were not doing and what we were not meeting. The conversation around patient safety and quality of care was not as prominent as it was about meeting the target.

But when you talk about the performance and reform induction, like with any of these inductions this is about an introduction into the department. If I was crafting it again, which I am just about to do with newly appointed Non-Executive Directors, one of the first things that needs to be done is take people through the papers that are prepared for the Trust Board and its committees to help them understand the thinking behind it, and not just a welcome and introduction into the Directorate. Then you build on that over a period of time is my view. 10:49

42 Q. We'll look at that and you can comment perhaps on the volume and appropriateness of your review of what's provided. If we go back to the table and we look at 30th August 2017. 30th August 2017, we can see MHPS training was provided by DLS. Then if we look at 24th May 2018, there is a workshop for Non-Executive Directors on understanding medical data; 1st December 2021, regional training on MHPS procedure for NEDs again, and you were at those training. Now they are 10:50

four years apart, but in relation to what you subsequently were to discover about the application of the MHPS procedure in relation to Mr. O'Brien, I know you didn't know about it at the time, the information was provided to the Board on an anonymous basis in 2017; but do you feel that the training that was provided in 2017 on MHPS was sufficient for you or any of the other NEDs at that time to understand the significance of that process and to properly perform an oversight role? 10:51

A. No, it wasn't. Certainly in 2017, that was the first exposé to it. My takeaway was you have a role there to keep momentum. We get to 2021 and there is a further -- what I would add to that is that Non-Executive Directors kept raising this for the need to have a deeper understanding into our role when assigned an MHPS case. I'd say that, whilst the training wasn't - and this isn't a reflection of June Turkington, okay - I think the MHPS process is just difficult and it was hard to really pin down and clarify what the Non-Executive Director was there to do and not. 10:51 10:52

We've had a further session, I'm not sure if it is on that list, it might be in 2023? 10:52

43 Q. It's not on that particular list.

A. Okay. There was a further session earlier this year which is far more detailed, and I suspect, as a result of this Inquiry, has helped informed the thinking of

both Department and DLS to that. Then we were able to have time with the trainer as Non-Execs so we could have that, I suppose, in camera conversation about the application of our role with reflections from our colleague John Wilkinson in relation to the Inquiry. 10:53

44 Q. We'll look at Mr. Wilkinson's role and I'll ask you to comment on that later on. There was a gap in the training, we can see there, 12th March 2019, and then 1st December 2021, I presume the Covid period probably interfered with some of the training. 10:53

If we look now at some of the all Board Member training, not just the NED. If we go to WIT-100447 for the transcript at paragraph 9.4, I just want to point out a couple of examples for the Panel to see the 10:53 flavour of the training that was provided. We'll see the first one there on 25th February 2016, Non-Executive Director Induction Program, Chief Executive's Business, overview of SH and SCT, Introduction and Overview of Directorates; Finance 10:54 Report and Financial Plan 2016/17, update; Performance Report, Quality Improvement Framework update.

Then, on 28th April 2016, there is an update on the whistleblowing survey, including training standards and 10:54 guidelines, presentation; then Board Governance Self Assessment Projected Outrun 2015/16 and performance report. The Board governance self assessment is something you were involved in?

A. Yes.

45 Q. What does that involve just for the purposes of learning?

A. Okay. It's an annual self assessment tool devised by the Department of Health for health and social care trusts and, I suspect, all their Arms Length Bodies within health and social care to complete. What happened was the Non-Executive Directors would meet with the Chair and discuss and complete. The executive and Operational Directors would meet with the Chief Executive and do that. Then the two pieces would come together and then that is submitted to the Department. Part of that process is about identifying areas of concern and risk, so not having a stable management team, having gaps, and Non-Execs would be part of that, and also identifying a case for learning and where there has been growth and development. 10:55 10:55 10:55

I suppose, there is two points I would like to make on it. Firstly, it's very much a tick-box exercise, not something - and I have not been an advocate of it since I first came across it - but it's a mandatory tool that must be completed and submitted to the Department. What I have attempted to do in my current role as Chair is have that as a unified conversation and a unified outcome that goes to the Department, so we work on it together as a Trust Board, which is what we did in August 2021, which was the first time we were able to physically come together post Covid. 10:55 10:56

46 Q. That's something that is still used by the Department, the Board governance self assessment, that is still in use, that tool?

A. It is. It goes to the Department and nothing comes back. 10:56

47 Q. That was my next question. What is the outcome of it?

A. Nothing comes back, so actually what is the purpose of it is my view. The Chief Executive and I have agreed that this year we will undertake as a trust what's called a well-led review. I think those are quite 10:57 familiar in England, if I'm right. We planned that to begin in April 2024. For me, even looking at the scope of it, the fact that it looks at leadership and governance throughout the entire organisation, this here is where we all sit in the room and say how good 10:57 we've been. It's not really a decent reflection and meaningful reflection of our governance as a Board. I would like our organisation to be able to say whether or not they felt the Board were carrying out their functions appropriately. So I look forward to the 10:57 well-led review. This is still required by the Department. I don't see a value and a purpose in it. We carry it out and I have attempted in the last few years to ensure there is a degree of meaning for us within the Trust that something positively comes from 10:58 it. That's it.

48 Q. The well-led review you think is perhaps a better fit for outcomes and learning that you would want to derive from the communications with other members of the

Board, does it sound like something that is the better tool to use?

A. Absolutely, that's what I view it as at the moment, yes.

49 Q. If we just look at another couple of examples of the training for all board members, 27th April 2017: Sharing the SHSCT pledge with our young people, Board governance is mentioned there; Board Effectiveness - A Good Practice Guide, 26th April 2018. There is mention of the corporate risk register; quality improvement, what does it mean for Trust Board? Board governance self assessment. 10:58 10:58

We have had witnesses that you may have been able to listen in or are aware of their evidence, we have asked people about the risk register. I know that mentions the corporate risk register, and you have touched upon it in your statement, but it doesn't seem that the particular issues that are of concern to the Inquiry found their way on to any risk register in order to move up to the Board and to allow them to be identified as a patient safety or risk issue; does that surprise you now that you know the extent of the issues of concern, would you have expected those to be on, perhaps not on the corporate risk register, but any risk register? 10:59 10:59

A. Yes, I would have.

50 Q. Would that, if they had have been included on the risk register in a sufficiently clear or detailed way, was

that a means by which the Board may have been alerted to the issues that are now subject to the Inquiry?

A. Yeah, you could see how it could escalate up to committee and then the Trust Board and then you would have that level of oversight and questioning and probing around it, yep. 11:00

51 Q. If we go to 17th October 2019, just skip down. This one includes training on reflection and learning from SAI in correspondence from the family to the Chair - just for the note the personal information has been redacted - and also roles and responsibilities of board members. Then if we go to 27th February 2020, the Clinical and Social Care Governance Review was on the agenda for the workshop and then a qualitative analysis of how learning from serious adverse incident reviews can contribute to reducing deaths by suicide of young people in the care of mental health services. 11:00 11:00

Now those two examples specifically mention SAIs and outcomes, what was your experience both as an NED and now as the Chair in relation to being informed about SAIs and then informed about learning and implementation of any recommendations or requirements after the SAI has been completed? 11:01

A. From the SAI perspective then, we would get an overview at the Governance Committee of the number of SAIs. There has been a journey travelled on this one with the committee to ask for themes to come through, maybe for some examples so we could get a sense of what these 11:01

SAIs were about and if there is anything in essence connecting the dots, rather we have 54, we have completed 22, there is 33 outside the realms. So it was moving it more into is there intelligence within this information that we need to be considering. That is a journey we travelled 2016-2020 and 2020 through to now, we are seeing that evolve more so in relation to the reporting. 11:02

Specific and serious SAIs and the learning from it, in the early part of my tenure we wouldn't necessarily have seen that coming through. But certainly as time has moved on then it's an opportunity to review and the seriousness of it has come through either committee or to Trust Board and we need to take stock and reflect and ensure, and certainly from our perspective as a Trust Board is there anything we needed to do differently as well as what's happening within the Trust itself. 11:02

52 Q. Does the Board or the Governance Committee have any involvement in the outworking of SAI recommendations or ensuring that themes of governance that might emerge are dealt with operationally by executive directors and the SLT generally? 11:02

A. When they have come to the Board or through the Committee, the serious ones that have come to us, then an action plan would be expected, that action plan and then a follow up to the Board or the Committee in due course as to the progress that is being made on that. 11:03

53 Q. That layer of oversight that wasn't previously there is now there?

A. Yeah.

54 Q. If we go to 15th October 2020, Mortality and Patient Safety Data - A Training Session. Now, in relation to that specific stream of intelligence or information or data for the Board, is it your view that the way it is presented from mortality and patient safety, is that something that assists you in trying to understand governance concerns or is that more of a specific clinical issue that the Board don't really get involved in? 11:03 11:04

A. I would -- there is yes and no, I'll explain why. I would say my reflection of 2016-2018 is that I was not fully aware or understood the information that was coming before us. If I think about mortality and morbidity, it was the previous Chief Executive Shane Devlin that really helped unlock that in terms of understanding what that report meant to us as a Committee, a Governance Committee at that time, and then, obviously, the piece there for that report is about how safe our service is. I never really got that until Shane Devlin had taken the time to explain that. 11:04 11:04

Patient safety data as well, incredibly important and it was about how the new scores that were coming through, the pressure ulcers, how that all impacts on patient care. It gives us, as lay observers, an indication of where care is not where it needs to be 11:05

and the patient safety element of that. So, the two parts is no in the early days but yes in a better state now.

55 Q. You've mentioned about patient safety and you've talked about risk a moment ago, is that language frequently used at Board meetings, is there a general culture around that that is the fundamental core by which all decisions should be assessed against, is that the culture of the Board, that there is a requirement to be constantly alert to those potential issues and detriment to patients? 11:05 11:06

A. Yes, it is, it is now.

56 Q. When you say "now", is that a difference from -- are we drawing the line at when you became Chair or is the line drawn before that, where would you say "now" begins? 11:06

A. I would say I draw the line when Dr. Maria O'Kane became the Medical Director for the Southern Health and Social Care Trust, she brought a different focus.

57 Q. Did that focus permeate with the Board and the SLT? 11:06

A. It did.

58 Q. In terms of a practical outworking of that cultural change, if I can use that term, you can correct me if you don't agree with that, but in terms of the practical outworkings of that, did that allow for more robust and honest conversations around patient safety and risk? 11:07

A. It has done so, yes.

59 Q. We will look at the chronology of some of the issues

around urology later on, but one of the things that other witnesses have been asked, and I'll ask you now just in relation to that, is that there does seem to have been perhaps individual or general lack of recognition that some of the issues that may be classed as administrative or not directly clinical didn't seem to alert people to the potential for patient risk or the impact on patient safety. Because, for example, charts or issues that seem to be carved off as not directly patient facing, if I can put it like that, do you think that that was an issue for the Board as well, that if things weren't directly clinical then there may have been a lack of focus on the potential risks? 11:07 11:07

A. My observations on that is that the interpretation by some of the role of the Board and the interpretation then of the role of senior leadership and senior management team, the operational stage in operational and the Board needs to stay where the Board is. But actually it is the Board's responsibility, it is all the Board's responsibility. So whilst our job as board members is not to go in and do the doing, our job is to ensure that the doing is being done and is being done in the right way. So you can't separate them like that. 11:08 11:08

I do recall language being used 'that's operational', 'don't go there, that's operational.' So we have, certainly in the last few years the language that we're using, Dr. O'Kane talks about safe high quality care,

talks about patient safety, what about the patient in this, what about the patient, that comes through more and more. That has just refocused all our tenets [sic] in that regard.

60 Q. It's an example of perhaps a reluctance or a failure, whichever way you might want to characterise it, of not recognising risk or asking questions around risk when the Board was told in 2017 about the MHPS process, it doesn't seem to have triggered any concern. I'll rephrase that: It doesn't seem to have triggered any action or curiosity on the part of the Board to ask about patient safety or to ask if there had been any investigation carried out, whether people were safe or was there a concern or a risk, it doesn't seem to have triggered any of that, not just from the Board but from others as well. But I am asking you as a Board member at the time, I know you weren't Chair, but you were on the Board; do you think that that was an opportunity when patient safety and risk may have been raised or explored at that point so that a wider look could have been considered as to what those issues were? 11:09 11:09 11:10 11:10

A. Absolutely. We should have been asking is there a patient safety risk here. Not one question is my recollection from any board member, and that includes the executive board members too. 11:10

61 Q. Again then would your answer be the same, if we fast forward to August 2020 when the Board was told and there was an absence again of any, I'll use the term curiosity because I have used it before, but any

interrogation of the information the Board was told to see if there was a patient safety or risk issue?

A. In August 2020?

62 Q. It was slightly different because of the alert.

A. It came up under "Any Other Business", it was a statement. Then we came to it in the September where the questioning came in. But, yes, patient safety, even in 2017, knowing the SAI as I do now, the patient safety was there, only these two pieces of information weren't being joined together. 11:11

63 Q. Do you see those as opportunities lost?

A. Absolutely.

64 Q. I just want to ask you about, just in front of us there there is reference, on 29th April 2021, the Muckamore Abbey Hospital, report of the independent leadership and governance review and structures review. Then if we just move down slightly, 9th December 2021, Muckamore Abbey Hospital, independent leadership and governance review update. 11:12

Just in relation to that particular review, was the purpose of that workshop to take the learning from that review and implement it more broadly, is that your recollection of it?

A. Yeah. We had asked Barney McNeany, who was our Director for Mental Health and Learning Disability, to look at the review. Then we as a Trust Board and as a Trust needed to look at what are the lessons for us and is there learnings there that we could deploy to ensure 11:12

that we wouldn't fall through the same challenges that they did at that time. So that was about identifying the lessons, it was about focussing in on the Southern Trust and saying what is it that we need to do differently or is there anything that -- have we got everything that we need, do we need to do things differently and do we need to shape something to ensure that we don't have the same challenges as Muckamore.

65 Q. Some of those reviews bring up issues or potential lacunas or training that might be required or services that might be required, is that a matter for the Trust and the Department to agree funding or the provision of that or is the Trust expected to meet the needs of review recommendations out of its existing budget? 11:13

A. Yes, it is. Any actions that come out, the expectation is that we need to meet them. 11:13

66 Q. If we could just go to 18th May 2023. Just on reading this, the language in this box seems slightly different, it just seemed aimed at more culturally significant language. When you talk about: 11:14

"What is the Trust doing to improve communication? Improving communication with patients, organisational development perspective, what more can we do? Setting the Trust Board's risk appetite." 11:14

Without being seen to look for any compliments for the Inquiry, it does seem as if some of those themes are matters that we have touched upon here, and I am just

wondering if there has been any learning already permeating through in May 2023 to inform some of the workshops?

A. I would say absolutely. It would be remiss of us not to take the learning so far. I invited the Ombudsman to a Board workshop. The Ombudsman was about to release a report particularly in relation to Health and Social Care Trust engagement with patients. I had known from our experience at the Trust that we get reported to at Governance Committee in relation to the number of cases, referrals, what is proceeded or not. So this was a great time to bring the Ombudsman in to hear from their perspective and for us then to reflect on what we heard and is there stuff we need to consider. Communication is one of our key complaints and remains so for the population that we serve. So, through this, it was about what do we need, what can or should we do differently. 11:15 11:15 11:15

67 Q. Now if we look at some of the ways in which some of the governance issues may make their way to the Board, I'll just touch on this topic briefly. If we look at WIT-100476 at paragraph 19.2. The reason to look at this is that later on we'll look at the way in which information was provided to the Board and you can maybe perhaps comment on where you think communication lines may have arisen or in fact fell down and didn't work. At 19.2, you say: 11:16 11:16

"The lines of management for providing information to

the Board on governance issues include the following: (A) from committees to Trust Board via Chair's report and copy minutes; (b) from Chief Executive and/or their senior management team to the committees and the Trust Board via reports and papers; and (c) from Non-Executive Directors through to the Board Chair and/or raised with the Chief Executive at the Chair/CEO Non-Executive Director meetings or through the Chair Non-Executive Director meetings." 11:17

19.3:

"The information would be received either by email or verbally depending on the situation and the timing. Where meetings were being arranged to discuss the issues, any papers would be uploaded on to Decision Time, which is the on-line portal for all Trust Board papers in advance or provided on the day for all members to review; what was in place to bring urgent issues to the Trust Board was through the Committee structure, directors' workshops, confidential Trust Board and Trust Board itself." 11:17

Then you say at 19.5:

"In my capacity as Chair the following communication lines currently exist in tandem with the formal touch points outlined in my response to question 13 above: (A) confidential Trust Board meetings allowing for the 11:17

CEO and directors to alert the Trust Board to any issues;

(b) Chief Executive briefings with Non-Executive Directors which happen every two months, providing the CEO with the opportunity to bring urgent matters to the Non-Executive Directors;

(c) as Chair I can alert the Board on an urgent issue through email or through arranging a meeting of the Board, if required; and

(d) any Board Member or Operational Director can bring to the attention of the Chair or CEO any concern on an urgent basis."

So there is a broad range of ways in which information can flow back and forth. Obviously that depends on the confidence of the people providing the information, the integrity of the information that is provided and the detail that you are given, so it is very much personality led in some ways, would you agree with that? 11:19

A. I would.

68 Q. I know we mentioned about culture before, but I'm just wondering, in practical terms, I know there is a lot of training and a lot of attempts to enhance people's confidence and attract the right people on to Boards, I am just wondering, with your broad experience and your expertise around Boards, is there anything in particular that you have found enhances the culture of a Board sufficiently to allow people to speak openly

and to bring problems without there being a sense of a blame culture or that someone is going to get in trouble, is there anything that you have come across and you think, well that actually works, that is beneficial or is it really something that is an ongoing challenge? 11:19

A. It is down to the individuals. Everybody in the room has got to want the same thing and got to come to the meeting with the same willingness to be open and honest all the time. So when you have that mix then it's great, you bottle it, you keep it, then you duplicate it and send it on its way. So you're always trying to achieve that. So when you get new members on your Board, the culture and the platform that you set, there is a role there for me as Chair to help new members understand this is how we work as a Trust Board, that it is open and it is honest and that it's a safe space for people to contribute, no matter what level they work at within the organisation. 11:20 11:20

69 Q. Does the existence of confidential meetings, does that enhance that? Does it allow that to be explored more fully or does it make little difference to getting the proper information that you need to make good decisions? 11:20

A. The confidential meetings primarily are, when they are about patients or about staff and about a service area that is not ready for the public domain because there is complexities around it, they shouldn't get to the public domain and is certainly a journey that we have 11:21

taken over the last number of years. So the confidential meetings are not a space that you can be honest in and you don't be honest here in a public meeting, you have got to be honest in them both. It is not an either/or situation. 11:21

70 Q. When we looked at the training we saw mention of whistleblowing, I just wonder what your views are on that as a means of identifying relevant information to allow you to look at governance through that lens?

A. It is, and I'll give you a short example of it, would that be helpful? In maternity we had as a Governance Committee noticed a level of increasing litigation, particularly child birth, and I hadn't realised just how difficult that process is, how dangerous it is. But what happened was we were noticing these increases 11:22 in litigation, we were asking questions and being curious around it. Then a whistleblowing case came in and that really just pinpointed and alerted the need for a focused effort and the Executive Director responsible then took a lead on that, so yes. 11:22

71 Q. It can be effective?

A. Very effective.

72 Q. In your experience?

A. Yes.

73 Q. Escalation of governance issues you have dealt with at 11:22 WIT-100480 at paragraph 22.1. And, at 22.2, you mention a list of methods for escalation, and we will just highlight them briefly. The first one are Early Alerts, point (a), which we will go on to discuss

briefly later on; (b) confidential Trust Board meetings that we have just looked at; (c) the Governance Committee then, which we have already looked at; point (d) Chief Executive briefings with the NEDs which happen on a monthly or bimonthly rota. Then there are 11:23
internal audit reports, you have mentioned at point (e); then the executive and Operational Directors also attend the Audit Committee. I think that goes back to the point you made earlier on where there is a collective responsibility for people to bring matters 11:23
to the appropriate Board and Committee.

Then, at (g), the Trust Board workshops, which we've looked at as well. Then, at (h), at the end of each Trust Board meeting, Executive Directors of Medicine, 11:24
Social Work, Nursing and Finance are asked if there are any other issues relating to their professional roles they wish to bring to the Board's attention. So that's an opportunity for anyone to raise anything at that particular point. 11:24

A. Yep.

74 Q. Just before, Chair, with your indulgence, just before we break, if I can just go to WIT-100479. Again for the Panel's note, looking at your attitude to risk and risk management, and I just want to read this in, 21.1: 11:24

"The Governance Committee has been the committee that receives and discusses the corporate risk register at its quarterly meetings. During my tenure as Chair of

the Governance Committee, 'deep dives' on corporate risks were instigated from 2019. These allow for risks and mitigations to be further explored to ensure that the right measures are in place in relation to a risk. The senior management team review the risk register on a regular basis and update it accordingly. Each directorate carries its own risk register and where risks can no longer be managed at Directorate level, they are escalated to the senior management team." 11:25

11:25

21.2:

"The Board receives the Chair's report from the Governance Committee and yearly receives the corporate risk register in full. The Chief Executive and Accounting Officer is the accountable director and holder of the risk register." 11:25

At 21.4: 11:25

"The risk register should be a fluid document which should and does change as risks are mitigated and removed and as new risks come into existence." 11:26

Just pausing there, we did see some risks just repeat on risk registers as though they were standing items almost?

A. Yes.

75 Q. Is that something now that isn't the case, is there more of a proactive oversight than management of risk registers?

A. There is some that still stay and that is because the environment we are in within health and social care, they are not going away any time soon. But certainly there is more fluidity to the risk register. You are see the risks being de-escalated and others being escalated and coming to the committee by way of Chief Executive. 11:26

76 Q. Then at 21.5, you say:

"The Trust has not in my time had a risk appetite statement. However, work has begun on this with a dedicated workshop in November 2021 externally facilitated. This has been further developed through a Trust Board workshops on 18th May 2023 and 18th September 2023. The current work on establishing an appropriate level of risk appetite will further support the Board." 11:27

Just 21.6:

"Although there is as yet no risk appetite statement, my experience on the Board has been that it takes the question of risk generally very seriously and that it has no appetite for any risks that relate to clinical concerns and patient safety."

Thank you. Just, we've talked about the risk and the cultural change you say has come about with Mrs. O'Kane taking up post, but just for purposes of the Inquiry, a risk appetite statement, you couldn't just explain what that is and what purpose it serves? 11:27

A. Okay. The risk appetite statement is a statement of the Trust to say this is the risk we are willing to accept. What we have done as a Trust Board through the two workshops is created a statement that we are all agreed on and a level of tolerance of risk. So we can 11:28 have a risk to say this is our risk but we know there is a bit of flexibility and we know how we can mitigate that in relation to the individual risk. So the risk appetite statement gives us the framework within which we will adopt our risks or, sorry, deploy across our 11:28 risk areas as a Trust Board from here on in, and that's coming to our Trust Board meeting at the end of this month.

77 Q. Is that something that has been around for a while or is that a relatively new approach? 11:28

A. The concept has been around for a long time. We used the Good Governance Institute through Dr. John Bullivant to start our thinking on it. A risk appetite statement at Trust Board level is something that hasn't been in place. 11:28

78 Q. And is there any -- do you understand why it hasn't been in place, is there any reason why it didn't exist before?

A. I honestly don't know why.

79 Q. Do you think it might have been something that would have been of assistance in both assessing and monitoring and overseeing risk?

A. I do. It sharpens your antennae, you are thinking about it. Certainly for me I can see how we deploy -- the outworkings of this risk appetite statement would translate over to the reports, cover sheets for all Trust Board papers and that the executive directors would be minded of the risk when they are presenting their papers. 11:29

MS. McMAHON: Chair, I wonder if that's a convenient time to take a break?

CHAIR: I think it's just after half past, so we will come back at 11:45. 11:29

THE HEARING ADJOURNED FOR A SHORT PERIOD

THE HEARING RESUMED AS FOLLOWS:

CHAIR: Thank you everyone. 11:46

80 Q. MS. MCMAHON: If I can take you back to paragraph 21.1 of your statement, WIT-100479. Just, I've read this out already, but there is mention there, the second sentence in that paragraph: 11:47

"During my tenure as Chair of the Governance Committee deep dives on corporate risks were instigated from 2019."

Just if you could explain what deep dives entails, please?

A. Happy to. On the corporate risk register, our corporate risk listed good mitigations and all of that, and we can sit and look at that as a Governance Committee for a 15 minute window and have a brief conversation. The idea about the deep dives is to allow us to get in underneath the skin of some of these very significant risks and to allow a broader conversation with the Governance Committee to test the controls and the mitigations that were narrated in the document. That is the purpose of the deep dives. There was one, at least one. We tried, we were very ambitious, we thought we could do two, but at least one at each committee where we were able to get into a deep dive situation. 11:47 11:48 11:48

81 Q. Does a deep dive involve any consultation with clinicians or other frontline staff who are providing the service that is being looked at?

A. No, the deep dive would be the Governance Committee with the Operational Director or the Executive Director that was there, the holder of that risk and the Chief Executive as well. 11:48

82 Q. Might there be some benefit of including frontline personnel in that review in order to, if there was, for example, any clinical concern or major concern that had resulted in the corporate risk being identified, that that would be properly understood, would that be something that you would feel would be useful or do you 11:48

feel that is not necessary?

A. Without a doubt having our frontline staff involved in the identification of risks is incredibly important. As to whether that can be pragmatically delivered and practically delivered within the realms of a deep dive within a Governance Committee I'm not sure. But my expectation would be that the directors responsible will have gone across this with their teams, they should be coming to the table having had the conversation and knowing how it works in practice for their staff teams. 11:49 11:49

83 Q. I think by your answer just before that one that there hasn't been a deep dive into anything involving the urology service?

A. No. 11:49

84 Q. Just in relation to the statement at 21.6 at WIT-100479 where you say that the Board takes the question of risk generally very seriously and that it has no appetite for any risks that relate to clinical concerns and patient safety. The Inquiry has heard evidence of long waits for review and admission for treatment, just general waiting list issues and delays in the provision of health care, do you see those as risks to patient safety? 11:50

A. I do. 11:50

85 Q. Given that statement and your answer, is there anything specifically that the Board is doing or has done or plans to do to try and reduce any risk to patient safety that exists because of waiting lists or to

negate them in any way?

A. There is in some part within the realms of what we as a Trust Board and Trust can do in relation to -- certainly if I was to use the example of elective care. Elective care, yeah, so the overnight centre which is now based at Daisy Hill Hospital, which is our second Acute site. The increasing numbers of lists being carried out there is to help reduce the waiting lists, the use of virtual clinics to help with waiting lists as well across the piece of the Trust. But in the whole gambit of all of this then there is the significant challenges faced with workforce and access to consultants and specialists in order to carry out these lists as well as the nursing and specialist nursing staff to support that function; then being commissioned to carry out work, so that work needs to be paid for, you need to be commissioned to carry it out in order then to be able to carry it out and have the staff team to do it. Those latter two, as much as we can try there is other elements that need to come in to support that. 11:51 11:51 11:52 11:52

86 Q. Now I want to move on to the Board Member Handbook which we have in the Inquiry papers which was issued by the Department of Health after the Hyponatraemia Inquiry and it can be found at WIT-101127. Now just for the Panel's note, and I'm sure the Panel know that the independent review -- sorry, the Inquiry into Hyponatraemia related deaths reported in 2018 and this report is dated May 2021. It is a resource to support 11:52

the delivery of safe and effective care. It is quite a large handbook, very detailed, and you will be relieved to hear that I don't intend to go through a lot of it, but I would like to jump through some of the main -- well some of the points that may have particular resonance with the issues for the Panel, if we go to WIT-101128. I should just ask you, this is a document that you are familiar with?

A. It is.

87 Q. Is it a document that you use with your board members, is it something that is used as a working document? 11:53

A. I wouldn't use it as a go-to document. Our terms of reference, our appointments, letters, all have similar threads going out and the standing orders then for Trust Board. But I am familiar, with it in terms of its content and its focus. I'm not sure did I say it has been shared, it was shared with all Non-Executive Directors at its release point by me. 11:54

88 Q. Just the middle paragraph, I am just going to read this paragraph which just sets the context: 11:54

"Mr. Justice O'Hara made 96 recommendations in his report, including 16 specifically in relation to leadership and governance. In response, the Department of Health set up an extensive programme involving over 200 individuals from a range of backgrounds, including service users and carers, health and social care staff and board members, and representatives from the third sector to take these recommendations forward.

I acknowledge that it has taken some time for implementation of the recommendations to start. This is regrettable, but sadly inevitable owing to the need to deal with the Covid-19 crisis. This handbook is the first product to emerge from the IHRD report and I intend, now that the worst of the pandemic is hopefully behind us, that the pace of implementation will increase."

I had asked you a question earlier about recommendations and whether they potentially or actually put a burden on the Board to implement what is suggested in some of the outworkings of either the Inquiry and indeed this handbook and whether the funding for that came from existing Trust funds; is this another example perhaps where the handbook indicates an expectation and the Trust has to finance or provide training or meet that expectation from its own funds? 11:55 11:56

A. Can I just clarify with you in relation to the implementation in the handbook or the implementation of the recommendations? 11:56

89 Q. Well both in some respects. Because obviously the implementation of the Inquiry recommendations are not complete and very wide ranging, but in relation to the handbook there is some expectation around training and a standard of service provision that may require the Trust to bring about some training and to focus some funds, so is it a separate answer for each or is it the 11:56

case that the burden falls with the Trust?

A. There is a separate answer for each, okay. So for the recommendations and the process that was involved to get to the point of the over 200 individuals, all trusts played their part in that. That was done within the realms of your business as usual. So that support -- and you were releasing staff to carry out those functions and to go to those meetings, that was done as part of that. 11:57

In relation to the training that is mentioned in relation to Non-Execs, when Non-Executive Directors are appointed, I mentioned earlier in my statement about the "On Board" programme. There is two programmes that are offered in the appointment letter, one is the On Board programme, the other is a programme offered by CIPFA, which is the Chartered Institute of Public Finance and Accounting, I could be wrong on that. For Non-Execs that is paid for by the Department, but for the executive directors it is paid for by the Trust. 11:57 11:58

90 Q. In relation to implementation of the expectations from either the recommendations from the Inquiry or from the outworkings of a handbook like this, do you find that the conversations with the Department are mutually beneficial, that there is an appetite to improve things and to try and provide funding that will allow that to happen? 11:58

A. The funding landscape for the Trust, whilst the Department would be supportive, obviously, for the

implementation to take place, as we would, as well, not always does that support follow with finance in order to be able to resource it. So the expectation is you do it within the gift of what you have, the envelope you are working within. The financial envelope within which the Trust operates has been one that has been challenging for many, many, many years. It is referred to as a capitation gap. So our population increases, the health needs of our population increases but the funding doesn't follow that increase to enable us to meet the demand that is in place. So that's an ongoing conversation with the Department. That is heard, that is understood but obviously in the current financial brackets they are not in a position to be able to address it in any shape or form. 11:58 11:59 11:59

91 Q. The handbook also serves as a reminder of where accountability stops, I know you have included the diagram in your statement, but if we look at WIT-101147. And just in the box, it says, and ALBs are Arm's Length Bodies. I think you mentioned earlier in your evidence that this incorporates many Boards, it is not just health. It says: 12:00

"While ALBs should operate with a level of autonomy to deliver their services, the Minister is answerable to the Assembly for the overall performance and delivery of its ALBs and, therefore, ultimate accountability for the exercise of proper control of financial, corporate, clinical and social care governance in the HSC system 12:00

rests with the Minister."

Just giving the specific wording of that in the structure of accountability, the current absence of a minister and the absence of an assembly in Northern Ireland, as the Chair of a Trust Board faced with - I know you will explain the significant and competing demands on the service provision in all the trusts, but in your expertise in the Southern - what impact, if any, does it have on your day to day operations, your ability to make decisions, that there is in fact no minister in place? 12:00 12:01

A. It has an impact on some of the changes that are needed to be made. If I can come back to that in a second, if you don't mind, but on a day to day, in terms of running the business of delivering health and social care, it doesn't make any difference. But if we are to change, and I am coming back to the beginning piece, if we are to effect the changes that are needed in light of Bengoa 2016, so here we are eight years later into a 10 year plan that didn't get started. So there is significant changes that need ministerial approval for. The absence of those and the absence of that change and reconfiguration and what health and social care in Northern Ireland needs to look like and needs to operate like in the future, that is a huge gap and a void. 12:01 12:01 12:02

In the meantime, though, there is work being done

between the Chairs, between the Chief Executives, working with the Department to try and shape and - I can't think of a word, I can't remember the word, sorry - to shape and basically create the pathway for some of that change to take place. So an example for us in the Southern Health and Social Care Trust would be, yesterday the Permanent Secretary announced the consolidation of emergency general surgery into Craigavon Area Hospital and it will no longer now be provided in Daisy Hill Hospital. We have gone through a programme of work over the last two years to put in temporary measures, to go out and consult, to engage locally with political reps and the community to get us to the point that that is the safest way to deliver that service. So that decision by the Permanent Secretary yesterday is to be very welcomed. It is those kind of decisions that are needed to help effect the change for the delivery of health and social care. 12:02 12:02 12:03

92 Q. The Panel have heard reference to Bengoa from other witnesses as well, you mentioned yourself it is eight years ago, and arguably the landscape has changed considerably both with Covid and post-Covid, do you think there is the potential for Bengoa to perhaps be slightly out of date and the need then for fresh eyes on a way of approaching health care services should a minister come into post? 12:03 12:03

A. The premise within Bengoa doesn't change. There is need for significant change in how we deliver health and social care without a doubt. As to what that might

look like now needs to be shaped by our staff, particularly our nursing staff and our clinicians across the piece of how best to deliver that in whatever shape or form that may look like. So at a regional level at the moment there is a piece of work ongoing in relation to hospital blue print; what will the hospital that is near you, what will it deliver, what will it be known for. We can't have everything on every site, so we have to rationalise as best we can to ensure that our expertise and our very limited resource of specialist staff are placed in the best location to provide the best service and care for our patients so there is a need for that change. 12:04 12:04

The premise of Bengoa stands, change is needed. There is work being done at a regional level with the leadership of health and social care to try and - navigate is the word that I was looking for - to navigate that process. 12:04

93 Q. I mentioned the diagram just a moment ago, and we will look at it just in passing, the Panel will be familiar with the set up, it is WIT-10119. It is just a familiar diagram, again emphasis on accountability and lines of accountability. Then if we go to the next page, at paragraph 1.5.3 "Accountability of Individual HSC Board Members". The report states the following: 12:05 12:05

"To what extent can a board member be held liable at law for their actions? Basically if an individual

Board member incurs a civil liability in the course of carrying out their responsibilities for the Board they will not have to pay anything out of their own pocket provided they have acted honestly and in good faith.

12:06

However, it should be noted that this indemnity does not protect any Board member who has acted recklessly, criminally or in bad faith. The issue of Board member indemnity cover should be covered in the letter of appointment and the ALB's code of conduct for board members."

12:06

Then if we move to WIT-101180. There is comment on what is required for a board member to be effective. The Nolan principles are mentioned, you mentioned those in your statement as well. At 3.2.4, "being an effective board member", I'll start at the third paragraph:

12:06

"In order to be effective in their role, board members should."

12:07

Then just the first one: "Actively participate in collective decision making and chair or participate in, where required, one or more of the Committees of the Board."

12:07

Then just move down to the third point, it says:

"Question intelligently, challenge rigorously, debate constructively and decide dispassionately."

That is a very eloquent but burdensome sentence perhaps, but it does encompass in a much more elegant way what I have been probably trying to say all morning which is that there is a requirement that the Board really focus their attention so that they can be the eyes and ears of the Minister effectively so that accountability can properly flow backwards and forwards. The reason why I'll stop on that point with the handbook and move on to the reality of Board membership is I want to look at the Board packs, I want to look at some of the information the Board are expected to look at. 12:07 12:08 12:08

Just by way of context can I ask you, what is the lead-in time for the board members to receive their packs before the Board meeting? Then and now if it is different but you can give us the full answer. 12:08

A. It is a constant challenge, it can be anything from one to five to six to seven days, depending. Not all the papers, a good majority of the papers will be arriving on time, but there will always be late comers. There will always be last minutes, there will be changes, just the nature of the work, those papers. It could only have just arisen and we have asked for a briefing on it or there is significant pressures within the system and the lead director is just pressed, so it can 12:08

come late and that's been an ongoing occurrence. That isn't about 2016 to 2020 or 2020 onwards, it is just a difficult timeline to meet.

94 Q. I just missed the start of your answer, how many days did you say? 12:09

A. Between one and five or it could go to seven. Ideally, the requirement is that, if our meeting is on a Thursday, we will get them the previous Thursday, we tend to get them on the Friday. Sometimes late ones will come through Monday/Tuesday. There has been 12:09 occasions where something doesn't come through till Wednesday evening.

95 Q. So sometimes operationally or even from the Board's own governance processes, there is a late addition to the pack that may result in people getting papers a bit 12:09 later?

A. Yes.

96 Q. We have obviously been provided with quite a volume of Board packs. I just want to take you through what a typical pack may contain. I know you're familiar but, 12:10 being a Public Inquiry, people online and also the Panel not being familiar with that, I just want to give them a flavour of the type of documents, the detail of those documents and also I will be calling out references so the Panel will know where these documents 12:10 could be found if they need to, but we don't need to go to any of them. It is just really to set the scene for the reality of Board membership when the Panel are considering the actions of the Board in their

deliberations?

A. Sorry, just before you go on, you had stopped at this statement, questioning intelligence and dispassionately, can I offer you a reflection on that?

97 Q. Please do, yes. Sorry, I should have given you the opportunity? 12:10

A. Apologies. This is the piece for me where the impression and interpretation of what a Board does gets lost. Because a Board should be about having an engaged, informed, intelligent conversation. We are all working for the same outcome, to get the best decision that will impact on those that we are here to serve. So it is really important that we do the rigorous piece, that we do the constructive piece and there is a support and challenge function in there for each other, not just that it is a support for the executives or the challenge for the execs and support for the Non-Execs, it has got to be a support and challenge function for both. 12:11 12:11

98 Q. Thank you for that. That does provide a better context then for some of the information we are going to look at. As I say I will just give the headlines of some of these, a typical pack. So obviously an agenda. So, Chair, if you don't mind, I'll just read out the references and if anything needs to come of any of this we'll know where the documents are. So when I read out a reference, it is just an example of one such agenda, an example can be found at TRU-122076. They also usually contain the minutes of previous meetings of the 12:11 12:12

Trust Board for approval, an example of that is at TRU-122113. The pack will contain minutes, annual reports of committee meetings for approval, and one such example from a Patient and Client Experience Committee is TRU-122756. It will also contain a Chief 12:12
Executive's business report as relevant, an example of that is at TRU-122098.

CHAIR: I hesitate to interrupt, Ms. McMahon, but it might be helpful to know just what volume of material one of these is. 12:13

MS. MCMAHON: I'll divide it up in content and volume, it was just easier for me to do it, or Ms. Smyth I should say, I am not taking any credit. The Chief Executive's business report can be found at TRU-122098; the good news stories for the Trust, TRU-112033. It 12:13
will contain the Chair and NED business which usually details the events that the Chair and NEDs have attended, an example is at TRU-112036. Then it will contain financial performance reports at various times, TRU-112011. 12:14

There is also potential for other financial reports, for example a summary report of capital and revenue proposals greater than £300,000, TRU-122390. Monthly corporate dashboard, an example of that is at 12:14
TRU-112116. That's a monthly performance report assessing performance against objectives and goals for improvement. Some of the packs also contained a document heading "Matters arising from previous

meetings", an example is at TRU-122132.

It also could contain a medical appraisal and revalidation annual report summarising the work undertaken by the revalidation team to ensure that doctors continue to meet GMC requirements, at TRU-121926. Medical director reports of various natures including, for example, research and development, TRU-115506. Health care associated infection was another example at TRU-122572. 12:15

It could contain human resources reports. These tend to contain very high level reporting of workforce issues, for example, HORD Trust Board report providing data on workforce productivity, sickness, movement and recruitment, an example is at TRU-122709. An estates services annual report, there is an example at TRU-115768. There was an example in one of the packs of a document which was a proposal to apply the Trust seal to documents, where the Trust Board is asked to formally endorse contract documents for the Trust framework, TRU-117683. It might also contain reports about children in need and looked after children, an example at TRU-123616. Also it may contain progress reports on statutory equality and good relations duties, an example at TRU-122424. There will be a report of the Executive Director of Nursing, Midwifery and AHPS setting out updates on activity and development within the professions, an example of that

can be found at TRU-122591. It might also contain at times a Trust delivery plan which sets out the actions the Trust will take in response to the Department of Health commissioning plan direction, an example of that is at TRU-122134. 12:18

Sometimes there are Powerpoint presentations on issues of interest. So, for example, organ donations or presentation on volunteer service, examples at TRU-122079. 12:18

Sometimes one of the packs had a Board governance self assessment tool - we talked about that earlier - it can be found at TRU-115100. 12:18

In later years there are various reports produced to discuss the Inquiry report into hyponatraemia-related deaths that we have talked about and accompanying recommendations and the Trust's work to take forward actions on that, an example of that is TRU-118807. 12:19

Just picking up on the Chair's question around the volume and the issue of the timing and the lead-in and the ability to actually read, absorb and develop a critical analysis that would allow people to ask, to 12:19 question intelligently, challenge rigorously, debate constructively and decide dispassionately. The Trust Board pack for 24/11/2016 contained 530 pages, that can be found at TRU-112538. For 25th May 2017 the pack

contained 809 pages, TRU-113942. For 26th October 2017, the pack contained 896 pages and that's found at TRU-116788. Those dates are chosen because of what was going on at the time on the operational side and the potential for governance issues to be highlighted, just to give an idea of the volume. 12:20

As well as the volume of detail and the volume of papers, also information is provided in relation to the time allocated for discussion of some of the issues which might give us a bit of a flavour of the level of detail that perhaps could have been achieved within that timeframe. If I can say from the outset, and you can push back on this if your experience is different, but the general impression given by the agendas is that the time set aside during the Trust Board meetings for consideration of minutes of the Trust Board committees was not extensive. So by way of example to back that up, at TRU-124356, the agenda for the meeting on 28th March 2019, 20 minutes is allocated for the Trust Board to consider the minutes and key issues of the Endowments and Gifts Committee, the minutes, key issues, terms of reference and committee schedule of reporting of the Governance Committee; the minutes, key issues, terms of reference and committee work program of the Audit Committee and the minutes and key issues of the Patient and Client Experience Committee. 12:20 12:21 12:21

Now there are other times but that is just a snapshot

of one, and I know that that was in 2019. I mean, you've sat in the meetings, you have received these Board packs, it would be an unfair question to ask someone with such extensive Board experience as you because your ability to review and analyse information may be somewhat more highly developed than others on the Board, but did you ever feel that the paperwork and the Board packs were - I don't want to use the word overwhelming - but certainly challenging to get on top of and to understand in advance of the meeting, just in relation to the variety of documents and the volume first of all before we look at the time? 12:22 12:22

A. I would agree with you, it is a huge volume to get through at whatever point you get it. The important - and this comes back to the directors being really clear and articulate in their cover sheet as to the key threads that they are presenting, the challenges and the risks and indeed what the ask is, either of the committee or the Trust Board, and then the detail is there for anybody who wants to delve into it. So you can only go so far. There is not one Non-Executive Director - I'll speak for myself - not one of us could sit here and say that we can thoroughly review 890 pages in a five day window, bearing in mind that, if we are getting it on Thursday and Friday, then you have the weekend. Obviously, we are not full time, so there is other activities going on during the week. So you are trying to pull this information into your sphere as best you can in the time you got it, so the cover sheet 12:23 12:23

for me is the critical component.

99 Q. Now the Trust Board meeting minutes of 24th October 2019, we can look at that, TRU-128380. We are going to these minutes because they reveal that a decision was made to change the manner in which the Committee Board minutes were presented to the Trust Board. So that's TRU-128380. So, just at number 14 there, where it says "Board Committees". So this was in Mrs. Brownlee's time: 12:24

12:24

"By way of introduction, the Chair advised of the implementation of a new standardised format for how each Subcommittee Chair communicates the work of their committee to the Trust Board. She stated each report will be taken as read unless there is an urgent issue the Committee considers the Board should be taking action on." 12:25

Now, just the wording of that, if you can help me understand the process by which a decision like that is made because it is not immediately clear, at least to me, on reading that. "The Chair advised of the implementation of a new standardised format", if we stop there and I ask: Does that mean there has been a discussion about this and there's been a unanimous decision that this should be the way in which something is implemented or is it the case that the first time the other members of the Board hear about this is by the inclusion of this paragraph on this, or do you have 12:25 12:25

any recollection around this being brought about or talked about or decided?

A. I have no recollection exactly on this front, but I would surmise, because Non-Executive Directors would repeatedly raise concerns in terms of the agenda, the length of time given to items and the challenge, obviously, in completing the business of the Board agenda within the start time and the end time that is given. I'm surmising that there was a conversation between the Chair and the Non-Executive Directors on this. I am surmising, I cannot recall. Because we would, as chairs of committees, we would need to have had a discussion on how this was going to be in terms of a new way of working. 12:26 12:26

100 Q. Is it the case that the Board, any Board Member, if they get a report from a committee, that they can unilaterally ask to talk about some of the issue on that so they can say can I just ask a little bit about what this says here? 12:26

A. Absolutely. 12:27

101 Q. Is there any sense that going to a default position of the report having been read unless somebody wants to raise it, and in fact the onus seems to be in this paragraph on the committee, "unless the Committee considers the Board should be taking action on it the reports will be deemed to have been read", is there any sense that that default position removes a layer of oversight from the Board in that the necessary interrogation or the possibility of there being a 12:27

conversation or a more detailed look at these things is not to be assumed to take place, the default is that it won't happen, do you think that is a possibility?

A. Yes, I do, I agree with you on that. The impression would be that we just take it as read and move on. But that does not stop any member raising their hand and raising a question. 12:28

102 Q. Is that still the position now, that you're Chair, is it still that each report will be taken as read unless there is an urgent issue? I know lawyers look at things slightly differently, but - I can't help myself - it does seem as if there is a criteria of urgency motivated by the Committee that are the two triggers before the report will be opened more formally? 12:28

I mean, I will accept I'm probably looking at that a wee bit through a different lens, but what's the position now, is it the same? 12:28

A. No, it's not. The Committee Chair Report, the revised version means a revised approach for committees, there is a Committee Chair Report plus the minutes of the meeting. Those are presented by each Committee Chair and there is an allocation, I think, of 10 minutes within each agenda for each committee. It is up to the Chair then to raise, to give an overview, to raise the issues or say 'everything is fine, I present this for information' and any work plans or any areas of work that they are presenting to the Trust Board for approval. So there is the allocation of time for each committee, there is the onus on the Chair to present 12:28 12:29

the paper and the reports and the minutes are there of the meeting as well so that everybody has had the opportunity and sighted on what has been covered.

103 Q. So the Chair of the Committees and the Directors, the executive directors of the SLT for example, they are responsible for highlighting on the cover sheet or the first bit of information what the Board should focus on given the volume, the volume of information that is put before them? 12:29

A. Yeah. 12:29

104 Q. You really do depend on that?

A. Just for my clarity, if you are talking about the cover sheet, there is one from the Chair of the Committee and there is one -- yes, okay. So the responsibility lies with all those individuals to make sure that that cover sheet is telling the story, the real story, and what is needed then from the Trust Board in that regard. 12:30

105 Q. I just want to ask you something about what Mr. Devlin said in his witness statement. We don't have to go to it, but for the Panel's note it is at WIT-00046. It is just a comment that he made and he says this: 12:30

"The Trust Board agenda is regularly 60% discussion of clinical governance issues."

12:30

Would that be your recollection?

A. It wouldn't. 60% of the Governance Committee would be -- if not more. The Trust Board covers a vast arrange of the goings on in the Trust. Even from the

list that you read out a short time ago, you have got estates, you have got finance, you have got Human Resources as well as the delivery of the professional governance reports. I wouldn't see it as 60%, but I wouldn't be saying that on the basis that it's less. It can change depending on the meeting, it can change in relation to the areas and the topics that we're looking at, that clinical governance could be popping up at 80% at one meeting depending on what we are focusing our attention on. 12:31

106 Q. Were there enough clinical governance issues arising over your period as an NED and now as Chair for you to think, yeah, the pathways exist and are functioning properly for clinical governance concerns to come before us? 12:31

A. Could you repeat that please.

107 Q. I wish I could, it is such a good question! We'll have to read the transcript. Really the essence of it is, did you hear enough about clinical governance problems or issues or concerns for you to be satisfied that yes 12:32 the pathways exist for us to get those concerns brought to our attention, if that was close enough?

A. I would say I don't think so, not in the earlier part, it is not coming to the fore as much as it is now.

108 Q. You've given us an example of you emailing questions in 12:32 advance from another NED at WIT-04222 and WIT-04223, and this was an email trail where one of the other NEDs had sought some clarity about a private patient issue, it is just really as an example of interrogation and

curiosity by one of the NEDs and you trying to resolve it. If we just move down, I don't need to read this, but Geraldine Donaghy. She draws attention to the fact that 15 minutes have been allocated to discuss a paper in relation to the internal audit report on Mr. O'Brien's urology private patients and compliance with relevant guidance. What Mrs. Donaghy has done is to identify that she needs to have more information before she can properly take part in the discussions at the Board, and she sends that to you. So you can see the last line there, the paragraph in her email: 12:33 12:33

"I would appreciate if sufficient time were provided at the meeting to hear and discuss the responses."

12:34

Just go up to the email before this, thank you. You then send this on to Shane Devlin explaining the context. You say in paragraph three:

"Geraldine has noted she had a number of questions and I encouraged her to send them in advance. Geraldine has raised a series of questions from the report." 12:34

Then you said, last sentence of paragraph 4:

12:34

"To manage time tomorrow, if these could be answered/reflected on in advance."

The reason why I am bringing that example, is that an

example of the change in culture that you referred to earlier on in your evidence where you said there seems to be more openness, more willingness for people to reach out and say 'I need a bit more information on this' and perhaps be more value adding when it comes to the actual meeting? 12:35

A. Yes.

109 Q. I just want to briefly, you mentioned it in your statement, the impact on staff turnover potentially on Board efficacy, most particularly with the Chief Executive, if we go to your statement at WIT-100468. You just mention this in two paragraphs, paragraph 16.6, and you say: 12:35

"The 2021/2022 Board governance self assessment recognised the risk to the stability and effectiveness of Trust Board as a direct consequence of vacancies at Senior Executive and Non-Executive Director level. Actions to address this included all senior executive positions to be advertised and appointed by December 2022 and Non-Executive Director positions competition programme, including SH and SCT vacancies, to be advertised by public appointments unit in October 2022." 12:35 12:36

Then you say at paragraph 16.7: 12:36

"In my experience, having instability in the Board and Senior Executive Team directly impacts on the

effectiveness of the governance structures. During the period 2016-2018 there were interim Chief Executives and Interim Executive Directors who were members of the Trust Board. In addition, six out of eight Non-Executive Directors were newly appointed during the 2016/2017 year. The appointment of Mr. Shane Devlin as Chief Executive in 2018 allowed for the beginning of a process to make substantive appointments to the senior team. August and November 2020 saw the end of tenures for two long standing Non-Executive Directors. This created two vacant positions which, as I write, remain vacant. The appointment of Dr. Maria O'Kane as Chief Executive in 2022 has seen the follow through on completing the restructure and recruitment of permanent and substantive posts across the senior leadership team." 12:37 12:37 12:37

So you've started that paragraph by saying "having instability in the Board and senior executive team directly impacts on the effectiveness of the governance structures"; given the change of staff and the quite high volume of turnover of personnel for Chief Executive, what was your experience of the impact on the effectiveness of the governance structures when you were NED and latterly as Chair, what was the actual impact of that? 12:37 12:38

A. You want me to look then and now?

110 Q. Yes, that would be helpful.

A. Okay. So this for me was without a doubt a moment in

time for the Southern Trust that it is still reaping and hurting from, not having that stability at senior, exec and Board level. At that time - obviously I'm only one/two, well one year in in 2016, well I start in 2016, so my observations for the instability absolutely rippled throughout the leadership team. You could see from their need to have leadership, to have a vision, to know where they were going and who was taking them there and what was going to happen when they got there and that they were doing it together as a body corporate. 12:38 12:39

So I would pinpoint this as one of the most pivotal times for the Southern Trust. Looking back and sitting where I am now, I am in the position, as I sit here today, viewing down the lens of having seven new Non-Executive Directors within a 12 month period. So we are back at this place again where you have such a change at that level. I'm sitting as Chair comfortably in that the senior leadership team bar the Executive Director of Social Work, which will be advertised later this month - and that has only been delayed as a result of the external review by Ray Jones - that that team is in place, there is a leadership there from the Chief Executive, that there is plans afoot for the vision and the strategy of the Trust that our team so desired. 12:39 12:39 12:40

But from the Non-Executive Director position, this organisation will see a massive change within the next

12 months, a loss of experience, skill and continuity, but that should not be a reason to extend. But I think if I asked them all to extend they may say no anyway. But you should not -- the tenure time for our Non-Execs is two tenures of four years and that comes to an end for the majority of them this year.

111 Q. Is there a difficulty in trying to address those particular issues arising, is there any solution to that?

A. There is two things: There was a delay in the recruitment process and there was 16 Non-Executive Director vacant posts across the Health and Social Care Trust alone in Northern Ireland. So we were all carrying vacancies for the last two, three or four years for some. That recruitment process has only just concluded there end of November, beginning of December for those 16 vacant posts. There is a waiting list that has been created as a result of that recruitment exercise to fill the upcoming vacancies in the next 12 months. So that's a helpful addition and one that should always be available in any recruitment process for this, because the recruitment process can take up to 12 months.

In this case, I think, you talked about what I had said around 2022 to be advertised for, that didn't happen and that's just pressures of the system. So we have got there. Two Non-Executive Directors have been allocated to the Southern Trust at this point. I have

two Non-Execs that are about to leave within the next 30 days and they will need to be replaced too.

112 Q. In your experience is this a particularly unique time for recruitment, is there anything that's feeding into that or has it always been historically challenging to get recruitment sufficiently, well done in sufficient time so that there is no gap, has it always been like that? 12:42

A. In my experience in health and social care, yes. But my experience other than that is succession planning. When you appoint somebody you know when their end date is going to be so you start your succession planning at that point; you know three years into a four year appointment, if you are going to be losing one or two members, you will be running a competition, you plan for that competition. You don't wait till you get to a couple of weeks before the end point and then run the competition, because then you have an extension to put in place, then the length of time of the competition to roll out, to give you an outcome. And you may not get an outcome is the other risk on that, you may not get the skills that you require for your Board at that point. So succession planning for both Non-Exec and executive directors in health and social care hasn't been particularly good and that is something that would need to significantly change. Because these are important leadership roles, they need to be planned for and recruited for in the most appropriate way to ensure we get the right skills at the right time for the 12:42 12:43 12:43 12:43

organisations.

113 Q. And who is responsible for that?

A. For the Non-Executive Directors, that sits with the Department of Health.

114 Q. Why has there been no succession planning if self-evidently time periods of tenure are going to expire and it is foreseeable that there will be difficulties, why do you think there has been a failure to bring about succession planning? 12:43

A. I honestly, I would only be giving you my thoughts, I don't know why it hasn't been. But I suspect that, in the scheme of what the department does, it is not up there in the top 10 things to keep an eye on. But from where I sit as a Non-Executive Chair of the Health and Social Care Trust the leadership of the Trust certainly is in my top three every day of the week. So I would be encouraging the Department to ensure succession planning was appropriately planned for from here on in. 12:44 12:44

115 Q. On one view, when one looks at that handbook, the detail and the expectation, the legal responsibilities, the statutory responsibilities and the governance responsibilities, it could be argued that it is difficult to see why keeping Boards fit and healthy and filled would not be something that would be in the Department's best interests? 12:44 12:45

A. These are not attractive roles. You've got to want to do this. You don't step into a Health and Social Care Trust as a Non-Exec because you have some time on your hands. You do it because you want to bring your

skills, your experience and your absolute commitment to health and social care to the table. I firmly believe, and it is with my Boardroom Apprentice and other hats on, people want to serve, they want to learn to do that, so let's create the space for people to be able to serve on our Health and Social Care Boards and get that right at the beginning. Succession planning needs to be thought about the moment you appoint somebody. The senior executive team succession planning, I know from talking with our current Permanent Secretary Peter May, this is something he has focused on, something he has focused on in relation to the training and development of Non-Executive Directors and that induction piece, that is on his agenda and he is watching it and he wants that to happen. We need to think of how we make these roles, not just Non-Exec, but the senior executive roles attractive to encourage people to apply, because they are incredibly rewarding. 12:45 12:45 12:46 12:46 12:46

116 Q. When you have a turnover at Chief Executive level to the extent that was apparent in the Southern Trust, is there a danger or possibility that the Chair, whether it be you or the former Chair Mrs. Brownlee, who will come and give evidence and answer questions herself, but is there a possibility that either advertently or inadvertently they become more involved in operational decisions because they have corporate memory or because they need to fill a gap that may exist at any time?

A. Absolutely. We talked earlier about Roberta Brownlee's tenure with the Southern Trust and within the Southern

Trust area and the legacy trust. She is constant, she was a constant individual for the Southern Trust. When you look at the flux of the senior executive and the Board, Roberta Brownlee was the constant person that was there. So either rightly or wrongly the stepping from the Chair to the Chief Executive role, you can see how easily that was for Roberta Brownlee to do and that she felt, I would suspect she probably felt that she needed to step in at that flux period. But that flux created that space that allowed Mrs. Brownlee then to become in essence what I have referred to in my statement as a de facto Chief Executive when we didn't have a substantive Chief Executive in post. 12:47 12:47

117 Q. We will look at Mrs. Brownlee later on in relation to her involvement on the Board. I just want to briefly touch on the urology departments being flagged up or being raised at Board level. A couple of these are before your time so I won't take you to them because you can't speak to them, but I am going to give those examples just for the Panel's note? 12:48 12:48

A. Okay.

118 Q. The first one is 2009 when the Trust Board was made aware of the ongoing capacity issues in urology and the related impact on patient waiting time, an example of that Trust Board is at TRU-105665 which is 24th September 2009. The minutes state that the Trust Board was advised that the trusted had undertaken a review of urology services and this had highlighted a capacity gap. 12:49

Then on 25th August 2011 the Trust Board was advised that the Trust is continuously aiming to improve urology services and the longer waits are, at that point, decreasing in numbers. However, again there is a capacity issue in terms of prioritisation of referrals, and that can be found at TRU-106429.

And then, 30th August 2012:

"The Trust Board members were advised by way of a monthly performance management report that the performance risks identified that in-patient day cases and urodynamics result from an established capacity gap in urology for which recurrent investment has been committed. The Trust Board is advised that current in-house capacity is entirely absorbed in managing red flag referrals and urgent cases."

The note of that can be found at TRU-106600.

Then in 2013, on 26th September, the Trust Board is advised that:

"Urology continues to present an ongoing risk which is the subject of regular discussion with the Health and Social Care Board. The Health and Social Care Board is said to have accepted the workforce constraints affecting this area of performance."

And that's at TRU-107138.

Then coming into your time, you started in February 2016, I don't expect you to remember this, but just to let the Panel know that we are moving into a more relevant period for you. Similar issues were raised in March 2016 the Trust Board is advised that the longest Trust waits are in urology. When you look at the numbers now, I suppose the example then with 34 patients at that point were waiting from 2012/2013, and that's found at TRU-109040. 12:51 12:51

In January 2017, the Trust Board are told that the majority of breaches of the 62 day waiting target are within urology, and that is at TRU-112949. 12:52

In January 2019 the Trust Board are advised that the longest wait in terms of in-patient and day case waits are within urology, and that's at TRU-123905. 12:52

There is an example of when the Trust Board discuss the issues and seek information from the directors and senior staff on their plans to resolve the issue. An example of that can be found in the minute of the Trust Board meeting of 24th January 2019, and that's at TRU-123905. That is an example when Aldrina Magwood presented the performance report for approval, the members considered it: 12:53

"One of the Board, Mrs. McCartan, referred to the longest wait in terms of in-patient and day case waits within urology at that point at 257 weeks.

The members recognised challenges within urology regionally and Ms. Magwood assured members controls are in place to review and manage lengthening access times." 12:53

When you're told something like that at the Board do you consider 'well operationally they are on top of it, so we have been reassured from a governance perspective.' I mean, hindsight is a wonderful thing, but is there a level of scrutiny and say 'well what are you doing and what are your timeframes for trying to turn this around', was there active conversations like that at any point? 12:53 12:54

A. I wouldn't recall specifically, but certainly there would be conversations around seeking assurance and getting it from the director responsible. I would also say that urology, as with other services under pressure and demand, so it wasn't the only one. If it was sitting as an outlier it would certainly raise a flag, but it wasn't sitting as an outlier in relation to us having pressure in our services in the Trust. And 2019, also 2016/2017 through, I know certainly our emergency department at Daisy Hill occupied a huge amount of the Board time but also other specialisms in the Trust. 12:54 12:54

So, back to your question, we would question, seek assurance from it. But, for me, certainly sitting listening to the minutes or the pointers that you gave from before 2016, I think you have four, if not five, were urology, pressures and demand capacity was raised. 12:55
And now we step into 2016 and 2019, I think 2019. So you have quite a number there where that would be saying to me as a Non-Executive Director 'this keeps raising its head', but at that point certainly assurance would have been sought from Aldrina Magwood 12:55
and the director responsible as well.

119 Q. Again there is another example in 2019, 24th October 2019:

"A report was prepared by the Chair of the Patient and 12:56
Client Experience Committee for the Board meeting."

We don't need to go to this, but this can be found at TRU-128158. The Committee had at that meeting considered a presentation highlighting the work in 12:56
urology. The presentation was by Kate O'Neill who we've heard from:

"The presentation by Kate O'Neill highlighting work in urology revealed the impact of the service on the 12:56
clients. In addition, the presentation revealed the real impact behind the performance figures on service users. The significant impact of service development was highlighted including the use of specialist nurses.

Challenges to the service were noted. Workforce planning, quality of life issues for the service user, inability to reach cancer targets, waiting lists, multiple attendances at ED due to urology-related issues; equipment needs, service improvement issues." 12:57

And then "innovation overload".

Just one of the sentences that jumps out slightly is: 12:57

"The presentation revealed the real impact behind the performance figures on service users."

I suppose that highlights the value adding of a service provider coming to the Board and giving the context 12:57 that may have just been a one dimensional performance figure, and Kate O'Neill is actually giving you the real life examples.

The subsequent minutes of that meeting for which the 12:57 report was prepared don't appear to reflect any substantive discussion about urology after that presentation, that can be found at TRU-128380. I am just wondering, by this stage was there a sense that 'well these are just the problems in urology' and 12:58 perhaps, I know we're focused on urology but obviously wider governance and perhaps in other departments as well, was there a bit of 'we know about this and it doesn't seem to be improving'?

A. At the minute I can't recall the full conversation at the committee meeting, but I do recall we did discuss the impact on the patients and that hit home for quite a number of us. I also recall that that conversation was continued with the Chief Executive I think as part of one of the meetings between the NEDs and the Chief Executive. So whilst the minute does not reflect certainly the impact on the patient, and that's what the Patient Client Experience Committee is there for, it was certainly heard. Having our service providers and our staff come and tell us as it is as well as our patients is something that is incredibly important to inform us both at committee and at Trust Board. So I am very taken by what we heard at that meeting in relation to the impact. 12:58 12:59 12:59

MS. McMAHON: And I fully accept the minute can't cover everything, but it was just as an example of specific issues in urology being raised. I am going on to a separate topic, Chair, and I wonder if that's a convenient time? 12:59

CHAIR: Yes, we'll come back, ladies and gentlemen, at 2.05.

LUNCH ADJOURNMENT 13:57

THE HEARING RESUMED AS FOLLOWS:

CHAIR: Thank you everyone.

120 Q. MS. MCMAHON: Ms. Mullan, I just want to move on now to a new topic, it's the chronology and the way in which you discovered the concerns around urology and Mr. O'Brien, and we will look at your witness statement at WIT-100503. I'll just read out the question that you've answered. We asked you at paragraph 31: 14:01

"Please provide full details of when, how and by whom you and the Board were first made aware of issues and concerns regarding the practice of Mr. O'Brien, to include all information about what was said and/or documentation provided." 14:02

You say at 31.1:

"At a confidential Trust Board meeting on 27th January 2017, Mrs. Vivienne Toal raised, under agenda item 6, Maintaining High Professional Standards, the following." 14:02

And you quote this:

"Mrs. Toal advised that, under the MHPS Framework, there was a requirement to report to Trust Board any medical staff who have been excluded from practice. She reported that one consultant urologist was 14:02

immediately excluded from practice from 30th December 2016 for a four week period. Mrs. Toal reported that the immediate exclusion has now been lifted and the consultant is now able to return to work with a number of controls in place. Dr. Wright explained the investigation process. He stated that Dr. Khan has been appointed as the case manager and Mr. C. Weir as case investigator. Mr. J. Wilkinson is the nominated Non-Executive Director. Dr. Wright confirmed that an Early Alert had been forwarded to the Department and the GMC and NICAS have also been advised." 14:03 14:03

At 31.2, you say: "The consultant's name was not disclosed to us at that time."

14:03

At 31.3: "There were no documents provided to us either. Information was provided verbally by Mrs. Toal and Dr. Wright."

At 31.4: "I now know that the consultant being referred to at this meeting was Mr. O'Brien. I believe that I only became aware of this in or about August/September 2020." 14:03

And you say at 31.5: "Up until that point, 27th January 2017, I was not aware of any issues or concerns regarding the practice of Mr. O'Brien." 14:04

Now the meeting on 27th January 2017 when you were

informed, the trigger for you being informed or the Board being informed was the requirement under MHPS that the Board is told, and we've read out what you had been told, was that the totality of the information that was provided at that time at the meeting, what you've quoted in 31.1?

A. As I recall, yep.

121 Q. Was there any discussion about this item after Mrs. Toal gave her information to the Board, do you remember anything? 14:04

A. No, I don't. I don't remember any discussion and actually I don't believe there was any discussion.

122 Q. Did anyone ask why he had been excluded?

A. I don't believe anybody asked.

123 Q. Do you think that that might be a natural question for someone to ask 'well, if a consultant has been excluded, what's behind it', would that have been -- there was no reason or there was no bar to anyone asking that question? 14:05

A. No. There is two questions should have been asked that day: First, what was the reason and, second, do we have a patient safety concern. 14:05

124 Q. Do you recall at all if the Chair made any comment or said anything or raised any queries like that?

A. No, I don't. My reflection, this is the minute from that meeting, it is, isn't it? This is the actual minute from the meeting? 14:05

125 Q. Yes, this is in your statement, and it is taken up from it.

A. Yeah. So, going on my experience, that would be the totality of what was discussed at that point in time.

126 Q. Do you recall if there had ever been an MHPS process or outcome or investigation brought to the Board at any other meeting that you had been at? 14:06

A. Since?

127 Q. No, before.

A. Before, no.

128 Q. No. At this point in 2017, given the training that we looked at earlier, were you familiar with what MHPS was, can you remember? 14:06

A. I don't recall, but the training for MHPS followed a few months after this. It was quite possibly that would be the first time I would have heard the term MHPS. That could be quite possibly the first time I heard it. 14:06

129 Q. Is it possible then that the Board weren't even aware what the framework was whenever they received this information?

A. It would be possible for some of the Board but not all of the Board. 14:06

130 Q. If we take it that it wasn't all the Board and some of the Board were familiar with what MHPS was, does that surprise you even more that they didn't ask 'well, what's behind this'? 14:07

A. Yeah, it does. Because you have three Non-Execs who are in less than a month, another three in less than a year. You have two further Non-Execs and you have an executive director sitting there who had longer term,

longer experience and knowledge and understanding, where MHPS I would like to think has come up in the lifetime before I was a member of this Board, that they would be familiar. So you look to them for, I suppose, their insight into this.

131 Q. Did it surprise you or even on reflection do you have any views that you were only told this after the consultant actually had been -- the exclusion had been lifted given that the requirement to report to the Trust Board was that someone had been excluded, but the Board is being told at the point at which the exclusion has been lifted four weeks later? 14:07

A. Yeah. The first part of your question?

132 Q. You are being told on 27th January 2017, the point at which you are being told is that the consultant is now back to work; the requirement under MHPS is to report an exclusion from practice, not a return from exclusion? 14:08

A. Yeah.

133 Q. Do you think you should have been told when the consultant was first excluded rather than when he was brought back? 14:08

A. Yeah, we should have been. Then there is the SAI that took place in 2016 as well which didn't come before. Those two pieces of information would have made a great deal of a connection. I have thought about this in terms of what I thought at the time at this meeting, it was in essence a sense that you are being told this, this is happening over here, don't need to worry about 14:08

it. They just felt that this thing called MHPS is happening here, we'll come back to you. That was just my reflections from that meeting. But, yes, the framework says we should be told of exclusion and this is the point of being returned from exclusion. 14:09

134 Q. So there was a sense that we are looking after this, we'll update you if there is anything else?

A. Yep.

135 Q. The reason why I'm just asking slightly about the detail of it is, if you are looking for fracture lines 14:09 in the chronology, opportunities for perhaps something to have been done and for perhaps people to look at things a bit more deeply, was this an opportunity in 2017, had people questioned that something might have arisen and there might have been, as you say, a patient 14:10 safety review or at least a risk assessment?

A. This is certainly a point of fracture, no questions asked, no exploration. Even following through from the Minister in that meeting to others, there is no follow up. So, absolutely, we did not question, we did not 14:10 explore properly, we were not curious enough. We did not engage in a conversation, we did not ask, we did not ask any questions at that point.

136 Q. I was just going to say, then the next time it came up was 27th August 2020, the confidential meeting, and it 14:10 was brought up under "Any Other Business". If we just move down. Then you've helpfully provided a table in your reply. The first item on that is 27th August 2020. There was an Executive Director update at the

Trust Board workshop by Maria O'Kane. The notes from the Trust Board workshop held on 27th August say:

"Dr. O'Kane brought to the Board's attention SAI investigations into clinical concerns involving a recently retired urologist. Members asked that this matter be discussed at the confidential Trust Board meeting following the workshop."

The next item, the minute from that is -- the last sentence of that box, the second box: 14:11

"Members request a written update for the next confidential Trust Board meeting."

14:11

Now were you at that meeting as well?

A. Yes, the August and the September.

137 Q. And did you know the name of the consultant at that point?

A. I don't, not into August. 14:12

138 Q. There had been no connection, because you didn't know the name in 2017 and you didn't know the name in 2020, there was no way you could have connected?

A. There is no automatic flag for me on that front, no.

139 Q. So in August '20, I just want to ask you about 14:12 27th August 2020, the meeting, can you remember the context in which Dr. O'Kane brought this information to the Board? I know it was under, "any other business", but was there any sense of a linkage, was there any

sense of urgency, was there any expectation that the Board would take decisions or was it really just providing you with information at that point?

A. Yep. So my observations on it is that the Early Alert was - I expect we will talk about it - but the Early Alert came earlier in the summer. This was the first meeting of the Trust Board. This was a workshop that we were doing other items on, so under "Any Other Business" in the workshop then that would be the first point in time for Dr. Maria O'Kane to raise this with the Trust Board in its entirety. That was done at the workshop piece. 14:13 14:13

And then there was - could you scroll back, can you go back, please, to the table with the two parts? Thank you. Yep. Then there was a confidential Trust Board meeting just following, immediately following that workshop and, as it wasn't on the agenda that was given, then Dr. O'Kane raised it under "Any Other Business" at that point. 14:13 14:13

140 Q. Again, it's the same question around patient safety and risk assessment, was there any consideration given to carrying out any - I'll use the phrase deeper dive - but any other further analysis of the information to find out if there was a risk at that point? 14:14

A. At that point there was no information other than the verbal update being given by Dr. Maria O'Kane. Then our discussions was that a fuller update to be provided at our next confidential meeting in September.

141 Q. Given that was a month away, would you have anticipated or expected or even assumed, not just you, the Board generally and the collective responsibility, that Dr. O'Kane would have been, had one eye on patient safety or risk or at least had that to the forefront of her mind whenever she is dealing with this issue? 14:14

A. Oh, I have no doubt.

142 Q. What would you have anticipated that she would have done to assure herself that patients were safe and the risk had been minimised or eliminated, if there was one at that point? 14:15

A. I suppose at this point the consultant in question was no longer an employee of the Trust, that's the first thing; secondly then, going on the information we got in September, looking back, the amount of work that was done to identify where patients were at risk and were not safe, that work was being done at pace in the background. So certainly from the September meeting and the document provided by Dr. O'Kane through her assistant Medical Director, it certainly showed the work and the efforts being -- I suppose the timeline and the chronology of all the events and the work that was being done. 14:15 14:15

143 Q. In tandem, at that time you mean, later on after this, the 2020/2021 timeline? 14:15

A. Yes.

144 Q. You mentioned the Early Alert, if we just look at that, it is at WIT-101965. Now this is the Early Alert dated 31st July 2020. The Panel has looked at this before

and, subject to the views of the Chair and the Panel, I don't intend to read it in. But it sets out in quite a bit of detail about the lookback review and the issues that had arisen and gives data on the number of patients, the time period and mentions the Royal College of Surgeons preliminary discussions and the GMC involvement. So it's quite a detailed Early Alert that indicates that, from 7th June, on 7th June 2020 the Trust became aware and they are sending this Early Alert to the Department on 31st July, so seven weeks after they became aware. They have obviously evidence gathered, got it together and put this in. 14:16 14:16

Now, that was an Early Alert. At the time as a member of the Board did you receive Early Alerts that were issued? 14:17

A. At that time it wouldn't have been a constant occurrence.

145 Q. But there would have been some that you might have got?

A. Some we would have received, yep. 14:17

146 Q. Was there ever any reason why you got some and not others, was there some understanding with the Board that only certain Early Alerts would make their way to the members?

A. I have no understanding as to why some would come and some would not, whether it was about the nature of it, because they were different. So it wasn't like it was only the ones with the media interest came our way or the ones with patient safety came our way. There was a 14:17

difference between them all, so I don't know why there wasn't a consistent issue out to Non-Executive Directors.

147 Q. Can I ask how you would know there was an alert if you didn't get it, how would you know you didn't get some, I suppose? 14:18

A. Exactly.

148 Q. You just assume you didn't get some or did you subsequently learn that they had been issued and you hadn't been told? 14:18

A. In the process of doing my Section 21 then I was able to go back and look at Early Alerts that had been shared. I think I have a schedule in there of some that we got. And, as an Non-Executive Director, I know that I would have got some coming through and from 14:18 conversations we would have had as Non-Executive Directors with the Chair and Chief in the past, we would have been asking about Early Alerts and having that shared. So we knew this Early Alert process was there, it would come our way sometimes but not all the 14:18 time.

149 Q. We'll look at some of the ones you received and your comments on that in a moment, but just while we are at this particular one which sort of sets the ground work for future actions of the Board. It was sent by 14:19 Stephen Wallace on 3rd August 2020 and the subject is:

"Confidential, Early Alert, Urology, July 2020."

It's addressed to "Dear Roberta". There is no recipient, but it says:

"Dear Roberta, please find attached an Early Alert regarding urology for your information. As per regional Early Alert processes, the Board and Department have been provided with the attached information. Dr. O'Kane has spoken to the CMO office to advise of the content. The CX..." 14:19

Which we know to be the Chief Executive:

"...has also been made aware. Please note, given the sensitivities and ongoing processes surrounding this issue, the internal circulation list has been limited and we ask that this is not shared wider at this stage. Regards, Stephen." 14:19

And Stephen Wallace was the Interim Assistant Director of Clinical and Social Care Governance. Does he still hold that post, Mr. Wallace? 14:20

A. No, he doesn't.

150 Q. Now there is no circulation list on this email so we don't know -- but it wasn't sent to you?

A. No, this wasn't sent to me. 14:20

151 Q. Do you know who else received it? I know Mrs. Brownlee received it, but do you know who else would have received this email and the Early Alert at that point?

A. I would suspect the Chief Executive got a copy.

Certainly all of them that's coming from the Medical Director, it would have went to -- the Board they are referring to there is the Health and Social Care Board, not the Board of the Trust or the Department. So I'm not sure if it went any further than that, I don't know.

152 Q. Did you see this email just for the first time because of the Inquiry disclosure?

A. Correct.

153 Q. Do you understand what the second paragraph means "given the sensitivities and ongoing processes surrounding this issue", do you have any understanding of what that refers to? Given Early Alerts usually do contain sensitive and ongoing issues, do you take that to indicate that there was something in particular about this Early Alert that made it different from others? 14:20 14:21 14:21

A. Yeah, because Early Alerts that we get now say "please find Early Alert attached", the reference and who it has come from. This one, you can check, or we can check certainly, I'm nearly sure that this email, because I would have included a copy within my statement, is only to our former Chair Roberta Brownlee. That second paragraph for me, I suppose I'm taking it is in relation to Mr. O'Brien and Mrs. Brownlee. 14:21 14:21

154 Q. Do you take that to be the case because of information that you have learnt from the Inquiry or because you know something else?

A. Oh, no, from the Inquiry and the process of the Inquiry.

155 Q. Now, Mrs. Brownlee didn't bring this to the Board, didn't raise this, didn't address any of the issues in this with you at that point? 14:22

A. At that point, no.

156 Q. Given that you have had a look at it now, you were provided with a copy of it, do you think it is something that should have been shared with the Board?

A. Oh, yes. 14:22

157 Q. And had it been shared with the Board, just based on your experience, your tenure at that time, your knowledge of the Trust, what do you think would have been the actions of the Board or what do you think the process would have been once the Board, if they had 14:23 have seen this Early Alert?

A. Yeah. Could you just remind me, the date of the Early Alert was 31st July?

158 Q. Yes.

A. Yes. If that Early Alert had have been shared with all 14:23 Trust Board members at the same time as it went to the Department, that certainly would have triggered a response particularly from Non-Executive Directors in terms of the seriousness of it and the patient safety issues that were contained within. For me that would 14:23 have warranted an urgent meeting of the Trust Board.

159 Q. In fact the meeting that did take place the next time was 27th August meeting that we just looked at?

A. Yeah, but that wasn't a Trust Board meeting, that was a

workshop. So our next formal meeting was in September, which was way too far out. If you are looking at the timeline, from 31st July towards the end of September, there is eight weeks of time where the Trust Board could have had a deeper understanding of what was going on, and certainly issues which I suspect you will come on to, being able to manage some of the issues that evolved around this process.

160 Q. I just want to ask you about an email that you sent on the same date, 27th August 2020, WIT-101126, I just see the timing of this email, it is from you and it is sent on 27th August 2020 at 12:17, would that have been after the workshop or? 14:24

A. At lunchtime, quite possibly after, yeah. I know we started in the morning. 14:25

161 Q. There are no times on the workshop, I wasn't sure. So to Roberta Brownlee, Shane Devlin, then Sandra Judt, Jennifer Comac, Elaine Wright. The subject is "blind spots". You say:

"Both the Muckamore report provides a great opportunity for the Trust Board to take a look at its blind spots. If a workshop could be planned, I think that would be a great use of time for all. We don't know what we don't know, and it is good to hear if anything is keeping our directors awake, or is bubbling up for them. 14:25

Regarding the Board composition and the pending loss of yourself, Siobhán, Martin's time out and first terms

ending for some, this needs to be flagged and I know you do. Last year the Commissioner for Public Appointments initiated a process where Non-Executive Directors would not be offered a reappointment without running a recruitment competition. That then brings its own challenges as we are not sitting at the end of August and a typical process can take six to nine months."

So some of the points that you have mentioned already in your evidence, the time to recruit. I think I was the one who said that you had mentioned we don't know what we don't know, I thought it was in your statement but it was in this email. Just wondering about the timing of the email on the same day, there may be absolutely nothing in it, but given that it is entitled "blind spots", I know you have mentioned the Muckamore report, but I was just wondering if there was anything that triggered in you a concern that perhaps there was a need to look at information that was being provided just a little bit more deeply and if it could have been the content of the meeting on the workshop on 27th August, I know it's asking you to cast your mind back, but is it entirely coincidental? 14:26 14:26 14:26

A. I think it is. But then, as you ask me, that meeting where it was raised, certainly there will be a sense of tension at that point in time which it would be hard not to feel, you being a part of that meeting. So did that trigger for me? I honestly, I can't say that it 14:27

did. But certainly this is the kind of thing that I would think about in relation to how we ensure that we are allowing our directors and enabling them the opportunity to state out loud any concerns that they have, outside of the realms of a formal meeting as well.

162 Q. So it was another way of trying to get to the information that you needed. Is it possible you were triggered by the revelation at the meeting?

A. It could be, it could be possible. 14:28

163 Q. Just for completion I just want to read in what you have said about the Early Alerts in your statement, if we go to WIT -- sorry, was there any reply to this email?

A. What email? This one? 14:28

164 Q. Yes.

A. I don't think so. I don't think so, it would have been in my statement, I don't think so, or it should have been.

165 Q. We will go to the Early Alerts, your comments on that, 14:28
WIT-100464. We had asked you about "how do you ensure that the Board is appraised of concerns against applicable standards" and you've used the Early Alert as an example. But you start off by staying, at 15.1:

14:29

"As Chair of the Trust Board I ensure that the Board is appraised of both serious concerns as well as current Trust performance against applicable standards of clinical care and safety through the mechanisms

outlined in my response to question 13 above. As Chair I have adopted a firm position on the need for the Trust Board to be notified first of any significant issues arising outside of the scheduled Board meetings. I understand fully that a balance needs to be struck in that a certain level of validated information is required before escalation of a concern to Board. Nevertheless, I have operated a no-surprises approach with the current and previous Chief Executives. Chair and CEO meetings provide for a formal and informal space for CEO to raise concerns or issues. I am content with this approach." 14:29 14:30

And you say at 15.3:

14:30

"Prior to 18th September 2020, Early Alerts were only shared with the former Chair. These alerts are issued through the Corporate Governance team by email. Since 18th September 2020, Early Alerts are now shared with all board members. I have set out below some examples of Early Alerts received by the former Chair which were shared with the Non-Executive Directors, along with the date of such sharing." 14:30

Then you set them out below that. 18th September 2020, that was before you took up post as Chair? 14:30

A. That's correct.

166 Q. What was it about that date that there was a decision made that all Early Alerts are shared with Board

Members, how did that come about during Mrs. Brownlee's tenure?

A. I don't know. But, if you don't mind, I think it would be important, because of what we talked about previously in relation to sharing of Early Alerts and I said as Non-Execs we would have got some. The inference there is that the Early Alerts, what it says there is Early Alerts were only shared with the former Chair. Some of them would have been forwarded on to us as Non-Execs, so it wasn't that they came to us directly. They didn't come to us directly - previously - they now come to us directly. 14:31 14:31

167 Q. Okay. They came through the Chair previously then?

A. Came through the Chair previously.

168 Q. That is where there was the ability for some to reach you and some not? 14:31

A. Yes.

169 Q. Okay. Just so I don't forget to mention, Mr. Lunny has helpfully suggested that the time of the workshop was at 9:15, relying on WIT-101541. Just to put the timeline then, that your email was probably at lunchtime, as you said, and the workshop was in the morning? 14:32

A. Yeah.

170 Q. It may well have lasted all day, I don't know? 14:32

A. Yeah, and it's virtual.

171 Q. It's virtual.

A. Because I was wondering, like was I sitting in the middle of a meeting writing an email which would have

been wrong.

172 Q. So you were multitasking?

A. Yes.

173 Q. Okay. You've given the Panel the Early Alert references, the ones that were sent to Roberta Brownlee and then when they were forwarded on. So all of those seem to have been provided? 14:32

A. Yes.

174 Q. So again you have just emphasised that it was inappropriate in your view, it wasn't adequate is what you have said for it not to be shared? 14:33

A. Yes.

175 Q. If we go to WIT-100482. You refer to the Early Alert again at this point and you say, at 22.7: 14:33

"In relation to urology specifically and, as mentioned at question 15 above, an Early Alert was issued on 31st July 2020. I have no record of receiving this Early Alert during July or August. However, I received confirmation that the former Chair, Roberta Brownlee, was notified with a copy of the Early Alert on 3rd August 2020. As also mentioned above at question 15 at a Trust Board workshop on 27th August 2020 under agenda item 6, 'Update from executive directors, verbal', the then Medical Director, Dr. Maria O'Kane, brought a governance issue to the Board's attention, namely an SAI investigation into clinical concerns involving a recently retired consultant urologist. Members asked that this matter be discussed at the 14:33 14:34

confidential Trust Board meeting immediately following the workshop.

At the ensuing confidential Trust Board meeting on 27th August, Dr. O'Kane brought to the Board's attention the SAI investigation into concerns involving the urologist in question. Members requested a written update for the next Trust Board meeting." 14:34

Then you say: 14:34

"This item was then brought to the next confidential Trust Board meeting on 24th September 2020 with a detailed paper provided by Dr. O'Kane and presented by Dr. Damien Gormley. This is also when board members other than the Chair were first notified that an Early Alert had been submitted, although the date of its submission was not clarified until the meeting of 22nd October. Further updates were provided to the Board on 12th November 2020 and 10th December 2020 and the issue has subsequent remained on the confidential Trust Board agenda." 14:34 14:35

Just the earlier paragraph, you mentioned the SAI and the information that was provided, what's the position now when SAI information is provided to the Board, is there more of an interrogation of the governance themes even while the investigation is ongoing or do you find out about it at the end, what's the current process? 14:35

A. What has happened is in relation to serious adverse incidents, a serious SAI that has come to us, they are all serious, but a significant one has come to the Board, it will come with an action plan, an update on an action plan from the appropriate directors. That will be quizzed then by the board members, then with either an update to come back at three or six months, depending on the nature of that. In some cases it maybe delegated down to a committee for closer observation. 14:35 14:36

176 Q. We talked earlier about the box or the escalation table that had to be filled in and that was a way of triggering people to remember about that, is there anything similar at Board level that prompts consideration of patient safety issues or risk in SAIs or any other governance, does anyone automatically say 'okay, that sounds like we need to do a risk assessment or look at patient safety', is that an ad hoc thing or is it more formal? 14:36

A. It's not formal, it just happens. It will either come from a Member of the Board or indeed the director reporting may highlight that there is a patient safety issue. If you want I can give you a short example? 14:36

177 Q. Yes, please.

A. Okay. So, our Director of Nursing, Allied Health Professional and Midwifery reported to a Governance Committee meeting, at the end of the meeting, only some months ago about concerns that she had in relation to one of our wards within Craigavon Area Hospital. It's 14:36

staffed predominantly - it's an uncommissioned ward which means we are not funded for the beds or the staff - but the ward is full of patients. It is staffed by agency and locums which brings higher levels of risk and there had been a number of incidents. She raised this at the Governance Committee to say that she had serious concerns about this, that she wanted governance to know. As a result of that then there was a commitment to come back with an update and an action plan on what was taking place. That happened, but also in between that then that was noted up to Trust Board and the actions that were being taken. 14:37 14:37

178 Q. If we go back to the statement that you have made about the Early Alert. When you say that the item was brought to the next confidential Trust Board meeting on 24th September and board members were first notified of the Early Alert had been submitted. Then you say: 14:38

"Although the date of its submission was not clarified until the meeting of 22nd October." 14:38

Can you give us a bit of context for that?

A. I can. I think it was Shane Devlin had said that the earlier it was sent up, the question was raised when was that sent, and that couldn't be answered at that meeting. So the answer was given at our next meeting in October. 14:38

179 Q. So it was more just a follow up of the administrative date rather than any difficulty getting information?

A. Yeah.

180 Q. If we go to WIT-100486. I just want to go through this just to make sure that we have covered what information you were given. You've reflected on this in your statement, you have said this in your evidence as well, at 25.2: 14:39

"The Trust Board were made aware of a consultant being excluded from practice at its meeting on 27th January 2017. I now know the consultant was Mr. O'Brien but did not know that in January 2017. This was I believe an appropriate point at which to raise an issue of potential concern with the Board. The issue having been raised, the Trust Board members including me did not question or dig deeper into the situation and on reflection perhaps we ought to have been more curious, if not on 27th January then perhaps in the months that followed when no further updates were provided." 14:39

Now you mentioned the meeting then in August and in September and there were no further updates. Just from your own perspective is there any reason now why nobody followed any of that up? I mean, even on reflection do you think it was an assumption that it was being dealt with, was it simply that? 14:39 14:40

A. In August or January? In January 2017 or in August?

181 Q. August, August 2020.

A. My view on it is that we were given the headline of the issue, it was being raised at Trust Board and a

detailed paper was going to come to us. This was being raised -- this wasn't a Trust Board meeting. If it had have been, then the expectation would have been that it would have been an agenda item under confidential. This wasn't an agenda item in August for either the workshop or the confidential meeting. If you go through the timeline of 7th June through to the Early Alert on 31st July through to the workshop and the confidential meeting, then if that information had have come out sooner it could have been an agenda item and it could have had the paper that came, it could have had, depending on, obviously, the team would have had to have concluded their work ensuring that they had all the information correct before they come. But it could have happened that it would be an agenda item in August with the papers to discuss. We had no agenda item, no papers to discuss, that came in September, which, in my view, is why there was limited discussions or questions. 14:40 14:41 14:41

182 Q. At what point do you think you were adequately informed about the issues? When did you start to think we are getting a handle on this or this is more concerning, what was the stage for you in the chronology? 14:41

A. The September meeting.

183 Q. Did that meeting then, did that involve more questions from you or anyone else? 14:41

A. Oh, it certainly did, it certainly involved a lot of questions and commentary from board members. It certainly raised a significant red flag in terms of the

seriousness of what had happened.

184 Q. The Panel has heard evidence then of the steps that were taken up to and including the establishment of the Public Inquiry, the different aspects, the look back review and the Royal College of Surgeons and the ongoing review; when you look at that now, do you feel that from that point on in September that the steps taken by the Board were sufficient? 14:42

A. From September? Sufficient in part but not in full.

185 Q. Okay. What might have been done differently, now looking back at events as they unfolded with the benefit of hindsight? 14:42

A. I think the Board should have -- we should have had dedicated meetings in relation to this from September onwards and not as part of other confidential meetings. I think we should have been meeting and getting updates in terms of the progress, mindful, obviously, that all these processes need to go on and us, as Non-Executive Directors and board members, need to get assurance that these are happening in the right way and the right timelines, but to give it the appropriateness of its place in terms of the importance of what has been presented to us. 14:43 14:43

186 Q. So apart from regular meetings or perhaps more focused meetings on the subject matters arising, could there have been any more proactive actions the Board might have taken around patient safety risk in order to ensure that going forward things were -- you had received enough assurance that everything was being 14:43

done operationally that was necessary?

A. I think we did. The SAI reviews, the lookback reviews, we had the external reference group that was established. We had the oversight assurance group from the Department that was established. There was regular updates coming to the confidential Trust Board meeting on progress that was being made. So certainly the work that is being done to assure, to be clear on what happened, to provide assurance on the steps that were being taken to build in improvements has certainly all been coming since then, I'm comfortable with that. I think as a Trust Board, we could have handled our meetings better in terms of our question and our exploration in the early parts. 14:44 14:44

187 Q. Now there were concerns and Mr. O'Brien has raised concerns about the adequacy of the service, the staffing and historical concerns and other current concerns. You mention that in your statement at WIT-100515, paragraph 34.1, and you say: 14:45

"I received an email from Sandra Judt, Board Assurance Manager, on instruction from Mrs. Roberta Brownlee on 11th June 2020 with other Non-Executive Directors a copy of a letter sent by Mr. O'Brien to the former Chair, Mrs. Roberta Brownlee, on 10th June 2020. This letter raised concerns in relation to the ongoing HR process, Mr. O'Brien's request for retirement and his request to return on a part-time basis post retirement. This was an operational HR issue which was being dealt 14:45

with through the director of HROD, Mrs. Vivienne Toal, in conjunction with the Medical Director, Dr. Maria O'Kane."

You say at 34.2: "The former Chair, Mrs. Roberta Brownlee, raised receiving the letter at the confidential meeting dated 22nd October 2020." 14:46

So this was a letter sent but the Board or you took the view that this was a staffing issue, a human resources issue and therefore operational in nature? 14:46

A. Yeah.

188 Q. Would it be usual for the Board to receive any documentation in relation to employment matters within the Trust or would that normally be carved out as being operational? 14:47

A. It wouldn't be. It wouldn't be unusual because people can email and communicate with the leadership of the Trust quite easily. So people can write in, send an email or put a call in to the Chair or Chief Executive's offices, so that wouldn't be unusual. And it's not unusual for staff to raise concerns at Board level either, that has happened in the past too. 14:47

189 Q. So who makes the decision then if letters are sent in about employment issues or HR issues, who makes the decision whether those correspondences make their way to the Board, would that be Vivienne Toal? 14:47

A. No, they can actually just write to the Chair directly.

190 Q. Such as this example?

A. Yeah.
191 Q. But the outcome of that was that it didn't find its way for consideration by the Board because it was deemed to be a HR/operational issue, if I am reading that paragraph correct? 14:48
A. I deemed it -- I deemed it to be operational. On receipt of that I deemed it to be operational because it was about his employment.
192 Q. And so it didn't find its way to the Board?
A. It did find its way -- 14:48
193 Q. Apart from Mrs. Brownlee, but it wasn't discussed?
A. No.
194 Q. No, that's the point?
A. It did find its way, sorry.
195 Q. That is the point. It didn't find its way to the 14:48 agenda, I suppose, I should have said?
A. No, it did not.
196 Q. Would that be the decision? So, for example, if there was correspondence between Mr. O'Brien and the Chief Executive about HR issues, issues around employment, 14:48 you would expect that to be dealt with by the Chief Executive and for him to exercise his judgment whether it should ever come to the Board?
A. Yes.
197 Q. Now, when you found out in the September that it was 14:49 Mr. O'Brien was the consultant and you say that that was really the start of their being a bit more investigation or questions asked or perhaps more focused attention given to the issue, would you expect

to be provided with documentation in relation to, for example, the MHPS procedure that would have informed you of Mr. O'Brien's view on what was alleged against him or his response to the investigation, would they be documents that should have or might have informed the Board's view of risk or patient safety if you had seen what the response was to the allegations, would that be something that normally would find its way? 14:50

A. No, it's not something that would find its way, nor would I expect it to find its way to the Board. But what I would expect is that there is an escalation then, when the director responsible, which would be the Medical Director, knows this information, then it is shared, escalated. 14:50

198 Q. So rather than see the actual originating documents you would expect to be given the context of 'well the consultant says this', reported secondhand but given the information nonetheless? 14:50

A. Yep.

199 Q. Does that also apply for the case manager's determination in the case, Dr. Khan, you didn't ever see that? 14:51

A. No, and I wouldn't expect to see that either.

200 Q. Again is that something that you would expect to be reported on rather than be provided? 14:51

A. Yeah, that's reported on and, if helpful, I can talk about the process now in terms of reporting from MHPS to the Governance Committee, but if not I can...

201 Q. Oh, yes, please do, that would be helpful.

A. Okay. So a new process has been put in place. Up until obviously the Inquiry, MHPS was just something that was mentioned or noted in terms of exclusion. The process that's now in place at a confidential Governance Committee includes the MHS process for doctors and dentists. We also have a nurses in difficulty report from our Executive Director of Nursing and there is the building of one for social works through our Executive Director of Social Work, MA2S process; details when the case started, who the case manager is, case investigator is, who is the named Non-Executive Director. It gives you a small synopsis of what the issue are, and it details then any outworkings and updates that comes to us at a confidential Governance Committee every quarter. So you can see very clearly, four, five, six cases. At the next meeting you will see that cases have concluded, there is a new one there. There is that visibility for everybody in terms of the MHPS processes that are under way within the Trust. 14:51 14:52 14:52 14:52

202 Q. So it's like a dashboard that gives you an immediate overview?

A. Correct.

203 Q. With a bit more detail perhaps. So along the same lines as what you might expect to see or not, would you ever expect to see a formal grievance from a consultant as a result of him being exposed to a procedure that he is not content with, again is that something that would be reported, the content of it but not provided? 14:52

A. No, I wouldn't expect to see the grievance within the HR discipline and then process then through the Chief Executive unless it needs escalated.

204 Q. What about a referral to the GMC or a deferral of re-validation, would they be matters that you might expect to see? 14:53

A. Yeah. That comes through on the confidential governance for MHPS, but it also would come through on the medical director's report on re-validation and appraisals. 14:53

205 Q. So any addendum to a formal grievance would fall into the same category as the original grievance, it wouldn't come up?

A. Yep.

206 Q. I wonder if we could go to your statement at WIT-100553, we'll move on to these in full in a moment, but I just want to ask you about one issue. Just move down to the second bullet point. So, at WIT-100554, you identify one of the issues as "the doctor was unwilling to be managed." You say: 14:53 14:55

"It appears to me that Mr. O'Brien did not want to be managed and was resistant to changing any of his problematic practices. I believe he attempted to thwart processes that were begun to address some of his issues, including threatening legal action. I also believe that he used his close relationship with the Chair of the Board as a tool to directly/indirectly warn people off." 14:55

I just want to ask you about that. Do you recall just a couple of moments ago when I was asking you about did you see Mr. O'Brien's answer to the MHPS, did you see his grievance, you would have expected summaries or overviews of those to be provided but not the actual documents; do you recall seeing any of those summaries of documents or anyone saying he has put a grievance in or he says this about the MHPS or he has added this addendum in where he has set out his reply to all of the allegations, do you remember getting that sort of information? 14:55 14:56

A. No. And, just for clarity, I wouldn't expect a summary. What I would expect is the director responsible to be able to escalate to the Board and the committee where it is needed. I wouldn't expect the Board to get summaries of grievances from doctors, nurses or social workers across the piece. But certainly the director responsible needs to be showing where there is concerns and what they are doing about it and if there is, obviously, trends there in relation to individuals or more. 14:56 14:56

207 Q. I suppose that's what I meant by a summary, basically giving you the bullet points of what the position is. And the reason I am asking you that is, I want to understand, when you say "I believe he attempted to thwart processes", what you mean by that and where you got the information from about his attempt to thwart processes? 14:57

A. Okay. So in preparing my Section 21 then I have an

array of information that I can glean from as well as the transcripts and the work of the Inquiry to date. So what I am saying there is, from my observations, that there was pauses, delays, challenges, all of those put a huge delay in the process of MHPS. That for me, it certainly came across to me that there was an attempt to thwart the process, to delay it, to stop it, to pause it, to slow it down, whatever the case may be. Certainly from the evidence that I have read in relation to his approach around stating his legal links, for the want of a better word. 14:57 14:58

208 Q. So it's mostly your information around that comes from the Inquiry rather than anything at the time that you knew or were made aware of?

A. No, that's right. 14:58

209 Q. And of course Mr. O'Brien would say that putting in a grievance or seeking legal advice or having recourse to legal action against an employer that in his view he has acted unlawfully are just proper recourses for him that are available should he wish to follow that route rather than representing any threat for legal action, they are simply avenues of redress for him, would you accept that, that there are legitimate avenues for him to pursue? 14:58

A. Oh, absolutely, yes. 14:59

210 Q. Again when you make reference to his close relationship with the Chair of the Board as a tool to directly, indirectly warn people off, again that's information you received as a result of the Inquiry's data?

A. Yes.
211 Q. Rather than anything that you know personally?
A. No.
212 Q. Thank you. Sorry for that detour but I just wanted to make sure I had given you the opportunity to comment on issues that have arisen or may arise. 14:59

I just want to ask you some questions about Mrs. Brownlee. It's clear from the statement, and I'm sure evidence that you have heard, that you now know that she had a friendship with Mr. O'Brien, can you just give us the context of when you found out about that, what your understanding was before you found out about that, if you had any idea that she had a close friendship with him. 15:00

A. I had no idea to the depth and the extent of their friendship, which obviously has come out as a result of the Inquiry. But even just at that September meeting, and I think I put it in my statement, a quick Google search told me that they were both on the Board of a charity for a number of years and their relationship went back sometime. So my observations on that, I wouldn't necessarily know who is friends with who within the Trust, but as a result of this and the interactions and observations I had from the period of August through to November was certainly clear to the extent of that relationship for our former Chair Mrs. Brownlee. 15:00 15:01
213 Q. If we just put in context what may have been

complicating about that when you look at the role of the Chair and the expectations around the revelation about conflicts of interest or potential conflicts of interest. The meetings and agendas always give the opportunity for anyone to declare potential conflicts of interest, I am sure you are familiar with that, it is just a general caveat for everyone at the start of a meeting, if any matter is on the agenda just declare them. And in fact there is an example of you having done so, if we just go to that, a meeting on 26th May 2016 at TRU-109276. 15:01 15:02

I'm just simply going to read out what the minute says just to indicate that you properly made a declaration. You'll see there at paragraph 2: 15:02

"Declaration of interest. The Chair requested members to declare any potential conflicts of interest to any matters on the agenda. Ms. Eileen Mullan declared an interest in Unison." 15:02

And the Chair at this point was Mrs. Brownlee?

A. Correct.

214 Q. There are also examples earlier than that, just before your time, but when Mrs. Brownlee was Chair and for the Board's note, evidence of members of the Trust Board being reminded of their codes of conduct during the relevant period. An example of that is found within the minutes of the public Trust Board meeting of 15:02

30th August 2012 at TRU-106646. You'll see at paragraph 2: "There were no declarations of interest in relation to any of that."

Then it goes on to note, at paragraph 3.1: "Revised codes of conduct and accountability. The revised codes of conduct and accountability have been issued to board members on 19th July 2012 together with a covering letter from the Chairman. The Chairman reminded board members of the importance of subscribing to these codes and demonstrating high standards of corporate and personal conduct." 15:03 15:03

Was Mrs. Brownlee the Chair in 2012, do you recall?

A. I believe so. 15:04

215 Q. And then, under point 2:

"Board meeting etiquette. The Chairman had written to board members on 9th August 2012 outlining good practice principles for Board and Committee meetings." 15:04

Then we have another example in 2017, again you were an NED at this point, a letter dated 24th March 2017, at TRU-113435. Now, this is a letter from the Department of Health to the Chairs of the health and social care Arm's Length Bodies and NIFRS. 15:04

A. Northern Ireland Fire and Rescue Service.

216 Q. The Department say:

"Dear Chairs, conflicts of interest. In response to a query raised at the Departmental Board, I wish to take the opportunity to remind Non-Executive Directors of the requirement for board members of public bodies to act appropriately when a conflict of interest situation arises. All NEDs must discharge their duties in line with the Seven Principles of Public Life and any conflict of interest must be identified and managed in a way that safeguards the integrity of board members and maximises public confidence in the organisation's delivery of public services.

I would draw your attention to the attached codes of conduct on accountability that all NEDs will have received on appointment. In particular I draw your attention to paragraph 8 on public business and private gain. I ask that all your Non-Executive Directors take the opportunity to refamiliarise themselves with the contents of the codes."

15:05 15:05 15:05 15:06 15:06

And then gives a website for more detailed guidance on that. Then the code of accountability sets out the requirement that Chairs and all board members declare any conflict of interest, and that code can be found at TRU-113448.

At paragraph 20, it says:

"Declaration of interests: It is a basic requirement

that Chairs and all board members should declare any conflict of interest that arises in the course of conducting HSC business. Chairs and board members must declare on appointment any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with a voluntary or other body contracting for HSC services. These should be formally recorded in the minutes of the Board. Directorships and other significant interests held by members of HSC Boards must be declared on appointment, kept up-to-date and set out in the annual report. 15:06 15:07

In addition the HSC Boards must keep a register of interests appropriate to the body's activities. The register should, as a minimum, list direct or indirect pecuniary interests which members of the public might reasonably think could influence board members' judgment. Board members are urged to register non-pecuniary interests which relate closely to the body's activities and interest of close family members and persons living in the same household as the Board Member." 15:07 15:07

Paragraph 22: 15:07

"Registers of interests must be open to the public. Details of how access can be obtained should be made widely available and included in annual reports.

Registers of interests should be published annually."

So that's the groundwork for the expectation around conflict of interest. I don't imagine any of that is news to you given that you triggered your own conflict whenever you thought it was appropriate. 15:08

If we go back to your statement at WIT-100547, just at the very bottom. I just want to look at the start of the table to see the heading that you have given to this. This is paragraph 47.1 where you say: 15:08

"I am now aware of governance concerns arising out of the provision of Urology Services as follows."

15:09

And we will look at those in a moment, but I want to go back down to WIT-100547 just at the bottom, the heading is:

"Declaration of conflict and interest and management of it. I was unaware of the extent and depth of the relationship between Mrs. Brownlee and Mr. O'Brien. When I now consider the confidential Trust Board meetings and the meetings between Chair, CEO and NEDs between August and the end of November 2020 I see an inconsistent approach by the former Chair from making no declaration of interest at one meeting to declaring an interest and leaving another meeting, to denying an interest yet still leaving another meeting. 15:09 15:09

As a result of evidence now before the Inquiry it appears to me that there was a clear conflict of interest for the former Chair. The Trust Board should have been made aware of the extent and fullness of the relationship between her and Mr. O'Brien. At the October 2020 meeting when I realised there was more to this issue, a very simple Google search revealed to me that the former Chair and Mr. O'Brien had governance roles in a charity. At this point the Chief Executive Shane Devlin raised the conflict with the former Chair."

And you quote: "The Northern Ireland Audit Office defines a conflict of interest as: 'A conflict of interest involves a conflict between the public duty and the private interest of a public official in which the official's private capacity interest could improperly influence the performance of his/her official duties and responsibilities'."

It further explains: "The interest in question need not be that of the public official or Board Member themselves. It can also include the interests of close relatives or friends and associates who have the potential to influence the public official or Board Member's behaviour."

(b): "As a benchmark, a close relative would usually refer to the individual's spouse or partner, children,

adult and minor, parent, brother, sister, inlaws and the personal partners of any of these. For other relatives it is dependent upon the closeness of the relationship and degree to which the decisions or activity of the public entity could directly or significantly affect them."

(c): "Where an individual has to declare interests of this nature, they may wish to seek advice from a senior public official or the Board Chairman to ensure all potential conflicts are identified." 15:11

(d): "A friend or associate should be considered as someone with whom the individual has a long standing and/or close relationship, socialises with regularly or has had dealings with which may create a conflict of interest. 15:11

The NIAO provides a checklist in their good practice guide as shown below." 15:11

Then there is an actual tick box that one has to fill in if you want to recognise a conflict of interest. Then you give a declaration or a summary of the Chair's declaration or non-declaration of interests. 15:12

You say:

"At the confidential Board meeting on 27th August the minutes of that do not indicate that Mrs. Brownlee

declared any interest nor that she left the room for any part of the meeting."

And that was the meeting where Dr. O'Kane brought the SAI investigation through, you will remember. There was also the meeting on 24th September 2020, the minutes of that can be found at TRU-130822, if we just go to that, please, for a moment. Sorry, just in advance of paragraph 7: 15:12 15:13

"The Chair left the meeting for the discussion on the next item. Mrs. Leeson took over as Chair at this point."

And item 7 is Urology. I'll just read the first sentence: 15:14

"The Chief Executive set the context to this item by advising that there is likely to be significant media interest and reputational issues with this case." 15:14

So on 24th September Mrs. Brownlee left the meeting. Is it the case that when you declare a conflict of interest that you simply have to declare the conflict without giving any context, is it normal just to say 'I have a conflict and I'm leaving the meeting', as you did in the example we gave, you say you had a conflict with Unison and you identified that? 15:14

A. Well your duty is to raise it. The decision then rests

with the Chair of the Board as to the management of that. So you should know when you get the agenda what's on the agenda. You should then, before the meeting, at least raise it with the Chair and let them know that you have a conflict, and you might want to give some background information to that at that point. But the register of interest, which we complete annually, should detail all. So there should be a natural alignment, unless something else comes up during the year which is not part of your register. But you would be raising it at the meeting, but you may have had a conversation with the Chair in advance. 15:15 15:15

217 Q. If we just move down to paragraph 7 we will see that there was a fair bit of detail provided and subsequent actions arising, so during this particular part Mrs. Brownlee wasn't there. Then the meeting on 22nd October 2020, which can be found at TRU-131853, this was a meeting after this meeting. At this meeting Mrs. Brownlee didn't declare a conflict of interest. You will see the update on clinical concerns within Urology at item 7. So we'll see there is a discussion around Bicalutamide, other issues in advance. 15:15 15:16

And then, at TRU-131854, we have a paragraph that says, the second paragraph on that page said: 15:16

"The Chair advised that Consultant A had written to herself in June 2020, the contents of which she shared with the Non-Executive Directors in which Consultant A

raised concerns at how the HR processes were being managed and requesting that his formal grievance and its included appeal are addressed. The Chair was advised this matter was being progressed through HR processes. The Chair also raised the fact that a number of different urology consultants had been in place over the years and asked why they had not raised concern about Consultant A's practice and similarly why had his PA not raised concerns regarding some delays in dictation of patient discharges. The Chair also asked should a GP not have recognised the prescribing of Bicalutamide as an issue?" 15:17 15:17

And that is in as a question:

"Dr. Gormley stated that patients remained under this one consultant's care and this will be examined under the SAI process. The Chair then asked about Consultant A's appraisal and asked if performance issues had been identified through this process and, if so, were professional development and training needs then identified. Dr. Gormley advised that Consultant A's appraisals were also part of the review process. 15:17 15:17

In terms of systems and processes, Mrs. McClements spoke of the SAI process since 2016 when a robust action plan was put in place at that time to address such issues as triaging communication et cetera and the 15:18

work since June 2020 to scope and review the patient records of Consultant A's cases. Mr. McAnuff noted that when performance issues were identified, additional measures were put in place and asked if these additional measures had not effected positive change, what further controls would need to be put in place should there be concerns raised about other consultants. Mrs. McClements referred to the query as to whether such clinical concerns could happen elsewhere and she advised that the Trust required more time to conduct its review and scoping exercises. 15:18 15:18

In response to a question from the Chair as to whether one consultant urologist reviewing the patient files was sufficient, Mrs. McClements provided assurance that, in addition to Mr. Mark Haynes' involvement, there is some clinical nurse specialist input and the Head of Service is involved in reviewing systems and pathways. She referred to the multi-disciplinary aspect of this work as detailed in the paper. 15:19 15:19

In addition there has been independent sector consultant sessions reviewing oncology patients and subject matter experts engaged as part of SAI process. Mr. Wilkins stated that this was a complex case with various strands. He advised that whilst he supported the Trust's request for delay in a ministerial announcement, it was important that this was not a prevaricated delay. Ms. Donaghy referred to this case 15:19

coming into the public arena and asked about natural justice and Consultant A's right of reply. She raised her concern at the issues Consultant A had raised in his grievance around his appraisals, pressure of work et cetera and she asked that these are addressed as part of any review. Mrs. McCartan restated the importance of the Trust releasing information only when it is assured it is accurate. Mrs. Leeson highlighted the importance of due process being followed with SAIs completed as a priority to ensure learning from this case for the benefit of patients. 15:20 15:20

Following discussion, the consensus view of Trust Board was to approve the Trust's request to seek a delay in the ministerial announcement. Members emphasised the importance of a robust timeline to conclude the review processes. It was agreed that following the Trust Board meeting the Chief Executive would informally advise the Department of Health of the Trust Board's decision followed by a formal letter." 15:20 15:20

I read all of that to put on the record the extent of the discussions in October during which Mrs. Brownlee stayed and was present for. There was discussion of SAI, discussions of the grievance. Who is Mrs. Donaghy? 15:21

A. Non-Executive Director Geraldine Donaghy.

218 Q. She mentioned "raised concern at the issues Consultant A had raised in his grievance around his

appraisals". I don't think you were given the grievance, we have established, you weren't given those documents?

A. No.

219 Q. So how would she have got that information, would that have been something that would have been reported to the Board? 15:21

A. She got it from the email from Roberta Brownlee attached with a copy of the letter from Aidan O'Brien.

220 Q. From the complaints that Mr. O'Brien was making? 15:21

A. Yep.

221 Q. So it is from that email --

A. Yeah.

222 Q. -- rather than from any of the original documents. So there is mention of the subject matter experts at that point. So as I read through it seems that Mrs. Brownlee has -- do you remember this meeting, were you at this meeting? 15:21

A. Yes.

223 Q. And do you remember the meeting itself? I know there is a lot of meetings, but do you remember this particular one given the nature of the discussions? 15:22

A. Yeah, I do. Not verbatim, I do remember the meeting, but I wouldn't remember every single word and detail, but I do remember the meeting. 15:22

224 Q. You remember the generality of it?

A. Yes.

225 Q. Were you surprised that Mrs. Brownlee remained in the meeting having excused herself from the previous one?

A. I was. I was also surprised that the precursor to this was an email to Non-Executive Directors to advise that she would be remaining in the meeting.

226 Q. The email that said she would be saying in for this. But we will look at the detail of the actual interactions with the Chair, this is obviously a step removed and a bit of distance in between. But what was your view at the time of the Chair's interactions about the issues in relation to Mr. O'Brien at this particular meeting? 15:23

A. Yeah, this didn't feel right at the time. I just felt this was -- the focus and the attention from the Chair did not feel as it should be from a Non-Exec collectively looking at the issues.

227 Q. When you say it didn't feel right, do you consider that it was, first of all, inappropriate for Mrs. Brownlee to be at this meeting given her conflict? 15:23

A. Absolutely.

228 Q. Do you think her interventions at the meeting or contributions to the meeting, do you consider those also to have been inappropriate? 15:23

A. I do.

229 Q. And why is that?

A. I have racked my brains on this one, No. 1 why was it accepted by me and the rest of the Board that it was okay for a former Chair to stay in for this item at this meeting and, No. 2, why did I or the rest of the Board not stop the Chair at this point and ask her to leave the meeting so the conversation could continue. 15:24

So I don't know why we didn't do that.

230 Q. What about the substance of what Mrs. Brownlee is raising at the meeting, where she is effectively -- she is raising concerns, she is saying that the consultant is raising concerns at the processes, she advises about the HR processes. She also raised the fact that a number of different urology consultants had been in place over the years and asked why they had not raised concerns about Consultant A's practice and similarly why his PA had not raised concerns regarding some delays in dictation of patient discharges. I mean, that's a level of detail around operational matters and the consultant's daily duties, did you get any sense at all that she was advocating on his behalf? 15:24 15:25

A. That's what it felt like. 15:25

231 Q. Do you know if it felt like that to other members of the Board?

A. I do. Certainly for our Chief Executive Shane Devlin at the time, I spoke to him after the meeting.

232 Q. We'll look at that in a second, he refers to that in his evidence to the Inquiry? 15:25

A. Okay.

233 Q. The last sentence in that second paragraph:

"The Chair also asked should a GP not have recognised the prescribing of Bicalutamide as an issue." 15:25

That level of detail around, an expectation around a GP, the prescription of Bicalutamide and the

identification of that, is that particular detail that you might expect a Chair of the Board to have awareness of?

A. Well certainly I don't.

234 Q. Again, do you think this is an example of Mrs. Brownlee advocating on behalf of Mr. O'Brien? 15:26

A. That's how it came across.

235 Q. Would you have had information that would have informed you to ask a question like that at that point in October? 15:26

A. Absolutely not.

236 Q. Obviously that information could have come from any source, and Mrs. Brownlee will come along and give evidence. But one of the possibilities, of course, is that the information came from Mr. O'Brien, at this point you weren't aware of the extent of their friendship? 15:26

A. No.

237 Q. You had googled after this meeting?

A. Yes. 15:27

238 Q. And was it Mrs. Brownlee's interaction and contribution to this meeting that made you think there was more to this as regards depth of friendship?

A. Absolutely, this for me triggered so many alarm bells.

239 Q. So just to be clear now that you are Chair of the Trust, it is your view that Mrs. Brownlee should have excused herself from this meeting and the sense at the time from you and now in evidence is that you got the feeling that she was advocating on behalf of 15:27

Mr. O'Brien at this meeting?

A. Yes.

240 Q. You mentioned about Mr. Devlin, about his concerns, the Inquiry has heard from Mr. Devlin and I am going to give a reference of his comments in relation to that before going to his transcript. He refers to this issue at WIT-00095. I am just going to read two extracts from that, we don't need to go to it, we have gone through it before. But Mr. Devlin states: 15:28

"Specifically with regards to urology during my tenure when items were brought to Trust Board I did not feel that the conversation was quite as open as with other topics. On reflection I would question the total commitment of the Chair of the Trust to be totally open with regards to her willingness to criticise urology and specifically Mr. O'Brien. At the confidential meeting of the Trust Board on 22nd October, we tabled the details of the case so far and strongly debated the concerns with regards to Mr. O'Brien." 15:28 15:29

Then he puts in some of the extracts from that note that we have just looked at. He then says in his statement:

"I was left with the strong impression during the meeting that the Chair was advocating on behalf of Mr. O'Brien, a feeling which was shared and relayed to me by a number of SMT colleagues." 15:29

Did anyone from the SMT mention this to you?

A. No.

241 Q. Did any other Board Member mention to you that they shared your concerns? 15:29

A. I don't recall. This meeting was virtual, so unlike other meetings where you would have everybody physically in the room, when the meeting ends the meeting ends, so I don't recall any conversation at that juncture. 15:29

242 Q. It was a couple of days after that meeting that Mr. Pengelly telephoned Shane Devlin, is that something -- to inform him of the care [sic] relationship and the closeness in friendship. That was something you found out by Googling rather than by being told by anybody in 15:30 the Board or the SMT?

A. That's correct.

MS. McMAHON: When he gave evidence Mr. Devlin was asked about this issue and he mentioned you, so I just want to read out the extract in case you have any 15:30 comment to make. That's at TRA-01809. Sorry, Chair, I have just realised time, do you want me to stop and I can come to this extract when we come back?

CHAIR: Yes, I think we'll take a short break. Just to let everyone be aware, I certainly have to be away by 15:31 five o'clock, so I don't know if we'll get you finished today, Mrs. Mullan, but I understand you are available tomorrow morning, if that's the case.

THE HEARING ADJOURNED FOR A SHORT TIME

CHAIR: Thank you everyone.

243 Q. MS. MCMAHON: Thank you. Mrs. Mullan, I had just gone to the extract from the meeting that we were looking at and I then asked just to go to the transcript of Mr. Devlin's evidence at TRA-01809. This is where Mr. Wolfe Senior Counsel asked Mr. Devlin some questions about that meeting and the note that we have just looked at. So you'll see at the top of the page he reads out the last extract from his Section 21, his view of that meeting. Then Mr. Wolfe starts his questions at line 8, he says: 15:49 15:50

"Q. Some questions arising out of all of that. First of all, you've alluded to the fact that after this meeting the concerns that you had about her attendance..." 15:50

And the reference here is to Mrs. Brownlee: 15:50

"...about her attendance and participation were shared with you by members of the SMT and that was then the subject of conversation before speaking to Mr. Pengelly, who specifically within the SMT did you speak to?" 15:50

And Mr. Devlin replies: "It would have been generally SMT. So I can remember talking to the Director of HR,

the Medical Director et cetera. There was also a conversation with one of the Non-Execs as well, with Eileen Mullan, who is one of the Non-Execs who also felt as I felt in the meeting. I am very conscious that I was aware that the Chair was not going to declare a conflict of interest." 15:51

If I just stop there. That's reference to the email exchange with Mr. Devlin and the Chair that the Panel have seen when Mr. Devlin gave evidence when he identifies the conflict. Then back to the transcript: 15:51

"Because she had emailed me to say so, and I am very conscious that I thought that that would be okay. I suppose the frustration I had at the end of the meeting was I think that was the wrong decision because actually in the meeting I felt that it was not as balanced as it should have been. Certainly after the meeting, initially after the meeting there would have been conversations across all of SMT. Then explicitly I had a conversation with Eileen Mullan as a Non-Executive about the meeting. She expressed her apologies to me, actually, for the way the meeting had progressed." 15:51 15:51

Now I just want to stop there. Do you recall speaking to Mr. Devlin about this meeting after it? 15:52

A. I do.

244 Q. And was it something that took place immediately after

the meeting or was it sometime after?

A. It was probably -- my recollection was that it was me and the Non-Execs and Shane still on a call, that would have been maybe a call either that day or shortly afterwards, but it was in close proximity. 15:52

245 Q. Do you remember if he brought up the meeting or did someone else or did you bring it up, do you recall that?

A. I brought it up.

246 Q. What was the context of you -- can you remember why you brought it up and what was said? 15:52

A. Yeah, I brought it up because, firstly, I was annoyed at myself and I was annoyed with my Board colleagues collectively, not individually, that that meeting had been allowed to go ahead in the way it did particularly for that item. The rest of that meeting was fine, but particularly for that item; that Shane Devlin as the Chief Executive should not have had to make a decision to say the Chair could be in attendance for urology, that the Chair of the Trust Board felt that it was okay to say that she could be at that meeting and just tell everybody she would be there and how the meeting unfolded. So for me the decision as to whether the Chair of the Trust Board can attend a section of a meeting where there is a conflict of interest is not for the Chair of the Trust Board to make. 15:53 15:53 15:53

247 Q. And is it for the Chief Executive to make?

A. No.

248 Q. Whose responsibility is that? Who is the gatekeeper

for that if the Chair is the one that is potentially making what could be reviewed as the wrong decision?

A. Yeah. Then that brings me to the Board. The Board should have met, the Board should have - without Roberta Brownlee being in attendance - the Board should have met, discussed it and agreed, agreed that Roberta Brownlee should not be in attendance for that section of the meeting. When you raise the conflict of interest and the management of it, sometimes the Chair will involve members, depending on the nature of it. Here we have the Chair who is usually the arbitrator of what happens in relation to conflicts of interest being the one that has the conflict of interest, hasn't raised the conflict of interest, is at the meeting. I believe the Board should have made it, I apologised to Shane, he should not have been put in that position nor should that agenda item progressed as it did. That should have been dealt with, if not by the Non-Execs, but definitely by the collective Board. 15:54 15:54 15:54

249 Q. When you were having this conversation with Mr. Devlin, were there other people on the link from the Board or the SMT? 15:54

A. My memory is other Non-Execs were there, but I have not asked them if that was their memory or not. I'm nearly sure that this was Non-Execs and Shane on that call. 15:55

250 Q. Do you remember the feeling that you expressed, Mr. Devlin expressed, if that was shared by those other Non-Execs?

A. Certainly there was an alarm for the Non-Execs as well

as a result of that meeting.

251 Q. You mention additional contact with Mrs. Brownlee in your statement, if we go back to that at WIT-100563 at paragraph 52.1. So, you are asked at paragraph 52:

15:55

"Given the Inquiry's Terms of Reference is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those terms."

15:56

At 52.1, you say:

"I am including below details of an exchange of emails communication between Mrs. Roberta Brownlee and myself on 8th and 9th September. I do not recall the content 15:56 of the voice message left on my phone that is referred to in the below email trail. Urology and Mr. O'Brien are not mentioned in these emails. However, this happened between the Trust Board workshop on 27th August and the next scheduled Trust Board meeting 15:56 on 24th September 2020."

Then you set out: "On 7th September 2020, 09:05, you got an email from Roberta Brownlee indicating that she plans to attend governance meeting on most of Thursday 15:56 morning and she hopes this is acceptable."

I presume, when we look at the third column across, this emails to you because you are the Chair of the

Governance Committee, or was that an email to everyone?

A. No, that was to me as Chair of the Governance Committee.

252 Q. Then on 8th September, 08:55, email sent from Roberta Brownlee Trust Board Chair asking: 15:57

"At the beginning of the confidential section when all members present may I speak to the Board on a few areas as Chair and after you do the welcome I need to speak." 15:57

Again the email was sent to you as Chair of the Governance Committee and Sandra Judt as the Board Assurance Manager that the Panel have heard from. Then, at 15:51 on the same date, email from you to Roberta Brownlee. You advised that there was not going 15:57 to be a confidential section of the Governance Committee:

"I offered the Chair five minutes at the start of the meeting before moving on the agenda items." 15:57

And you say, on the right-hand side column: "Busy agenda. Happy to give a few minutes but must move on to Covid 19 outbreak and other substantial items." 15:58

Given the contents of 27th August meeting that we have looked at at length, was the only reason you weren't facilitating a confidential section of the governance meeting because of Covid and because of issues that

needed to be discussed?

A. No, the Chair didn't give me an indication as to the item she wanted to discuss but was asking for time at the meeting. We already had a very substantive agenda. The 27th August meeting, the outcome from that or the action from that was a paper to come to the confidential September Trust Board meeting and that's where I expected it to be. So the agenda for the Governance Committee and particularly the issues around the Covid 19 outbreaks was on our workload that day. 15:58

253 Q. Did you ask her what she wanted the time for? I know she hadn't told you, but did you ask her?

A. I don't believe I specifically asked her for it, no.

254 Q. Then on that date, at 18:41, email from Roberta Brownlee to you. And she says: 15:59

"Eileen, message noted. I could not address my comments in five minutes as Chair of the Board. Several serious matters. Will ensure my point is highlighted and asked to be addressed/actioned in the full agenda. Roberta." 15:59

What did you understand her to mean by this or was that all you got?

A. That's all I got. 15:59

255 Q. And you didn't reply to that email?

A. No, I don't believe so and I can't scroll up to show you. Yeah, that's okay.

256 Q. Back down again.

A. No, I don't believe so. I think what happened was a phone call after that from Roberta.

257 Q. If you put it in chronology order, so the next thing is 9th September phone call. Did you find out what she meant by that email on the 8th when she talks about several serious matters? 16:00

A. No, I didn't find out.

258 Q. You didn't get any other email about that. So 9th September 2020, you got a missed telephone call from her, there was a message left. You returned the call and there was no answer. Then you used the follow up email, which we will look at now as a guide for the message: 16:00

"The Chair indicated significant issues she wanted to bring to the Board's attention." 16:00

Then we go to 9th September, 15:23. This is the email from you to Roberta Brownlee:

16:00

"I advised the Board Chair Roberta Brownlee that if she had several serious matters she wished to share as Chair of the Board then it might be prudent for her to hold an emergency Trust Board meeting. That would mean all Non-Executive and Executive members would be in attendance. The Governance Committee has other staff attending and two absent executive members." 16:00

So in that email you are saying the pathway for her to

raise serious matters is not through the Governance Committee, it's to hold an emergency Trust Board meeting so that everyone could attend?

A. Yeah. And, if I recall back, this was about, she wanted to speak to the Trust Board. This was a Governance Committee meeting and not all Trust Board members would be present. So I was very clearly setting down the delineation, if this was serious matters for Trust Board attention then call an emergency Trust Board meeting and bring Trust Board members together. 16:01 16:01

259 Q. Then Mrs. Brownlee replies that night at 20:25, that was the previous email from the morning and copied in the Chief Executive and Board Assurance Manager:

16:01

"She noted that the Chief Executive and she would be updating the following day's meeting on issues that were all well known to the Trust Board members at that time. Further she went on to say that she did not wish to delay the start of the meeting. She stated that she did not see the need for an emergency Trust meeting as all Trust Board members would be present for the confidential section, excluding those on holidays and the absence of one NED." 16:02

16:02

So she has come back and said I don't need an emergency meeting, I thought in a previous email you had said there wasn't going to be a confidential section?

A. No.

260 Q. She is working on the presumption that there still was going to be one?
A. Yes.
261 Q. And that as everyone would be at that then that was still a proper vehicle for her to utilise to raise her concerns? 16:02
A. Yeah, but we weren't having a confidential meeting. The people attending confidential -- the only difference between confidential in terms of the attendance would be the likes of Dr. Tracey Boyce, Director of Pharmacy. 16:02
262 Q. Thank you. I just need to look at this. Now, did you reply to this email?
A. I don't believe so.
263 Q. If you don't mind me saying, there does seem to be a little bit of tension in the back and forth between you and Mrs. Brownlee, is that an unfair characterisation? 16:03
A. No, it's not. The Chair of the Board was looking, without giving the details as to what she wanted covered, was looking for time at a Governance Committee meeting that wasn't confidential to discuss serious matters, for all the Trust Board members. I was pushing back to say, if it was serious enough, then bring the Trust Board together for an emergency meeting. I am also very mindful of the timeline of this from the workshop in August and the pending Trust Board meeting at the end of September. 16:03
264 Q. The later September meeting. It does seem as if there is a bit of a dance going on, that Mrs. Brownlee is not

telling you what she needs to say and you're not asking. The back and forward is in relation to the opportunity to say something, that you don't know what she is going to say and she is not telling you what she is going to say, that's how it reads? 16:04

A. Yeah, that's a fair point.

265 Q. Was there anything happened between 27th August meeting and these emails that resulted in a deterioration or a difficulty between the two of you, was there any interaction that resulted in this sort of reluctant 16:04 email exchanges?

A. I don't recall, I don't recall. That's like within 10 days, I don't recall.

266 Q. Did you ever find out what it was that she wanted to say? 16:04

A. No. When I looked at the minutes of the Governance Committee meeting, there was nothing substantive that came through in her commentary at that meeting.

267 Q. She uses the phrase "serious matters", as a member of a Board, I presume if you as a Chair would have used that 16:05 phrase to your NEDs or to your Board generally, you wouldn't use it just casually?

A. No, you wouldn't.

268 Q. You would want it to indicate that there was something of particular import that you wanted to draw to their 16:05 attention. Now, Mrs. Brownlee can give her own evidence about her use of language, but if you were to use that or you were to read that, would that indicate to you that there was indeed something that she needed

brought to your attention given the issues around liability that we looked at earlier on, that you have collective responsibility as well as an individual duty to act appropriately, did you think what is this, this must be serious, we need to know about this, was there any sense of that? 16:05

A. Well there is -- and you're right, I didn't ask her what it was about. But what I will say is that if it is serious enough then bring together the Trust Board and share your serious matters with them. 16:06

269 Q. Do you know if she spoke to anyone else about this matter or raised it with Mr. Devlin or any other NED?

A. I don't know.

270 Q. And as you say there was nothing then on the subsequent minutes of the Governance Committee that might have been reflective of this indication of seriousness? 16:06

A. No, not on my review.

271 Q. I know we have also provided you with Mr. Wilkinson, he was the NED for the MHPS process from the Board. As we understand it, Mrs. Brownlee appointed him or asked him would he take that role on, is that a decision for a Chair, is that something that you have had to do as a result of an MHPS where you have had to appoint an NED? 16:06

A. It is.

272 Q. And is that the role of the Chair as an individual or is it usually the Trust Board to make that decision collectively? 16:07

A. It is the role of the Chair.

273 Q. When you make that decision what are the factors that

you take into consideration when you are deciding who is most appropriate?

A. Who is available.

274 Q. So it just goes down to availability?

A. Yes. 16:07

275 Q. There is no matching of skill set or personality types given the nature of the NED role in the MHPS process?

A. No.

276 Q. You don't consider who might be best suited to support or facilitate that role with someone else, it is just who can do this? 16:07

A. Yep, who is available and in essence who doesn't have one right now, that would be point one, and then, point two, who is available.

277 Q. If we look at Mr. Wilkinson's Section 21 at WIT-26092, at paragraph 2 Mr. Wilkinson says: 16:07

"On 19th January 2017 I was appointed as the designated Non-Executive Director by the Chair of SHSCT, Mrs. R. Brownlee. The primary purpose of my role was to liaise with Mr. Aidan O'Brien and ensure the momentum of the Maintaining High Professional Standards process in respect of Mr. O'Brien was maintained by ensuring timely responses to requests made by him. I met with Vivienne Toal, Director of Human Resources, and Organisational Development to review the role of designated NED. 16:08 16:08

On 24th January 2017 a meeting was held with

Mr. O'Brien, Mr. Weir and Mrs. Siobhán Hinds. Mr. Weir was the case investigator and Siobhán Hinds is the Head of Employee Relations who was assisting Mr. Weir with the investigation.

16:09

On 25th January 2017 I sent a letter to Mr. O'Brien introducing myself as the designated NED. I made him aware that I was informed about his immediate exclusion which became effective on 30th December 2016. At this time the case manager was Dr. Khan and the case 16:09
investigator was Mr. Weir. The relevant documents can be located."

And he gives a reference of where they are:

16:09

"On 25th January 2017 I received an email from Vivienne Toal outlining the next steps in the process. I received another email from Vivienne Toal providing me with an update prior to the Trust Board meeting."

16:09

Then at paragraph 6, he says -- so you can see that that's the context in which Mr. Wilkinson had been secured for that position, just in the preceding days leading up to this contact with Mrs. Brownlee.

16:10

Paragraph 6: "On 26th January 2017 I met with Mrs. Brownlee and we discussed the case. Mrs. Brownlee expressed her opinion about the case. She explained that she had known Mr. O'Brien for a number of years

and that he had been her consultant, that he was an excellent surgeon and that he had helped many people, that he had built up the Urology Department in the Southern Health and Social Care Trust and had worked hard to meet patients' needs as they awaited surgery or a diagnosis. She asked me to make contact with Mr. O'Brien." 16:10

Then he talks about receiving an email and goes on explaining the rest of the chronology. So that's paragraph 6, contact with Mrs. Brownlee. If we go to WIT-26095 and look at paragraph 19, this is on 2nd March 2017 he says at paragraph 19: 16:10

"On 2nd March 2017 Roberta Brownlee telephoned me and expressed her concerns about case progression and time scales. She stated that Mr. O'Brien was a highly skilled surgeon who had built up the Urology Department and was well respected by service users. She further expressed concern about the handling of the case by Human Resources. Mrs. Brownlee pointed out that the case was having an adverse effect on Mr. O'Brien and his wife. She asked me to contact Mr. O'Brien." 16:11

And if we go to paragraph 35 at WIT-26099, on the 15th, Mr. Wilkinson says: 16:11

"On 15th February 2018 Mrs. Brownlee made an informal oral inquiry to me regarding Mr. O'Brien's case."

So can we just go back to paragraph 6, please, it's at WIT-26092. We can see that the first contact was on 26th January 2017 and I've highlighted other contacts with Mrs. Brownlee. What's your view on the appropriateness of those contacts between Mrs. Brownlee and Mr. Wilkinson?

A. Well certainly when I was given my MHPS case I didn't have this level of interaction with the Chair in regard to the case. The place for testing whether there is momentum and progress and challenges should be within the confidential section of the Governance Committee. This feels for me that the Chair is carrying out her own oversight and scrutiny of one case.

278 Q. Is there perhaps a little bit more than that, that there is some advocacy on behalf of Mr. O'Brien taking place in paragraph 6?

A. Absolutely.

279 Q. "Excellent surgeon, helped many people, built up the Urology Department", what's your view on that?

A. That should never have been discussed. If I may, if I allocate a case, a case goes to the Non-Exec, the Non-Exec is given it, then their engagement then is between the case manager and case investigator and HR. I don't phone them up and ask them how things are going and tell them about the individual in question, that is not appropriate. That certainly just makes it a case for advocating on behalf of the doctor in question by the Chair of the Board.

280 Q. It is one interpretation of that, advocating for the

doctor or potential for that, trying to influence the outcome?

A. Yeah, you could see that too.

281 Q. Now, that paragraph 6 was on 26th January 2017. When we went through the chronology of meetings that Mrs. Brownlee either did or didn't declare a conflict of interest, we started off in the August one. But there was, of course, the meeting on 27th January, just the day after Mrs. Brownlee contacted Mr. Wilkinson, when Mrs. Brownlee actually left the meeting. Now it is not recorded in the notes that it was because of a conflict, but she left the room for the discussion of the item involving Mr. O'Brien. It was the day immediately after this. 16:14

A. Yes. 16:14

282 Q. Then when we come to 27th August she is back at the meeting again following this particular process. So that is just for the note of the Panel, that meeting on 27th January 2017 is at TRU-112985. 16:15

Just for completion for you, I don't know if you heard Mr. Devlin's evidence or you are aware of his view, even though his observations about Mrs. Brownlee have been put before the Inquiry Panel. He states in his Section 21 the following, we don't need to go to it, but for the note of the Panel is at WIT-0096. And he says the following: 16:15

"It is important to note that even though our working

relationship was less than optimal, I do not believe that this had any impact on the path that was followed with the Mr. O'Brien case and/or Urology. All appropriate regard to Mrs. Brownlee as Trust Chair was given from me. Out relationship did not alter my behaviours with regards to sharing information with the Chair and Board and I am of the view that the actions Mrs. Brownlee chose to take were not affected by our relationship."

16:16

Now we have spoken earlier about when there were fracture times of potential interventions and I think you agreed that 2017 was an opportunity when things might have been handled differently. So just on that discrete issue would you slightly part company with Mr. Devlin's view that Mrs. Brownlee's position as Trust Chair perhaps didn't lend itself to issues rising to the surface as soon as they might have?

16:16

A. Well I wouldn't disagree with Shane Devlin's comments on that. We have evidence before us that on the - and forgive me, it is late in the day - 27th January was the Trust Board meeting in 2017. Very clearly Mrs. Brownlee knew who the doctor was that was going to be referenced at the meeting, and she knew that before that meeting. Mrs. Brownlee at the meetings then in August, whilst nobody, none of us know what the directors are going to say when they are asked is there anything else, she may or may not have known at that point, but she certainly knew in September, October and

16:16

16:17

November.

MS. McMAHON: Just a comment - again for the Panel's note - Martina Corrigan around Mrs. Brownlee's relationship and friendship with Mr. O'Brien and the way in which she considers he used his connections. Just for the note that is WIT-26300. 16:18

I am just conscious that you have said it is late in the day, you have been answering the questions all day, I just have a discrete section that I can move on to in the morning and then the Panel will have some questions. We are going to move into the learning and it may well be that you want to give us more detail around that. So tomorrow it will be the learning and update on where we are, just to give you a heads up of where we will start, and, if the Chair is content then, would that be an appropriate time to rise? 16:18 16:18

CHAIR: Yes, I think it has been a long day for everyone, not least of which the witness, and the first day back after the holiday break is always difficult for us all. So we will see you all again at 10 o'clock in the morning then. Thank you. 16:18

THE HEARING STANDS ADJOURNED TO WEDNESDAY, 10TH JANUARY 2024 AT 10 AM