



Oral Hearing

Day 79– Thursday, 11th 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.

Gwen Malone Stenography Services

I N D E X

W I T N E S S

P A G E

MS. PAULINE LEESON (CONTD.)

DIRECTLY EXAMINED BY MR. WOLFE	3
QUESTIONED BY MR. HANBURY	53
QUESTIONED BY DR. SWART	56
QUESTIONED BY THE CHAIRPERSON	65

THE INQUIRY RESUMED ON THURSDAY, 11TH JANUARY 2024 AS
FOLLOWS:

CHAIR: Good morning everyone, Mr. Wolfe.

MS. PAULINE LEESON, HAVING PREVIOUSLY AFFIRMED,
CONTINUED TO BE DIRECTLY EXAMINED BY MR. WOLFE AS
FOLLOWS:

1 Q. MR. WOLFE: Good morning, Mrs. Leeson. Just to recap, 10:00
we finished yesterday having looked at issues around
the Early Alert. I suppose your evidence sits as
follows: By the end of August, 27th August 2020, you
had a meeting with your fellow Non-Executive Directors
with Dr. O'Kane which then moved into a Board meeting 10:00
and it was at that point you were told in relation to a
consultant that there were a series of SAIs that were
being examined and it was the view of you and your
fellow NEDs that this should be committed to writing and
brought formally to the next Board meeting 10:01
scheduled for September. The issue was introduced to
you under "Any Other Business", and really not in
writing, as I think you would have preferred looking
back on it. And at that point you hadn't been told
about the Early Alert. At that point you didn't know 10:01
that this was the same practitioner, Mr. O'Brien, whose
MHPS case had been introduced to you in January 2017.
Furthermore, you did not know the outcome of the MHPS
process and nor did you know that he had been referred

1 to the General Medical Council in 2019, is that all an
2 accurate recap?

3 A. Yes, that's correct.

4 2 Q. Yes. It would appear that shortly after that meeting,
5 and certainly in advance of the next Board of 10:02
6 Governors, I should say, mixing roles up here, in
7 advance of the next Trust Board meeting which took
8 place on 24th September, you were contacted by
9 Mrs. Brownlee, the Chair of the Board, to discuss
10 whether you would step in and chair the meeting, at the 10:02
11 next Board meeting if the issue of this doctor's
12 performance and the issues arising from the doctor's
13 performance came onto the agenda again, is that right?

14 A. Yes, I was asked to chair the item on the serious
15 concerns. 10:03

16 3 Q. Yes. And as we sort of saw yesterday the name of the
17 doctor wasn't mentioned in the August records of the
18 Board or the workshop?

19 A. No.

20 4 Q. But was the name, did the name become known to you at 10:03
21 some point?

22 A. When Mrs. Brownlee rang me she named the consultant.
23 She stated that she had or felt herself that she had a
24 conflict of interest because she had been a patient of
25 his and I think that she said that he had saved her 10:03
26 life.

27 5 Q. Yes.

28 A. And asked me to chair the item in the next Confidential
29 Board meeting on the serious concerns that were going

1 to be brought to the Board.

2 6 Q. Right. So she had, perhaps you all had a view of the
3 road ahead, that this wasn't going to be the end of the
4 matter, it was going to be the subject of further
5 discussion in September? 10:04

6 A. Well, we had asked, as you correctly said, for a paper
7 to be brought to us, to supplement the verbal report,
8 we really needed to see the facts and we needed to have
9 the timeline.

10 7 Q. Yes, and we'll spend some time now this morning looking 10:04
11 at that. Could I just start by putting in front of you
12 Mrs. Brownlee's perspective on her communications with
13 you, and if we start with that. It's her Section 21
14 statement at WIT-90873. So she records, if I could
15 just read it aloud: 10:05

16

17 "Because of what could have been perceived a conflict
18 of interest, I spoke around July/August 2020 in a
19 conversation with Pauline Leeson to explain that I did
20 not wish to attend Board meetings where Mr. O'Brien was 10:05
21 going to be discussed. I asked Pauline Leeson, as a
22 NED, would she chair the Board meeting when this topic
23 arose about Mr. O'Brien. I reminded Pauline of the
24 importance of following due process in a timely manner
25 and asked her to check when Mr. O'Brien had his 10:06
26 appraisal completed and about his revalidation.
27 I also asked Pauline to check whether his personal
28 assistant had any comments on lack of administration
29 and if there were any concerns raised by medical

1 colleagues who worked alongside Mr. O'Brien. I
2 questioned what the GPs had prescribed for the same
3 conditions because I knew there was an issue about what
4 medicines Mr. O'Brien had been prescribing.
5 The conversation with Pauline was not for the purposes 10:06
6 of advocating on behalf of Mr. O'Brien but to protect
7 the Trust and to ensure that due process was being
8 followed in procedures and governance adhered to.
9 I was alerting Pauline regarding the systems in place.
10 I never asked the outcome, only if these questions had 10:07
11 been asked. Pauline was merely asking for advice and I
12 was helping her prepare for the Board meeting in August
13 2020. "
14
15 And that should probably refer to the Board meeting in 10:07
16 September 2020, isn't that right?
17 A. Yes, because it was a workshop in August.
18 8 Q. Yes. And just to be clear in terms of your
19 recollection, we saw yesterday the workshop and it
20 moving into a Board meeting yesterday; the conversation 10:08
21 with Mrs. Brownlee that you remember, did it occur
22 before that, those August events, or did it occur in
23 advance of the September meeting?
24 A. My recollection was that it was in advance of the
25 September Board meeting. 10:08
26 9 Q. Yes.
27 A. And she was quite specific about chairing the item in
28 the September meeting.
29 10 Q. Yes. Now, you've indicated, I have read that out in

1 full, and you've indicated in your witness statement
2 that you disagree with elements of what Mrs. Brownlee
3 has said there. Could you outline your points of
4 disagreement?

5 A. Okay, could I ask you to scroll. 10:08

6 11 Q. Of course, and I can bring you to your witness
7 statement.

8 A. Scroll up.

9 12 Q. Yes, if we scroll up to the start of where I started.

10 A. Okay. Certainly when Mrs. Brownlee spoke to me she 10:08
11 didn't perceive it as a conflict of interest, she said
12 it was a conflict of interest. She named Mr. O'Brien.
13 My recollection of it was that she said there were
14 serious concerns that would be brought to the Board
15 meeting and asked me if I would chair the item at that 10:09
16 Board meeting. I mean, this was quite a normal
17 practice. Mrs. Brownlee would have rung people, you
18 know, either to chair consultant panels or to maybe
19 chair parts of the Board meeting, so I didn't think
20 there was anything unusual about that. And she had 10:09
21 clearly stated her conflict of interest so, as far as
22 I was concerned, that was the end of the conversation.

23 13 Q. Yes. You made a note, or you've said you have made a
24 note in respect of that conversation. If we just can
25 bring that up, it's a very short note, WIT-99862. And 10:10
26 it's written on what appears to be notepaper relating
27 to another organisation, Relate NI, is that just
28 something you had handy?

29 A. Yes, it was on my desk at home. I just made a quick

1 note of what she had asked me to do, what she had said,
2 just to remind myself.

3 14 Q. what does the note say?

4 A. It says: "Take the Chair. Conflict of interest.
5 Urology. If there were concerns that was the issue 10:10
6 that she wanted me to raise in the Board meeting, if
7 there were concerns why weren't they raised before, why
8 weren't they flagged before."

9 15 Q. Flagged before, okay. And just going back to
10 Mrs. Brownlee's statement, you were working through it 10:11
11 at WIT-90873. And she, as you've heard read by me, she
12 sets out in her statement a range of issues that she
13 says she was telling you to raise at the Board meeting
14 or suggesting that you might think about and raise,
15 including issues relating to prescribing, about 10:11
16 re-validation, about the role of his personal
17 assistant. Were those issues raised with you?

18 A. My recollection was that they weren't. I know these
19 issues came up in the email that Mrs. Brownlee sent the
20 day before the Board meeting so maybe she has got 10:12
21 confused there.

22 16 Q. Yes, we will certainly ask her about that. I think the
23 email you refer to is to be found at WIT-98812, if we
24 just take a brief look at that. No, I've got the wrong
25 reference there. See if I can come back to that in due 10:12
26 course. Yes, thank you. Michael was about to tell me
27 that as well so thank you. So, what you were saying is
28 Mrs. Brownlee in her witness statement has recounted a
29 range of things she believes she may have raised with

1 you or did raise with you for the purposes of chairing
 2 this item on the next Board meeting. You say you think
 3 she is mistaken and you point to this email that she
 4 sent to, as we understand it, her fellow Board members
 5 on the eve of the Board meeting and we can see she is 10:13
 6 speaking to a paper that was circulated in advance of
 7 the Board meeting. It says:

8
 9 "This paper references many HR areas."

10 10:14
 11 She has read the paper and she's asking a series of
 12 questions including why hasn't an alert paper on this
 13 area never come to the board before. She is asking
 14 about performance with comparison with other consultant
 15 urologists. "Have we any concerns raised by GPs." 10:14
 16 She's asking about appraisal process. Scrolling down,
 17 just to the end of it, please. So she is essentially
 18 asking colleagues to take these matters on board and
 19 think about them in advance of the meeting on the 24th.

20 10:15
 21 Just in terms of your engagement with Mrs. Brownlee,
 22 was this the first time that she had, to the best of
 23 your memory, declared a conflict to you and explained
 24 the basis for it?

25 A. The first time was when she phoned me and asked me to 10:16
 26 chair the item in the Board meeting, that was the first
 27 time that I was aware that she had a conflict of
 28 interest.

29 17 Q. Yes. In terms of the basis for that conflict it was

1 explained to you as arising from her patient
 2 relationship with the clinician, Mr. O'Brien?

3 A. Yeah, it was, yeah, purely that she had been his
 4 patient.

5 18 Q. We know through evidence to this Inquiry that there are 10:16
 6 potentially other sources to the conflict including a
 7 friendship and a quasi business relationship through an
 8 organisation called "CURE", and we'll ask Mrs. Brownlee
 9 about that when she gives evidence. Were those
 10 potential sources for conflict ever raised with you by 10:17
 11 her?

12 A. I only knew about those by reading through the
 13 transcripts for this Public Inquiry, they were never
 14 raised with me.

15 19 Q. Mrs. Brownlee, as we have observed from her statement, 10:17
 16 has explained that in speaking with you, it wasn't for
 17 the purposes of advocating on behalf of Mr. O'Brien, it
 18 was simply with a view to protecting the Trust and
 19 ensuring that due process was being followed. In her
 20 dealings with you, the conversation that you've 10:18
 21 referred to, did you regard it as advocacy on behalf of
 22 Mr. O'Brien or, in the alternative, was it simply in
 23 your view a straightforward and appropriate transaction
 24 asking you to take over the Chairmanship because of her
 25 conflict? 10:18

26 A. I thought that it was an appropriate conversation, that
 27 she had rung me to tell me that she had a conflict of
 28 interest. She explained what it was. Whether or not
 29 her asking me why these serious concerns had not been

1 flagged before was appropriate or not, I'm not sure
2 but...

3 MR. WOLFE: I've received an objection to how I framed
4 the question in relation to the "CURE" relationship
5 where I described it as quasi business. 10:19

6 CHAIR: well, they were both directors of a charity.

7 MR. WOLFE: Yes, it was a company which was set up for
8 charitable purposes, that's why I used --

9 CHAIR: Yes, but they were both directors, so quasi
10 business was reasonable. 10:19

11 MR. WOLFE: well I agree, Chair, so I thought I would
12 draw that to your attention in case the record required
13 correction in your view, I don't believe it does.

14
15 20 Q. In terms of the meeting then which you were being asked 10:19
16 to chair on 24th September, we are aware that a
17 report was furnished to members of the Board in
18 advance of that meeting, you clearly received that
19 report, isn't that right?

20 A. Yes, that's right. 10:20

21 21 Q. And we can take a look at that. The report is to be
22 found at WIT-99831, and it's apparently authored by
23 Dr. O'Kane, although no doubt, given the range of
24 issues covered in it, it's the product of a number of
25 contributors no doubt. This was no doubt a helpful 10:20
26 report for the Trust Board in that it comprehensively
27 brought the Trust Board into, I suppose, contact with
28 the whole background to events that had transpired and
29 brought you - that is the organisation - to the place

1 it was in in September 2020. How did you regard the
2 report?

3 A. Well I have to say when I read the report I was
4 stunned. I had to sit down and read it about three or
5 four times. I suppose for me there was, you know the 10:21
6 report was well written, it's what we asked for, it was
7 factual, there was a timeline. But I suppose in my
8 role as NED I had, you know, two major concerns and a
9 range of emotions I have to say. My first concern was
10 for the families involved. Sometimes when you see 10:21
11 these reports, and you will see it a lot, I have seen
12 it a lot in child protection investigations that I have
13 been involved in, they are listed as cases and behind
14 these cases are people. They are fathers and mothers
15 and sons and daughters. So for the families involved 10:22
16 I think this was very distressing and traumatic.

17
18 But my second concern was also for our staff. Our
19 caring, dedicated, committed staff who had worked so
20 hard through Covid now had a separate challenge. They 10:22
21 had to go out and contact all these families. In the
22 report it said there was over 700 cases where there was
23 potential for causing harm. So I think that was quite
24 distressing for the staff as well. So for us,
25 obviously the report was helpful as you say, Mr. Wolfe, 10:23
26 in terms of giving us the full range of information,
27 but I think it also had quite a huge emotional impact
28 on NEDs as well. You know, I think when I look through
29 the timeline and looked at the length of the time that

1 these problems were going on and the staff who had very
2 little support from us as NEDs, apart from John
3 wilkinson, and I felt that certainly we had not
4 provided safe enough systems to keep these patients
5 safe and obviously to support our staff.

10:23

6 22 Q. Yes, we'll look at some aspects of the report just now.
7 You pointed out that your initial response to it was
8 concern for the patients, concern for the staff, did it
9 also jar with you that you are now getting this
10 information, and we'll see the kinds of information
11 that you were now being given, but did it not jar with
12 you that you're getting information in September 2020
13 that perhaps ought to have been provided to you at
14 appropriate stages several years earlier?

10:24

15 A. Well, I mean I've thought about this a lot, if we had
16 had these systems in place that we have now we would
17 have seen this report earlier. You know, obviously
18 I don't know why we weren't told earlier, why did the
19 staff not feel that they could approach us earlier with
20 these concerns, was it around confidentiality, was it
21 around gathering the information? I don't know.

10:24

22 23 Q. Well, we'll maybe come to some specific aspects of that
23 in a moment. I've described the report as
24 comprehensive, there is at least one area where perhaps
25 isn't wholly comprehensive and I want to raise that
26 with you. But if we scroll down the initial page, and
27 just on to the next page please, we're provided with an
28 introduction. And just looking at the first paragraph
29 it sets as its context the events of June 2020, three

10:25

10:25

months earlier, and it's observing that on the Associate Medical Director's initial review of a list of patients which had been sent into the system by Mr. O'Brien, he noted that two of the patients were stated to have been listed on 11th September and 11th February 2020 but it appeared, on his review, you're being told that there was no, essentially no record for those patients on the Trust's systems.

10:26

Now just to point away from this document, that issue has been the subject of some controversy before this Inquiry. Mr. O'Brien has given evidence that that is quite wrong, that there were records for these patients on the system. Has that issue been reviewed by the Board in light of that evidence, do you know?

10:26

A. I don't know, I would presume that some of these cases were part of the SAI.

10:27

24 Q. I think it's a slightly different issue, it's about record keeping and it's about, if you like, the triggering for this process, Mr. O'Brien's point being that the premise for getting into all of this is wrong, that there were records, he had made appropriate records for these two patients and that they were to be found on the lists?

10:27

A. Well if Mr. O'Brien has provided that evidence, I certainly haven't seen it.

10:27

25 Q. Okay. It hasn't -- what I'm asking you is has it been discussed on the Board?

A. No.

1 26 Q. No. And getting back to what you were being told then
2 at the time, if we just scroll down, the initial pages
3 are taken up with the Trust, that is Mrs. O'Kane
4 explaining to you the preliminary investigative steps
5 being undertaken by her team to get to grips with the 10:28
6 problem, essentially an initial fact-finding stage. We
7 then, if we scroll forward to WIT-99841, a few pages
8 further on, she sets out, if we scroll down the page,
9 she sets out the findings of the MHPS investigation and
10 she explains that there were 783 untriaged referrals by 10:29
11 Consultant A, of which 24 were subsequently deemed to
12 be needed to be upgraded, a further four with confirmed
13 diagnosis of cancer. She then gets into the findings
14 that there were charts being kept at home. And, just
15 scrolling down, she documents the findings of the MHPS, 10:29
16 which are not uncontroversial in light of Mr. O'Brien's
17 evidence, but she has pointed out that there were a
18 substantial number of clinics, 66, affecting over 600
19 patients where there had been no dictation done. And,
20 finally, she points out problems in relation to the 10:30
21 management of private patients into the NHS with unfair
22 priority is the sense of it. So that's the information
23 that the Trust Board is being given more than two years
24 after Dr. Chada has made these findings in her MHPS
25 investigation report. 10:31

26
27 Now, you say you thought about whether there were
28 perhaps good reasons for not bringing such information
29 to the attention of the Board before now, do you think

1 there are any good reasons, can you conceive of good
2 reasons why the Non-Executive Directors were not given
3 this information?

- 4 A. Having read the report, and obviously the transcripts
5 of the Inquiry to date, it seemed that alongside this 10:32
6 there was a long running grievance where, you know,
7 particularly HR staff were asked to provide a lot of
8 information. I think that maybe slowed that process
9 down quite a bit. The consultant concerned was also
10 ill for part of the time so he was in work and out of 10:32
11 work, but it seemed to me that he was reluctant to
12 engage with the process. And, as I said before,
13 Managing High Professional Standards, I was unsure, is
14 it a clinical process or is it a HR process. The
15 clinical process probably needed just to go ahead in 10:32
16 terms of looking after our patients and ensuring that
17 patient safety was the priority and the HR process, in
18 my view, and the grievance, could have been handled in
19 priority. But, obviously, the Medical Director and the
20 Chief Executive didn't feel that they had a complete 10:33
21 enough suite of evidence to bring to our attention.
22 Having looked at a lot of the evidence given to the
23 inquiry, I suppose the conflict of interest of the
24 Chair is something that stands out to me. Because
25 normally you would go from Medical Director to Chief 10:33
26 Executive to the Chair, but if the Chair had such a
27 conflict of interest, I only knew it as a patient
28 conflict, but if there was also a personal friendship
29 and some sort of involvement with a charity, then that

1 was a much bigger conflict of interest than I certainly
2 would have imagined and I would imagine that that would
3 make it very difficult for the senior leadership team
4 to take this sort of issue to the Chair.

5 27 Q. Now I wonder in all fairness to the various 10:34
6 perspectives that you have just outlined whether you
7 are overcomplicating it, my question to you is was
8 there any good reason, underscoring the word good
9 reason, why this kind of information would not be
10 brought to the attention of the Non-Executive 10:34
11 Directors?

12 A. Well it should have been brought to our attention and
13 it wasn't.

14 28 Q. Thank you. If we scroll back up the page, you're told
15 in this timeline that on 1st October 2018, again a 10:35
16 little shy of two years beforehand, that Dr. AK, who we
17 know to be Dr. Khan, met with the consultant to outline
18 the outcome of his determination, that the case should
19 be forwarded to a conduct panel under MHPS. Now, you
20 now know that Dr. Khan produced a written determination 10:35
21 setting out his view in light of the investigation
22 report produced by Dr. Chada. That written
23 determination, was that ever provided to the Trust
24 Board?

25 A. No. 10:36

26 29 Q. Did you know about its existence before the Inquiry
27 provided it to you?

28 A. No, and I suppose under the present system that
29 determination would have come in the quarterly report

1 to Governance Committee.

2 30 Q. Let's leave that aside for the moment. We need to
3 focus on what the Executive Directors of the Trust did
4 and didn't do in realtime and whether their performance
5 in this respect is of concern to you. So if we focus 10:37
6 on what Dr. Khan said. If we can open up his
7 determination at AOB-01923, and I know that you will
8 have had an opportunity to read the report. I want to
9 draw your attention to his final conclusions and
10 recommendations. You are familiar with this now, is 10:37
11 that fair?

12 A. Yes, yes.

13 31 Q. What he is saying, if I can paraphrase, is that the
14 MHPS investigation has raised concerns that don't just
15 rest with Mr. O'Brien, they also affect and relate to a 10:38
16 management system within Acute Services that has gone,
17 in his view, badly wrong. And if I can read he says:

18
19 "The investigation report highlights issues regarding
20 systemic failures by managers at all levels, both 10:38
21 clinical and operational within the Acute Services
22 Directorate. The report identifies there were missed
23 opportunities by managers to fully assess and address
24 the deficiencies in practice of Mr. O'Brien. No one
25 formally assessed the extent of the issues or properly 10:39
26 identified the potential risks to patients."

27
28 He goes on to say:
29

"The default processes were put in place rather than addressing the deficiencies."

The findings of the report, he says, should not solely focus on one individual, Mr. O'Brien. And in his final paragraph he recommends the conduct of an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes.

Now, is it fair to say that you have only been able to read that report in the last three to four weeks?

A. Yes.

32 Q. And that's because it was given to you by the Inquiry?

A. Mhm-mhm, yes.

33 Q. And if we go back to the report that you received from Mrs. O'Kane in preparation for 24th September meeting and we'll find it at WIT-99841 where she talks about - just scrolling down - where she talks about the Case Manager's determination. She solely refers to that part of his decision that discusses the need for a Conduct Panel in association with Mr. O'Brien's practice. What is hidden from the view of the Trust Board is all of those concerns expressed by both Dr. Chada and then Dr. Khan about the performance of management within Acute at all levels and the need for an independent review of this. As you say none of this was brought to your attention?

1 A. No, and I wouldn't use the word "hidden".

2 34 Q. Okay.

3 A. I think in the general scheme of things these reports

4 would not be brought to Governance or Trust Board. You

5 wouldn't see the full determination or the full reports 10:42

6 under Maintaining High Professional Standards, you would

7 see the outworkings of it, what the determination was

8 and then what we were going to do about it.

9 35 Q. Okay. So you are being told within this timeline one

10 aspect of the determination, open and above board, 10:42

11 transparent, that there is to be a Conduct Panel or that

12 there ought to be a Conduct Panel. If "hidden" isn't

13 the right word to describe not telling you about the

14 criticisms of the performance of management, what is the

15 appropriate word? 10:43

16 A. Well, when we look at these sorts of reports and

17 incidents, in my view it is never about one individual,

18 it should be about the systems that we have or have not

19 got in place. So the discussion, as we went through

20 after this report in Trust Board, was about the systems 10:43

21 as well as what had happened with this particular

22 individual and we were very clear that the systems that

23 we had were not keeping the staff supported and the

24 patients safe enough.

25 36 Q. So, is it satisfactory that you were not told the views 10:43

26 of Dr. Khan in respect of the failures of management

27 back in 2018 given that it was the same management,

28 largely, which remained in place through 2020 when

29 these other difficulties associated with Mr. O'Brien's

1 practice were revealed?

2 A. I think we should have been told about them. I mean,
3 we should have been told what Dr. Khan had found in his
4 determination. Something that was so serious should
5 have been brought to Confidential Governance or 10:44
6 Confidential Trust Board meeting.

7 37 Q. And why do you consider that to have been important?

8 A. Sorry, ask again?

9 38 Q. It may appear obvious, but could you spell out to us,
10 in light of that answer, why would it have been 10:44
11 important that you would know this?

12 A. Because then we could look at the events in the round.
13 I mean, it's our job to look at the systems, it's our
14 job to improve them, it's our job as a Trust Board,
15 both Executive and Non-Executive, to improve the 10:45
16 services. Patient safety is the No. 1 priority. But
17 alongside that, and it's something that Dr. O'Kane has
18 really emphasised, is psychological safety, that staff
19 feel empowered and feel safe enough to bring those
20 issues to us to discuss and obviously they didn't. 10:45

21 39 Q. Yes. By the end of 2018 and the commencement of 2019
22 Mrs. O'Kane was Medical Director?

23 A. Yes.

24 40 Q. And in some respects, perhaps with others, had
25 ownership of aspects of this together with the relevant 10:46
26 management within Acute. Have you ever asked her why
27 this information, obviously you couldn't have asked her
28 about the Dr. Khan report only knowing about it
29 recently, but have you ever asked her to explain why

1 the MHPS findings in the round didn't come to the Trust
2 Board prior to September 2020?

3 A. No, I don't think we have had that discussion.

4 41 Q. Now that you know about Dr. Khan's report in all its
5 glory, including his recommendation that there should 10:46
6 be an independent review, is this something that
7 Dr. O'Kane should now be asked about?

8 A. Well I think that as a Trust Board we should take some
9 time out to talk about what's happened here. Certainly
10 that's one of the issues that we should be talking 10:47
11 about, to explore with Dr. O'Kane why the reports
12 weren't deemed serious enough to be brought to us.

13 42 Q. Put it this way: If Dr. Khan's opinions had been put
14 before you towards the end of 2018, maybe the early
15 months of 2019, you as a Board would be saying 'right, 10:47
16 we need to do an independent review here, we need
17 answers to the questions which Dr. Khan has posed and
18 we need a remedy, we need a solution so that things can
19 be done better moving forward,' does that sound
20 sensible and appropriate? 10:48

21 A. We should have taken some time out.

22 43 Q. You weren't told about it?

23 A. Yeah.

24 44 Q. My point is, if you had been told about it, does it
25 sound sensible that that is the kind of steps that a 10:48
26 governance savvy Board would have responded with?

27 A. Yes, I think we would have discussed it and taken some
28 action on it given that there was also an ongoing
29 grievance.

1 45 Q. I used the word "hidden" from you, is there a better
2 word to describe a failure on the part of the
3 Executives to tell the Non-Executives about the
4 criticisms that they had received?

5 A. Well, I mean that's the call of the Medical Director 10:49
6 and the Chief Executive, what's appropriate information
7 to be brought to Governance and a Trust Board. Certainly
8 having read Dr. Chada and Dr. Khan's reports I think
9 the determination should certainly have been brought to
10 us for discussion in terms of the failings of these 10:49
11 systems around governance.

12 46 Q. If we could just scroll through the remainder of this
13 report just so that the Panel can remind itself. So
14 the findings of the MHPS are set out, just scrolling
15 down. Then you're told, again for the first time, as 10:50
16 I understand, that this consultant had been the subject
17 of a referral to the General Medical Council. Again is
18 that something you should have been told previously,
19 even on a confidential basis?

20 A. I would have thought so. Under the present system 10:50
21 we're told.

22 47 Q. Yes. Then we're into a timeline for a grievance
23 process. You will recall yesterday that was the
24 subject of the expression of concern by Mr. O'Brien in
25 his June correspondence, but you took the view that 10:51
26 this wasn't something that bore further inquiry from
27 you as a NED?

28 A. I think, as I said yesterday, Mr. O'Brien's letter,
29 I considered it to be a HR matter, where he was

1 aggrieved and he said in the letter that he was
 2 aggrieved that he was not being asked back to undertake
 3 part-time employment.

4 48 Q. And I'm curious, the fact that you received that letter
 5 and your colleagues received that letter, did that not 10:51
 6 even arouse your interest to ask of Mrs. Brownlee why
 7 are we getting this, does Mr. O'Brien deserve a
 8 response, what is behind all of this?

9 A. From my point of view I thought it was inappropriate
 10 for Mr. O'Brien to send it to the NEDs. I thought it 10:51
 11 was entirely appropriate for him to send that letter to
 12 Vivienne Toal, the Director of HR. I also thought it
 13 was unwise and inappropriate of Mrs. Brownlee to send
 14 the letter or ask for the letter to be sent on to the
 15 NEDs. For me it was clearly a HR matter. I have been 10:52
 16 a senior manager for 25 years, I've dealt a lot with
 17 HR. In the letter, in my opinion, it was about
 18 Mr. O'Brien's employment. He didn't, there was no
 19 whistleblowing issues and certainly he didn't raise any
 20 patient safety issues. So it was entirely appropriate 10:52
 21 that he sent it to HR, but I thought it was
 22 inappropriate for him to send it to Mrs. Brownlee.

23 49 Q. And did you tell her that?

24 A. Did I tell?

25 50 Q. Her that? 10:52

26 A. No, I just ignored it.

27 51 Q. And then, if we continue scrolling down to the next
 28 page, 44 in the series. You're told about the serious
 29 adverse incidents starting with the index incident of

1 Patient 10, and then you're told about further
2 incidents or SAIs that had materialised at a much
3 earlier point. I don't think anywhere in the document
4 is it spelt out to you that the omissions giving rise
5 to these SAIs occurred in 2016 and were only the 10:54
6 subject of a finalised SAI report in May 2020. You are
7 now aware of that, is that fair?

8 A. Yes, I am, yes, yep.

9 52 Q. Again does that add to your sense that this issue in
10 the round hadn't been well managed if an SAI 10:54
11 investigation on the subject of failure to triage had
12 been allowed to drift for three years or so?

13 A. Yeah. I mean, I've read the SAI from 2016, the root
14 cause analysis, and I have also read the root cause
15 analysis of these SAIs. I would say that really we 10:55
16 should have been appraised of the seriousness. I mean,
17 SAIs are serious any way, but in 2016 my understanding
18 now, that it wasn't just one patient, there were more
19 patients. Also these issues had gone back a longer
20 time, which we certainly weren't told about in 2017. 10:55

21 53 Q. Yes. We'll come to your preparation for 24th September
22 meeting in just a moment because I think some of those
23 points emerge in your thinking at that time and I just
24 want to work through them with you. But just one point
25 that you could maybe help us with, if we go to 10:55
26 WIT-90874, it concerns whether Mrs. Brownlee was privy
27 to the report that we've just been looking at and she
28 has said, just about... yes, so she says, just in the
29 middle of the page:

1 "Pauline Leeson took the Chair in my absence. Prior to
2 receiving Inquiry discovery documents I had never seen
3 the paper prepared for agenda item in September 2020.
4 I knew none of this detail of the allegations regarding
5 Mr. O'Brien."

10:57

6
7 I think you're quite clear that Mrs. Brownlee had seen
8 the paper in advance of 24th September meeting?

9 A. Well my reading of Mrs. Brownlee's email the day before
10 the meeting was, I thought that was the paper that she
11 was referring to and she was quite clear in that email
12 that she had seen it. I think she had also asked the
13 Chief Executive to make some changes in it in regards
14 to Mr. O'Brien's name.

10:57

15 54 Q. Well, I think we'll just go back to that email and
16 perhaps Mrs. Brownlee, in fairness, will be able to
17 clarify it for us, but it is WIT-99812 and we touched
18 on this earlier. And she's saying "You're aware I'm
19 removing myself from this agenda item" and she still,
20 she says, has a very serious responsibility for this.
21 She has discussed it with the Chief Executive
22 yesterday:

10:57

10:58

23
24 "I have read this paper and have noted many areas that
25 need explained. This paper references many HR areas."

10:58

26
27 So it may be that there is some confusion there, but
28 the only paper that you are aware of that was prepared
29 in advance for this 24th September meeting is the one

1 we have been discussing?

2 A. Yes, yes, that's right.

3 55 Q. You have, as part of your disclosure to the Inquiry,
4 sent us some notes that appear to be your preparation
5 for chairing the item on 24th September. If we can 10:58
6 pull those up, they are found at WIT-99863. You
7 appear, I suppose diligently, to have worked your way
8 through the report that Dr. O'Kane had provided for the
9 meeting. You're summarising, as we can see from these
10 notes, what you're picking up from the paper itself. 10:59
11

12 Just scrolling down, so you're starting with what had
13 occurred in June 2020 or at least what the AMD, that is
14 Dr. Haynes, Mr. Haynes had reported, as occurring,
15 patients assessed in September 2019 and February 2020 11:00
16 but not added to the in-patient list. You regard that
17 as or you're describing that, picking up on the paper,
18 as potentially very serious clinical risks. You've
19 noted earlier that Mr. O'Brien vehemently disputes
20 that. But then you're into describing, summarising - 11:00
21 if we scroll down - the various other aspects of the
22 paper.
23

24 If we could bring you, I suppose, to rather laboriously
25 go through it. If we could bring you to the list of 11:00
26 queries that you arrived at and they are at 6-7 in this
27 series, four pages through. Just that bottom half of
28 the page, yes, just from there, thank you. I suppose,
29 the first thing on the list is "This is the first time

1 this is being brought to the Trust Board." That has
2 echoes of what Mrs. Brownlee, I think, on your
3 handwritten note had been saying to you, that was a
4 concern to her, why is this only coming to the Board
5 now? 11:01

6 A. Yeah.

7 56 Q. You shared that concern?

8 A. Well it was the first time that it had been formally
9 brought in writing to the Trust Board. We had had a
10 verbal report of concerns about a number of SAIs in 11:02
11 August, but this was the first formal written paper.

12 57 Q. Yes. Then there is a question for John, is that John
13 Wilkinson?

14 A. John Wilkinson.

15 58 Q. And you've said: "How long you have been involved." 11:02
16 Just translate that for us?

17 A. "And when did it terminate."

18 59 Q. Right. Thirdly, "what level is this SAI at", comparing
19 the outset, that's 2016, and "what level of SAI is it
20 now", in 2020. Is this a focus on the SAI that started 11:02
21 life in 2016/2017?

22 A. Yes, yes.

23 60 Q. And does that say, "what determined the level of the
24 SAI"?

25 A. Yes. 11:03

26 61 Q. And then you asked, "why no formal action in 2016"?

27 A. Yes.

28 62 Q. Scrolling down, can you help us with that one?

29 A. "After identified in 2016, why did it take until 2020".

1 63 Q. Yes, quite. 7: "Was there any evidence to state that
2 patients suffered harm." And if you could help us with
3 8.
4 A. Yes: "Look at decision making, who made the decisions.
5 What evidence -- how was he allowed to continue to 11:03
6 practice?"
7 64 Q. Yes. I suppose aspects of that have echoes in
8 Dr. Khan's determination around decision making, who
9 made the decisions?
10 A. Hmm. 11:04
11 65 Q. That's directed at the failure of decision making, is
12 it?
13 A. Yes, and also where good decisions were made.
14 66 Q. And if we could look at the minutes of the Trust Board,
15 we can find those, so far as is relevant to urology, 11:04
16 it's item 7 on the agenda at TRU-130826. And just at
17 the bottom of the page:
18
19 "The Chief Executive set the context of this item by
20 advising of the likelihood of significant media 11:05
21 interest."
22
23 Scrolling down. Then Dr. Gormley intervened and took
24 the matter forward. Dr. Gormley was the?
25 A. Deputy Medical Director. 11:05
26 67 Q. Deputy Medical Director. She attended that
27 September meeting in lieu of Dr. O'Kane?
28 A. He, Damien.
29 68 Q. He, sorry?

1 A. Yes.

2 69 Q. And Dr. O'Kane was absent from the September meeting.
3 She was also absent from the October meeting, which we
4 will come to. Did you think that unusual? I'm not
5 sure if you ever received an explanation for her 11:06
6 absence, but it's hard to think of anything more
7 significant in terms of the life of a Trust as
8 something like this which was bubbling up towards what
9 was to become a Public Inquiry territory?

10 A. Yes, I wasn't aware of why she wasn't present. 11:06

11 70 Q. For two meetings in a row?

12 A. Yes. Well, I suppose to give some context, during this
13 time, obviously we were just coming out of Covid, there
14 were huge challenges, particularly in the acute
15 hospitals. Dr. O'Kane in my opinion was trying to 11:06
16 manage a lot of very different pressures. And it's not
17 just in hospitals, it is also in the community
18 services. She has -- I mean, Dr. Damien Gormley is a
19 very able Deputy Medical Director. He gave a good
20 summary of the clinical concerns, he went through the 11:07
21 paper in great detail and laid it all out for us.

22 71 Q. Yes. So he lays it all out for you, you intervene
23 asking about previous SAIs, sorry asking about new SAIs
24 given that there had been previous SAIs and you're told
25 that an External Chair has been appointed. You ask how 11:07
26 far back the process would go and you're told that the
27 focus has to be on immediate concerns. You had, as we
28 saw, a list of questions or concerns prepared as part
29 of your homework or your preparatory work for this

1 meeting, notably:

2
3 "Why hasn't this come to us before now? What was the
4 decision making that has led up to all of this?"

5
6 Again, we're vulnerable to whether the minute is a full
7 account of what transpired at the meeting, did you get
8 an opportunity to ask the kinds of difficult questions
9 that you had in mind?

11:08

10 A. Yeah, I mean those questions are usually part of my
11 prep, what I'm thinking through, you don't always ask
12 all those questions. Dr. Gormley gave a really very
13 detailed report on the paper that he had presented.
14 Certainly I thought that they were the most important
15 questions to ask. I would have been concerned that
16 there were previous SAIs that we didn't know about in
17 2016 and also how many more were there given that we
18 have been told that there were over 700 untriaged cases
19 where there might be potential for harm.

11:09

20 72 Q. So you got the facts from him that you, as a Board,
21 were now fully in the picture, there was nothing else?

11:09

22 A. Well, I think he gave a very full account of what was
23 in the paper. I was certainly reassured, particularly
24 when an External Chair has been appointed to take
25 forward those SAIs, that would have assured me that
26 this matter was being treated very, very seriously and
27 once that happens that then goes into a different
28 process.

11:10

29 73 Q. So your priority, I suppose, was to seek assurance that

1 we're now getting to grips with this, that the
2 appropriate investigative processes are in train?

3 A. Well the pragmatic side of me said that we've got this
4 situation now, so we have to look at how we're going to
5 deal with it and what systems, what kind of processes 11:11
6 were going to be put in place to, No. 1, deal with the
7 SAIs that we had but also to look back and see was
8 there anything else that we had missed.

9 74 Q. Yes. To the extent that your instinct was to ask
10 questions and to probe about the failures, if they were 11:11
11 failures, or the omissions that led to this situation,
12 have you ever asked those questions?

13 A. I think that we should have taken time out,
14 particularly as a group of Non-Executive Directors, to
15 discuss this paper and what had happened and where the 11:12
16 failures had been and we haven't done that. But - and
17 it's not in terms of any excuse - the process then went
18 into a completely different direction. Obviously we've
19 got, we had the External Chair, then in November we had
20 the announcement, initially I think in October where 11:12
21 they were talking about a review, and now in November
22 they announced, the Department announced, the Minister
23 actually announced that it would be going to Public
24 Inquiry. So that's where the learning will come from
25 and that was then our focus in terms of the opportunity 11:12
26 to explore what had happened and where we had failed as
27 a system and what recommendations and learning could
28 come out of this process to strengthen our governance
29 going forward. But having said that, we had already

1 started to strengthen the governance from the June
 2 Champion report in terms of putting in those reports
 3 into the Clinical and Social Governance part of the
 4 Governance Committee.

5 75 Q. Is that to imply that the deficit of information 11:13
 6 sharing with the Board, which you have already alluded
 7 to in response to my questions, is not now the picture,
 8 it shouldn't have been the picture at the time but the
 9 position has now changed?

10 A. I think there's been a considerable cultural shift in 11:13
 11 the Board. We're working together much more as a
 12 collaborative Board. It doesn't mean that you don't
 13 ask hard questions, you don't scrutinise. I mean, some
 14 of the meetings are quite robust in terms of the many
 15 challenges and pressures that come up in the Trust 11:14
 16 Board. But I think that the culture has really
 17 encouraged I think particularly through the current
 18 Chair and the Chief Executive, encouraged an
 19 environment where staff feel much more psychologically
 20 safe, where they can come to us and tell us if they 11:14
 21 have concerns, where there are risks and together we
 22 look at how we can minimise those and put in
 23 mitigations.

24 76 Q. Just looking at minute in front of us, we see that
 25 Ms. Donaghy has picked up on a point which I was 11:14
 26 addressing yesterday, which is the Early Alert. She is
 27 asking when was this Early Alert submitted, that seems
 28 to indicate a view that perhaps there was a degree of
 29 unhappiness on the part of NEDs that you had been kept

1 in the dark about this for more weeks than was healthy.
2 The Chief Executive undertook to clarify and we know
3 that this was clarified. Was there a sense amongst the
4 NEDs that you had been kept in the dark for more time
5 than was healthy, not just over the summer months of 11:16
6 2020 but stretching it back further to the MHPS and all
7 of that?

8 A. I think, you know, Ms. Donaghy asked a really good
9 question. The context to that was that Early Alerts
10 were only shared with us on an occasional basis and only 11:16
11 in the last year. Now, we would see all the Early
12 Alerts. The situation then was that you wouldn't
13 necessarily see all of the Early Alerts, certainly this
14 Early Alert in my opinion should have been shared with
15 us. 11:16

16 77 Q. You were explaining to us how there has been something
17 of a cultural change and I just wanted to help you
18 illustrate that, if we go to WIT-90675. This is an
19 example of a report which, as I understand it, is
20 brought to Governance Committee, I'm not sure if the 11:17
21 report has changed in form over time. But if we just
22 open it up, essentially - and bring that up, yes, thank
23 you, that's very kind of you. We've received evidence
24 already, the Panel will remember, explaining that the
25 cases that are triggered or are potentially going to be 11:18
26 screened into the MHPS Framework are now routinely
27 brought to the Governance Committee's attention and you
28 have full visibility on the processes as they wind
29 through the system, is that right?

1 A. Yes, that's correct.

2 78 Q. We can see the relevant date the case being opened, the
3 name -- well, you get a summary of, I suppose, the
4 issues at stake. We've taken the liberty of redacting
5 that for obvious reasons and then you get to know who 11:19
6 is involved, whether the PPS are involved, whether the
7 GMC has been informed, whether there is impact on
8 patients, that is a patient safety issue, and whether
9 there is an SAI. I think - just scrolling down - there
10 is other elements of the data. So this is indicating 11:19
11 new cases coming into the system as well as, up above
12 that, cases that are further down the track.

13
14 So are there any aspects of this information flow to
15 the Non-Executive Directors that you think are healthy 11:20
16 or, on the other hand, do you see room for even further
17 improvement along the lines of this model?

18 A. Well, I mean, there is always room for improvement.
19 Yesterday I did give you my opinion on the role of the
20 NED in this process. I think that this is such a 11:20
21 helpful document in terms of a Clinical and Social
22 Governance report to Governance Committee. It's one of
23 the suites of, what we call the triangulation of data,
24 that will show us what issues are coming through, what
25 sort of -- the reasons why some doctors, you know we 11:21
26 have it for nurses and social workers as well in
27 difficulty, so that we're getting a good idea of what's
28 going on in those professional areas. It sits
29 alongside the reports from SAIs which sits alongside

1 the complaints, litigation, clinical audit. So you get
2 a much rounder view of trends and patterns over a
3 period of time rather than just separate reports that
4 give you snapshots of what the challenges are in
5 certain areas. So for me I think that this provides a
6 much fuller, more comprehensive data for us to really
7 get an understanding of what's going on in the Trust.

11:21

8 79 Q. Yes. It is perhaps something of a solution, and it
9 will be for others to judge whether it's a wholly
10 adequate solution, to the lacuna that I have been
11 exploring with you at some length this morning. And
12 just to revisit it in conclusion: The events of 2020,
13 in the summer of 2020, happened against a background
14 where the Non-Executive Directors of the Board were
15 deprived of an opportunity to scrutinise the patient
16 safety issues that had arisen and been revealed by the
17 findings of the MHPS investigation as well as the
18 management failings that had been revealed by the MHPS
19 investigation. Can I assume that you would agree with
20 the proposition that, if the Non-Executive Director
21 members of the Board had been allowed to challenge,
22 had been given the information to permit scrutiny,
23 that action could have been taken to improve matters
24 long before you got to 2020?

11:22

11:22

11:23

25 A. Well, as I said yesterday, I mean governance is a
26 dynamic process, it's always improving, you're always
27 looking to make the systems better. So it would have
28 been more helpful if we had have got timely reports
29 about some of the incidents to help us provide better

11:23

1 oversight.

2 80 Q. But, I appreciate the sentiment that governance is a
 3 dynamic thing, but what we're talking about here is
 4 basic behaviours, are we not, the sharing of and the
 5 legitimate sharing of information with the very people 11:24
 6 who are employed by the Department to exercise scrutiny
 7 and to provide challenge. This should have been a
 8 basic response on the part of the executive employees
 9 of the Trust to a real live problem?

10 A. I think on reflection the decisions to share 11:25
 11 information have improved greatly and that's been
 12 through a number of discussions and conversations
 13 around Trust Board where we recognise that all of the
 14 Directors, Non-Executive and Executive Directors, have
 15 a responsibility for patient safety and for governance 11:25
 16 and they feel, I would say, more safer to come forward
 17 and give us that information. I mean, certainly since
 18 2020 the systems have improved. I think the Directors
 19 have greater trust in us in terms of sharing
 20 information. I don't know why the -- in the grand 11:25
 21 scheme of things those sorts of reports from Dr. Khan
 22 and Dr. Chada wouldn't be shared in their entirety, but
 23 certainly the determinations and the outworkings of
 24 them would now be shared under this sort of framework.

25 81 Q. I suppose the question, Mrs. Leeson, is do you have 11:26
 26 trust in them, if they have failed to share the
 27 findings of Dr. Khan, even in a confidential forum,
 28 particularly where those findings highlight managerial
 29 failings?

1 A. Well I suppose, Mr. Wolfe, for me, do they trust us,
2 that's my question. Trust is a two-way process. Did
3 they not trust us to share the information with us? I
4 don't know.

5 82 Q. Okay. Please answer it by reference to the proposition 11:27
6 that I put: If you're not getting information from the
7 Executives, information that you believe you should
8 have received, where is the basis for trust in those
9 Executives? Have you thought about that?

10 A. Yeah, I have thought about it quite a lot. I mean, 11:27
11 I'll go back to what I said, you know, did they trust
12 us enough to hold that information, to give it to us.
13 I think for me a lot of it is about systems, what
14 systems were there to support them to share
15 information, to be assured that we would treat it in a 11:27
16 way that would be helpful and supportive to practice.

17 83 Q. The difficulty, of course, is that you're answering
18 this question in something of a vacuum in that you
19 haven't yet and nor have your colleagues asked the
20 likes of Dr. O'Kane why didn't you share this with us? 11:28

21 A. And I think that's a discussion going forward, having
22 seen a lot of the transcripts and obviously the
23 evidence in the Inquiry that we will need to address.
24 MR. WOLFE: It's 11.30, should we take a short break
25 and conclude? 11:28

26 CHAIR: we'll take a 10 minute break, if that suits
27 everyone, come back at twenty to.

28

29 THE HEARING ADJOURNED FOR A SHORT PERIOD

THE HEARING RESUMED AS FOLLOWS:

CHAIR: Thank you, Mr. Wolfe.

84 Q. MR. WOLFE: I want to bring you finally to the Board meeting that took place on 22nd October 2020. As we recall, you had been asked to asked to chair the, let's call it an urology item in the September meeting because of Mrs. Brownlee's actual conflict of interest in terms of how you believe it was described to you or, as she puts it, her perceived or possible conflict of interest. But on 22nd October she did not leave the meeting for the urology item but stayed in the chair and participated in the meeting, isn't that correct?

A. That's correct.

85 Q. And we'll just look briefly at that meeting. In advance of the meeting you were shared a report that Dr. Gormley spoke to in Dr. O'Kane's absence at the meeting. The report, if we just briefly open it, I don't wish to examine it in any detail, but it's to be found at WIT-99846. It, in essence, if we just scroll down, it is explaining to you that there is likely to be considerable interest, media interest in this matter. It updates you on the first substantive pages - just scrolling down - in terms of, it's a duplication here, keep going, sorry. So that's something of the background to the events that were unfolding.

Then, if we scroll down, I think it's the next page,

1 they set out a summary table of the serious adverse
2 incidents, of which I think there were ultimately nine,
3 I think there is nine set out in this summary table for
4 which an external, who we now know to be Dr. Hughes,
5 and what is described as a subject area expert, 11:43
6 Mr. Gilbert, were appointed to take through. So that
7 information, by way of update, is given to you ahead of
8 the October meeting.

9
10 Then if we go to the meeting itself, we can find the 11:43
11 minutes at TRU-131853. So Dr. Gormley spoke to that
12 report and we can see, just scrolling down, that the
13 Chair, that is Mrs. Brownlee, intervened to make some
14 remarks. She recalled that she had written --

15 Consultant A had written to herself in June, she had 11:45
16 shared that with Non-Executive Directors. She raised
17 concerns at how the HR processes were being managed and
18 requested that - sorry, I've got that wrong -

19 Consultant A is raising these concerns and
20 Mrs. Brownlee is bringing them onto the table at this 11:45
21 meeting and she was told that this matter would be
22 progressed through HR channels. She also raised the
23 fact that a number of different Urology Consultants had
24 been in place over the years and asked why they had not
25 raised concerns about Consultant A's practice. 11:46

26 Similarly, why had his PA not raised concerns regarding
27 delays in dictation of patient discharges and she
28 asked: "Should a GP not have recognised the
29 prescribing issue in association with Bicalutamide."

1 Just scrolling down. Dr. Gormley responded to aspects
 2 of that and then the Chair asked about Consultant A's
 3 appraisals and asked if performance issues had been
 4 identified through this and again Dr. Gormley
 5 responded. Just in terms of Mrs. Brownlee's presence 11:46
 6 at the meeting were you alerted in advance of the
 7 meeting that your role as Chair, or temporary Chair for
 8 the urology item, would no longer be required?

9 A. I can't remember if she had maybe indicated through an
 10 email that she would be attending this meeting, I can't 11:47
 11 recall.

12 86 Q. But what I'm asking you specifically, I suppose is, did
 13 Mrs. Brownlee ever approach you --

14 A. No, no.

15 87 Q. -- to discuss the fact that she would attend the 11:47
 16 meeting?

17 A. Not me directly, no.

18 88 Q. No. In terms of her attendance at the meeting for this
 19 item first of all, what is your view of that or what
 20 was your view of that in terms of its appropriateness? 11:48

21 A. Well, I mean, in my view, once she had declared a
 22 conflict of interest to me in her phone call, she
 23 should have taken herself out of all the processes.
 24 She should not have participated in meetings, she
 25 shouldn't have sent that email before the Trust Board 11:48
 26 meeting in September, as much as to keep herself right
 27 as well as the Trust Board. But, you know, she had
 28 declared a conflict of interest, very clear about that,
 29 and I was surprised that she was coming to the meeting.

1 89 Q. Yes. We can see from some email correspondence that
2 Mrs. Brownlee's proposed attendance at the meeting had
3 been the subject of discussion, not with the
4 Non-Executive Directors it would appear, but with
5 Mr. Devlin and, through Mr. Devlin, with Dr. O'Kane. 11:49
6 If we could just briefly look at that. If we could go
7 to TRU-253705. She's telling Mr. Devlin: "I wish to
8 confirm that I will be staying in for this item". This
9 is an email of 20th October, two days before the
10 meeting: 11:49
11
12 "It is an extremely serious matter - she says - for the
13 Board and I need to be present. I have no conflict
14 with this particular matter. My past personal illness,
15 I will try to overcome the emotions." 11:49
16
17 Then she sets out in the body of the email some of the
18 issues that she is concerned about.
19
20 Just scrolling back up, please, so Mr. Devlin raises 11:50
21 this with some of his executives. We can see just
22 above that on 20th October at 23:54 Mrs. O'Kane, or
23 Dr. O'Kane is writing:
24
25 "Shane, my understanding from what the Chair has 11:50
26 disclosed openly is that she has been a patient of this
27 doctor in recent years. Given that we will be
28 discussing the impact on patients potentially, I am
29 concerned."

1 Then just further up Mr. Devlin goes back to Dr. O'Kane
2 and says:

3
4 "Happy to discuss. Although the Chair has not been a
5 patient in recent years, she was a patient nearly 20 11:51
6 years ago. I think as Chair she needs to be part of
7 the conversation and the whole Board need to be in the
8 middle of this."

9
10 Can we assume that this kind of conversation was not 11:51
11 something that you were privy to in October 2020?

12 A. That's correct.

13 CHAIR: Mr. Wolfe, I think Ms. Leeson was copied in to
14 the email from Mrs. Brownlee, if we can just scroll
15 down. 11:51

16 MR. WOLFE: Yes.

17 A. Apologies, Chair, I was copied in to the decision for
18 her to come.

19 90 Q. MR. WOLFE: Yes. Her presence then two days later at
20 the meeting wouldn't have come as a surprise in that 11:52
21 sense, it had been heralded in this email. I am
22 wondering in light of her open disclosure, certainly
23 with you and for the record in respect of the September
24 meeting, that there was a conflict, whether that should
25 have triggered an objection, or at least a debate, at 11:52
26 the commencement of the meeting on 22nd October?

27 A. Well, I have to say I was surprised at the decision
28 being made. I think in his evidence Shane Devlin said
29 in retrospect that it was a mistake for Mrs. Brownlee,

1 for her sake as well as the need for the discussion to
 2 be open and frank. I had presumed, and this was normal
 3 practice, that the Chair and the Chief Executive looked
 4 at the agenda in advance of Trust Board meetings and
 5 decided what the agenda items were going to be and who 11:53
 6 was going to attend. So, yeah, in retrospect I should
 7 have made an objection and I didn't.

8 91 Q. Was this development ever the subject of a conversation
 9 between you and your fellow NEDs with or without the
 10 input of Mrs. Brownlee even after this meeting? 11:53

11 A. No. I think, it's not to excuse it, but during this
 12 time a lot of the meetings were virtual. So if they
 13 had have been in person, usually we would meet
 14 afterwards and might have made some comments. But a
 15 lot of these meetings were virtual and you just came 11:54
 16 off the call and that was it. But I personally was
 17 surprised at the decision and I thought it was unwise
 18 and inappropriate that she attended.

19 92 Q. And I think you now are accepting that it should have
 20 been challenged -- 11:54

21 A. It should have been challenged.

22 93 Q. -- in some way and at least an explanation sought?

23 A. Yes, yeah, yep. But obviously it was a decision that
 24 she had discussed with the Chief Executive and he had
 25 agreed. 11:54

26 94 Q. You've described in your witness statement at paragraph
 27 30.24, we needn't bring it up, that you found this to
 28 be an uncomfortable meeting and I have drawn attention
 29 to some aspects, the majority of aspects of

1 Mrs. Brownlee's input and the issues that she raised,
2 drawing comparison with other practitioners, asking
3 about the performance of general practitioners and the
4 PA, asking about the fitness for purpose of the
5 appraisal arrangements and what have you. Is it those 11:55
6 issues and the raising of those issues that caused it
7 to be an uncomfortable meeting or what are you alluding
8 to?

9 A. I think that I found Mrs. Brownlee's behaviour to be,
10 what's the word, defensive of the consultant concerned. 11:55
11 A lot of the questions were not about what we had found
12 in the report, they were more about other consultants,
13 his PA, prescribing of medicine, I just thought it was
14 really inappropriate.

15 95 Q. And in terms of her input, in your view did it have any 11:56
16 practical impact or effect on how the Trust and the
17 Trust Board was intending to pursue matters?

18 A. No, I don't think so. I mean, I think, you know Shane
19 Devlin managed the meeting very professionally, very
20 well. I think certainly I try to keep a focus on SAIs 11:56
21 and the process rather than looking at other areas.
22 So, you know, in retrospect I think that we were able
23 to have the discussion that we needed to have and then
24 move on. But I felt, and I've said it in my evidence,
25 that I didn't feel that Mrs. Brownlee could be 11:57
26 objective in that meeting because she had been a
27 patient of Mr. O'Brien.

28 96 Q. Again your discomfort with the approach adopted, did
29 you feel that she was placing the emphasis in the wrong

1 place as opposed to a focus on the risk of patient
 2 harm, the focus was in defence of Mr. O'Brien and
 3 criticism of others or how were you viewing it as you
 4 heard it?

5 A. Well the discussion should have been on patient safety, 11:58
 6 that's what the purpose of the meeting was. I felt
 7 that Mrs. Brownlee was defensive of Mr. O'Brien. She
 8 raised the issues that she had outlined in her email in
 9 September and brought those into the meeting, whereas
 10 the processed had actually moved on in terms of, we now 11:58
 11 had a process around SAIs, the Department was talking
 12 about a review. Ultimately in November it was, quite
 13 rightly in my opinion, a Public Inquiry.

14 97 Q. Yes. We can go back to the minute of the meeting
 15 itself, TRU-131854. And we have the Chair, as we have 11:58
 16 noted her intervention, Dr. Gormley responding to it.
 17 Scrolling down, Mrs. McClements' intervention.
 18 Scrolling down again, a question from the Chair about
 19 the process of using one Consultant Urologist and
 20 whether that was sufficient. Scrolling on down. One 11:59
 21 notes from the record that, although a number of the
 22 respondents to Mrs. Brownlee's interventions indicate
 23 that certain matters would be taken on board, it's a
 24 matter for the process going forward, there is no
 25 direct or indirect criticism or effort to stop her or 12:00
 26 to challenge her in circumstances where everyone round
 27 the table knew that there was a conflict. Was this
 28 just a matter that you put up with whereas with the
 29 benefit of hindsight you think she should have been

1 stopped?

2 A. I think the context for this was that Shane Devlin had

3 agreed that she should come to the meeting. So in my

4 opinion we just had to manage the meeting and get

5 through the business as best as possible, keep the 12:00

6 focus on patient safety and address any other concerns.

7 98 Q. Do you think it's unfair to suggest that a Chair with

8 this acknowledged conflict coming in and being given

9 free rein to raise issues like this, do you think it is

10 unfair to suggest that this says something adverse or 12:01

11 negative about the quality of governance and the

12 quality of the culture of this particular board at that

13 time?

14 A. I think that it was unwise to agree to let

15 Mrs. Brownlee attend the meeting. It was unwise of her 12:01

16 to say that she was coming to the meeting. It's

17 difficult when it's a Chair, it's been agreed with the

18 Chief Executive. As I've said, my view was that we

19 just had to try and keep it on to patient safety and

20 any of the issues that we needed to discuss. And, to 12:02

21 be fair, I think Shane handled it very well. We did

22 get the information from Dr. Gormley that we needed and

23 we got an update on what was happening and the way

24 forward.

25 99 Q. Thinking back on these matters now and the approach of 12:02

26 yourself as a member of this Board and your

27 Non-Executive colleagues, do you consider that there

28 was perhaps an unhealthy degree of deference to both the

29 Chief Executive and the Chair and perhaps to the

1 other Directors in not standing up and not asking the
2 kinds of hard questions and opposing the kinds of
3 interventions that we see from Mrs. Brownlee?
4 A. Well in retrospect we should have challenged it and
5 stopped the meeting and ask her to leave but we didn't. 12:03
6 100 Q. Was there an unhealthy degree of deference?
7 A. I think, you know, there was a lot of respect for
8 Mrs. Brownlee. She worked long hours, she was a very
9 caring, she is a very caring and kind person. But I
10 think she made a very unwise decision, once she 12:03
11 declared that she had a conflict of interest, to send
12 emails and to come to meetings when this matter was
13 being discussed.
14 101 Q. If we look at what was, I suppose, the end point of
15 this meeting, there was, I suppose, an emphasis placed 12:04
16 on trying to slow up the process of any public
17 announcement in respect of the difficulties faced by
18 the Trust and the consensus of the meeting was to
19 approve the Trust's request to seek a delay in the
20 ministerial announcement. Just scrolling up the page, 12:04
21 I think Mr. Wilkinson made the point that, whilst he
22 supported the Trust's request for a delay, it was
23 important that this was not, what he described as a
24 "prevaricated delay."
25 12:04
26 What was at the root of that in your view, was it
27 simply a case of the Trust trying to get certainty or
28 get increased precision around the extent of this bad
29 news story before the announcement was made or what was

1 it?

2 A. Yeah, I mean, my recollection was that we were not
3 asking for a long delay. I think it was around perhaps
4 making sure that staff, relevant staff would be told
5 about it in advance. So there was no desire to, as 12:05
6 John wilkinson said, to have a long delay or
7 prevaricated delay. It was just a very simple matter
8 of -- my understanding was making sure that staff knew
9 that we were clear about what the Terms of Reference
10 were. 12:06

11 102 Q. Yes. Obviously shortly after that meeting then matters
12 moved into the sphere of a Public Inquiry announcement
13 and here we are today. Obviously the Trust has engaged
14 with the Department and various reform processes have
15 been examined and no doubt put into effect and some of 12:06
16 your evidence this morning touches upon aspects of
17 that. Your reflections within your statement, if we
18 could bring up WIT-99802. You were asked, or you say:

19
20 "The governance arrangements were fit for purpose but 12:07
21 they were not robust enough to deal with the practice
22 of Mr. O'Brien."

23
24 Just that one sentence seems to reveal an inconsistency
25 and I just want to give you the opportunity to deal 12:07
26 with it. We've heard from you this morning about the
27 kinds of information that wasn't shared with you. You
28 have observed from Dr. Khan's report his view that
29 there were managerial failings, since writing this

1 you've heard more evidence through the Inquiry about
 2 the problems faced by the Trust in dealing with this.
 3 Do you still think that the governance arrangements
 4 were fit for purpose?

5 A. I would say the governance arrangements were fit for 12:08
 6 purpose at that time, but, as I've said before,
 7 governance always needs to be improved, it needs to be
 8 reviewed, it needs to be made better. I think the
 9 governance arrangements that we have in now are much
 10 better and potentially would deal in a better way with 12:08
 11 what has happened with this case.

12 103 Q. I'm struggling a little bit with that. In what way do
 13 you think they were fit for purpose at any point
 14 between 2016 and 2018 or even before that if the kinds
 15 of problems that have been identified by this Inquiry 12:09
 16 were not being scrutinised, challenged and remedied?

17 A. Well, we did have the reports. I think the difficulty
 18 with the reports, that they were separate reports so we
 19 weren't able to see patterns and trends, but we still
 20 had reports. I think, as I've said there, the big 12:09
 21 failing was that, in this particular case, that we
 22 didn't have an overview of Maintaining High
 23 Professional Standards. I think that alongside the
 24 SAIs would have shown us more clearly about both the
 25 performance of urology and the practice of Mr. O'Brien. 12:09

26 104 Q. Does that not suggest that they weren't fit for purpose?

27
 28 A. Well, they were fit for purpose at that time but...

29 105 Q. But how were they?

- 1 A. Well, we did have reports. We did have -- they weren't
 2 fit for purpose. They were fit for purpose at that
 3 time in terms of having governance meetings, having
 4 reports. The difficulty was that they didn't come
 5 together as a composite report to tell us what was 12:10
 6 happening in terms of these cases and performance in
 7 more general terms.
- 8 106 Q. With the effect that patient safety was jeopardised?
 9 A. Well obviously patient safety was jeopardised here.
- 10 107 Q. And the heart of governance is protecting patients, 12:11
 11 maintaining their safety?
- 12 A. Yes. I have said before it's a deep matter of regret
 13 that the governance systems weren't safer enough to
 14 make our patients safe and support our staff.
- 15 108 Q. In 2022 the Southern Trust suffered another difficulty 12:11
 16 in that it was reported that the laboratory screening
 17 system in association with cervical smears were
 18 reporting results which other centres wouldn't have
 19 regarded as negative but would have prompted further
 20 inquiry as a potential abnormality. Now, I understand 12:12
 21 that as a Board you have had an involvement in dealing
 22 with this issue?
- 23 A. Yes, that's correct.
- 24 109 Q. Have you observed any change, any improvement by
 25 comparison with the urology situation in terms of 12:12
 26 information coming to the Board, in terms of you and
 27 your colleagues in the Non-Executive role having
 28 opportunity to scrutinise and challenge what has
 29 occurred in cytology or have things not improved?

1 A. well I think they have improved considerably. The
2 context for this is that this is not just limited to
3 the Southern Trust. You have also got other Trusts who
4 have faced similar challenges and also the PHA is a
5 major partner in the roll out of this programme. But 12:13
6 as soon as those matters were brought to our attention,
7 we met about them, there was an action plan produced.
8 There was arrangements for some capacity in other
9 Trusts to do some extra screening and lookback. So
10 I think our reaction to that has been much swifter. 12:13
11 You know, all the information I think has come to us
12 and we have had several really in-depth discussions
13 about this.

14 110 Q. Yes. So, I'm more interested in the role of the Board
15 and particularly the Non-Executives on the Board as 12:13
16 opposed to the substance of the issue itself which
17 obviously may have sensitivities at this point in time.
18 What you're saying to us is, by contrast with your
19 experience through the urology issue, the information
20 coming to you as a board member is both quicker, it is 12:14
21 coming to you more swiftly and in turn does that enable
22 you as a Board to challenge more effectively and attempt
23 to shape the agenda?

24 A. Yes, absolutely. The swiftness of the response has
25 been much better than obviously this situation. All 12:14
26 the reports, everything we've asked for has come to us.
27 We have had a number of meetings, I think one on a
28 Friday night. So we have been very engaged with that
29 issue and, yeah, with very, very little delay.

1 111 Q. what would you put that down to? would you say that
2 that's improved leadership, would you say it's improved
3 culture as a result perhaps of learning from urology or
4 what is it?

5 A. Yeah, I think there is a number of factors. I think 12:15
6 certainly the current Chair and the Chief Executive are
7 very mindful that our priority is patient safety.
8 Alongside that, particularly Dr. O'Kane would emphasise
9 psychological safety. So staff are encouraged to come
10 to us with any risks, any concerns as quickly as 12:15
11 possible. So there has been a big cultural change
12 there in terms of the swiftness of issues being raised
13 and the information being given to us very quickly and
14 comprehensively.

15 MR. WOLFE: Okay. Thank you for answering my 12:16
16 questions, I apprehend that the Panel might have some
17 further questions for you. Thank you.

18 CHAIR: Thank you, Mr. Wolfe. I am afraid we can't let
19 you go just yet, Ms. Leeson, Mr. Hanbury has a couple
20 of questions. 12:16
21

22 THE WITNESS WAS THEN QUESTIONED BY MR. HANBURY,
23 AS FOLLOWS:
24

25 MR. HANBURY: Just a couple of questions for you. 12:16
26 Thank you very much for your information statements.

27 112 Q. You managed to, as a Board, make a difference when the
28 issues of the cardiology department and stroke problems
29 came through, obviously on the medical as opposed to

1 the surgical side. But we've had evidence that the
 2 waiting times both for surgeries, assessment,
 3 outpatient, new and follow-up appointments, had been a
 4 problem, not just in urology, but in about nine
 5 surgical departments, so over quite a period. I guess 12:17
 6 my question is, on reflection do you think that you
 7 should and could have done more as a Board to address
 8 that as a separate issue?

9 A. To address urology?

10 113 Q. Not just urology, just the whole thing about waiting 12:17
 11 times?

12 A. Waiting lists. I mean, I think, you know that's a
 13 constant theme in the Board, both waiting lists and
 14 delayed discharge. It's not something that is just
 15 particular to the Southern Trust. I mean, it's an 12:17
 16 issue for Northern Ireland in particular and we are
 17 continually exercised about the waiting lists. I think
 18 Covid really, really made things much more difficult
 19 for us in terms of tackling that. And also, and it's
 20 not by way of excuse, I mean we as a more rural Trust 12:18
 21 face enormous challenges in terms of workforce,
 22 attracting staff, specialist staff in particular to the
 23 Southern Trust. Most consultants, surgeons, doctors,
 24 want to work in Belfast. You know, they feel safer
 25 there, they probably get better terms and conditions in 12:18
 26 terms of weekends off. But it is certainly something
 27 that we are continually mindful of. We are always
 28 looking at ways that we can -- you know, sometimes you
 29 can make applications to the Department for specific

monies to come in and clear some of the backlogs. But, I think to be honest going forward it's going to be something that's going to be challenging us for some time.

114 Q. Okay. But I mean, this had been going back right to 2009, so it is not just a recent thing. But was it discussed in detail at the Board? I just have a feeling it was continually reported and 'oh, it is just the waiting list again', no one grabbed this nettle and made particular issue of it? 12:19

A. Yeah, yeah. I mean --

115 Q. Whereas you did get more resources for other problems?

A. Yeah.

116 Q. And it wasn't just urology?

A. Yeah. 12:19

117 Q. Okay, we'll move on. In a similar view, looking at cancer care, the peer review picked up from a gap analysis that there were problems, again not just in urology, but breast, colorectal, lung as well. It is like reading a Datix, there is a lot there, but just picking out a couple of things: Radiology and clinical oncology and availability of clinicians and this thing of quorum of multi-disciplinary meetings, which obviously can affect the quality of opinion, of care; so did you discuss that at the Board, the sort of specific cancer problems and whether there anything that you could improve there? 12:20

A. Yeah. I mean, a lot of these services in my opinion were impacted by our failure to recruit specialist

1 staff. You know, urology was down, the Chair I think
 2 said yesterday that we lost nine consultants in one go
 3 through retirement and obviously wanting to move on out
 4 of Daisy Hill. It is such a high pressured service.
 5 I mean, and I'm sure you know yourself as a consultant, 12:21
 6 there are so many services, particularly under Acute,
 7 that were coming up with longer waiting lists, more
 8 challenging issues. I know certainly that the Director
 9 of Performance, who I would have worked with quite
 10 closely, in Performance Committee was always putting in 12:21
 11 bids for extra money to try and bring some of those
 12 resources in.

13 MR. HANBURY: Okay. Thank you very much, that's all I
 14 have.

15 CHAIR: Dr. Swart? 12:21

16
 17 THE WITNESS WAS THEN QUESTIONED BY DR. SWART,
 18 AS FOLLOWS:

19
 20 118 Q. DR. SWART: I think the evidence we've heard throughout 12:21
 21 the Inquiry, and I think it's quite obvious, was that
 22 there was a blind spot with respect, on the Board of
 23 the Board, with respect to the totality of the issues
 24 in urology, and the impact on safety, quality and all
 25 the other things we have talked about. This is 12:22
 26 generally a combination of issues, to do with
 27 governance, culture, management processes,
 28 organisational development focus and all of this is the
 29 responsibility of the Board. Now, I agree this is a

dynamic process, you never get it right and I know that myself from my work in health care and you have to put a lot of emphasis. I absolutely agree that one of the ways to get round it is to start with a clear statement of what the most important thing is. You have articulated the desire to put patient safety first on behalf of the Board and we have heard that also from your Chair.

12:22

Now, I have just got a number of questions as to how that is playing through. So the first question is, how many board development days did you have solely on helping the Board to understand what patient safety is, how to measure it, how to develop it, how many days overall?

12:22

A. Well every other month would be a workshop, so some of those workshops, like understanding medical data.

12:23

119 Q. No, but how many, just on the whole safety focus, specifically to say what does my board need to know about patient safety?

12:23

A. I couldn't honestly tell you that.

120 Q. So you haven't looked at it in that way maybe?

A. No.

121 Q. Okay. When you say we care about patient safety, we've got a situation here where your staff have said pretty much across the board 'well the Trust cared about targets', your Chair and others have said 'well now we are starting to move towards patient safety', that's pretty easy to say, it's quite difficult to do. So,

12:23

1 the first question around that is, how is that
2 manifested in the Board discussions? Can you give an
3 example of how the Board sets out that it lives and
4 breathes patient safety over everything else? How is
5 that manifested in the discussions in the Board or the 12:24
6 agenda or do you have a view about that?

7 A. Well I think, you know, at the beginning of each Board
8 meeting we invite a particular area, sometimes the
9 focus is patient safety and that's really to look at
10 from the staff's point of view what the issues and 12:24
11 concerns are. I think that's a really helpful way to
12 look at patient safety because sometimes as a Board, as
13 you know, you can be quite remote and you can talk
14 about strategy a lot.

15 122 Q. What's the first item on your agenda, though? 12:24

16 A. Sorry?

17 123 Q. What is your first formal agenda item on the Board?

18 A. Well usually we have a presentation.

19 124 Q. After that, a formal agenda item?

20 A. It would be minutes. 12:25

21 125 Q. And after that?

22 A. Then you would have reports.

23 126 Q. Okay. Now, one of the things you can also do as a
24 Board, and I know you've mentioned, your Chair has
25 mentioned this, you go round and talk to different 12:25
26 areas and you ask them about things; what questions,
27 how do you do appreciative listening with the staff
28 that let them know that you care about safety more than
29 the target, how do you do that?

- 1 A. Yeah. well typically I would spend maybe about one and
 2 a half to two hours on a leadership walk. we do have a
 3 guide about what sort of questions you would ask. For
 4 me, given my background, I would be very interested in
 5 safeguarding and part of that is patient safety, 12:25
 6 safeguarding vulnerable adults in particular. So I try
 7 and get a sense, I mean I did a recent walk in one of
 8 the wards in Craigavon and talked, asked the sister
 9 from the patient journey, when they come in, how is
 10 everything, how are they treated when they come in as a 12:26
 11 person, but also how all that is recorded and how the
 12 patient perceives their experience. So on that
 13 leadership walk what was really helpful was they had an
 14 uncluttered ward, they had their white boards which are
 15 for both staff and for patients to look at, where they 12:26
 16 were on their patient journey. Also what was really
 17 helpful there that I thought was that they had pre and
 18 post-op on the same ward, I mean obviously a divide, so
 19 that they could look at how patients were received,
 20 treated and how they were looked after in recovery 12:26
 21 afterwards.
- 22 127 Q. So if you went to the emergency department on a
 23 leadership walk, have you done any of those?
- 24 A. Some of the other NEDs have done that, I haven't done.
- 25 128 Q. So you don't know what questions they routinely ask in 12:27
 26 that department?
- 27 A. well, you know, the general questions are very open
 28 questions.
- 29 129 Q. Yep.

- 1 A. About their workload, how they feel about their job,
 2 how they communicate with patients, what sort of issues
 3 would come up to them, particularly I imagine in an
 4 emergency department, obviously overcrowding, all those
 5 sorts of things. 12:27
- 6 130 Q. How much emphasis do you think has been made in terms
 7 of you as a team, the whole Board understanding what
 8 will send the right message to staff about what you
 9 care about, have you specifically talked about that?
- 10 A. Yeah, we have. We have talked quite a lot about what 12:27
 11 the purpose of leadership walks, doing joint walks, the
 12 value of them. Obviously we write reports which are,
 13 you know there isn't a tick box any more. There used
 14 to be a tick box, now it is more an open conversation,
 15 open discussion. Staff can raise any issue. Of course 12:28
 16 I would prompt staff to raise issues as well around
 17 risks and concerns and that's reported on and brought
 18 back into governance.
- 19 131 Q. You don't specifically ask, for example, 'do you feel
 20 your department is safe today?' Is that a general 12:28
 21 question or not?
- 22 A. If I was going into a surgical ward I would ask that.
- 23 132 Q. Good. Then at the Governance meeting you have got some
 24 safety indicators, but there are not very many of them
 25 and they are quite basic really. I can't see a suite 12:28
 26 of safety metrics coming to Governance or to the Board,
 27 most organisations I have worked in there is quite a big
 28 suite of safety metrics at the Board and a bigger suite
 29 at Governance and a bigger suite in the

1 Directorates. It is about trying to say how are we
 2 doing. You will be familiar with stroke, there is 10
 3 indicators in the national stroke audit which most
 4 places use as a sort of 'how are we doing.' It is a
 5 mixture of performance, practical things that make a 12:29
 6 better service and so on, and that generally would come
 7 to committees regularly as would, for example, overall
 8 compliance with cancer standards, which are part of
 9 performance really, because they are basic, 'have you
 10 done this, have you done that', they are not individual 12:29
 11 quality of care. So what discussions has the Board had
 12 about what the Board would like to see about safety
 13 throughout the Trust and has that discussion happened
 14 in terms of what do we need to know, how do we need to
 15 know more, how has that been informed by your Medical 12:29
 16 and Nursing Directors and others?

17 A. Yeah. I mean, I think that's a conversation that
 18 Dr. O'Kane has started with us. I would have a concern
 19 that standards and guidelines, that part of governance
 20 is under resourced, that has come to the Board. 12:30

21 133 Q. I mean, that's a huge piece of work. But even before
 22 fixing all of that, there is an indicator in almost
 23 every service that relates to a national audit, there
 24 is at least one, probably four or five indicators that
 25 can be tracked. Then you don't need people to come and 12:30
 26 tell you there is a problem because you know there is a
 27 problem, you can see it changing over time. If you are
 28 now waiting three days to have your fracture, like a
 29 femur operated on and you were waiting 12 hours, you

1 know there is a problem; if your stroke patients aren't
 2 on a stroke ward most of the time, you know there is a
 3 problem. So how far has that discussion got and, if it
 4 hasn't got very far, is there a recognition that it is
 5 needed in some detail?

12:30

6 A. Yeah, I don't think it has got very far. And to be
 7 fair to Dr. O'Kane, I mean that's something that
 8 I think that she would like to progress and it is
 9 certainly something -- I mean, I think she has had so
 10 many challenges since she has come into post.

12:31

11 134 Q. Yes, I mean this requires ongoing work, investment,
 12 buddying, all kinds of things. You don't do it just
 13 like this?

14 A. No.

15 135 Q. It is not a sprint, it's a marathon over many years.
 16 However, what I am familiar with is this focus on
 17 safety comes first and then you start to understand
 18 what it means and it gets broadened out. So I just
 19 wondered what the understanding of the Board was
 20 really, it is not something you can fix straight away?

12:31

21 A. No, I don't think it is that developed.

22 136 Q. Okay. Then going back to -- so those are objective
 23 things you can measure. Then you say the Governance
 24 Committee is much better, and we can see that in the
 25 papers. Can you give me an example of something that
 26 came to Governance and, because of the triangulation,
 27 the Governance Committee were saying well actually 'we
 28 are not satisfied with this, we need a further report
 29 on it, we're worried about it' and

12:31

1 that's resulted in a change?

2 A. Yeah. I mean the example that springs to my mind is

3 maternity, litigation, SAIs.

4 137 Q. Okay. Is there any other area where that has happened

5 where you have thought 'oh, hang on a minute'? 12:32

6 A. I am trying to think.

7 138 Q. Because maternity is right up there?

8 A. Yes, I know it is. I'm trying to think. I suppose a

9 lot of the deep dives for me have been in performance.

10 139 Q. Again in performance there is a lot more to it than 12:32

11 waiting times?

12 A. Yes, yes.

13 140 Q. I don't think we have seen evidence that that breadth

14 of performance is considered together. I mean, it is

15 very difficult because it does overlap with governance 12:32

16 and other things, but it is very hard to consider that

17 on its own, isn't it?

18 A. Yes, it is indeed.

19 141 Q. Just another thing, and I am afraid it goes back to the

20 Board culture. We've heard that now there is a more 12:32

21 united collaborative atmosphere in terms of Executives

22 and Non-Executives, and maybe that wasn't always the

23 case before, there is work ongoing to improve that, and

24 again that's something that always needs constant

25 attention. When you were sent that letter from 12:33

26 Mr. O'Brien to the Chair and it was just forwarded on

27 to you, my experience of any Non-Exec receiving such a

28 letter would be, what is this about, speaking to the

29 Chair, they probably pop into the office of the Chief

Executive or the Medical Director and say 'what is all this about, do we have a policy on retirement, what's all this, it doesn't sound very good, senior consultants don't write letters like this all the time'. It appears that didn't happen. Was that because you didn't feel comfortable talking to the Chair about it? I mean, you think it's an HR issue, I'm not discussing that, it's really what was your curiosity? Did you not feel comfortable to drop into the Medical Director and say 'what's this doctor, is this a problem?' why do you think that was? why did you just sort of want to ignore it which seems to be what happened?

12:33

12:34

A. Yes, I didn't feel comfortable talking to the Chair about it. I think if that letter came in now I would talk to the Chair.

12:34

142 Q. Did you think there was a general issue in the Board of the Chair versus everyone else or was it a personal thing with you and the Chair, what was the atmosphere?

A. No, I mean the Chair, the ex-Chair was a very approachable, kind person. I think that the present Chair is probably a lot more approachable in terms of those sorts of issues.

12:34

143 Q. Okay. The Early Alerts were not circulated, who pressed for that change? Was it from that September on that people said 'hang on, we need to have these', how did that change?

12:34

A. Well I think it was a culmination of factors. Certainly we had begun to get occasional Early Alerts,

1 but, no, I think that...

2 144 Q. Did somebody stamp their foot and say 'this is enough
3 and it must change'?

4 A. well I think the current Chair did.

5 DR. SWART: Okay, thank you. 12:35

6

7 THE WITNESS WAS THEN QUESTIONED BY THE CHAIRPERSON,
8 AS FOLLOWS:

9

10 145 Q. CHAIR: If I can just come back to the letter that you 12:35
11 got that was forwarded by Mrs. Brownlee to you all,
12 I know you've said you ignored it, are you aware of
13 what the other NEDs did, did they all ignore it?

14 A. I don't know if anybody went back to Mrs. Brownlee on
15 it or not. 12:35

16 146 Q. CHAIR: And certainly, I mean I'm subject to correction
17 from anybody who can point it out to me, but
18 Mr. O'Brien writes to the Chair of the Board, there
19 doesn't seem to have been a reply from her to him?

20 A. I haven't seen a reply. 12:35

21 147 Q. CHAIR: No, I don't think any of us have. But again if
22 the Trust can identify a reply then we would be glad to
23 see it. But, in any event, she may have spoken to him
24 verbally about it, we don't know and we can ask her
25 that. But would you accept that it is not particularly 12:36
26 good governance not to reply to such a letter?

27 A. Yes, as I have said before anyone can write to the
28 Board, particularly if they are concerned about
29 whistleblowing or patient safety, we would welcome

1 anyone raising concerns. I would have presumed that,
2 you know, certainly Vivienne Toal would have replied,
3 the direct letters.

4 148 Q. CHAIR: well there were three letters?
5 A. Three letters. 12:36

6 149 Q. CHAIR: There were three letters to Shane Devlin, to
7 Vivienne Toal and to Roberta Brownlee. The very least
8 Mr. O'Brien was entitled to was a reply from each of
9 them or a reply saying 'I have left this to be dealt
10 with by HR' or whatever the case may be, but there were 12:37
11 no letters that we have seen from Mr. Devlin or Mrs.
12 Brownlee?

13 A. No, I haven't seen those.

14 150 Q. CHAIR: The other thing you said, you ignored it, you
15 thought it to be an HR issue but you didn't recognise 12:37
16 there to be any element of whistleblowing in it, but
17 this is a letter that is complaining about the Trust
18 not following its policies and procedures, is that not
19 effectively whistleblowing?

20 A. well I interpreted that: is there policies and 12:37
21 procedures about his return to employment.

22 151 Q. CHAIR: But you didn't ask anything more about that or
23 say 'well were the procedures followed'?

24 A. well I didn't think it was a whistleblowing enquiry.
25 The letter had already gone to Vivienne Toal, so 12:37
26 I presumed as the Director of HR that she would be
27 replying to that.

28 152 Q. CHAIR: No, I think you are missing my point. My point
29 is that the complaint is about HR processes and

procedures, so as a board member did you not recognise that when you read it?

A. Yes, but I suppose the overriding theme of the letter was about his own employment and his wish to return to employment, that would be my interpretation.

12:38

CHAIR: Okay, well thank you very much.

MR. WOLFE: Just on that, Mr. Beech has kindly referred me to AOB-04361 which shows that Mrs. Brownlee at least sent something of a reply, it's not substantive as such, you can see it there:

12:38

"Confirming receipt of your email, copied to the NEDs. I have also spoken to the Chief Executive on your correspondence and he too has received a copy."

12:38

whether there is anything more from...

CHAIR: We can ask Mrs. Brownlee.

MR. WOLFE: Certainly the Trust will point out to us if the Chief Executive and Mrs. Toal provided substantive responses.

12:39

CHAIR: Thank you. I think you are certainly free to go, Ms. Leeson. I think that concludes our evidence for this week, Mr. Wolfe, isn't that correct?

MR. WOLFE: It does, thank you.

CHAIR: Okay. So thank you everyone, we will see you again next Tuesday at 10 o'clock.

12:39

THE HEARING ADJOURNED UNTIL TUESDAY, 16TH JANUARY 2024