



Oral Hearing

Day 89 – Tuesday, 12th March 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

WITNESS	PAGE
<u>DR. MARIA O'KANE</u>	
QUESTIONED BY MR. WOLFE	3

1 THE INQUIRY RESUMED ON TUESDAY, 12TH MARCH 2024, AS
2 FOLLOWS

3
4 CHAIR: Morning everyone. Mr. Wolfe.

5 MR. WOLFE: Good morning, Chair. Your witness this 10:02
6 morning is Dr. Maria O'Kane, who you will recall joined
7 us for the first time on the 6th December 2022, which
8 was Day 15 of our proceedings. And the transcript for
9 that day's hearing is to be found at TRA-01412. I
10 think in light of the fact that she has been away from 10:03
11 us for so long and essentially technically has not been
12 under oath during that period, she would need to be
13 re-sworn.

14 CHAIR: Very well.

15 MR. WOLFE: I'm obliged. 10:03

16
17 DR. MARIA O'KANE, HAVING BEEN SWORN, WAS QUESTIONED BY
18 MR. WOLFE AS FOLLOWS

19
20 MR. WOLFE: Good morning, Dr. O'Kane. 10:03

21 A. Good morning.

22 1 Q. We remind ourselves for the record that your employment
23 relationship with the Southern Trust commenced in or
24 about December 2018, when you were appointed Medical
25 Director for the Trust? 10:03

26 A. Yes, that's right.

27 2 Q. I think -- I've have never been quite sure, I think you
28 started in December 2018, but became responsible
29 officer in January 2019, is that the way of it?

1 A. That's correct, yes.

2 3 Q. And you held that Medical Director's role through to
3 the 30th April 2022?

4 A. Yes.

5 4 Q. Is that correct? 10:04

6 A. Yes.

7 5 Q. You had, from the 14th February 2022, been appointed
8 Interim Chief Executive, is that correct?

9 A. That's correct, yes.

10 6 Q. And you continue in that role substantively or 10:04
11 permanently as Chief Executive to today's date?

12 A. That's correct.

13 7 Q. Again, we recall that we've troubled you to reply to
14 some, I think at the last count, eight Section 21
15 notices, and we have your response to all of them. 10:04
16 After you gave evidence on the last occasion you were
17 served with Section 21 Notice No.4 of 2023, and I'm
18 going to ask you whether you wish to adopt that
19 statement? we didn't obviously get the chance to ask
20 you that on the last occasion because this notice 10:05
21 post-dated your appearance. So if we could have on the
22 screen please WIT-91953? In essence you will recall
23 this was a notice which interrogated you on an issue to
24 do with you're initial relationship with a number of
25 managers within Acute. You were pointing to your 10:05
26 evidence to I suppose a certain difficulty in what you
27 saw as the culture of Acute in relation to the sharing
28 of information, responsiveness to your inquiries, do
29 you recall that?

1 A. Yes.

2 8 Q. And we'll maybe touch upon that as we go on later this
3 morning or into the afternoon. So that's the first
4 page of your response. And if we go to WIT-91960, and
5 that's the last page, and your signature, 18th April 10:06
6 2023. Are you content to adopt that response as part
7 of your overall evidence?

8 A. Yes, thank you. Yes.

9 9 Q. Thank you. Now, the primary purpose in asking you to
10 return to give evidence is so that the Inquiry can hear 10:06
11 from you in terms of, I suppose, the insight which the
12 Trust has gained in respect of the issues, primarily
13 governance issues, that have emerged in relation to the
14 issues set out in the Terms of Reference, and to hear
15 from you also in terms of issues of reform and 10:07
16 improvement within the organisation, and I suppose to
17 get a temperature check on how well that process of
18 improvement has gone and, I suppose, a status check in
19 terms of where it is at and what's still to be done.
20 So that's the primary reason for your attendance. But 10:07
21 I also, as part of the first section of your evidence,
22 wish to ask you some questions about some evidential
23 issues or factual issues that have emerged since we
24 last heard from you. So that's the first part of your
25 evidence which I'm going to commence now. 10:08
26

27 Could I ask you to take a look at something you said in
28 the transcript when you were last here? It's
29 TRA-01441. This first set of questions, Dr. O'Kane,

1 just to be clear, relates to the impressions that you
2 formed as Medical Director of Mr. O'Brien. I'm
3 conscious that in your evidence you've said you never
4 met him directly, you've never had a discussion with
5 him? 10:09

6 A. That's correct.

7 10 Q. Yes. And what we are looking at here, if we go down to
8 line 14, you're being questioned by counsel about your
9 engagement with Mr. Carroll. Mr. Carroll was Assistant
10 Director for surgery, isn't that right? 10:09

11 A. That's correct.

12 11 Q. And you're asked "Did Mr." -- this is line 14:

13
14 "Q. Did Mr. Carroll ever speak to you about
15 Mr. O'Brien?" 10:09

16
17 And you answer:

18
19 "A. My contact with Mr. Carroll would have been through
20 any of the surgical meetings or any of the discussions 10:09
21 that we would have had in relation to Mr. O'Brien. He
22 would have mentioned him then. But I think he found,
23 my sense was certainly he found him difficult to
24 manage."

25 10:10
26 So, just in relation to that, that sense that
27 Mr. Carroll found him difficult to manage, could you
28 help us better understand that? Was Mr. Carroll, to
29 the best of your recollection, pointing to any specific

1 difficulties which he was able to give by way of
2 example in terms of his management of Mr. O'Brien?

3 A. It's a long time ago since I've had these discussions
4 with Mr. Carroll, but certainly, as I've said in that,
5 my sense at that time was if I had asked about, you 10:11
6 know, did he have any concerns, were there any concerns
7 within the team, you know, made reference to what I had
8 picked up from the Maintaining High Professional
9 Standards Investigation in relation to, you know, the
10 triage of records, tardiness in dictation, all of those 10:11
11 things, you know, there was certainly a strong sense
12 from Ronan that, you know, "that was just Aidan",
13 everybody -- would have been the phrase that was used
14 -- everybody would have known that you had to work
15 round him and that -- I didn't ever pick up that there 10:11
16 was any animosity between either of them in any shape
17 or form, but just that in terms of helping Mr. O'Brien
18 and the Urology Service stay in a straight line
19 essentially, that that was definitely a challenge for
20 Ronan Carroll. 10:11

21 12 Q. So, MHPS and those issues, but was he pointing to any
22 particular example that you can recall at this stage of
23 difficulties?

24 A. No. No, the discussions would have been purely in
25 relation to what came out of the Maintaining High 10:12
26 Professional Standards recommendations in terms of what
27 had to be managed,

28 13 Q. Mmm. And did you get a sense that Mr. Carroll needed
29 help or was he asking for help to manage Mr. O'Brien?

1 A. He wasn't specifically asking for help. I mean, I
2 think, you know, particularly whenever we were working
3 through the recommendations that came out of that to
4 understand if they were being implemented, I think what
5 he was describing was that it was difficult to keep a, 10:12
6 you know, it was difficult to make sure I think that
7 Mr. O'Brien was, you know, following the rules. And
8 certainly, mostly we got the sense that he did.
9 Although I mean in other parts of the statement I make
10 reference to, you know, the fact that he hadn't been 10:13
11 compliant over the summer of 2018 before I arrived, and
12 then 2019, but I think we approached this as a
13 collective team in terms of thinking about how this
14 could be managed rather than suggesting to Mr. Carroll,
15 you know, any particular changes in terms of what he 10:13
16 would have to do.

17 14 Q. If we can move forward in the transcript. If we go to
18 TRA-01458. And if we just go down to line 11. Again,
19 in terms of the impressions that you formed from your
20 discussions with colleagues about Mr. O'Brien, you say: 10:14
21
22 "The history that was given about Mr. O'Brien was that
23 he had always been problematic. That, basically, he
24 was difficult to manage. He felt that the system was
25 always to blame. Didn't take any personal 10:14
26 responsibility for anything going wrong at any point in
27 time. I think the sense I got from people was they
28 were hugely frustrated with having to manage him."
29

1 I don't need to bring this up on the screen, but you
2 say in one of your witness statements, it's WIT-45034,
3 that it was your impression that:

4
5 "Mr. O'Brien's colleagues had developed ways of not 10:14
6 confronting him for fear of having to deal with
7 unpleasantness but had found ways of working around
8 him."

9
10 Do you recall saying that? 10:15

11 A. Yes. Yeah.

12 15 Q. Again, did anyone actually tell you they were
13 frustrated trying to manage him?

14 A. It's quite a long time ago since these things were
15 discussed, so I couldn't hand on heart say they used 10:15
16 the word "frustrated", right, but I've certainly, as
17 I've said there, I was left with a sense of this, and
18 certainly when you look through, you know, the
19 Maintaining High Professional Standards Investigation
20 and the paperwork around that is fairly extensive and, 10:15
21 you know, when you refer back to, you know, some of the
22 comments that were made by Heather Troughton, Eamon
23 Mackle, some of the others that were involved, there
24 was certainly a sense that they were trying very hard
25 to work with the system that they had and to improve it 10:15
26 and that, you know, what was communicated to me in
27 that, and then, you know, in discussions as we went
28 along, was that sometimes getting Mr. O'Brien to
29 understand the point of what the ask was, was

1 challenging, and that rather than actually take on
 2 board and deal with the things that should be his
 3 responsibility - and I think I made mention of it there
 4 - there was this tendency to blame the system and not
 5 take personal responsibility. And certainly that came 10:16
 6 through in Maintaining High Professional Standards
 7 documentation. And I think, and particularly in
 8 relation to not taking any personal responsibility, I
 9 have to say I was quite taken aback at the time when I
 10 read down through all of that, that there was no 10:16
 11 mention of apology for, you know, harm caused to
 12 patients, or in creating, you know, the challenges to
 13 the system, not bringing to the manager's attention,
 14 you know, the backlog of untriaged referrals, the lack
 15 of dictation - the way that was being managed, that 10:17
 16 lack of insight, and that's what I described it as
 17 being at the time, I think was the one overriding sense
 18 I was left with in relation to what had happened in the
 19 past.

20 16 Q. I'm struck by your evidence that you never actually met 10:17
 21 Mr. O'Brien?

22 A. No.

23 17 Q. And I wonder whether, when you reflect upon it now,
 24 whether you feel that, as Medical Director, when you're
 25 getting this sense from people you're speaking to or 10:17
 26 from what you're reading in the report, whether you
 27 should have deployed somebody from your team, or
 28 yourself, to taking a more direct interest in this
 29 difficulty by either sitting down with the Urology team

1 or, indeed, sitting down with Mr. O'Brien, or both, to
 2 try to see what exactly was the problem?

3 A. So my role as Medical Director was to professionally
 4 manage doctors and to support the governance systems
 5 within the Trust. And, you know, certainly in terms of 10:18
 6 my review of the Maintaining High Professional
 7 Standards Report, which was undertaken before I
 8 arrived, there had been numerous attempts at this by
 9 very able people from a variety of backgrounds, you
 10 know, through a series of medical managers, a series of 10:18
 11 operational managers, to try and address all of this.
 12 And I think as I've written in another bit of my
 13 statement, you know, we were trying the traditional
 14 routes in order to manage Mr. O'Brien. He was not --
 15 any other doctor who would be managed under Maintaining 10:19
 16 High Professional Standards would normally be subjected
 17 to the same process. You know, either in my role as I
 18 undertook it in the Southern Trust, or when I was
 19 involved in this work in my previous Trust, this is the
 20 way we would have approached this. And I think, and 10:19
 21 I've put it in as part of my reflection in relation to
 22 the Section 21s, I think what I came to an
 23 understanding of late was that the usual approaches to
 24 all of this did not address this problem. So I can't
 25 think of another case that I've been involved with over 10:19
 26 the years in relation to Maintaining High Professional
 27 Standards were there would have been that level of
 28 input from so many experts in terms of trying to manage
 29 the way an individual works that it would not have got

1 that person over the line, or got to a decision
 2 probably a bit sooner. So this is highly unusual. And
 3 you know, he was -- as I say, all of this was explained
 4 to him at various stages. He was asked about the
 5 management of all of this and, again, you know, when he 10:20
 6 was under review, when he was being closely monitored,
 7 we were able to see that that made a difference, it
 8 took that level of containment to actually get him to
 9 the point of delivering on what he was supposed to be
 10 doing, but in between times, you know, if there was 10:20
 11 distraction, for whatever reason, you know, when
 12 Martina Corrigan was off [REDACTED], or when, you
 13 know, the following summer whenever, sadly, [REDACTED]
 14 [REDACTED], it fell by the wayside and he
 15 didn't declare to us that he hadn't been undertaking 10:20
 16 the work that we had tasked him with.

17
 18 So, you know, I know that this has been extremely
 19 difficult in relation to manage, but I have to say in
 20 relation to all of the cases that I've managed over the 10:20
 21 years, this has been the most problematic of all.

22 18 Q. Yes. We'll go on in due course to look at the issue of
 23 idiosyncratic practice and the steps that the Trust has
 24 now got in place to, I suppose, focus on what might be
 25 described as low level concerns. So we'll look at that 10:21
 26 directly in due course. But just in light of what we
 27 have just discussed, do you consider that there are
 28 lessons to be learned here? Your last answer was,
 29 "Well, we were managing this in just the way we would

1 manage everyone else." There was a template there, "I
2 had the experience from elsewhere of managing people
3 successfully according to this pathway, but now I see
4 that it didn't work here." So what's the lesson in all
5 of that?

10:22

6 A. So, I have to say other doctors I have been involved
7 with in a similar process have found this extremely
8 humiliating and quite a shameful position to find
9 themselves in and have been preoccupied with the impact
10 that their behaviour has had on the patients, right. I
11 was not picking this up with this doctor that was being
12 managed in this process. And I think on the back of
13 all of that, if we'd had better governance systems
14 around this at a much sooner stage I think we would
15 have got to the crux of this a bit sooner and realised
16 that the difficulties probably couldn't be resolved
17 using the usual means. So as a result of all of this,
18 and I think I've spoken about it in previous evidence,
19 I, along with the Director of HROD, we have completely
20 revised our approach to managing doctors in difficulty.
21 So, I set up oversight groups, we pulled in a lot more
22 information in terms of a governance heat map, if you
23 like, of how the doctors function, in relation to how
24 all of that is reported through, and then certainly
25 when it comes to re-validation and the different steps
26 that doctors have to step through, that all of that is
27 scrutinised in great detail. And I think we are a lot
28 more assertive now in relation to, you know, pausing
29 the system and going back and having a very thorough

10:22

10:22

10:23

10:23

1 look at, you know, the environment the doctor is
 2 working in and what their practice has been, you know,
 3 if presented with any difficulties now. And you made
 4 mention of the low level concerns works. So that has
 5 been started over the last six to nine months within 10:23
 6 the Trust in earnest. We've had over 60 of the medical
 7 managers through that, or people involved in medical
 8 management, whether they're medical or not, through all
 9 of that in terms of addressing those concerns and,
 10 again, we're beginning to see that we are getting in at 10:24
 11 an earlier stage in terms of supporting doctors in
 12 difficulty to help them through, and by and large that
 13 has been really successful in terms of how we get
 14 people through this system.

15 19 Q. I'll pull some of that material up later. Just in 10:24
 16 terms of the sequence it's a bit out of time to do it.
 17 Sorry to cut across you, I want just to move on to one
 18 sort of final observation you've made in respect of
 19 Mr. O'Brien. If we go to one of your witness
 20 statements at WIT-45033. And you're recording at 10:24
 21 paragraph 28.1 that -- sorry, 28.1 and 28.2, that prior
 22 to the concerns that were raised in June 2020 in
 23 relation to Mr. O'Brien, you had limited engagement
 24 with all of the staff in Urology Unit. Your main
 25 points of contact were through one-to-one monthly 10:25
 26 Associated Medical Directorate group meetings, and that
 27 was primarily with Mr. Haynes. And then over the page,
 28 or, sorry, down the page, regular contact with
 29 operational management including Mr. Carroll and

1 Mrs. Corrigan.

2

3 So, if we move forward in your statement just over,
4 down the page please, at 30.1, you say:

5

10:26

6 "From my limited interactions with them..."

7

8 - and Mr. Haynes, Mrs. Corrigan and Mr. Carroll I think
9 you're referencing there:

10

10:26

11 "...my sense is that they did and do work well
12 together, with the exception of the working
13 relationship with Mr. O'Brien."

14

15 You say:

10:26

16

17 "My impression is that the remaining staff had the
18 greatest respect for each other regardless of
19 discipline and were very professional in their
20 interactions with their patients and each other. They
21 appeared to work well together outside the challenges
22 of having to manage and work with Mr. O'Brien."

23

24 So, are you intending to convey the message that
25 exceptionally across the team of urologists,
26 Mr. O'Brien did not work well with his colleagues?

10:27

27 A. Yes.

28 20 Q. And struck by the fact that your contact within Urology
29 was limited, as you have described, what was, I

1 suppose, your source of information, and what was the
 2 information that led you to form that view that he
 3 didn't work well with his colleagues?

4 A. well, in my discussion with, you know, meetings with
 5 Mr. Haynes in relation to concerns that he would have 10:27
 6 had, you know, primarily about medical staff, the
 7 person that would have been mentioned most frequently,
 8 you know particularly as we were working our way
 9 through Maintaining High Professional Standards was, or
 10 not working our way through it, in the aftermath of it 10:28
 11 - because it had finished before I arrived - was in
 12 relation to ensuring that the system worked reasonably
 13 smoothly. And, again, it was that it seemed to be that
 14 Mr. O'Brien had one way of working and everybody else
 15 worked as a team, was the way I was left with that. 10:28
 16

17 Now, again, I don't think there was any animosity there
 18 at all, I never picked up that this was aggressive in
 19 any shape or form, but it was just again this sense
 20 that Mr. O'Brien had to be worked round, whereas the 10:28
 21 others could function together really well as a team.
 22 And, you know certainly, you know, as my relationship
 23 with this team has continued, and deepened I think in
 24 the course of the Inquiry, I see that at large. They
 25 get on extremely well, they're very professional, 10:28
 26 they're very patient focused, and they embrace I think
 27 challenge and change and move on and get that done and,
 28 you know, are very enthusiastic about the work that
 29 they do. And I'm not now picking up any sense at all

1 that people are having to work round any individual in
 2 order to get the best outcome for the patient, they are
 3 working as a team, and I think that was always there
 4 but I think it's not now diluted by some of the
 5 workarounds that had to go on in relation to
 6 Mr. O'Brien.

10:29

7 21 Q. And just to be clear, your, I suppose, informant for
 8 these impressions was primarily Mr. Haynes on the
 9 clinical side?

10 A. It was. But it also came from the, as I say the
 11 extensive work that was done around the maintaining
 12 High Professional Standards work, the whole history of
 13 that, and then the discussions that I would have had
 14 with the series of managers who were involved with
 15 Mr. O'Brien in the course of all of this, whether that
 16 was Ronan Carroll, or Martina Corrigan or, you know,
 17 people who had previously been involved with
 18 Mr. O'Brien, such as Eamon Mackle, or Heather
 19 Troughton, or others, there was this sense that the
 20 team worked well but Mr. O'Brien did not work in the
 21 same way as everybody else.

10:29

10:29

10:30

22 22 Q. Would it be fair to suggest to you that your sense of
 23 this, the sense that, as you suggest here, there wasn't
 24 much respect for Mr. O'Brien, has been to some extent
 25 exaggerated by your knowledge of, I suppose by what we
 26 know now, to put it in those terms?

10:30

27 A. Mr. O'Brien was, and I'm sure is, was incredibly
 28 popular among staff in the Southern Trust. And, again,
 29 you know, I had people who approached me at various

1 stages to say to me that they felt how he was being
 2 treated was very unfair, that he had always been very
 3 kind and very supportive, and all of those things, and
 4 I have no doubt personally Mr. O'Brien, you know, has
 5 always had great relationships with people. Right. I 10:31
 6 wasn't so much interested in that, I was interested in
 7 the professional side of this actually. How was this
 8 relationship impacting on the functioning of the team
 9 and the outcome for patients? And, you know -- and,
 10 again, as I say, there was never any animosity picked 10:31
 11 up in the midst of all of this. There were slight
 12 tensions that I noticed came through in terms of some
 13 of the reporting that was done in relation to
 14 maintaining High Professional Standards where there
 15 seemed to be this sense that if Mr. O'Brien was 10:31
 16 challenged, you know, he would take legal redress and
 17 all of that, and that seemed to be a threat that was
 18 around - rightly or wrongly, I don't know - but by and
 19 large Mr. O'Brien was very highly respected, very well
 20 liked by staff, but the bit I was interested in was 10:31
 21 patient safety.

22 23 Q. Again, getting back to what we can learn from this?

23 A. Yes.

24 24 Q. My sense from your evidence is that in terms of the
 25 time when you're hearing this stuff, it's before 2020, 10:32
 26 you're getting through Mr. Haynes, Mr. Carroll,
 27 Mrs. Corrigan, these impressions of a senior clinician
 28 who is difficult to work, isn't a team player, "we have
 29 to work around him", and yet there wasn't any

1 particular initiative, other than the monitoring plan,
 2 or the action plan as we call it, to get to grips with
 3 him. Is that the way it would be dealt with today?
 4 A. The attempts that had been made were through job
 5 planning process, appraisal process, the usual 10:32
 6 governance procedures that are in place for doctors
 7 and, again, the history with Mr. O'Brien had been that
 8 there was delays in all of those systems, in that, you
 9 know, it took him a while to get to actually undertake
 10 his appraisal, the job plans he was very tardy in 10:33
 11 signing off, all of those things. So there was
 12 something about, you know, the conversations that were
 13 had with him weren't landing him where he needed to be.
 14 There was always more work to be done, there was always
 15 more information that had to be brought to bear to 10:33
 16 improve in all of this, and the deadlines just kept
 17 getting pushed back and back. Right. So that,
 18 together with the discussions that were there,
 19 suggested to me, you know, together with the fact that
 20 he had been through a Maintaining High Professional 10:33
 21 Standards Investigation...
 22 CHAIR: I think we have a tendency to speak quickly,
 23 but if we can slow down, because not only the
 24 stenographer has to get everything you say, but we have
 25 to try and keep a note as well. So if you can slow 10:33
 26 down, please, doctor.
 27 MR. WOLFE: So, yes, you were saying - you were taking
 28 us through the various conventional governance steps in
 29 respect of Mr. O'Brien and you were pointing out delay

1 or tardiness in respect of compliance with those.

2 A. Yes. So when I think about that history, and I suppose
3 - and I appreciate they've only been recently
4 published, but when you look at the recommendations
5 that have come out of the Neurology Inquiry in relation 10:34
6 to appraisal, those mirror some of what we were dealing
7 with in relation to Mr. O'Brien. And in relation to
8 job planning obviously, you know, very tardy to sign
9 off in relation to that too. I had, you know, he had
10 been part of a Maintaining High Professional Standards 10:34
11 Investigation. As I became increasingly familiar with
12 the case, you know, I became aware of other aspects to
13 his practice that there had been worry about previously
14 but had been closed off, and I had referred him to the
15 GMC. So this was someone that I was concerned about. 10:35

16 25 Q. Mm-hmm. And I suppose the focus of my question is,
17 you, and those employed at senior level within the
18 system, knew about these shortcomings, the
19 non-compliance, the team work issue, the delays in
20 co-operating with job planning appraisal. That's your 10:35
21 evidence, or your perspective on it, and I'm sure
22 Mr. O'Brien may have a different perspective. But from
23 your perspective, with the knowledge of those things,
24 what was the reaction to it? What was the response to
25 this knowledge? And do you think it was satisfactory, 10:36
26 looking at it from today's standpoint?

27 A. So, the overall response to this has been, as I
28 mentioned earlier, a revision in our systems and
29 processes in relation to how we manage appraisal,

1 re-validation and job planning. We now have much
 2 tighter structures around all of that. There's very
 3 timely escalation in relation to any of the challenges
 4 within all of that, and it's dealt with, you know,
 5 personally and in groups to try and help people get 10:36
 6 over the line. So, when I look at the history of the
 7 appraisal and job planning before, the numbers were
 8 low. I mean as of today we're sitting at over 90%
 9 compliance with appraisal. And job planning we're
 10 sitting at over 60% of compliance with that as we come 10:37
 11 into the new financial year. That's much better than
 12 it was previously. I think again with the training
 13 that has been done, you know, in connection between the
 14 Medical Director's office and the Director of Human
 15 Resource's office in relation to bringing all levels of 10:37
 16 staff to a greater understanding of their roles and
 17 responsibilities in relation to speaking up,
 18 whistleblowing, reporting low level concerns, you know,
 19 how that's escalated. You know, we've done training in
 20 relation to all of that to improve the visibility of 10:37
 21 all of that, and the systems and processes that are in
 22 place now are taken very seriously. I now get monthly
 23 reports in relation to how all of that is progressing,
 24 it's discussed at Senior Leadership Team, Trust Board,
 25 it's through the whole organisation in terms of being 10:38
 26 mindful that these systems and processes are there for
 27 a purpose and that we need to take them seriously and
 28 respond to them if we have concerns.
 29 26 Q. But you're not saying - and we'll come later in your

1 evidence to look in more detail at some of those
 2 improvements - but just to be clear, you're not saying,
 3 are you, that how the Trust responded to this in
 4 real-time through those years until 2020 was adequate
 5 even by the standards of the day? 10:38

6 A. I think that, at the time any doctor who was coming
 7 through the Southern Trust would have got the same
 8 response. And my sense is, from the history of doctors
 9 in difficulty in the Southern Trust, that that approach
 10 that was used, even though it was light touch, actually 10:38
 11 was helpful in other doctors responding to it and
 12 improving. Right. The same approach as was prevalent
 13 within the organisation was used towards Mr. O'Brien at
 14 that point in time and did not deliver, you know, the
 15 improvement that was actually needed in any sustainable 10:39
 16 way, other than when he was constantly being monitored
 17 in relation to his performance to ensure that he
 18 delivered what he was employed to deliver.

19 27 Q. That doesn't directly answer my question. If he's
 20 getting, that is Mr. O'Brien is getting a response that 10:39
 21 would have been used with every other doctor...

22 A. Yes.

23 28 Q. - with success.

24 A. Yes.

25 29 Q. The impression I get from your evidence is that you 10:39
 26 were aware, and others were aware that he was, even
 27 though broadly complying with the action plan and the
 28 monitoring plan, he was still causing problems, and
 29 they went unaddressed. Is that fair?

1 A. In terms of the problems we were aware of that had been
2 identified through the Maintaining High Professional
3 Standards Investigation, those problems were being
4 monitored. There was nothing else concrete coming
5 through at that point in time in relation to his 10:40
6 performance and behaviour. So it was when we got to
7 June 2020 that we then realised that there were further
8 problems in relation to the management of cancer
9 patients, but none of that had come through in
10 maintaining High Professional Standards and none of 10:40
11 that had come through in various discussions that we'd
12 had on the way through in terms of ensuring that he was
13 compliant with the recommendations that came out of
14 Maintaining High Professional Standards.

15 30 Q. But what was coming through? And we heard from you 10:40
16 earlier on, this is through your conversations with
17 Mr. Carroll, Mrs. Corrigan, Mr. Haynes, this sense
18 still that he wasn't performing as the rest of the team
19 would be expected to perform, you had to work around
20 him, there was always this tension, is the impression 10:41
21 from your evidence?

22 A. Yes, but that was a sense, but in terms of actually,
23 you know, that translating into, you know, anyone
24 saying "I have particular concerns about this patient",
25 "I'm concerned that Mr. O'Brien isn't doing A, B and 10:41
26 C", there wasn't anything concrete said in relation to
27 that. I think the frustration certainly at that time
28 was in relation to the monitoring of these different
29 areas and making sure that he was compliant, and that's

1 where the focus was. But in relation to other concerns
 2 that, as I say, those weren't clearly identified then
 3 until June 2020. If they had been, you know, we were
 4 very vigilant in the system and, you know, in relation
 5 to all doctors at this point in time, because we did 10:42
 6 realise that some, you know, that the systems and
 7 processes in relation to appraisal and re-validation,
 8 or leading into re-validation, and particularly job
 9 planning, were not as tight as they could be. So, we
 10 were really vigilant then to any concerns about doctors 10:42
 11 in the system at that point in time.

12 31 Q. Let me take you to June 2020 and something you said on
 13 the last occasion. If we go to TRA-01467. Just the
 14 second half of the page, please. So it's from line 14,
 15 and I'm asking for your observations on: 10:42

16
 17 "When Mr. O'Brien retired from the Trust on 17th July,
 18 when we had discovered..."

19
 20 - sorry, I'll start again: 10:43

21
 22 "Mr. O'Brien retired from the Trust on 17th July. When
 23 we had discovered the difficulties after, I think I was
 24 informed on 11th June in a clinical team, principally
 25 Mr. Haynes and Mrs. Corrigan had been working on an 10:43
 26 email that they had received that suggested there was a
 27 discrepancy in two waiting lists, and that caused them
 28 a bit of concern. When they worked their way through
 29 that they realised there wasn't a discrepancy, but what

1 they also discovered on the back of those explorations
 2 were the concerns then around the cancer
 3 multi-disciplinary team meeting."

4
 5 So, what you appear to be saying is you were informed 10:43
 6 about a discrepancy on the 11th June by Mr. Haynes?

7 A. Yes.

8 32 Q. Mr. Haynes and Mrs. Corrigan worked their way through
 9 that at that time because there was a bit of concern,
 10 as you describe it. But when they worked their way 10:44
 11 through it they realised that there wasn't a
 12 discrepancy?

13 A. Yes.

14 33 Q. Can you explain to me just what you mean by that and
 15 what your knowledge of that was? 10:44

16 A. This is a clinical system that I haven't used in recent
 17 times, so I'm not familiar with all of the nuances of
 18 it. But, as I under - and I think it's a Cloud system,
 19 so as you update it, it changes. And the - sorry.

20 34 Q. I don't mean the technical information around the two 10:44
 21 patients concerned.

22 A. Mmm.

23 35 Q. It's the question of when they realised that there
 24 wasn't a discrepancy, what is your understanding of
 25 that? 10:45

26 A. I think we realised that there wasn't a discrepancy in
 27 and around late September, whenever they had gone back
 28 and revised all of this, looked at the comparisons
 29 across the different patient lists that they had, and

1 realised that the two patients that we thought weren't
2 on - were on one list and should be on another list,
3 weren't. So this was a red herring in terms of these
4 two patients, thankfully. But, you know, what was
5 fortuitous in all of that was that it provoked a review 10:45
6 of systems and processes in relation to the management
7 of cancer patients in relation to Mr. O'Brien's
8 practice, and that's when we then realised that there
9 was a problem in terms of the cancer multi-disciplinary
10 teams and in terms of those patients getting access to 10:46
11 that, being on surgical lists, all of that area, and we
12 had been - certainly in terms of the information I had
13 available to me in what was looked at in the
14 Maintaining High Professional Standards Review, I
15 hadn't been aware of that, until that point. 10:46
16

17 So these two patients were a red herring, but actually
18 they were - it was fortuitous that that was approached
19 in that way, because then that took us into realising
20 that there were much bigger concerns about other 10:46
21 patients.

22 36 Q. When you say "these two patients were a red herring",
23 the initial concern, as the Inquiry understands it
24 through Mr. Haynes's evidence, is that when he received
25 an email from Mr. O'Brien in relation to a set of 10:46
26 patients who were to come in for surgery, he initially
27 formed the view that the two patients weren't on PAS,
28 they weren't on the Trust's waiting list, and that then
29 caused him to report to you on the 11th June, and then

1 in turn with Mrs. Corrigan, they carried out I think
 2 what you've described as a scoping exercise to see if
 3 there were any other problems, and as you say
 4 fortuitously you got to that and that's why, in
 5 essence, we're here today.

10:47

6
 7 The red herring was identified as being a red herring
 8 by September 2020?

9 A. Yeah, in and around, yes. I think it was as we were,
 10 as we were working our way - as we went back to track
 11 what happened with those two patients in the context of
 12 what became known. Now, I became aware that actually
 13 then those two patients hadn't been part of that cohort
 14 of patients, that we then began to identify as nine
 15 Serious Adverse Incidents and then concerns about
 16 significant other numbers of patients, yep.

10:47

10:48

17 37 Q. And the person who spotted it as a red herring was who?

18 A. I think between Martina and Mark Haynes, I think -
 19 Martina Corrigan and Mark Haynes - I think when they
 20 revised the data and looked at the pathway through for
 21 those patients they realised that those two patients
 22 weren't patients that we should be concerned about
 23 based on the original information. So it would have
 24 been they who brought that to my attention.

10:48

25 38 Q. And it is the fact that the Department was briefed
 26 about the circumstances in which the Trust moved from a
 27 concern about those two patients into, if you like,
 28 this deeper dive, this scoping exercise in relation to
 29 Mr. O'Brien's practice, and I just want to look at what

10:48

1 the Department was told.

2
 3 If we go to SPP - we don't often use that prefix, but
 4 it's SPP-00629. And this is now 14th October 2020, and
 5 this is a report to the Department of Health in 10:49
 6 relation to Consultant A. And if we scroll down, some
 7 of the background is explained. If we just go down a
 8 little further, please, next page. So it's explaining
 9 that on 7th June 2020, the Trust became aware that two
 10 out of 10 patients listed for surgery under the care of 10:50
 11 Consultant A were not on the hospital's patient
 12 administration system at this time.

13
 14 "As a result of these potential safety concerns a
 15 review of Consultant A's work was conducted to 10:50
 16 ascertain if there could be wider service impacts."
 17

18 And then the wider service impacts are explained.
 19 Going back to the red herring point, I think you've
 20 explained it was discovered as being a red herring the 10:50
 21 previous month in September, the Department is getting
 22 an explanation here as to why further concerns emerged,
 23 or the trigger for those further concerns. The reading
 24 of that first paragraph suggests that the two out of
 25 the 10 patients were not on the patient administration 10:51
 26 system at the time, whereas, as I understand your
 27 evidence, that had been corrected, or understood to be
 28 wrong in the previous month?

29 A. In and around. So I think it was in the course of

1 preparation for this. And I think, you know, when I
 2 reflect on this, this could have been more clearly
 3 written, and a sentence could have been put in there to
 4 say that, you know, something along the lines of, you
 5 know, when we've undertaken this more comprehensive 10:52
 6 review or scoping exercise, that we've realised that
 7 those two patients aren't patients that we should be
 8 concerned about, that actually they have been on the
 9 right lists, but actually what we've discovered as a
 10 result of all of this, you know, has been, as you say, 10:52
 11 eventually what has led to this Public Inquiry.

12
 13 So I could have put - Melanie and I could have put a
 14 more clearly stated statement in there basically to
 15 explain out the end of that, that those two patients, 10:52
 16 as I say, were - and I don't like referring to anybody
 17 as a "red herring", but I know that was my language,
 18 but certainly fortuitously those patients were
 19 discovered and led us into understanding about all of
 20 these other patients. 10:52

21 39 Q. Yes. So just to be clear, what you had discovered in
 22 September or thereabouts...

23 A. Yeah.

24 40 Q. - was that these two patients were in fact on the
 25 waiting list and that the initial concern about it was 10:53
 26 unfounded?

27 A. Yes, the initial concern was unfounded, but the rest
 28 certainly hasn't been unfounded. Yes.

29 41 Q. Yes.

1 A. Yep.

2 42 Q. Do you consider that, when you look at this, the
3 Department may have been misled by how the situation
4 was described?

5 A. I don't, I don't remember, because bearing in mind this 10:53
6 paper was prepared for what was to become the Urology
7 Assurance Group with the Department of Health, I
8 haven't looked recently at the minutes from those
9 meetings, but I am fairly confident that we would have
10 explained to the Department that those two patients 10:54
11 weren't patients we were any longer concerned about,
12 but that may or may not be in the minutes, but I do
13 know that that was certainly communicated at a point in
14 time.

15 43 Q. Just to be absolutely fair to Mr. Haynes, who was I 10:54
16 suppose your primary informant around these issues.

17 A. Mmm.

18 44 Q. I think it's fair to say he cannot recall a precise
19 date when he discovered that the two patients were in
20 fact on the waiting list, but I think it accurately 10:54
21 characterises his evidence to say he's doing his best
22 in terms of his recollection, he thinks his discovery
23 of that issue came more closely to the date when he
24 came to give evidence to the Inquiry, which would have
25 been in or around November 2022. Your evidence by 10:55
26 contrast, both on the last occasion and today, is
27 unequivocal I think, that it was discovered - the "red
28 herring", as you put it, was discovered in the autumn
29 of 2020. Can I ask you just to comment on Mr. Haynes's

1 evidence in that respect? Do you think he is clearly
 2 wrong, in your view, to put a much later date on it?
 3 A. I haven't had a specific conversation with Mr. Haynes
 4 about this, but my sense of the realisation, as I say,
 5 was in and around September/October time, and probably 10:56
 6 a bit more fulsomely after that, but I think that came
 7 out of discussions back and forth that I would have had
 8 with Martina at that point in time. So I - as I say, I
 9 haven't spoken to Mr. Haynes about when, you know,
 10 specifically, you know, did he think it was a different 10:56
 11 date, I don't know.

12 CHAIR: Mr. Wolfe I hesitate to interrupt but, you
 13 know, I think we're spending an awful lot of time on
 14 what is essentially an admitted point, that we had two
 15 cases that were identified as a catalyst that led to 10:56
 16 greater discovery, and the actual timing of when it was
 17 discovered that those two cases were in fact on the
 18 patient administration system and were not, are really
 19 not the issue here. The issue is what that led, the
 20 discovery that that led to. So I think we're spending 10:56
 21 an awful lot of time on what is, to my mind, a minor
 22 issue.

23 45 Q. MR. WOLFE: Let me move on then to the point that you
 24 make, that notwithstanding the red herring,
 25 notwithstanding what was in essence, let's call it 10:57
 26 neutrally a mistake of interpretation, Mr. Haynes, with
 27 Mrs. Corrigan, went on to discover issues or
 28 shortcomings with Mr. O'Brien's practice that you have
 29 no concerns about, is that fair?

1 A. That's true, yes.

2 46 Q. And when I say "no concerns about", you've no concerns
3 about the accuracy of the conclusions which they drew
4 from their investigations?

5 A. No, because I think, you know, their concerns have been 10:58
6 dealt with through Dr. Dermot Hughes' Serious Adverse
7 Incident reporting on the nine cases, and then the work
8 that we have undertaken to date in relation to
9 identifying more than 2,000, or reviewing more than
10 2,000 cases and then identifying, you know, within 10:58
11 that, the stratification of areas of concern. So I
12 think that that work has shown to us that we were right
13 to be concerned.

14 47 Q. Now, just briefly. One of the concerns that was
15 identified and referred to Mr. O'Brien in 10:58
16 correspondence in July 2020, was in relation to a
17 concern about other patients not appearing on waiting
18 lists. Let me draw that to your attention. It's at
19 AOB-02534. So Mr. O'Brien is written to by Mr. Haynes,
20 and he is in essence telling him to stand down from any 10:59
21 clinical activity, and he sets out within the body of
22 the letter the steps that were taken in light of the
23 7th June email. And if we just move through that to
24 page 38 in the sequence, it's four pages down, and just
25 scrolling down. So one of the issues raised with 11:00
26 Mr. O'Brien is that there were other patients on
27 Mr. Haynes and Mrs. Corrigan's estimation who had not
28 been added to waiting lists, as we can see here, when
29 they should have, and were mostly done a few days

1 before Mr. O'Brien had the patients admitted. It goes
 2 on to say:
 3
 4 "One patient re-admitted as emergency and had their
 5 stent removed under a different consultant. There had 11:00
 6 been no plan to admit them by Mr. O'Brien."
 7
 8 Is that what you were aware of at the time? Were you
 9 aware that there was a concern that patients had not
 10 been placed on appropriate waiting lists? 11:01
 11 A. Can you remind me what date this was from, please?
 12 48 Q. This is July 2020. So your attention was drawn to what
 13 you now accept was a red herring on the 11th June.
 14 Mr. Haynes, with Mrs. Corrigan, conducted certain
 15 further investigations by way of a scoping exercise 11:01
 16 leading to this letter to Mr. O'Brien in advance of his
 17 retirement date. So the question is: in general terms
 18 were you made aware that, quite apart from the two
 19 patients that you've said was a red herring, that there
 20 was nevertheless a broader concern that there were 11:02
 21 other patients who had not been added to waiting lists?
 22 A. Yes, and I think I much prefer the word "catalyst" I
 23 think to "red herring" - I'm feeling anxious about
 24 having said that! I think that, you know, as I recall
 25 this, and in terms of how this process unfolded, on the 11:02
 26 basis of Mr. Haynes raising concerns about these two
 27 patients and then the work that he and Martina Corrigan
 28 undertook in relation to understanding or searching to
 29 find out were there any other patients missing, I think

1 this started to come to light, and then based on all of
 2 that they began, I think with the other people that
 3 worked with them, to understand just the implications
 4 of all of this in relation to these patients and how
 5 they were being managed. So I would have been - I 11:03
 6 would have been aware that that was the growing pattern
 7 or concern in relation to all of this throughout the
 8 summer, yes. Yes.

9 49 Q. Before we leave this area, can I just bring you to
 10 something you said in your witness statement about it, 11:03
 11 or one of your witness statements. WIT-45159. If you
 12 just look at - just scroll down. Scrolling down. You
 13 have recorded "Patients found" - these are concerns
 14 about Mr. O'Brien, and the left-hand margin:

15 11:03
 16 "Patients found to not have been added to lists for
 17 required surgery 7th June."

18
 19 And you go on then to comment on what was done, you
 20 say: 11:04

21
 22 "When this was discovered a review of Mr. O'Brien's
 23 clinical work was immediately commenced by
 24 Mrs. Corrigan to determine the extent of this problem.
 25 Ongoing discussions were held with the relevant 11:04
 26 directors throughout the summer until Mr. O'Brien
 27 retired on the 17th July. Progress to date in the
 28 timeframe 1st January 2019 until 31st May 2020 was
 29 formally reviewed by directors oversight on 6th July.

1 I discussed the unfolding concerns with Joanne Donnelly
2 of the GMC, the Deputy Chief Medical Officer, and with
3 the Department of Health."

4
5 - the latter being on the 24th August, and then you go 11:05
6 on to detail some further discussions.

7
8 I'm struck that although you were aware at the time of
9 finalising this statement that in fact these two
10 patients, while being the catalyst for further 11:05
11 investigations were not in fact the subject of any
12 concern at all, but you don't take the opportunity
13 within your statement to address that. Should you
14 have?

15 A. Yes, I think I should have added that information at 11:05
16 that point in time just as it unfolded, and I think,
17 you know, we have been - there is the balance between,
18 you know, looking at smoke signals and those two
19 patients that I think who were the catalyst for this
20 were definitely, you know, took us to other smoke 11:05
21 signals in the system, and those have to be tested out
22 to ascertain whether or not patients have come to harm
23 in the process of all of that. And I think by that
24 stage I wouldn't have been clear - by July/August I
25 wouldn't have been clear if any of those patients had 11:06
26 come to harm. I think as we got farther through the
27 autumn and the winter that became increasingly obvious
28 to us, certainly as Dermot Hughes pursued the Serious
29 Adverse Incident Review. So, yes, in retrospect I

1 could have added in more information in relation to
2 that.

3 50 Q. Can I then take you to a new issue? It concerns the
4 events of the autumn of 2019, it was discovered that
5 during a period of ill-health within Mr. O'Brien's 11:06
6 wider family, he had not complied with what was
7 expected of him in terms of dictation and triage, and
8 it was determined that Mr. McNaboe would meet with him,
9 and that's the context for what you say - if we go to
10 TRA-01522, and at line, just line 9: 11:07

11
12 "I think Mr. McNaboe and Mrs. Corrigan wrote to
13 Mr. O'Brien offering to meet with him in November. He
14 came back to say he didn't have enough notice and
15 cancelled the meeting but that would have been 11:07
16 Mr. O'Brien's pattern."

17
18 Can you help us with that? You refer to Mr. O'Brien's
19 pattern, which I think is intended to suggest that he
20 didn't come willingly to meetings, or cancel meetings 11:08
21 when he was expected to attend them, is that what you
22 intended to suggest?

23 A. Well, I think this resonates with what happened during
24 the Maintaining High Professional Standards
25 Investigation, when I think it took Dr. Chada nine 11:08
26 months to, you know, get through her investigation in
27 relation to producing a report, and that was largely
28 down to the fact - now bearing in mind this is the most
29 important investigation any doctor can have in their

1 career. My experience of that always is that, you
 2 know, if you had that hanging over you, you would
 3 prioritise it above all other things. Right. But it
 4 took Dr. Chada, who is very skilled and experienced in
 5 this area, nine months to pin this down to get that 11:09
 6 report developed because of Mr. O'Brien's approach to
 7 meetings, and here it was again.

8
 9 So this was, this was the outworkings of the 2017/2018
 10 recommendations in relation to Mr. O'Brien. He knew 11:09
 11 that the Trust was taking this seriously. There had
 12 been a lot of work done around it. They wanted to
 13 speak to him about it, and when they offered to meet
 14 with him in a timely fashion, he came back again then
 15 to say he didn't have enough notice and he cancelled 11:09
 16 the meeting. That was his pattern, and that - when you
 17 look at the process throughout Maintaining High
 18 Professional Standards, when you look at the history of
 19 any of this, that tends to be my sense certainly of how
 20 Mr. O'Brien approaches what should be really important 11:09
 21 meetings for any doctor.

22 51 Q. Okay. There's obviously more than one perspective on
 23 all of this. Mr. O'Brien would no doubt say, and the
 24 records perhaps bear him out, that he made himself
 25 available at various times to meet Dr. Chada, but it 11:10
 26 was sometimes difficult to get a mutually convenient
 27 date. There were also issues about supplying him with
 28 material that he needed to be aware of before
 29 subjecting himself to an important, in fairness to him,

1 interview, which could affect his professional
 2 standing.

3
 4 On the McNaboe incident - I don't have the email
 5 reference to hand, but a date was suggested for the 11:10
 6 meeting that coincided with Mr. O'Brien's attention to
 7 cancer review clinics, if my memory is correct. So do
 8 you think it entirely fair to criticise his willingness
 9 to attend meetings in the way that you have just done?

10 A. I completely understand that there can be clashes with 11:11
 11 very important clinical work, but in that situation I
 12 think what most doctors would reasonably do, given what
 13 Mr. O'Brien has been through in terms of maintaining
 14 High Professional Standards, would realise that there
 15 should be an urgency about complying with the requests 11:11
 16 and that they should come back themselves. You know,
 17 if they're not being offered other appointments, come
 18 back themselves with suggestions around when that might
 19 be done. So for example, on a Tuesday morning I know
 20 that Martina Corrigan had arranged with him to have 11:11
 21 additional administration time above and beyond what
 22 the other consultants were being offered in order to
 23 help him get his paperwork done. That might have been
 24 a time, for example, he might have suggested to
 25 Mr. McNaboe and Mrs. Corrigan that he could have met, 11:12
 26 or any other opportunities within his diary. But I'm
 27 not aware that he would have offered those appointments
 28 himself. He would have waited for other people to
 29 suggest them to him.

1 52 Q. We'll come to the issue of whether he was provided with
2 support for his administrative work in a moment. But,
3 why, upon reflection, was the meeting with Mr. McNaboe
4 important or significant?

5 A. That meeting was important because it was to ask Mr. - 11:12
6 remind Mr. O'Brien that he was to complete I think both
7 appraisal and job planning, but essentially job
8 planning, that needed to be done.

9 53 Q. And it didn't take place in a formal setting. We
10 understand that there was a brief corridor conversation 11:13
11 on Mr. McNaboe's account, or Mr. O'Brien's account - I
12 can't remember which. So from a Trust management
13 perspective, an important meeting didn't take place and
14 the manager didn't make it take place, is that fair?

15 A. I think it didn't take place in the way it was 11:13
16 originally intended to take place, and I know that when
17 I came back to ask about that, I think it was then in
18 early 2020, it was still being pursued at that point in
19 time.

20 54 Q. Another issue. You've said, if you go to the 11:13
21 transcript again at 01545, just scrolling down. Yes.
22 You were asked about your recollection of the culture
23 of the Board, and you recall that:

24
25 "At the end of Trust Board each of the executive 11:14
26 directors were asked for any comments."

27
28 This is during your time as Medical Director of course:
29

1 "Up until that point I hadn't brought anything to the
2 Board because it wasn't anything particularly outside
3 the confidential section that needed to be raised,
4 until August 2020 when I was asked the question and I
5 raised it in relation to Mr. O'Brien. I think the 11:15
6 feedback that I got indirectly at that point in time
7 was that it shouldn't have been raised in that way."
8

9 Could you help us understand - I see there wasn't any
10 particular follow-up on what you said. What were you 11:15
11 told about the way that you had raised the O'Brien
12 issue at the August 2020 Board meeting?

- 13 A. My recollection of that was I had a - I think it was
14 with Shane - Shane and I had a - Shane Devlin, the
15 Chief Executive at that point in time - and I think in 11:15
16 my one-to-one soon after that he had mentioned to me
17 that some of the members, now he didn't say who they
18 were, some of the members on the Trust Board felt it
19 was inappropriate that I had raised this, and my
20 response to him was, "well, I was asked the question so 11:15
21 I gave the answer, that's what that part of the agenda
22 is for", and he said "I completely agree with you. I'm
23 just making you aware that some people may not have
24 been happy with that approach", and you know, I said to
25 him "well, if I was faced with that again I would - you 11:16
26 know, and I had concerns and I was asked the question,
27 I would answer the question", and he said no - you know
28 his view was the same, I think the same as mine, which
29 was "Yes, you were asked the question, you gave the

1 answer, you had concerns about it." You know, it
2 wasn't a surprise to either of us because we had some
3 conversations back and forth that this was being
4 pursued. But that's what that's in relation to, he had
5 mentioned to me at that time.

11:16

6 55 Q. Yes. I must profess a little confusion about the
7 process. So 27th August 2020 was the first date on
8 which the Non-Executive Directors, and perhaps some of
9 the Executive Directors, became aware that there was
10 this Aidan O'Brien issue?

11:17

11 A. So, if you...

12 56 Q. The Early Alert - just to fill in some of the
13 background.

14 A. Sorry.

15 57 Q. The Early Alert that went to the Department at the end
16 of July/start of August, had, as we'll discuss later in
17 more detail, only been copied to Mrs. Brownlee, amongst
18 the Non-Executives. So if we bring up TRU-158997.
19 There was a so-called Trust Board workshop on the
20 morning of 27th August, leading into a full Board
21 meeting, albeit remotely, in the afternoon.
22 TRU-158997.

11:17

11:17

23
24 So this is the workshop. I don't need to bring you to
25 the opening page. The Chair left the meeting at that
26 point, Mrs. Brownlee - it's well worn ground. So you
27 brought to the Board's attention - what's described
28 here is:

11:19

1 "SAI investigations into clinical concerns involving a
2 recently retired consultant urologist. Members asked
3 that this matter be discussed at the confidential Trust
4 Board meeting following the workshop."

5 11:19

6 Is that the point that you're getting at, that you were
7 told that you should not have raised the issue in the
8 way that you did? Is the point that it shouldn't have
9 been raised at the workshop, it should have been
10 brought to the Board meeting, or have I missed the
11 point?

11:19

12 A. I think I was being asked at that point to bring it
13 more fulsomely to the Board meeting, but it wasn't
14 mentioned to me at that point in time that anyone
15 thought it was inappropriate.

11:20

16 58 Q. Okay. And then if we just go to the Board meeting at
17 WIT-90951. And, again, bottom of the page, it's again
18 - do you know why it's being described as "SAI" when we
19 know that an Early Alert, based on the catalyst event
20 in June leading to the scoping exercise and the
21 revelation of other issues, why it's being described as
22 an "SAI"?

11:20

23 A. So I think probably the language around that would have
24 been, we would have been describing what was ongoing
25 as, you know, concerns about serious adverse incidents
26 - I don't remember exactly. SAI means - using capitals
27 like that particularly means something particular in
28 Northern Ireland. So I think what was probably being,
29 or would have been discussed at that point in time was

11:21

1 that we had concerns about there being Serious Adverse
 2 Incidents and we were undertaking a review at that
 3 point in time to understand just the depth and breadth
 4 of all of that. So that's what would have been
 5 discussed at that time and I - but at that point - I 11:21
 6 don't think at that - not on 27th August, I don't think
 7 we would have had that firmly, we wouldn't have been
 8 firmly of the opinion that these were all Serious
 9 Adverse Incidents and be getting into the realms then
 10 of approaching Dr. Hughes about undertaking the 11:21
 11 investigation.

12 59 Q. Okay.

13 A. I may have got the chronology wrong, but it is probably
 14 a misnomer in terms of how it's actually recorded.

15 60 Q. Yes. We'll come back to this issue in a slightly 11:22
 16 different way later, bearing in mind when the Early
 17 Alert was issued, and bearing in mind that the Early
 18 Alert isn't mentioned at this first opportunity
 19 meeting, if you like. But just going back to where I
 20 started in the piece that jarred with me in your 11:22
 21 earlier evidence, where you said that you were told
 22 that you should not have brought this issue in the way
 23 that you did, and that was a conversation with
 24 Mr. Devlin as you've now explained, and he agreed with
 25 you that it was appropriate to bring it to the Board at 11:22
 26 that time and in the way that you did, is that your
 27 evidence?

28 A. We didn't discuss - Mr. Devlin didn't form an opinion
 29 about whether it was appropriate or not.

1 61 Q. No, he was reporting what somebody else had said to
2 him.

3 A. Yes. And, you know, the essence of our discussion,
4 from my memory, was around essentially the
5 communication of the information, that you know what I 11:23
6 - I mean it was fairly concrete, I was asked the
7 question and I gave the answer, you know. Do you - "As
8 Executive Medical Director are there any concerns you
9 wish to raise?", that would be the normal question.
10 And I said "Yes, I've got a concern here." 11:23

11 62 Q. Right.

12 A. Yeah.

13 63 Q. And, again, just to be clear in the way that you have
14 now explained it, does that suggest that you hadn't
15 gone to that Board meeting or, indeed, the earlier 11:23
16 Board workshop, with the intention of revealing what
17 was, I would suggest to you an important event, the use
18 of an Early Alert, and the investigation, the ongoing
19 investigation of these initial concerns in respect of
20 Mr. O'Brien, that wasn't your intention until you were 11:24
21 asked the question?

22 A. If I had - it was certainly weighing on my mind because
23 I was aware that this was a Board that, you know, I
24 came in to, that should have been through the process
25 of the Maintaining High Professional Standards 11:24
26 Investigations and Report in relation to Mr. O'Brien
27 previously. So they had - they should have had a whole
28 history with Mr. O'Brien and what unfolded in relation
29 to all that of before I ever arrived. I, I think,

1 would have assumed that they would have been familiar
 2 with that whole history, and I would have brought this
 3 by way of saying to them, you know - and it was an
 4 assumption on my part, which I probably should have
 5 tested out beforehand that - they would have been 11:25
 6 familiar with all of that, and what I was saying to
 7 them was the person who was, you know, essentially
 8 drawing their attention to the fact that the same
 9 consultant I now had concerns about again. But without
 10 formulating it all, without all of the information 11:25
 11 around it. Because, you know, at that point we weren't
 12 completely clear where this was taking us, we were
 13 still undertaking an excavation to try and understand,
 14 as I say, the breadth and depth of what was actually
 15 going on. So I hadn't anything fully formed at that 11:25
 16 point in time, but I did have a sense that they needed
 17 to know, because they had been - first of all they
 18 should know and, secondly, they would had been involved
 19 before, I would have assumed.

20 64 Q. Yes. As I say, I wish to come at this issue in light 11:25
 21 of Mrs. Mullan's evidence and about Board cultures in
 22 general from a slightly different direction later, but
 23 for now, thank you for that.

24 A. Mmm.

25 65 Q. Can I ask you to look at WIT-45070, and at 48A, again 11:26
 26 you're looking at concerns in relation to Mr. O'Brien.
 27 Just scrolling down, you say - just that paragraph
 28 beginning "On my arrival":
 29

1 "On my arrival I was aware that for patients about whom
2 there were concerns these could be placed in hot
3 clinics, that is same or next day clinics Monday to
4 Friday. Consultants had the opportunity to use these
5 hot clinics on their weeks as urologist of the week to 11:26
6 review any patient about whom there were imminent
7 concerns."

8
9 And you go on to say - just scrolling over the page.
10 Yes. Sorry, at the bottom of the page: "It would 11:27
11 appear..." you say:

12
13 "...that despite having long waiting lists with the
14 propensity then for patients to deteriorate, these hot
15 clinics were not used as intensively by Mr. O'Brien as 11:27
16 they were by other consultants."

17
18 Can I ask you just about that and the factual basis or
19 the information basis for saying that? First of all,
20 who led you to form this impression, if it was an 11:27
21 impression, that Mr. O'Brien wasn't using the hot
22 clinics as intensively as others?

23 A. Could I suggest I come back to you with the answers for
24 this, because this data is not at the front of my head?
25 So I will revise that and come back to you in the next 11:28
26 couple of days, if that's okay?

27 66 Q. Right. Certainly, by all means explore that. I think
28 that's fair if you don't have the answer. I'm
29 conscious that this witness statement was filed almost

1 18 months ago.

2 A. Mm-hmm.

3 67 Q. Just before we perhaps take a short break, could I
4 bring you to the conversations that took place in
5 relation to Mr. O'Brien's retirement. If we bring up 11:28
6 to the screen, please, AOB-56498. And just while
7 that's coming up - yeah, just scroll down to - thank
8 you. There was, I suppose, a bit of a lead in to a
9 conversation that took place on 8th June 2020 between
10 Mr. Haynes and Mr. O'Brien. Mr. O'Brien had indicated 11:29
11 in March 2020 his intention to retire from full-time
12 employment with the Trust, but he had had conversations
13 with colleagues about his wish to return on a part-time
14 basis in August 2020, and he certainly had formed the
15 understanding that there would be no barrier to that, 11:30
16 and he was getting, if I can summarise his evidence as
17 getting, I suppose, receptive or positive noises back
18 in terms of whether that would be possible. This
19 conversation with Mr. Haynes, again I paraphrase, takes
20 the rug from underneath Mr. O'Brien's feet. He's told 11:30
21 on 8th June, you'll not be coming back as a part-time
22 worker following your retirement, and Mr. Haynes at
23 item C, or number C on the left-hand margin, explains:

24
25 "I've taken that forward with a number of conversations 11:31
26 within the Trust, with HR, and at Medical Director
27 level. Okay. Unfortunately, the practice of the Trust
28 would be that they don't re-engage people while there's
29 ongoing HR processes."

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In terms of the discussions at Medical Director level around this subject with Mr. Haynes, can you recall participating in such discussions?

A. Yes. 11:31

68 Q. And was it explained to you that Mr. O'Brien had this intention or at least this wish to return following retirement on a part-time basis?

A. Yes, it was suggested to me I think both by Mark Haynes and I think at a stage Martina Corrigan, that 11:32

Mr. O'Brien had suggested that he would like to return post retirement. And my response was clear throughout, which was, this is a doctor who had been through a Maintaining High Professional Standards Investigation, who had not been able to comply, and by that stage, you 11:32

know, what we realised was on a couple of occasions with, you know, the recommendations that were being made, that it was, you know, he was difficult to manage as a result of all of that, and in addition to that I had concerns about the fact that he hadn't been 11:32

complying with appraisal and job planning throughout, and that I also, I remember also speaking to Melanie McClements about this as well, to explain to her that if - the difficulty in this process was going to be that if he were offered a post that I couldn't 11:33

authentically stand over him being there as responsible officer, because I have a - I had a responsibility, obviously professionally, to sit between the doctor and the GMC to say that they were a person of good standing

1 and someone that we could rely on going into the
2 future, if I decided to go forward with that, and what
3 I was explaining at that time was that it would be
4 difficult for me to be his responsible officer, given
5 all that I knew about his past and the concerns I had 11:33
6 about the present.

7 69 Q. You had of course by this time referred him to the
8 Medical Council?

9 A. Yes. Yes. Yep. Could I just ask? This conversation
10 looks like it was recorded? 11:33

11 70 Q. Yes, indeed.

12 A. Was Mr. Haynes aware it was recorded?

13 71 Q. We've dealt with that with him.

14 A. Okay.

15 72 Q. It would appear that he wasn't. 11:34

16 A. Okay.

17 73 Q. In terms of this phrase that "the practice of the Trust
18 is not to re-engage people while there's ongoing HR
19 processes", when Mr. Haynes was asked about that I
20 think it's fair to say that he acknowledged that this 11:34
21 was really a term of convenience, the reality being
22 that, if you like, the difficulties being caused by
23 Mr. O'Brien in terms of the management of him and how
24 he was perceived as a colleague and a team player, and
25 I paraphrase, were really at the root of the decision 11:34
26 not to have him back, as opposed to any formal or
27 informal policy on the part of the Trust not to have
28 people back when there's ongoing HR processes?

29 A. Well, I think, as you've reminded me, I had referred

1 this doctor to the GMC at that point in time and, you
 2 know, we had concerns about his behaviour and in
 3 relation to how he managed patients. So it would have
 4 been highly unusual in that circumstance for me, as
 5 Medical Director, to agree to take a doctor who was in 11:35
 6 this position back to work once they had retired.

7 74 Q. And is it fair to say that that's the sense of it that
 8 you communicated to Mr. Haynes?

9 A. Yes, I think maybe not just as precisely as that. And
 10 as you said, I think Mr. Haynes, you've just referred 11:35
 11 to the fact that this probably was an economic use of
 12 language in relation to how all of that conversation
 13 was described, but essentially we are talking about
 14 similar processes here, but the root of it all was
 15 concerns about, you know, what I knew about this 11:36
 16 consultant's previous and current practices and whether
 17 or not I would be prepared to continue as responsible
 18 officer knowing all of that, and I felt authentically,
 19 I couldn't.

20 75 Q. Ultimately whose decision was it to take? Who owned 11:36
 21 the decision, in your view?

22 A. Well it would be very difficult for any permanent
 23 member of staff to work in a Trust if they hadn't a
 24 responsible officer within that Trust, or as an
 25 alternative they weren't being managed by a responsible 11:36
 26 officer from another Trust or through the GMC. So what
 27 I offered to Melanie at that point was my view that I
 28 couldn't remain as responsible officer, given the
 29 concerns that I had and, again, that would have

1 impacted then on the decision whether to continue
2 employment or not. But certainly in my opinion we
3 couldn't continue to employ this man given the
4 concerns.

5 76 Q. Okay. Thank you for that. Chair, would it be 11:37
6 convenient to take a break?

7 CHAIR: Yes. we'll take a 15-minute break and come
8 back again at 11:55, ladies and gentlemen.

9
10 THE HEARING ADJOURNED FOR A SHORT PERIOD AND RESUMED AS 11:37
11 FOLLOWS

12
13 CHAIR: Thank you everyone. Hopefully the injury has
14 been resolved? There's a few doctors about the place
15 just, you know, if needed! Mr. Wolfe. 11:57

16 MR. WOLFE: Thank you. Just a few minutes before the
17 break I was asking you about the subject of hot
18 clinics, and you had made the point in your statement
19 that despite having long waiting lists it appeared to
20 you that Mr. O'Brien did not use such hot clinics or 11:58
21 the opportunity of such hot clinics as extensively as
22 his colleagues, and you invited me to come back to that
23 issue in due course.

24 A. Mmm.

25 77 Q. If I could show you WIT-48519? And it's an email to 11:58
26 you, I think probably shortly before you finalised the
27 statement containing the reference to "hot clinics",
28 and you're being told by Martina Corrigan that here is
29 the breakdown of patients to hot clinics during that

1 five-year period. Just scroll down so we can see it
 2 all. So your point was Mr. O'Brien didn't appear to
 3 you to be using the hot clinic opportunity as
 4 extensively as others. It would appear, just confirm
 5 for me, that it's on the basis of this information that 11:59
 6 you made that point?

7 A. Yes.

8 78 Q. And in what sense was that significant, in your view?

9 A. It gave me -- well, I think that those hot clinics, as
 10 I understand it, are where consultants, if they have 11:59
 11 particular concerns about patients, will bring them up
 12 for review, you know, to monitor their progress, all of
 13 that, and they use the opportunity of being urologist
 14 of the week to actually, you know, get these reviews
 15 done in the context of the rest of the busyness of 12:00
 16 consultant of the week. It struck me that - I suppose
 17 what my concern was that there was less, and given how
 18 busy Mr. O'Brien, you know, was constantly concerned
 19 about being, it gave me an indication that actually in
 20 terms of the volumes of patients that he was seeing 12:00
 21 through that, it wasn't as high as others, and if there
 22 were concerns about patients and, you know, if patients
 23 had been phoning in, if that was being, you know,
 24 communicated into all of this and those patients
 25 actually being reviewed. So it was an observation 12:00
 26 because, you know, as you can see there, it's as much
 27 as half, and at times, you know, almost a third of what
 28 some of the others were seeing, and it seemed to me he
 29 was an outlier in relation to that and just, I suppose

1 it raised concerns to me about concerns about patients
2 essentially.

3 79 Q. I'm conscious that you put this information, or the
4 conclusions you formed from this information into your
5 statement in 2022. Was it an issue that came to your 12:01
6 attention during the time that he was employed within
7 the Trust?

8 A. Would you mind scrolling, because I would have first
9 known about this whenever Martina sent me the email?
10 So the 26th June. 12:01

11 80 Q. So, yeah, she's writing to you in 2022.

12 A. Yes, yep.

13 81 Q. And we can go back to your statement where this issue
14 arises. It's paragraph 48A at WIT-45070, and it's an
15 answer to question 48 which in terms: 12:02

16
17 "What were the concerns raised with you? Who raised
18 them? And what, if any, actions did you or others
19 take?"

20
21 Et cetera. And if we scroll down the answer comes -
22 there's various aspects to the answer, but from halfway
23 down the page you're dealing with the hot clinics. On
24 your arrival you're aware that this hot clinic option
25 was available to consultants, and you then say in the 12:02
26 last paragraph - I think I used the word "extensively"
27 earlier, but it is "intensively":

28
29 "The opportunity to use the hot clinics was not used as

1 intensively by Mr. O'Brien as they were by other
2 consultants."

3
4 So my question to you is: was this a real-time concern
5 for you, or was it only a concern or an issue drawn to 12:03
6 your attention at the time of filing your statement?

7 A. I think the first I would have been aware of that so
8 explicitly was when Martina sent me that email in 2022.

9 82 Q. So it wasn't something which was the subject of query
10 or investigation by you during the course Mr. O'Brien's 12:03
11 employment?

12 A. No. No.

13 83 Q. Martina Corrigan, for example, in pointing the
14 information out to you, would appear to have been aware
15 that this was an indicator of Mr. O'Brien not using 12:03
16 opportunities that were available to him to deal with
17 patients which might have caused concern?

18 A. I think this came about in the context of - Mr. O'Brien
19 raised concerns constantly about the busyness of the
20 urologist of the week experience and, you know, on the 12:04
21 back of the history of all of that where, you know
22 there were delays in getting triage finalised, because
23 as I understand it, and I am not a urologist so forgive
24 me if I don't get this precisely, but as I understand
25 it, when the urologists take on urologist of the week 12:04
26 they take all - they don't do outpatient or surgery
27 unless it's emergency surgery, and they basically take
28 on the referrals, they see any patients that they're
29 concerned about in relation to hot clinics and they do

1 the triage. So they'll take the ED referrals, they'll
2 take any urgent GP referrals, they'll do hot clinics in
3 relation to all of those and any other patients that
4 they're worried about, and they'll also do the triage
5 then in relation to the work that's coming in, and I 12:05
6 think they also have an in-patient ward presence. So I
7 mean it's a busy intense week. And Mr. O'Brien, as I
8 understand it, constantly stated that he couldn't get
9 to completing triage as quickly as the others could
10 because he was so busy during the urology of the week 12:05
11 discussions, and I think then eventually when we
12 drilled down into that to try and understand what that
13 was about I was surprised that his activity during
14 these hot clinics seemed to be so different from
15 everyone else's, given that the volume of activity that 12:05
16 would have been coming from other sources such as GPs,
17 ED, you know, ward referrals, whatever, wouldn't have
18 been that much different for the rest, but yet there
19 was still delays in terms of him getting this paperwork
20 done. 12:05

21 84 Q. And what conclusion do you, did you form in light of
22 that analysis or that process of thinking, in terms of
23 Mr. O'Brien's activity?

24 A. Well, I think it was an observation on my part, right,
25 and I think that it struck me that, you know, 12:06
26 throughout all of the concerns that Mr. O'Brien raised,
27 you know whether directly with managers or when he made
28 reference to it in his appraisal, it was in relation to
29 how busy he was and about the demands of all the

1 waiting times, but actually whenever we have drilled
2 down into this and looked at it, there isn't an
3 evidence base to suggest that Mr. O'Brien was a lot
4 busier than his colleagues.

5 85 Q. Thank you. Could we turn to issues arising out of job 12:06
6 planning and whether Mr. O'Brien was provided with
7 assistance by way of extra administration time, for
8 example, to enable him to cope with what he has
9 described obviously as a very busy clinical practice.
10 If we go to your statement WIT-45086, and at paragraph 12:07
11 53.3, just at the top of the page:

12
13 "It was reported to me in October 2019 that the first
14 sign-off of Mr. O'Brien's job plan was not completed in
15 a timely fashion, as Mr. O'Brien would not agree what 12:07
16 was being offered, despite the fact that he was given
17 the administration time on a Tuesday morning that he
18 requested."

19
20 I just want to put that piece to you and let me join it 12:08
21 with another piece in your statement further on.
22 WIT-45158 at 62.4, and you say here:

23
24 "I'm led to believe that in the course of the
25 development of the 2017 Action Plan, Mr. O'Brien was 12:08
26 given a Tuesday morning, four hours, as extra SPA
27 [Supporting Programmed Activity], to allow him to
28 complete his dictation from the Enniskillen Clinic on a
29 Monday."

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So taking those two pieces of evidence together, it seems to be your impression that through the job planning process, more was being offered to him by way of hours to complete his administration, and you say here's a concrete example of four hours extra SPA being granted to him in a particular context. Can you recall who reported these matters to you? 12:09

A. Oh, Martina Corrigan and I had this conversation because I think she had, you know, reviewed all of that along with - I'm not sure whether it was Mr. Haynes at that point in time but, no, it was Martina I had the conversation with, because she drew to my attention that in order to support this Enniskillen Clinic this extra time had been given. 12:09

86 Q. Yes. And it's that concept of extra or additionality that I want to briefly explore with you. So it appears to be your understanding that take, for example, the Tuesday following the Enniskillen Clinic, that he was being given something additional to that which was otherwise provided for in his job plan, is that your understanding? 12:10

A. I am not - well I'm not sure whether it was that it was in place of something else or whether it was additional, but it certainly was ascribed time that was purely to deal with administration and it was out of keeping with what the rest were receiving. So, normally when any of us would have done clinical work you would expect that you would see your patients and 12:10

1 get the dictation done by the end of the clinic or, you
 2 know, you would have other administrative time in the
 3 week that would have been, you know, recognised for
 4 supporting clinical activity to get that done. My
 5 sense with this was this was four hours in his week 12:11
 6 that was carved out to get this completed, and I think
 7 I was left with the impression it was above what he was
 8 getting previously, but it might well be that it
 9 displaced something that he was doing previously, and
 10 I'm sorry, I can't remember the detail of it. 12:11

11 87 Q. Yes. I think Mr. O'Brien would say that rather than it
 12 being extra or additional SPA, that in fact the hours
 13 made available for this administrative work was in fact
 14 designated as direct clinical care. In other words, as
 15 I understand it, not additional, but regarded as part 12:11
 16 and parcel of what was required for the clinical work?

17 A. So I think it's probably a moot point, although I do
 18 appreciate it's important, whether it's described as
 19 SPA or DCC, but certainly the important part of it was
 20 that it was time identified in his working week to get 12:12
 21 his administration done.

22 88 Q. So is it your understanding, just to be clear, because
 23 it may be of some significance, that there was -
 24 however it is described, that there was a dispensation
 25 or a flexibility arrived at to enable Mr. O'Brien to 12:12
 26 progress the dictation work in this instance, that
 27 wasn't otherwise available to someone else or hadn't
 28 historically been available to him?

29 A. Yes.

- 1 89 Q. Just going back to the paragraph we left at WIT-45085,
 2 at paragraph 53.3 - sorry, I'm just scrolling down.
 3 There we are. So in terms of what was reported to you
 4 October 2019, in addition to what I've just read out,
 5 it was described for you that he was spending long 12:13
 6 hours on the ward at times, that he was neither
 7 required nor expected to be there, and then was asking
 8 for additional payment in recognition for this. Again,
 9 in terms of the request for additional payment, who was
 10 telling you that? 12:14
- 11 A. I think there had been - and, again, I don't have the
 12 dates in front of me - but I think in a previous
 13 iteration of a job plan he had raised this as a concern
 14 and he had been job planned to try and offset some of
 15 this, but there - what was reported to me, I think 12:14
 16 again through the operational managers, was that on
 17 occasion he had said to them that he was doing this
 18 extra work and that he felt that that should be built
 19 in to his job plan for additional payment, even though
 20 the Trust wasn't requiring him do it. 12:14
- 21 90 Q. I think there's certainly plenty of evidence before the
 22 Inquiry of Mr. O'Brien working into the night, late
 23 into the night perhaps.
- 24 A. Mm-hmm.
- 25 91 Q. Being seen on the wards. Never leaving the hospital is 12:15
 26 perhaps exaggerated a little bit. But have you seen
 27 actual documentary evidence, for example, of requests
 28 for payment in those circumstances, or are you relying
 29 on what you were told?

1 A. I don't think I have seen - I could be wrong, but I
2 don't think I have seen a written request, but I can
3 certainly go back and check on that, but I think it was
4 communicated to me verbally.

5 92 Q. Thank you. Just staying with this paragraph, let me 12:15
6 see if I can spot it. You seem to suggest, and I'm not
7 quite sure if I can see the precise language, but was
8 it your impression that there was a pattern of
9 Mr. O'Brien agreeing to sign off job plans but then not
10 following through? Yes, there it is: 12:16
11
12 "By the time I arrived in 2018..."
13
14 - it's about 6 lines down:
15 12:16
16 "...there was a pattern of him agreeing to sign off job
17 plans and then not following through."
18
19 who created that impression for you?

20 A. well, again, I think certainly that was coming from the 12:16
21 operational managers in that, you know, there was - I
22 don't know how you would best describe it, but this
23 sense that "well, you know, we've been trying that for
24 a long time", you know, and again the example of the
25 Tuesday morning was used, you know, "has promised to do 12:17
26 it but actually then, you know, we never seem to get it
27 tied down", and there just seemed to be - I wouldn't
28 say it was hopeless or despairing, but there seemed to
29 be a sense of inevitability around it I think and, you

1 know, what struck me, and I've put it into the bottom
 2 of that, is then around the process for escalation. I
 3 felt because it wasn't clearly delineated in the
 4 Clinical Director and Associate Medical job
 5 descriptions at those times, then it wasn't escalated. 12:17
 6 Because in ordinary circumstances, if our governance
 7 processes had been tight, you know, once there's a
 8 failure for that to happen, then that should be
 9 escalated up through the system. So that's now in
 10 place, but it wasn't in place at that point in time. 12:17
 11 So that shouldn't have allowed - as a system, you know,
 12 we should have responded to that I think medically a
 13 bit more strongly than we did in the past.

14 93 Q. What more generally is the impact for the organisation
 15 of allowing delay and, as you suggest, some 12:18
 16 prevarication and excessive debate around the content
 17 of a job plan?

18 A. Well I think that, you know, the importance of the job
 19 plan is that it clearly delineates, it mostly focuses
 20 on activity rather than quality of care, right. So it 12:18
 21 should be about the activity that is expected from a
 22 doctor at any given time, the hours that are worked,
 23 the on-call, the responsibilities, all of that. And I
 24 think, you know, it was suggested to me that, you know,
 25 he was working to one interpretation of what was 12:18
 26 already on paper and other people were finding it
 27 difficult to get that contained in terms of having a
 28 very clear expectation of roles and responsibilities.
 29

1 So it should be - the job planning process is a
 2 partnership, you know, and as a consultant what you
 3 want to do is make sure that you're very clear about
 4 what your roles and responsibilities are, because from
 5 a medicolegal point of view that's important, from a 12:19
 6 clinical responsibility point of view it's really
 7 important, and the system and you should work in tandem
 8 to do that. But there just seemed to be an inertia
 9 around this in that it was suggested that he would say
 10 yes, then it wasn't followed through on. He would say 12:19
 11 yes again, and it wasn't followed through, and all of
 12 that just lingered on and on until we got to an end
 13 point with it.

14 94 Q. Mmm. Yes. Of course, and maybe it's unfair to deal
 15 specifically with the substance of Mr. O'Brien's 12:19
 16 disputes, but any doctor can take the view that "I'm
 17 not being - my activity is not being fairly reflected
 18 in the job plan", whereas I think what you are perhaps
 19 suggesting is that in Mr. O'Brien's case he was taking
 20 an unreasonable or at least an unconventional view of 12:20
 21 the responsibilities that he held and which he expected
 22 to be reflected in the job plan?

23 A. The job plan is a joint venture, it's between the Trust
 24 and the consultant to agree. So the Trust should come
 25 with the expectation of the work that is to be done, 12:20
 26 and then the consultant, you know, will negotiate
 27 within that in terms of what they feel is reasonable
 28 and fair and how much time they need for various things
 29 and, you know, that will get described then usually in

1 allocations of four hours in terms of roles and
 2 responsibilities. So both parties have a
 3 responsibility in all of that. And, again, you know,
 4 where you have - and this is the vast majority of
 5 doctors, you know, where a clinician is very engaged 12:21
 6 with their clinical work, is very clear about what
 7 their roles and responsibilities are, realises that,
 8 you know, this is a really important contractual area
 9 that needs to be tied down to enable them to do their
 10 job safely, so they know what the Trust expectation is 12:21
 11 of them, you know, that's something that normally I
 12 would see consultants/doctors stepping forward to say,
 13 you know, "I need to get this done."

14
 15 From the Trust's point of view, and from Mr. O'Brien's 12:21
 16 point of view, then in a very practical way it can
 17 affect the amount that you're paid, because you can be
 18 over or underpaid, you know, depending on what you're
 19 contractually required to do, and of course then that
 20 can create a whole tale in terms of, you know, catching 12:21
 21 up with that, which, you know, can add burden and
 22 stress to the individual and to the system.

23
 24 Also then when it comes to understanding roles and
 25 responsibilities in particular in relation to patient 12:22
 26 care, that it is really fundamental in terms of
 27 understanding what the consultant's activity should be
 28 based around.

29 95 Q. Yes. Later we'll go on to look at job plan, appraisal

1 and re-validation, and the steps which the Trust has
2 taken in more recent times to try and make improvements
3 in that area.

4
5 Just one final point before leaving this paragraph. 12:22
6 You say that eventually the 2019 job planning process
7 with Mr. O'Brien moved on into 2020, and he only signed
8 off on the job plan before he retired to allow his
9 pension to be finalised. Again, could you just account
10 for that impression? Is that something that was said 12:22
11 explicitly, "I'm only signing off on this for these
12 reasons", or is it something you infer or somebody else
13 has inferred from the circumstances?

14 A. It was never explicitly said, but it struck me at the
15 time that the job plans were signed off at that point 12:23
16 in time so that the - so it's simply a statement of
17 fact, they were signed off at that point in time and
18 that coincided with his pension being processed.

19 96 Q. Let me move on to what you describe as your first
20 awareness of issues around Mr. O'Brien. It's contained 12:23
21 in your statement, if we move a few pages on to
22 WIT-45091. And, just before - sorry, just after you
23 commenced in the Trust you attended a meeting along
24 with Dr. Khan, who was responsible officer at that
25 time. You attended a meeting with the General Medical 12:24
26 Council's Employment Liaison Adviser, Ms. Joanne
27 Donnelly, isn't that right?

28 A. That's correct.

29 97 Q. And I just want to ask you about an aspect of that.

1 You have written into this section of your statement -
2 this is paragraph 55.4, as we can see. Mr. Gibson also
3 attended the meeting. He was Deputy Director within
4 the Medical Director's office at that time?

5 A. Yes. So he is - he was and he is Assistant Director. 12:24

6 98 Q. Assistant Director?

7 A. Yeah. For Medical workforce.

8 99 Q. Yes. Yes. And you record within your statement some
9 of the background that Joanne Donnelly was told through
10 Mr. Gibson, and it's recorded - just where you see 12:25
11 January 2019, towards the bottom of the page:

12
13 "Mr. Gibson reported that the doctor still had local
14 restrictions on his practice, the 2017 Action Plan, and
15 these were being kept under review." 12:25

16
17 The suggestion that Mr. O'Brien was the subject of
18 local restrictions on his practice, what were those
19 local restrictions?

20 A. So I think "restrictions" is probably not the right 12:25
21 word now that I reflect on this. I think it was local
22 supervisions on his practice, because he was
23 undertaking all of his clinical duties at that point in
24 time and he should have been undertaking all of his
25 administrative duties, but in a much more controlled 12:26
26 way in that there was oversight of triage, private
27 patients, you know, the areas that we're familiar with
28 out of that action plan. So "restrictions" is not the
29 right word, I think it should have been local

1 supervisions on his practice.

2 100 Q. Yes.

3 A. Or enhanced supervisions on his practice.

4 101 Q. If we go to TRU-264716. This is an email from
 5 Ms. Donnelly on 9th January 2019. She had been
 6 promised at the meeting with yourselves, the meeting
 7 took place in I think it was 4th December 2018, that
 8 she would receive the outworking of the MHPS process,
 9 which had been earlier promised to her and hadn't
 10 materialised. So she receives the report and makes
 11 some observations on it, and she says, middle
 12 paragraph:

12:26

12:27

13

14 "On the basis of the information you have provided
 15 these concerns appear to me to meet the threshold for
 16 referral to the GMC."

12:27

17

18 And then at the end of that section she records:

19

20 "I acknowledge that the doctor's practise is currently
 21 restricted in the interests of patient safety and that
 22 the doctor is complying with a Local Action Plan."

12:27

23

24 So it would appear on the basis of that, that the GMC
 25 carried away from this meeting a belief that there were
 26 local restrictions in place in the interests of patient
 27 safety, albeit that the doctor separately was complying
 28 with the action plan. When you look at these various
 29 strands now, would you accept that the GMC should have

12:28

1 been more accurately informed about the situation?

2 A. I don't know what -- until I joined the Trust, and I
3 had never worked in the Trust before, in December 2018,
4 being present at the GMC meeting on 4th December and
5 then became aware of this doctor and then started to 12:29
6 review his notes throughout January/February, I wasn't
7 cognisant at all of any of the discussions that had
8 gone on between the Trust and the GMC at that date.
9 In, again, reviewing that, I think "restricted" is not
10 the right word, I think it should have been 12:29
11 communicated that this was a supervision of some
12 description, because as I understand it, you know,
13 supervision and restriction are two different aspects
14 in relation to medical practice. So the word is wrong,
15 and the GMC - and I'm not sure whether they were 12:29
16 mirroring what they heard from the Trust at a point in
17 time, or whether that was their belief, but I think
18 it's the wrong word on there.

19 102 Q. Certainly I don't think I need to take you to the other
20 documents, but certainly it is recorded that when 12:29
21 Mr. Gibson spoke to the meeting it's Ms. Donnelly's
22 record that he used the term "restrictions"?

23 A. Okay.

24 103 Q. Whether he did or not we'll have to go back in time and
25 be there, but that's certainly what she recorded, and 12:30
26 it finds it's way into the note. Nobody sees fit to go
27 back to her, and I'm conscious that you're just into
28 the job and trying to learn on your feet, but nobody
29 goes back to her and says "Actually, restrictions isn't

1 exactly what we're doing, it's more in the line of
 2 supervision", which is perhaps a significant
 3 shortcoming in terms the Trust's relationship with the
 4 GMC, particularly when she views the risks associated
 5 with the doctor so significantly, so significant that 12:30
 6 it, in her view, requires or suggests the need for
 7 referral?

8 A. Well I think she came to that decision after she and I
 9 obviously had had a conversation and I raised concerns
 10 about what I was starting to read in the midst of all 12:31
 11 of this.

12 104 Q. Sorry to cut across you, she forms that view on the
 13 basis of reading the MHPS report, as we can see from
 14 this email from her.

15 A. Mm-hmm. 12:31

16 105 Q. You're referral eventually comes through in April of
 17 2019, isn't that right?

18 A. That's right, yeah.

19 106 Q. Could I move from there, please, to your witness
 20 statement at WIT-45143, and at paragraph 58.10, if we 12:31
 21 just scroll down, you're reflecting on the action plan
 22 and Mr. O'Brien's deviation from it in 2019. You
 23 record that he was offered support in clearing the
 24 backlog, and it was understood that this had come about
 25 at a time he had been supporting his family due to 12:32
 26 illness in the family. Could you help us in terms of
 27 the help that was offered, can you particularise who
 28 was offering him and what he was offered in terms of
 29 clearing the backlog?

- 1 A. I can't remember the - so this is more than four years
 2 ago, I can't remember specifically what was stated at
 3 the time.
- 4 107 Q. Yes.
- 5 A. But I think in relation to how I became aware of the 12:33
 6 information, that came through Martina and Melanie
 7 McClements at that point in time. And as I, and as I
 8 say, I cannot remember the specifics of it, but
 9 certainly the sense I was left with was they recognised
 10 with him that, you know, he had had this [REDACTED] event 12:33
 11 that had interrupted all of those, and they spoke to
 12 him about what would be needed to help him get this
 13 cleared, but I couldn't tell you chapter and verse
 14 exactly what that entailed.
- 15 108 Q. Certainly there's a record of Mr. Haynes writing to you 12:33
 16 at that time and saying, "Listen" - he doesn't touch
 17 upon the [REDACTED], but he says, "Listen, we
 18 tend to be somewhat flexible around triage, so if it's
 19 a particularly busy week we allow perhaps another
 20 couple of days for the triage to be completed", so 12:34
 21 don't hold the clinician to, you know, Friday evening
 22 or whatever the cut-off date is. But the question I
 23 suppose is, you're unable to recall any specific offers
 24 of assistance to Mr. O'Brien around his triage at that
 25 time? 12:34
- 26 A. Yes, I don't know - I can't remember specifically what
 27 those would have been. But in relation to Mr. Haynes's
 28 email, again that I think was not specific to this
 29 episode in September. I think he was drawing my

1 attention to that generally to say, you know, "we're
2 not completely hard and fast in relation to this being
3 on this date, because we appreciate that all of this
4 clinical activity can impact", and I think was making
5 me aware that they give an extra 48 hours in terms of
6 getting this work done. 12:34

7 109 Q. Could I bring you to the issue of appraisals? We've
8 touched on it briefly earlier, and your sense that
9 there was often delay in association with the
10 completion of that exercise in the case of Mr. O'Brien. 12:35

11 A. Mm-hmm.

12 110 Q. If we go to your witness statement WIT - let me just -
13 no, it's a few pages back. WIT-45095, and at 55.9, you
14 record that:

15
16 "There was no clear evidence in the appraisals that his
17 appraiser had been made aware of any concerns."

18
19 That's an issue I'll come back to later when we look at
20 appraisal. This is the point I want to focus on. You 12:35
21 say?

22
23 "In addition to this, his 2017 appraisal had not been
24 completed."

25
26 And this is by 11th March 2019, as appears in the
27 question. So by that date his 2017 appraisal had not
28 been completed nor had his 2018 appraisal, for which a
29 360 degree feedback was required, and this is 12:36

1 significant because his revalidation date was due for
2 renewal on 4th April 2019. I just want to seek your
3 observations on whether or not that is factually
4 accurate.

5
6 If we look at TRU-294256, and Zoe Parks is writing to
7 Therese McKernan, post Mr. O'Brien's retirement, and
8 presumably information is being gathered perhaps for
9 Inquiry purposes or whatever. And she says:

10
11 "I have spoken to our appraisal..."

12
13 - this is the bottom of the page:

14
15 "...our appraisal revalidation lead who has confirmed
16 for me that Dr. O'Brien completed the following
17 appraisal s..."

18
19 And it seems that in terms of the 2017 appraisal, which
20 you were suggesting hadn't been completed by the
21 revalidation due date in 2019, it had been completed in
22 fact, according to this, in October 2018. I'm
23 conscious that you're maybe seeing this for the first
24 time, but that clearly appears to jar with what you're
25 saying in your statement?

26 A. would it be possible, would it be possible for you to
27 pull the appraisals up to have a look, or do you want
28 me to have a look at it and come back because...

29 111 Q. we'll come back to that.

1 A. Yeah. Okay. Yeah.

2 112 Q. So on the face of it this jars with what you've said in
3 your statement, but you'd like to check the appraisals
4 themselves to see when they were finally signed off?

5 A. Yes. Yes. 12:38

6 113 Q. Very well. And you appear to be correct about the 2018
7 appraisal. It didn't, according to this, come in until
8 October 2019?

9 A. Yes. Now, again I'm only thinking out loud, but if I -
10 there is something in my mind that the 2017 appraisal 12:39
11 wasn't complete in that actually all the information
12 wasn't there, rather than a signatory date, which is
13 what that tends to be, but I will go and check.

14 CHAIR: I think in fact, in fairness to you doctor, you
15 did say in that last paragraph that was read out, that 12:39
16 the 360 feedback had not been completed.

17 A. Yes. Yeah. Yeah, on the 2018. Yeah, I think that's
18 right. I'm not sure about the 2017.

19 114 Q. MR. WOLFE: I'm not quite sure. If we could just go
20 back, because I think there is - there's an issue just 12:39
21 to explore with the 360. If we go back to your
22 statement WIT-45095. So what you're saying about the
23 2018 appraisal, you're saying - you're saying his 2017
24 appraisal had not been completed nor had his 2018
25 appraisal. So the document that I just brought you to 12:40
26 would seem to suggest that's right, the 2018 appraisal
27 wasn't complete until late in 2019.

28
29 It would appear, if we can bring up on the screen

1 AOB-07937? This is a note from Dr. Scullion. He's now
2 Assistant Medical Director, is that correct?

3 A. He's Deputy Medical Director, yes.

4 115 Q. Deputy Medical Director, yes?

5 A. Yes. Yes.

12:41

6 116 Q. So he is dealing with appraisal issues and he's writing
7 to Mr. O'Brien just before this - actually on the date,
8 I think, of the revalidation becomes due, and he is
9 speaking to Mr. O'Brien about colleague feedback. Is
10 this the 360 degree process or is it something that
11 sits beside that?

12:41

12 A. It's part of it. So in addition to colleague feedback
13 there should also be patient feedback.

14 117 Q. I see. So it appears in any event that the colleague
15 feedback has been completed by that date. Of interest
16 perhaps in this email is Dr. Scullion's observations on
17 a respondent colleague who has scored Mr. O'Brien
18 negatively against patient confidentiality,
19 trustworthiness and ill-health, and what Dr. Scullion
20 says is:

12:42

21
22 "Since all your comments have been supportive and
23 commendable, I think this is a case of
24 misinterpretation of the question. I think it is
25 reasonable to ignore this outlier feedback. Otherwise
26 an excellent colleague feedback survey."

12:42

27
28 Just on that point, do you think that's appropriate to
29 take the view that the respondent to the survey didn't

1 know what they were answering and decide ultimately to
2 ignore the negative feedback?

3 A. The colleague feedback questionnaire as part of the 360
4 degree appraisal is an interesting concept, because
5 within the realms of all of this you produce a list of 12:43
6 colleagues that are then approached to give feedback.
7 So there's - my concern about it is that there is
8 already inherent bias because you get to chose. Right.
9 That's the first thing.

10 12:43

11 The second thing then is that in terms of the
12 completely disagree statements, usually where you would
13 expect to find that is in the patient feedback, because
14 it's not, these are not particularly sophisticated or
15 well constructed forms very often, but they are the 12:44
16 standard that's used, and sometimes what you'll find is
17 that, you know, if someone has read it really quickly
18 they'll put one thing when they mean another thing, and
19 you usually pick it up through the outliers and, you
20 know, we might make comment about that. 12:44

21

22 It will have depended - it may well be that that's what
23 has also contaminated the colleague feedback
24 questionnaire, and given that I mean he has said - it
25 doesn't give any indication there as to how many 12:44
26 colleagues fed back, or that because it's anonymised
27 whenever it comes back to the appraiser and the
28 appraisee, you've no idea what grades or where the
29 colleagues were actually chosen from. So, I think

1 usually, or what would happen now I think is that there
 2 would be some discussion about that particularly at the
 3 revalidation meeting in terms of whether or not that
 4 was a reasonable assumption, and the way revalidation
 5 meetings work now is that Divisional Medical Directors 12:45
 6 are all together, along with the Medical Directors and
 7 the support from the Medical Director's office and HR,
 8 to review all of that and understand actually in the
 9 context of not just a standalone questionnaire but in
 10 the context of all the information available, is that 12:45
 11 reasonable or should there be further exploration of
 12 that to understand.

13 118 Q. The earlier part of your answer, if I may say so, was
 14 to I suppose criticise the weaknesses or point to the
 15 weaknesses of the process, but I suppose the point I'm 12:45
 16 making to you is that, this kind of response may point
 17 to something that needs to be investigated, in other
 18 words you shouldn't just cast it to one side as
 19 Dr. Scullion appears to have done, without further
 20 analysis. His analysis seems to be limited to "well, 12:45
 21 your other colleagues say this, this person says that,
 22 therefore they must be wrong"?

23 A. And in fairness to Dr. Scullion, this was on the back
 24 of having being his appraiser and being presented with
 25 all of the information that didn't include anything to 12:46
 26 do with Maintaining High Professional Standards. So
 27 already, you know, he had been given a set of
 28 information in the context of this doctor that
 29 suggested that there weren't any concerns. So, you

1 know, that - if you were thinking about cognitive bias,
 2 you know, you can see where all of that would come
 3 together easily to assume actually this is just an
 4 average score rather than actually something that
 5 should be a smoke signal.

12:46

6 119 Q. Yes. And I'm sure when we go on to look at it you'll
 7 be explaining to us that the material, such as SAIs,
 8 MHPS, that kind of material, will now go into the
 9 process?

10 A. Yes.

12:46

11 120 Q. And what Dr. Scullion had to put up with, if you like,
 12 or had to address, is unrecognisable by today's
 13 standards, is that fair?

14 A. I think that's fair. And I think very helpfully I
 15 think again when you look at the recommendations coming
 16 out of the Neurology Inquiry, I think it underpins the
 17 position that we've taken in relation to this in terms
 18 of providing very comprehensive information whenever we
 19 come to describe a doctor's practice.

12:47

20 121 Q. Just one further issue. If we go to TRU-266 - sorry,
 21 yes, TRU-266586. And a GMC officer is writing to you
 22 on 12th August 2020, and if we just go - he's seeking
 23 from you further information in respect of

12:47

24 Mr. O'Brien's employment and, indeed, some issues
 25 raised with the GMC, it appears by Mr. O'Brien in his
 26 dealings with them, and could I ask you just to go down
 27 three pages to 589 in the sequence. Thank you. He,
 28 in the left-hand margin is saying, he's dealing with a
 29 meeting which was lined up to take place in December

12:48

1 2018 between management and the consultants in the
2 Urology Department, and he's asking that you provide an
3 account of the circumstances of the cancellation of
4 both the September meeting and the December meeting.
5 And as regards the December meeting, it's recorded - I 12:50
6 think this is your answer, or The Trust's answer:

7
8 "The meeting schedule for December 2018 did not
9 progress as three of the six consultant urology staff
10 were unable to attend." 12:50

11
12 Just scroll down. Yes. You sign off on that letter.
13 This is an event, this December meeting, that didn't
14 ultimately progress with management attendance. This
15 was an event where the five substantive urology 12:50
16 consultants were available and did attend, according to
17 the evidence before the Inquiry, whereas you've said
18 the meeting scheduled for December did not progress
19 because three out of the six consultant urology staff
20 were unable to attend. Can you help us in terms of how 12:51
21 you formed the view that three of them were unable to
22 attend?

23 A. Would you mind scrolling back to the top, please?

24 122 Q. Sure. Of this?

25 A. Yes. 12:51

26 123 Q. The top of the letter?

27 A. The top of the letter, yes.

28 124 Q. Yes. So it starts at 586. So you're writing to Chris
29 Brammall.

1 A. Yes.

2 125 Q. And you're answering an email of the 30th July, and
3 just in terms of how the letter is constructed. You're
4 putting in the left-hand margin each of the queries
5 raised by Mr. Brammall and then providing your answer 12:52
6 on behalf of the Trust in the right-hand column?

7 A. Yeah. I think to set - the reason I'm asking just to
8 see the date again was to set this in context. So I
9 would presume I responded to this in early August 2020,
10 which would have been nearly two years after that 12:52
11 event, which I wouldn't have been aware of I think
12 until I was asked for information from Chris Brammall
13 to respond, because I was only just into the Trust and
14 the information that I would have been relying on would
15 have come from other people. And, again, I am not sure 12:52
16 where that would have come from, but it presumably came
17 from my correspondences with people within the urology
18 service to ascertain whether or not the meeting
19 happened and what it was supposed to be, who was
20 supposed to be there. But I think until Chris raised 12:53
21 this with me, I wouldn't even have been aware of the
22 existence of that meeting.

23 126 Q. Yes. And just to be clear, the gathering of the
24 consultants was the subject of recording on
25 Mr. O'Brien's part. 12:53

26 A. So Mr. O'Brien recorded that meeting?

27 127 Q. Yes. And we can - just so that the Inquiry can see it,
28 if we go to AOB-56478, and that's the title page, if
29 you like, it's suggesting that Mr. O'Brien was in

1 attendance with Mr. Glackin, Young, Haynes, O'Donoghue,
 2 and with Mrs. Corrigan available, and the date is
 3 3rd December 2018, and if one works through the
 4 transcript itself, it certainly suggests that each of
 5 the people named on the title page were in attendance. 12:54
 6 The answer you gave on behalf of the Trust back to the
 7 GMC was three out of the six urology practitioners
 8 wasn't available. I think Mr. O'Brien's evidence would
 9 be that the sixth person, that is Mr. Tyson, was a
 10 locum at that point and hadn't been invited to the 12:54
 11 meeting, but certainly the substantives were available,
 12 and that was not accurately communicated to the GMC.
 13 And if this transcript, or this recording is right,
 14 that would appear to be the case. I'm conscious that
 15 you weren't employed in the Trust until around about 12:55
 16 that date and so, in real-time you wouldn't have known
 17 perhaps about the meeting, but who would have been the
 18 person giving you the information so that you could go
 19 back to the GMC some two years later?

20 A. It would be, it would be somebody within Urology. So I 12:55
 21 will track back and find out. But, again, I can't
 22 remember the specifics of it.

23 128 Q. Yes.

24 A. And can I ask, is there a sense that it makes material
 25 difference whether there were five consultants there or 12:55
 26 three?

27 129 Q. Well, it's - the suggestion is that that is the reason
 28 why the meeting didn't take place.

29 A. Right. Okay.

1 130 Q. That's what the Trust is communicating to the GMC as
2 being the reason why it didn't take place?

3 A. Okay.

4 131 Q. And if that isn't the reason why it didn't take place,
5 then the Trust - the Inquiry might think the Trust 12:56
6 should explain what was the real reason for it not
7 taking place?

8 A. Yeah. And I think what I also need to check is are we
9 talking about the same meeting?

10 132 Q. Well... 12:56

11 A. Yeah.

12 133 Q. You can come back with whatever explanation you think
13 is appropriate?

14 A. Yeah. Okay. Thank you.

15 134 Q. It's 1:00 o'clock, Chair. I think... 12:56

16 CHAIR: I think it's certainly lunchtime. We'll come
17 back at 2:00 o'clock, ladies and gentlemen.

18

19 LUNCH ADJOURNMENT

20

21

22

23

24

25

26

27

28

29

1 THE HEARING ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

2
3 CHAIR: Good afternoon everyone.

4 MR. WOLFE: Good afternoon, Dr. O'Kane. So we now move
5 into the, if you like, the second area or the second 14:01
6 section of your evidence and, as I indicated this
7 morning, this allows the Inquiry to, in essence, have a
8 conversation with you through my questions about the
9 opportunities that the Trust has engaged in to improve,
10 reform and develop in light of the shortcomings in 14:01
11 governance and related issues that have been, I
12 suppose, unveiled or discovered as a result of
13 primarily the events of the summer of 2020 and what
14 followed. It's also an opportunity for you to inform
15 the Inquiry of any residual concerns, disappointments, 14:02
16 challenges, that the Trust hasn't been able to address
17 to date.

18
19 I think it's useful before looking into, if you like,
20 the reform or improvement work, to take a moment for 14:02
21 you to explain to the Inquiry what, on reflection, you
22 would define or diagnose as being the problems that the
23 Trust has had to address.

24
25 On the last occasion when you were with us you, I 14:03
26 suppose, referred to almost two stages of insight.
27 When you came into the role of Medical Director you,
28 and you might comment on this, you very quickly
29 realised that clinical and social care governance was

1 weak and you commenced a review through Mrs. Champion,
2 isn't that correct?

3 A. That's correct, yes.

4 135 Q. And that was in large part looking at the governance
5 structures...

14:04

6 A. Yes.

7 136 Q. Within the Trust, and she provided a series of
8 recommendations, some of which were grappled with and
9 developed immediately and some were put on the
10 backburner for reasons that the Inquiry is familiar
11 with. Maybe we'll come back to that in a moment.

14:04

12
13 The second stage of knowledge for you, as you explained
14 on the last occasion, arose out of the events of June
15 2020, and particularly in relation to Mr. O'Brien and
16 what that revealed. Is that a fair way to put it, that
17 there were these, if you like, two different avenues or
18 two different stages to an awareness that things were
19 not all that they should be?

14:04

20 A. I think that's a good summation, yes.

14:05

21 137 Q. And on the issue of Mr. O'Brien and all that came with
22 that, I think you were asked to reflect on the last
23 occasion on the weaknesses within the Trust which
24 caused or contributed to a situation where shortcomings
25 in his practice, which from the Trust's perspective
26 placed patients at risk, you were asked to reflect on
27 what caused or contributed to that, and I suppose the
28 headline from your answer was that the Trust and those
29 who were charged with responsibilities in the

14:05

1 governance area were unable to join the dots, and they
2 were unable to join the dots and therefore unable to
3 see what was, I suppose, hidden in plain sight, and
4 that led to a situation where you and others, perhaps
5 not deliberately as you suggested, were given false 14:06
6 assurance. Is that again a fair reflection of how you
7 see it?

8 A. Yes. Yep.

9 138 Q. So, you have problems with the governance structures
10 identified by you quite quickly, and then a whole raft 14:06
11 of other areas emerging from what you saw in June 2020.
12 Would you like to give the, I suppose, the Inquiry a
13 summation of looking back at it from today's
14 standpoint, bearing in mind all that you've heard in a
15 yet uncompleted inquiry. What's your key reflections 14:07
16 on the state of governance within the Trust, pick any
17 date, 2019/2020, which you have had to go about trying
18 to fix, what were the key problems?

19 A. Em, so I think in terms of my reflection of the stages
20 of all of these, I think that it is, you know, for any 14:07
21 of us who have been involved in this throughout that
22 period of time, I think it would be fair to say that it
23 is a source of regret to us that we didn't know in 2019
24 what we learned in June 2020. Okay. And hence the
25 reason that, as you say, it has been a two-stage 14:08
26 approach.

27
28 So in relation to governance, or in relation to the
29 state of play and what I see as the fundamental

1 challenges, it probably falls within the four areas of
2 culture, governance - and within that I mean clinical
3 and social care governance and corporate governance -
4 how we've used data, and then the quality and safety
5 within the organisation. And as I've mentioned in some 14:09
6 of the previous submissions, we have brought on board
7 an External Reference Group to help us with the
8 thinking in relation to all of that, and I think, you
9 know, in terms of those four main domains, then within
10 all of that, if we apply, you know, a model for 14:09
11 improvement such as, you know, the Vincent model, which
12 looks at, you know, were we safe yesterday, are we safe
13 today, will we be safe tomorrow, are our systems and
14 processes sensitive enough to operations so that we
15 understand that if things are going askew that we have 14:09
16 the governance arrangements in there to pick that up at
17 an early stage? And also the fifth leg of all of that,
18 which is, then how do we drive improvement based on all
19 of that? If I use that as the framework for thinking
20 of this, this is my easiest way into it. 14:10

21
22 So in relation to where we were in relation to
23 corporate governance. As you have pointed out, the
24 June Champion review was undertaken across the summer
25 of 2019 and, again, that was in response to my concerns 14:10
26 about the lack of framework and structure around some
27 of the patient safety and quality issues that we were
28 dealing with. As you know, there were 48
29 recommendations in that report. We have filled out on

1 the vast majority of them. The first 13 were to do
2 with corporate governance at a point in time and,
3 again, I think in fairness, Eileen, as Chair of the
4 Trust, has really grasped those 13 now, but there was a
5 period of time when that took a bit of debate for us to 14:10
6 try and understand, and I think, you know, fair to say
7 before Eileen arrived a realisation and acceptance that
8 actually the corporate governance across the
9 organisation needed to be strengthened, along with all
10 of the other governance aspects that were there. 14:11

11
12 So I think that gave me a framework then in terms of
13 improvement in relation to the overall corporate
14 governance of the organisation and has, you know, been
15 helpful to me in developing then the operational 14:11
16 governance within the Trust. So we have concentrated
17 on completely reforming the way we undertake corporate
18 governance and, again, that has taken a lot of
19 engagement, reflection, discussion, and we now have a
20 revised corporate governance structure in place that 14:11
21 brings patient safety and the quality of care very much
22 into the minds of staff within the organisation, and
23 feeds into the Governance Committee and sits alongside
24 the Risk and Assurance Committee - or, sorry, the Risk
25 Assurance and Audit Committee - that basically then 14:12
26 quality assures some of that work that comes in. And
27 then the other committees that are developed, the other
28 five committees that are alongside that then are to
29 support the overall approach to corporate governance.

1 And I think the reflections that I'm getting back from
2 the people that are involved in that now, is that we
3 certainly have a bit of refinement to do in terms of
4 how we report data and use data, but I think we feel
5 that we have a stronger grip on the organisation in 14:12
6 terms of understanding how all of the information flows
7 throughout the organisation and we make decisions and
8 drive improvement based on patient safety and quality.
9

10 At the operational governance level then, as part of 14:12
11 the reaction to what went on before and a realisation
12 that the Acute Directorate was too big to function
13 properly, when I became Chief Executive I split the
14 Directorate into Directorate for Surgery and Cancer
15 Services, and a Directorate for Medicine and 14:13
16 Unscheduled Care. And, again, those two directorates
17 in particular are more immature than the other
18 directorates in the Trust because we've had to develop
19 more staff to actually support some of the functioning
20 in there to make sure that we capture, you know, 14:13
21 patient safety and quality issues through the
22 governance system as robustly as possible. Right.
23

24 So, what we have done is to try and support all of
25 that, and this was introduced when I was Medical 14:13
26 Director, have a weekly governance meeting. So it's a
27 live governance feed, half eight to half nine every
28 Thursday morning, when, under all of the headings that
29 are to do with patient safety and quality, there's a

1 report done through to the Executive Directors in the
2 Trust other than me. So it comes to the Director of
3 Medicine, Nursing, Social Work, but not the Finance
4 Director either, and all of that is run through and
5 then that is escalated on a weekly basis to the Senior 14:14
6 Leadership Team. We challenge the information that
7 comes in there, and this is reported every week, and
8 then pursue, you know, the agenda around improvement in
9 relation to that.

10
11 We've now been doing that long enough I think that we
12 have built up an awareness of some of the patterns.
13 We've certainly driven improvement in some of the areas
14 such as how we report out on incident reports. So
15 Datix, for example, and the IR1 reporting system. We 14:14
16 introduced additional software in May 2022 that has
17 really bolstered that in terms of the usefulness of it.
18 So I think that has given the Clinical and Social Care
19 Governance teams, along with the operational teams,
20 more information in terms of how we triangulate data. 14:14

21
22 So, for example, at the beginning when I went along in
23 January 2019 to look for the supporting evidence
24 around, you know, where is the heat in the system in
25 relation to quality and safety incidents? It was he 14:15
26 really difficult to pick it up, because the information
27 wasn't speaking to itself internally. We have improved
28 on that quite a bit in that there's a number of feeds
29 now that go into Datix, including the reporting through

1 on Serious Adverse Incidents and the management of the
2 action points out of that. But there's still a way to
3 go in terms of really bolstering that. And, again,
4 there's a direct feed, you know, comes into the
5 governance feed, you know, a Thursday morning meeting 14:15
6 in relation to that. Alongside other areas such as,
7 you know, reports out in relation to, as I say, Datix,
8 Serious Adverse Incidents, any workforce pressures that
9 are in there in terms of us being concerned about the
10 impact of workforce shortages in certain areas, 14:15
11 standards and guidelines come in there, so that we make
12 sure everybody in the organisation, you know, has
13 access to information in relation to what the latest
14 standards and guidelines are, you know, any feed that
15 comes from RQIA as the Regulator, any college reports 14:16
16 that are worthy of mention that come up through the
17 various directorates, and so it goes on and on. It's a
18 very comprehensive report. Plus, you know, a readout
19 on any of the delays in the system, such as we're about
20 to introduce the Ombudsman delays in respect of 14:16
21 complaints, but we have readouts in terms of, you know,
22 the timeframes around responding to complaints, Serious
23 Adverse Incidents, those things. So it is basically
24 live and in front of us every week and it gets talked
25 about frequently. 14:16

26
27 Now, I think in terms of galvanising what has come into
28 that, and now that we have got the Datix system better
29 embedded, I think our next phase then we have been

1 approaching learning I think probably through different
2 systems and processes, but not - we don't have an
3 overarching approach to learning and embedding some of
4 this in the system. So the discussions I've been
5 having with the governance team and the Medical 14:17
6 Director have now been around how do we bring that into
7 the body of the organisation?

8
9 So one of the other things that has happened over the
10 last 18 months or so since I was appointed Chief 14:17
11 Executive is that I have replaced a lot of the staff
12 who have retired or left to go to other places, by a
13 new team of Directors. So we have just finished the
14 last replacement of an Executive Director. And in
15 addition to that, in order to make sure that we pursue 14:17
16 the agenda of embedding improvement in the
17 organisation, I have appointed for the next two years
18 in the first instance a Director of Transformation and
19 Improvement, who will take forward the outworkings of
20 what we've learned, again under those domains that I 14:18
21 mentioned earlier in relation to this Public Inquiry,
22 but also to look at what is coming out of the Neurology
23 Public Inquiry, potentially Muckamore Abbey, you know,
24 any other learning that's there. Plus dealing with
25 some of the issues within the Trust in terms of how we 14:18
26 address specific areas in terms of concerns in relation
27 to improvements, such as overcrowding, and all of the
28 ED issues that you would hear about. So that's now in
29 place.

1
2 And now that we are moving out of the phase of the
3 External Reference Group that has supported us in terms
4 of thinking about how we take forward on those four
5 domains, our last meeting with the External Reference 14:18
6 Group is this Friday. Once that's closed off then we
7 will be moving to the position of having essentially
8 our own Internal Reference Group, which is essentially
9 the oversight through the Director of Transformation
10 and Improvement to really drive and quality assure then 14:19
11 the impact of some of the changes that we're making
12 across the organisation. So that is kind of the grand
13 plan, if you like, in terms of how that comes together.

14 139 Q. Yes. Okay. Well thank you for that overview. I'll
15 pick up on some of the aspects of that in more detail 14:19
16 as we move on.

17
18 But what I want to get clear from the outset, before we
19 explore some of the improvements is, can you help us
20 from your perspective to understand how below the 14:19
21 acceptable standard was this Trust before this
22 improvement work commenced and, secondly, and related
23 to that, how could you have been standing in Craigavon
24 Hospital - well not just you personally, but I mean you
25 as a Senior Management Team, be standing in Craigavon 14:20
26 Hospital in the early summer of 2020 thinking
27 everything is working well, or working reasonably, and
28 not understand that there were these raft of issues
29 that we see addressed through the Serious Adverse

1 Incident reviews? So can you help us with those two
2 points?

3 A. So, I think that in terms of the level of performance
4 of the Trust, right, this was a Trust that probably up
5 until there were a significant number of changes of 14:21
6 Directors, or Chief Executives and Medical Directors
7 over a relatively short space of time, I think was seen
8 as a high performing Trust, right, and it was
9 recognised for that on the basis of it's activity and
10 the way it used money, so based on those two parameters 14:21
11 essentially. And I think that then with all of the
12 disruption that came with the constant churn in Chief
13 Executives and Medical Directors, I think it lost its
14 way a bit and, again, got stabilization back I think
15 then whenever Shane Devlin was appointed and was there 14:22
16 for that period of time, and then, you know, obviously
17 I came as Medical Director, continued on and, you know,
18 there has been less churn certainly in the meantime in
19 relation to that. And the Directors who are now
20 appointed to the Senior Leadership Team have been in 14:22
21 the system either as Assistant Directors or have come
22 in as very experienced people from other places and are
23 very familiar with health. So that has been helpful to
24 us.

25
26 So I think to some extent, and maybe this is - I think
27 it probably rested on its reputation of the past, and I
28 think didn't completely recognise that it was missing a
29 lot of the governance processes that it required in

1 order to ensure patient safety and quality.

2 140 Q. Just - I'm anxious not to intervene too much - but how
 3 does that happen? How can experienced people fail to
 4 see that standards expected of Trusts in terms of
 5 governance are not being complied with, and why does it 14:23
 6 take an event such as, or a series of events such as
 7 what was unpacked from June 2020 onwards, to trigger
 8 that realisation?

9 A. Well, I think it was relying very heavily on really
 10 good clinical practitioners and people who were there 14:23
 11 as managers who were trying their best. I think it's
 12 difficult to describe, but the biggest parameter that
 13 we would tend to go to or, you know, it's not, it's a
 14 proxy for quality of care very often, rightly or
 15 wrongly, is the mortality review. It hadn't been 14:24
 16 reviewed for a number of years when I got there. So
 17 actually the evidence wasn't in front of people. Now
 18 we've since reviewed it and there wasn't anything out
 19 of kilter with it. But I think in terms of all the
 20 nuances of that, trying to understand actually, you 14:24
 21 know, where the serious problems were, you know, and
 22 these are common to all Trusts in terms of, you things
 23 like insulin prescribing, anticoagulation, you know,
 24 acts of violence and aggression and all of that. It
 25 wasn't robustly recorded and reported anywhere in terms 14:24
 26 of understanding about patient quality and safety.
 27 Right. So I think it was relying on the fact that on a
 28 day-to-day basis people did what they always did, which
 29 was they turned up to work, they did a really good job

1 for each individual patient as they saw it, but in
 2 terms of bringing the system together and the system
 3 learning that we need it in order to know whether or
 4 not, you know, where we were in relation to the mean, I
 5 think that was difficult and the evidence wasn't 14:24
 6 automatically there. It took quite a lot of work to
 7 understand where we were in relation to other people.

8
 9 At a point in time to save money the clinical audit
 10 team had been stood down. Now we have, you know, as 14:25
 11 part of the whole governance review we have reinstated
 12 that and, you know, through the papers you will see
 13 some of the outworkings of that and what they've done
 14 with that in a relatively short space of time and,
 15 again, not all of that information was available to the 14:25
 16 organisation in terms of where it was, you know, in
 17 relation to its own activity, but also then in terms of
 18 driving improvement and being able to benchmark itself
 19 locally and nationally. So...

20 141 Q. Sorry, again. 14:25

21 A. Yes.

22 142 Q. Hopefully I don't take you off your track of thinking,
 23 but sometimes if I wait to the end of your answer I'll
 24 miss an important point.

25 A. Sorry. 14:25

26 143 Q. And the important point I think that you've just made
 27 is that at some point in history, I think from memory
 28 it was '16/'17, some time around then, the audit
 29 function was essentially sidelined, resources were

1 needed elsewhere, and this audit was seen as
 2 expendable. So when we think about that, and this may
 3 not be an entirely straight line, if we bring it to
 4 what we know about the urology multi-disciplinary team,
 5 but it could be any service in the Trust estate, you 14:26
 6 have a practitioner, according to the SAI outcomes, who
 7 is not complying with NDT recommendations. So patients
 8 don't get the recommended treatment, they don't get
 9 referred down the road to oncology and what you have,
 10 but behind that it can't be spotted, it can't be 14:26
 11 identified, or it's going to be difficult to identify
 12 it because you don't have resources into audit or
 13 tracking, or whatever label we put on it, it's - is it
 14 as blunt as that in some respects?

15 A. Yes, I think so, and I think, you know, if people had 14:27
 16 concerns in certain areas then they didn't readily have
 17 the tools available to them to help them understand
 18 what the problem was, you know. So if you were
 19 concerned about, you know, some of the clinical
 20 processes in relation to urology, it would have been 14:27
 21 very difficult to have had an audit project down around
 22 that because you didn't physically have the staff there
 23 do it for you.

24 144 Q. And obviously the commissioning process, and we'll come
 25 to that perhaps towards the end of your evidence, or at 14:27
 26 least that's my plan, we can't forget as we go through
 27 your evidence that you are existing as a Trust - in
 28 terms of your income, very much dependant upon what is
 29 allocated to you from the commissioners - but it

1 appears from what you're saying that those budgetary
 2 considerations, and the emphasis which your
 3 predecessors maybe put on delivery as opposed to
 4 quality and safety in terms of audit and all that goes
 5 with that, those were choices that are made because of 14:28
 6 the context, the budgetary context in which the Trust
 7 has to inhabit?

8 A. Yes, and I think, you know, there's an old adage which
 9 is "What gets measured gets done". Right. So at a
 10 point in time in the past what got measured was how 14:28
 11 much money you spent and how much activity you did.
 12 Right. There was less attention given to - and it's
 13 difficult to put a figure to it - quality and safety.
 14 So the two things that were easily measurable were done
 15 extremely well in relation to that. But then behind 14:29
 16 that, I believe that that was at a cost in terms of the
 17 clinical governance construction within the Trust.

18 145 Q. So when we go back to my question about how the senior
 19 leadership team - and maybe my premise is wrong? I
 20 said Senior Leadership Team standing in Craigavon 14:29
 21 Hospital June 2020, before Mr. Haynes and Mrs. Corrigan
 22 do their scoping work, you think all is well, obviously
 23 the June Champion Report freshly delivered late the
 24 previous year, and you have to work through some
 25 structural changes which are obviously very important, 14:29
 26 but it doesn't seem to me that you or your colleagues
 27 in the Senior Leadership Team had a sense of - and take
 28 the cancer services as our primary example, you didn't
 29 have a sense of how degraded the governance

1 arrangements had become?

2 A. I think that's a fair reflection. And if you think
 3 back to the Maintaining High Professional Standards
 4 Investigation, right, which I think at this point in
 5 time was misleading, you know there was a suggestion 14:30
 6 that a wide range of people were consulted with at that
 7 point in time and that the feedback they gave was - I
 8 mean, one of the ultimate decisions that came out of
 9 that was that there weren't any concerns about
 10 Mr. O'Brien's clinical practice and, again, that was - 14:30
 11 and what was presented through the Maintaining High
 12 Professional Standards Report suggested that this was
 13 about administration and about professional, you know,
 14 management, but actually wasn't about - there weren't
 15 any clinical concerns. And I think that reassurance, 14:31
 16 and it was a reassurance, it wasn't an assurance, I
 17 think blinded us to the fact that actually what really
 18 hadn't been looked at in there was the cancer side of
 19 the house. So in normal circumstances, you know, if I
 20 were, for arguments sake, asking for a dermatologist or 14:31
 21 a psychiatrist, you know, to be investigated, you would
 22 assume that all of the activity would be within their
 23 department. I think what wasn't appreciated within
 24 that investigation was the fact that there was a part
 25 of his clinical activity sat without the people who 14:31
 26 were spoken to and that there was information in
 27 interest, and that I think came to light very forcibly
 28 then in June 2020.

29 146 Q. Mmm.

- 1 A. So that side of the house, the cancer side of the house
 2 was quiet until we got to June 2020, and then there was
 3 a realisation that actually all of this was going on in
 4 there. And, in fact, you know, the concerns about
 5 workload, waiting times, triage, all of those things 14:32
 6 were important but didn't completely map on to what we
 7 found then in relation to cancer.
- 8 147 Q. That perhaps provides some of the explanation and
 9 understanding about what was deficient.
- 10 A. Mm-hmm. 14:32
- 11 148 Q. You know from your reading, and obviously it's before
 12 your time, that even amongst the triage dictation,
 13 private patients, notes at home shortcomings, they were
 14 known about for quite a long time?
- 15 A. Yes. 14:32
- 16 149 Q. So there was something deficient in the, whether it's
 17 the systems of governance or whether it's the people
 18 who work those systems in terms of their understanding
 19 of what they do when they are aware of shortcomings?
- 20 A. Yeah. 14:33
- 21 150 Q. So we'll come back to cancer in a moment.
- 22 A. Yeah.
- 23 151 Q. But is that a fair observation to make, that it's not -
 24 problems existed not just because stuff was hidden from
 25 plain sight, the cancer stuff, or it hadn't come, but 14:33
 26 there were problems on the other side of it as well
 27 amongst the stuff you did know about?
- 28 A. Yes. So I think at a point in time it functioned like
 29 two different departments almost, there was the urology

1 side and then there was the cancer side, and there were
 2 assumptions made I think about both parts of that and
 3 by each other, and I think that, you know, the
 4 individuals involved I think were very caught up - I
 5 mean these are really busy jobs, so I'm not - and I 14:34
 6 mean the volume of cancer activity and urology
 7 activity, you know, as you know from the statistics,
 8 you know, just has mushroomed over the years, and I
 9 mean the workforce hasn't kept up with that in terms of
 10 numbers. But, you know, they were very busy. I think 14:34
 11 they dealt with what was in front of them, and as you
 12 say, in terms of the connection across the system I'm
 13 not - it wasn't there at times. They didn't see the
 14 big picture, they saw the piece that was in front of
 15 them. And, again, you know, very busy jobs, people 14:34
 16 preoccupied with trying to get the best out of what
 17 they're doing, that's not completely unusual. But I
 18 think as a system where we could have been much better
 19 was actually taking a step back and understanding how
 20 that system should fit together, rather than leaving it 14:34
 21 always to the people on the ground to work that out for
 22 themselves.

23 152 Q. Mmm. Because I mean one of the explanations here, and
 24 perhaps the primary explanation that you've given so
 25 far for the deficiency in the governance arrangements, 14:35
 26 was the budgetary consideration forcing the Trust's
 27 choices or choice to go down one route, and to
 28 sacrifice, for example, audit and what flows from that.
 29 But I suppose the Department would say that there is a

1 limited purse and you have to make decisions that are
 2 balanced. You can't simply point to the person and say
 3 "well, I can't do governance, or I can't do governance
 4 to the extent that I'm going to shrug my shoulders and
 5 put people at risk", I'm sure that's maybe to 14:36
 6 exaggerate the point. But the Trust made a decision
 7 here at one point in time to undernourish the
 8 governance arrangements?

9 A. The way commissioning works in Northern Ireland, it's
 10 different from Scotland, England and Wales, in that 14:36
 11 you're given an allocation per Trust and it's based on
 12 the activity that the Department buys from you on
 13 behalf of the population. Right. So, there is an
 14 increment built into that, usually about 10%, which is
 15 about providing systems to support that. So there was 14:36
 16 a tendency in the past when systems were commissioned
 17 basically to work it out on the basis of activity, the
 18 numbers of doctors and nurses for arguments sake that
 19 would be needed, and then some finance given towards
 20 administration. There was never a budget towards 14:36
 21 governance. I mean what every Trust does is make,
 22 internally make a decision about that in terms of how
 23 much or how little they want to put to it. Right. So
 24 when things tend to get tight, what happens is the
 25 governance gets stripped away and it is put into the 14:37
 26 patient facing activity to get the patients seen, but
 27 it doesn't necessarily mean that the quality of that
 28 activity is as good as it should be and, you know, it
 29 restricts the ability to quality assure it. So there's

1 always a balance to be struck on that. So I think the
2 reason that, with the best will in the world, I think
3 that there was high levels of productivity, but
4 actually in terms of the government support to that to
5 provide the quality assurance, that that's the part 14:37
6 that was missing.

7 153 Q. Yes. Another aspect of this, and interested in your
8 views about whether the diminution in governance
9 activities may have had some impact on attitude or
10 behaviours or culture amongst the middle management 14:38
11 staff, you talk in your witness statement about your
12 exposure to some middle managers, and you were asked
13 about them on the last occasion and you came back with
14 a Section 21 response and identified Mr. Carroll and
15 Mrs. McVeigh as being examples, I suppose, of what you 14:38
16 saw as being a problem culture.

17 A. Mm-hmm.

18 154 Q. And I think it's perhaps a little unfair to focus on
19 the two of them directly, but perhaps let me set it in
20 the context of the evidence that you gave. So if we go 14:38
21 to your witness statement at WIT-91953. Sorry, if we
22 go - just scroll down. Sorry, it must be I think over
23 the page, please, towards the bottom of this page,
24 yeah. Okay. Thank you.

25
26 This is setting out the question that counsel put to
27 you on the last occasion. You were - just up a little
28 bit - you were explaining in your evidence that coming
29 into the Trust you got pushback from some staff, and 14:39

1 this is within the question, you felt that your queries
2 - they felt your queries were criticisms, and you were
3 asked about that, and the answer then towards the
4 bottom of the page:

5
6 "There was certainly a number of occasions when I was
7 very robustly challenged by middle managers within the
8 Trust, not Martina Corrigan and not any of the other
9 people who worked to her, in relation to what my role
10 and function was, why I was asking these questions, and 14:40
11 were a bit alarmed, I think, about the level of
12 curiosity in relation to how this worked. That didn't
13 stop me asking the questions, but it did make it more
14 difficult in that I had to keep coming back and back to
15 try to get the answers that I needed." 14:40

16
17 And then over the page. So just scrolling down, and
18 not having perhaps refrained from giving the answers on
19 your last occasion because of perhaps the sensitivities
20 around it, you gave the names of the people here, and 14:41
21 you go on then within your statement to set out some of
22 your concerns.

23
24 If we go, just to go forward in this to the bottom of
25 page 57 in this sequence. So what you're saying is 14:41
26 that within the Acute Directorate it was your
27 experience that it held on to its information under the
28 guise at that time of managing its own governance,
29 which is a system that had been instigated in the past.

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"As a result of this it was very difficult for the Director of Nursing and me, as Medical Director, to access the governance information we required in order to provide accurate assurance to the organisation. By the same token, Acute regularly believed that it was left to fend for itself."

14:42

And then just finally just scrolling down, when you:

14:42

"...spoke to others in the organisation about these behaviours by the Assistant Directors, there seemed to be an acceptance that this was the way in which individuals behaved and business was done and everyone worked around them. I hadn't encountered attitudes like this from middle managers in previous organisations."

14:43

So you gave those two names as examples of people who appeared to be oppositional towards your requests for information, and you've seen their responses, and they denied behaving in any way that could be considered untoward. But what I really, and you can comment on that by all means, what I really am interested in asking you is, is it your observation that as well as the systems being undernourished in governance in terms of resources allowed towards governance, there was also a people problem. The culture was such that management, relatively senior management, wasn't

14:43

14:43

1 sharing governance related information with those who
2 needed to know it?

3 A. Yes, and just in relation to, you know, naming Anne and
4 Ronan. As you know, I was quite uncomfortable about
5 doing that, and I think in fairness to both of them, I 14:44
6 think they ended up being the voices I think of what
7 was the culture in that Directorate at that point in
8 time. So, you know, they were fairly discrete
9 examples, which was the reason that they were
10 mentioned. But I think they did - they were the voice 14:44
11 of it. And, you know, in fairness to the two of them
12 as well, they had been through numerous changes, and I
13 think had been there a long time, had been trying to
14 manage in really difficult circumstances. But the
15 approach that was taken towards me was - and this is a 14:44
16 fairly crass way of describing it - but it was, you
17 know, "get your tanks off my lawn, this is not your
18 business, we manage this, why do you want to know the
19 answers to these questions?", and I think that's
20 because the way that - that was the way they had been 14:45
21 used to operating for long periods of time, and without
22 a realisation that this was a systems problem that just
23 didn't belong to the Acute Directorate.

24
25 So on the basis of that and, again, you know the 14:45
26 changes that we have made in relation to operational
27 governance have been to centralise it now. So it is
28 all brought under the office of the Medical Director,
29 and the governance leads and staff are business

1 partners along with the different directorates. Now,
 2 it's on the premise that there has to be a really close
 3 working relationship with these directorates, because
 4 we are completely dependant on their expertise and
 5 local knowledge to actually understand but also to try 14:45
 6 and help us develop and standardise what's going on
 7 there so that we're not getting these pockets where
 8 actually business is done differently and runs the risk
 9 of being unsafe.

10 155 Q. Yes. So you are no longer - so as an organisation 14:46
 11 you're no longer isolated as a senior management team
 12 from what is going on within each of the directorates,
 13 because there is now an energy or a requirement
 14 propelling the information out of the services up
 15 towards the top table on a very frequent basis, is that 14:46
 16 the position?

17 A. Yes. And I think, I mean I think the weekly governance
 18 report helps with that, and there is an expectation
 19 that we, you know, if anybody is worried about anything
 20 that they raise it. And, again, it may not be 14:46
 21 something that we're going to react to immediately, but
 22 in terms of building up the knowledge level of, you
 23 know, or taking, you know, a temperature check in
 24 relation to the organisation, all of that information
 25 is really useful. So, you know, we actively encourage 14:47
 26 people to speak up. And, again, you know, back to the
 27 piece of cultural work that we have started across the
 28 organisation in relation to being open, which came out
 29 of the IHRD Inquiry, and the work that Justice O'Hara

1 did, and the work then that we're pursuing in relation
 2 to being open and developing an open and just culture,
 3 all that of is embedded in that as we try to take that
 4 forward.

5 156 Q. Okay. Well we've touched upon a number of strands, 14:47
 6 hopefully with a degree of connectiveness by way of
 7 overview over the last 50 minutes or so. I want to go
 8 back a little. I want to ask you about, I suppose the
 9 External Reference Group is my starting point, but I
 10 think the Inquiry wants to get a sense from you about 14:48
 11 where the Trust is going from now. Having completed
 12 something of the journey, what are the next steps? So
 13 in terms of the External Reference Group leading in to
 14 the work that's been done around the Trust's vision
 15 through, I think it's Mrs. Wilson, is that right? 14:48

16 A. Yes, she's Director of Performance and Planning and
 17 Informatics.

18 157 Q. Yes.

19 A. Yes.

20 158 Q. And the work that's going to go into the five-year 14:48
 21 strategy. Could you help us first of all in terms of
 22 the External Reference Group. You've kindly supplied
 23 the Inquiry with a lot of papers in relation to it.
 24 The Inquiry is interested to know the origin of that
 25 group, why it was brought together, and what has it's 14:49
 26 role been over the past several months?

27 A. Okay. I think I was - I think we all where, but I know
 28 that I was particularly shocked by the fact that we'd
 29 had this blind spot that we discovered in the summer of

1 2020, and I felt that, you know, the history in recent
2 times in relation to Mr. O'Brien and what had happened
3 was full of blind spots and actually here was another
4 one, and I had been, you know, inadvertently complicity
5 with it and that troubled me, and I think that on the 14:50
6 basis of that I started to have conversations with
7 people, as, you know - I mean it resonated with some of
8 the other members in SLT, just in relation to how we
9 would take this forward. So I spoke broadly to, you
10 know, trusted advisers around the system in relation 14:50
11 to, you know, if you're faced with something like that,
12 how do you develop a reflective mirror for your own
13 organisation to spot things that you don't normally
14 see, because, you know, there's a whole psychology of
15 group think and, you know, finding yourself repeating 14:50
16 mistakes and all of that inadvertently. So the advice
17 I got back then was to maybe think about bringing
18 together a group of experts, which I did. So I
19 approached Dr. Frawley, who was Ombudsman for a long
20 period of time, and a huge career in terms of NHS 14:50
21 management throughout Northern Ireland, and has been
22 involved, you know, nationally in various bodies, and a
23 huge source experience and expertise, and on the basis
24 of the conversations then with Tom Frawley then, you
25 know, approached Mary Hinds who was previous chief 14:51
26 nurse whenever I worked as a consultant in the Mater
27 Hospital, and also, you know, had various other high
28 profile roles across Northern Ireland, you know, very
29 well regarded in terms of patient safety and quality.

1
2 I had done the patient safety, the Scottish patient
3 safety fellowship a number of years ago, and the focus
4 of that for those 18 months/two years is around
5 developing systems around safety and quality, and had 14:51
6 met - Simon Watson was the person in charge of all of
7 that at that point in time. He's Medical Director for
8 NHS Improvement Scotland, and Robbie Pearson is the
9 Chief Executive of NHS Improvement Scotland. So I went
10 to Scotland to have a conversation with them, just with 14:52
11 Robbie in the first instance, and his Chair, to find
12 out if they would be interested in supporting this work
13 with us, given that they are involved in regulation and
14 improvement, and then Robbie suggested to me to bring
15 Simon on board given his background. 14:52

16
17 And then alongside all of that, Hugh McCaughey has been
18 involved with us and, again, he, as previous Chief
19 Executive of the South Eastern Trust, hugely recognised
20 figure in relation to patient safety and quality, and 14:52
21 was an NHS England lead director in relation to safety
22 and quality in England in the last few years before he
23 retired, and then Veryan Richards, who I worked with
24 when I Chaired the Invited Review Service for the Royal
25 College of Psychiatrists, and she originates from 14:52
26 Northern Ireland but works, you know, across Wales and
27 for Welsh government, and through one of the colleges
28 in Oxford, she's an ethicist.

29 159 Q. Yes.

1 A. So that I felt gave us - and, again, that was built
 2 over time and conversations, and that I felt gave us a
 3 really robust group of experienced experts who wouldn't
 4 be frightened to challenge us as a group in terms of
 5 some of our thinking, had huge years of experience in 14:53
 6 the NHS and understood it intimately and, you know, had
 7 enough distance from the system at this point in time
 8 to be able to see us a bit more clearly than we could
 9 ourselves.

10 160 Q. Could I just - I think it might be helpful if we bring 14:53
 11 up on the screen, Mrs. Toal, I think it was her attempt
 12 to define or describe the group's purpose. TRU-303726.
 13 303726. TRU. So this is taken from the record of the
 14 External Reference Group's seventh meeting which took
 15 place on 10th November 2023, and just scrolling down. 14:54
 16 So I think in this instance Mrs. Toal is describing
 17 what you said to a Trust Board meeting in describing
 18 the work of the External Reference Group, she is
 19 summarising a workshop or a talk you gave to the Board
 20 on the subject, and so, it said - she said: 14:55

21
 22 "She had explained to the meeting that the purpose of
 23 the ERG is to fulfil the role of a critical friend by
 24 providing independent challenge and support to the
 25 Chief Executive and Directors who were leading the 14:55
 26 Southern Trust's Improving Organisational Effectiveness
 27 Programme. "

28
 29 She explained she had advised the subgroups - and we'll

1 come to this in a moment:

2

3 "...the subgroup representatives that the central aim
 4 of this programme is to improve organisational health,
 5 maximise safety, quality, and the experience for 14:55
 6 patients and service users and staff by identifying
 7 areas of concerns highlighted by the Inquiry into
 8 urology services. Heather continued that she also
 9 explained to the meeting that the External Reference
 10 Group had identified four themes which had led to the 14:56
 11 formation of the four subgroups."

12

13 And they are set out there as the Patient Safety and
 14 Quality Subgroup, the Governance Subgroup, Data
 15 Analytics, and Culture and Leadership. 14:56

16

17 So just help us to better understand this. So the
 18 External Reference Group, you've described it's
 19 membership, come together at some point in 2023.

20 A. Yes. 14:56

21 161 Q. And have a series of meetings, and it's due to conclude
 22 it's work this month. Is that right?

23 A. Yes.

24 162 Q. And we see, just scrolling back down, please, or back
 25 up, we see that it's being described as leading the 14:57
 26 Trust's Improving Organisational Effectiveness
 27 Programme, and also assisting the, as part of that,
 28 assisting the Trust to improve against the areas which
 29 are the subject of this Inquiry. So is it - tell us

1 how it works and what is the, if you like, the end game
 2 for the External Reference Group? Is it, for example,
 3 going to produce a report of recommendations or is it
 4 not that kind of group?

5 A. It's not that kind of group. And what it does is, it 14:58
 6 has led - it has helped - it has led the thinking in
 7 relation to this rather than the doing, if you know
 8 what I mean? So it's there to stimulate us to think
 9 and to guide us towards improvement and to think how
 10 things might be done differently. 14:58

11
 12 So in the spirit of all of this, and given that this
 13 started out with concerns about a blind spot, what we
 14 will do and, again, it's the end stages of development
 15 at the minute, is we - those of us from the Trust, and 14:58
 16 that's myself, the Director of Nursing, Heather
 17 Troughton; Director of Medicine, Stephen Austin;
 18 Vivienne Toal, who is the Director of HROD, and Elaine
 19 Wilson, we will - and Jane McKimm who leads out in the
 20 Inquiry; and Margaret Higgins, who is now Director for 14:58
 21 Transformation and Improvement - we are putting
 22 together a report on where, what our progress has been
 23 over the last year with the involvement of the External
 24 Reference Group to report back to them to say, you
 25 know, "These are the problems that we brought to you in 14:59
 26 terms of what concerned us in relation to the Inquiry
 27 and what you heard yourselves", given that Veryan does,
 28 you know, an update in relation to each of these
 29 hearings, "this is what we heard from you and now we're

1 reporting back to you to make sure that what we said,
 2 what we all heard actually aligns and that we've got
 3 this right". So they won't produce a report, we from
 4 the Trust are producing a report, and then we will
 5 sense check it with them to make sure that we're all on 14:59
 6 the same page and that we have, you know, heard their
 7 suggestions and guidance in relation to this and that
 8 they can see that we have taken that on board and are
 9 enacting it as best we can as a bigger group.

10 163 Q. So can you put that to an example? We can see, and 15:00
 11 maybe I'll bring it up now, it might be helpful to
 12 assist the discussion around this, Veryan Richards, one
 13 can see from the papers supplied that she's following
 14 very intently the questions I'm asking of witnesses and
 15 the answers that come back, and the questions that the 15:00
 16 Panel is asking and the answers that are coming back,
 17 and she has provided the External Reference Group with
 18 extracts from the transcript, and a series, if you
 19 like, provocative, "have you thought of this?", kind of
 20 question, isn't that right? 15:00

21 A. That's right, yes.

22 164 Q. And I'll show the Inquiry some examples of that. So if
 23 we go to TRU-303646. And this is a matter that was
 24 discussed at the External Reference Group meeting on
 25 the 29th September. And so, the aims, she said, I 15:01
 26 think she's referring to this exercise, is set out
 27 there, and then she does a transcript, notes and
 28 analysis, and if we scroll down the page she sets out
 29 the various themes that she's going to explore, or have

1 been explored in the Inquiry, and then over the page,
 2 we can see, and this was I think Day 42 of the
 3 Inquiry's work, so she records the questions and the
 4 answers, and then in blue she extracts, as I understand
 5 it, and you can correct me if I'm wrong, an issue which 15:02
 6 the Trust will have to grapple with, or she thinks
 7 might be wise to grapple with, arising out of the
 8 evidence that has been given. Is that a correct
 9 interpretation of her approach?

10 A. Yes. No, I mean as I understand it, Veryan listens 15:03
 11 very intently to all of this, and then I think, you
 12 know, given her perspective, and particularly her
 13 perspective as ethicist, she comes back to ask these
 14 questions, you know. But she's very clear that this is
 15 coming from her alone, it's not coming from the group, 15:03
 16 and it is to feed into a development of the group's
 17 thinking. But, yes, that tends to be the pattern of it
 18 in terms of how it is done.

19 165 Q. And if I could bring you to another document, because I
 20 think it originates from her, but maybe you can clarify 15:03
 21 it, if not today at some future point, TRU-304137. And
 22 here we have across eight areas, here's the first one,
 23 the Trust Board, and it goes into Senior Leadership
 24 Team, workforce, quality, patient safety, MHPS,
 25 communications, all of the sort of themes that the 15:04
 26 Inquiry is interested in, and on the right-hand side we
 27 have the Inquiry's Terms of Reference. So do you know,
 28 is this document something that has originated from
 29 her?

1 structures, you know driving up the quality of
 2 governance, you know, running the lookback review in
 3 relation to all of that, you know, against a whole
 4 backdrop of what was originally Covid, you know, the
 5 concerns about Daisy Hill Hospital, cytology, you know, 15:06
 6 the Caudrey Review, all of those things that have been
 7 going on in the background, sometimes involving the
 8 senior staff. So against the backdrop of that, I think
 9 this is now part of how we start to test our systems in
 10 terms of some of the changes that we've made, to say, 15:06
 11 "Actually, in terms of how we've put this together, is
 12 this representative?" So when I look at those
 13 questions, for example, in relation to Trust Board, you
 14 know, I will file down through all of the committees
 15 that are there, what actually gets discussed, and think 15:06
 16 to myself "Actually, have we addressed these?", and I
 17 can see areas where we need to improve and other areas
 18 there where I think "yes, we're nearly there or we've
 19 got there with them", and the same with each of these
 20 sections. I think this is a good way for us to 15:07
 21 challenge ourselves, you know, in terms of whether or
 22 not we've delivered.

23 170 Q. Yes. Yes. So again just for clarity purposes.

24 A. Mmm.

25 171 Q. You've described it I think quite well there. Before 15:07
 26 the External Reference Group came together, you had
 27 done a lot of work in terms of changing structures, a
 28 lot of focus on governance. This is related but a
 29 different strand or a different exercise that the Trust

1 is now pursuing?

2 A. I think - so this was part of the reflection to us in
3 terms of, you know, what we've done and what we need
4 do.

5 172 Q. Yes. 15:07

6 A. Right. And I think the next step in this process then
7 is the work that will be driven under the leadership of
8 the Director of Transformation and Improvement in terms
9 of taking the learning that we've got internally
10 obviously, you know, and this is anticipating what this 15:08
11 Inquiry will report on, because I, I completely accept
12 we may not have got this right. But what we're trying
13 to do is improve as much as we possibly can in the
14 interim, because we felt this was too important for us
15 to put to one side and wait, you know, part of this 15:08
16 will be for us to continually consider this to drive
17 the improvement within the organisation and to build on
18 it. So, you know, in relation to this to think if we
19 haven't got - if we're not answering these questions,
20 if they're the right questions, then are there other 15:08
21 things that we could do to try and improve in all of
22 this? And we will keep going with that and keep
23 reporting on it.

24 173 Q. Yes. Yes. So if we go - I just want to highlight some
25 issues or some developments that have emerged through 15:08
26 the external reference groups. If we go to the minutes
27 for the 29th September last year, TRU-306 - sorry,
28 303681. That is 303681. And Vivienne Toal is updating
29 the meeting, and she's explaining - if we just scroll

1 down - that - sorry, it's just down on over the page.
 2 Just down a little further, please. Down to the next
 3 page. Sorry, I've lost my place. Could you go back to
 4 the bottom of page 81. So, Ms. Toal - I can't find it
 5 on the page - but she's explaining to the Reference 15:10
 6 Group that Elaine Wilson, as you've said Director of
 7 Planning?

8 A. Mm-hmm.

9 174 Q. Has been asked to develop a new organisational vision?

10 A. Mm-hmm. 15:10

11 175 Q. And to be under-pinned by a new five-year strategic
 12 plan. I hope if I can just take another look down a
 13 page, she sets out - just keep going. Yes. So just
 14 below that bullet point. Yes. Is that something that
 15 has been agreed now that's being taken forward? 15:11

16 A. Yes, and the purpose in me presenting that to Trust
 17 Board in September was to essentially get their
 18 affirmation in relation to this, because we needed to
 19 be absolutely sure that Trust Board was behind all of
 20 this, you know, us as collective, in order to deliver. 15:11
 21 So Elaine has started this week and essentially - and
 22 we see the five-year vision as being, you know, the
 23 vision for 2030 essentially, I know it's slightly
 24 longer, but, you know, within all of that, you know,
 25 she has - she and other members of the team have 15:11
 26 consulted widely across the organisation with our
 27 external stakeholders, she's working our way through
 28 that, with our public, with patients and carers, and
 29 service users, in relation to what they see we should

1 be delivering over that period of time, and then, you
 2 know, internally with any of us who are Trust Board
 3 members. So that's a work in progress at the minute.

4 176 Q. Is that, just to be clear, this work on vision and work
 5 on strategic plan, is that something that comes up in 15:12
 6 the calendar every five years and now is the time do
 7 it, or is this, if you like, new thinking borne out of
 8 the experiences of working through problems with the
 9 External Reference Group?

10 A. So naturally in the lifespan of any Trust there will be 15:12
 11 a refresh in some of these things, okay, but I suppose
 12 in recent times because we haven't had a Stormont
 13 assembly until recently there hasn't been a programme
 14 for government renewed, and usually the corporate plan
 15 and corporate strategy falls out of that and then each 15:12
 16 Trust then designs its own interpretation of that in
 17 terms of taking that forward. In the absence of -
 18 although we don't imagine it will be terribly
 19 different, but we will keep an eye to it - in the
 20 absence, before this started, of a programme for 15:12
 21 government and, you know, the usual steer from
 22 Stormont, we went on ahead and started this anyway,
 23 because whenever you look at, and again this was
 24 pre-pandemic but, you know, has been a theme and was a
 25 theme that came through in relation to the changes made 15:13
 26 in Daisy Hill. One of the things that was constantly
 27 said was "we don't have a vision in terms of where
 28 we're going", and that was one of the reasons that
 29 people felt at sea, which I completely agree with, I

1 think that wasn't clear. So built into all of this was
 2 about us setting strategic direction so that, you know,
 3 particularly staff and service users would understand,
 4 you know, what it was we were trying to achieve. And
 5 within that I think, and what we're modifying at the 15:13
 6 minute are essentially the areas that we'll focus on.
 7 So it's about quality and safety, about adding value
 8 for money, and then about listening and acting
 9 intentionally.

10 177 Q. Yes, and I'm trying to - I've been struggling to find 15:13
 11 these key principles. I think they're just down the
 12 page. Yes. And so Mrs. Toal is explaining that the
 13 work to be taken forward in terms of the vision and the
 14 strategy will be under-pinned by, or she hoped that
 15 they would be under-pinned by these four principles as 15:14
 16 you've outlined:

17
 18 "safety and quality of care.
 19 Investing our resources where they add most value.
 20 A commitment to following through all actions that are 15:14
 21 agreed, and all under-pinned by intelligent use of
 22 data."

23
 24 So has that work started?

25 A. Yeah. Well this was part of the consultation. So 15:14
 26 based on what we learned in the process of the Inquiry,
 27 you know, the staff cultural survey that had been done
 28 at an earlier stage, and then some of the more recent
 29 learning that had come out of our experiences with

1 Daisy Hill Hospital and, you know, the Covid review and
 2 all of that, these are the themes that kept emerging.
 3 So that shaped our vision in relation to that. And
 4 they have been refined in terms of, you know, with the
 5 presentations to the different groupings, you know, it 15:15
 6 has been through various iterations, but essentially
 7 this is getting close to what we will see the vision of
 8 the Trust being.

9 178 Q. And we can see, jumping ahead to the next meeting of
 10 the External Reference Group. If we go, for example, 15:15
 11 to TRU-303732. And Ms. Richards is explaining that
 12 it's essential that a protected resource is agreed to
 13 support the process and also that an updated narrative
 14 was developed on the Trust's website so that that could
 15 be shared with the staff. In terms of the senior 15:16
 16 leadership, and I include you in that obviously, and
 17 the Chair of the Trust Board, to what extent is it
 18 important to bring the workforce and, indeed, other
 19 stakeholders along with you in developing the strategy
 20 and the vision? 15:16

21 A. It's pointless do it without them because, you know, I
 22 can stand at the front and talk about what we might
 23 aspire do, but if the hearts and minds of, you know the
 24 patients and service users and the staff who work in
 25 the organisation aren't with us as well, then we won't 15:17
 26 deliver on it.

27 179 Q. There is talk within the External Reference Group
 28 papers, to the need for an engagement plan?

29 A. Yes.

- 1 180 Q. That is engagement with the staff, with external
 2 stakeholders as well. Is that something that is being
 3 developed?
- 4 A. Yes, and that's ongoing at the minute.
- 5 181 Q. Yes. 15:17
- 6 A. So through the work that Elaine leads, she and her team
 7 lead in terms of these meetings with various groupings
 8 and getting their feedback on all of this, you know
 9 what they're doing is explaining the background to
 10 this, you know, what we're proposing to do and, you 15:17
 11 know, then modifying anything that they hear in there
 12 in relation to that. So she will come back to present
 13 - she gives us updates on that at the Senior Leadership
 14 Team, but she will come back I think with a draft
 15 proposal in relation to that over the next number of 15:18
 16 weeks, you know. So that will happen reasonably
 17 imminently.
- 18 182 Q. And the principles that I outlined there, we saw on the
 19 page in front of us, patient safety and quality,
 20 accountability and - sorry, I was reading from 15:18
 21 something else. Sorry.
- 22 CHAIR: Resources.
- 23 A. The second one is adding value for money.
- 24 183 Q. MR. WOLFE: Yes. Sorry, I'll just get my note to get
 25 it absolutely - I'm sorry, I'm causing confusion. 15:18
 26 Bottom of the page. So why were those principles
 27 selected? Do they, I suppose, give an indication as to
 28 where you and your team see the need for development
 29 and the need for clarity?

1 A. Yes, I think so. These came out, you know, they came
 2 out of our experiences through the Public Inquiry, the
 3 work that we undertook as I say in Daisy Hill and, you
 4 know, some of the learning that came out of the Covid
 5 experience, plus we had a big review to do in relation 15:20
 6 to that at a point in time, and then the culture review
 7 that was done 2016/2017 in relation to where the
 8 organisation was and, you know, some of the feedback
 9 we've had recently has resonated with that. So it came
 10 out of that because - and then underpinned by - we've 15:20
 11 two statutory duties in Northern Ireland; one is to
 12 provide safe quality care and the other is to break
 13 even and, you know, I think, you know, we also have to
 14 be pragmatic in the midst of all of this and be
 15 cognisant of the financial environment we're in, that 15:20
 16 we cannot waste resource. So it is really important
 17 that we do these, but not in an unrealistic way, and
 18 that we realise that what we do must add value and we
 19 must change what doesn't add value. Then I think, you
 20 know, one of things - again, I was very struck by 15:20
 21 whenever I arrived in the organisation but I think we
 22 are getting better at is, you know, a commitment
 23 basically to listen and to act intentionally, because I
 24 think, you know, one of the things that was, you know,
 25 I heard whenever I came into the organisation, and I 15:21
 26 think led to that apathy around understanding the
 27 impact of the loss of governance in all of that, was
 28 this sense that, you know, "It doesn't matter what you
 29 say, nothing changes", you know, it just felt all a bit

1 hopeless and, again, I think, you know, what has come
 2 through certainly in the consultations with
 3 particularly our, you know, the staff within the
 4 organisation, has been that we need to listen to what
 5 is being said and then we need to respond, and 15:21
 6 sometimes that response might be "I can't do anything
 7 about it at the minute", but people need to feel that
 8 they're being taken seriously. And then I think as
 9 well, it is again this intelligence use of data. How
 10 do we join the dots to actually make sense of all of 15:21
 11 this and try and reduce our tendency towards blind
 12 spots?

13 184 Q. Yes. There is another group that, as I understand it,
 14 has recently formed under Mrs. Toal's chairmanship, and
 15 that's the People and Culture Steering Group? 15:22

16 A. Yes.

17 185 Q. The Terms of Reference for that group are to be found
 18 at TRU-305063. And it's purpose is concisely described
 19 there at the top. And if we just scroll down. The key
 20 - just pause there. So the purpose of this group, it 15:22
 21 appears, is to provide support to the Strategy and
 22 Transformation Committee. Is that the Committee that
 23 Mrs. Wilson is leading to bring forward the strategy
 24 and vision or is that a different group?

25 A. So, the Trust Strategy and Transformation Committee is 15:23
 26 Chaired by Eileen Mullan as Chair of the Trust, okay,
 27 and that is again about bringing forward into the body
 28 of Trust Board by reporting, but also to hold within
 29 the organisation, you know, the strategic changes that

1 are being developed within all of this and any of the
 2 transformation that's made. So basically, I mean
 3 you've heard the quote, you know, "culture eats
 4 strategy for breakfast", and I mean we see at large all
 5 over the place. So it was really important that 15:23
 6 actually, you know, the people plan was developed last
 7 year along the lines of wellbeing belonging and
 8 growing, again completely evidenced based in terms of
 9 how that was pulled out as being the things that are
 10 really important in developing, you know, an excellent 15:24
 11 workforce that enjoys doing its job and does a good
 12 job. But in order to be able to do all of this, all of
 13 this needs to be aligned. So the people plan was
 14 developed and is developing, continues to develop
 15 alongside the strategic work that's going on, and these 15:24
 16 committees then report into this, or these steering
 17 groups report into this Committee that's chaired by the
 18 Chair of the Trust, to make sure it gets right to the
 19 heart of the organisation.

20 186 Q. Okay. So just so that we're clear. The job of 15:24
 21 bringing the strategy and the vision, it's being taken
 22 forward by Mrs. Wilson under the auspices of a
 23 Strategic Implementation Programme Board, is that
 24 right?

25 A. Yes. That's right, yes. 15:25

26 187 Q. It's going to report into Mrs. Mullan's Committee, is
 27 that right?

28 A. Yes. Yes.

29 188 Q. So that's the Strategy and Transformation Committee?

1 A. Yeah. Mm-hmm.

2 189 Q. But Mrs. Toal's group, it has an opportunity to connect
3 into those processes, is that right?

4 A. Oh, yes. Yes. And that works hand in glove, because,
5 you know, that's very much about how do we deliver what 15:25
6 we've promised through the people plan, you know,
7 strategically, in terms of making sure that staff are
8 aligned with what this vision is going to be and see it
9 as being worthwhile?

10 190 Q. Okay. So her committee, or her group, that is 15:25
11 Mrs. Toal's group, is the conduit to ensure that your
12 people, that is your workforce, are given an
13 opportunity to have a say on the development of the
14 strategy, the development of the vision?

15 A. It's the staff on the ground who are exploring all of 15:26
16 this with the various stakeholders come through the
17 Director of Planning's Directorate, their Directorate
18 of staff from there, but they're supported by Vivienne
19 Toal's HROD staff, okay. But both of them would say
20 that that is very much about, you know, helping to test 15:26
21 these concepts to understand if we are heading in the
22 right direction with it, and we think we are, the
23 iterations seem to be repetitively saying the same
24 thing, which is good, in and around. But in terms of
25 the delivery of this, this will be delivered out 15:26
26 through each of the directorates across the Trust,
27 because they can help shape it and describe it. But in
28 terms of the delivery it has to come into the lived
29 experience of staff every day, so that's the next bit

1 in terms of how do you make that transition so that
 2 this becomes the way we do business.

3 191 Q. Okay. So to summarise, the Trust is about to embark on
 4 a process where a five-year strategy and vision will be
 5 prepared. There are opportunities for staff and other 15:27
 6 stakeholders to contribute to the shaping of that?

7 A. Mm-hmm.

8 192 Q. And you have been supported in getting that project to
 9 the starting line by the expertise and experience of
 10 the External Reference Group, who have listened to your 15:27
 11 ideas, to your senior leadership team's ideas, and
 12 offered comment and advice?

13 A. Mm-hmm.

14 193 Q. How useful has been the engagement with the External
 15 Reference Group? 15:28

16 A. I think it has been enormously helpful because, you
 17 know, to have such ready access to so much expertise is
 18 rare and, you know, they come - the people involved
 19 externally I think come from a position of, you know,
 20 having had experience of some of these things 15:28

21 themselves in previous lives, but come with, you know -
 22 and the knowledge of other people going through some of
 23 these things, and I think can provide us with a lot of
 24 information, point us in the direction of finding
 25 things out, that I think have given us the confidence 15:28
 26 to function because, you know, I haven't been a Chief
 27 Executive very long, some of the other people on our
 28 senior leadership team haven't been directors very
 29 long. I think in terms of providing us with the

1 confidence, you know, to be able to deliver out on some
 2 of these things, that has been enormously important.

3 194 Q. And in terms of looking in the rear view mirror and
 4 seeing the potholes and the problems that you're
 5 hopefully leaving behind, at least in terms of 15:29
 6 governance, but perhaps more broadly than that, what is
 7 your ambition for the strategic plan and the vision in
 8 terms of where it will take the Southern Trust as an
 9 organisation and the people it employs?

10 A. Well, I mean, we are embedding governance. I think, 15:29
 11 you know, in terms of growing our workforce, you know,
 12 we know that that has been a very unstable system over
 13 a period of time. So over the last year/18 months, I
 14 mean we have employed 155 international nurses, we have
 15 recruited 72 internationally trained doctors, I mean a 15:30
 16 huge piece of work in terms of bringing stability into
 17 the system and, you know, educating people to, you
 18 know, work in the NHS. I mean super colleagues, you
 19 know, really enthusiastic and ambitious, and very
 20 enthusiastic about the work that we do, and that has 15:30
 21 really opened up lots of possibilities. So there's all
 22 of that stabilization piece that has gone on. You
 23 know, I think we have developed ourselves in terms of
 24 just understanding our own business much better, being
 25 a lot more strategic and planned and purposeful in what 15:30
 26 we do. We're trying to get away from being reactive
 27 but, you know, you're constantly hijacked by horrendous
 28 winter pressures and overcrowding in emergency
 29 departments, which everybody had, which can very often

1 take you away from the business. But again I think,
2 you know, as we - and we've had, you know, the concerns
3 about Daisy Hill, which we've managed to stabilise in
4 the medium term, you know, the cytology review, which
5 was well documented as well, again that has all been 15:31
6 about, you know, really making sure that all of these
7 governance processes that we have in place now, which
8 are sensitive to operations, are working well for us so
9 we can get through these problems. So bit by bit, and
10 I think as we encounter these difficulties we are 15:31
11 approaching them with more confidence, we now have the
12 armament in place to actually deal with them
13 expediently and get them over the line and get
14 stability back the system. So I can see, I can see
15 from a maturational point of view that we are slowly 15:31
16 but surely working our way through there and, you know,
17 our intention each time that we're hit with a
18 difficulty - and there will always be difficulties in
19 Trusts - is that we touch at once and we make sure that
20 what we leave behind is sustainable so that we don't 15:31
21 have to keep coming back in crisis mode.

22 MR. WOLFE: Chair, I know we've been going for an hour
23 and a half. Should we take a short break and aim to
24 come back or can we sit to say ten past or a quarter
25 past four. 15:32

26 CHAIR: Okay. So let's take a 15-minute break then and
27 come back and ten to and then sit for a maximum half an
28 hour after that.

29 MR. WOLFE: Very well.

1 THE HEARING ADJOURNED FOR A SHORT PERIOD AND RESUMED AS
2 FOLLOWS

3
4 CHAIR: Thank you everyone. Just before you start,
5 Dr. O'Kane, can I ask you again to slow down slightly, 15:46
6 please. There's a great desire to get it all over
7 with, I understand!

8 195 Q. MR. WOLFE: In the time that remains this afternoon,
9 Dr. O'Kane, I want to break into some discussion about
10 leadership issues, and we'll look at whether there was, 15:47
11 if you like, a problem with leadership that brought us
12 to the circumstances which give rise to the Inquiry,
13 and we will want to explore what has been done to
14 develop leadership both on the Board and among, in
15 particular, the medical leadership. 15:47

16
17 Is it fair to say, you were reflecting just before the
18 break on what was the perfect storm of issues that have
19 confronted the Trust in recent times. Is it fair to
20 say in your view that the work that has been done in 15:47
21 relation to building leadership, developing leadership,
22 has allowed you as a Trust to approach some of those
23 issues with greater confidence?

24 A. I think so, but, you know, it's always in development,
25 you know, just in terms of the learning that goes into 15:48
26 all of that. So in terms of, you know, supporting the
27 leadership of the senior team, we have partnered with
28 Mersey Care, it's recognised as being a high performing
29 Trust. You know, they recently again rated as

1 outstanding in terms of well-led review, you know, have
2 given us some really robust support and help through
3 their Chief Executives and their other senior leaders
4 in terms of how we can develop ourselves. So, you
5 know, we've taken that on board and used it.

15:48

6
7 we have taken time out on a regular basis to review or
8 progress ourselves in relation to what we actually do
9 and then to work with an organisational consultant
10 basically to help us, you know, develop confidence as a
11 team to deal with issues, all of that. And a number of
12 the senior directors have taken on national training.
13 So, you know, with the support of the King's Fund, a
14 number of them are, you know, have taken on top
15 director training, all of that, to try and build that
16 confidence and resilience.

15:48

15:49

17
18 But we're not finished with that yet. We still have
19 got others to help, you know, to develop their
20 confidence just as they've come into the roles. And
21 also, you know, we have been in the process of trying
22 to develop and embed coaching in all of that to help
23 people along.

15:49

24
25 And then in relation to the staff. Throughout the
26 organisation, particularly through the Director of
27 Nursing's office, she has led in leadership development
28 among nursing staff, particularly at Band 7, 8A, 8B
29 level, to drive that up to give the nurses there the

15:49

1 confidence, I think, to be able to speak up and to
2 lead. And we appointed a cadre of divisional medical
3 directors about 18 months ago and, again, they are
4 being taken through, you know, a developmental process
5 with each other. But, again, what we're planning to do 15:50
6 now over the next financial year is to develop a
7 leadership programme that will take in the senior
8 leader - a collective senior leadership programme that
9 will take in the leadership and the organisation. And
10 then for the other disciplines as well, certainly 15:50
11 through social work, AHP and others, that's being
12 developed alongside, and they have a fairly strong
13 tradition of support and supervision and development
14 within all of that.

15
16 One of the areas I think that we noticed that certainly 15:50
17 was put under a lot of stress at various stages was the
18 administrative teams and, again, through the HR
19 Department they have run a series of trainings with
20 staff across the organisation, particularly those 15:51
21 involved in administrative roles, to encourage them to
22 step up and to start to think about the what the
23 leadership opportunities are there. Because, again, if
24 we are going to develop ourselves as a collective
25 leadership organisation, you know, it's really 15:51
26 important that everybody is given the opportunity to
27 lead in the area that they can and that people are
28 given, you know, the support to speak up. So all of
29 that's in progress. And, again, it comes down through

1 the work that Vivienne Toal has been leading on in
2 relation to the people plan and the cultural
3 development with that.

4 196 Q. Yes. I'm going to touch on some of those aspects in a
5 moment. One issue that arose in Ms. Mullan's evidence 15:51
6 concerned you and the pressures on your diary and the
7 time that you can commit to attendance at various
8 meetings that she regarded as important, and I'm
9 anxious to have your view in relation to that.

10
11 She explained that I suppose you face significant time
12 pressures, perhaps not surprisingly given some of the
13 issues that you outlined a few minutes ago, that no
14 doubt required your personal and direct attention. But
15 she explained - this is - I needn't bring it up on the 15:52
16 screen - it's TRA-10154 and into 55, that as a result
17 of the demands placed on you, you have not been able to
18 attend four out of the five governance meetings, I
19 think last year.

20 A. Mm-hmm. 15:52

21 197 Q. And you've missed two Audit Committee meetings in
22 recent times, and this has caused a ripple of concern
23 with the Non-Executive Directors. Albeit, in fairness
24 to the evidence, and the balance in the evidence that
25 she gave, she said it would be remiss of her not to 15:53
26 acknowledge that whilst all this other stuff is going
27 on there has been tremendous work done as a result of
28 the outworkings of the Inquiry.

29

1 Do you have any concern that because you're perhaps
2 being pulled in several different directions at the one
3 time that there is a risk there in terms of your
4 leadership role and the lead that you must give to
5 staff and the assurances that you must find the time to 15:53
6 obtain across the Trust? In essence, are you
7 sufficiently resourced to do your job safely?

8 A. So, in relation to the Governance Committee and the
9 Audit Committee, I think it's fair to say - well I
10 don't want to give the impression that those meetings 15:54
11 aren't important, they are. But, in terms of the
12 papers do with all of that and my opinion going into
13 that Committee either through the Deputy Chief
14 Executive or other people, those are all discussed at
15 the Senior Leadership Team meetings, and then the 15:54
16 papers are passed in, and if there's anything of
17 concern I bring those up in my one-to-one with Eileen,
18 which happens every fortnight, or through the Executive
19 Directors meeting which happens every fortnight, or,
20 you know, bring it to the NEDs meeting which happens 15:54
21 approximately every month or so in relation to me
22 meeting with the Non-Executive Directors. So that's
23 brought into there. I think - and the same with the
24 Audit Committee. I think in terms of the
25 non-attendance, I think the last year we've all been 15:55
26 trying to catch up on annual leave that was stored up
27 over Covid in terms of trying do that, and then in
28 terms of some of the other pressures on my team, those
29 have been regional meetings or training courses.

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So one of the things I've undertaken is a coaching course, and again that, you know, signed up for that in advance and then the dates clashed. The same with the PTED meetings, which tend to be the regional departmental meetings, clashes with the Area Integrated Partnership Board, which I Chair the pilot for for Northern Ireland. So there are significant demands on times. And I am also on a lot of committees.

15:55

15:55

So, again, getting the balance with that I think is important. I think as we have come into this year we have planned more purposefully around that so that, you know, now that we've a longer oversight I think of the timetable of the committees and when those are actually happening, it makes it easier then for me to attend, you know, either virtually or in person, depending on what's going on and, you know, I actively encourage everyone else who is supposed to be involved to be there.

15:56

15:56

So, I am very cognisant of the information that flows into that and I need to stay on top of that and, you know, I have nothing to suggest that I don't, but I'm also very aware of the example that it sets for other people if I'm not there and it is important that I do attend these things. And I think as we've got ourselves into a better system of planning that has improved.

15:56

1 Now some of the changes that we're making within the
 2 office of the Chair and the Chief I think have been
 3 important in relation to this. So we're in the process
 4 of appointing new secretarial staff in there. There
 5 have been, you know, there have been churn and change 15:56
 6 for a variety of reasons. I've also appointed an
 7 Executive Head of Office, which there wasn't one
 8 before, to try and manage all of this better and to
 9 make sure that, you know, everybody is in the right
 10 place at the right time. So that appears to be going 15:57
 11 to plan. And then in relation to again the
 12 streamlining of some of these processes and the sharing
 13 of information, you know, that's now being done.

14
 15 So I would hope, you know, the aspiration certainly for 15:57
 16 this year is that it should be a bit better organised
 17 in terms of the use of my time in relation to that, and
 18 I think one of the things that we - that I asked the
 19 executive head of office to do was to do a review of my
 20 time usage and, again, I think what, you know, what 15:57
 21 really came to light in relation to that was the number
 22 of meetings that I am involved in, in terms of trying
 23 to attend. So, again, we had some internal
 24 conversations in relation to how some of that work
 25 could be delegated to free me up to, you know, give 15:58
 26 attention to the really important things and, again,
 27 that has helped in terms of re-organising that.

28 198 Q. Okay. So to summarise, you have this awareness of a
 29 perception?

1 A. Yep.

2 199 Q. That not being present rings alarm bells?

3 A. Yep.

4 200 Q. But you're understanding of your role is such that
5 you're using mitigations, whether alternative means to 15:58
6 communicate, additional staffing resources as well as
7 prioritising, what you do to ensure that you're there
8 when you need to be?

9 A. Yes. Yep.

10 201 Q. Let me move to the Board, Board membership, development 15:58
11 and how it works, I want to briefly touch upon some of
12 the issues that arise from that. Again, coming back to
13 Ms. Mullan's evidence, she, I suppose makes two points
14 which I want to have your views on. One is that at
15 least until 2020 she was a member of a Board that, I 15:59
16 hope I don't do injustice to her evidence by saying
17 that it was a Board that wasn't asking all of the
18 necessary questions. And, secondly, she was a member
19 of a Board that didn't receive all of the information
20 from the executive side that it needed to receive to do 15:59
21 it's job effectively. Now, let me put meat on the
22 bones of that.

23

24 January 2017, the Board is told a doctor in Urology is
25 to be the subject of an MHPS investigation - 16:00
26 Mr. O'Brien, and she acknowledged in her evidence that
27 they, the Board, should have been asking is there a
28 patient safety risk? They didn't, to her recollection,
29 ask any questions about that event, and nor for that

1 matter until you brought the issue to the Board in
 2 August 2020 did the issue or the issues around
 3 Mr. O'Brien, and in particular the conclusions reached
 4 by MHPS, come back to the Board? So a clear example of
 5 a problem I think, would you agree? 16:01

6 A. Yes, yep. The communication should have been more
 7 robust, yeah.

8 202 Q. Yes. So - and equally on the other side, a clear
 9 problem on the part of Board members, they weren't
 10 asking the questions? 16:01

11 A. Yes, and I - yes, no, I think across the piece the
 12 communication wasn't what it should have been.

13 203 Q. Another example, if we go to WIT-101964, and Stephen
 14 Wallace, 3rd August 2020, writing to Roberta Brownlee
 15 with a copy of the Early Alert in respect of the 16:02
 16 concerns that had arisen in relation to Mr. O'Brien.
 17 Just scroll down on to the next page. You're the
 18 author of the Early Alert, or the signatory to the
 19 Early Alert, which went to the Chief Medical Office
 20 four days previously. Only Mrs. Brownlee was sent the 16:02
 21 Early Alert. The other non-execs didn't know about the
 22 Early Alert it would appear until - on Mrs. Mullan's
 23 evidence - until September of 2020. So, again, and
 24 maybe you could help us with this, another example of
 25 important information not being shared with the 16:03
 26 entirety of the Board?

27 A. Yes.

28 204 Q. Is that something that was conscious and deliberate
 29 and, if so, what was the thinking behind it?

1 determination, and that would pass without either
 2 information coming from the Medical Director's Office,
 3 or pass without questioning by the Board itself, poses
 4 clear questions about the governance instincts of the
 5 Board and the governance instincts of those in the 16:05
 6 Medical Director's office, or whatever level it's at
 7 within the operations side. Has that culture, if it is
 8 a culture, changed in your view? Is there a greater
 9 appetite on the part of the non-executive members, and
 10 indeed the executive members of the Board to ask 16:06
 11 questions, and is there a greater willingness to share
 12 information with the Board?

13 A. Yes, and I think, you know, I think there should be
 14 anyway, but I think possibly based as well on the
 15 outworkings of the Neurology Inquiry and, you know, the 16:06
 16 attention that was given to Michael Watt, I think
 17 certainly Boards are now - well, certainly our Board is
 18 a lot more curious about maintaining High Professional
 19 Standards and medical staff generally and, you know,
 20 the flow of information is a lot better than it would 16:07
 21 have been in the past.

22 210 Q. In terms of the Board that you inherited as Chief
 23 Executive, and maybe even in the period before that, is
 24 it your view that it wasn't, at least on - I'll focus
 25 on the non-executive side, that it wasn't sufficiently 16:07
 26 developed or attuned for the work that it needed to do
 27 on the governance side, or the holding to account side
 28 of their work?

29 A. I think that, you know, this was a Board that had been

1 through many changes and, again, hadn't had anything in
 2 particular raised with them over a period of time that
 3 wasn't good news, either in relation to financial
 4 break-even or performance and, you know, understandably
 5 thought they were presiding over a high performing 16:08
 6 Trust that didn't have any particular difficulties.
 7 So, on that basis I, I mean some of those Board members
 8 have been with us now in the last year/18 months and,
 9 you know, given the opportunity and the change of
 10 environment they're very able to challenge and ask 16:08
 11 questions and, you know, if the conditions are created
 12 they certainly have, you know, have been quite
 13 challenging to me and other people in a very respectful
 14 way, but the questions still get asked. So I do think
 15 that there was something about the cultural that 16:08
 16 created this sense that actually everything was okay,
 17 you didn't need to ask questions, it was all being
 18 taken care of, and that probably then, I think unfairly
 19 to them, I think lulled them into a false sense of
 20 security. 16:09

21 211 Q. And, again, as an observer as well as participant in
 22 some of this from 2019, where do you see the, if you
 23 like, the culpability for that? Is it a case that they
 24 were being fed the good news, "nothing to worry about
 25 here", or is it a case that the information was there 16:09
 26 and whether because of cultural issues or leadership
 27 issues they didn't ask the challenging questions?

28 A. Probably a combination of both because, you know, Shane
 29 Devlin had arrived in the Trust about - he arrived in

1 the Trust about six months before I did, and up until
 2 that point they'd had a whole series of rapid turnovers
 3 of Chief Executive and, you know, Medical Director. So
 4 nobody really had had the chance I think to settle and
 5 understand the organisation in the way it needed to be 16:10
 6 understood, you know, after Mairead McAlinden left. So
 7 I think that rapid turnover I think meant that, you
 8 know, it was constantly, you know, and not through any
 9 individual's fault, it was constantly about superficial
 10 management and keeping the day-to-day going, but then 16:10
 11 in terms of, you know, recognising some of these deep
 12 rooted problems and actually moving them on and sorting
 13 them out, I think there wasn't anybody there in post
 14 long enough to have that view of it all and to bring it
 15 together. 16:10

16 212 Q. Obviously the Chair of a Board is an important
 17 function.

18 A. Mm-hmm.

19 213 Q. He or she should arguably lead by example, set the tone
 20 for what is expected. You've had opportunity to work 16:10
 21 with both Mrs. Brownlee and Ms. Mullan. Are there
 22 differences in style and is there, as a result of that,
 23 a difference in how the Board performs in terms of
 24 holding the executives to account?

25 A. Well, I think that Mrs. Brownlee was Chair of the Trust 16:11
 26 for a long time, most of, you know, she had been on the
 27 Board in and around 10 years I think and, you know,
 28 since the development of the Trusts in 2007, you know,
 29 the nature of Board business has changed quite a bit,

1 and certainly whenever I would have started out as a
2 consultant, you know, moons ago, you know it was
3 largely an honorary position, you know, and that's not
4 an unfair description of it, but it was very much, you
5 know, about having, you know, an awareness of being 16:11
6 accountable, but actually was very much about being a
7 figurehead, about being out there selling the Trust,
8 you know, doing all of those things, you know,
9 presenting a very well formed optimistic profile in
10 relation to what the Trust was. I think as health has 16:12
11 become increasingly more complex and, you know, less
12 able to meet demand, and difficulties have arisen, and
13 as we have become more sophisticated in terms of
14 understanding the business the Trust, I think the role
15 of the Chair has changed. 16:12

16
17 So, you know, I imagine whenever she started out that
18 the role was different from how it ended up having to
19 be and, again, you know, if you are an incumbent in
20 that position it is difficult I think to realise that 16:12
21 change if you're staying with one organisation.

22
23 So, I think that, you know, there probably, you know,
24 it was much - it was much a legacy of that as of
25 anything else. And in fairness to her, you know, she 16:12
26 was the one constant with all of these changes in Chief
27 Executive and, you know, had to keep, you know, the
28 public face going, if you like, in terms of business
29 continuing. So I think it was probably lost in the

1 midst of all of that.

2 214 Q. Yes. And I don't wish to have my questioning
 3 interpreted as suggesting Mrs. Brownlee was
 4 unprofessional, but is there a difference between her
 5 role as the figurehead and perhaps a more - a greater 16:13
 6 professionalisation of the role of Chair under
 7 Ms. Mullan in terms of their approach to the work?

8 A. I think, I think over time the expectation of the Chair
 9 has changed in that there is an expectation of greater
 10 professionalisation. And if you think about the, you 16:13
 11 know, the composition of Trust Board, the majority of
 12 people who come on to Trust Board have never worked in
 13 health before. It's a very sharp learning curve. It's
 14 very different, I imagine, from many other Boards that
 15 I hear about and, you know, the level of responsibility 16:14
 16 and everything else tends to be much greater. So I
 17 think through necessity, in order to be able to make
 18 sense of the job and to, you know, be able to hold me
 19 to account, hold Trust Board to account, you know to
 20 report to the Permanent Secretary and the Minister, I 16:14
 21 do think there has had to be an increase in
 22 professionalisation of that over time, yes.

23 215 Q. Yes. It has always been the case, and we saw this
 24 through the evidence provided by Mrs. Brownlee, that
 25 the Non-Executive Directors have received training, and 16:14
 26 there'll be different views as to how adequate the
 27 training was, et cetera. We can see that - if we bring
 28 up TRU-306058, and this is the, if you like, the Trust
 29 Board workshops for the past year. 306058. And,

1 again, covering a broad range of subjects. And just
 2 scrolling down, regular workshops, you see there "Risk
 3 appetite in September, Board governance,
 4 self-assessment tool". So, the training, maybe you can
 5 help us with this, has it changed to any great degree 16:15
 6 over the years, or how can you account - because I
 7 think your evidence has been this is now a Board that
 8 does hold you to account, is much more - "interfering"
 9 may be the wrong word, but certainly asking the hard
 10 questions? Is there a sense in your view that this 16:16
 11 approach of the Board has changed for the better, and
 12 what do you put it down to?

13 A. I am - I can see - certainly during the time I have
 14 been Chief Executive I can see the Non-Executive
 15 Directors who have been there being more assertive, you 16:16
 16 know, in terms of challenging me, you know, and other
 17 people. Not in an unfriendly way, but in a very
 18 constructive way. And then, you know, the other
 19 problem I think for Trust Board Non-Executive Directors
 20 has been that we've been short of some for a period of 16:17
 21 time. Now before Christmas there were public
 22 appointments, and more have been appointed and, you
 23 know, we have lost some recently, we've gained a few
 24 others and, you know, there will be more change before
 25 the end of the year, and certainly, you know, when 16:17
 26 Eileen has taken this forward and developed it, it has
 27 been with that in mind. Because previously the
 28 induction was very much about understanding the purpose
 29 of the Board, the Nolan Principles, you know, how all

1 of that fits together. This starts to take us into
 2 more of actually the accountability arrangements in
 3 terms of what Trust Board has to be responsible for in
 4 terms of helping them think about, you know, the
 5 clinical and social care governance, and the financial 16:17
 6 governance, and how to understand how to join the dots
 7 and, you know, ask all of those questions. Because I
 8 think, I can certainly see that that is starting to
 9 come through more strongly than it would have done in
 10 the past. Yes. 16:18

11 216 Q. So is that a suggestion that the quality of the
 12 training has improved in the sense that it is more
 13 meaningful and directs the member more specifically to
 14 the kinds of questions that they need to be thinking
 15 about and raising in their work? 16:18

16 A. Yes, I think so. But bearing in mind that these
 17 Non-Executive Directors are extremely part-time and
 18 haven't come largely from a health background before,
 19 you know, this is about equipping them to hold the
 20 accountability and to understand health and social care 16:18
 21 at speed.

22 217 Q. Yes. Is it possible, sitting in your chair, to assess
 23 the effectiveness of the Board in terms of the
 24 challenge and support that it provides? Ms. Mullan
 25 referred to the assessment tool, which those who sit on 16:19
 26 Boards, whether it's Board of Governors in schools or
 27 wherever, are asked to complete - she described it as
 28 something of a box ticking exercise, I don't know
 29 whether that's fair or unfair, but how do you assess

1 the effectiveness of the Trust, of the Trust Board
 2 sorry, in terms of the work it's expected to do?

3 A. I think it's increasingly effective, and I think when
 4 we get the full compliment of Non-Executive Directors I
 5 think that will give it even more scope. One of the 16:19
 6 things that we have planned to do in this financial
 7 year is to carry out a well-led review. Now, we don't
 8 have that in Northern Ireland, but it is part of the
 9 function of CQC in England, just to look at the
 10 Governance structures and how the Board functions and 16:20
 11 all aspects in relation to all of that. The Chief
 12 Executive in Mersey Care certainly has helped us with
 13 some of that and has been part of, you know, he has
 14 visited our Board and watched it's functioning and
 15 everything else and has given some really constructive 16:20
 16 feedback in relation to that. So, you know, it is
 17 something that we take seriously. But I think in order
 18 to know if this is functioning as well as we think it
 19 is, I think it will be helpful to have the well-led
 20 review done so at least we get that reflective back to 16:20
 21 us in terms of, you know, what's functioning and what
 22 isn't.

23 218 Q. Yes. Just finally for today, in terms of Board
 24 membership, I'm thinking again about the Non-Executive
 25 side, what is the biggest challenge that your Trust 16:20
 26 faces in terms of that part of its membership? Is it
 27 recruitment issues and ensuring that you have a steady
 28 stream of well qualified Non-Executive Directors ready
 29 to step in to the shoes of the outgoing, or is it

1 finding the time to provide for their development
 2 needs? Maybe they're not issues at all, but are there
 3 any particular challenges in relation to the
 4 composition of your Board that you regard as risks?
 5 A. So, some of the membership have recently changed and 16:21
 6 they do come from a variety of backgrounds, which I
 7 think, you know, it's not yet as diverse, I think, as
 8 it needs to be. But, you know, I know that that's the
 9 aspiration. And I think that, you know, it's always
 10 about getting the balance between having enough 16:22
 11 knowledge about health and social care and
 12 accountability mechanisms to be able to do that part of
 13 it. But also then to be able to think differently so
 14 that you can actually challenge the status quo, which
 15 is also really important. So I think I am beginning to 16:22
 16 see that in different ways in terms of the questions
 17 that come through. I think they need to get to a
 18 position of stability with full Board compliment and I
 19 think, yo know, their time is always pressurised, you
 20 know because there's a day of month - the most of a day 16:22
 21 a month taken up with the Trust Board, you know there
 22 are the statutory visits to children's homes which we
 23 get feedback on which is really helpful, and then we
 24 try to do the leadership visits around, and then
 25 chairing committees and attending to committees. So 16:23
 26 their time is really heavily used and I think, you
 27 know, ideally if we had more of their time I think it
 28 would bring even more value to the system, but the way
 29 it's constructed at the minute that's not where it is,

1 you know.

2 219 Q. Can the Department do anything to assist Trusts in this
3 respect?

4 A. It's possible. I know that certainly, you know, the
5 foundation Trust structure in England is different in 16:23
6 that there are councils and there are Trust Boards, and
7 there's probably a lot more input from the public, you
8 know. But again, you know, we're - I imagine one of
9 the limitations on this is we are working in a really
10 financially restrictive environment currently and all 16:23
11 of these things obviously have to be accounted for.
12 But certainly, you know, anything at all that can add
13 to the breadth and depth of the expertise and the time
14 allowed to the Non-Executives I think would be welcome.

15 220 Q. Clearly a strong Trust Board, strong Non-Executive 16:23
16 Directors, could have the potential, viewed from one
17 perspective, to make life difficult for executive
18 directors and leaders, such as yourself. From your
19 answers you would wouldn't appear to see it that way.
20 What do you see as the value of a strong set of 16:24
21 Non-Executive Directors for the overall health of the
22 organisation?

23 A. I think it's the informed challenge position, and
24 that's really important. And, again, back to, you
25 know, the issue of blind spots, being able to see 16:24
26 things that we can't see because we're caught up in the
27 day-to-day business, that's really important in terms
28 of, you know, helping us to stay safe as an
29 organisation in terms of patients.

1 221 Q. And in terms of the journey, if it has been a journey,
2 do you think, finally, that you would have greater
3 confidence in the Board as it is equipped today to do
4 that work of challenge and identifying blind spots,
5 than perhaps was the case four or five years ago? 16:25

6 A. I think so, but, you know, I am also mindful that I
7 have a responsibility in helping them with that. So,
8 you know, I am cognisant of that, and I know certainly
9 the other members of the Senior Leadership Team are
10 cognisant of that, you know, we need to help them 16:25
11 develop in terms of knowing what they need to know, but
12 not actually, you know, influencing that so strongly
13 that we just extend the group. I think they need to be
14 separate and they need to be slightly separate from us
15 to be able to hold us to account and to be able to 16:25
16 challenge.

17 222 Q. Okay. I'm at risk of being told off if I ask another
18 question! So thank you for that, and we'll commence at
19 10:00.

20 CHAIR: 10:00 o'clock tomorrow morning. Thank you 16:25
21 Dr. O'Kane, and thank you Mr. Wolfe. See you all in
22 the morning, ladies and gentlemen.

23
24 THE HEARING ADJOURNED UNTIL 10:00AM ON WEDNESDAY,
25 13TH MARCH 2024 16:25

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