Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Dr Neta Chada
C/O
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Dr Chada,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage

throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or the Trust's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

Issued by Urology Services Inquiry on 29 April 2022. Annotated by the Urology Services Inquiry.

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 41 of 2022]

pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO:

Dr Neta Chada
C/O
SHSCT Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

Issued by Urology Services Inquiry on 29 April 2022. Annotated by the Urology Services Inquiry.

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 10th June 2022.**

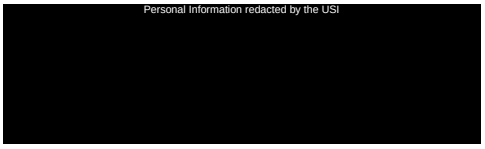
APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 3rd June 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 29th April 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE
[No 41 of 2022]

General

1. Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order using the form provided.

2. Provide any and all documents within your custody or under your control relating to paragraph (e) of the Terms of Reference except where those documents have been previously provided to the Inquiry by the SHSCT. Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. If you are in any doubt about the documents previously provided by the SHSCT you may wish to contact the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. When answering the questions set out below you will need to equip yourself with a copy of *Maintaining High Professional Standards in the Modern HPSS' framework ('MHPS')* and the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' ('Trust Guidelines').*

Policies and Procedures for Handling Concerns

4. In your role as Case Investigator what, if any, training or guidance did you receive with regard to:
    I. The MHPS framework;
    II. The Trust Guidelines; and
    III. The handling of performance concerns generally.

5. Specifically, what if any training or guidance did you receive with regard to the conduct of investigations under Section I paragraph 31 of MHPS and the Trust Guidelines.

6. The Inquiry is interested in your experience of handling of concerns regarding any staff member. Prior to your involvement in respect of the case of Mr O'Brien, specify whether you ever have had occasion to implement or apply MHPS and/or the Trust Guidelines in order to address performance concerns and outline the steps taken.

7. If you were not aware of or had not previously implemented or applied MHPS and/or the Trust Guidelines, what was your understanding of how you should address concerns relating to the performance of clinicians?

8. Outline how you understood the role of Case Investigator was to relate to and engage with the following individuals under the MHPS Framework and the Trust Guidelines:

    I. Clinical Manager;
    II. Case Manager;
    III. Chief Executive;
    IV. Medical Director;
    V. Designated Board member,
    VI. The clinician who is the subject of the investigation; and
    VII. Any other relevant person under the MHPS framework and the Trust Guidelines, including any external person(s) or bodies.

9. With regard to Section I paragraph 29 of the MHPS framework, what processes or procedures existed within the Trust to provide a clear audit route for initiating and tracking the progress of investigations, their costs and resulting actions? Who was responsible for ensuring such processes were in place and what role, if any, did you have as the Case Manager in relation to these matters?

Investigation in relation to Mr. O'Brien

10. In respect of concerns raised regarding Mr. Aidan O'Brien:

    I. When did you first become aware that there were concerns in relation to the performance of Mr. O'Brien?
    II. If different, also state when you became aware that there would be an investigation into matters concerning the performance of Mr O'Brien?
    III. Who communicated these matters to you and in what terms?
    IV. Upon receiving this information what action did you take?

11. Outline all steps you took, information you considered and advice you received from the designated HR Manager, NCAS or any other person in preparing the investigation report into concerns relating to Mr. O'Brien dated 12th June 2018.

12. Section I paragraph 37 of MHPS sets out a series of timescales for the completion of investigations by the Case Investigator and comments from the Practitioner. From your perspective as Case Investigator, what factors contributed to any delays with regard to the following:

    I. The conduct of the investigation;
    II. The preparation of the investigation report;
    III. The provision of comments by Mr. O'Brien; and
    IV. The making of the determination by the Case Manager.

Outline and provide all documentation relating to any interaction which you had with any of the following individuals with regard to any delays relating to matters (I) – (IV) above, and in doing so, outline any steps taken by you in order to prevent or reduce delay:

A. Case Manager;
B. Designated Board member;
C. the HR Case Manager;
D. Mr Aidan O'Brien; and
E. Any other relevant person under the MHPS framework and the Trust Guidelines.

13. Outline what steps, if any, you took during the MHPS investigation, and outline the extent to which you were kept appraised of developments during the MHPS investigation?

MHPS Determination

14. On 28 September 2018, Dr Ahmed Khan, as Case Manager, made his Determination with regard to the investigation into Mr O'Brien. This Determination, inter alia, stated that the following actions take place:

I. The implementation of an Action Plan with input from Practitioner Performance Advice, the Trust and Mr O'Brien to provide assurance with monitoring provided by the Clinical Director;
II. That Mr O'Brien's failing be put to a conduct panel hearing; and
III. That the Trust was to carry out an independent review of administrative practices within the Acute Directorate and appropriate escalation processes.

With specific reference to each of the determinations listed at (I) – (III) above address,

A. Who was responsible for the implementation of each of these actions?
B. To the best of your knowledge, outline what steps were taken to ensure that each of these actions were implemented; and
C. If applicable, what factors prevented that implementation.

D. If the Action Plan as per 14(I) was not implemented, fully outline what steps or processes, if any, were put in place to monitor Mr O'Brien's practice, and identify the person(s) who were responsible for these? Did these apply to all aspects of his practice and, if not, why not?

Implementation and Effectiveness of MHPS

15. Having regard to your experience as Case Investigator, in relation to the investigation into the performance of Mr Aidan O'Brien, what impression have you formed of the implementation and effectiveness of MHPS and the Trust Guidelines both generally, and specifically as regard the case of Mr O'Brien?

16. Consider and outline the extent to which you feel you can effectively discharge your role as Case Manager under MHPS and the Trust Guidelines in the extant systems within the Trust and what, if anything, could be done to strengthen or enhance that role.

17. Having had the opportunity to reflect, outline whether in your view the MHPS process could have been better used in order to address the problems which were found to have existed in connection with the practice of Mr O'Brien.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

An addendum to this witness statement was received by the Inquiry on 20 March 2023 and can be found at WIT-91937 to WIT-91938. Annotated by the Urology Services Inquiry.

USI Ref: Section 21 Notice No.41 of 2022

Date of Notice: 29th April 2022

A further addendum to this witness statement was received by the Inquiry on 22 March 2023 and can be found at WIT-91939 to WIT-91940. Annotated by the Urology Services Inquiry.

Witness Statement of: Dr Neta Chada

I, Neta Chada, will say as follows:-

1. Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order using the form provided.

1.1 Response: My name is Neta Chada. I was awarded a medical degree in June 1988 from Queens University Belfast and progressed to Membership of the Royal College of Psychiatrists in 1994 and then was appointed Fellow of the College in 2008.

1.2 I have previously held posts as the Northern Ireland Medical and Dental Training Agency/ Royal College of Psychiatrists Regional Advisor for Postgraduate Studies in Psychiatry, the Deputy Chairman of the NI Division of the Royal College of Psychiatrists and have been a member of the NI Mental Health Review Tribunal.

1.3 I was appointed as a Consultant Psychiatrist to the Southern Health and Social Care Trust on 1st February 1999. I remained in that role until 2nd March 2020 when I retired, though I returned on 25 March 2020 for a further period (until June 2021) to assist through the Covid pandemic.

1.4 I had successfully interviewed for the Clinical Director in Mental Health and Disability post and then later the Associate Medical Director post. I believe my Associate Medical Director in Mental Health and Disability role started in approximately 2011.

1.5 I was unaware of any issues with Mr O'Brien's practice until I was approached by the Medical Director, Dr Richard Wright in late February 2017 and asked to take over as a Case Investigator under the Maintaining High Professional Standards Framework (MHPS). I was assisted as Case Investigator by Mrs Siobhan Hynds a senior member of staff from Employee Relations.

1.6 I was advised issues had first been raised by clinical and non-clinical managers with Mr O'Brien in March 2016 in relation to areas of his practice. I was advised after that meeting Mr O'Brien was sent a letter detailing the concerns discussed and asking him to respond with a plan to address the issues. (Later Mr O'Brien advised me at interview that he did not reply to the letter but did respond to concerns by making changes in his practice.) Subsequently Mr O'Brien was off with unrelated sickness absence. I was provided with the paperwork related to the investigation to date including the Preliminary Report by the previous Case Investigator, Mr Colin Weir dated January 2017, the letters sent to Mr O'Brien by the Mr Weir in his role, and the letters to him from Dr Richard Wright the then Medical Director. (I understand all of these have been provided to the Inquiry.)

1.7 Through the investigation I was advised a Serious Adverse Incident (SAI) carried out towards the end of 2016 identified an untoward patient outcome in a patient whose referral letter had not been triaged by Mr O'Brien as per Trust processes. I later discovered through information provided and his statement, the SAI had been chaired by one of the other urologists, Mr Glackin, who realised during the review that the patient's referral letter had not been triaged. The concerns arising from the SAI were brought to the attention of the Medical Director and an investigation was progressed.

1.8 I was informed by Dr Wright that Mr Colin Weir, Consultant Surgeon, was initially appointed as a Case Investigator assisted by Mrs Siobhan Hynds. I was told Dr Wright sought advice from the National Clinical Assessment Service in December 2016, noting there had been a failure to resolve issues informally. Following advice from the National Clinical Assessment Service, Mr O'Brien was immediately excluded in line with Maintaining High Professional Standards Framework to allow for preliminary inquiries/investigation to be undertaken. Dr Khan, Associate Medical Director in Maternity and Children's Services was appointed as the Case Manager and Mr Weir as the Case Investigator.

1.9 I was told Mr O'Brien was asked to return all case-notes and all undictated outcomes from clinics. Mr O'Brien did so, though there remained some missing sets of case records which the Trust continued to pursue with him.

1.10 I was advised to speak to Mrs Hynds who had been involved and was aware of details of the process to date. I was advised at the end of the four-week immediate exclusion period, and the completion of the preliminary investigation by Mr Weir, it was felt there was a case to answer in respect of the concerns identified. The matter of the immediate exclusion was also considered, and it was felt this could be lifted provided there was a clear management plan in place to supervise and monitor particular aspects of Mr O'Brien's work. (This is all information I was told by either Dr Khan or Mrs Hynds, and then later confirmed from reading the file information that was provided.)

1.11 I was appointed as Case Investigator in place of Mr Weir in approximately February 2017. I was advised Mr Weir had been a manager within the specialty and therefore might have been required to be interviewed, and therefore it was felt appropriate he should step aside.

1.12 The Terms of Reference (ToR) had already been formulated and were shared with me. These are included in the Trust's discovery and in my Investigation Report. Mrs Hynds asked the Case Manager, Dr Khan, to share these ToR with Mr O'Brien.

1.13 A list of witnesses was agreed by Mrs Hynds and I after reviewing the Terms of Reference. I quickly realized this would only be a few of the people who would need to be interviewed. The list was shared with Mr O'Brien with the information that this was an initial list, and we may identify others in the course of the investigation as it progressed. I am unable to recollect exactly how the witness list was put together. Certainly, I am aware of having input into the witness list, in that I realised we needed to speak to the current managers of the service to begin with (Mr Ronan Carroll and Ms Martina Corrigan), as well as the Clinical Director (Mr Young) to understand how the service functioned and his account of the issues. Having read the investigation and chronology to date, I felt it was important also to interview Mr Eamon Mackle, who had previously been the Clinical Director and whom I understood had raised issues with Mr O'Brien previously, as well as Mr Weir who also had clinical managerial responsibility more recently.

1.14 The list of witnesses grew as I gained more information from the first interviews and, by April, a further eleven (approximately) witnesses had been identified whom I believed could inform the investigation.

1.15 Dr Khan regularly emailed Mrs Hynds and me about the investigation to ask about progress and to keep track of the investigation timeline. Mrs Hynds kept Dr Khan updated with the interviews and the progress of the other information-gathering that was being undertaken, for example, the information on untriaged referrals and whether they had been examined by other urologists and what the outcome was, and the undictated clinics, etc.

1.16 I realized this was creating a lot of additional work for the urologists, and I suggested via Mrs Hynds that Dr Khan should approach Dr Wright and discuss the possibility of further assistance to move that part of the investigation on more quickly. I felt it was important we had as much information as possible before we met Mr O'Brien so that he would know the extent of the issues and have an opportunity to address those concerns. This information is all included in emails from Mrs Hynds to Dr Khan through the course of the investigation and I understand the Inquiry Team has been provided with those.

1.17 It became clear this was a complex and far-reaching investigation and we would not meet the (frankly totally unrealistic) timeframes suggested by the MHPS framework. The

Case Manager was advised of this, and we agreed to keep him updated on at least a monthly basis.

1.18 If issues were raised by witnesses which we felt pertained to the service and needed to be addressed even before the Investigation was completed, we raised these with Dr Khan. An example of this is when one of the witnesses indicated Mr O'Brien was not assigning clinical priorities to his theatre list, making it difficult to know how to sort the lists if theatre sessions to be cancelled to adjusted for some other reasons. I was advised this clinical prioritization was routine with the rest of the Surgeons. (Paragraphs 1.15-1.17 are covered in an email dated 12 April from Mrs Hynds to Dr Khan *located in Relevant document can be located at Relevant to PIT/ Evidence Added or Renamed 19 01 2022/ Evidence no 77/ No 77 – Dr Neta Chada/ 20170412 – E MPHS Case Update).* I understand Dr Khan, as Case Manager, asked for updates on Mr O'Brien's compliance with the action plan which had been put to him by the Trust. Oversight of this part of the process was not in my remit as the Case Investigator as outlined in MHPS.

1.19 In parallel to the witness interviews, I was also given regular updates on the progress of the gathering of the information in relation to each of the Terms of Reference, as this assisted in some of the questions I had for witnesses and was needed to understand the extent of the concerns. I was also copied into updates to Dr Khan from managers on whether any further charts had been removed/clinics not dictated etc.

1.20 When I took over as Case Investigator, I believe I was advised of four Terms of Reference, as outlined in the Trust's discovery documents. However, as the information was being gathered it became clear to me that a further Term of Reference needed to be considered. ToR 5 was to determine to what extent any of the above matters were known to managers within the Trust prior to December 2016, when the outcome of the SAI was shared with the Medical Director, and to determinate what actions were taken to manage any concerns. I believe I added this ToR by mid-March 2017.

1.21 Some witnesses wanted details of the agenda of the meetings and were sent the Terms of Reference when they were invited to the interview.

1.22 Witness statements were gathered between the middle of March 2017 and 5th June 2017, allowing for work commitments of witnesses and the Case Investigator (me), holiday periods and annual leave. I interviewed each witness accompanied by Mrs Hynds. I took copious notes as is my practice and Mrs Hynds also took notes. Whilst I led the interview, I asked Mrs Hynds to add questions or queries I had omitted if they would assist the investigation. At the end of each interview, I asked each witness if they had anything else to add that might increase my understanding of the issues under investigation or any other comments they felt were relevant. Some of the witnesses expressed concern about Mr O'Brien seeing their statement. Others found being involved in the investigation difficult and needed reassurance. To collate the statements, Mrs Hynds produced a draft of each statement and then I used my notes to add additional information or clarify issues. The statement was then shared with each witness, and they were asked to correct it as needed, sign it, and return it to Mrs Hynds. This process took a considerable amount of time. Some of the agreed statements were not back to the Case Investigator until mid-September, as witnesses remembered more things that they thought were relevant to the investigation and added those comments or clarified points to make them more easily understood. (I understand all the statements have been provided to the Inquiry Team.) I shredded my handwritten notes when I retired from the Trust in March 2020, due to GDPR regulations.

1.23 It was my view Mr O'Brien was essentially a witness as well as the subject of the investigation and I wrote to Mr O'Brien by email suggesting meeting dates towards the end of June 2017. I included as much of the information which had been gathered in relation to the Terms of Reference to date. Mr O'Brien suggested Saturday 1st July 2017. This was accommodated to the best of our ability. However subsequently Mr O'Brien felt it would be better to wait until the beginning of August after everyone's annual leave. (Annual leave of the Case Investigator, Mrs Hynds and Mr O'Brien.) This was facilitated. (I understand this has all been made available to the Inquiry Team in email correspondence from Mrs Hynds to Mr O'Brien and I, dated June 2017.)

1.24 I asked that information from the reviews (5 patients being diagnosed with cancer) was shared with Mr O'Brien if this was appropriate from the MHPS process point of view, as these were issues we needed to raise with him, and I felt he needed to be given time to reflect on these. (This was one of the issues that led to delays in the first meeting with Mr O'Brien,

as well as delays with getting signed witness statements back.) In the meantime, I understood the Trust were progressing SAIs in relation to those cases. (This is captured in emails in May 2017 between Mrs Hynds, Mr Carroll, Mr Weir and which I understand have been shared with the Inquiry Team.)

1.25 Before the meeting in August, Mr O'Brien wrote to Dr Khan and expressed concerns about how the investigation was being conducted. (Letter from Mr O'Brien sent by email dated 31.7.17.) Mr O'Brien copied Mr Wilkinson, the designated non-Executive Director, into the email and also copied it to me. Most of the email referred to processes which had occurred prior to my involvement in the matter, but he did raise issues about not being provided with a list of witnesses, as he had been promised, nor their statements. He indicated he was grateful at the flexibility I had shown in arranging an interview date which did not interfere with patient care. He felt he had been failed by management who had not offered the informal route at an earlier stage or remedial action. (It had been decided to go ahead with the meeting with Mr O'Brien in the absence of the witness statements being ready to gather an understanding of his perspective of the issues and discuss his responses to the information gathered in relation to the Terms of Reference. It was apparent a second meeting would be needed due to the extent of the matters under discussion in any event, and witness statements could be provided before then.) Given the time that was passing, I decided to go ahead with the interview with Mr O'Brien.

1.26 At the meeting in August 2017, Mr O'Brien indicated he had raised issues with the Trust about patient safety in the past and his concerns. I noted there had been letters from Mr O'Brien after the Trust informal processes had been commenced, and prior to my involvement. I asked Mr O'Brien to provide anything he had in writing to indicate he had raised these issues previously and provide those to Mrs Hynds or I for consideration and inclusion in the investigation. (Mr O'Brien had reiterated previous concerns in correspondence to Dr Khan and Mr Wilkinson which was also copied to me, dated 31.7.17). At this meeting Mr O'Brien indicated he did not wish to respond to No. 4 in the Terms of Reference until the patient information requested by him had been provided and therefore it was agreed the other Terms of Reference would be addressed and a further meeting would be arranged. Mrs Hynds wrote to Mrs Corrigan on my behalf and asked for the information on the process which had identified the private patients it had been alleged had been given

clinical priority, so that this could be shared with Mr O'Brien. This was provided in an email from Mrs Corrigan to Mrs Hynds and I dated 14 September 2017.

1.27 Mr O'Brien was provided with a full witness list at the end of September when all the statements were received. (See Email from Mrs Hynds to Mr O'Brien dated 28 September 2017 *located at Relevant to PIT/ Evidence Added or Renamed 19 01 2022/ Evidence no 77/ No 77 – Dr Neta Chada/ 20170928 – E Strictly confidential)* To ensure balance, I also asked Mrs Hynds to enquire of Mr O'Brien if there were other witnesses he believed could provide information relevant to the investigation. Some of the statements were sent to him with that email and the rest were to follow. Mr O'Brien was also sent a draft copy of his own statement from the August meeting approximately a week before the next meeting, for any corrections/amendments. (There is email correspondence around 27 October from me to Mrs Hynds indicating how busy my clinical caseload was at that time, which had led to a delay in my reading the statement. This email *can be located at Relevant to PIT/ Evidence Added or Renamed 19 01 2022/ Evidence no 77/ No 77 – Dr Neta Chada/201710127 – E Statement Mr O'Brien*

1.28 The second meeting with Mr O'Brien occurred on 6th November 2017. An email suggesting dates in the third week of October was sent, but was not suitable to Mr O'Brien and the 6th November was agreed. This additional delay in dates being offered was due to the witness statements not all being received until the end of September and wishing to give Mr O'Brien a chance (3 weeks) to go through them and the other information he had requested.

1.29 At that meeting Mr O'Brien advised he wished to comment on his first statement (meeting in August), the statement which would be put together in terms of the current meeting (November) and wished to comment in detail on witness statements. He indicated however, his priority was to complete his appraisal and therefore he indicated he would not be able to provide responses in November or December 2017. Given the importance of annual appraisal, this was agreed by me. It was therefore my understanding that Mr O'Brien would get back to us with his commentary by January 2018.

1.30 By February 2018, Mr O'Brien still had not provided his comments. This was discussed by me as Case Investigator with Mrs Hynds, initially at the end of January and then again in

the middle of February by phone and email. Then an email was received from Mr O'Brien on 22 February indicating he hadn't had the time to respond and hadn't received his second statement. He requested a copy of his statement from November and indicated he would provide a response to all documents (his first statement, his second statement and the witness statements) by 31st March 2018. I indicated this was too long a time frame, given he had most of the information for over 3 months now, and had taken his own notes of the November meeting, so these were available for him. We sent Mr O'Brien his second statement on 4 March 2018 and asked for an update. We received no response. (I have no memory of why sending Mr O'Brien his second statement took so long.)

1.31 We agreed Mrs Hynds would write to Mr O'Brien and ask again for an update. This was done at the beginning of March, along with a copy of his second statement. He did not respond. (All of this is covered in email correspondence between Mrs Hynds and Mr O'Brien dated February and March 2018, shared by the Trust to the Inquiry Team.)

1.32 After discussion, a further email reminder was therefore sent.

1.33 Mr O'Brien's comments were not received by 9th March. He was sent a further reminder on 16th March requesting comments no later than 26th March. He was advised in that correspondence that, in the interests of moving things forward, the investigation report would be concluded thereafter if he had not responded by 26th March 2018.

1.34 Mr O'Brien did not respond.

1.35 Mrs Hynds and I decided to extend the period by another few days. Mr O'Brien was given a further opportunity to respond by 30th March, as Mrs Hynds was keen to have his response considered. Whilst I was also keen to have Mr O'Brien's response so that I could include it in the analysis and findings of the investigation, given his complaints about the length of time the process was taking, I felt Mr O'Brien had been given plenty of opportunity and time to respond. In any event, no comments were received by the 30th March and I started to put together the report.

1.36 Mr O'Brien responded on 2nd April 2018 with several queries, many of which related to the preliminary investigation and processes, as well as comments on his two statements and the witness statements; however, it was agreed by myself and Mrs Hynds that, in order to ensure the Investigation Report was concluded without any further delay given the investigation had started over a year earlier, the commentary from Mr O'Brien would be appended in full to the report so that it could be considered in full by the Case Manager. Mr O'Brien was informed of that decision by email.

1.37 The details in the investigation outline the extent of the 'Look Back Exercise' and data gathering that was undertaken. This included checking each set of case-notes returned by Mr O'Brien from his home to see if management plans had been actioned and to dictate on letters as needed, to look at where private patients were being added to waiting lists and assess if the level of prioritization was appropriate, and to go through all the untriaged referral letters which had been uncovered during Mr O'Brien's Consultant of the Week rotas. It was an extensive piece of work that we were asking managers and clinical staff to carry out. It was also agreed that Consultant Urologists would be asked to look at the patients who had been added by Mr O'Brien from his private patient list into NHS theatre lists, as well as reviewing charts which had been returned from Mr O'Brien's home without dictation. The former was to consider if private patients had effectively been allowed to 'jump the waiting list', and the latter to ensure any investigations/treatment which needed to be arranged for the affected patients had been actioned

1.38 At meetings with Mr O'Brien, it became clear he had a number of concerns and reservations about conclusions reached by other clinicians in reviewing cases including his private patient list and the triage list. He also had concerns about the process itself and about the delays. I understand the reasons for the delays were outlined to him, including the complexity of some of the background work that needed to be undertaken to inform the questions, clinical pressures on other staff etc. It was also highlighted to him that some of the delay had been as a result of his own requests for delays and his non-response to emails.

2. Provide any and all documents within your custody or under your control relating to paragraph (e) of the Terms of Reference except where those documents have been previously provided to the Inquiry by the SHSCT. Provide

or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. If you are in any doubt about the documents previously provided by the SHSCT you may wish to contact the Trust's legal advisors or, if you prefer, you may contact the Inquiry

2.1 I am no longer employed by the Trust. I have not retained any documents in relation to this investigation. Any documents I have considered in preparing this response have been provided by the Trust Inquiry Liaison Team or by Mrs Zoe Parks, Head of Medical HR, who kindly responded to an email and provided information about training and previous investigations in which I had been involved. I have copied the email in its entirety below. I did have extensive handwritten notes of each witness interview and the meetings with Mr O'Brien but, in keeping with GDPR requirements, I shredded those when I left the Trust in March 2020.

2.2 I believe I have been provided with comprehensive records to permit me to prepare this statement, but I have not been provided with an email from Mr O'Brien to Dr Khan (or Dr O'Kane?) enquiring about my fitness (qualifications, satisfactory appraisals, and training) to carry out such an investigation. I was sent the email and asked to provide the requested information. I did so. I no longer have access to the Trust email system and therefore am unable to locate the email for the Inquiry Team, but I expect the Trust team supporting the Inquiry will be able to locate it.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. When answering the questions set out below you will need to equip yourself with a copy of Maintaining High Professional Standards in the Modern HPSS' framework ('MHPS') and the 'Trust Guidelines for

Handling Concerns about Doctors' and Dentists' Performance' ('Trust Guidelines'). Policies and Procedures for Handling Concerns

3.1 I believe I have specifically addressed the issues raised in this Section 21 notice in my answers above and have added the additional information to each further question below.

4. In your role as Case Investigator what, if any, training or guidance did you receive with regard to:

I. The MHPS framework;

II. The Trust Guidelines; and

III. The handling of performance concerns generally.

4.1 I previously attended the National Clinical Assessment Service training on Case Investigation in the Trust. This was an intensive two-day training programme in March 2017, and a previous similar training event in 2010. (See below para 5.3.) I specifically asked to attend the update event in March which was to include training on the investigation role and responsibilities under the MHPS Framework.

4.2 I am aware of the Trust Guidelines for Handling Concerns about Doctors and Dentists' Performance. These Guidelines were issued in September 2010. As a Clinical Director and then Associate Medical Director, I would have had cause to refer to these Guidelines on several occasions. I believe the Trust Guidelines were mentioned at various AMD forum meetings and development days. I have not retained the agendas for those days. I have been involved with other investigations as a Case Manager and Case Investigator. Assistance and guidance were provided by staff from Medical HR and Employee Relations as needed.

4.3 As a medical manager, I was regularly involved with managing performance of other doctors in my Directorate.

4.4 I have extensive experience in acting as an independent expert in Court proceedings. This has involved in-depth interviews, detailed note-taking, and analysis of volumes of notes and records before weighing up information and reaching conclusions based on all the information available. I am accustomed to asking for additional information when I believe that is needed before I may form an informed, balanced, and fair opinion.

4.5 My background in working in mental health and the training I have received through that has also meant I am accustomed to listening, hearing, considering, and looking for other sources of corroboration.

5. Specifically, what if any training or guidance did you receive with regard to the conduct of investigations under Section I paragraph 31 of MHPS and the Trust Guidelines

5.1 Guidance was provided by staff from Employee Relations who had extensive experience of using the Maintaining High Professional Standards Framework. In this particular case, appropriate advice was appropriately sought from a specialist within the field (the Clinical Director, Mr Young) in cases where questions of clinical judgement were raised. Confidentiality was maintained. The investigation was primarily carried out by face-to-face interviews with witnesses, recorded at the time and then set into a statement and sent back to the witness for factual checking. All meetings were carried out by both me as Case Investigator and Mrs Hynds. Mrs Hynds provided guidance about the MHPS and Trust Guidelines in relation to all of this, though I had copies of both and referred to them as needed.

5.2 A written record was kept of the investigation by Mrs Hynds. We both also took notes of each interview and we used both sets of records to collate each witness statement. Mrs Hynds prepared the first draft, and I would have checked her draft against my own notes and made amendments as needed, before it was sent back to the witness for a further check. It has always been my practice to take very detailed notes, and to ensure records are accurate and comprehensive.

5.3 I attended a Medical Leadership Forum at which staff from NCAS undertook training on 24 September 2010. There was a specific 'Handling Concerns about Doctors Workshop' undertaken by an NCAS representative. (I have forwarded details of the course to the legal team which can located at *S21 No 41 of 2022 Attachments, Handling Concerns slides 2010 medical forum*. I had further training from NCAS staff specifically in relation to Maintaining High Professional Standards Framework Investigations on 7 and 8 March 2017 through the

Medical Management Training and Development Programme. This covered the roles and responsibilities of investigators and other people under the Framework and the training was titled, 'Case Investigators Training Workshop.' (I have copied this course programme to the legal team for it to be appended to this statement and *can be located at S21 No 41 of 2022 Attachments*, *Programme C1 SHCT170307-08 Delegate v2 Draft).* I have also had training in relation to investigation of serious adverse incidents (SAIs) and managing concerns in relation to trainee doctors, in my previous role as the Regional Advisor for Psychiatric Training in Northern Ireland. This is a role I undertook for almost five years. In my remit as a medical member of the Mental Health Review Tribunal I was required to assess patients and critically evaluate information and treatment plans as an independent expert. I provide reports for court as outlined at paragraph 4.4 above.

6. The Inquiry is interested in your experience of handling of concerns regarding any staff member. Prior to your involvement in respect of the case of Mr O'Brien, specify whether you ever have had occasion to implement or apply MHPS and/or the Trust Guidelines in order to address performance concerns and outline the steps taken.

6.1 I have previously had experience of using the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance in relation to investigations about senior trainees as well as consultants. I have carried out at a number of such investigations which involved interviewing witnesses, interviewing the doctor concerned, drawing conclusions from the investigation and, if appropriate, making suggestions towards recommendations to the Case Manager/Medical Director. On all occasions I was assisted by a senior member of staff from Medical HR or Employee Relations. On one occasion I undertook the Case Manager role.

6.2 I have also informally addressed concerns in relation to trainees in my roles through NIMDTA and as Associate Medical Director. Some of these would be in relation to concerns about psychiatric trainees and some would have been under the Trust Guidance in relation to trainees in other specialties. I have also dealt with complaints made by trainees about training which required investigation and interviews. A number of these would have ended at the informal level, as the level of concern was less significant, was a single incident and /or

the doctors involved showed good insight into the issue and a willingness to accept and address the issue.

6.3 I have been provided with the following detail from the Medical HR Manager, Mrs Zoe Parks:- (Her email in full to me May 2022)

To the best of my knowledge, I have you down for the following (6 cases). There were also a few other investigations that I know you were involved with, but they weren't managed/investigated under MHPS as such, such as the Dr AS queries into training in O&G DHH.

1. Dr XX 2021 ******** CI: N Chada CM: ******* HR ***** NED
2. Dr XX 2019 GMC CI: **** CM: N Chada HR ***** Bank Locum so referred
3. DR XX 2016 ******** CI: N Chada CM: ****** HR ***** NED:
4. Dr XX 2013 assigned CI: N Chada CM ***** HR ****** NED
5. Dr XX 2013 assigned CI: N Chada CM ***** HR ***** NED
6. Dr XX 2013 assigned CI: N Chada CM: ****** HR ****** NED

7. If you were not aware of or had not previously implemented or applied MHPS and/or the Trust Guidelines, what was your understanding of how you should address concerns relating to the performance of clinicians?

7.1 Not applicable.

8. Outline how you understood the role of Case Investigator was to relate to and engage with the following individuals under the MHPS Framework and the Trust Guidelines:

- **I. Clinical Manager;**
- **II. Case Manager;**
- **III. Chief Executive;**
- **IV. Medical Director;**

V. Designated Board member,

VI. The clinician who is the subject of the investigation; and

VII. Any other relevant person under the MHPS framework and the Trust Guidelines, including any external person(s) or bodies.

8.1 Clinical Manager

During the investigation I had contact with the clinical manager through a witness interview as well as email contact via Mrs Hynds to gather the information required to inform the investigation. No discussion or contact with the clinical manager outside those spheres occurred.

8.2 Case Manager

The Case Manager (Dr Khan) was kept appraised of the progress of the investigation and if any other concerns arose which might widen the investigation, for example, in this case, as the investigation progressed it became clear an additional term of reference should be considered and that was added. Concerns brought to the attention of the Case Manager were shared with us (myself as Case Investigator and Mrs Hynds) as appropriate, but otherwise the Case Manager did not take part in the investigation process. A Non-Executive Director (Mr Wilkinson) from the Trust Board had been appointed. My impression was the Designated Non-Executive Director appeared to also provide a support role for Mr O'Brien and contacted Mrs Hynds about the progress of the investigation, but I do not recall having any direct contact with the Non-Executive Director.

8.3 Chief Executive

As the Case Investigator I had no direct contact with the Chief Executive.

8.4 Medical Director

I had no direct contact with the Medical Director (Dr Richard Wright) other than when I was asked to engage in the investigation process when the previous Case Investigator had to be replaced. This occurred because it became apparent that, as the clinical manager involved in the service, he would be required to be interviewed as a witness. Contact with the Medical Director beyond that time would have been by the Case Manager (Dr Ahmed Khan).

After the investigation ended, and there were queries from the General Medical Council, the Medical Director contacted me and let me know about the queries and asked me to provide the answers to questions which were in my remit, as quickly and fully as possible.

8.5 Designated Board Member

There was email contact with the Designated Board Member (Non-Executive Director) in relation to the process of the investigation and the timeframe, as indicated above. Otherwise, I had no contact with the Designated Board Member. (Mr Wilkinson.)

8.6 The clinician who is the subject of the investigation

I believe I contacted Mr O'Brien by telephone to explain I had been asked to be the Case Investigator given Mr Weir, the previous Case Investigator, was required to step down because of a potential conflict. Beyond that time, contact with Mr O'Brien was always through the Employee Relations representative, Mrs Siobhan Hynds, to ensure one point of contact for Mr O'Brien. Mr O'Brien also contacted the Case Investigator (me) through Mrs Hynds or the Case Manager rather than contacting me directly.

Mr O'Brien was interviewed on two occasions, once earlier in the investigation and again later in the investigation after he had the opportunity to review the witness statements to allow him to comment. Mr O'Brien was provided with witness statements as they were being returned and signed. Some of the statements took longer to get back. Mr O'Brien reported dissatisfaction at both the length of time and the form the investigation was taking.

8.7 As Case Investigator I had direct contact with the following people involved in the investigation: the people interviewed for witness statements, the Case Manager and the clinician who was the subject of the investigation. I had limited contact with the Medical Director as outlined above. I had no direct contact with the Designated Board Member. Most of the email contact with the people involved was through Mrs Hynds, who did all the organizing and keeping Mr Khan appraised of the process. This entailed a substantial

amount of work on her behalf. I did not have any contact with external persons or bodies, though am aware the investigation had been progressed to a formal investigation following discussion with the National Clinical Assessment Service.

9. With regard to Section I paragraph 29 of the MHPS framework, what processes or procedures existed within the Trust to provide a clear audit route for initiating and tracking the progress of investigations, their costs and resulting actions? Who was responsible for ensuring such processes were in place and what role, if any, did you have as the Case Manager in relation to these matters?

9.1 I was not the Case Manager. I am aware the Case Manager tracked the progress of the investigation (as did I and Mrs Hynds). The Case Manager would have contacted us about delays and timeframes. The Case Manager was advised the time the investigation was taking was because of the need to interview a number of witnesses who had competing clinical demands, and the delays at the request of Mr O'Brien. I believe Mrs Hynds updated the Case Manager on a regular basis by email and by phone.

9.2 I don't believe any of us (the Case Manager, Mrs Hynds who was assisting me, nor I) were made aware of the costs as such, though all of us knew there were extra sessional payments being made to Consultants in Urology for review of clinical data (look-back exercise) to inform the Investigation.

9.3 I am not aware of any formal processes undertaken which would have provided a clear audit route for initiating or tracking the progress of investigations. Nor am I aware of a process within the Trust to be able to audit who was carrying out investigations though I understand a record of trained individuals was kept, and a record of completed investigations was also retained. (For example, I was able to access information from Medical HR for this statement about investigations with which I had previously been involved.) Whatever processes were in place, they were through the HR/Employee Relations Department. I had no role in relation to this.

Investigation in relation to Mr O'Brien

Urology Services Inquiry

10. In respect of concerns raised regarding Mr. Aidan O'Brien:

I. When did you first become aware that there were concerns in relation to the performance of Mr. O'Brien?

II. If different, also state when you became aware that there would be an investigation into matters concerning the performance of Mr O'Brien?

III. Who communicated these matters to you and in what terms?

IV. Upon receiving this information what action did you take?

10.1 I first became aware of concerns in relation to Mr O'Brien's performance in February 2017 when I was approached to become the Case Investigator for an investigation being carried out under maintaining High Professional Standards Framework. I was a Consultant Psychiatrist and an Associate Medical Director in Mental Health and Disability at that time. I was not involved in the Surgical/Acute Directorate and therefore wasn't aware of any discussion/issues prior to my being approached.

10.2 As above.

10.3 I believe I was contacted by the Dr Richard Wright, Medical Director, by phone indicating there was an ongoing investigation. The Case Investigator needed to step down from his role as he had a clinical management responsibility for the doctor being investigated which would mean he might be called as a witness. I was advised there had been contact with the National Clinical Assessment Service who had recommended the investigation should follow the Maintaining High Professional Standards Framework rather than the Trust framework and that Terms of Reference had already been drawn up. I was advised the person assisting the investigator was Mrs Siobhan Hynds, who would remain in her role.

10.4 Upon being invited to be the Case Investigator, I contacted the senior HR manager who was to assist me, Mrs Hynds. I believe I also met or had a telephone conversation with Dr Ahmed Khan who was the appointed Case Manager. Dr Khan and Mrs Hynds updated me in terms of the background issues, the areas of concern, what work had been undertaken, why Mr Weir was being replaced as a Case Investigator, and the Terms of Reference.

Urology Services Inquiry

11. Outline all steps you took, information you considered and advice you received from the designated HR Manager, NCAS or any other person in preparing the investigation report into concerns relating to Mr. O'Brien dated 12th June 2018.

11.1 I met with Mrs Hynds and we considered the Terms of Reference and the information that was required in order for us to be able to fully address the issues raised in the Terms of Reference. I established what audits and reviews were being undertaken/needed to be undertaken to gather the information. We discussed the timeframe and the fact information needed to be gathered to ensure we could appropriately put questions to Mr O'Brien. Mrs Hynds and I went through the Maintaining High Professional Standards process and Guidelines. Mrs Hynds clarified the training I had received. She advised me NCAS had already been consulted.

11.2 As part of the investigation, face-to-face interviews were carried out with a number of witnesses. Statements were produced and the witnesses were asked to factually check their statements. The information gathered from audits, reviews, SAIs, clarification about undictated clinics and missing records was gathered. The information about Mr O'Brien's private patients was gathered and Consultants were asked to comment on whether those patients should have been added to theatre lists at that particular time, and to consider what triage rating they would have given to referral letters which had been allocated to Mr O'Brien for triage but which had not been triaged by Mr O'Brien.

11.3 Mrs Hynds advised me of the timeline of the investigation to date and outlined the meetings that had already been undertaken with Mr O'Brien. She advised me Mr O'Brien had initially been immediately excluded and had been asked to return all casenotes and undictated charts/dictation from his home. She indicated Mr O'Brien's exclusion was subsequently lifted and it was planned that Mr O'Brien would return to work with a clear management plan for supervision and clear monitoring arrangements. Mrs Hynds also advised me Mr O'Brien had been off work due to unrelated health problems. I am not aware of the parameters under which Mr O'Brien returned to work, or whether they were adhered to. This was not my role under MHPS.

11.4 Through the process of the investigation a significant amount of data was gathered. It was clear gathering the data had been time-consuming and painstaking work. I was advised there had been meetings with Mr O'Brien in December, January and February 2017. My first meeting with Mr O'Brien was in August 2017 when the concerns highlighted under the Terms of Reference were put to him. Mrs Hynds and I subsequently met with Mr O'Brien again in November 2017 to seek a response to one particular Term of Reference, which he had asked to be put to him later as he wanted to have more time to consider the information gathered and the comments of his colleagues on the private patient issue. We were also to gather any other comments from Mr O'Brien in relation to the investigation.

12. Section I paragraph 37 of MHPS sets out a series of timescales for the completion of investigations by the Case Investigator and comments from the Practitioner. From your perspective as Case Investigator, what factors contributed to any delays with regard to the following:

I. The conduct of the investigation;

II. The preparation of the investigation report;

III. The provision of comments by Mr. O'Brien; and

IV. The making of the determination by the Case Manager.

Outline and provide all documentation relating to any interaction which you had with any of the following individuals with regard to any delays relating to matters (I) – (IV) above, and in doing so, outline any steps taken by you in order to prevent or reduce delay:

A. Case Manager;

B. Designated Board member;

C. the HR Case Manager;

D. Mr Aidan O'Brien; and

E. Any other relevant person under the MHPS framework and the Trust Guidelines.

12.1 Section I. The investigation's Terms of Reference required significant additional work to be carried out so that concerns could be properly quantified and understood. The senior clinicians were therefore required to trawl through undictated clinics, look at private patients and assess the referrals for patients who had not been triaged, i.e., providing the information needed to inform the investigation with facts and figures. These clinicians all also had a service to run. A number of the other witnesses needing to be interviewed also had competing managerial and other demands. There were difficulties in arranging meetings with Mr O'Brien due to the clinical commitments both of Mr O'Brien and my own clinical commitments, as I was also a full-time clinician, and the other demands on Mrs Hynds' time. Annual leave also became an issue as the investigation progressed over the summer months of 2017. Indeed, in an effort to expedite the process I had agreed to a suggestion by Mr O'Brien that we would meet him on 1st July which was a Saturday, however, Mr O'Brien later indicated he would prefer to wait until the beginning of August. Delays were also incurred with people being on annual leave/sick leave impacting on their ability to attend interviews for witness statements and review and return their witness statements. A number of the witnesses were clearly very anxious about their statements and took a long time to return them. As Case Investigators, we felt it was important for Mr O'Brien to have had sight of all the witness statements prior to the second meeting. Mr O'Brien indicated he was of the same opinion. Mr O'Brien was given time to respond to the witness statements. Mr O'Brien provided a commentary at a time from all the information being provided to him and indeed to avoid further delay with concluding the investigation, Mrs Hynds and I agreed Mr O'Brien's drafted statement and his comments on it would be included in full as appendices.

12.2 Section II. The preparation of the investigation report also was a time-consuming process as the investigators considered all the information available to them, and had to consider whether they had sufficient information to draw informed conclusions. We also had to ensure we had addressed the issues that had been raised in the Terms of Reference. There was a lot of information to go through and we had to ensure we had properly understood processes, outcomes and what had happened and why. We needed to ensure we understood what Mr O'Brien's role was in what had happened and the outcomes.

12.3 Section III. As indicated above, the commentary provided by Mr O'Brien was somewhat delayed and was therefore added in full to the Report along with the drafted

statement. We met with Mr O'Brien for a second (and last) time in November, but he did not provide his comments until April. We had extended the timeline on a number of occasions and felt we needed to progress the investigation, draw conclusions and present findings to the Trust.

12.4 Section IV. I am unable to comment on any delays in the making of the determination by the Case Manager. Once the case investigation report was finalised by Mrs Hynds and I, the matter was shared with the Case Manager, Dr Khan, who was to consider the investigation report and our conclusions. I had no further involvement.

12.5 In order to speed up the process, correspondence by phone and email was utilised in interactions between the investigators, the Case Manager, and Mr O'Brien. I understand there was also regular email correspondence between the managers and others who were responsible for providing the investigators with the information needed. (There is reference to the HR case manager in this Section 21 question, in this case the HR case manager was also assisting the Case Investigator.) There were also meetings between Mrs Hynds and I to ensure the appropriate information was being gathered, to monitor any delays, and to ensure that information was shared with the Case Manager. Mrs Hynds undertook to have regular contact with the Case Manager to appraise him of the progress and outline any delays.

13. Outline what steps, if any, you took during the MHPS investigation, and outline the extent to which you were kept appraised of developments during the MHPS investigation?

13.1 I believe I was kept appraised of developments in terms of the findings of various audits, reviews and information gathered, in a timely fashion. This was mostly by email.

MHPS Determination

14. On 28 September 2018, Dr Ahmed Khan, as Case Manager, made his Determination with regard to the investigation into Mr O'Brien. This Determination, inter alia, stated that the following actions take place:

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I. The implementation of an Action Plan with input from Practitioner Performance Advice, the Trust and Mr O'Brien to provide assurance with monitoring provided by the Clinical Director;

II. That Mr O'Brien's failing be put to a conduct panel hearing; and

III. That the Trust was to carry out an independent review of administrative practices within the Acute Directorate and appropriate escalation processes.

With specific reference to each of the determinations listed at (I) – (III) above address,

A. Who was responsible for the implementation of each of these actions?

B. To the best of your knowledge, outline what steps were taken to ensure that each of these actions were implemented; and

C. If applicable, what factors prevented that implementation.

D. If the Action Plan as per 14(I) was not implemented, fully outline what steps or processes, if any, were put in place to monitor Mr O'Brien's practice, and identify the person(s) who were responsible for these? Did these apply to all aspects of his practice and, if not, why not?

14.1 As Case Investigator I drew a number of conclusions in relation to the Terms of Reference. Dr Ahmed Khan as the Case Manager made his determination in relation to the investigation and outlined actions which needed to be undertaken. I was not informed in a formal way of the outcome/detail of Dr Khan's determinations. I believe I was advised by Mrs Hynds that Dr Khan had accepted our findings and was contacting the Practitioners Performance Advice Service (previously known as NCAS). I was advised Mr O'Brien's failings were likely to be put to a Conduct Panel. None of this was formal feedback. Though I was copied into an email from Mrs Hynds on 23 September 2019 to Dr O'Kane (then Medical Director) indicating there had been a request from the GMC triage team for more information in relation to Mr O'Brien's practice, his lack of insight as reported by the Investigation, and highlighting the Investigation Report's conclusions of systemic failures by

managers. I was asked to confirm the Trust's responses to questions posed were accurate and complete. I did so for the areas of which I had knowledge.

14.2 With reference to these determinations, I am not aware of who was responsible for the implementation of any action plan/Dr Khan's determination. My involvement in this process ceased once the Investigation Report was handed over to Dr Khan. I am therefore unable to comment on Dr Khan's action plan or how it was implemented.

14.3 I was later (June 2019 email from Mrs Hynds to me located at *Relevant to PIT/ Evidence Added or Renamed 19 01 2022/ Evidence no 77/ No 77 – Dr Neta Chada/ 20190609 – E Urgent response for tomorrow* contacted to provide answers to queries from the General Medical Council about the investigation and did so by email to the then Medical Director, Dr Maria O'Kane.

Implementation and Effectiveness of MHPS

15. Having regard to your experience as Case Investigator, in relation to the investigation into the performance of Mr Aidan O'Brien, what impression have you formed of the implementation and effectiveness of MHPS and the Trust Guidelines both generally, and specifically as regard the case of Mr O'Brien?

15.1 The issue with Maintaining High Professional Standards and the Trust Guidelines are the timeframes which are unrealistic (one might even say impossible unless it is a very straight forward investigation) and don't seem to consider the varying demands on peoples' time. Indeed, as happened in this process, people are being asked to continue with their clinical work and day to day demands, and to gather the information for these processes outside of that. i.e., mostly these investigations are not part of anyone's job plan, and this leads to delays causing frustration/upset for the person under investigation. It is my view that the effectiveness of the investigation process under Maintaining High Professional Standards and the Trust Guidelines depends on the commitment of the people involved, the thoroughness of the investigation (which needs time to do it properly), the information that can be provided to inform the investigation and the resource available (time and secretarial time). For example, whilst my secretary (who was very obliging) kindly did some of the

typing needed, some of the typing I did myself as I made changes and added information, and I am aware the assistant I had from HR did a lot of work, as well as a significant amount of typing herself. This seems a very inefficient use of our time.

15.2 Mr O'Brien repeatedly complained about delays in the process. These were caused by the sheer volume of information to be gathered, the difficulty with getting timeslots for witnesses, delays in witnesses returning their signed statements, competing demands on my time as a clinician and also the significant delays incurred as a result of Mr O'Brien's own availability (sickness absence, clinical demands, appraisal and not responding to emails in a timely fashion). We were mindful about pushing too strongly when Mr O'Brien did not respond as we had been informed he had been unwell in the previous year.

15.3 I would offer much the same comments about the Trust Guidelines when using the informal process; although those timeframes are not quite the same and my experience is that use of the informal process doesn't seem to cause the same amount of angst in doctors under investigation.

15.4 Generally, I believe the processes and findings on this occasion were robust, balanced (note our adoption of ToR 5), and led to clear conclusions which then generated and informed a clear action plan.

16. Consider and outline the extent to which you feel you can effectively discharge your role as Case Manager under MHPS and the Trust Guidelines in the extant systems within the Trust and what, if anything, could be done to strengthen or enhance that role.

16.1 On this occasion I was not the Case Manager, but I feel having people allocated as Case Managers and Case Investigators as part of their job plan, i.e., protected time, would be helpful. This allows individuals to build up their skills and familiarize themselves with the processes, so they are not having to refer back to the MHPS Framework or Trust Guidelines as often. Specific administrative/secretarial time would also be helpful for both the clinical and non-clinical/HR investigators.

17. Having had the opportunity to reflect, outline whether in your view the MHPS process could have been better used in order to address the problems which were found to have existed in connection with the practice of Mr O'Brien.

17.1 As a Case Investigator I formed the view issues with Mr O'Brien's practice had been identified in the past and not fully addressed. It is my view this happened for several reasons. Secretaries, managers (at various levels) and colleagues were aware of some of the issues. However, I formed the impression no-one appeared to be aware of all of the issues. I understood there were difficulties in addressing issues in the past as Mr O'Brien had made complaints and this appeared to have led to anxieties within the system about how concerns could be progressed, being mindful to ensure everyone's rights were upheld. There were also changes of personnel in various management posts which I think also added to the difficulties in recognizing the extent of issues and addressing them.

17.2 It seems appropriate to address issues initially informally and then to progress down more formal routes if informal processes don't result in the desired outcome. I think the MHPS process might have been used earlier in this case, however, I am aware one of Mr O'Brien's complaints to us was that it was being used at all. He believed it was used too soon, and without other avenues being exhausted. It seemed to me from the time these processes started in March 2016, a long period of time passed as the Trust tried to ensure the process was properly adhered to in an effort to prevent any future criticism or threat of legal action. The Trust management's level of anxiety about this was clear to me. Mr O'Brien had already made complaints and he had accused a previous medical manager, who was trying to address Mr O'Brien's practice, of harassing him. (Refer to MHPS witness statements by Mr Mackle and Mr Weir.) *Relevant documents can be located at Relevant to HR/ Reference No 1/ MHPS Investigation/ Appendix 15 Witness Statement – Mr E Mackle 240417 and Appendix 18 Witness Statement – Mr C Weir 240517.* I believe there had been a threat of legal action, though I am not sure from where I heard that.

17.3 It does seem having dedicated time for staff, both from a Case Investigator/HR point of view and from an admin point of view, would speed up the process, however, there would still be a requirement for data gathering, comparison with standard practice etc., some of which can only be carried out by clinicians. The process was aided by being able to speak to

clinicians who explained how the referrals into the specialty/theatre lists/waiting lists should operate.

17.4 It was clear to me through the investigation that managers had tried to address issues with Mr O'Brien in the past and had been thwarted in doing so. "Work arounds" had been set up by managers and even admin staff to try and ensure the system remained as safe as possible in the absence of Mr O'Brien carrying out the triage work, dictating on clinics and keeping notes at home. Admin staff tried to ensure notes were returned as needed. At investigation, it seemed to me that Mr O'Brien is "an old school" consultant surgeon who had been supported by a personal secretary for many years and who had worked under a system he had essentially set up until increasing demand, more consultants and a review of the service and processes meant he was no longer able to continue to operate as a sole practitioner and needed to work as part of a team. I believe Mr O'Brien had difficulties adapting but failed to adequately bring to peoples' notice the things that he wasn't doing. He continued to work in the way that he always had, for example, by taking notes home with him and not always dictating following a clinical contact. These were out-dated practices which were not consistent with GMC Guidance, nor Trust policy.

17.5 I understand Mr O'Brien was advised about the outcome of the investigation on 1st October 2018, following the Case Manager's review of the investigation report.

Additional Comments

18.1 It would be helpful for Case Investigators to receive feedback from the Case Manager, indicating whether the investigation had addressed the issues. At a later stage, it would also be helpful if the Case Investigator was advised about the Case Manager's Determination (as this is a learning opportunity and a form of feedback).

18.2 My experience of this process is one of concern. These investigations are voluntary roles undertaken along with clinical and management roles rather than instead of those roles. Significant time, often personal time, is entailed. It is often undertaken due to a sense of wanting to improve the quality of patient care, a sense of responsibility and to some extent a sense of '*quid pro quo'* i.e., if there is a similar investigation required within your own Directorate, another clinician will volunteer to carry out an independent investigation.

Unfortunately, with Case Investigators, Case Managers, and SAI Chairs facing the prospect of being called to a Coroner's Court or Public Inquiry, it seems likely these roles are going to have to be formalized, as it would be difficult to imagine people would continue to volunteer. There is a significant amount of time involvement in these processes which is time taken away from frontline services, at a time when Trusts are under so much pressure. Answering these 17 questions alone has taken many hours of reviewing notes and records and away from other work. That is not to say we don't strive to improve and to learn, but how we do that more efficiently along with addressing increasing clinical demand is the conundrum.

18.3 In providing my answers above I have not gone into the detail which is contained in the investigation report itself which I understand is already available to the Inquiry Team, nor the detail provided in the witness statements, which are lengthy and detailed. (The Inquiry Team has also been provided with all the witness statements.) Whilst I believe a number of different people knew there were issues with Mr O'Brien's practice, I formed the impression different people knew different things at different times, and the pressures on workload, waiting lists and changes of personnel meant that no-one (in my opinion) appeared to be aware of the full extent of the issues. Once the extent of the issues became more apparent it does seem the Trust management system attempted to address those issues with Mr O'Brien, and my impression was that he thwarted them by making complaints, hinting at legal action and trying to deflect/distract. At interview he was arrogant at times, and I believe there were subtle attempts to intimidate, for example, by bringing along a relative who was a [redacted] and sending an email enquiring about my qualifications to lead such an investigation, whether I had revalidated, was up-to-date with my CPD, etc. (I believe the email was sent to Medical Director or Dr Khan, which I think was after the investigation was completed.)

Personal information redacted by USI

18.4 I understand Mr O'Brien was allowed to return to work under supervision and with monitoring. I was copied into some emails during the process of the investigation indicating that the supervision and monitoring was progressing reasonably well, though I note other managers had indicated when they had raised issues with Mr O'Brien in the past in an informal way his practice would often improve for a period but then slip back. I am unaware of how he progressed on his return as I was not advised of that. (I believe emails of progress

during the investigation were the emails to Dr Khan from the Service Manager Mr Carroll in May or June 2017.)

18.5 I was not involved with this process beyond the conclusion of the Investigation Report in the spring of 2018. The following year I was advised that, whilst the MHPS Case Manager Determination notified to Mr O'Brien in October 2018 had been that a referral to the GMC was not appropriate until internal processes were concluded, (as the Case Manager was awaiting outcomes of further SAI reviews), I received an email in September 2019 indicating discussion with the Trust's GMC Liaison Officer led to the Trust being asked to make a referral to the GMC. Subsequently, there were further queries from the GMC about the investigation, some of which I was asked to provide answers for. (*20190609 - Email - URGENT FOR RESPONSE TOMORROW Letter to GMC from Medical Director, 20190609 - Attachment - Letter to MD from GMC 23 May 2019, 20190609 - Attachment - Draft letter from MD to GMC 10 June 2019 located at Relevant to HR, Evidence after 4 November HR, Reference 77, S Hynds No 77*)

18.6 I am not aware of anything else that would assist this Inquiry.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: [redacted]

Personal Information redacted by the USI

Date: ___24.6.2022_____

S21 41 of 2022

Witness statement of: Dr Neta Chada

Table of Attachments

Attachment	Document Name
1	1. Handling Concerns - slides 2010 medical forum
2	2. Programme CI SHCT170307-08 Delegate v2 Draft

Southern Health and Social Care Trust

Medical Leadership Network

Handling Concerns Workshop
24th September 2010

Southern Health and Social Care Trust

Objectives

- To understand the Trust's guidance on Handling Concerns
- To discuss the internal and external support available for CDs and AMDs
- To clarify the CD and AMD roles in applying the Guidance

Workshop Outline

WIT-23793

Southern Health and Social Care Trust

- Background to workshop – Dr Loughran
- NCAS – Dr Colin Fitzpatrick
- Trust Guidance- Vivienne Toal and Siobhan Hynds
- Case Studies to explore CD and AMD roles

National Clinical Assessment Service

Case investigator training workshop

For Southern Health and Social CareTrust

Tuesday 07 – Wednesday 08 March 2017

09:15-16:45 (Day 1) and 09:00-16:00 (Day 2)

Seagoe Parish Centre, 46 Seagoe Road, Portadown, BT63 5HS

DRAFT DELEGATE PROGRAMME

This two-day workshop has been designed specifically for anyone who undertakes the case investigator role in investigations about practitioners, which may emerge from the processes underpinning revalidation or from concerns raised about performance. The workshop is interactive and uses case studies to explore and develop the key skills and knowledge required by case investigators.

Learning objectives
By the end of the two-day programme, delegates will be able to:

- Explore how concerns about a practitioner's practice arise and identify the most common factors affecting performance
- Explain why the decision to investigate is made and suggest other options to resolve performance concerns
- Describe roles and responsibilities of those involved in investigations
- Plan for an investigation which meets national requirements
- Describe the principles of robust and meaningful terms of reference and know how to work within them
- Collect, review and weight evidence
- Conduct an investigative interview using a structured approach
- Recognise the key skills and attributes of a case investigator
- Recognise their own limits of competence and access sources of support and expertise
- Reference relevant national/local standards
- Write an investigation report with conclusions
- Describe the potential legal challenges to an investigation.

Pre-reading
Questions to consider prior to attending the workshop:

- What is the role of the Case Investigator?
- When might an investigation of a concern be necessary?
- What is the purpose of an investigation?

Draft programme

This programme is indicative of the content areas which will be covered. Timings are flexible and will be tailored to focus on areas of particular interest to delegates.

Facilitators: Dr Colin Fitzpatrick, Senior Adviser (NI) and Dr Grainne Lynn, Adviser, National Clinical Assessment Service

DAY 1

08:45-09:15	*Registration and refreshments*
09:15	Welcome, introductions and overview of the workshop
09:35	**Dealing with concerns about a practitioner's practice:** • Performance concerns • Overview of investigations • Frameworks for managing concerns: - Toolkit for managing performance concerns in primary care - PLR - MHPS • Workshop A: Dealing with concerns about a practitioner's practice.
10:45-11:00	*Break and refreshments*
11:00	**Investigation roles and responsibilities:** • Case investigators • Case managers • Responsible officers • Decision making groups • Other stakeholders/parties, including clinical experts • Supporting the practitioner.
11:30	**Starting the investigation:** • Linking with the case manager • Terms of reference • Planning the investigation • Principles of investigation • Bias and prejudice (perceptions and reality).
12:00-12:45	*Lunch*
12:45	**Workshop B: Critiquing terms of reference and responding to a case manager's request.**

13:45*	**Gathering evidence:** • Sources of potential evidence • Evidence log • Documentary evidence • Evidence/comments from the practitioner • National and peer standards and guidance • Weighting and judging evidence • Workshop C: Investigation of Dr Purple – review of documentary evidence.
	**Refreshments available from 15:15*
15:45	**Gathering evidence:** • Collecting evidence from interviews • Inviting witnesses to interviews • Structuring interviews • Workshop D: Investigation of Dr Purple – interviewing witnesses (trainer-led role play).
16:35	Briefing on homework
16:45	*Close*
Homework	**Approx 1 hour to be undertaken in advance of Day 2** Prepare for Workshop E: Investigation of Dr Purple – interviewing witnesses (delegate-led role play)

DAY 2

09:00-09:15	*Registration and refreshments*
09:00	Review of day 1 – learning points
09:10*	**Workshop E: Investigation of Dr Purple – interviewing witnesses (delegate-led role play)**
	**Refreshments available at 11:00*
11:15	**Report writing:** • Drafting a witness statement • Following up with witnesses • Structure • Workshop F: Investigation of Dr Purple – report writing.
12:45-13:30	*Lunch*
13:30	**Workshop F: Investigation of Dr Purple – report writing (cont)**
14:00	**Supporting the practitioner**
14:05	**What happens next?** • Presenting the management case • Consideration of report • Outcomes • Remediation.
14:25	**Responding to legal challenges – the role of the case investigator**
14:40-14:55	*Break and refreshments*
14:55	**Workshop G: Investigation of Dr Purple - responding to legal challenge**
15:40	**Support for case investigators**
15:50	**Review of learning**
16:00	*Close*

Learning methods

There will be a number of opportunities for delegates to discuss and explore their own experiences and case studies in an appropriately confidential setting. Case studies will be used as learning tools for individual skills development and sharing of learning and experience.

NCAS' Statement of principles

During the workshop NCAS will present fictional learning material, which has been compiled through NCAS' work, to enable the sharing of your and NCAS' experiences of dealing with concerns about practitioner's performance. When discussing your own experience of cases, please make every effort to ensure that any information which identifies individuals or organisations is removed and fully anonymised. If you do hear information about a case which leads to, or gives the impression of, identification of the details of the case please treat this information as **strictly confidential**.

For more information about NCAS' Statement of principles please access our website on http://www.ncas.nhs.uk/events/confidentiality-principles/