Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
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Esther Gishkori
C/O
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Madam,

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

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

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.

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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 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 35 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:

Esther Gishkori
C/O
Southern Health and Social Care Trust
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**.

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

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: Personal information redacted by USI

Christine Smith QC

Chair of Urology Services Inquiry

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

SCHEDULE
[No 35 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 Director of Acute Services 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. In your role as Director of Acute Services what, if any, training or guidance did you provide or arrange on the MHPS framework and the Trust Guidelines to be provided to:
    I. Clinical Managers;
    II. Case Investigators;
    III. designated Board members; and
    IV. Any other relevant person under the MHPS framework 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. Outline how you understood the role of Director of Acute Services 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. Case Investigator;
    IV. Chief Executive;
    V. Medical Director;
    VI. Designated Board member,
    VII. The clinician who is the subject of the investigation; and

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

8. 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 Director of Acute Services in relation to these matters?

9. Fully describe your role with regard to the establishment, responsibilities and functioning of the 'Oversight Group,' as referred to at paragraph 2.5 of the 2010 Guidelines. Further, please outline how your role differed from that of other regular attendees at the 'Oversight Group' namely:

    I. Assistant Director – Medical Directorate;
    II. Medical Director;
    III. HR Director; and
    IV. Medical Staffing Manager.

Handling of Concerns relating 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. Were the concerns raised, registered or escalated to the Chief Executive as required by Section I paragraph 8 of MHPS and paragraph 2.3 of the Trust Guidelines? If not, why not?

12. Outline the circumstances and the process by which you understand concerns in relation to Mr O'Brien came to be discussed by the Oversight Group on 13th September 2016 and address the following:

    I. From what source did the concerns and information discussed at that meeting emanate?
    II. What do you understand to have been decided at that meeting?
    III. What if any action did you take on foot of same?
    IV. If no action was taken, please explain why and refer to all relevant correspondence.

13. With specific regard to Section I Paragraph 15 of MHPS:

    I. Outline any attempts you, or those within your Directorate, made to resolve concerns in relation to the performance of Mr O'Brien informally in accordance with Section I Paragraph 15 of MHPS.
    II. What advice, if any, did you seek or receive when attempting to resolve the concerns informally?
    III. What, if any, engagement, did you have with Mr O'Brien in an attempt to resolve matters informally?

14. Outline when and in what circumstances you became aware of the following Serious Adverse Incident investigations and that they raised concerns about Mr O'Brien, and outline what action you took upon becoming aware of those concerns:

    I. Patient "Patient 10" (Personal Information redacted by the USI),
    II. The care of five patients (Personal Information redacted by the USI); and
    III. Patient "Patient 16" (Personal Information redacted by the USI).

15. Outline the circumstances and the process by which you understand concerns in relation to Mr O'Brien came to be discussed by the Oversight Group on 22 December 2016 and address the following:

    I. What information was before the Oversight Group on that date, and from what source did the information discussed at that meeting emanate?

II. What do you understand to have been decided at that meeting, and what action was to take place following that meeting?

III. What steps did you take as Medical Director to ensure that those actions took place?

16. With reference to specific provisions of Section I of the MHPS and the Trust Guidelines, outline all steps you took as Director of Acute Services once a decision had been made to conduct an investigation into Mr Aidan O'Brien's practice in line with that Framework and guidance.

17. When, and in what circumstances, did you first became aware of concerns, or receive any information which could have given rise to a concern that Mr O'Brien may have been affording advantageous scheduling to private patients.

18. With regard to the Return to Work Plan / Monitoring Arrangements dated 9th February 2017, see copy attached, outline your role, as well as the role of any other responsible person, in monitoring Mr O'Brien's compliance with the Return to Work Plan and provide copies of all documentation showing the discharge of those roles with regard to each of the four concerns identified, namely:

I. Un-triaged referrals to Mr Aidan O'Brien;

II. Patient notes tracked out to Mr Aidan O'Brien;

III. Undictated patient outcomes from outpatient clinics by Mr Aidan O'Brien; and

IV. The scheduling of private patients by Mr Aidan O'Brien

19. What is your understanding of the period of time during which this Return to Work Plan/Monitoring Arrangements remained in operation, and which person(s) were responsible for overseeing its operation in any respect?

20. With specific reference to each of the concerns listed at (18) (i)-(iv) above, indicate if any divergences from the Return to Work Plan were identified and, if so, what action you took to address and/or escalate same.

21. 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 Director of Acute Services, what is your understanding of the factors which contributed to any delays with regard to the following:

a. The conduct of the investigation;
b. The preparation of the report;
c. The provision of comments by Mr O'Brien; and
d. 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:

i. Case Manager
ii. Case Investigator;
iii. Designated Board member;
iv. the HR Case Manager;
v. Mr Aidan O'Brien; and
vi. Any other relevant person under the MHPS framework and the Trust Guidelines.

22. 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

23. 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:

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

c. 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,

i. Who was responsible for the implementation of each of these actions?
ii. To the best of your knowledge, outline what steps were taken to ensure that each of these actions were implemented; and
iii. If applicable, what factors prevented that implementation.
iv. If the Action Plan as per 27(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

24. Having regard to your experience as Director of Acute Services, 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 regards the case of Mr O'Brien?

25. Consider and outline the extent to which you feel you can effectively discharge your role as Director of Acute Services 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.

26. 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

USI Ref: Notice 35 of 2022

Date of Notice: 29/04/2022

Witness Statement of: Esther Ann Gishkori

I, Esther Ann Gishkori, will say as follows:-

Paragraph 1

My name is Esther Gishkori and I was the Director of Acute Services in the Southern Health and Social Care Trust (SHSCT) from August 2015 until June 2020. I graduated from the University of Ulster Jordanstown in 2009 with a masters degree in public administration. I am from a nursing background, and I am also qualified to teach post graduate community nursing students.

This was my first job in the SHSCT. I had previously worked in the South Eastern Health and Social Care Trust (SEHSCT), working there since 1989 when it was Down Lisburn Trust. This was across several operational, governance roles and management roles, the last of which was the Assistant Director of Prison Health Care. A large part of this role was measuring practice in Northern Ireland Prisons against a given set of standards (audit) used elsewhere in the UK. Managing change and conflict as well as education in relation to safe and evidence-based practice was also part of this role. Before this I worked in a governance role (8B) in the "Safe and Effective Care" department of SEHSCT. This involved leading, designing, and completing clinical audit, monitoring trends and patterns in relation to incidents and accidents and leading reparative change. I managed the standards and guidelines team, helping junior doctors design audits and assisted consultants who needed to write or amend policies procedures or guidelines.

Finally, before joining the Southern Trust I had the opportunity to do some consultancy work in The Bahrain Prison System.

Paragraph 2

My predecessor in the SHSCT was Mrs Debbie Burns. Whilst I had the opportunity to shadow her on occasions throughout the summer of 2015, I didn't receive a handover, neither formal nor informal.

Mine was an operational role, looking after the day-to-day operations of all the acute sites in the Trust. These were Craigavon Area Hospital (CAH) Daisy Hill Hospital (DHH) and South Tyrone Hospital (STH) which did not have an Emergency Department (ED) but had a minor

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injuries unit, elective surgery sessions and Out-Patient clinics. There were 4 broad areas I needed to consider as part of my role: Finance, Performance, Governance and Human Resources. In terms of "lines of reporting", I reported to the Chief Executive (who changed 7 times during my tenure) and of course Trust Board who were nonexecutive members and who held the Chief Executive and Directors to account by way of a monthly Trust Board Meeting.

In terms of training, I received a large folder which contained my responsibilities in relation to Trust Board. I no longer retain this folder and expect it is still in the possession of the Trust. I was taken through this folder by the Chair's personal secretary. I also received training on how to deal with the press and how to give an interview to the media. This was delivered by the organisation called "Red Box".

There was no other training of any kind.

My initial objectives were to find out about the Trust and its systems and processes, and what the organisational culture was like.

In terms of guidelines, there was no recognised Trust policy on writing guidelines or policies. A consultant physician decided to write a policy within his field of practice and put it on the Trust website with no problem. This posed many risks at many levels.

I immediately told the CE who agreed that this particular policy should be taken off the website.

I then told the Medical Director and offered to borrow a copy of the policy on the writing of guidelines and policies from the South Eastern Trust. This was an all-inclusive process to the writing, maintaining and monitoring of guidelines and allowed disciplines from all areas to comment and add to the guideline. By means of a systematic process, the author of the policy included /excluded all comments, and this process continued until everyone was satisfied. There wer then a strict set of rules as to who can put this guideline onto the intranet.

When Dr Maria O'Kane became Medical Director, I explained the same thing to her and shared the policy from the other Trust. This was not implemented during my tenure.

The Chair of the organisation during my time there was Mrs Roberta Brownlee.

My peers were:

The Director of Human Resources and Organisational Development – Vivienne Toal

The Director of Finance – Stephen McNally / Helen O'Neill

The Medical Director – Richard Wright / Maria O'Kane

The Director of Children and Young People's Services – Paul Morgan

The Director of Older People and Primary Care – Melanie McClements

The Director of Mental Health and Disability Services – Francis Rice

The Director of Performance and Reform – Aldrina Magwood

At this time, governance was an add-on to the responsibility of the Medical Director. Nursing and Allied Health Professionals were the responsibility of the Director of Mental Health

(because he was a registered nurse and therefore able to hold this executive role) and Estates was managed by the Director of Finance.

As the Director of Acute Services, I was also responsible for Maternity provision across the sites of CAH and DHH. Together they made up the biggest Maternity service in Northern Ireland.

Paragraph 3

I had six Assistant Directors (AD) who were a band 8C and who reported directly to me. They were:

AD for medicine – Anne McVey

AD for Surgery, Elective care and Anaesthetics – Ronan Carroll

AD for Radiology – Barry Conway

AD for Pharmacy – Tracey Boyce

AD Maternity and Women's health – Heather Trouton (Barry Conway when Heather moved to Director of Nursing).

AD Patient Experience (Including medical records) – Anita Carroll

AD HR – Helen Walker (This post was from the HR directorate but worked in conjunction with my other ADs in Acute Services).

In turn, my ADs had heads of service (HOS) who were normally grade 8B reporting to them. There were between 5 and 2 HOS per AD, depending on the size of the division. The teams cascaded down to 8As who were lead nurses, specialist nurses and some Allied Health Professionals (AHP) and then band 7s who were normally ward or department managers or other AHPs, right to band 5, 4 and 2 who worked right at operational level. Everyone had a vertical line of reporting.

I was insistent on very clear vertical lines of reporting with sound horizontal lines of communication. This was necessary in such a big team. Everyone was required to know what each other's roles and responsibilities were as well as their own. In a multidisciplinary arena failure to follow this caused chaos and ill feeling between staff members. I had an open-door policy and unless the person was discussing sensitive issues, I always asked if they had discussed things with their manager and if not, why not.

Within the acute directorate and as far as medical staff were concerned, all professional issues including job plans and revalidation were the responsibility of the Medical Director. All operational issues were the responsibility of the Acute Director. Clearly there was a big overlap in the roles with not every issue fitting neatly into either box. It was arranged therefore that the Medical Director and the Director of Acute would meet fortnightly but this was difficult to arrange with ongoing time pressures and the meeting did not always take place.

I agreed to give one of my Assistant Directors to the Medical Director. I was informed by the Director of Finance that this post would still be included in my budget as the medical Director no longer had the money for it. This was Simon Gibson. He is an 8C but was not a qualified Doctor. His was a senior clerical post and even though he was 8C I understood he was to work to the old 8B Job description with a few other duties added. I never saw this job description.

Paragraph 4

The Acute Directorate has always been by far, the biggest division in the organisation and spends annually circa 99% of the money. To that end, the following support was part of the Acute structure:

- From Finance - 2 divisional accountants who met all the assistant directors and their teams individually on a monthly basis. Further, the same accountants met the Director separately, also on a monthly basis. At these meetings, any drift from the agreed budget was discussed and reparative measures initiated. I found these meetings extremely useful, especially since such an emphasis was put on the financial health of the Trust. There was often unmet need in terms of finance which I then reported to the corporate Senior Management weekly team meetings which consisted of the Chief executive, all Directors and the Head of Communications. Towards the end of my tenure, the two divisional accountants were removed without explanation or notice.
- From Performance and Reform – 2 members of the performance team (normally the assistant director and an 8B) visited the acute teams separately and discussed all issues of performance. They also visited the Acute Senior Management meeting on a monthly basis. These were long and complex meetings that reflected the harsh reality that there simply wasn't enough staff or space to see patients or for the surgeons to operate. Interestingly, money was not usually the issue here. Getting it spent was a recurrent difficulty. Often the Health and Social Care Board (HSCB) allocated money that had to be spent before the end of the financial year in March. This was non recurrent money so staff could not be recruited in time. Every Trust was in the same position so the private sector was saturated and could not facilitate the demand. 3-5 yearly budgets were requested but this was not agreed by the department during my tenure. Another problem was a hospital full of medical patients taking up beds that should have been reserved for surgical patients. Surgery was postponed on a regular basis.
- Human Resources It had always been the case that a senior member of HR was based in and worked solely for the Acute Directorate. Having so many staff in the division, this was an invaluable resource. They dealt with secondments, recruitment, disciplinary issues, job descriptions and anything else that fell within the HR remit

Paragraph 5

As previously stated, I was responsible for the operational element of delivering the service. To communicate in a meaningful and organised way with my medical colleagues, I met with the Associate Medical Directors (AMD)s monthly. They were appointed by the Medical Director and answered directly to me in terms of operational delivery. They were responsible for the following areas:

Dr Philip Murphy – AMD for medicine and ED

DR Charlie McAllister /Dr Damien Scullian – AMD for anaesthetics (consecutively)

Mr Eamon Mackle / DR Charlie McAllister /Mr Mark Haynes – AMD for surgery (consecutively)

Dr Stephen Hall (now deceased) Dr David Gracey/ Dr Shahid Tariq - AMD for radiology (consecutively)

Dr Martina Hogan – AMD for maternity and women's health.

At the monthly meeting with the AMDs the Assistant Director from that area also attended. It meant that any actions from the meeting would be disseminated to the whole team and go to the appropriate personnel for action. Often the representative from HR or Finance attended depending on what was going to be discussed.

In turn, the AMD had a Clinical Director (CD) reporting to him/her. They were responsible for clinically managing their team. This included training and development, housekeeping issues, collating information to present to the AMD, answering their part in complaints in a timely way and any other business in relation to the smooth running of their section. This was a busy role and they often deputised for the AMD at meetings and as appropriate.

Paragraph 6

Below is a table of the regular meetings that required clear lines of reporting within the Acute Directorate.

MEETING	CHAIR	FREQUENCY	ATTENDEES	AGENDA
Acute SMT	Director of Acute	Weekly – on same day, after Corporate SMT	All ADs and any colleagues with specialist input e.g. performance team or divisional accountants.	Corporate agenda items from earlier passed on for info or action. Governance, Finance, HR and Performance rotated each week. On extra weeks in the month, training items are added, eg, visiting presentations from a range of specialties.
Corporate SMT	Chief Executive	weekly	All executive directors	Finance,Governance,Human Resources,Performance always on the agenda. Was mostly applying for funding for a project. Chair shared a corporate overview of all Trusts and HSCB over the week.

Friday Morning Governance	Director of Acute	Every 4th Friday Morning at 8am.	Governance team, all ADs, All AMDs and all CDs. Video linked to DHH.	A wide range of governance agenda items. **See note below.
AMD meetings	Director of Acute	Monthly wherever diaries could correlate	AMD,Director and AD from the AMD'S area.	Normally led by the AMD or AD, this informal style meeting discussed any topic or issue they felt appropriate

*Governance meetings;

When I joined the SHSCT, there was no governance team in the Acute Directorate. There were a few admin band 2s in the corporate office and one band 8A in acute.

Having looked at my budget, I found that there was funding for an 8C, an 8B, two band 7s and some 5s, 4s and 3s. One of my first priorities was to fill these posts. Once appointed, the 8C and 8B led the Friday morning governance meeting.

Unfortunately, due to a backlog in the processing of Serious Adverse Incidents (SAI)s, this meeting was largely taken up with those but the eventual aim was to cover a wide range of governance topics.

Dr Gillian Rankin was the Acute Services Director before Debbie Burns. She told me she had set up the Friday governance meeting as governance did not feature anywhere when she joined. The meeting was virtually non-existent when I joined but it was not difficult to revive as the Terms of reference and list of attendees were already there. I included the Clinical Directors in the list of attendees as they often brought a different perspective to the topics discussed.

Paragraph 7

Mr O'Brien

An e mail to me from the Medical Director, Dr Richard Wright on 9th February 2016, suggested that in replying late to an e mail from a member of the legal team, Mr O'Brien (who from the time line of his e mails suggested that he was working almost 24/7) was crying out for help. This was the first time Mr O'Brien had been mentioned to me as possibly having an issue.

At their AMD meeting around the end of February / beginning of March, Heather Trouton (Assistant Director for surgery) and Eamonn Mackle (AMD for surgery) told me that they were going to write to Mr O'Brien telling him he needed to complete his triage referrals quicker, complete timely dictations and that he needed to be quicker in general. I did not see all of the contents of the letter. I asked what prompted them to initiate this letter and they told me this was an ongoing problem that had dated back to Dr Rankin's time. It was just that it was getting harder and harder to manage his "slow style of working" and that others were now complaining as they were having to help with his unfinished work.

Received from Esther Gishkori on 27/06/2022. Annotated by the Urology Services Inquiry.

I did not know Mr O'Brien at all nor did I know his history in the ST. However, Mr Mackle and Heather Trouton did know him well. In fact, Mr Mackle stated he had been having issues with Mr O'Brien "dating back a number of years". I understand that Mr O'Brien accused Mr Mackle of bullying (p32 para 4 and 5 Investigation report; Dr Neta Chada) Mr Mackle left his post soon after the sending of said letter.

Mr O'Brien was always described to me as an excellent clinician who was trusted with patient safety issues by his colleagues. They never doubted his clinical ability. This was a surgeon who had been instrumental in setting the service up. He agreed as to how referrals would be triaged and never, to the best of my knowledge, said he was not going to do these referrals.

Paragraph 8

After there was no response to the AMD and AD's letter of March 2016 and after Mr O'Brien protested profusely to a member of the legal team, blaming unnecessary administration on his late response, Mr O'Brien became an item on an already existing Oversight committee. I was first aware of this when I looked at the agenda on my way to the meeting and his name was included on that.

Sensing real and meaningful remedial action was necessary, I spoke with both Mr O'Brien's CD, Mr Colin Weir and AMD (now Dr Charlie McAllister) and asked if they could suggest an efficient solution to address Mr O'Brien's issues with administration in particular. Being an Anaesthetist and having worked in theatre for a long time with Mr O'Brien, Dr McAllister said he was almost certain that if Mr O'Brien was "relieved of his theatre lists" until his administration was up to date, he would soon catch up. Mr O'Brien loved the operating theatre. I understand that he would be prepared to spend all day and into the evening there if he could. If someone else did his lists, he would consider this intolerable. Both clinicians thought that it would take 3 calendar months to rectify.

Mr Weir was to meet Mr O'Brien and discuss the plan. It was to be supportive, constructive, and low key but very clear with no room for deviation. This plan was set out in an e mail from Colin Weir to Charlie McAllister on 16th September 2016. I was hopeful about it, but when I told him, the Medical Director was reticent. The Medical Director and Vivienne Toal (Director of HR) preferred to continue with the oversight Committee deciding on what action was to be taken next. I was invited to this committee and was a member, completing actions and reporting back to the committee as appropriate.

Mr O'Brien went off Personal Information redacted by the USI in November 2016. He was due to return to work in January 2017. However, it had latterly come to light that there had been further issues of concern with a possibility of actual patient harm, again in relation to the referral process. It was therefore decided at an oversight committee meeting in December (at which I was represented by one of my assistant directors, Ronan Carroll) that Mr O'Brien be excluded from work for the duration of what was now a formal investigation.

Paragraph 8

On 13th January 2017, in my capacity as the Director of Acute Services, I wrote to Mr O'Brien, giving him the opportunity to review and return comments on the SAI review into patient Patient 10. He replied on 25th January with 11 pages of comments.

Mr O'Brien's 11 pages of comments and questions sent people in all directions answering and gathering comments. For me, he simply didn't follow a system which had been religiously and ably followed by ALL the other team members.

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Paragraph 9

Miscellaneous

Sometime between August 15 and September 16, I read a letter of complaint. Not about Mr O'Brien but about the fact that the ward staff were not expecting the complainant to appear for surgery and therefore there was no bed for the patient. It transpired that Mr O'Brien himself had phoned the patient the night before and told him to come in the following day. Unfortunately, the ward staff nor consequently theatre staff had been informed.

Personal Information redacted by the USI

Personal Information redacted by the USI The case of Mr O'Brien was managed by the oversight group during that time and thereafter. I know that Ms Corrigan, the HOS for Urology, monitored Mr O'Brien's weekly activity in relation to his admin duties. I checked on a weekly basis with the AD and any time I met the HOS. When I went off Personal information redacted by USI at the end of May 2019 I never returned to the Southern Trust.

SCHEDULE
(NO 35 of 2022)

1. Please see paragraph (para) 2, 3, 5 and 8.

2. I have now left the Trust's employment and hold absolutely no documentation of theirs at all.

4. I did not receive any training on either I, II or III.

5. Each division has its own mandatory training as agreed within the teams and verified by HR and then there is training identified by individuals at PDP. This is facilitated by the line manager as being something needed to be able to do the job. For all other training or compliance with guidelines, staff are referred to Trust standards and guidelines. I do not recall specific training I personally organised but PDP would have retained records of training. Generally:

   I. Clinical Managers would have been subject to the rules above. Their line manager was the AMD.

   II. It was necessary for case investigators to have had training before they conducted the investigation.

   III. Designated Board members, if part of an investigation also had to have the training above. This was normally facilitated by the HR director and appointed by the CE.

   IV. Any other relevant person would also be facilitated and trained in line with the chain of command as outlined above.

6. Any steps taken by me would have been recorded in HR records. I do not have access, nor have I retained, any such records.

7. I understood that my role as Director of Acute with the following individuals was:

I. Clinical Manager – this, for me was normally the CD or the AMD. In relation to the Clinical Directors, there was one for each department and they reported to Associate Medical Directors (AMDs). AMDs were responsible for all surgery and reported to Medical Directors professionally and me operationally.

II. Case Manager – to support and cooperate with their conclusion.

III. Case Investigator – to support their investigation and encourage my team to cooperate with any requests.

IV. The Chief Executive – irrespective on anything else, this was my line manager, so all my usual responsibilities still applied. I would also respect his decisions and support the whole process as my position in the oversight group and as the Director of Acute.

V. Medical Director – Support and respect his decisions on the Oversight Committee.

VI. Designated Board Members – Their roles were to keep the process moving and I would assist and support when requested.

VII. The clinician – I wrote to him with the conclusion of the SAI and worked in accordance with my duty to keep matters confidential.

VIII. I would support and assist the investigation in any way that I could.

8. In terms of tracking the process, the Head of Service and the Assistant Director would have reviewed and monitored Dr. O'Brien and fed back to me. I would have received the results of audits and recommended further actions where applicable. The actioning of the recommendations would have then been discussed in meetings where a wider group would then discuss whether further action would be taken and if so, what action.

9. I was a member of the oversight group. I therefore followed the TOR, taking part in the meeting, coming to agreed conclusions, completing my agreed actions and supporting the chair in all related matters. The chair was Vivienne Toal.

I. The Assistant Director would have reported to me

II. The Medical Director was, in this case, also the chair of the oversight group. He led the meetings and appointed Dr Khan to be the case manager.

III. The HR Director was my peer and we would liaise with each other where our required actions overlapped.

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

I. Please see para 7 – from Mr Mackle and Heather Trouton

II. I became aware when Dr. O'Brien was listed on the agenda for a meeting of the Oversight Committee. I was not aware prior to attending that meeting. The agenda for the meeting was circulated one day before but due to a busy work schedule, I had not had sight of the agenda in advance of the meeting.

III. As above

IV. I went to the meeting. Minutes from the meeting could contain detail about the decisions taken.

11. The concerns had been escalated to the CE before I knew the extent of the problem or that AOB was going to be discussed at an oversight meeting. Simon Gibson (AD to the Medical Director) had provided a "screening report" with recommendations in the conclusion even before the oversight committee met. The matter escalated formally after the Oversight Committee meeting. The Chief Executive would have been kept appraised of all matters thereafter by the Oversight Committee generally and the Director of HR.

12. Please see below.

I. Mr Aidan O'Brien just appeared as number 2 on the agenda as a "potential MHPS case" at the Oversight Committee meeting. Simon Gibson provided background and advised that a letter would be sent to Dr. O'Brien Please see minutes for further detail.

II. A letter was to be drafted by Simon Gibson for Colin Weir and Ronan Carroll) to be presented to AOB. Please see minutes for further detail.

III. Please see minutes from the oversight committee meeting for further details in relation to what was decided therein. Following the oversight committee I immediately spoke to Charlie McAllister (the AMD for surgery) and Colin Weir (the Clinical Director). Ronan Carroll was also present at this meeting. As both these individuals were line manages to Aodhan O'Brien I wanted to confirm what information they held in relation to the problems that I had just been informed of. Charlie informed me that he had received one email from Simon. Charlie had suggested a resolution to the problem which I have outlined further at paragraph 8 above.

IV. N/A

13. Please see below.

I. see para 7. I tried to get line managers to deal with Dr. O'Brien informally once the issue game to my attention.

II. see para 7.

III. (Please see paragraph 8. I did not engage with Dr. O'Brien informally as I had to comply with the directions of the Oversight Group. These directions were focussed on formal and structured action, rather than an informal response.

14. Ronan Carroll, my AD for surgery told me verbally that some referrals had been found in a drawer belonging to Mr O'Brien and raised a concern that some patients could potentially have come to harm. Urology consultants were going through them at that time.

    I. Patient "Patient 10" (Personal Information redacted by the USI) – The plan of action in relation to Patient 10 was already in motion before Ronan Carroll came to see me. A consultation with the patient had already been arranged by the Head of Service and in agreement with other consultants. My governance lead, Tracey Boyce] set up the SAI and I received weekly updates on same.

    II. The care of 5 patients (Personal Information redacted by the USI) – this was actioned in tandem with the above. I was updated on the process on a weekly basis by Ronan, during AMD meetings with Mark Haynes, and during bi weekly oversight meetings.

    III. Patient Patient 16 – this was actioned in tandem with the above. I did not take part in the SAI.

15. Please see below.

    I. I was not at the meeting of the Oversight Committee on 22nd December. I was deputised by Ronan Carroll. Please see meeting minutes for detail.

    II. Please see meeting minutes for detail as I was not present.

    III. As the Director of Acute services I did not have to do anything as Simon Gibson arranged and completed all actions, i.e. meet with AOB, with the appropriate others and informed him of the decision.

16. Once a decision to investigate AOB's practice was made, I and the team involved complied fully with the oversight committee's decisions. I met weekly with 2 of my governance team and they kept me abreast of the ongoing SAIs. I made sure my team complied with all requests in relation to information gathering. I also dealt with any media requests. In doing so I provided information to the media team at Trust Headquarters. Personal information redacted by USI during much of the investigation and had no further involvement after March 2019.

17. This became apparent when records held by Dr O'Brien were returned to the Trust from his home but I was no aware before this.

18. Martina Corrigan was responsible for making sure that this action plan was complied with.

    I. Untriaged referrals to AOB – all 4 colleagues agreed to clear the backlog of these but it would be on WLI terms (Waiting list initiatives).

    II. Patient notes tracked out to AOB – there was a big tracking exercise by Anita Carroll and her team to ascertain what notes, if any were missing or not returned. Anita reported on this directly to me.

III. AOB was the only one who could do some of the dictations because he saw the patients and sometimes nothing was written in the notes. His colleagues therefore undertook an extensive exercise to ensure all the patients had an outcome dictated and a plan of care outlined. This was overseen by Martina and reported on to me by Ronan Carroll.

IV. Martina Carroll dealt with this and I understand if Mr. O'Brien wanted to take notes home he had to check same out and there was a formal process in place which was overseen by Martina.

19. The monitoring arrangements were still in place when I ceased employment at the Trust. I have no knowledge of an end date. Martina (Head of Service) was responsible for overseeing it.

20. I do not believe there were any divergences.

21. As the director of acute services, I do not know of any factors, attributed to us, as to why a. – d. may have been delayed. I know that Mr. O'Brien requested extension to comply and that Personal Information redacted by the USI at the time of the investigation and Personal Information redacted by the USI which caused delay. I was also on Personal Information leave during this period. I had no formal contact with any of the parties listed at (i)-(vi). As I was on leave, the ADs who deputised fed back to me on my return.

22. I really don't recall much about the investigation process. There were always minutes and notes sent out from the oversight committee, and I attended/sent a representative where appropriate. The oversight committee met monthly and occasionally held more frequent meetings. Minutes were always recorded at the oversight committee and the Trust would retain these. Whilst I was on Personal Information redacted by leave Anita Carroll attended the oversight committee in my place.

23. Please see below:

I. Martina Corrigan was responsible for oversight. This was reviewed by Ronan Carroll who then reported directly me. These actions were implemented.

II. The medical director was responsible and I have no further information in relation to this action as it was beyond my remit.

III. This was the responsibility of Anita Carroll's team and I have no further information in relation to this however Anita would be able to provide this.

24. I do believe the guidelines to be fair, comprehensive and fit for purpose. I believe the guidelines could be better implemented by staff; for example, I believe the issues with Dr. O'Brien when they came to light could have been practically resolved at a lower level.
Within the Trust there are issues of individuals going outside their roles and responsibilities and not communicating with the right people. There is a culture of the Trust that not everyone followed the guidelines as they should be followed. There was no policy on writing guidelines for the Trust for example. There was also no process to update any policy.

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25. I am no longer the Director of Acute Services. I do however believe that the Trust would be more effective and efficient if it observed the fundamentals of multi-disciplinary working and ensuring each individual understands their own role and responsibilities as well as those of others. Throughout my tenure I believed this worked very well within my directorate.
I believe a meaningful, non-judgemental meeting with Mr O'Brien in March 2016 would have been beneficial. This would have allowed attempts to give him the help that was ultimately provided through the formal action plan which was developed months later. The suggestion from Charlie McAllister would again have been a more efficient method to resolve this issue. Operationally therefore, those patients who had not had their referral actioned may have been reviewed at an earlier stage.

Statement of Truth

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

Signed: Personal Information redacted by the USI

Date: 27:6:22