Mr. Ronan Carroll
C/O Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

26 June 2023

Dear Sir,

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.

This Notice is issued to you due to your held posts, within the Southern Health and Social Care Trust, relevant to the Inquiry's Terms of Reference. The Inquiry is of the

view that in your roles you will have an in-depth knowledge of matters that fall within our 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 detail 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 may be aware the Trust has 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 your 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 an 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

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

Chair's Notice

[No 13 of 2023]

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:

Mr. Ronan Carroll
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

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 24th July 2023.**

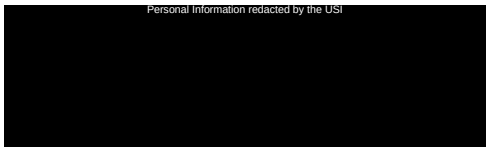
APPLICATION TO VARY OR REVOKE THE NOTICE

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 17th July 2023.**

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 26th June 2023

Signed: 

Christine Smith QC
Chair of Urology Services Inquiry

SCHEDULE

[No 8 of 2023]

The Inquiry asks that you consider the following extracts from the oral and written evidence of Maria O'Kane at paragraphs 1 and 2 below and reply to the questions which follow at paragraph 3:

1. The following extract is taken from the evidence of Maria O'Kane, now Chief Executive and formally Medical Director at SHSCT, on Day 15 of the Inquiry hearings:

TRA-01438, Lines 11 - 29

Q. Do you see that then as a failing, from you as Medical Director, in having proper oversight to ensure that you got proper information on which you could assess whether the action plan was effective or something else needed to be done?

A. In hindsight, I would do things differently. Right? I would have asked probably different questions in that context. But I think the context is important. I had just arrived in an organisation. It takes a year to get into a job like that properly. I didn't know anybody. I didn't know the systems and processes. One of the experiences I had was that when I asked questions, you know, I think some people felt that those were critical rather than curious, and that was a really difficult environment to work in. In hindsight, if I were doing this again I would do it differently, but at the time what I was reliant on was people who had worked in the organisation for a long time, understood how it worked, to give me information

TRA-01438, Lines 1 - 29

and responses to the questions that I asked in relation to systems and processes. I think, you know, one of my concerns in referring Mr. O'Brien to the GMC was in relation to insight. I also think, looking back on all of that, we didn't have full insight either in terms of how we managed that process.

Q. You have mentioned you didn't know anybody at the time. Sometimes that can be an advantage in a new job where you don't have friends or enemies. You are coming in as a new brush and that gives you the opportunity to do things that are more difficult had you been promoted from within. Essentially your answer is you got a little bit of push back from some staff. You felt they thought your queries were criticisms. Did that play a part in your decision making as to how to manage this situation?

A. I don't think so, but I do think it made it a bit more difficult.

Q. Can you expand a little bit more on what that criticism was aimed at and how it may have impacted your choice of behaviour at that time?

A. There were, certainly, on a number of occasions, when I was very robustly challenged by middle managers within the Trust -- not Martina Corrigan and not any of the other people who worked to her -- in relation to what my role and function was, why I was asking these questions, and I think were a bit alarmed, I think, about the level of curiosity in relation to how this worked. That didn't stop me asking the questions but

TRA-01439, Lines 1 – 20

it did make it more difficult in that I had to keep coming back and back and back to try to get the answers that I needed.

Q. Did you consider that to be a difficult working environment, that the culture of being robust towards the Medical Director –

A. Yes.

Q. -- probably a little bit ambitious for people to take on the most senior medic in the SMT. Did you see that as a sign there was some reluctance to do things differently?

A. Yes.

Q. You've mentioned who it wasn't. You haven't mentioned who it was in your Section 21. You're clearly not going to say any names. You're

very free to do so now if you wish to, but obviously the Inquiry would like the opportunity to ask certain individuals, if we had the information, how their behaviour may have impacted on clinical decision making. I'll leave that thought with you.

2. The Inquiry asked Ms O'Kane to provide further detail on the answers she gave in her oral evidence in a follow up section 21 request, and she replied on the 19 April 2023 and, as relevant to you, answered the questions asked as follows [at **WIT-91955 – WIT-91958**]:

(i) Identify by name and position the middle managers to whom you referred in your oral evidence:

"*Mrs Anne McVey Assistant Director Acute Medicine;*
Mr Ronan Carroll Assistant Director ATICS and Surgery and Elective Care."

(ii) Set out the detail of your interactions with these individuals, including:

(a) the content of discussions and dates/times/locations as appropriate:

"I had contact with Ronan and Anne through clinical directorate meetings throughout the overlap in their tenure and mine, usually in different formats and on average about 1-2 times weekly."

(b) what you took to be being communicated to you by these middle managers, and

"They both adopted a defensive approach to my questions around clinical and social care governance. The general

explanation for this appeared to be that when staff were asked about any activity in the past that they had felt criticised. This then seemed to have set the tone across the Acute Directorate. I was left with a strong sense that they viewed me as interfering and that inquisitiveness was viewed as questioning with a negative agenda rather than curiosity in a bid to understand. Comments were made about me being an outsider. The approach to me at times was of sarcastic comments being made particularly by Anne to me in front of others if I asked questions even as a relatively new person learning my way in a new organisation.

When I drew others' attention to this there seemed to be an acceptance that this was the way business was done in the Trust and couldn't be challenged. …

…

I was very mindful of the fact that, as someone who was recently new into the role of Acute Director with limited experience in that Directorate, Melanie was extremely dependant on the support of the ADs in order to get the job done. Particularly before the onset of the pandemic, the organisation felt quite split at times. Acute held onto its own information under the guise at that time of managing its own governance, which is a system that had been instigated in the past. As a result of this it was very difficult for the Director of Nursing and me, as Medical Director, to access the governance information we required in order to provide accurate assurance to the organisation. By the same token, Acute regularly believed that it was left to fend for itself in isolation while regularly being wary of those of us trying to support it.

On another occasion, while Director on Call soon after my arrival, the Emergency Department was under pressure, I asked Ronan about processes with surgical patients. He became

extremely angry on the phone with me, told me that none of this was my business and that he would be complaining about me to his Director. As time went on, particularly as we have progressed through the process of the Urology Services Inquiry, the relationship with Ronan improved.

When I spoke to others in the organisation about these behaviours by the Assistant Directors in Acute Services there seemed to be an acceptance that this was the way in which individuals behaved and business was done and everyone worked around them. I hadn't encountered attitudes like these from middle managers in previous organisations in which I worked where the approach to patient management was more collective and less defensive."

(c) what, if any, impact these interactions and reluctance to do things differently had on your:

1. ability to obtain answers to your queries and

2. respond appropriately to issues, make decisions and take actions?

These interactions and the reluctance to share information resulted in slowing me in identifying and piecing together relevant information and understanding governance in the organisation. At times I seemed only to be given information on a 'need to know' basis, rather than as a complete narrative and I didn't always know what I didn't know. A prime example of this was the eventual realisation in 2020 that the MHPS investigation that had been undertaken in relation to Mr O'Brien was not in relation to his whole practice but had excluded urology cancer services which were in a different division. In the course of that investigation, it appears that it hadn't been mentioned that Mr O'Brien did not include the Cancer Nurse Specialists in patient

care, that he didn't always follow the expert advice of the Multidisciplinary Team and that his cancer patients were not always being followed up. I had to rely heavily then on being guided by governance staff within the Medical Director's Office. Generally, there was manifest an underlying competitive and controlling culture of defensiveness, particularly in Acute services. When asked, the rationale for this given by middle managers in the Trust for this stance appeared to be historic, that the Trust had been high performing (that is, undertook significant activity without comment on quality and experience, knew its own internal business best and that given the previous and recent turnover of personnel, Medical Directors and Chief Executives were viewed as not fully committed, as only passing through and more to be tolerated than heeded. This culture contributed to the first 8 months or so in the Southern Trust being some of the most challenging of my career.

(iii) Did you consider these interactions to be reflective of the culture existing in urology at that time? If so, in what way?

I considered these interactions to be largely reflective of the culture in the Acute Directorate.

(iv) Did you raise the content of these discussions with anyone else? If yes, please provide full details.

Yes, as outlined above. I also discussed the challenges generally with Shane Devlin, the Chief Executive, in the context of how different staff could be approached to access information without them perceiving this as an attack on their performance rather than curiosity to improve.

3. The Inquiry asks that you reply to what Mrs O'Kane has stated about you in oral and written evidence. You may do so in a narrative form as

you wish, but please be mindful of addressing the specific allegations made by Mrs O'Kane as detailed below. You should provide full answers to all questions, including an explanation and/or example where appropriate to explain your answer.

(a) Questions about extracts from the transcript of Mrs O'Kane's oral evidence set out at para 1 above -

(i) Did you ever "*robustly challenge*" Mrs O'Kane as to what her "*role and function was*" and why she was asking questions?

(ii) Did your attitude make it more difficult for Mrs O'Kane to get answers to her queries to the extent that she had to "*go back and back to try and get the answers that [she] needed*"?

(iii) Do you agree with Mrs O'Kane that it was "*a difficult working environment*"?

(b) Questions about written answers provided by Mrs O'Kane detailed at para 2 (ii) (b) above –

(iv) Did you adopt a defensive approach to Mrs O'Kane's questions around clinical and social care governance?

(v) Did you feel criticised when asked about anything by Mrs O'Kane?

(vi) Did you view Mrs O'Kane as "*interfering*" and having a "*negative agenda*"?

(vii) Did you make comments about Mrs O'Kane being "*an outsider*"?

(viii) Did you make "*sarcastic comments*" to Mrs O'Kane "*in front of others*"?

(ix) Do you accept that "*this was the way business was done in the Trust and it couldn't be challenged*"?

(x) Do you agree that "*before the onset of the pandemic, the organisation felt quite split at times*"?

(xi) Is it correct, as Mrs O'Kane states, that "*[a]cute held onto its own information under the guise at that time of managing its own governance*"? Whether you agree or disagree with this statement, please provide examples to illustrate your answer.

(xii) Whether your answer to (xiv) is agreement or disagreement, what is your response to Mrs O'Kane's assertion that "*it was very difficult for the Director of Nursing and [Mrs O'Kane], as Medical Director, to access the governance information we required in order to provide accurate assurance to the organisation*"?

(xiii) In what ways could the Director of Nursing and Mrs O'Kane as Medical Director access the governance information they required in order to provide accurate assurance to the organisation? What was the ease with which they could access that information? Please explain your answer by way of examples as appropriate.

(xiv) Do you agree that "*[a]cute regularly believed that it was left to fend for itself in isolation while regularly being wary of those of us trying to support it*" as alleged by Mrs O'Kane?

(xv) Please provide, to the extent that you recall, your version of what Mrs O'Kane describes as the occasion when "*the*

Emergency Department was under pressure" and she asked you "*about processes with surgical patients*".

(xvi) With regard to the incident referred to at (xiv) above, did you:

a. "*[Become] extremely angry on the phone with*" Mrs O'Kane? If yes, please state why?

b. Tell Mrs O'Kane "*that none of this was my business and that [you] would be complaining about [her] to [your] Director*"? If you did say this, did you then speak to your Director? Please provide full details.

c. Do you agree with Mrs O'Kane that "*[a]s time went on, particularly as we have progressed through the process of the Urology Services Inquiry, the relationship with Ronan improved*"?

(xvii) Mrs O'Kane states that "*there seemed to be an acceptance that this was the way in which individuals behaved and business was done and everyone worked around them*" – do you agree with this statement?

(c) Questions about written answers provided by Mrs O'Kane detailed at para 2 (ii) (c) above –

(i) Do you agree with Mrs O'Kane's statement that "*interactions and the reluctance to share information resulted in slowing me in identifying and piecing together relevant information and understanding governance in the organisation*"?

(ii) Did you only provide Mrs O'Kane with information on a "*need to know basis*"?

(iii) What is your view of Mrs O'Kane's statement that *"[g]enerally, there was manifest an underlying competitive and controlling culture of defensiveness, particularly in Acute services*"?

(iv) Do you agree with Mrs O'Kane that *"[m]edical Directors and Chief Executives were viewed as not fully committed, as only passing through and more to be tolerated than heeded*"?

(d) Questions about written answers provided by Mrs O'Kane detailed at para 2 (iii) above -

(v) Do you consider the interactions as detailed by Mrs O'Kane in her answers to be "*largely reflective of the cultures in the Acute Directorate"?*

(vi) When "*approached [by Mrs O'Kane] to access information*", did you perceive "*this as an attack on [your] performance rather than curiosity to improve*"?

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

USI Ref: Notice 13 of 2023
Date of Notice: 26th June 2023

Witness Statement of: Ronan Carroll

I, Ronan Carroll, will say as follows:-

The Inquiry asks that you consider the following extracts from the oral and written evidence of Maria O'Kane at paragraphs 1 and 2 below and reply to the questions which follow at paragraph 3:

1. The following extract is taken from the evidence of Maria O'Kane, now Chief Executive and formally Medical Director at SHSCT, on Day 15 of the Inquiry hearings:

TRA-01438, Lines 11 - 29

Q. Do you see that then as a failing, from you as Medical Director, in having proper oversight to ensure that you got proper information on which you could assess whether the action plan was effective or something else needed to be done?

A. In hindsight, I would do things differently. Right? I would have asked probably different questions in that context. But I think the context is important. I had just arrived in an organisation. It takes a year to get into a job like that properly. I didn't know anybody. I didn't know the systems and processes. One of the experiences I had was that when I asked questions, you know, I think some people felt that those were

critical rather than curious, and that was a really difficult environment to work in. In hindsight, if I were doing this again I would do it differently, but at the time what I was reliant on was people who had worked in the organisation for a long time, understood how it worked, to give me information

TRA-01438, Lines 1 - 29

and responses to the questions that I asked in relation to systems and processes. I think, you know, one of my concerns in referring Mr. O'Brien to the GMC was in relation to insight. I also think, looking back on all of that, we didn't have full insight either in terms of how we managed that process.

Q. You have mentioned you didn't know anybody at the time. Sometimes that can be an advantage in a new job where you don't have friends or enemies. You are coming in as a new brush and that gives you the opportunity to do things that are more difficult had you been promoted from within. Essentially your answer is you got a little bit of push back from some staff. You felt they thought your queries were criticisms. Did that play a part in your decision making as to how to manage this situation?

A. I don't think so, but I do think it made it a bit more difficult.

Q. Can you expand a little bit more on what that criticism was aimed at and how it may have impacted your choice of behaviour at that time?

A. There were, certainly, on a number of occasions, when I was very robustly challenged by middle managers within the Trust -- not Martina Corrigan and not any of the other people who worked to her -- in relation to what my role and function was, why I was asking these questions, and I think were a bit alarmed, I think, about the level of curiosity in relation to how this worked. That didn't stop me asking the questions but

TRA-01439, Lines 1 – 20

it did make it more difficult in that I had to keep coming back and back and back to try to get the answers that I needed.

Q. Did you consider that to be a difficult working environment, that the culture of being robust towards the Medical Director –

A. Yes.

Q. -- probably a little bit ambitious for people to take on the most senior medic in the SMT. Did you see that as a sign there was some reluctance to do things differently?

A. Yes.

Q. You've mentioned who it wasn't. You haven't mentioned who it was in your Section 21. You're clearly not going to say any names. You're very free to do so now if you wish to, but obviously the Inquiry would like the opportunity to ask certain individuals, if we had the information, how their behaviour may have impacted on clinical decision making. I'll leave that thought with you.

2. The Inquiry asked Ms O'Kane to provide further detail on the answers she gave in her oral evidence in a follow up section 21 request, and she replied on the 19 April 2023 and, as relevant to you, answered the questions asked as follows [at **WIT-91955 – WIT-91958**]:

(i) Identify by name and position the middle managers to whom you referred in your oral evidence:

"*Mrs Anne McVey Assistant Director Acute Medicine;*
Mr Ronan Carroll Assistant Director ATICS and Surgery and Elective Care."

(ii) Set out the detail of your interactions with these individuals, including:

(a) the content of discussions and dates/times/locations as appropriate:

"I had contact with Ronan and Anne through clinical directorate meetings throughout the overlap in their tenure and mine, usually in different formats and on average about 1-2 times weekly."

(b) what you took to be being communicated to you by these middle managers, and

"They both adopted a defensive approach to my questions around clinical and social care governance. The general explanation for this appeared to be that when staff were asked about any activity in the past that they had felt criticised. This then seemed to have set the tone across the Acute Directorate. I was left with a strong sense that they viewed me as interfering and that inquisitiveness was viewed as questioning with a negative agenda rather than curiosity in a bid to understand. Comments were made about me being an outsider. The approach to me at times was of sarcastic comments being made particularly by Anne to me in front of others if I asked questions even as a relatively new person learning my way in a new organisation.

When I drew others' attention to this there seemed to be an acceptance that this was the way business was done in the Trust and couldn't be challenged. …

…

I was very mindful of the fact that, as someone who was recently new into the role of Acute Director with limited experience in that Directorate, Melanie was extremely dependant on the support of

the ADs in order to get the job done. Particularly before the onset of the pandemic, the organisation felt quite split at times. Acute held onto its own information under the guise at that time of managing its own governance, which is a system that had been instigated in the past. As a result of this it was very difficult for the Director of Nursing and me, as Medical Director, to access the governance information we required in order to provide accurate assurance to the organisation. By the same token, Acute regularly believed that it was left to fend for itself in isolation while regularly being wary of those of us trying to support it.

On another occasion, while Director on Call soon after my arrival, the Emergency Department was under pressure, I asked Ronan about processes with surgical patients. He became extremely angry on the phone with me, told me that none of this was my business and that he would be complaining about me to his Director. As time went on, particularly as we have progressed through the process of the Urology Services Inquiry, the relationship with Ronan improved.

When I spoke to others in the organisation about these behaviours by the Assistant Directors in Acute Services there seemed to be an acceptance that this was the way in which individuals behaved and business was done and everyone worked around them. I hadn't encountered attitudes like these from middle managers in previous organisations in which I worked where the approach to patient management was more collective and less defensive."

(c) what, if any, impact these interactions and reluctance to do things differently had on your:

1. ability to obtain answers to your queries and

2. respond appropriately to issues, make decisions and take actions?

These interactions and the reluctance to share information resulted in slowing me in identifying and piecing together relevant information and understanding governance in the organisation. At times I seemed only to be given information on a 'need to know' basis, rather than as a complete narrative and I didn't always know what I didn't know. A prime example of this was the eventual realisation in 2020 that the MHPS investigation that had been undertaken in relation to Mr O'Brien was not in relation to his whole practice but had excluded urology cancer services which were in a different division. In the course of that investigation, it appears that it hadn't been mentioned that Mr O'Brien did not include the Cancer Nurse Specialists in patient care, that he didn't always follow the expert advice of the Multidisciplinary Team and that his cancer patients were not always being followed up. I had to rely heavily then on being guided by governance staff within the Medical Director's Office. Generally, there was manifest an underlying competitive and controlling culture of defensiveness, particularly in Acute services. When asked, the rationale for this given by middle managers in the Trust for this stance appeared to be historic, that the Trust had been high performing (that is, undertook significant activity without comment on quality and experience, knew its own internal business best and that given the previous and recent turnover of personnel, Medical Directors and Chief Executives were viewed as not fully committed, as only passing through and more to be tolerated than heeded. This culture contributed to the first 8 months or so in the Southern Trust being some of the most challenging of my career.

(iii) Did you consider these interactions to be reflective of the culture existing in urology at that time? If so, in what way?

I considered these interactions to be largely reflective of the culture in the Acute Directorate.

(iv) Did you raise the content of these discussions with anyone else? If yes, please provide full details.

Yes, as outlined above. I also discussed the challenges generally with Shane Devlin, the Chief Executive, in the context of how different staff could be approached to access information without them perceiving this as an attack on their performance rather than curiosity to improve.

3. The Inquiry asks that you reply to what Mrs O'Kane has stated about you in oral and written evidence. You may do so in a narrative form as you wish, but please be mindful of addressing the specific allegations made by Mrs O'Kane as detailed below. You should provide full answers to all questions, including an explanation and/or example where appropriate to explain your answer.

(a) Questions about extracts from the transcript of Mrs O'Kane's oral evidence set out at para 1 above -

(i) Did you ever "*robustly challenge*" Mrs O'Kane as to what her "*role and function was*" and why she was asking questions?

3.1 I do not believe that I ever robustly challenged Dr O'Kane as to what her "role and function was" and why she was asking questions.

(ii) Did your attitude make it more difficult for Mrs O'Kane to get answers to her queries to the extent that she had to "*go back and back to try and get the answers that [she] needed*"?

3.2 In the 1st year of Dr O'Kane's appointment as Medical Director I had limited interaction with her and would not have had meetings 1 to 2 times weekly. My interactions with Dr O' Kane increased as a member of the multi-disciplinary team through the Urology Lookback Review process which commenced in 2020. Dr O'Kane's perception that it *was* difficult for her to get answers to her queries to the extent that she had to *"go back and back to try and get the answers that [she] needed"* does not in any way reflect my experience nor my involvement and interaction with Dr O'Kane. Dr O'Kane has not presented any concrete and specific examples to substantiate her evidence and I believe my attitude and approach with Dr O'Kane was at all times a professional and cooperative one.

(iii) Do you agree with Mrs O'Kane that it was "*a difficult working environment*"?

3.3 I do agree with Dr O'Kane that those of us who worked within Acute Services worked in a very difficult working environment with extreme challenging, unrelenting pressure and a perennial shortage of nurses and doctors. However, I am not sure that Dr O'Kane has fully acknowledged these operational pressures or their impact upon staff in Acute in her above evidence.

(b) Questions about written answers provided by Mrs O'Kane detailed at para 2 (ii) (b) above –

(iv) Did you adopt a defensive approach to Mrs O'Kane's questions around clinical and social care governance?

3.4 My recollection is that I never adopted a defensive approach to Dr O'Kane's questions around clinical and social care governance. As mentioned above I had limited interaction with Dr O'Kane in her 1st year as Medical Director and when I attended meetings during the Lookback Review. I do not recall any single occasion when I adopted a defensive approach to Dr O'Kane when she enquired regarding clinical and social care governance.

(v) Did you feel criticised when asked about anything by Mrs O'Kane?

3.5 I have no recollection of feeling criticised when asked about anything by Dr O'Kane.

(vi) Did you view Mrs O'Kane as "*interfering*" and having a "*negative agenda*"?

3.6 In my opinion, Dr O'Kane was more inquisitive than all of the previous Medical Directors and she was prepared to lead change initiatives e.g., the 'Drive Through Phlebotomy Hubs'. I do recall one incident at the start of the Trust planning to implement the Drive Through Phlebotomy Hubs where I provided feedback to Dr O'Kane following our meeting with the South Eastern Health and Social Care Trust (SEHSCT) on their model to implement Drive Through Phlebotomy Hubs. In the SEHSCT their model was 'drive up and park', rather than 'drive through'. When I advised Dr O'Kane of this and queried whether this might be a model we should explore, Dr O'Kane became very cross, raised her voice, and told me and those present that

she was fed up with people not doing what they were asked and the model for the Southern Trust was going to be a Drive Through Phlebotomy Service. At the time I thought Dr O'Kane's response was inappropriate and verging on being aggressive, her manner was imperious and an example of where she was not prepared to listen to anyone's suggestions. I also understood she had many pressures as Medical Director, and she could have been having a 'bad day' so accepted her position and did not raise this again.

(vii) Did you make comments about Mrs O'Kane being "*an outsider*"?

3.7 No, I did not ever make any such comments. I would add in this regard that we have had another Medical Director, Dr Wright, who had come to the Southern Trust from the Belfast Trust and I do not recall him being viewed or referred to as "an outsider".

(viii) Did you make "*sarcastic comments*" to Mrs O'Kane "*in front of others*"?

3.8 No, I never made sarcastic comments to Dr O'Kane.

(ix) Do you accept that "*this was the way business was done in the Trust and it couldn't be challenged*"?

3.9 By the time Dr O'Kane came to work in the Trust as Medical Director (2019) I had been an Assistant Director within Acute Services for 12 years. During these 12 years I had worked with 3 Medical Directors (Drs Loughran, Simpson, and Wright) and 6 Directors of Acute Services (Mr McCall, Mrs Youart, Dr Rankin, Mrs Burns, Mrs Gishkori, and Mrs McClements). Each

Medical Director and Director of Acute Services had their own unique styles of management, how they wanted things done and what they viewed as priorities. So as Acute Assistant Director, I believe that we were used to change and to adapting to pressures as they presented themselves.

(x) Do you agree that "*before the onset of the pandemic, the organisation felt quite split at times*"?

3.10 For my entire career I have only worked in hospitals, and I would be unaware and uninformed as to the other programmes of care and the pressures and challenges experienced by them. My view was that Acute Services was by far the largest programme of care in the Southern Trust but I do not believe that this was reflected in the allocation of resources to Acute. I would have heard Directors of Acute Services say that at the Corporate Senior Management Team (SMT) meetings it could be a lonely place as there was the view that all the problems in the Trust lay within Acute Services.

(xi) Is it correct, as Mrs O'Kane states, that "*[a]cute held onto its own information under the guise at that time of managing its own governance*"? Whether you agree or disagree with this statement, please provide examples to illustrate your answer.

3.11 Information that was used by Acute Services Managers were derived from corporate and regional information systems e.g., Datix for incident reporting, PAS (regional), Boxi, PTLS lists, Theatre Management System (TMS, regional), CAPPS (regional), Risk Registers, and Early Alert forms to the DOH/SPPG for issues that needed to be notified. So, given the plethora of systems, the information from which was widely

available and accessible to all who required access, I fail to comprehend how Dr O'Kane could consider that Acute held on to its own information.

3.12 I do recall receiving a phone call from Dr O'Kane following the submission of my paper detailing my concerns over Ward 3 South. I previously referred to this paper in my first Section 21 response at *WIT-13602-13617*. In writing this paper I triangulated all the governance information available with the purpose to demonstrate my belief that 3 South was a ward that needed an immediate bed reduction for the reasons I detailed in the paper. Dr O'Kane commended me on the comprehensiveness of the paper, and it was used as the template for other wards and departments where concerns from managers were being expressed, e.g., at that time Female Medical Ward in Daisy Hill Hospital. This is an example where I personally freely shared information as a member of Acute for the benefit of the whole Trust.

(xii) Whether your answer to (xiv) is agreement or disagreement, what is your response to Mrs O'Kane's assertion that "*it was very difficult for the Director of Nursing and [Mrs O'Kane], as Medical Director, to access the governance information we required in order to provide accurate assurance to the organisation*"?

3.13 I would require clarity and examples from Dr O'Kane and the Executive Director of Nursing, Mrs Trouton, as to what governance information they had difficulty accessing. As detailed in my response to question (xi), Acute Service Managers used the information systems that were accessible to all, including Dr O'Kane and Mrs Trouton.

(xiii) In what ways could the Director of Nursing and Mrs O'Kane as Medical Director access the governance information they required in order to provide accurate assurance to the organisation? What was the ease with which they could access that information? Please explain your answer by way of examples as appropriate.

3.14 Please see my responses to questions (xi) and (xii). In my opinion, both the Director of Nursing and Dr O'Kane had full and easy access to governance information either directly or through other members of their team.

(xiv) Do you agree that "*[a]cute regularly believed that it was left to fend for itself in isolation while regularly being wary of those of us trying to support it*" as alleged by Mrs O'Kane?

3.15 Yes, I would agree that we middle managers (both Non-Medical and Medical) in Acute Services believed that we were alone. I say with this with the experience of 16 years working as an Assistant Director in Acute Services. With the exception of Mrs Mairead McAlinden, we rarely saw or received the visible support of the Chief Executives and Medical Directors during my tenure. I can only assume that they viewed the pressures in Acute Services as 'normal'.

(xv) Please provide, to the extent that you recall, your version of what Mrs O'Kane describes as the occasion when "*the Emergency Department was under pressure*" and she asked you "*about processes with surgical patients*".

3.16 My recollection of the incident presented by Dr O'Kane is as follows:

a. It was a Sunday and I would have been on call with a Head of Service and a Director. This particular Sunday was very busy with many phone calls between myself, the Head of Service, and Bed Managers, and possibly also conversations with Emergency Department Senior Doctors. I also believe we may have had several Zoom meetings during the day to assess, plan, and make decisions.

b. In the early evening, as I remember, I received a call from the Head of Service with an update on both Hospitals (CAH & DHH) and what the predicted numbers in both EDs could be. In the course of this conversation the Head of Service advised that, when they were last speaking with the Bed Manager in CAH, she advised that Mrs Trudy Reid had rung the Bed Managers asking about the pressure in the ED and expected waits.

c. To me, this was highly unusual as there was no requirement for Mrs Reid to be making such enquiries as she was not on call and she was the Infection Prevention Control ('IPC') Assistant Director and there were no IPC issues.

d. I rang Mrs Reid asking if she had made a phone call and, if so, why. Mrs Reid advised that Dr O'Kane had asked her to make the call. Mrs Reid asked if I would like to speak to Dr O'Kane as she was sitting beside her in an airport lounge as they had been attending a conference together and were returning home.

e. I then spoke to Dr O'Kane and I did ask her why she had instructed Mrs Reid to phone the Bed Managers when 'we' were the Acute Services on call team and were only too aware of the status of both hospitals. I viewed Dr O'Kane and Mrs Reid as acting out-with the normal on call process and, in terms of

governance, introduced unnecessary communication which did not contribute or add value to the operational pressures to find beds for patients requiring admission to both CAH and DHH. It was my view that, if Dr O'Kane and Mrs Reid had wanted to be helpful and add value, they should have communicated with the Director on call or Assistant Director on call (myself) and not directly with the Bed Manager on one hospital site (CAH).

(xvi) With regard to the incident referred to at (xiv) above, did you:

a. "*[Become] extremely angry on the phone with*" Mrs O'Kane? If yes, please state why?

3.17 My recollection was that I did not become angry but I certainly was irritated as to why Dr O'Kane and Mrs Reid would bypass the Director or Assistant Director on call and speak directly to the Bed Manager. If the Bed Manager had not advised the Head of Service that she had received a call from Mrs Reid, the on call team would have been unaware of this. For me, this represented a governance risk as it was out-with the normal on call arrangements, presenting a risk to the on call team in regard to controlling activities and decisions. The system for on call involves a single designated team of managers for that on call period and not 2 teams communicating ineffectively.

b. Tell Mrs O'Kane "*that none of this was my business and that [you] would be complaining about [her] to [your] Director*"? If you did say this, did you then speak to your Director? Please provide full details.

3.18 I do not recall telling Dr O'Kane that this was none of her business. I do recall advising Mrs Gishkori that I had an exchange with Dr O'Kane. I also know that Dr O'Kane spoke about the exchange at the next corporate SMT as Mrs Gishkori advised me of same and that Dr O'Kane was annoyed that she was questioned by a "Manager".

c. Do you agree with Mrs O'Kane that "*[a]s time went on, particularly as we have progressed through the process of the Urology Services Inquiry, the relationship with Ronan improved*"?

3.19 I was never of the view that the relationship between myself and Dr O'Kane needed to improve. The on call exchange referred to immediately above and the exchange I refer to in my response to (b)(vi) above (Drive Through Phlebotomy Hub) were the only two exchanges that I recall where we had a difference of opinion.

(xvii) Mrs O'Kane states that "*there seemed to be an acceptance that this was the way in which individuals behaved and business was done and everyone worked around them*" – do you agree with this statement?

3.20 I do not agree with this statement.

3.21 Working within Acute Services exposes all concerned to an unrelenting high-pressure environment, with many of the reasons for the high-pressure situations having no 'off the shelf' solutions. For example, from an unscheduled emergency care perspective: patient attendances at ED, admission to wards from ED, wards being short staffed and/or over-reliant on non-core staff, and an inability to discharge patients when medically fit

due to insufficient community/primary care resources. From an elective care perspective: the need to reduce waiting lists from an outpatient and inpatient/day care operating standpoint. Given these pressures it is inevitable that incidents and/or disagreements will arise between individuals working in this environment. However, I have not known such incidents or disagreements to have affected how we deliver the service to the patients we serve.

(c) Questions about written answers provided by Mrs O'Kane detailed at para 2 (ii) (c) above –

(i) Do you agree with Mrs O'Kane's statement that "*interactions and the reluctance to share information resulted in slowing me in identifying and piecing together relevant information and understanding governance in the organisation*"?

3.22 I do not agree with this statement. I would ask for greater detail on examples of where Dr O'Kane was not provided with the information she requested. I cannot personally recall any such situation where there was a reluctance to share information.

(ii) Did you only provide Mrs O'Kane with information on a "*need to know basis*"?

3.23 Not at all. Any information that Dr O'Kane asked for I believe I provided. Throughout the urology Lookback Review exercise Mrs Corrigan, Ms Clayton, and myself provided much information in the form of reports, patient information, and continuous updates as the Lookback Review progressed.

(iii) What is your view of Mrs O'Kane's statement that *"[g]enerally, there was manifest an underlying competitive and controlling culture of defensiveness, particularly in Acute services*"?

3.24 As I have stated previously, my only experience has been in Acute Services and I did not believe that there was an underlying competitive and controlling culture of defensiveness. Dr O'Kane, coming from another Trust, coming with other experiences, and not having worked in an Acute Hospital for some time, formed her view of Acute Services in the Southern Trust, which is not a view that I share.

(iv) Do you agree with Mrs O'Kane that *"[m]edical Directors and Chief Executives were viewed as not fully committed, as only passing through and more to be tolerated than heeded*"?

3.25 As stated in my response to (b)(xiv), with the exception of Mrs Mairead McAlinden, we rarely saw or received the visible support of the Chief Executives and Medical Directors during my tenure. As Assistant Directors, we got our support from ourselves (as the Assistant Directors were all in post for many years) as well as from our Acute Director.

(d) Questions about written answers provided by Mrs O'Kane detailed at para 2 (iii) above -

(v) Do you consider the interactions as detailed by Mrs O'Kane in her answers to be "*largely reflective of the cultures in the Acute Directorate"?*

3.26 My 16 years of experience as an Assistant Director enables me to form the view that the culture within Acute Services was one of dedicated staff working and wanting to do their very best. To work in Acute Services requires resilience and strength of character to withstand intense pressure, knowing that support from corporate services would not be forthcoming.

(vi) When "*approached [by Mrs O'Kane] to access information*", did you perceive "*this as an attack on [your] performance rather than curiosity to improve*"?

3.27 No, I did not perceive any of Dr O'Kane's requests for information as an attack on my performance rather than curiosity to improve.

3.28 However, Dr O'Kane did have a mantra which she used often: "*services must be clinically lead, data driven, and managerially supported*". I, and I suspect many of my colleagues, found this mantra belittling and disrespectful. It did not engender a team ethos and appeared contrary to the philosophy of collective leadership. It was in my view a very simplistic and hierarchical view on what it takes to manage hospitals.

3.29 I would add that, over the course of 16 years from 2007 to 2023 as Assistant Director in Acute Services, I have been subject to Appraisals and Personal Development Plans (PDPs), reporting to 7 Directors of Acute Services. At no time was my attitude or manner assessed as anything other than positive. Therefore, in respect of Dr O'Kane's evidence, if I had in fact exhibited such an attitude as she has described, I would have

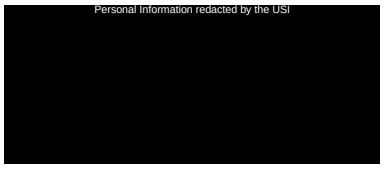
expected at a minimum for my respective Managers to have raised this with me and addressed same, yet there was no requirement for this to happen at any time over 16 years. I can say that I worked with many staff over that time in a collaborative, collective, and productive manner.

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.

Statement of Truth

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

Signed: 

Date: 14th July 2023