Urology Services Inquiry

Oral Hearing

Day 15 – Tuesday, 6th December 2022

Being heard before: **Ms Christine Smith KC (Chair)**

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

_____

Gwen Malone Stenography Services

I n d e x

INQUIRY RESUMED ON TUESDAY, 6TH DECEMBER 2020 AS FOLLOWS:

CHAIR: Good morning, everyone. Dr. O'Kane. Ms. McMahon.

MS. McMAHON BL: The witness this morning is Dr. Maria O'Kane. The Medical Director for the Southern Trust 1st December to 30th April 2022. Also, the Temporary Acting Officer since 14th February 2022, and she was appointed the Trust Chief Executive from 1st May this year. She's here with all of those hats on but, as regards her evidence today and tomorrow, we'll be working through the scene-setting aspects of that as they relate to governance. I understand Dr. O'Kane wishes to take the oath.

CHAIR: Thank you.

DR. MARIA O'KANE, HAVING BEEN SWORN, WAS EXAMINED BY MS. McMAHON AS FOLLOWS:

MS. McMAHON BL: Good morning. Thank you for attending today. My name is Laura McMahon. I'm junior counsel to the Inquiry. The Panel you'll see on your right, and the legal representatives, in various roles, on your left. I think you have some water in front of you. If you need to take a break at any time, please just say.

You've provided the Inquiry with quite a number of Section 21 replies. Eight in total with, I think, two of those were amended. We'll just work our way through those. If you can confirm your signature, that those are your statements, and that you're happy to adopt those as part of your evidence.

A. Yes, there are two amendments I'd like to make, please. WIT-44959 paragraph 1.14, I make reference to paragraph (ix) but actually it should say 1.12. Then the second one is WIT-45048, paragraph 40.1. That should say 26th November 2020. There's a 0 missing.

1 Q. It has fallen off the end of the table, I think.

A. Yes.

2 Q. Is there, perhaps, one more typo? It may be I misread it, but at WIT-44977? You've said:

"In my role as Medical Director (1st December 2019)". I think that should be 2018?

A. It should be 2018, yes. Thank you.

3 Q. Other than that, are there any amendments you have at this point?

A. Not at this point, thank you.

4 Q. If I take you to those statements and we will take you to the signature pages of them. The first one Section 21 notice number 1 of 2022, your signature can be found at WIT-04502. That's dated 28th March?

A. Yes.

5 Q. Do you recognise your signature on that, and do you wish to adopt that as part of your evidence?

A. Yes. Thank you. Yes.

6 Q. The next Notice is 1A of 2022, and the signature can be found at WIT-10900. Again, that's 29th March at the end of that.

A. Yes. 10:10

7 Q. That's your signature. Again, do you wish to adopt that as your evidence?

A. Yes, thank you.

8 Q. Statement number 3 of 2022, WIT-11172.

A. Yes. 10:11

9 Q. That's dated 1st April. Again, you wish to adopt that as part of your evidence?

A. Thank you. Yes.

10 Q. Then we have statement number 4, which is the amended number 1. We'll go to that. WIT-20106. Again, that's 10:11 your statement on 13th May 2022?

A. Yes. Thank you.

11 Q. You wish to adopt that as part of your evidence?

A. Yes.

12 Q. Then we have amended Section 1A notice again. 10:11 WIT-20169. I think this might be the one that -- 20169 -- yes, that's fine. That`s dated 13th May 2022. Do you adopt that as your evidence?

A. Yes, thank you.

13 Q. Notice number 29 of '22, WIT-45187, dated 23rd August 10:11 2022, and that's your signature?

A. Yes, thank you.

14 Q. You wish to adopt that?

A. Yes.

15 Q. We have notice number 64 of 2022 at WIT-55914. That's dated 22nd September 2022. That's your signature?
A. Yes.
16 Q. And you wish to adopt that?
A. Yes, thank you. 10:12
17 Q. The final one is notice 51 of '22. That's WIT-57972? Again, I don't know if there's a date on the next page of that. It's 26th September 2022. Again, previous page, please. That's your signature, and you wish to adopt that? 10:13
A. Yes, thank you.
18 Q. A lot of those statements are as a result of your role as Chief Executive, and also you have been sent specific notices around MHPS, around Lookback Review, and seeking updates on the various things the Trust 10:13 have done since you became Medical Director and also Chief Executive, so there are a variety of topics littered throughout those notices.
A. Yes. I want to take the opportunity to thank the Inquiry for giving me the additional time to complete 10:13 the six witness statements and the two amendments between April and September 2022. I am very grateful for being supported in that way.
19 Q. Thank you for that. We appreciate it was quite a lot of work and we did ask for a lot of information. We're 10:13 grateful for you taking the time to do that.
A. Before we start, can I just take the opportunity just to repeat and echo the apology issued by the Trust by Mr. Lunny KC on 10th November at the opening of the

Inquiry. Just to, again, apologise for the failings of The Trust in relation to any harm that has been caused to patients and their families.

20 Q. Okay. Thank you.

10:14

Just by way of roadmap and where we might take the evidence today, given the time that we have, we can't cover all of those Section 21 notices. They don't need to be covered, in any event, for the purposes of this part of the Inquiry, which relates to scene setting. 10:14
We may touch on some more than others. I want to focus mainly on those aspects of your evidence, which will allow the Panel to have a broad overview of Governance and how it was applied, what was done, perhaps what wasn't done, what might have been done, to give the 10:15
Panel an idea, at this stage, of events during your time as Medical Director, in particular at this point. Your evidence will speak to the Governance and management actions and decisions through the duration of concerns around Mr. O'Brien during your 10 years as 10:15
Medical Director.

You have been informed that you will, no doubt, be returning at later stages in the Inquiry as we move through different aspects of it. I'll try and take 10:15
your evidence in some sort of chronological order, but you touch on so many points, we might jump about a bit. I'll keep it on track as far as possible.

I just wonder at the outset if I could ask you, did you get the opportunity to listen to the evidence of Mark Haynes?

A. I listened to all but the last day of his evidence. Yes.

21 Q. Did you listen to the evidence of Dr. Hughes and Dr. Gilbert?

A. I did, yes.

22 Q. I just wonder, given that, is it your view that the Corporate Governance procedures and arrangements within the Trust were effective in highlighting and addressing the concerns raised and known about in relation to Mr. O'Brien given what you have heard so far?

A. When I came to the Trust and started as Responsible Officer effectively from 1st January 2019, I think one of the things I quickly began to discover was that the Governance structure within the Southern Trust was not as robust as it needed to be. On the basis of that, I commissioned a review of the Governance structures, and that took place in the course of 2019. That produced 48 recommendations that The Trust has been working its way through. Certainly we have significantly invested in improving in all of that. I think some of the work that was being done at that point in time, and certainly some of the struggles that we had in terms of bringing together some of the information around Mr O'Brien and other aspects within the Trust, I think highlighted to me that some of the aspects of that, that you would ordinarily expect to be

10:15 10:16 10:16 10:16

in place weren't. So what we have done is I believe we are in a very different place now to where we were then.

23 Q. I will come on to that. What I want to do is ask a general question. Has your position changed from your position from your witness statement? Do you consider now that from what you've heard that it appears clearer that there could have been more done? 10:17

A. Yes.

24 Q. Do you think the issues around communication between staff and the escalation, now that you've heard that evidence, was ineffective? 10:18

A. Yes, I do.

25 Q. We will go on to speak to the changes you've made but that's helpful. The Panel has heard quite significant evidence from Mark Haynes and a lot of the information overlaps with your evidence. I don't want to repeat any of that. Given your position, that allows me then to modify what I need to take you to. 10:18

10:18

Just if we can start out from the beginning, your role and your occupational history. If we look at your Section 21 response at WIT-44957. You've been Chief Executive since 1st May 2022 and, before that that post was held by Shane Devlin? 10:18

A. That's correct, yes.

26 Q. You've been Temporary Accounting Officer since February 2022 and the Medical Director for, more or less, four years, three and a half years, roughly,

from 1st December 2018 to April 2022?

A. Yes.

27 Q. Before you arrived, Mr. Khan was the interim Medical Director for a short period?

A. Yes. He had been there, I think, for nine months. 10:19

28 Q. He was there from April to December 2018. Before him, then, it was Richard Wright?

A. Yes, that's right.

29 Q. He had held the post from 2015 to 2018. Just before we go into the detail of your qualifications, if I can 10:19 just ask you at this point, did you know either Dr. Wright or Dr. Khan before you took up post?

A. I didn't know Dr. Khan. I had worked as Associate Medical Director with Dr. Wright in the Belfast Trust. He was Associate Medical Director for some of the 10:19 services there. We had worked together as part of the senior medical leadership in Belfast.

30 Q. You qualified as a medical doctor in Queens 1990. You completed your MA in Psychoanalytical Studies in 2001, and an MSc in Health and Social Services Policy and 10:20 Management in 1998. You also completed the Scottish Patient Safety Fellowships through NHS Scotland in 2014 to 2015, and you worked in the NHS for 30 years. Prior to your employment in the Southern Trust, you held a number of senior managerial and leadership roles in 10:20 the Belfast Trust, and nationally through the Royal College of Psychiatrists. Your clinical expertise is in Psychiatry?

A. Yes.

31 Q. You never worked in the Southern Trust before taking up that post; is that right?
A. That's right, yes.
32 Q. But you spent most of your time in the Belfast Trust?
A. Belfast, the Northern, and I'd worked in the Western and South Eastern in the past, but I had never, as a trainee or as a medical student, been in the Southern Trust other than, I think, for a few weeks in Paediatrics in the '80s. 10:20
33 Q. You weren't familiar with the management structure down there or anything about that? 10:21
A. No.
34 Q. If we could look at your job description as Medical Director. WIT-45271, it starts substantially in 272. WIT-45273 relates to Clinical Governance. In short form, your role is to provide professional leadership and guidance to support the Associate Medical Directors, the Clinical Directors and the Lead Clinicals throughout the Trust in relation to Governance of the medical workforce, and in relation to 10:21 10:22 Clinical Governance you're a member of the senior management team and the Trust Board. You assume corporate responsibility for ensuring an effective system of integrated governance within the Trust which delivers safe, high-quality care, a safe working 10:22 environment for staff and appropriate and efficient use of public funds.

In a nutshell, the buck stops with you, I suppose, as regards Clinical Governance. Ultimately, the Chief Executive, which you are now, is responsible entirely for all of it, but you're the most senior medical person on the SMT. You were when you were Medical Director? 10:22

A. Yes. The role of a Medical Director is about supporting, I think, the medical management structure in relation to professional governance, and then in relation to Clinical and Social Care Governance it has been around quality assurance of the systems and processes in place. 10:22

35 Q. When you speak to systems and processes, that incorporates any of those that touch upon Clinical Governance as well? 10:23

A. Yes.

36 Q. Just to clarify that just a little bit more. Do you see any distinction from your role as Medical Director between Clinical Governance and Operational Governance? Do you see those as two separate entities or do you think that sort of separation is no longer in vogue? 10:23

A. I think there are different ways of describing this. I think the lines between them are very blurred. In terms of Operational Governance, I mean what we would mean in relation to that, on a day-to-day basis, is the operational management leadership within each Directorate. In terms of the Clinical and Social Care Governance responsibility that the Medical Director has is not in the day-to-day management of those functions 10:23

but in being able to assure SMT And Trust Board that the systems and processes that are in place to support those are robust.

37 Q. We'll go on to discuss the information you've provided in your Section 21 as to how you, as Medical Director, 10:24
ensured those systems were robust, or at least relied on them in order to provide assurance to the Board?

A. Yes.

38 Q. When you took over from Dr. Khan, was there a handover at that point? Did he provide you with a handover? 10:24
Did you have either a formal or informal handover as he departed the role? I think you overlapped. He left in January 2019 and you took up post in December 2018?

A. In December 2018 I had leave to take, and I also had the remaining weeks that weren't Christmas to take as 10:25
an induction. So basically given I had never worked in the organisation that was about me familiarising myself with some of the key people there. The handover took the form of 2 pages, which I think are submitted in Dr. Khan's submission and mine, basically with a long 10:25
list of areas that he had been involved in. Then I think we met for about an hour and a half and he took me down through some of the aspects of that. There was not, I have to say, a huge concentration at that point in time in relation to Urology. I think he explained 10:25
they had been through a Maintaining High Professional Standards process, but a vast majority of the rest of the discussion was around different aspects of the Trust he had been concerned about and that,

essentially, was the handover.

39 Q. Was the Maintaining High Professional Standards, was that only one of those, or had other doctors been put through that process and reflected in the handover?

A. There were others ongoing at that point in time. I had, again as part of my induction, I joined a matter with the GMC ELA, I think, on 4th December, basically to get a handover from that aspect of it to learn about those doctors. Again, Urology was mentioned there but very much in the context of Maintaining High Professional Standards has been done and finished. There was an awareness that a grievance had been placed at that point of time, but other that there was little discussion about it. 10:26 10:26

40 Q. Was that the meeting you had about Dr. Khan and Joanne Donnelly? 10:26

A. Yes.

41 Q. That was referred to, Panel, for your note WIT-44957, paragraph 1.4. I will just read that out because you have referred to that as being part of your handover and I want to look at that a little bit more. 10:26

"As part of the hand-over between the then Interim Medical Director Dr. Khan and the GMC ELA Joanne Donnelly, I learned that an MHPS investigation had been carried out in relation to a Urology Consultant, the result of which was an action plan in relation to administration activity. There were not thought to be any concerns about his clinical practice and did not 10:27

require formal referral to GMC."
The minutes of that meeting are found at WIT-4508.
CHAIR: I'm sorry to interrupt. Perhaps whenever the documents are called up on the screen, if they could move to the paragraph that you're reading from. It is very difficult to see it on the screen.
MS. McMAHON BL: Apologies. It is paragraph 1.4. I have it in my notes, I'm not looking at the screen, but thank you for that.
CHAIR: Thank you. That's better. 10:28
MS. McMAHON BL: Thank you. I think that reflects what I have read out.
42 Q. In summary form, you attended a meeting, Dr. Khan was still in post at the time, Joanne Donnelly was there, and they discussed Mr. O'Brien? 10:28
A. They discussed that there had been a Urology Consultant who had undertaken Maintaining High Professional Standards, and I think there was mention at that point in time about him having raised a grievance against the process, and that he had not necessitated referral to the GMC. 10:28
43 Q. Was that the only doctor discussed at that meeting?
A. No, there were other doctors who were discussed as well.
44 Q. Was any detail gone into around the build-up to the MHPS process, given you were new in post and you hadn't had any background in understanding what had led to this point? 10:28
A. Not comprehensively, but the way the GMC records its

minutes, it updates the minute before, so eventually you get a summary of the previous. There were mentions all the way through that certainly Dr. Wright and Dr. Khan had had discussions with Joanne Donnelly about Mr. O'Brien. 10:29

45 Q. Did you ask any questions at the meeting? Did you think, 'I'm taking over here, this is someone who has actually been through had the MHPS, a determination has been made'. Did you enquire about the details of it?

A. I didn't enquire very much at that meeting. 10:29
I listened. The sense, certainly from the meeting, was this was done and discussed. He had been through the Maintaining High Professional Standards process. There was now an action or -- you know, the recommendations had been made but were being stalled by the grievance. 10:29
Then after I left that meeting I asked Vivienne Toal, who is our Director of HR, if I could have a conversation with her about anything that I needed to be concerned about in relation to this. She and I met, I think it was 10th December, and had a discussion 10:30
while she took me through the outworkings of Maintaining High Professional Standards and explained that there was a grievance process in place. Alongside that I spoke to Simon Gibson, who was the Assistant Director in the Medical Director's office and asked him 10:30
if there was anything about any of the doctors that I should know that wasn't obvious to me in the GMC writing. He gave me information about a number of other doctors and then directed me towards the

Maintaining High Professional Standards files on Mr. O'Brien and said it would probably be helpful for me to read those. I took those home and, over the next couple of weekends, worked my way through them. That's how I ended getting back in contact with the GMC. 10:31

46 Q. Just from what you say, was the impression given to you this wasn't an ongoing concern?

A. The sense had been this man had been involved with HR and Medical Director processes since 2016, 2015/2016. They had worked their way through a process in terms of 10:31 understanding what the shortcomings were and the February 2017 action plan had held the situation. I certainly wasn't aware at that point in time that there had been concerns in 2018 about deviation. And that, with all of that in place, that the patients were 10:31 safe. That was my understanding of it. In addition to that, I think, when I read down through Dr. Chada's case investigation and the determination from the Case Manager, who was Dr. Khan, and looked at the witness statements, that was reiterated throughout. There 10:32 were, I think, three fairly senior doctors in there who said that clinically he was sound, but what they were concerned about were his administrative processes. Certainly the phrase that sticks in my mind when I spoke to Simon about him was, he said this is done 10:32 and dusted. Those are the Maintaining High professional standards files. Now we have to do is to make sure we operationally manage his administration.

47 Q. You mentioned, just at the beginning of your answer,

that you were reassured patients were safe?
A. Yes.
48 Q. Was that explicitly stated to you?
A. It was not explicitly stated in that way. It was stated that there were no clinical concerns about Mr. O'Brien, that they felt they had bottomed out any concerns about patients through the review that had been undertaken in relation to discovering the 783 un-triaged referrals, the looking at the process of the notes that were held at home and in his office, the un-dictated clinics, the aspects around private patients. There was a sense all of that had been looked through and all that was arising out of that were operational concerns about his administration. 10:32 10:33
49 Q. Just on that point, when you speak about operational concerns. Is it right to separate clinical concerns from operational precisely in that sort of setting where, if someone doesn't get an appointment or their clinic isn't dictated, or later on their reports aren't looked at, is that not, in effect, a clinical concern? 10:33 10:33
A. That was certainly my thought whenever I then asked to refer him to the GMC because I thought it was difficult to separate out aspects of a Consultant's work from their technical ability as a surgeon, because all of that was part and parcel of patient care. 10:34
50 Q. Presumably you would accept that people having delays to treatment isn't just an administrative concern, it clearly has a Patient Safety impact and raises the potential of significant clinical risk?

A. Yes. The simple rationale behind managing his administration operationally was to eliminate the risk of that. The rationale was that if that was managed then the patients would be safe.

51 Q. When you say about being managed, you're referring to the action plan from February 2017; is that right? 10:34

A. Yes, that's right.

52 Q. Did you look at that at the time this was brought to your attention? Did you consider the action plan at that point? 10:34

A. Yes.

53 Q. When you looked at that, the Inquiry will have heard from Mr. Haynes that he now looks at that and thinks -- I paraphrase him -- it wasn't adequate for the task that it was set to do. Did you take the view, at that time when you looked at that action plan, that it was appropriate and proper given the MHPS concerns and also the determination from the MHPS? 10:35

A. When I looked at it at that point in time, the areas that were highlighted in relation to Mr. O'Brien's practice were around triage, dictation, record-keeping, and in relation to private patients. The private patients aspect, there were fewer concerns about delays. In fact, very much the opposite, there were concerns about escalation. 10:35 10:35

In relation to the other three aspects of it, it was felt that certainly, if there were monitoring of all of that and he was nudged constantly, basically, to do

those things, that actually the treatment of those patients would fall into place. I think what I came to learn from July 2020 onwards was that the statements around management of Outpatient dictation and booking appointments and following up of results didn't automatically translate to the multi-disciplinary meetings. Right? Because my understanding had always been that whenever particularly a cancer patient comes through a system, they get referred to an MDM, they are picked up by that system, they have a tracker and a nurse assigned to them, and that on the basis of the advice from the MDM, the patient will be reviewed at Outpatients and everything flowed from that. I think I made the assumption that, actually, when we were talking about Outpatients we were talking about those patients too. I think, when we got to July 2020, we realised that was something we had been blind to. 10:36 10:36 10:36

54 Q. I just want to take you back, because the Inquiry has heard outline from the opening and will hear further detail of episodes of harm and potential harm that occurred. During your time as Medical Director while that action plan was being relied on, so I will push back a little bit on that and seek to establish with you how you assured yourself when you looked at that action plan that the Clinical concerns that you've acknowledged arose from Mr. O'Brien's behaviour were appropriately addressed by him? What did you do to re-assure yourself? How did you test that action plan? How did you stress test it? How did you consider it 10:37 10:37

against the information you were receiving? What gave you reassurance about that for a period from January 2019 until June 2020?

A. At the point I inherited the action plan it had been in place for nearly two years. Throughout that time -- 10:38
I mean what became obvious in July 2020 was there had been nonadherence in 2018, and that, I think, wasn't robustly communicated within the system. My understanding at that point in time, and I think it's written through various things that are there, was that 10:38
there had been no deviation. There are emails to the effect from Mr. Haynes, I think, in and around March, where he raises queries about this. Again, in the lead up to that, and at the time that I inherited the Maintaining High Professional Standards files, I went 10:38
back and spoke to Simon, Dr. Khan, the various other people including, eventually, Mrs. Gishkori in relation to making sure that all of those things were in place. They were saying to me that they weren't aware of any deviation at that point in time, they felt this was 10:39
accurate. I took my reassurance from that because if it had been running successfully for 2 years, I had no reason to believe it wasn't, and there had not been any other Patient Safety concerns that had been turned up in the midst of all of that. 10:39

What Mr. Haynes queried in March 2019 was he said he wasn't clear about how the information was communicated. Again, I think that was to do with the

escalation processes within the Directorate. Then, secondly, what he also raised attention to was Patient 90 who he wondered about in relation to he had been through an SAI process from February 2018 and he wondered about his care.

On the basis of that, I went back down through all of this to double-check that what was supposed to be in place was in place, and people felt it was operational. In addition to that, I spoke to anaesthetists and various others to try to ascertain if there were any concerns about Mr. O'Brien's practice but also particularly in relation to the recommendations that came out of that SAI. Those were very much in relation to Preoperative Assessment, VTE monitoring, consent, and -- sorry, my memory escapes me. But there were various aspects of that. When I worked my way down through that, with the anaesthetists and other people, they were basically saying this was not attached to one professional's behaviour. This was a systems problem. In relation to that, what we then started to look at what is how we enhanced improvement in preoperative assessment, consent and all of those aspects.

55 Q. If I can summarise that before bringing you to some examples of the previous two years when concerns were still ongoing?

A. Yes.

56 Q. I know you said you took comfort that the action plan was being effective?

A. Yes.
57 Q. I'm assuming you're saying that because it wasn't brought to your attention that it hadn't been?
A. There was an escalation process within it. Basically what was active at that point in time was that Martina Corrigan checked the information weekly, and if there were any deviations from that she then reported those to Dr. Khan. He had asked for exception reports before I arrived, and that had been agreed, so that basically if she had any concerns about deviation on that, then those automatically went to him. 10:41 10:41
58 Q. Sorry to cut across you, but just as regards timing. He asked for, effectively, a default where she didn't report compliance, she reported noncompliance?
A. Yes. 10:42
59 Q. He asked for that to start in December 2018?
A. Yes.
60 Q. That was when he was leaving post and you were coming in?
A. Yes. 10:42
61 Q. His position up until that point was, let me know the numbers so I can keep an eye on it, and later on we'll go and look at those numbers and the robustness of that data that was being relied on. But his position was only let me know if you need to, if there's been a deviation? 10:42
A. Yes.
62 Q. And we'll look at the deviation that subsequently didn't get escalated in 2018, then the one

in 2019.

Did you have any concerns that Dr. Khan would make a decision like that just as he was handing over the baton to you? 10:43

A. I don't think I was aware that the exception reporting was in place until we got to about the summer of 2019. I had assumed that that was part of the way it had been done up until that point. I think what had changed with that as well was, I think prior to that it had 10:43 been monthly reports, and the exception reporting then moved to weekly reports. On the face of it, it looked like a stepping back but, actually, on a different level it was an increase in the monitoring. Just to say as well, I think whenever the deviation reports 10:43 came through when the secretarial staff had noticed these in March 2019, I think as well it offered an assurance to me as well that, actually, there were eyes on the bigger system. They were aware that this was an issue, and they were actively chasing any results that 10:43 seemed to be outstanding or any appointments that seemed to be outstanding. What I took from that was actually these systems and processes were working because the system seemed to be aware of them.

63 Q. Just now that you've mentioned that particular point, 10:44 we're jumping about a little bit, but there's so much happening at the one time. You mentioned Martina Corrigan, who was Head of Service, was responsible for oversight of the action plan and

ensuring compliance and reporting any deviations, and the secretaries then for alerting their line managers of administrative failings. You've already said, at the start of your evidence, that these administrative failings are clearly Clinical Governance concerns. Do you think it is appropriate that non-medics and people who are not in positions of authority, if I can put it like that, like secretaries, for example, are left to monitor Consultants and to report any deviations in their practice? Did you feel assured by that? 10:44 10:45

A. The Consultant secretarial staff are Band 4 workers and they are trained in different aspects of managing clinical processes. My experience, I have to say from my own clinical practice, was that secretaries in relation to that would have been really proactive. They would have understood that that was part of the role, if there was deviation in the system, they didn't just report to the Consultant, they also reported to their own admin system. Actually I would have had experience in the past where Clinical secretaries would have spoken to managers and to me to say, you know, I'm concerned about how things are. Right? So that would have been my experience over the years in relation to how secretaries work. 10:45 10:45

10:46

I do think it is a significant responsibility. I also think it is particularly difficult if you have a very good working relationship with a Consultant, then to feel that, actually, you're also reporting on their

activity and, essentially, that's what that is. I think that needed to be more clearly described, I think, to the secretarial staff than it was at the time to understand that the job is not just to provide for the Consultant's patients, but also to report to the Operational Managers in relation to activity. I don't think we described that clearly enough.

64 Q. Setting the description aside, this wasn't a scenario where secretaries who were being asked to chase up tardy admin, this was a doctor who was subject to an action plan? 10:46

A. Yes.

65 Q. Who had been through the MHPS procedure, and the monitoring of that particular Consultant was left to admin staff? In hindsight, from this perspective now, do you still consider that to be appropriate? 10:47

A. The collecting of the information was left to the admin staff. The monitoring of it, at that point in time, sat with Martina, Martina Corrigan. My reflection on that is I think we should have been a lot clearer in terms of what our expectation was of everybody at the different levels. I also think that Martina shouldn't have been left to do that on her own. I think there should have been more clinical wrap round to support her. 10:47

66 Q. The Inquiry has received evidence from Noeleen Elliott who was Mr. O'Brien's secretary at the time. Aspects of that evidence would then perhaps suggest that she hadn't been escalating information. When you mentioned

earlier on about secretaries, some of them can be very loyal to the Consultant that they work for, and that puts them in a pretty invidious position, perhaps, in then having to pass on information that may reflect badly on that consultant? 10:48

A. Yes.

67 Q. Is Noeleen Elliott an example of what happens when that sort of relationship prevents good governance being monitored?

A. Yes, I think so. Yes. 10:48

68 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? 10:48

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 10:48 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 10:49 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

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.

69 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.

70 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

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.

71 Q. Did you consider that to be a difficult working environment, that the culture of being robust towards the Medical Director -- 10:51

A. Yes.

72 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? 10:51

A. Yes.

73 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. 10:52 10:52

One of the things I did want to look at, and we mentioned it a while ago, and I don't want to forget to do it, is to just give the Panel some examples of issues that arose immediately preceding your appointment, because you said you were reassured there hadn't been any concerns, that the action plan had worked well since 2017, and it is really just for reference. I'll just give two examples, and these are 10:52

from Mr. O'Brien's AOB-01929. I am not sure exactly which case this is, but its emails from W Clayton, R Carroll and Martina Corrigan dated 16th October 2018. You'll see there, there are 82 charts tracked out specifically to Mr. O'Brien. There were other issues about the action plan. We might have to go down 01936. These are a series of emails from Ronan Carroll. These are emails back and forward. Did you work much with Ronan Carroll? 10:53

A. Only with him being Assistant Director in Surgery. 10:54

74 Q. I'm not sure what that means. Did you have much contact with him?

A. Not a huge amount. No.

75 Q. Did he ever speak to you about Mr. O'Brien?

A. My contact with Mr Carroll would have been through any of the Surgical meetings or any of the discussions that we would have had in relation to Mr. O'Brien. He would have mentioned him then. But I think he found -- my sense was, certainly, he found him difficult to manage. 10:54

76 Q. I ask you that because it's clear from emails, as the Inquiry will hear, that Mr. Carroll had considerable knowledge of issues around Mr. O'Brien. I'm just wondering, in his position did he ever come to you and say, you know, that action plan isn't effective? We have had to highlight some issues along the way and chase him up. Did that conversation ever take place? 10:54 10:55

A. No. He didn't volunteer that information to me.

77 Q. This is an update from Martina Corrigan. This is an example of the updates that were provided before the

system of only deviations to be reported. For example, there in concern 2 at the bottom of that page:

"I have checked as today on PAS. There are 74 charts tracked to Mr. O'Brien's office. I've asked Maria to go to his office to check, and she confirms there are a large number of charts in the office, sitting in bundles on the floor, on his desk and in pigeonholes, so this is in breach of the action plan." 10:55 10:56

That's just one example among several in the papers. I won't take you to them all. Because I made the point to you that the action plan, perhaps, wasn't as effective, I just wanted to make that good by showing you evidence of that on the papers. As far as I know, that wasn't escalated, even though it is clearly expressed as a breach of the action plan. 10:56

Just looking at the engagement with staff. You've set that out in your statement at WIT-45033 at paragraph 28.1: 10:56

"The Urologists form approximately 1% of the Medical Workforce in the Southern Trust." 10:57

What was the workforce you were in charge of as Medical Director? Do you have an idea of numbers?

A. In relation to the entire number of doctors, between Consultants and SAS Doctors there's about 700, 730,

then the junior doctors there are between three and 400.

78 Q. As a percentage at that time, how many had been through the MHPS procedure and had determinations adverse to them made? 10:57

A. Every month in the Trust we have a doctor who goes through the formal or informal aspects of Maintaining High Professional Standards, and that's not out with the region.

79 Q. That was the case even back then? 10:57

A. Yes.

80 Q. If we look at 28.2:

"Prior to the concerns that were raised in June 2020 in relation to Mr. O'Brien, I had limited engagement with 10:58 all of the staff of the Urology Unit."

When you talk about limited engagement, what does that look like for a Medical Director?

A. In relation to, I suppose, daily contact with Urology 10:58 staff, whether the Consultants and SAS and junior doctors -- SAS and junior doctors and with the nursing staff, my contact would have mostly been through Mr. Haynes. There would have been meetings with the general surgical family at various stages to look at 10:58 issues in relation to all of that, but other than that it wouldn't have been a department I would be in and out of on a daily basis because of concerns or things that needed attention.

81 Q. Did you know that Mr. Haynes wasn't aware of the action plan?

A. He made reference to it, which I was surprised at but I understand why. He made reference to it in March 2019 that he wasn't familiar with the aspects of it. Again, when I had explored that -- and this is, I think, what caused some of the confusion at an early stage because there was a view that he wasn't involved in the early monitoring of it because he was the person who had raised the concerns, and there was a concern about him being involved in all of that. 10:59 10:59

I took the view, I have to say, that I didn't think that was reasonable. I thought given he was the Associate Medical Director he needed to know about it. He and I did have discussions about that in March 2018 when I discovered he wasn't au fait with it. Particularly since we know from the emails, Mr. Haynes was very well placed to raise any concerns if there were concerns. 10:59 10:59

82 Q. Did you give him an active role in monitoring the action plan once you realised that he was an appropriate person to be involved in that?

A. At that point I didn't physically say to him, you're in charge of it, because the monitoring of it still sat with the Case Manager because it was the outworkings of the Maintaining High Professional Standards process given the grievance had slowed everything up. Certainly what I was very clear about was that he had 11:00

to be involved in the discussions and the monitoring in relation to this.

83 Q. Do you think it was a mistake, in retrospect, prior to your taking up post, that Mr. Haynes wasn't actively involved in that action plan given his position? 11:00

A. I think he should have been, yes. I think there was probably a greater role for the Clinical Director. Again, the history of this, as you know, has been challenging because they had a number of Acute Directors, they had a number of Clinical Directors, 11:00 they had a number of Medical Directors and they had a number of Associate Medical Directors that were involved with all of this. So the constant turnover in staff, I think, in terms of people having responsibility was quite challenging in terms of 11:01 maintaining any consistent narrative around all of these aspects of the history.

84 Q. Do they have a lot of turnover in Chief Executives as well?

A. There was significant turnover in Chief Executives over 11:01 a relatively short space of time. The history of Medical Director role before I arrived was obviously Dr. Wright was there then had to be off for periods of time, and Dr. Khan was there essentially for 9 months. That was very unstable as well. 11:01

85 Q. The impact of staff turnover and vacant posts, obviously, must, by its very nature, impact badly on Clinical Governance systems.

A. It does. I think principally because you lose the

narrative. The history is really important in relation to all of this. If that starts to break down because there are too many interfaces or too many changes, then you do lose the impact of it, yes.

86 Q. Going back to what we were discussing earlier, it's an even greater significance on handovers. 11:02

A. Yes.

87 Q. So people have that corporate knowledge moving forward?

A. Yes.

88 Q. I seem to recall when Dr. Khan took up position as Medical Director Dr. Wright had already gone off? 11:02

A. Yes.

89 Q. I don't think he had a handover. Of course Dr. Khan was intimately knowledgeable about this issue with Mr. O'Brien, having been the MHPS case manager? 11:02

A. Yes.

90 Q. Just while we're on that subject. What's the position around handover now for staff? Is there a formalised system in place? Have the Trust sought to codify in some way, the way in which information should be passed from one person to the next when roles are taken over? 11:02

A. I think its difficult to set a template for each individual situation but, certainly, I have been very mindful. Our new permanent Medical Director has now started in the last couple of weeks in the Trust and, certainly I think, mindful of my experience and the experiences before, we're in the process of making sure that that handover is very robust to the point that, you know, I will attend meetings with him and make sure 11:03

that, actually, all of that is handed over, as will over people to make sure that the history isn't lost. Inevitably, I think it is very difficult for it to be perfect because, again, what takes priority at a point in time loses priority maybe with the next person coming along, as we've seen with this. Then picking up on what went before can be very challenging, you know.

91 Q. That again shifts the spotlight, I suppose, to Governance systems as such, such as the Risk Register, the Acute Governance meetings where someone could look at those, look back and capture the picture of what may present clinical risk. For example, if I were to take over as Medical Director and I wasn't told, you know, the top of this handover list are your red light concerns, this is what you need to keep your eye on immediately. These are the escalating concerns of your day-to-day job at the top. If that information isn't provided, then I may look at the Risk Register or the Acute Governance, look at meeting notes of Division and the Directorate and the Board in order to get a fuller picture. I just wondered at this juncture if we could have a look at some of that.

It does seem, on a look at all of those documents, that there's almost no mention of the clinical concerns around Mr. O'Brien until late on -- I think in 2017 it was mentioned about the Board, about the MHPS. Then I think you mentioned in 2020 about the new concerns. But if I could say, the silence was deafening from the

Corporate and Clinical Governance paperwork highlighting -- there's no highlighting of those clinical concerns. Does that surprise you?

A. I think, knowing what I know now, yes. At the time, you know, the understanding was that this was a doctor who had been through a process over a number of years, that there were escalations in relation to any deterioration in his performance, that those then were explored and understood. They didn't raise any Patient Safety concerns at that point in time and, as such, you know, were definitely being discussed as they arose and worked through. But because, on the face of it, it didn't look like there was anything different to what the starting point was from within Maintaining High Professional Standards there wasn't, I think, a clear rationale for escalating at that point in time. 11:05 11:05 11:06

I suppose, to assure you as well, I spoke to the GMC on 9th January because I was concerned. I had, if you like, third level assurance on that as well, because everything that we knew we were giving to them in relation to that. There had been previous discussions with NHS resolutions in relation to this doctor and, again, we had followed their advice in relation to all of that. There were eyes on, inside and outside the organisation. There weren't any changes made to the fundamentals, I think, of the management plan as we went along, because we hadn't anything at that point in time that it needed to be changed. There was 11:06 11:06

a lengthened period of time for him to sign off results that had been given in early 2019. There was an understanding of the impact of, you know, an unwell relative in terms of his performance later in 2019. But, to all intents and purposes, there was a rationale for things having happened the way that they did. In terms of acute escalation there wasn't anything immediate at that point in time to take back to the Trust Board to say we have concerns here. 11:07

92 Q. You were sufficiently concerned to contact the GMC. That was based on, initially, concerns around his lack of insight? 11:07

A. Yes.

93 Q. Mr. O'Brien's lack of insight. Then Patient Safety became an issue for you subsequent to that? 11:07

A. Yes. That was initially in relation to Patient 90, in terms of the anaesthetic concerns. When we went back and looked at all of that we couldn't locate that principally with Mr. O'Brien. That was a systems difficulty. 11:08

94 Q. When you contacted the GMC, what was your expectation at that point? Dr. Khan had looked at the same information and hadn't triggered a referral. You looked at all of the information available to you and considered that it was appropriate. Joanne Donnelly, I think it's fair to say, was very professionally involved and proactive in seeking information and to assist in the appropriateness of that referral. When you had that in your mind and you thought, yes, this is 11:08

appropriate for a referral, first of all, how did you think that would improve Mr. O'Brien's insight, which was the basis for your referral and, secondly, what did you expect to happen as a result of it?

A. In order to make the GMC referral what I also had to do was to review -- and I made mention of it in various aspects -- I had to review all of his paperwork. I looked at his appraisals, his medical report, any complaints there had been about him, any other characters they were there with our CHKS systems, which is part of our outcomes data. It is limited because of GDPR processes and how we compare with the rest of the UK, so it is very limited, and I knew that. Based on that, there wasn't anything that was jumping out at me from that. 11:08 11:09 11:09

In addition then to Maintaining High Professional Standards -- and there was no comment about insight or anything else in relation to those documents. What concerned me was when, as I say, Dr. Chada undertook Maintaining High Professional Standards investigation and some of the responses she got to that. The fact when I listened to that it was very much apportioning blame to other people rather than any sense of remorse, concern, regret for any of his patients, which, I have to say, I found highly unusual in a doctor. That was the bit I was concerned about. All of that information was handed over to the GMC, along with then the Patient 90 concerns initially and anything we were concerned 11:09 11:09

about was handed across. They acknowledged in January that he met the threshold. It took a while to gather up some of that information because, back to the lack of robustness in our governance structures, that did not come easily, that had to be dug about for, essentially. But, on the basis of that, they then formally accepted him as requiring investigation and his revalidation was suspended on 27th April 2019 on the basis of all of that.

95 Q. I just want to get underneath the process. You described the process very well, and the Panel are familiar with that. The Inquiry will be interested to understand what it was you thought the GMC would be able to do to reduce any risk you perceived to exist at that point as a result of what you considered Mr. O'Brien's lack of insight and lack of remorse? What did you think? Why would that be the first thing you would think, I know how we can approach this, we'll go to the GMC, as opposed to, maybe he needs a greater intensity of supervision? 11:10 11:10 11:11 11:11

A. I think in relation to that, my sense was, from what had been written in the documentation that had gone before, that, actually, Mr. O'Brien wouldn't have agreed he had lack of insight. I think that anything local I'm not sure would have landed. Having been through cases before with doctors where there's been lack of insight, there are no kind of ready-made programmes that help with that. Usually very often those cases do end up in front of the GMC. I suppose 11:11

my experience of working with them before was that once they take on a doctor in relation to investigation and management, that then they follow through a process and they come back and ask, you know, really robust, challenging questions in terms of what has been done, what needs to be done, and they become involved in all of that.

I think the thing that surprised in all of this was that I was sending information but, despite conversations, actually I wasn't clear that there was an investigation proceeding in the way I had expected. Also, I think they possibly took comfort as well from the fact that the Maintaining High Professional Standards investigation had been carried out and that there was an action plan, albeit it was a 2017 one. Again, throughout 2019 they were fully in receipt of the information but my hope would have been that they would have come back with questions to me, questions to the system, if they weren't content with what they got. Given that wasn't in the system, you know, usually you take the assurance that, actually, they are content with how things are progressing.

11:12
11:12
11:12
11:13
11:13

96 Q. Given your knowledge of the action plan, was it not clear at that stage that the action plan was really just asking Mr. O'Brien to do what was expected from him, rather than provide any, either support to him or training or any programme that would allow him to gain insight into the potential impact of his administrative

practices? Were you at all concerned that when you read the action plan it certainly seems, from an objective reading, you really asked him to do what everyone else was doing?

A. I think the action plan relied on the fact that whenever -- you know, again, what's stated at various points in the communication and the emails and various other places, is that when the action plan was put in place there was a sense that that would contain him well enough to actually get the job done. Right? And that he might continue to be upset about what he saw as other failings in the system but, actually, in terms of reinforcing to him his own personal responsibility for looking after his patients, that that should be enough to do it. I suppose, you know, in 2019, I wasn't aware there had been any deviation in the usefulness of that plan, and my understanding was that that actually was enough to contain him at that point in time. I think, you know, insight is a really difficult thing to tackle. We were never going to do it through just an operational plan. My hope was that actually through some of the dealings with the GMC that when it eventually got underway, that actually that would be helpful in terms of, you know, reminding him that it wasn't just about the system, it was also about personal responsibility. 11:14 11:14 11:14 11:14 11:15

97 Q. Do you think that staff fell into the error of looking through the wrong end of the telescope and focusing on containing Mr. O'Brien and not focusing on making sure

patients were safe?

A. I think the assumption was made at that point in time that if the admin processes were sorted out that would contain the system and keep the patients safe. Knowing what we know now and given, I think, how far we have come in terms of the development of our governance processes and the information that's available to us that wouldn't have been available then, I wouldn't have been making those decisions. I don't think other people would have been either. I think we would have taken a different approach. 11:15 11:16

98 Q. The information that was available then, either through asking or through questioning other staff who had corporate memory, was a series of historic attempts to deal with Mr. O'Brien and his inability or reluctance or resistance to adopt suggestions to improve his practice and his administration. It had been going on for years. No one ever said to Mr. O'Brien, we have tried this before with Mr. O'Brien and it seems to make some small difference and then it falls by the wayside. No one ever said, anything we tried before hasn't been effective? 11:16 11:16

A. No. In fact, it was a bit different from that. What I gradually learned over a period of time, and some of it came to light in the discussions with the Urology Oversight Group with the Department of Health was there had been prior knowledge of Mr. O'Brien. Right? Right back to 2009/2010 where there had been concerns about antibiotic prescribing and cystectomy, and other 11:17

aspects, the narrative I was picking up at that point in time was there certainly had been difficulties in the past, but when they put systems and processes in place to manage it, actually the problem had disappeared or certainly been managed. 11:17

99 Q. Who told you that? Who assured you previous attempts had been successful?

A. That was some of the discussion that came through in relation to conversations that I would have had on the way around. Mr. Haynes was in the same position as me. 11:17 He started in the Trust around 2014/2015, so he didn't have all that memory from the past in relation to what had gone on. But when we got to, I think, the summer of 2020, and then beyond that particularly, as I say, with the Departmental meetings, some of that came 11:18 through then with discussions from the PHA and the Department. In the past they had had some awareness, particularly in relation to antibiotic prescribing and cystectomy there had been previous difficulties.

100 Q. You had Head of Service Martina Corrigan from 2009, did 11:18 she never tell you that previous attempts had been unsuccessful? She had been directly involved in a lot of this in different guises of trying to find a solution. Did she never say to you, it hasn't worked in the past. That action plan is really just asking 11:18 him to do what everyone does, and it will slip. Did she never indicate that or suggest that would happen?

A. When I found out from PHA Department and other places there had been the previous concerns, the conversations

I would have had with Martina were specifically in relation to cystectomy and antibiotic prescribing.

101 Q. If I can just cut across you again. I'm trying to draw a line from what you subsequently knew and what you could have found out at the time just by asking. If I can be as blunt as that. 11:19

A. Yes.

102 Q. Did you have any curiosity at the time that people were pushing back, there was an action plan that could be seen to be oversold by calling it an action plan, which was really just asking someone to comply with reasonable standards in their practice. There seemed to be no-one who was telling you what had happened before. There had been a letter given to Mr. O'Brien, had you been told about that, on 23rd March 2016, setting out the concerns that they had at that time? 11:19

A. Yes.

103 Q. When did you know about that?

A. That was part of the Maintaining High Professional Standards bundle. It was in there at that point in time. 11:20

104 Q. Did that not ring alarm bells at that time when you read that and saw in 2016 the same issues, it's almost identical these issues. Again here we are now with the action plan. A lot of this is replicated. This is now two years later, three years by the time we turn the corner into 2019. There's a potential that people are being harmed for all of that time. Did that not ring alarm bells and you think, I need to do something more 11:20

than refer to the GMC?

A. The letter, if we are talking about the same letter of 23rd March 2016, and it is the one written by Mrs Trouton and Mr. Mackle. Yeah? It's in relation to concerns about those aspects of his care that were then dealt with through Maintaining High Professional Standards. I certainly didn't pick up from that letter that prior to 2015 that that had been a concern that had been dealt with before and failed. Right. 11:20

105 Q. Just to stop you there. It is correct that eventually it was dealt with under Maintaining High Professional Standards, but there was a period between March and December when Ester Gishkori had indicated that informal route would be a more appropriate way, and that didn't come to fruition. It seems to have tailed off, if I can put it like that. 11:21 11:21

A. Yes.

106 Q. The Maintaining High Professional Standards was something that was entered into after attempts to try and resolve it informally. It didn't just go from 23rd March into MHPS. There had been windows of opportunity where other staff sought to assist. Did you work with Esther Gishkori? 11:21

A. I did briefly, yes.

107 Q. Did you work with Heather Trouton? 11:21

A. Yes.

108 Q. Did you work with Eamon Mackle?

A. No.

109 Q. Did you work with Colin Weir?

A. No.
110 Q. Did you work with Ronan Carroll? You said you did work with him.
A. Yes.
111 Q. You worked with Martina Corrigan. 11:22
A. Yes.
112 Q. These are names that are all very familiar over the years. You never thought of approaching them to find out a fuller picture beyond what you were able to read in the paperwork? 11:22
A. The history that was given about Mr. O'Brien was that he had always been problematic. That, basically, he was difficult to manage. He felt that the system was always to blame. Didn't take any personal responsibility for anything going wrong at any point in 11:22
time. I think the sense I got from people was they were hugely frustrated with having to manage him. I suppose my reading of the -- there were bits and pieces of information but no coherent story. Right? I would have heard about the antibiotics and 11:23
cystectomy. Then there was some point in 2020 there was something about him having thrown notes into a bin that caused a bit of alarm. But, again, in terms of getting a clear picture of what that was about or what the working out of it was about, you know, there was 11:23
a sense that he was told to stop doing that, he did, and it didn't happen again. Same with the antibiotics, that's what happened.

In relation to the backlog of patients, the sense was that had gone back to 2015 whenever the numbers of referrals and everything else had gone up and the Consultant numbers had changed. There was always -- part of the narrative was incredibly difficult to manage, difficult to work around, but each time they hit a problem it was dealt with, and then everybody moved on. Right? 11:23

I think the thing about 2016, between March, between Heather Trouton and Eamon Mackle letter in 2016, then the email communication that Esther Gishkori sent in September was a reversal of the position that had been taken by the Medical Director in September 2016. Dr. Wright, I think, was proposing one form of action, then Mrs Gishkori came back and said, I've spoken to the Clinical Director, the Medical Director, I think we can do that differently. That wasn't the advice coming from the Medical Director. I think essentially that caused a lot of confusion in there and -- 11:23 11:24 11:24

113 Q. Would that be usual for a Director to overrule a Medical Director in a Clinical concern?

A. Not like that, no.

114 Q. You have been very general in what you say you heard around Mr. O'Brien. 11:24

A. Yes.

115 Q. Did anyone ever come to you formally or come into your office and say, I have ongoing concerns, or, he's difficult or all of the words you used. Was that said

to you directly or was this information you might have picked up?

A. This was information I picked up on the way round. I never had a formal approach. Probably the person who came closest to it was Mr. Haynes in terms of identifying, you know, and he put those emails in terms of what he had identified. I didn't have a formal approach from anyone else to say, I am discerned about Mr. O'Brien.

116 Q. He might have been difficult to manage but you were being paid to manage him, you were the Medical Director. 11:25

A. Yes.

117 Q. That was your role?

A. Yes. 11:25

118 Q. You were a couple of roles above his grade. There were people below you paid to manage him, but ultimately you were in charge of the medics. Was there any other factor, anything else that prevented you from dealing with him directly? Mr. Haynes has referred to being frightened of the fear of litigation, family members and the law. Did any of that play any part in what you heard or how you felt? 11:25

A. I heard that through the system. I think what made the job of managing more difficult, I think, is the facts you referred to there, among other things, was a concern throughout the system about Mr. O'Brien's connections. You know, one of the first things I heard about him was he had legal connections. Then the other 11:26

thing I heard about him was that he was a close friend of the Chair of the Trust. I think that put people off, actually, challenging him. You know, what they would have said to me was he made threats back to them about who he was connected with and how he would get them into trouble if they challenged him in any shape or form.

119 Q. Did he ever say that to you?

A. No, he didn't.

120 Q. This is information you heard? 11:26

A. Second-hand, yes. The only experience I had of that was after I started in the Trust in January 2019, in the one -- the first one-to-one I had with Mrs Brownlee she made comment about the fact she felt he had been essentially persecuted by my predecessors, he was an excellent Surgeon and a good man, and she hoped I wouldn't treat him in the same way. 11:27

121 Q. We'll come on to look around the information around Mrs Brownlee. Just before, I think it might be appropriate to take a break, but just before we do that, finally, on that particular section. Would it be fair to say that those concerns that you heard about Mr. O'Brien, or the perception he may have had some sway, either personally or professionally, operated a chill factor in dealing with him? 11:27

A. Yes, it did. Definitely.

MS. McMAHON BL: Chair, I don't know if that's a convenient moment?

CHAIR: Yes. A quarter to 12.

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

MS McMAHON BL: Doctor O'Kane, I wonder if I could pick up on one of the points you mentioned in passing, the revalidation issue about Mr. O'Brien. He contacted you on 1st May seeking recommendation for revalidation. We don't need to go to the document but for the Panel's note it is AOB-04269. You replied to him, stating that the GMC has been informed. It might be helpful to look at that, AOB-04271. You had written to the GMC in April prior to this? 11:47 11:48

A. Yes.

122 Q. If we stop there, 1st May, 2019. 11:48

"Dear Dr. O'Kane, I have received the below email from the GMC advising that a recommendation regarding my revalidation is overdue. I have been advised to contact my Responsible Officer." 11:49

That would be you as the Medical Director?

A. That's correct, yes.

123 Q. "I would be grateful if you would communicate your recommendation to the GMC." 11:49

You reply on 2nd May, the next day. You say:

"Mr. O'Brien thank for your email. The GMC has been informed".

What does that mean, that email, the GMC has been informed? What did you hope to convey by that?

A. Once a referral has been accepted by the GMC they automatically move to suspending a person's revalidation until the investigation is complete. 11:49

124 Q. Probably I should have asked a question before that. Did Mr. O'Brien know that you had written to the GMC?

A. He did.

125 Q. Who told him that? 11:50

A. It had been communicated to him by letter by Mr. Haynes.

126 Q. You have informed him that the GMC has been informed that you're not going to revalidate him, is that correct, or you're not going to put him forward? 11:50

A. No.

127 Q. Explain that to me?

A. He was informed he had been referred to the GMC. The decision about revalidating him wasn't my decision, it was the GMC's decision. Again, what I thought he was intimating in that was he was suggesting I hasn't been in contact with them. We had been in contact with them to say he was still on the books and we had made the referral to the GMC. On the basis of that, then they withheld his revalidation. 11:50 11:50

128 Q. What's the effect of, I think it is pausing the revalidation at that point because it is only a referral; is that right?

A. Yes.

129 Q. Does that have any impact on the ability to practise as a doctor?
A. It doesn't. No, it doesn't.
130 Q. Was that in your mind whenever you referred to the GMC that one of the outworkings of that would be that the revalidation process would be paused pending consideration of that referral? 11:51
A. That would be in the hands of the GMC. I mean, I referred him to the GMC based on my concerns. They made the decision that he met the threshold in terms of an investigation, and then in the course of that they made the decision about deferring the revalidation. The decision I made in the middle of that was to refer the rest of it is the decision of the GMC. It wasn't in my mind that it would be disruptive to any of this, because I didn't know if they were going to accept the referral or not and I didn't know how long it was going to take them. 11:51
131 Q. The first time you wrote to the GMC was it January 2019 or was it April? 11:52
A. The first time I spoke to them was January 2019, then I had a number of conversations with them in between times. Then, as we collected the information, because of annual leave and everything else, I think they eventually got the final draft of the submission on 2nd April 2019. 11:52
132 Q. You do refer to that in your statement. At the point, whenever you referred to the GMC, whenever you made the decision to do that, had you had conversations with

Dr. Hughes and that point around any of the SAIs?
A. No.
133 Q. Had you spoken to him around any of that information? Were you aware that was ongoing?
A. Yes, but I hadn't had any clear conversation with him about it at that point. I referred to the GMC in January 2019, so Dr. Hughes became involved at the end of 2019 into 2020. 11:52
134 Q. Sorry, that's my mistake. When you did speak to Dr. Hughes initially, was it early on in the commencement of his looking at the SAIs? Was it around October 2019? 11:53
A. Yes. It was quite soon. Because, obviously, we started to discover in the course of June 2020 that there were concerns. There was a significant amount of work done in terms of rapidly reviewing charts and having, you know, scoping up what the extent of this might be. Some of the concerns that were raised obviously meant the threshold for Serious Adverse Incident. Given the seriousness of this and given there had been SAIs connected to Mr. O'Brien previously, we approached Dr. Hughes to become an independent Chair in relation to all of that. Then in and around this time we had discussions with the Invited Review Service in the Royal College of Surgeons. 11:53 11:53
135 Q. That was all around the latter end of 2019?
A. That was all around the end of summer 2020.
136 Q. 2020?

A. Yes.
137 Q. Did Dr. Hughes update you before he ultimately published his findings on the SAI? Did he update you as he went along?
A. We had a couple of phone calls in the course of all that. He raised the Bicalutamide difficulties with me and his concerns about that. 11:54
138 Q. When was your first knowledge of that?
A. In and around the time Mr. Haynes then undertook the rapid review of Bicalutamide. That was around November/December 2020, I think, from memory. The other discussion then he had with me was he talked about a concern about the cancer multi-disciplinary team meetings and the nonengagement with the CNSs, the Clinical Nurse Specialist by Mr. O'Brien. I remember 11:54 11:55 that conversation because I think both of us were a bit shocked. I think he had come across this information, and I think he talked about it last week, in the course of speaking to the families who were involved and realising as they were trying to manage their cancer 11:55 care in the course of the pandemic they didn't have access to a Clinical Nurse Specialist, so he spoke to me about that. Then the other area he spoke to me about before he published the SAIs in draft and then finally was he was exercised around we used EGRESS, 11:55 which is an electronic record transfer system which is held on a cloud so it means the records don't physically leave the Trust but they can be viewed, and he was concerned because there had been comments made

in relation to the SAI in relation to the use of EGRESS to respond to that just to let me know that that had happened. Those, I think, were the different times I spoke to Dr. Hughes.

139 Q. At that point then you became aware that there were actually verifiable or potential clinical concerns around the practice? 11:56

A. Yes.

140 Q. These are new issues, as it were, for you?

A. Yes. 11:56

141 Q. At that stage did you think it might be best to take some action or to do something around clinical practice of Mr. O'Brien at that point?

A. Mr. O'Brien retired from the Trust on 17th July. When we had discovered the difficulties after -- I think I was informed on 11 June and the Clinical team, principally Mr. Haynes and Mrs Corrigan had been working on an email that they had received that suggested there was a discrepancy in two waiting lists, and that caused them a bit of concern. When they worked their way through that they realised there wasn't a discrepancy, but what they also discovered on the back of those explorations were the concerns then around the cancer multi-disciplinary team meeting. 11:56 11:57

142 Q. I think Mr. Haynes explained the issue around the waiting list and the two patients. 11:57

A. Yes.

143 Q. If we go back to 2019, there was a bit more information, if I can put it that way, a bit more

information coming through your office around concerns that meant that you then thought it was appropriate to have a meeting in October. Do you remember that meeting? Mr. Haynes indicated in his evidence that he wasn't able to attend. 11:57

A. Yes. That was about 16th or 18th September. Martina contacted me and the other people involved basically to say that she had noticed that there wasn't dictation and sign-off and triage done. I can't remember the exact details of it. Basically on the basis of that, 11:58 that was escalated. Again, whenever that was looked at there was a discovery that Mr. O'Brien had been off for a period of time across August -- the end of July, August, early September, in relation to his mother-in-law being unwell, and that that had delayed 11:58 the management of those results. Those were addressed then and taken forward at that point. At the same time I think Mr. Haynes also raised a concern about an MDM patient that had been discussed in Belfast. Again, when we looked at that there were concerns about 11:58 a patient who had missed a window of opportunity in terms of Radiotherapy or Chemotherapy treatment that had to be taken.

144 Q. What time did you find about the MDM patient?

A. 16th September 2019. 11:59

145 Q. In 2019 there were clinical concerns coming to you?

A. But in relation to -- so when we looked at the MDM, so when we looked at this patient, what was very clear was the reason there had been the delay was right back to

this delay in the dictation and referral that had come about because Mr. O'Brien actually wasn't physically there. So those were all tied in together. That wasn't seen as a separate issue. But also what I thought that highlighted to me at that point in time was, actually, the MDM was being captured through those clinical processes that we already had in place.

146 Q. You thought the governance system was working then? That was an example of it working?

A. It had that appearance of it at that point in time, yes. 11:59

147 Q. The backdrop to that, of the dictation and noncompletion of administrative tasks, you hadn't realised the year before, when Martina Corrigan was off for a prolonged period, that no-one was overseeing Mr. O'Brien at that point? 12:00

A. Yes.

148 Q. This was before you started. You hadn't been informed of that, there was a period when the reporting system to Dr. Khan just fell away because she was off longer than anticipated and no-one was reporting back that there had been a previous deviation you weren't aware of? 12:00

A. No, I wasn't aware of it. I have really struggled to think did we have any conversations about that and I definitely can't remember any, and I couldn't find anything written down to suggest I had been told. I think, to be honest with you, particularly when the time frames were not dissimilar in 2018 and 2019, 12:00

I think then, eventually, if it was mentioned at the end of 2019, I think some of the history was getting a bit conflated. Certainly, whenever we looked at that issue in 2019 I hadn't been aware of 2018, no.

149 Q. In February 2019, you refer to that period in your statement at WIT-45094. You've mentioned this earlier. I just want to put this in the time frame. You'll see the top box there: 12:01

"On 19th February 2019, Mr. Haynes brought SAI 82946 to my attention. On the same date, I contacted Mrs Gishkori, Director for Acute Services, about my concerns, based on my review of the SAI and the MHPS paperwork. She did not identify any ongoing concerns and expressed the view that he was a 'well-respected surgeon'." 12:01 12:02

Were you contacting Mrs Gishkori about any concerns?

A. Yes. That was the point, because I had looked at what was there. I started the conversations in relation to what might be the underlying contributory factors in relation to the SAI Patient 90 that Mr. Haynes was concerned about. Again I had looked at his medicolegal work or any legal claims against him, serious adverse incidents, those kind of things, appraisals, and there wasn't anything jumping out from me. The natural approach would be to go to the Director and ask her to find out whether or not there are any concerns, and she said she hadn't heard any. 12:02 12:02

150 Q. Would it have been the natural approach to go to the AMD?
A. I had spoken to Mr. Haynes, yes.
151 Q. What about the Clinical Director?
A. I know that Mr. Haynes had spoken to the clinical -- I think the Clinical Director at that point in time -- again, there was quite a switch in people at that point in time was either Mr. McNaboe or Mr. Weir. Certainly he wasn't getting -- I think it may have been Mr. McNaboe at that point in time. He wasn't getting any concerns at that time. 12:03 12:03
152 Q. Did you ever speak to Mr. Young about Mr. O'Brien as the Lead Clinician?
A. No. Not until after -- no, I hadn't any conversation with Mr. Young until, I think, autumn 2020. 12:03
153 Q. Did you ever speak to Mr. O'Brien? Did you ever go and see him and speak to him about issues?
A. No. I haven't spoken to Mr O'Brien.
154 Q. Did you ever meet him?
A. No. 12:03
155 Q. Were you at any meetings with him ever?
A. No.
156 Q. Do you think, in hindsight, it might have assisted in getting a better insight into managing him or finding a way forward if there had been a meeting at that level? 12:03
A. In my mind, right, and again I think I was wrong at that point in time. In my mind, he was being managed through a system of escalation, and everything else.

The GMC were involved. The usual clinical managers were involved. In an organisation the size of ours, you know, Mr. O'Brien didn't approach me. I know that previously he had approached Medical Directors and Chief Executives to complain about his treatment. He didn't make any approach to me during all of that. I corresponded with him through the usual lines of management that would have been there. That wouldn't have been unusual. That's not unusual practice in terms of how doctors are managed who have been through Maintaining High Professional Standards or other procedures. 12:04 12:04

157 Q. Just to keep in sequence around actions you took around that time. I know yesterday you provided the Inquiry with a couple of documents that you had recently found. 12:04

A. Yes.

158 Q. Handwritten notes. I think you had been moving offices and found in a box some notebooks that you then discovered they had relevant notes in them. They have been Bates numbered. They are at WIT-90980. They run for 4 pages. I'm afraid I'm going to have to ask you to translate some of this. I wouldn't want to guess anyone else's handwriting. This first one is a handwritten note of your meeting with Mark Haynes in relation to AOB -- I'm reading out the description provided to us of what this is, and that the meeting took place, we can see the date at the top, 11th March 2019. I know it is a couple of years ago. Does that note trigger memories, I suppose, why you were meeting 12:05 12:05

Mr. Haynes and what was the outcome of the meeting or what was discussed?

A. Mr. Haynes and I would have been in fairly regular phone contact at various stages. Again, in relation to -- I'm slightly perplexed because there's an identified name on that belonging to a patient. Can that be redacted? 12:06

CHAIR: It will be redacted, I can re-assure you. There's also a restriction order so that anyone in this chamber who sees any patient name is prohibited from disclosing it in any way. 12:06

DR. O'KANE: All right. Thank you.

There were others issues that we had in relation to Mr. Haynes's responsibilities in relation to that time. We had concerns about different aspects of staff shortages and surgery and, you know, various aspects of the Trust he had responsibility for. I would have had conversations with Mr. Haynes on a fairly regular basis, as I would have done mostly by phone with the other Divisional Medical Directors, because it is a fairly big diffuse Trust. It is difficult -- I know you visited, but the parking and everything else around the Craigavon site or Daisy Hill site is challenging, so a lot of the discussion I would have had is over the phone. On this occasion I met with Mr. Haynes in person. We were there to talk about a variety of things, but including Mr. O'Brien, for me to get an update, because this was just a couple of months after 12:06 12:07 12:07

I started, in terms of where we were. What I was checking out with him, I think, in relation to this, you know, were there any complaints, had he concerns about appraisals and, I think, was there anything in relation to litigation, was there anything coming through from his point of view? Because I had checked on my side and I couldn't see anything.

Then in terms of the management of these results and everything else, it was to get him to try and explain to me just exactly how these were managed and who was responsible for what in relation to all of this, and also to have a conversation with him about the fact that I was in the process of referring Mr. O'Brien to the GMC. I think I was double-checking with him that there wasn't anything else that I was missing in midst of all this I needed include. 12:07 12:08 12:08

159 Q. Is this page a reflection of the concerns that you were discussing with Mr. Haynes?

A. Yes, in relation just to Mr. O'Brien. There were other pages at the back of that, but that was all to do with other aspects of Surgery and other aspects of patients that came from within the rest of the Directorate. 12:08

160 Q. I see the top one says "complaints." Is that asking if there were any complaints? 12:08

A. Yes.

161 Q. It was a negative answer, was it?

A. When you look at the pattern of complaints, actually, there were very few. Mostly they were about patients

waiting times. They weren't about Mr. O'Brien, per se.

162 Q. Then you have "appraisal" circled and asterisked. What was the significance of the appraisal and that point?

A. One of the things I came to realise when I came to the Southern Trust was how the Appraisal system was quite 12:09
interesting. At that point in time the number of people being appraised was quite low. Secondly, the doctors chose their own appraiser, right, and they also brought their own information into the appraisal. It was purely based on the principle of probity. I think 12:09
I was concerned about that because appraisal isn't about performance management, although there are aspects of professional governance that come into it that you have to be really mindful of; it is about supporting the doctor to develop. I thought there 12:09
needed to be more objectivity and robustness in that process. Mr. Haynes began to explain to me what the enactment of appraisal looked like in the Trust. On the back of all of that I went back to Mr. O'Brien's appraiser and had discussions with him. His appraiser 12:10
is a very experienced appraiser. I went through all of this and everything else, and he was able to produce the evidence that he had available to him in terms of where all this was. Mr. O'Brien hadn't been appraised since he had gone through the Maintaining High 12:10
Professional Standards investigation, so that hadn't been mentioned. But to all intents and purposes the rest -- at that point in time -- but with hindsight I think there was a lot of things missing out of it.

At that point in time it looked like the information was in there that needed to be in there, but it didn't stop me going back, on a regular basis, to make sure any time there was an issue raised to check those all those usual parameters in relation to Mr. O'Brien's safe practice.

163 Q. Can the Inquiry take from that that you consider the appraisal process and subsequent documentation should be reflective of live concerns as well as ongoing issues around both Clinical Governance and Operational? 12:11

A. Yes. It's supposed to be a platform if there are any concerns about a doctor's practice they are given the opportunity for improvement, and I wasn't picking that up. What was in the appraisal was any comments that Mr. O'Brien made were basically around his concerns about waiting times and the lack of support in the system, you know, generally to provide for patients. But there wasn't anything about anything else in there.

164 Q. Is the appraisal process and that documentation a valid route by which a doctor can indicate that they would require some support or help? 12:11

A. Yes. Usually that's where it's raised. You know, typically there's a section, I think it is Box 3B or 3C would be one of my go-to places in terms of the appraisal to find out what the doctor's reflections are. In relation to that, what he did on a couple of occasions was raise concerns about waiting times and the support in the system, but no concerns were raised about, you know, the fact he was struggling to do his 12:12

dictation, return his patient notes, anything like that. There was no mention of it.

165 Q. If he had raised issues like that, when we look at the appraisals, you would have expected that to trigger a response? 12:12

A. Yes, and an action plan. Again, I think one of the things that was interesting about the appraisal process was it seemed to act in isolation from ordinary medical management. Right? Again, there has to be a degree of independence with it. If we're going to really support 12:12 doctors to, you know, do their work and improve, then actually it has to be linked in with that in some shape or form. One of the improvements that had been made over the last couple of years has been completely revamping all of that so it is a lot more robust to 12:12 support the doctors and to bring together the information. But also now, again, and it's the follow through and the use of appraisal to revalidation, there's a very comprehensive document that has been developed in terms of checklists of all the things that 12:13 need to come through, as well as appraisal, to determine whether or not the RO will recommended a doctor for revalidation. So this was the beginning of a lot of change.

166 Q. When you talked about the appraisal being someone that 12:13 you could choose yourself --

A. Yes.

167 Q. -- or the appraiser, do you think that served to undermine the robustness of appraisals as a governance

tool?

A. Yes.

168 Q. Would you agree that it may have done it in both spheres as in the doctor may not have responded to or been minded to, as you say, rely on probity in relation to information, but also may not have concerns triggered or actioned upon because of the nature of the relationship? It wasn't built or being proactive around that? 12:13

A. I think human nature, you will generally choose people who are sympathetic to you in your own mind. Whether they are or not is another issue. I think that probably helped determine how people chose their appraiser at that point in time. Appraisal has to be objective, so it is really important that actually the appraiser is well trained, comes into that with an objective point of view, knows what the job is, and gets the person out the other end and isn't concerned about their relationship with the person interfering with the questions that they have to ask. 12:14 12:14

169 Q. Rather than put those forms in a drawer and leave it until the next appraisal, if concerns were raised, if there was some seeking assistance or it was clear from the information being provided that someone could do with some support, what would you have envisaged was the duty of the appraiser to do with that information? What was the next step in the Governance ladder, if that concern was raised? 12:14

A. The system I had developed in Belfast, before I left

there, was around how appraisal concerns could be escalated. Basically in the system I was used to previously the Clinical Director and the Associate Medical Director -- sorry, the Associate Medical Director signed off the appraisals -- right? That was an opportunity for them to have a look at the appraisal documentation, see whether the doctor needed support and everything else. If there were concerns raised in it, then when I was Associate Medical Director I wouldn't have signed off that appraisal until I had an action plan out the back of that to see how exactly the improvements were going to be made. None of that was happening in the Southern Trust when I arrived. Now we have that in place. Now there's not the same disconnect between appraisal and medical management, so, actually, if there are doctors raising concerns in there that they need support with, there should be overall signoff in relation to that, and there should be an action plan and support put in around them. 12:15 12:15 12:15

170 Q. The appraisal is not for performance, really, it is for professional practice? 12:16

A. It depends how you define performance. Right? In the true sense mostly in the NHS performance is looked on as being activity. It is not about quality of care or patient experience. The appraisal doesn't take activity into consideration. That's mostly dealt with in a job plan. But it should take the quality of care and the patient experience in there. Hence the reason for having the 360-degree and the patient feedback, but 12:16

also an emphasis on the four different domains of appraisal that include Quality Improvement, Audit, and things like that.

171 Q. Leaving appraisal aside just for the moment, I want to go back and ask you more about the culture as in the scene-setting aspect our evidence gathering at the moment. I'm sure you would agree that culture in an organisation can very much influence how it is governed, both clinically and organisationally. 12:16

A. Mm-hmm. 12:17

172 Q. When you first started in December 2018 you said in your statement at WIT-45034 -- I will go back to those notes I just want to deal with this before dealing with some of the issues later on in those notes. 45034 at 30.1 you were asked about the relationships, and you've said: 12:17

"From my limited interactions with them my sense is that --."

12:17

Sorry, I should read the question first of all for the transcript. You were asked.

"During your tenure did medical and professional managers in Urology work well together." 12:18

You have been asked to explain that.

"From my limited interactions with them my sense is they did and do work well together with the exception

of the working relationship with Mr. O'Brien."

You also say: "My impression is that the remaining staff had the greatest respect for each other regardless of discipline and were very professional in their interactions and their patients and each other. They appeared to work well together outside the challenges of having to manage and work with Mr. O'Brien. 12:18

My impression based on reading MHPS papers, including witness statements and SAI documents, was that over the years Mr. O'Brien's colleagues had developed ways of not confronting him for fear of having to deal with unpleasantness, but had found ways of constantly working around him to avoid antagonising him and get the work of treating patients done." 12:18

When we spoke about this earlier you said you got these views from other people telling you that their impression rather than anything you experienced. Did you ever have anyone directly indicate that you should not engage with Mr. O'Brien in any managerial way? Was that ever intimated to you or said to you directly? 12:19

A. The only time was, and it's mentioned there in 30.4, in terms of my interaction with Mrs. Brownlee, when I took up post, basically, and, you know, apropos of nothing, she said this to me. Certainly, in terms of, you know, not pursuing him, she believed he had been badly 12:19

treated by people before, she felt he was an excellent surgeon, he`d helped a lot of people, he'd saved her life. I was quite surprised, actually. I didn't say anything to her, but I went round after that to speak to Mr. Devlin, the Chief Executive, to say to him that Mrs Brownlee had said this to me, and I wanted to make him aware that, from a professional point of view, that could not interfere with my work. He completely agreed. 12:20

173 Q. Did he indicate that he had any similar conversations or that he was aware of that having happened before? Did he indicate any of that? 12:20

A. He didn't mention to me about any discussions he'd had with her, but he said to me that he knew that she had a close working relationship with Mr. O'Brien. I'm not sure whether it was then or at a later point, he mentioned the fact that they both had been part of the same charity, and he didn't say very much beyond that, other than to say to me he agreed with me, I had to get on and get my job done. 12:20 12:21

174 Q. Just two words jump out there. "Fear" and "unpleasantness." They are quite strong words. Are they words people used to you or is this an atmosphere you picked up? I'm trying to get an impression of what it was like in the Department, in the Directorate? 12:21

A. They certainly have used the word "fear." The unpleasantness was what I picked up in relation to people's description of what his response to them was. I think probably the one that stands out most in my

mind is I had a conversation with Mr. Eamon Mackle at a point in time, and he talked about the fact that whenever he was Associate Medical Director, and that was in and around March/April 2016, and again I think was trying to put some kind of structure and process around the management of Mr. O'Brien at that point in time was approached, by, I think it was maybe the Director or the Assistant Director of Acute Services at that point in time to be told basically that Mr. O'Brien, on the basis of that, had raised bullying and undermining allegations against him. He said to me he found that quite shocking at that point in time and he felt he had nowhere to go with it because he felt he was being warned off him. 12:21 12:22

175 Q. Mr. Mackle intimated -- did he tell you this directly? 12:22

A. He did, yes.

176 Q. That the complaint had been made to Mrs Brownlee; is that right?

A. I'm not sure he said to me about Mrs Brownlee or whether it was his impression, whether she had spoken to someone else at that point in time. But he certainly felt he was being told to stop doing what he was doing. 12:22

177 Q. The Inquiry will hear conflicting evidence on that and we'll hear from the witnesses as well. Mrs. Brownlee denies there ever being a complaint made or her being involved in anything like that, and Mr. O'Brien also says he didn't raise an issue. But several witnesses have raised that, and the Inquiry can listen to the 12:22

evidence and make their own decision around that.

One of the things that Mr. Haynes talked about at length, and also referred to in his statement quite a bit, was his inability to properly do his job because of the tension and conflict in his roles. I mean that as regards time and his ability to meet the demands of his role. Was that something that you could see when you took up post? 12:23

A. Yes. Mr. Haynes, I think, was allocated about three PAs which is 12 hours a week to do clinical management of a fairly big Directorate or Division within the Directorate. I think in relation to his job planning, he had had to change that down at times to around 2 PAs because physically that's all the time he could give to it. Like hopefully all doctors he prioritises patient care above all else, but the difficulty, I think, for him, on a personal level, then was in terms of trying to keep up with patient workload, the demand around that, really furthering the cause of cancer management, all of things he was involved with, the part that got squeezed was the medical management bit of it. He did speak to me about that on a regular basis in terms of how we could give him support to actually manage that. I also think, as well, that was part of the driving change behind me undertaking a review of the medical management structures in the Southern Trust. It was partly to do with the busyness of the clinicians there. I could see they were incredibly busy, they had the 12:23 12:24 12:24 12:24

management roles they were trying to do on top of their ordinary day jobs. There are significant shortages across the piste in terms of off-setting the workload. Urology is a very high-volume speciality. A lot of patients coming through very fast. I could see that he wanted to do a good job but he hadn't got the time to do a good job, so that was concerning. On the basis of that I undertook the review of medical management and leadership in the midst of all of that. We have a greater number now of Divisional Medical Directors instead of Associate Medical Directors, and we have a significantly increased number of Clinical Directors, and also then within each Division we have shared out the different Governance roles across the different medical staff, so it all doesn't just sit with the one person in terms of managing that. 12:25 12:25 12:25

Again, I think I have submitted an update in relation to that in recent days but, basically, that's almost at completion. That got slowed up, obviously, with the pandemic and everything else and retirements and everything happening, but it is more robust than it was then. 12:25

As well as that we appointed two permanent Deputy Medical Directors and a third for the purpose of Inquiry in terms of appraisal revalidation and the aspects of professional governance. In addition to that, as I say, we've recently now appointed 12:26

a permanent Medical Director. It is in a lot better shape than a couple of years ago when I got it.

178 Q. You have covered a lot of my questions in the one answer, that's helpful. One of the things I would like to ask you about, because the Panel may be interested to hear. You mentioned in your witness statement that WIT-45063, this is about training induction. I just want to read what you said. You identified an area that might require improvement, you can update us if there have been any. Yes, 46.1, just halfway through that paragraph: 12:26 12:26

"Medical Leaders had limited time in their respective time plans to deliver on their areas of responsibility. Medical Leaders also had not traditionally had much in the way of formal training or induction to their rules and, as such, at times struggled to provide leadership." 12:27

The first question that springs from mind from that, do you believe that impacted on the quality of Governance? 12:27

A. Yes. I don't think there was confident -- there wasn't universally and consistent confident leadership throughout the system. I think that really has impacted on it in that in terms of having the confidence to speak up or feel that they will be taken seriously or, you know, feeling that they can access information. I think that has been problematic. Again, to address that, you know, we've engaged now 12:27

with the new medical leaders to develop their management roles, and we're now in the process of developing fairly robust leadership training in relation to all that. I think, you know, when you make reference to culture, my sense of the Southern Trust has been that they have been incredibly busy and that we ended up in situations where doctors were seen purely as -- not universally but at times I think because of the busyness, almost as technicians, that they had to do their job but the management and leadership bits were left to everybody else. In my experience it works well if doctors are good leaders, because they have a lot of experience and training, and they also bring a system with them, and I think that bit had been lost. Part of the aspiration at the minute is to try to really develop that. Again, I think that hadn't been around for a while, and I do think it was partly because of the busyness and demands on the system. 12:28 12:28 12:28

179 Q. One of the things that does come across is really how busy everyone is to try to meet the Service needs, and also the little time they had to do that and the stress and anxiety that certainly seems to have come across in a lot of the witness statements. Do you think there might have been a reluctance to raise issues or to identify concerns if you thought then that you would have to get involved in dealing with them because you had little enough time as it was? 12:29 12:29

A. I don't know whether that was a conscious concern but

I would expect at some level it was an unconscious concern. It meant more work for people, and we have seen that. I don't think anybody was consciously obstructive, but I do think it did require a lot of effort to be able to speak up. 12:29

180 Q. That works back to the human nature of how to inform Governance as well, to factor in people's response when they are under pressure. I suppose that's a difficult concept to try to feed into any Governance process?

A. We're very dependant on openness and candour. Again, I think if people are tired and they're beleaguered with workloads and everything else, I think that's quite hard for people to, you know, probably give as much thought to at times as they probably needed to. 12:30

181 Q. I know we we will come on to a lot of the improvements that have been made around governance, but would you agree that it is difficult to develop systems that are only as good as the information that is put into them, and is responsive to that information? They would seem to be the two main triggers in any of the governance processes, certainly, that the Inquiry have looked at. It is the quality of the information it receives, and also whether that triggers the appropriate reaction or not defines the effectiveness of that process? 12:30 12:31

A. I think that's right. I think there's something about the breadth and depth of the information and about it being robust. But there's also what information is actually useful in unusual circumstances. I think

there's a suite of information that you would normally use if you had concerns about a doctor you would run down through. Those were used, and it still wasn't throwing this up. I think, you know, that has made me wonder. Again, I think it has influenced how we have developed Governance processes in the Southern Trust and thought about how we feed in revalidation, and everything else. If you have a doctor who is particularly hard to manage, or any healthcare professional particularly hard to manage, almost reminding yourselves to constantly take a step back and think about it from a different angle rather than doing what we normally do. I think that was one of my learnings out of this as well. 12:31 12:31

182 Q. In your role as Medical Director, what weight did you place on the data you were receiving? Without looking at the source, first of all, when you got information in what best of your knowledge of your decision making was informed by that data? 12:31

A. I could only know what I was told after I asked for it or what I found out. Right? Again, you are relying on systems being robust and information being given to you in good faith. I think I make reference throughout my statement about the realisation I now have that there were false assurances in there. I don't believe that anybody was consciously telling me lies, but I do think they didn't fully understand again the breadth and depth of the information that I was asking them to report to me, if you know what I mean. The 12:32 12:32

significance of it was lost a bit. But also I think what we weren't good at was the system was joining up all the dots and recognising that triangulation was a really important aspect of this. We needed to put out all the aspects at the same time. But also that we were sensitive enough to what the smoke signals were in the system in terms of how we thought about the system. 12:33

183 Q. Would you have expected data to be interrogated robustly before it reached you --

A. Yes. 12:33

184 Q. -- so your default position would be to rely on it?

A. Yes.

185 Q. Whose role would that be?

A. That should have come up through the Operational and Professional Governance lines. Again, in relation to appraisal revalidation data, complaints, all of that, in relation to any of the clinical outcomes or any of the information that was shared in relation to the data about dictation, all of those kind of things. I was working on the assumption that we had been over this so many times that what I was given was robust. 12:33 12:33

186 Q. I can't remember the name of the witness just at the moment, someone gave an example of there being eight letters up for dictation and three of them are done, it could be that those three letters are for one patient. 12:34

A. Yes.

187 Q. As a very simple example, that shows a straightforward piece of data actually can completely misrepresent the true backlog in a situation like that?

A. Yes.
188 Q. It sounds easy from this perspective to say how did no one notice that, but I wonder who should have noticed that and where the fault line would lie in data being sent to you, and to others, that is so clearly erroneous? 12:34
A. I don't think the fault lies with any one person. I think it lies with the system.
189 Q. I said fault line. I wasn't looking for anyone to name. What part of the governance pyramid, if there is a pyramid, was fractured to stop that information being properly sent up? 12:34
A. I think probably the assumptions around how much people understood the importance of the information they were working with and the relevance of it. 12:35
190 Q. Does that go back then to the absolutely fundamental significance of having the right people oversee at the right time?
A. Yes, it does. Also I think, probably more broadly than that, being very clear that the communication throughout is well understood and shared; that everybody has the same understanding of what it is they're trying to do. 12:35
191 Q. In a system where there is any sort of power imbalance, even perceived, or knowledge around the importance of that sort of data, it does lend itself to being more likely to provide data that is not reliable. Wouldn't that be right? 12:35
A. Yes. It does, yes.

192 Q. I know we have talked about the secretaries before. We'll go into that at another time. Stephen Gibson, I think, was someone who raised the issue about the robustness of data. I don't know if you have had sight of Melanie McClements statement, but at the moment it is just one -- 12:36

A. I don't think I have seen her statement.

193 Q. It is for the Inquiry as well as our own notes that he raised this at WIT-34231 and 34233. He refers to the backlog information that had been sent had significant weaknesses in it, and was raised by Simon Gibson at a meeting he chaired on 24th January 2020 where backlog reports were discussed. It is also something that Mr. Haynes gave evidence about. He raised concerns about the information not representing the reality. 12:36 12:37

A. Would you mind if I saw that on the screen?

194 Q. Okay. I'm trying to get exactly where that is. I think it might be WIT-34235. I copied and pasted it out of context. Sorry.

12:37

What you did here, Mr. Haynes also raised concerns about the data that was being relied on. He also was concerned that it wasn't reflective of the proper numbers?

A. Would it be possible, can I have a copy of that to look at it, because I think the context is probably important. 12:38

195 Q. Of Mr. Haynes's evidence?

A. Just in terms of what you are referring to.

196 Q. We'll do that. We'll come back to that this afternoon.
A. Yes.
197 Q. I suppose, just in general terms then, when we are looking at governance and scene setting, rather than just focus on the date, part of the terms of the reference the Inquiry would be interested in is the way in which governance operates and how reliable it is and how any unreliability may lead to outcomes that impact on Patient Safety. 12:39

Just in general terms, as the Medical Director how did you re-assure yourself about the information that you were given and the Governance systems that you were responsible for? How did you re-assure yourself that they were fit for purpose? 12:39
A. I think, as I stated at the beginning, I was concerned about them, and that's why, obviously, I asked for the review of governance structures across the Trust.
198 Q. If we just pause there. I don't want to stray into that just at the moment. When you go into the job you say you were worried about them. What triggered that concern? 12:39
A. I think it seemed to take a lot of time to get information. Also then it seemed to take -- you know, again, when I went looking for information around Mr. O'Brien it seemed to take an inordinate amount of time and effort to pull down things that should automatically be there. That concerned me. Then I realised there were people involved in all of this 12:40

and that very often they were trying to do other jobs and get this done for me at the same time. So there was that aspect of it. I think, you know, some of the electronic systems had only been developed about 2016/2017, so in terms of getting information beyond that was really problematic. Again in terms of the systems then bringing together, for example, Serious Adverse Incidents, complaints, it all seemed to be dealt with in silos down through the different Directorates but not shared or given oversight by the Medical Director. Again, I think historically there had been a view that governance was managed by the Operational Directors and the Medical Director was there, then, basically to comment or give an opinion on some of the processes, without it being a full assurance process. There was very little audit going on of actually governance processes. There was very little, I think, transparency in relation to how some of those things were done. Again, back to my earlier comments in terms of trying to get information, if I asked for anything at all that was governance related, and given at this point in time I was mostly concentrating on the Acute Directorates and, to some extent, the Mental Health Directorate which also was undergoing significant challenge at that point in time too, it took an inordinate amount of time to get the information. Then sometimes it wasn't of good quality and you had to go back and ask for it again. Then you had to try and make sense of how it all fitted

12:40 12:40 12:41 12:41 12:41

together, I think what I increasingly realised was then that my sense of governance and what that should look like, in terms of being systems and processes to ensure Patient Safety, was not that shared with the organisation. I think over the years what had happened was, between numerous changes in Chief Executive, Medical Director, Acute director, Mental Health Director, that, as I say, they had lost their narrative in terms of how understanding how a good governance structure within a Trust should function to ensure patient safety, but when there had been savings to be made, those were the posts that disappeared. They kept the Clinical posts but in terms of the governance structure post -- there was no clinical audit team. For example, there was no Datix Manager. The SAIs were managed in a whole different series of ways. How complaints were dealt with were always within the Directorates but never coming to the Medical Director's office. There were things like that that you should automatically expect to find in an organisation that weren't there. 12:42 12:42 12:42 12:43

199 Q. Was part of that the sense that people worked in their own lines of management?

A. Yes.

200 Q. I don't want to use the word "silo", but there were events that people knew what their line were doing but not necessarily what the other? 12:43

A. Yes.

201 Q. Do you think then by its very nature that structure led

to confusion about roles and responsibilities?

A. I think it did. Also when you look at the job descriptions. I mean it was one of the -- you know, in the course of responding to the Inquiry I went down through -- I knew the work I had had to do in relation to the Divisional Medical job descriptions to get all of those to align. Each of the AMDs when I arrived all had different job descriptions. They had been developed at different times, they did different things, and had different levels of responsibility. We're in the process of virtually replacing all of the senior management team in terms of reappointments and, again, all of those jobs are now lined up with each other and their connection with the system are a lot clearer. The other part we have been working on then in particular the Assistant Director roles because, again, no two Assistant Directors had the same level of responsibilities. I think there were aspects I looked at and between the Associate Medical Director and the Assistant Director, nobody seemed to have responsibility for Governance explicitly. They were doing it but, again, in terms of who had overall responsibility that wasn't clear. All of that is being tidied up or has been tidied up. 12:43 12:43 12:44 12:44

202 Q. Do you think there was, perhaps, not necessarily an error but there was a perception from the outset that the problems were administrative in nature and, therefore, fell more on the operational side of the house, if I can put it that way, and that perhaps 12:44

inadvertently blinded the potential patient risk issues that have subsequently arisen?

A. I think we collectively had the perception that if the administration side of it improved, because that's where all the problems were being pointed to, if we had good governance around that and that was working well in relation to Mr. O'Brien's administration, then the patients would be safer as a result. I think that was the basic premise we worked on. There wasn't anything coming from any other information at that point in time to suggest otherwise. When I did the sweep of the usual professional clinical social care governance review in terms of the other indicators, there wasn't anything red flagging in there to suggest there were others problems. As I say, it wasn't until June 2020 when we had come at it from a different angle in terms of waiting lists, we realised there were other difficulties in there. 12:45 12:45 12:45

203 Q. I know the issues are in triage and there's electronic systems in place. If the issues that are live to this Inquiry were to arise now in the Health Service and that they would fall under what might traditionally be seen as administration, where would the governance route lie for that? Who would be responsible? Is that now, if I can use the word, tied up as to who is in charge of those sort of issues? 12:46 12:46

A. I suppose we've tested this in recent times in two different areas to see. It's very clear now where that goes. I think the admin staff are very cognisant of

the fact these things need to be escalated. In recent times that was brought forward by the admin staff and the clinical staff in relation to particular concerns escalated to the Director, brought to me initially as Medical Director, then Chief Executive, and brought to senior management team. Again, we have very clear sight of any concerns like that now.

204 Q. I just want to take you back, briefly, to the photographs of the notes. You don't have a hard copy of those. You can see okay on the screen? 12:47

A. It hasn't come up yet, but it will. Thank you.

205 Q. I'll find the reference. It is WIT-90980. That was on 11th March 2019 and there are a few words that jump out that are very familiar and raise insight in MHPS, results, NIECR. What is that in reference to? 12:47

A. That's the Northern Ireland electronic record system. It's an interface between primary and secondary care. Basically it tends to be, very simplistically it tends to be a communication tool between primary and secondary care for patient information. So aspects of it can be used for making patient referrals, holding patient results across the system, sending letters, all of that kind of thing. 12:48

206 Q. It holds information that might be readily available for people coming into the hospital? 12:48

A. Yes.

207 Q. Why is it on this page, the results? Why would you have written that down?

A. What I was trying to ascertain -- again, the other set

of people who look at NIECR are the GPS. I suppose just to say, the GPS hadn't raised any concerns with Mr. O'Brien either. They talked about the delay in his administration processes, but they didn't talk about any concerns about prescribing or any other aspect of it. He has a high-volume speciality. He had a lot of contact or interfaces with the general practitioner. Again as another assurance system --

CHAIR: Sorry, Dr O'Kane. We are trying to get a transcript. If you can talk into the microphone. Thank you. 12:49

A. Sorry. That was another area that wasn't -- again it was on my mind in relation to this. I put down some of the aspects there. CHKS data, I know that Mr. Haynes and I discussed that because he explained to me, at that point in time, the limitations of that. As I understand, if we were functioning like the rest of the UK, that would yield a lot more clinical information for us in terms of some of the parameters that are important in terms of understanding the robustness of surgical practice, such as blood loss and, I think, knife to skin, things like that. I'm not exactly over it, so I don't know the details of it. He was explaining to me that we were limited in terms of CHKS data and all that gives us is an indication of volume. In terms of the results, he was describing to me that in terms of where results should be located, you know, they could be found down through NIECR. It is not just secondary care that has access to that, it

is General Practice.

208 Q. Would you be familiar with that through your previous practice the NIECR?

A. Slightly. I would have used the Paris system instead.

209 Q. Would you be raising any concerns that results weren't being looked at? 12:50

A. In relation to that? I don't think we specifically had that conversation at that point in time. I think this was about where we would find results if we were looking for them. 12:50

210 Q. Were you aware that results weren't being looked at promptly at that point?

A. I think that came through shortly after that in an email that he sent me where he raised concerns about, I think it was a 4 or 7-day delay on results being 12:51 reported by Mr. O'Brien.

211 Q. When was that email? Do you remember the date?

A. I think it was about -- was it about 24th March?

212 Q. At this point did he raise it with you at this meeting? Did he mention it? 12:51

A. I don't think he would have -- now we're relying on my memory here, but I think at that point in time Vicky, who was one of the admin managers, I think she was raising a concern about results not being signed, and I think it was over a period of 4 or 7 days before 12:51 that. I think from memory it was 24-26 March, I think, rather than February. I think it would have outdated this time frame, if my memory is right, but you would probably need to check the dates.

213 Q. I see the results DARO processed. That's another issue that has arisen about some reluctance on Mr. O'Brien's part to use. Was this something you discussed with Mr. Haynes in March 2019?

A. I think it was purely -- I don't think I was aware of Mr. O'Brien's reluctance in relation to DARO. I think what I was interested in was if we were looking for information, where would we find it. I think where he was saying clinical information store was through CHKS NIECR and DARO. 12:52

214 Q. Was this all information in relation to Mr. O'Brien's practice?

A. Generally.

215 Q. I see Noeleen Elliott's name there as well. She's Mr. O'Brien's secretary. 12:52

A. Yes.

216 Q. Were there discussions around her?

A. Yes. That's why I'm wondering about the dates of that, whether it was February or March. What I was trying to understand at that point in time is who would know and where would the escalation be. I think what he was explaining to me was that Mr. O'Brien's secretary was Noeleen Elliott, then she reported to Colette McCaul and Katherine Robinson. 12:52

217 Q. What the word "Trust." Does that mean -- 12:53

A. I think in that case it is, I put there trust -- sorry my handwriting is so bad -- trust processes.

218 Q. What is just beside that to the left? Sorry, I just can't make it out?

A. It's something about a manager.
219 Q. Line manager?
A. Line manager. Yes, that's what it was. It was about Noeleen Elliott, Colette McCaul, Katherine Robinson.
220 Q. They're her line managers? 12:53
A. Yes.
221 Q. What's Option 3, just on the right there, above the right there, insight concern, guilt?
A. I'm just wondering, I can't remember what that was about. I don't know if it is something to do with the 12:53 GMC referral form. But I talked to him about what I was considering in terms of the GMC referral. So it is probably in relation to that, whatever I was looking at.
222 Q. Just go over the page. There's another handwritten 12:53 note of a meeting on 24th April 2019. We haven't previously had these. This fills in a chronology of actions, as it were, so it is helpful to look at that.
A. Can you make that bigger?
223 Q. Yes. Okay. This is March. Specifically a meeting 12:54 about Mr. O'Brien at the top left?
A. This is 24th April 2019. The reason I know that, there's not a date on the top of that page but I looked at the page before and the meeting immediately before that had 24/4/2019, and the day after then -- it runs 12:54 in chronological series. I think whenever I checked the diary there was a meeting in on 24/4/19 with Dr. Khan, Siobhán Hynds and Simon Gibson, I think. Those were all of us that were present.

224 Q. I don't want to read all of this out but was this meeting called by you or did someone else call it?
A. No, I called it. I think it was to do with just trying to mop up any concerns that there were in relation to Mr. O'Brien at that point in time given that there had been those emails prior to that, and the concern about Patient 90. It was to try to bottom this out because I thought we had an understanding where we were going with this in relation to having a rationale for what happened, but it was to make absolutely sure I had got this right. 12:55 12:55
225 Q. This is after the email of 24th March from Mr. Haynes about the results issue?
A. Yes. 24th March. Yes.
226 Q. Is that noted on this? First of all, I suppose, when you got that email from Mr. Haynes, did you take action in relation to that, about the results not being pulled down from the system? 12:55
A. Yes. When we went back to check and spoke to Martina, basically what had been agreed at that point in time, and again it was part of the mitigations that were put in place to try to support Mr. O'Brien. He had been given a Tuesday morning to try and work with results to help him along and get those done. Also then his concern he raised was trying to process results on the same week he was Consultant of the Week, which happened on a one in six rota, I think. He found the volume of all of that difficult. What had originally been arranged with him would be that he would be reporting 12:56 12:56

by, I think, 4 o'clock on a Friday. But basically what was then arranged with his operational managers was he would get an extension through until the Tuesday to get that done. So whenever these concerns were being raised about 4 and 7 day delays, actually what it was related back to was where those extensions and those didn't seem to have been communicated back into the system, but that was the rationale for the delays with that. 12:56

Then the other issue that was around this point in time was Patient 90 who was the man who had had the intervention, I think, in February 2018, that Mr. Glackin had chaired the SAI on, and then had raised the five recommendations in terms of anaesthetic and postoperative practice. 12:57

227 Q. There was no sense at this stage about the prolonged period of failing to look at results.

A. No. And there was no mention of 2018.

228 Q. I just notice on the right-hand side, I presume this is the same meeting? 12:57

A. Yes.

229 Q. Expectation -- sorry, about five out of service. Manager action plan. At this point still relying on the action plan from 2017? 12:57

A. Yes. I have written in there, 'escalated to case manager by Dr. Khan`. That was me checking out all that was in place.

230 Q. Just from, Mr. O'Brien considered that that action plan

expired at the end of the MHPS procedure in September 2018. It had been intimated to him that that action was with time limited. You weren't aware of that?

A. No. 12:58

231 Q. I'll take you to that this afternoon, I just to see the time. It is still the default position, even in light of these new concerns, was default escalation and reliance on the action plan?

A. Yes. I think just to, you know, to go back to what I said earlier, because the secretarial staff seemed to be raising concerns fairly immediately about delays, I think it reinforced the idea that this was working. 12:58

232 Q. I see you have asked there:

"Are we confident that this is robust?" 12:58

A. Yes.

233 Q. Is that self-reflection or something you asked the other members of the --

A. That's a question I put to them. 12:58

234 Q. What was the answer?

A. They were confident it was. That all was in place that needed to be in place.

235 Q. I think that meeting was with Dr. Khan, Simon Gibson and Siobhán Hynds? 12:58

A. Yes.

236 Q. They all reassured you there was no divergence of opinion that we need to do more?

A. Mostly the assurance would have be come from Dr. Khan,

because he was the case manager. He was explaining to me that he hadn't had any escalations, he knew what the process was and he was confident that it was being done because he was getting communication about it. Then the other bit that I did in relation to that was I said 12:59
I would email Mrs Gishkori in relation to doubly making sure so I emailed her. She didn't respond. But recently I have seen -- I had a conversation with her, I think we were at Trust Board the following week, and she said to me she understood that was being managed 12:59
internally and there weren't any concerns. I think, certainly in terms of recent discovery and, again, you know, I've had 37 lever arch files in the last 14 days so I can't tell you exactly where this is, but certainly in the midst of Mrs. Gishkori's or someone 13:00
else's disclosure, I noticed she had sent my email on to, I think other people to try to get assurance.

237 Q. I don't think she got any reply, if I remember. I don't think anything came back. We can check that?

A. I think Mr. Haynes responded. I haven't seen 13:00
a response from Mrs. Corrigan. Again, I was basing that I wasn't aware she had asked the rest of the system as well. Certainly in terms of the response she gave me it was the assurance that she thought things were in place. 13:00

238 Q. Just before we finish, I see on the left "NED". Is that "NED informed"?

A. Yes, NED is a nonexecutive director, that was John Wilkinson.

239 Q. What was he informed about?
A. He was aware of the Maintaining High Professional Standards process.
240 Q. He had been previously involved in that so he was aware of that? 13:01
A. Yes.
241 Q. Was he informed of anything else?
A. I can't remember whether or not he was informed of the recent concerns or not. I would need to check that. I honestly don't remember. 13:01
242 Q. Just so we're right in the chronology of when the Board were aware of issues, it would be helpful if you could clarify that.

Chair, I just see the time, if that's convenient? 13:01
CHAIR: 2 o'clock then, everyone.

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

243 Q. Dr. O'Kane, I wonder if we could pick up where we left off, and the email you had referred to receiving from Mark Haynes, 24th March 2019. I think we located that. If you could call it up. TRU-279349. It is about chasing up information. You'll see that is from Katherine Robinson, the Booking Centre Manager; is that right? 14:02 14:03
A. That's right.
244 Q. If you move up one email after that. This email is dated 15th December 2018. It is from Mark Haynes to

Katherine Robinson and Colette McCaul in reply, talking about the results. He said:

"The issue for me is not whether or not it was ever received. My concern that there are individuals who think the reported "results for dictation" data is robust. It isn't. The number is generated at best for some as a guess. Because this regular report is taken by senior personnel in the Trust as robust it is seen as a monitoring tool within Governance processes that results are being actioned and communicated to patients in a timely manner with no risk of unactioned significant results. I fear your team are at risk, if we have a situation where a patient comes to harm because a result isn't actioned and subsequent investigation reveals a large number of unactioned results. Your team would be open for criticism for reporting inaccurate information. For Tony, and me, Liz/Leanne look at e-sign-off and the number outstanding on here, plus any sets of notes with hard copy reports, and this is the number reported. Ironically, although we are the most up-to-date with our admin, we regularly appear to be the ones who are most behind. A question to all secretaries asking them how they get the numbers that they report would be a starting point, along with a meeting to highlight why this information is collected and the potential consequences of misreporting."

That was forwarded to you on 11th March 2019 by

Mr. Haynes as a result of results not being actioned. The three months difference in date, was that the first time, 11th March, that you were aware results not being actioned was an issue?

A. Yes. I think not necessarily -- because it wasn't a specific reference to -- I think what is confusing is it wasn't a specific reference to the summertime of 2018 when there actually had been a default, and that I learned about later on. I don't know what the email trail was beyond 15th December then between Mr. Haynes and Katherine Robinson, but my understanding of all that at the time and when I spoke to him about it, he had concerns that actually the secretaries were managing the data in the same way, and it was to ask her to make sure that they were. He talks there, obviously, in terms of himself and Mr. Glackin in relation to the signoff and the number outstanding and just how that is managed. My understanding was that, on the back of that, he was drawing her attention to the fact that the system might be vulnerable and to make her aware, I think along the lines of what we have been talking about, which is to make sure that actually they are monitoring the results in the way we expected them to be, or we thought they were, and, you know, warning them that basically being unable to do this could result in patient harm.

14:06
14:06
14:06
14:07
14:07

My understanding of that was he raised concerns about that, about having it drawn to her attention so at

least she would be aware of it when she was managing them.

245 Q. You can see in the body of that email, whatever the correspondence back and forth in advance of it, that he's raising the issue that there's a risk of unactioned significant result and the line": 14:07

"I fear your team are at risk if we have a situation where a patient comes to harm because a result isn't actioned and a subsequent investigation reveals a large number of unactioned results." 14:08

Some of that sits four-square with the information that the Inquiry has received.

A. Yes. 14:08

246 Q. I'm just trying to identify the point at which you had knowledge of this. 11th March 2019, that was my question, is that the first time you were aware that that was an issue?

A. Yes, and that there had been concerns and that he had been in contact with the administrators in relation to this, just to make them aware they needed to keep eyes on that. 14:08

247 Q. Did you action anything after that, when you became aware -- when people use phrases like "patient harm," does that trigger a certain escalation of response in your mind that this is something that needs to be actioned quite promptly? 14:08

A. Yes. I mean, from memory that email was shared with

a variety of people, including the people who had a responsibility for the monitoring, just to make sure that they were aware of it, and for them to come back to me if they had any concerns about discrepancies and that. Again, I don't have the email trail obviously on there beyond that, but that would have been shared. 14:09

248 Q. Just, if it assists at all, this was sent to you on 11th March at 1703. That's the same day of the note we just looked at 11 March 2019, which was when you had the meeting with Mr. Haynes. 14:09

A. This would have been sent after that meeting. Yes.

249 Q. Would the results and the reference to results in that be an acknowledgment that the results issue was certainly flagged as a Governance concern at that point? 14:09

A. Yes.

250 Q. Do you recall what action you took then after that?

A. My memory is -- but, again, I would need to check the email trail on it -- my memory was that that was shared with other people to make them aware of Mr. Haynes's concern and for them to go back, check and, again, based on the assurances they were given, to make sure that they were aware of the same information that Mr. Haynes and I were aware of. 14:10

251 Q. Did you take any action to interrogate that to see just precisely what the situation was at that time; what were the numbers, what was the potential harm, and had some already occurred by, potentially, late consideration of results? Was there any proactive 14:10

action on your part or anyone else's to look behind this email?

A. I think in relation to this email and then what, again, Mr. Haynes highlighted on 24th March, again it was about bringing all that together again to make sure with the system -- and you'll see it in the questions I asked on 24th April -- around are we sure that all of this is robust, that those systems and checks were in place to make sure those were in place, because I personally wouldn't have been in a position to deconstruct all of that, understand every step and then check it at every step. What I was relying on was the fact the information was shared, I raised the concern in relation to it, and the assurances I was getting at that point in time indicated that this was reliable, that that was being done. 14:11 14:11 14:11

252 Q. Those assurances, then, were received to you by email, were they?

A. I think they were given to me, certainly, verbally on 24th April. 14:11

253 Q. Who was that by?

A. That was the meeting with --

254 Q. Simon Gibson, Dr. Khan and Siobhán Hynds?

A. Yes.

255 Q. At the meeting on 24th April those three individuals were also aware that the results not pulling down results from the system at the time was also a live issue? 14:11

A. Yes. That was definitely discussed. I would need

to see the email trail on this, the full versions of it, just to make sure.

256 Q. The email trail between 11th March and 24th April?

A. Yes.

257 Q. We can have a look at those so you can refresh your memory about that. 14:12

If I could ask you to look at your witness statement, WIT-45079. The background to the question was one of the themes that is possibly emerging is the fragmented way in which people knew of some things but not everyone knew of everything. There was reliance on governance processes that, perhaps, arguably not fit for purpose, or not being fed the correct information, or when they were being fed the correct information, not being acted on. I just want to look at paragraph 49.3. I'll just read the question. We can leave that up on the screen. 14:12 14:13

"Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were - 14:13

properly identified,

their extent and impact assessed,

and the potential risk to patients properly considered?"

You substantially addressed that at paragraph 49.3

where you said:

"I believe that the issues of concern were eventually properly identified and fully acknowledged, but not all at the same time. Until 2019 and the referral to the GMC, I think that the system as a whole found it difficult to identify the seriousness of the concerns, despite the fact that a number of individuals over the previous 10 years in particular had been trying to draw attention to these." 14:13 14:14

Just over the page at WIT-45080, the bottom half of that paragraph, the sentence begins "when the concerns," about halfway through that. The second line on the screen. 14:14

"When their concerns were not taken seriously enough by the system, and in particular by Mr. O'Brien, the colleagues had to resort to workarounds to make the process work for patients. This had the unfortunate and unintended impact (I believe) of helping to minimise the impact of the behaviours and governance failings and thus inadvertently hiding and prolonging the difficulties in plain sight as various personnel changed and the narrative and memory of the concerns were thus diluted as a result." 14:14 14:15

The email we looked at, would that be an example of a serious clinical concern hiding in plain sight?

A. I'm not avoiding the question but I think I would need to see the entire email trail to see.

258 Q. Before you look at the email trail, which you identified as being after 11th March -- between 11th March and 24th April, on the bare face of the email Mr. Haynes sent you, he is clearly identifying a potential patient risk issue? 14:15

A. Yes. Yes.

259 Q. He actually used the word "harm"?

A. Yes. 14:15

260 Q. Is that an example of what you are referring to in your statement when sometimes things are right in front of people and it didn't trigger a Clinical Governance alarm that one might expect?

A. Yes. I think, I mean -- and, again, not having full context of it in front of me, I think there were definitely smoke signals throughout the whole system and, you know, always with a group of us, you know, or groups of people at any given time having access to all the information but not actually getting to -- again, I think having this idea that actually he was doing his best in the middle of it all, that actually if we could get the Governance systems, if we could get the administration systems to work, then everything would be fine. I think it's not until you -- it is a bit like taking a clinical history. Sometimes you get, you know, ideas of what might be wrong with the patient but, actually, until you get a period of time to actually undertake the assessment diagnosis yourself it 14:16 14:16

can be really difficult to see what the pattern is and what is emerging. I think this is the same. All of us had different information at different points in time and I think it is not until we got a bit further through it and had some longitudinal history with this and could see how all of the pieces fitted together and where proxies for other things that we began to make real sense of this and realise that some of these things were smoke screens.

261 Q. Is it possible at this point in time, March 2019, was actually the high watermark of your knowledge about Mr. O'Brien, because you are preparing your GMC referral? You've read the MHPS, you've had a look around all the relevant data. It could be suggested to you, and I will suggest, that if anyone knew the whole picture as was possible to be available without actually speaking to anything else from a paper review, it was you. So would that have informed your referral, or do you think maybe now looking back that other actions should have been taken given the clear indication of potential patient harm? 14:17 14:17 14:18

A. The information that I had stretched back to 2016 with the beginning of the approach into Maintaining High Professional Standards. Until, I think, we got June/July 2020, a lot of the information that had gone before that I was completely blind to it. It had not been shared to me. I maybe had snippets of things, but nothing very comprehensive. On the face of it, it looked like this doctor had been difficult to 14:18

manage for a long time and had got into difficulties since 2015/2016, and, again, the narrative at that time was if the administration processes could be sorted out, that would get him back on track again. Right? In hindsight, knowing now what I know, these difficulties were going back to at least 2009 and that, actually, you know, these were symptoms of something else, not what they looked to be on the face of it. I think I would have approached it differently. I do think if I had known then what I know now, my approach to this would definitely have been different. Right? But I also think, in fairness, the one person in all of the middle of this who knew his entire history was Mr. O'Brien. Again we were relying, I think wrongly at this point in time, on his probity and honesty in relation to letting us know if he wasn't doing the things we asked him to do, and at no time did he present that information. 14:18 14:19 14:19

262 Q. The next sequential email for the purposes of this engagement is TRU-252529. It is an email from you sent on 8th October 2019. You'll see your name at the top of it and the date 8th October 2019 from you to Mark Haynes, Melanie McClements, Dr. Khan and Siobhán Hynds, subject AOB-oversight meeting. Attachment, urgent, AOB concerns, urgent, oversight meeting request, action plan. You have written this. I'll read it out for the transcript? 14:19 14:20

Discussion draft notes:

1. Concerns re escalation,
2. Concerns process,
3. Concerns re PP. I presume that means private patients?

A. Yes. 14:20

263 Q. Making arrangements for investigation through the NHS. Query interface with PP policy. Letters no longer on NIECR now that patients are on list without letter. Consider how tracking. 14:21

Plan point 1, how can each be monitored and how is this escalated if concerns. Monitor through the Information Office.

2. Concerns re notes at home - weekly spot check? 14:21
Meant to sign notes out - he has a condition on his action point that he is not to take notes home - make assumption that if notes not in his office or clinic or theatre they are in his home? No transport to take notes between Cah and Swah. Monitoring difficult. 14:21

3. Martina can only monitor what she is given - his secretary has not engaged. Martina has had to go on to ECR to check if notes uploaded.
There is no point 4. 14:21

5, IR1 went in from MDT on Wednesday last re first delayed cancer patient. AOB letter on patient sent Friday.

6, second patient did not come to harm following escalation to MBT by trackers, which builds contingency checks into the system for all clinicians in Urology.

Then you put a plan. 14:22

1, We'll ask Mr. McNaboe to discuss concerns with AOB to make aware that this has been raised with the MHPS case manager on leave until Monday. Will consider escalation plan including option to exclude. Will 14:22 consider the full system review September 2018 and progress."

Do you remember what triggered this email?

A. Yes. This was the outworkings of the discovery that 14:22 Martina made in September 2019. Mr. O'Brien's secretary had gone on annual leave and the secretary who was in in her place brought to Martina's attention that there was a discrepancy in the way results were being reported. In relation to that, at about the same 14:23 time then, Mr. Haynes had raised with me that the multi-disciplinary team in Belfast had raised concerns about a delay in patient care about a patient who potentially missed a three-month window of treatment. Right? Those two issues were overlapping in terms of 14:23 the delay. So on the basis of that, and then on the basis of discovering then that Mr. O'Brien had been on leave in the midst of all of that, what I asked them to do was to go back and check the systems and processes

to make sure that we were capturing the information and that there weren't any gaps in all of that. Martina had gone on and checked off against what was going on. It was at that point then she discovered, I think from the replacement secretary, that actually when she was turning up, for example, to say to the secretary, you know, Mr. O'Brien saw 11 patients last Monday, or whichever day he went, is the dictation there? The secretary was reporting back, yes, I can see 11 letters on the system, but the bit of information that was missing at that point at the time was those 11 letters belonged to 11 patients rather than five patients with, approximately, two letters apiece. Right? So that was something she was concerned about, and went back and checked all of that to make sure everything was up-to-date and there wasn't anything else missing in relation to that. That was a point that Martina made in relation to saying that the secretary hadn't engaged. She felt she had answered the question she had been asked but she hadn't given the full answer when she was asked these questions, do you have 11 letters? Yes I have 11 letters, but not the caveat to it. 14:24 14:24 14:24 14:25 14:25

The IR1 that's in there, as I say, is in relation to the Belfast MDT patient. We don't think an IR1 ever went in, but what we did was we followed it anyway and realised there was an overlap with one of the patients we discovered in this that did have the delay.

264 Q. Is there an email trail before this then?
A. There should be emails back and forth, I think, from September 2016 in relation to this.

But just to re-assure you, all of our business did not happen on email. There were lots of conversations in between times. 14:25
265 Q. You don't have to re-assure me. I appreciate that. I think it was Melanie McClements -- and we'll come to it -- where she suggests that the dominant form of governance in Urology was by email. It springs to mind when you say that, but that's a point for another day. I think, from the information we have, that certainly is borne out; a lot of the information that is available is as a result of email. I know it is not the be all and end all, people do talk to each other, it's just trying to find the narrative. That's, you know, where I'm at. We're leading up to the end of 2019 when I know there were attempts made then to meet with Mr. O'Brien. He tasked Mr. McNaboe to arrange a meeting with Mr. O'Brien. Was that in the hope that all of those issues would be resolved? I assume this was another informal way to try and get things sorted out, if I can use that shorthand. You were asking somebody to have a word with him? 14:26 14:26 14:27
A. Yes. Again, it is back to one of the things that clearly did not exist within the Southern Trust that we were working on at that time was a robust process around job plan escalation and management. This had

been mentioned all the way through in terms of Mr. O'Brien's nonengagement with the job planning process, until he retired. Part of the discussion then was in relation to asking Mr. McNaboe just to speak to him about the Maintaining High Professional Standards, concerns in relation to the records and how those were being recorded, but also to speak to him then about his job plan. There are other emails in the system about that. I think Mr. McNaboe and Mrs Corrigan wrote to Mr. O'Brien offering to meet with him in November. He came back to say he didn't have enough notice and cancelled the meeting, but that would have been Mr. O'Brien's pattern. Then, I think, to try to have the conversation with him Mr. McNaboe had met him in passing one day, and I think had raised these issues with him, basically to make him aware and also to raise with him again that I was still wondering where this job plan was, as was the rest of the system. The assurance Mr. O'Brien, as I understood, gave to Mr. McNaboe at that point in time was in relation to the job plan that was in hand, and by the time, I think, Mr. McNaboe got to speak to Mr. O'Brien we were farther through in relation to this in understanding that there had been a gap in the proceedings because of his leave, and that we were -- again the system was assuring itself that in terms of results we were getting reporting on that.

14:27 14:28 14:28 14:28 14:28

266 Q. Just for the Inquiry note, Mr. O'Brien has included in his bundle various emails. I'm just going to read out

the references. You don't have to go to them. AOB-02259 to AOB-02261. That's email correspondence between Mr. O'Brien, Martina Corrigan, Mr. McNaboe dated 6th November 2019, arranging a meeting to discuss concerns about Mr. O'Brien's deviation from the work plan. Mr. O'Brien saying he won't have time as he works through lunch than to risk to Patient Safety. 14:29

Then a further email, AOB-02262. This is a letter to Martina Corrigan to Mr. O'Brien dated 7th November 2019 responding to requests for a meeting re deviation from the work plan. Mr. O'Brien doesn't want to meet during the cancer review clinics and said that the action plan expired in September 2018 -- we discussed that earlier -- with the conclusion of the MHPS investigation. Then there is AOB-02269. This is an email from Joanne Donnelly to you on 12th November 2019. She is looking for further information about the alleged deviation from the action plan, asking if Mr. O'Brien was complying before, has he made any comments about it, what is the Trust's plan for action taken, are measures put in place to address Mr. O'Brien? You responded, and that letter is at AOB-02270 to 02273. It is a letter from you to Joanne Donnelly. It is undated but the body of it explains that it's a response explaining the action plan put in place, weekly, summary, email initially, then from November 2018 only advised about significant deviations as determined that Mr. O'Brien was 14:29 14:30 14:30 14:31

reasonably compliant at that point. Intend to meet with Mr. O'Brien to agree an action plan but once agreed it will be monitored and non-compliance will lead to disciplinary procedures.

That particular email, given that you have asked Mr. McNaboe to meet with Mr. O'Brien, and I know there's a bit of toing and froing about whether that actually happened. It's another area of contested evidence the Inquiry will hear, but it, sort of, doesn't sit with what you've told Joanne Donnelly. There seems to be a suggestion that you are going to meet with him to agree an action plan which will be monitored, and non-compliance will lead to disciplinary procedures. Was that a change in tact from what the expectation was with Ms. Corrigan and Mr. McNaboe in their being with Mr. O'Brien? 14:31 14:31 14:32

A. Would you mind if I saw that on the screen, please?

267 Q. Certainly. That is AOB-02270. That's your signature at the end. 14:33

A. Mm-hmm.

268 Q. Then we go back, that's from you to -- the last email from Joanne Donnelly had been dated 12th November 2019. You have obviously dated her letter in your reply, so that's where we know the sequence is because it's dated. 14:33

She's asked you three questions: Can you advise whether there's any evidence to demonstrate that

Dr. O'Brien was complying with his agreed local action plan up to September '19 when the deviation occurred? This is obviously February 2017 action plan. If you just move down, you said it was shared with Mr. O'Brien in February 2017, that there was a summary email weekly by the Service Manager to the Case Manager. There were occasions when the backlog reports identified small deviations, but given the complex nature of the monitoring process we could not be confident that these were true deviations that actually resulted from delays in transcription of clinic letters by administrative staff and so continue to assess compliance. These small deviations were not showing consistently from one month to the next. In or around November 2018 the Case Manager sought only to be advised on significant deviations from the action plan as he determined that Dr. O'Brien was reasonably compliant. 14:33 14:34 14:34

In terms of evidence of compliance with the action plan the following monitoring arrangements were and remain in place. Then the next page is the February 2017 accounts plan. You're familiar with that? 14:34

A. Yes.

269 Q. Clinical dictation, triage, keeping notes at home, and the private practice issue. 14:35

The next question they ask is: Has Dr. O'Brien made any comments to the Trust in response to the recent

deviation from his agreed action plan in September '19, and he had made comments.

Then: Regarding the recent incident in September '19, can you provide an update on what actionS the Trust plans to take against Dr. O'Brien? Specifically, are any measures being put in place to support Dr. O'Brien and help him address current deficiencies? 14:35

The Trust had offered a meeting with Dr. O'Brien on 12th December for further discussions on his job plan which will include measures to support him in working practices. As this meeting has not yet taken place we have not had the opportunity to discuss the issues raised in this letter to clarify expectations, agree an action plan, and consequence of continued non-compliance. Once an action plan has been agreed, it will be monitored and non-compliance will lead to the implementation of appropriate Trust disciplinary processes. 14:35 14:36

That's it.

I want to marry up the emails and the content of that letter to Joanne Donnelly. It seems, taking it at face value, that is suggesting to her that there is going to be an attempt to meet Mr. O'Brien and to agree a different action plan, or amend the current action plan in the belief that that action plan was still valid. Obviously Mr. O'Brien has a different view on 14:36

that, but is that what the expectation was, that talk of an action plan was a new action plan that was envisaged?

A. No. It's not very well expressed there. In my mind it was reinforcement of the existing action plan to make sure it was still in place, and if there were any reasons it should be changed, then obviously, that would be done. But, again, back to the point what we were mindful of was that if there was significant deviation from that that, then we would process that as non-compliance. 14:37

270 Q. Sorry, just so I'm clear on your answer. It says to agree an action plan and once the action plan had been agreed. You're saying what you are talking about there is the action plan from February '17? 14:37

A. Yes. To go back and revisit it to make sure that, actually, the idea behind that was to make sure that he knew that he was being monitored in all of those domains, and if there was anything else that arose out of that, that that would have been identified within all of that. Again, just to emphasise if that wasn't being complied, then we would be following the Trust disciplinary processes, the same as we had been trying to. 14:37

271 Q. This is 2019. Is it fair to suggest that he was being monitored in all of those areas, given this was 2 years later? 14:38

A. Yes.

272 Q. As regards an effective way forward, do you agree with

me if one were to read that letter and not ask you the questions I've just asked you, it would seem to suggest, on the bare face of the letter, that there's going to be a new action plan?

A. I don't think I worded it particularly well but the idea behind it was to reinforce what was already there. Because, you know, the areas that were identified as part of the action plan from 2017 still stood at that point in time. Those were the areas that we were monitoring. We hadn't had any discussion about monitoring anything different at that point in time, because there was nothing to indicate that we should. 14:38 14:38

273 Q. Given what you knew at that stage, the parameters were broadening, the parameters of concern seemed to be broadening. This is the point which you knew about the results, for example. Do you think the way the letter is worded might have given the GMC some sort of false reassurance? 14:39

A. I hadn't thought about it until now but, yes, I think there is a suggestion in there that we would be proactive or do something we weren't already doing. But in relation to how we were managing Mr. O'Brien already and escalating any concerns we had to the GMC, they knew that -- you know, I would have presumed they would have -- I don't remember having a specific conversation with them about it, but it wasn't any deviation from what our usual plan would have been which was, when we bottomed out, when we investigated what was presented to us, bottomed out, and if there 14:39 14:39

was anything for us to be concerned about, we would have managed it. But the difficulty, I think, is when you talk about the parameters of this broadening, I think what we're finding is there's a repeated pattern rather than it getting any wider. Because, again, it's still back to the business of how notes or dictation is monitored from clinics and other work. Again, I think the pattern with this was from early 2019, that's what the anxiety was raised about. In late 2019 that is what the anxiety was raised about. It wasn't being raised about any other point in his practice at that point in time. 14:40 14:40

274 Q. Is it two consistent governance concerns were non-compliance and deviation; would you agree with that? 14:40

A. Yes.

275 Q. They alone maybe would have triggered a different approach, perhaps, at this point?

A. Yes. My difficulty was there always seemed to be a reasonable explanation for it. Right? In retrospect, now I know a lot more about this, I think that I wouldn't have accepted the reassurances that I heard at that point in time. I think I would have taken it a bit further. 14:41

276 Q. There was obviously a meeting held after this, a week later. There's a letter from Joanne Donnelly. It's not dated I am not sure if it was before or after. It is WIT-90984. It is a written notes of meeting on 19th November 2019. This is your notebook again. 14:41

A. Mm-hmm.
277 Q. I don't suppose you remember if the letter predated this?
A. I actually don't. I would need to --
278 Q. It's okay. 14:42
A. I honestly don't.
279 Q. I don't suppose point number 1 says AOB-letter, does it? I just can't make it out?
A. Yes, it does.
280 Q. I should have read it before I asked the question. I'm 14:42 not sure it helps us, but there we are.

TED, number 3 there, I'm not sure what number 2 says, but you will know?
A. JP, job plan, finalised. 14:42
281 Q. Just on the job plan. There's a lot of documentation on that we're not going to go into detail on it today, but it certainly seemed to take up a considerable amount of administrative time backwards and forwards and the negotiations, if I can put it like that, on 14:42 what would be an acceptable job plan. This was before your time, but I can see that obviously the thread continues to run during your tenure. Do you think that negotiations around things like job plans can serve to remove a governance lens from what time might be better 14:43 spent looking at? If you have staff here that are constantly engaged in trying to settle job plans, is that a potential governance weakness because they're not doing other things?

A. Yes. The vast majority of people will engage with the job planning process. You know, sit down with their Clinical Director, Head of Service, and negotiate what needs to be done, put it within a timetable, then if there are deviations on that, they'll come back and work that out. Right. Very often people are in established ways of working, that will get rolled over from year to year, maybe with some changes. But, actually, it is a fairly straightforward process. 14:43

With Mr. O'Brien, as I understand it, the issue was that he -- despite the fact we didn't ask him to -- worked late into the evening. He would have done ward rounds at night or gone to see the patients at night, he would have done various things at night, and he wasn't job planned to do that and we didn't ask him to do it because we didn't think it was necessary to do it because there were people on the wards, junior doctors and other people about. He was quite persistent, as I understand it, in asking to be paid for that, even though we were saying it is sitting outside hours of work. What you need to do is finish the job and go home. That is, as I understand it, what most of the frustration was around. It was, again, about trying to channel him back into that. He already was on a reasonably high number of PAs to cover the work we were asking him to do. Again, I know there had been various attempts at various stages to do that. 14:44 14:44 14:44

I think back to the point earlier, the job planning process escalation wasn't well embedded in the Trust at

the time. We have since rectified that, so there should be a clear escalation if job plans aren't agreed within a time frame of 3 weeks it starts the escalation right through to appeal. There aren't any other job plans that should sit for extended periods of time like this in the way this did.

I think what it serves to you do, as you say, is obfuscates from some of the main issues, which is a lot of time and energy put intol trying to negotiate that, and then it takes the time and energy off some of the other areas that should be looked at. 14:45

282 Q. I was making the point in relation to a management viewpoint rather than any suggestion otherwise, but I think your answer has addressed that. 14:45

It is also the case that the job plan, in parallel with an appraisal is a way in which someone could indicate that they need support and help if they are not able to either meet the demands of their current role or feel that they need more time to do that. Is that fair comment? 14:46

A. That's absolutely right. It is in the doctor's interest to get their job plan, their appraisal done, because the appraisal is based on the job plan. That is what they are appraised against. 14:46

283 Q. Back on this note, head speaking to him about retirement. Is that Mr. O'Brien?

A. Yes. There had been some suggestion at that point in

time, and I think -- if I remember this properly. I think there was some suggestion that Mr. O'Brien was suggesting he was going to retire at that point in time. I think that had been mentioned to me, that there had been a discussion about that. But that discussion didn't go any further at that point in time because very often you hear about people retiring in the Health Service all the time, and until you actually see the paperwork it may or may not happen.

284 Q. Were you involved in the lead up to Mr. O'Brien's requirement? Let's just deal with that now, as it has come up. Did you play any role in preparing him for that or speaking to anyone about that? I know there was an expectation or a hope that he would come back after his requirement, which didn't come to fruition. Did you play any part in any of that time period?

A. As I understand it, Mr. O'Brien contacted Mrs Corrigan to tell her he was thinking of retiring. I think he maybe alerted her to that about February 2020 and then, I think, submitted the paper work in March 2020 with a view to finishing end of July. In normal circumstances what particularly senior consultants would do is write to their Responsible Officer, who was me, and Director of Operations, who was Melanie McClements at that point in time just expressing the fact that they are coming to an end to give the Responsible Officer and the Operational Director time, I suppose, to, you know, support them through that process and actually then, you know, appoint

a replacement. I didn't have any communication from Mr. O'Brien at all. I was being made aware that he was certainly thinking about it. I know at the time when HR spoke to me about processing his paperwork they said -- now off the top of my head I can't remember who it was in HR, but I know that I had a conversation, you know, drawing their attention to the fact that he had been recently managed under Maintaining High Professional Standards. I had referred him to the GMC and he had not been revalidated on 27th April, and that had been rolled over. You know, if there were any thoughts about him coming back that would be highly unlikely because he was a doctor and we had concerns. If he was going to retire, that would be the end of it.

14:48

14:48

285 Q. Who would be the final decision maker in that process of saying no?

14:49

A. Well, there's no -- basically you don't -- it's not an another right of passage that you retire and you come back to work. You have to be invited by the Trust. Neither Melanie McClements nor I invited him to come back. I'm fairly sure Mrs. McClements didn't. I haven't spoken to her but I'm pretty sure she didn't. Usually it would be at that level, or at the level of Associate Medical Director and Co-Director in consultation with the system to make the Directors aware. You can only practice as a doctor if you have a Responsible Officer: If I was voicing concerns about being his Responsible Officer he wasn't going to have one if I wasn't happy to stand over, you know,

14:49

14:49

a continuation of what was going on.

286 Q. Once he retired then the Responsible Officer becomes the GMC?

A. It automatically becomes the GMC, yes.

287 Q. Did you speak to Mr. Devlin about that, about the possibility of both Mr. O'Brien retiring and the decision to be made about whether he comes back or not? 14:50

A. The time that sticks out in my mind that I spoke to Mr. Devlin about it was in and around the time that we discovered the difficulties in June in relation to the discrepancies, then explained to Shane that Mr. O'Brien was planning to retire that summer. I made a remark along the lines of there's some suggestion that he wants to come back and work for us. He hasn't made any formal approaches. We certainly haven't invited him back but given all that's going on I wouldn't be suggesting that. I wouldn't be happy to stand over it, essentially. But that was the gist of the conversation that we had. I think it was in the context of making Mr. Devlin aware that we had these concerns about Mr. O'Brien but, actually, we knew that his tenure was coming to an end quite soon. 14:50 14:51 14:51

288 Q. It was ultimately Mark Haynes then who spoke to Mr. O'Brien?

A. Yes. That would be typical. It would usually be the Clinical Director, or the Associate Medical Director, or the Head of Service. Yes. 14:51

289 Q. Just back to the note. Backlog -- if you could read that out rather than me trying to get what it is.

Number 4. "Backlog." Can you read that out for me?

A. Backlog importance and response by 22nd.

I'm not sure -- I looked at this and I'm not sure if that was in relation to Urology or if that was in relation to Surgery generally, because the next points we were talking about desist notices in surgery, which was about blood desist notices and mental capacity desist notices.

290 Q. You talk about ENT there as well. 14:52

A. Yes, ENT is mentioned there as well.

291 Q. Is this a general meeting?

A. Yes, this was a general meeting one. That discussion with the IRS was a discussion not about urology, it was a discussion about colorectal surgery at that point in time. 14:53

292 Q. Where we are in relation to Mr. O'Brien is that you've liaised with the GMC, Mr. McNaboe is to meet up with him and discuss the concerns that you have articulated in that letter to the GMC, and supposed to meet with Martina Corrigan. Mr. McNaboe then indicates that he met Mr. O'Brien in the corridor and had the discussion with him. Martina Corrigan reflects in her statement that she wasn't part of that discussion because it happened in that more ad hoc way. Mr O'Brien's version is he went to Mr. McNaboe's office, it was locked and there never was that meeting. I just want to put that to you. Did Mr. McNaboe report back to you after he spoke to Mr. O'Brien? 14:53 14:53

A. I didn't speak to Mr. McNaboe himself, but Martina explained to me that Mr. McNaboe had spoken to Mr. O'Brien and it had been an informal conversation. She meant it wasn't at a set time and place and in an office. I think they met in a corridor, had the conversation about it, and she wasn't party to it. The original plan was both of them would meet with Mr. O'Brien.

293 Q. As regards the assurance that you received that Mr. O'Brien was going to try and adhere to the action plan, I presume that was the assurance that you did receive at that point? 14:54

A. I mean, as I understand it, and, again, we're relying on my memory because I can't see where I've written it down anywhere, Mr. McNaboe was to speak to him about his job plan and he said he would get to that and to draw to his attention that obviously we'd had concerns about some of the discrepancies in this and to make him aware that those needed to be kept up to date. 14:54

294 Q. Also about the -- I don't see any reference in that email of the 8th October 2019 to the job plan but there's certainly -- and I'll ask Mr. MaNaboe to discuss concerns with AOB to make aware that this has been raised with the MHPS case manager, will consider escalation plan, including an option to exclude. So that's what you thought he was talking to him about but he talked to him about the job plan? 14:55

A. By the time Mr. McNaboe had got to speaking to Mr. O'Brien, right, in relation to the thought about

exclusion, that had been stood down because whenever we looked at -- that would have been in relation to the combination of the delayed -- the discrepancies in the reporting that Martina had picked up, plus the concern that Mr. Haynes had raised in relation to it the Belfast Trust MDM patient. Right? When we got in underneath all of that we discovered that the MDM patient wasn't an addition to the discrepancies in reporting, it was part of that. What we found then, whenever we got underneath the discrepancy and reporting, that was to do with annual leave -- or not annual leave, leave because his mother-in-law had been unwell and there was a rationale for why it was delayed at that point in time. 14:55 14:56

So is there wasn't enough clinically, at that point in time, to suggest that he should be escalated at that point in time and we thought we had got the monitoring back on track again, after he had taken the leave. 14:56

295 Q. I don't want to the labour the point, but you have my point about the results issue, the clinical harm, the potential it's not -- I'm just going to remind you of that. 14:56

A. Yeah.

296 Q. So this was September 2019. 14:57

A. Yes.

297 Q. What happened after that. What happened after Mr. McNaboe spoke to Mr. O'Brien? I don't want to put words in your mouth but do you agree you received an

assurance about that conversation through Martina Corrigan?

A. Yes.

298 Q. As far as you were concerned, the GMC thing was going on in the background effectively? 14:57

A. Yes.

299 Q. What happened as you turned the corner into 2020 with you? Was there any change in approach, any concerns raised, any issues?

A. No, there weren't. So there weren't any other escalated deviations and there weren't any other Patient Safety concerns raised. Then, as I say, in February there was some mention that Mr. O'Brien had announced that he was retiring. In March he submitted his letter and by that time -- I mean by the end of March the world had changed because we were in the throes of trying to manage COVID. So a lot of surgical activity -- I mean it has been one of the big victims of COVID, there's been a lot of surgical activity, including a lot of work the urologists did was stood down. Again, in terms of patient contact and everything else, that was really limited at that point in time. 14:57 14:57 14:58

300 Q. Just before we move into the look-back area and what triggered that -- 14:58

A. Yeah.

301 Q. -- I just want to briefly speak about the way in which you engaged with the Board during this period of time. As I said earlier this morning, there was one mention

in 2017 to the Board of MHPS and then there doesn't appear to have been any discussion at all of Mr. O'Brien at Trust Board meetings until 2020 - the period we're just about to move into - there don't seem to be any updates to the Board on the MHPS or the Board don't seem to have sought any updates, to be fair, not explicitly on the notes anyway.

Now, Roberta Brownlee, in her Section 21, indicates that there was always an opportunity at the end of each Board meeting for any member of the SMT present, or the Chief Executive to raise any issue, it was basically an open question: Is there anything we should know about, are there any concerns? You attended many of those Board meetings in your role as Medical Director; is that right? 14:58 14:59 14:59

A. Yes. Yes.

302 Q. Just the way you were looking, I don't want to assume anything. And you would have known about the MHPS and the subsequent deviations and I think what we've established is there's still inherent clinical risk and certainly harm - the word harm has been used a couple of times. Did you or anyone else ever, either raise it with the Board or think of telling the Board about it? 14:59

A. There were definitely doctors who were discussed with the Board in the confidential section of Trust Board, right? But in relation to Mr. O'Brien because, on the face of it - and I accept that it was a false truth - on the face of it we seemed to be understanding these 15:00

deviations and managing it and we couldn't identify that any patients had actually come to harm. There wasn't anything that triggered an escalation. They would have -- she was made aware, I think, certainly, that Mrs. Brownlee was made aware that I had referred him to the GMC at that point in time because I do remember that was done. I can't remember exactly how it was done but I do know that she was made aware of that. But in relation to the rest of it, it didn't trigger high enough to bring the doctor to attention on its own. In retrospect it probably should have. 15:00 15:01

I think you're right, there wasn't a tradition of reporting on MHPS to Trust Board and the Southern Trust. That has now been established so that's now in place but it certainly wasn't there up until July 2020. 15:01

303 Q. It wasn't standard practice to tell them?

A. No. No. Hadn't been.

304 Q. Would it be fair to say there was a bit of timidity about challenging Mr. O'Brien because you were unsure of Trust expectations around some of the work you were expecting from him, for example, triage or turnaround, that there was no policy or guidance? Would you agree that there was a little bit of reluctance to challenge him directly? There wasn't a firm footing? Did you have any recollection of that? 15:01 15:01

A. I don't think it was to do with a lack of policy on triage because it is managed through the IAEP, which is the national guidance in relation to that. And

Northern Ireland has its own standards for triage and Mr. O'Brien, insofar as I know, when he was Chair of NICaN many moons ago had signed up to all of that. So I mean --

305 Q. What about the dictation? 15:02

A. In relation to the dictation there was no -- I'm trying to think which policy that would come under, but I mean there was a reasonable expectation, not necessarily even from the Trust but from the GMC that you would keep up to date in relation to your patients and record 15:02 and refer appropriately - all of those kind of things. It's written in through different policies but certainly it would be a good medical practice expectation. But I don't think -- I mean speaking for myself, personally I wasn't being timorous in terms of 15:02 challenging it but I got the feeling that over time it had been worn down by, you know, trying to manage, you know, trying to work around him and I think probably as a system I don't think we were courageous enough in doing that. 15:03

306 Q. Now, in relation to the Board, go back to that, Roberta Brownlee, in her Section 21 - I'm sorry, Chair, I haven't written down the WIT reference, but it's at paragraph 9 - she indicates the way in which she gained assurance. I'll just read the extract for you. It'll 15:03 be information you're familiar with but I want to ask you about, number 1, was she right to gain reassurance from that? And, number 2, should these processes have been better reflective on what was happening on the

ground and in the unit?

As chair I regularly assessed the systems through internal audit, external audit, Board Assurance Framework, Performance reports, Board Committee minutes, Serious Adverse Incidents, Medical Director and Director of Nursing reports to the Board, Patient Safety and quality of care reports to the Board, Corporate Risk Register, and the Management Statement signed by the Accounting Officer - the CX. Each CX that I worked with undertook a Clinical and Social Care Governance Review as well as the high-level, overarching Governance reviews generally." 15:03 15:04

Just if I could pause there, the clinical and social care governance review, everybody does that when they come in and sets things up the way they think is the most efficient, is that right? 15:04

A. I don't know. I certainly hadn't been aware of it being done in recent times with previous Medical Directors in the Southern Trust, maybe it was done I'm not aware of it. It had definitely been done at a point in time but it wasn't -- certainly what I saw wasn't as comprehensive as the governance review that I think was needed at the time that I arrived. But governance is something I think that's really dynamic, you know, what passed as governance in 2010 is not what would pass as governance now. It's one of those systems, I think, that has to be constantly thought 15:04 15:04

about and reviewed and updated in the context of what's going on and the increasing, I suppose, evidence base in terms of where you look to try and make sure that patients were seen. So, you know, it wouldn't be unusual for that to be carried out on a regular basis. 15:05

In relation to the governance review carried that was out after I arrived, I know that Mrs. Brownlee was certainly hesitant about the recommendations in relation to Trust Board and that, I think, meant that 15:05 we then progressed with some of it in terms of the improvement but the rest of it I think needed to be teased out over a period of time. So the first 13, I think there were concerns about what was being suggested there, but in relation to the rest of it, 15:05 I took the view that that was operational, clinical and social care governance and that we would proceed with that to try and improve on it. Certainly that was the support I got from the Chief Executive.

307 Q. I'll go on and read the rest of what she says. I just 15:06 want to know if you agree with it:

"At the end of every board meeting..."

This is the reference I made earlier. 15:06

"At the end of any meeting under Any Other Business' I always asked the CX and the Executive Director of Nursing, Medical Director and Director of Social Care

and Children's Services if they had anything further that they needed to inform the Board about which was not on the agenda. Minutes will confirm this monthly meeting and this question posed to each I have mentioned. 15:06

The Board always wished to learn and follow up on SAIs, near misses and any governance issues that they were made aware of. Follow-up reports would come to Governance Committee for assurance of action and 15:06 completion. I ensured that there was always a provision of clear reporting, ensuring the correct structures and reporting lines were in place and adequate time to discuss such issues. The CXs and the SMT at every meeting always had the time allowed to 15:07 inform the Board of any Governance issues or concerns. This was strongly encouraged and challenged by NEDs and me."

Is that your recollection of the culture of the Board? 15:07

A. Certainly at the end of Trust Board each of the Executive Directors - so that's Medicine, Nursing, Social Work and Finance - are asked for any comments. Up until that point I hadn't brought anything to the Board because it wasn't anything particularly outside 15:07 the confidential section that needed to be raised, until August 2020, when I was asked the question and I raised it in relation to Mr. O'Brien. I think the feedback that I got indirectly at that point in time

was that it shouldn't have been raised in that way.

308 Q. Before we move on to that, it's clear that the Chair is indicating that the wish to learn and follow up on SAIs; do you know if any SAIs ever reached the Board in relation to Mr. O'Brien? 15:08

A. Well, the SAIs that were undertaken in relation to Mr. O'Brien were released in, I think, March 2020 and May 2020. So Dr. Johnson's SAIs had begun in 2016 and then were reported at that point in time and Dr. Hughes's then were reported in March 2020. So we 15:08 were in the process of working our way through that. It had certainly come up through the Governance Committee that those had been done and there was -- because they would have been part of the ordinary reporting in relation to governance. But I think -- 15:08

309 Q. If they come up in the Governance Committee, are you saying then that they made their way to the Board?

A. Well Governance Committee reports to Trust Board, yeah. So there would have been a link there.

310 Q. Are you saying they should have done or did do? 15:09

A. There would have been a link there. So the Serious Adverse Incidents, their number - and now their manager - are mentioned through the Governance Committee.

The other part of it as well, though, just to bear in 15:09 mind, was because it was 2020 everything was really disrupted. So the Trust Board meetings were disrupted, governance was disrupted. Lots of things were not working in the way that they normally did. So it was

a lot slower. So even in terms of us creating the capacity to deal with all of that and then to bring that back in proper form to Trust Board and everything else would not have been done in the way it normally would have been done. 15:09

311 Q. But prior to 2020, if we were to look at those Trust Board minutes, you would expect us to find reference to SAIs?

A. In relation to specific -- they would have been -- I think they would have been reported generally through 15:10 Governance Committee to Trust Board - and I could be completely wrong because I haven't thought about this - but I'm not aware -- there was an obstetric and gynaecology SAI that certainly was brought to Trust Board and discussed. That was mentioned. Obviously 15:10 there were elements in relation to the Cawdrey Review that were brought and there were other issues brought at various stages. So SAIs were not unknown to Trust Board but they usually came there because there was significant concern, usually about an individual case. 15:10

312 Q. I know you've mentioned the Cawdrey case, but having looked through the minutes, there is no urology SAI brought to the Board; is that news to you?

A. At that point in time, probably because of the timing of it, yes, not at that point in time. It would have 15:10 been discussed. Now, in terms of the outworkings of the SAIs and then, you know, what fell out of everything in June 2020, that would have been in the urology discussion with Confidential Trust Board. That

probably didn't start With Trust Board until September/October 2020.

313 Q. The first reference in the confidential minutes is at TRU-130799 and it's 27 August 2020.

A. About that time, yes. 15:11

314 Q. We'll look at that in a moment.

I want to just test with you your understanding or agreement with what the Chair of the Board is saying. If any of this, you disagree with it, for example it 15:11 wasn't routine to bring SAIs or they weren't actively sought by the Board or any information like that, then this is your opportunity in relation to this specific issue. So that's why I'm pushing it a little bit on it so we understand exactly what the contours of the 15:12 accountability was at that particular time.
Ms. Brownlee goes on to say?

The risk register, SAIs and reports from the Chief Executive and SMT members was paramount. I nor any NED 15:12 would not know what was happening, operationally, on a day-to-day basis unless the Chief Executive and the SMT informed us. This was constantly stressed, the importance of keeping the NEDs and myself informed. All the Chief Executives that I had worked with on many 15:12 occasions would have phoned me to inform of Serious Adverse Incidents and serious clinical issues but I never recall any phone calls or informal meetings to inform me of serious clinical issues in urology, other

than what is recorded in my statement.

Which is that she didn't find out anything until 2020, just to give you an idea.

A. Okay. 15:12

315 Q. As Chair of the Board I was not aware of the detailed information that is now before the Urology Services Inquiry in relation to clinical issues with Mr. O'Brien. As I refer later, I did not see the detailed Medical Director's report on Mr. O'Brien, 15:13 clinical issues that came to the Trust Board in November 2020.

So you can take it from that the Chair's position is that no one told her anything about any of this and it 15:13 was only when the Board were in receipt of your report in September 2020 that she had knowledge of that. How does that sit with the evidence earlier that -- just in relation to timeframe, forgive me, I can't remember, where you felt -- well, I think you said she said, that 15:13 Mr. O'Brien had been, I think you said persecuted by --

A. That was 11th January 2019.

316 Q. If we just take that. Are you saying that from your perspective she knew about the issues in relation to Mr. O'Brien because she referred to that with you or 15:14 did you have another discussion with her at some other point?

A. No, I never had another discussion with her at any point. She made reference to that in January 2019 in

reference to what had gone on before I arrived. But I hadn't had any further discussions with her in the interim.

317 Q. So she could have been referring to the fact that the MHPS was brought to the Board in 2017? That could have been the extent of her knowledge at that point? 15:14

A. Eh --

318 Q. When she made that comment to you in 2019?

A. Yes, she could have been but she didn't specify that.

319 Q. She didn't indicate anything to you after 2017 or before?

A. No. There was no timeframe put on it but she did talk about all of my predecessors.

320 Q. You've set out in your statement as well, just for the Panel's note, at WIT-44977, the systems from which you obtained assurances. Now we've heard about what the Chair looked to to satisfy her governance role. You have a listed a list that includes the Weekly Governance Debrief, the Governance Committee Report and the SAI Oversight Group. 15:14 15:15

If we park the last one because obviously that became quite central once the SAIs were triggered, but prior to that formal instigation of investigation, the Weekly Governance Debrief and the Governance Committee Report, did concerns around Mr. O'Brien, or any other aspect of urology, ever find a way to any of these reports during your tenure as the Medical Director? 15:15

A. Not so -- that was one of the developments that we made

on the basis of just concerns about how we kept a real-time eye on governance across the trust; right? And that's a fairly comprehensive meeting, the Weekly Governance Review that happens now on a Thursday morning and brings together all aspects. 15:16

321 Q. Can I just ask who attends that weekly meeting?

A. It's chaired by the Medical Director with the Nursing Director and the Director of Social Work present and then all the governance leads attend, the Divisional Medical Directors and the Education and Quality Improvement leads. 15:16

322 Q. It's a broad church, if I can use that?

A. As well as people from Complaints and Medical Negligence, all those aspects of it, yeah.

323 Q. So there's a potential there to get intelligence from all those different specialties? 15:16

A. Yes.

324 Q. And professionals?

A. Yeah. All of the different areas provide a report into that every week. Now that wasn't always there. That was something that we developed throughout, I think, 2020 in particular in terms of trying to develop it, because just to try to hold the system together in relation to governance. There was quite a lot of work went into it beforehand to get it up and running. So by the time it was fully operational we had already bottomed out some of the concerns about Mr. O'Brien and we were dealing with that. 15:16 15:17

Now what gets mentioned on the Weekly Governance Report is an update on where we are with the Urology Inquiry in terms of servicing, you know, information, but also then in terms of patients who we've referred for STRR. So there's some mention in there in relation to all of that. And any learning that comes out of that at all is shared through that forum.

325 Q. But before we get to that stage, because at that stage there's quite a number of spotlights on what's happening -- 15:17

A. Mmm.

326 Q. -- quite a few processes have been instigated by that point, we just come back into the darkness slightly in the 2018/2019. When you talk about Weekly Governance Debrief, you're saying that they didn't occur in 2018/2019? 15:17

A. Not to that extent.

327 Q. But there were weekly meetings in the Urology Department?

A. There were -- I don't know if I was referring to that specifically in the Urology Department. Was I or was I talking about general -- because I know that I - 15:18

328 Q. I think you were talking about just your --

A. Governance.

329 Q. -- how you obtained assurance as Medical Director. 15:18

A. Yeah. So, basically --

330 Q. I suppose governance for me, just to -- I probably should have framed the question somewhat better, I presume that that is the Medical Directorate

Governance --

A. Yes, yes.

331 Q. -- scenario. All governance comes through there, I presume if there's a potential to result in patient harm or risk, increased risk at all, it's going to come through that funnel. 15:18

A. Yes.

332 Q. But I don't think it was just a new invention in 2020, I think there were procedures prior to that, in 2019, that would have enabled the same concerns to come to you through a different name? 15:19

A. Yes. So I think what I've referred to in that question, if I'm remembering properly, is in relation to the Medical Directorate Governance meeting on a weekly basis. So the purpose behind that was to give the Medical Directorate staff, from their contacts into the governance world across the Trust, the opportunity to escalate anything that had come to their attention and to make me aware. 15:19

333 Q. So that could be the Director of Nursing could say it's come to my attention that one of the consultants isn't using the cancer nurse specialists and I'm concerned about that from a governance perspective; that could have been a route that that particular concern may have been escalated through? 15:19

A. It could have been. It should have been. But actually I think probably what was more likely to happen in reality given, I think, the disconnect that we talked about right at the beginning in relation to

Operational, Clinical and Social Care Governance and Corporate Governance, that actually if it was known at all it was known within the Acute Directorate and probably didn't make its way out of it.

334 Q. You can see from a remove, when you look at all of these possibilities for highlighting areas of concern, and you don't see any concerns that are now so stark on documents finding their way into those, do you see that as a governance failure or an individual failing or is it a combination of both of those? 15:20

A. I think it's a combination of both. I think, you know, all doctors have a personal responsibility for their own work. That's part and parcel of their training, that's what you're brought up to believe. So there's -- you know, there's a significant element of personal responsibility in this. In addition to that, we, as a system, I think, should have been more astute, better developed, all of those kind of things, to try and make sense of all of this at an earlier stage. If we were faced with this today I think we'd be in a stronger position to deal with it but there has been a huge amount of learning has come out of this. 15:20 15:21

335 Q. You mentioned earlier about staff turn over --

A. Yes.

336 Q. -- it's clear from the information that you've made available that you're still not at capacity -- 15:21

A. No.

337 Q. -- for what your commissioned and funded for. I think you're still a couple of consultants short. That's

something that has been ongoing for a while and, to be fair to the Trust, they have advertised and sought people but I think that's a UK-wide shortage of appropriate consultants and everyone's trying to capture probably the same individuals.

A. Yeah.

338 Q. But does that mean that the concerns we talked about earlier this morning about when you're not at full capacity, governance tends to fall slightly down the pecking order; is that a real concern for you at the moment?

A. It's always a concern but I think the message very strongly at the minute is whenever we're at our busiest or most challenged - so at the minute we're in the middle of industrial action, you know, significant shortages all over the place, the winter pressures, all of those things, that's when you have to be increasingly mindful of governance. So, you know, I know that the systems are not standing down their governance procedures at the minute to try to help them support their way through that. But I also think, you know, the jobs of the clinicians, I think, in a situation where they're very short-staffed is really difficult because what they tend to get then are the sickest patient only, those are the people who are prioritised. So our waiting lists in Urology in the Southern Trust are not out of keeping with the rest of the region and for some routine appointments extends as far as, you know, 5 years. I mean it's very long. But

it does mean that the people that are coming to their attention now are really unwell. Again, that's another argument, I think, for us making sure that our governance processes are really robust.

339 Q. I suppose it goes back to what we were discussing earlier about culture. 15:23

A. Yeah.

340 Q. Even if you have a full capacity, a full complement of staff, they have to be staff who are motivated to utilise governance and feel confident about drawing attention to what they consider to be potential risks. 15:23

A. Yeah.

341 Q. So it goes back to the learning, I suppose --

A. Yes.

342 Q. -- that you had identified in your statement. 15:23

A. Yes.

343 Q. The other thing that I just wanted to touch upon briefly is the Risk Register.

A. Yes.

344 Q. Again, I won't go over all the points, the simple direct point is that none of this risk, clinical risk, operational risk, whatever way you want to define it, found its way on to the Risk Register. Would you expect it to? Is that what traditionally risk registers were seen to be about or is there more of a, 15:23 15:24 well, that's for -- I know there are different types but is it more well, clinical stuff doesn't really find its way on to the Risk Register, it's more corporate stuff and nonclinical risks? Or should it have been

on? Should the stuff that we're discussing have been reflected in those registers?

A. I think I find -- so it's rarely -- in fact I don't think I've ever seen it centred around one individual's practice in the way that this has been, right? So it tends to be more general than that. So I think how it found its way on to the Risk Register was in relation to waiting lists, staff shortages, latterly I think electronically signoff, concerns about multi-disciplinary working, I think, at a point in time. It tends to find its way on that way rather than specifically outlining the concerns located in a particular service or individual. 15:24

345 Q. I think you'd said in your statement, I can't find the bit of paper I've written it on, but you will recall it, I think, you said sometimes willingness can actually hide the problems? 15:25

A. Complete smokescreen because a lot of this was around, you know, there was an acceptance that patients were falling off the end in relation to getting investigations and diagnostics done when, actually, that wasn't the rationale, it was actually to do with individual behaviour. So I think if we hadn't had such long waiting lists we would have picked this up sooner. 15:25

346 Q. If there was a general reluctance to put the type of concerns you were aware of and other people were aware of, on the Risk Register, because they seemed so difficult to solve? 15:25

A. Well, by and large, I mean anything that goes on the

Risk Register, as I understand it, has to align with smart objectives in terms of it being something that you can actually sort out and improve on. What tends to happen is they tend to be a bit more generic than that and they tend to be multi-system. I think 15:26
probably it was broken down into parts. And, again, these concerns, particularly in terms of waiting times and staff shortages and some of the issues around electronic signoff general around Northern Ireland aren't unique to Urology, they're part and parcel of 15:26
the NHS at the minute. So I think, you know, they would have been thought about under that heading but, actually, when you were reading it you wouldn't have realised that Urology was also included in it. It doesn't specifically mention. I mean Orthopaedics have 15:26
huge waiting lists as well, staff shortages and lots of things. So I don't think it was an obfuscation, I think it was just that given the level of the corporate and directorate risk registers, I think that it probably didn't give, I suppose, a minute enough 15:27
description of what this was about.

347 Q. And I suppose departments like Orthopaedics, obviously falls is one of their significant risks so some of those did find their way on and they're usually about managed the environment or risk-managing the patient so 15:27
they do have perhaps a more streamline approach to try to remedy that. The nuances of the issues that were arising at different times through urology perhaps don't lend themselves to such a straightforward answer.

A. Not easily. I mean something like falls, for example there's a regional approach to falls. There's kind of a national campaign around them. Again, it's not just about orthopaedics, it's very often about, you know, geriatric medicine and various other aspects. You know, that's a good example of how that would be something that would apply to the whole Trust and then would be placed on there. But, again, in terms of breaking down the elements of Urology, I think it was trying to be captured under waiting lists, staff shortages, those things we mentioned. 15:27 15:28

348 Q. Do you think that was a mistake given that the Board's position -- well, certainly Mrs. Brownlee's position is no one told us? Well, I'll let you answer that: Do you think it was a mistake that the Board weren't made aware of all these issues? 15:28

A. Well, I think, you know, there are reports that go now, right? So I now get a monthly report from the Medical Director in relation to Maintaining High Professional Standards. That's now discussed with SMT. That now goes to the Board, right? They're made aware of it now and I think they should not have been made aware of it in the past but that wasn't have been the tradition. 15:28

349 Q. And even though the individuals who knew about that were sitting at the meetings do you still think it was right that no one spoke out and said: We're having problems in Urology that are coming from different directions now and things are bubbling up? Do you think that it should have been said? 15:29

A. And it's not to minimise the seriousness of this in any shape or form but in the context of what we usually deal with on a day and daily basis, right, because it looked like these were local issues and they were being resolved, they wouldn't have made it to the top of the pile in terms of thing we had to talk to the Trust Board about. So some of the other things that were mentioned, I mean that particular year, 2019, I think we had two invited review services into the Trust because we'd concerns in different areas. We had the Cawdrey discussions that are ongoing that haven't been completed yet, for example. There were a few very difficult coroner's cases that had to be negotiated. There was a turndown in surgical activity because of staffing. There was the beginning of the nursing strike. So all of those were the big issues, as well as waiting times in the Emergency Department and waiting lists for surgery that would have got topped there and it's in no way to minimise the harm that's been caused. Bringing up an issue around what on the face of it seemed to be a single surgeon who wasn't managing to do his dictation and get through his work in the absence of Serious Adverse Incidents Reports at that point in time would not have been the first thing we would have been talking to Trust Board about. 15:29 15:29 15:29 15:30 15:30

350 Q. And your answer lends itself to the suggestion that the thing that wasn't brought is the subject of a public inquiry.

A. Exactly. Yes.

351 Q. Just in the last part of your answer, you framed it as a surgeon who wasn't doing his admin. Do you think that what's permeated a lot of the information available to the Inquiry that you would be familiar with from the Trust as well is the failure to put the patient at the centre of the concerns that were arising? To look at it from the patient's perspective, not from the doctor's? 15:30

A. Well, I think -- I think what we tried to do was to keep the patient at the centre of it in relation to getting him to perform the way that we needed to. Okay? I think knowing what I know now, as I say, I would have taken a different approach to all of this and I think that, you know, one of my reflections on all of this is that actually the patients weren't - and I wouldn't expect them to - but the patients weren't complaining about Mr. O'Brien. They weren't raising any concerns with us about, you know, missed results or delays or not having a nurse or any of those things. They were completely quiet. And I think, you know, I've often wondered why that is. I think it's probably down to, you know, what their perception of the service was that they were being offered, because obviously, you know, he was very charming towards them. He seemed to have been kind towards them and I think they didn't realise what they were missing at that point in time. 15:31 15:31 15:31

352 Q. Given the subject matter of what they might want to complain about --

A. Yes.

353 Q. -- and given the demographic of people who might frequent Urology --

A. Yes.

354 Q. -- and the geographical location of your Trust all play a factor in people's reluctance to complain? 15:32

A. Yes. I think it probably does. Yeah. Yeah.

355 Q. If we could just -- I'm not going to take you through them but there are significant amounts of entries from you making comments or attending the Trust confidential meeting and finding your way on to the confidential 15:32 minutes then from 27th August 2020, October, November, December, February '21, March, May 2021. I think it's fair to summarise that to say it started with you bringing to the Board's attention the SAI investigations into a recently retired - so Mr. O'Brien 15:33 has left at this stage - consultant right through to updating them on all of the activity that took place, with the Lookback Review, RQIA, the Royal College of Surgeons, all of the advancement that was made in order to try to get on top of the issues. 15:33

A. Yea.

356 Q. Just give me a second, there's just a point I want to raise. If you just give me a second.

One of the things that came across quite starkly, I think, from Dr. Hughes and Dr. Gilbert's evidence and 15:34 from Mr. Haynes was the disconnect between the Cancer Service and Urology.

A. Yes.

357 Q. You know, it sort of mirrored the operational clinical

ways of thinking. Everybody was working toward the same general aim but they weren't really communicating with each other.

A. Yes.

358 Q. That appeared, on the evidence so far, to create a void that was filled by potential suboptimal practice. So I'm just wondering, I know you have mentioned a couple of times about the different advancements that have been made when you became Medical Director and now Chief Executive. What's the situation now? Has anything been done to address that disconnect and, if it has, could you maybe update us? 15:34 15:35

A. I mean, I think describing it as a "disconnect" is a good description; right? I think, again, one of my reflections in relation to the MHPS investigation and the comments that were made in relation to all of the information that we were working on at that point in time was -- I think we were blind to the fact that we concentrated on the surgical side but not on the cancer side -- right? So that, again, has been a learning, I think, for all of us. So I think my sense is that it's more integrated than it was before. Certainly I can see signs of better integrated working and more, I think, joint ownership of some of the challenges around that. 15:35 15:35 15:36

Now we have invested outside of our commissioned budget in increasing the tracking system and that and trying to put administrators in place and trying to address

some of the difficulties we had with the MDM tracking before. Because what was happening was, as we know, Mr. O'Brien's patients may or may not have been referred into multi-disciplinary team meeting and then, based on the advice of the multi-disciplinary team meeting, may or may not then have been followed up appropriately. And for all other services, the lynchpin in all of that is always the CNS, the clinical nurse specialist. So we have tied all of that in to make sure that every patient who is receiving cancer care has a clinical nurse specialist and also that the trackers are on it in relation to not just the 31 and 62-day targets but that also there's an oversight to make sure that patients are seen, their investigations are done, and their results followed up. So that's a lot more robust than it was before. And that's involving both sides of the house in terms of surgery and cancer. 15:36 15:36 15:37

Now, they are managed within the same directorate. One of the things we have done in terms of the restructuring and review of all of this is that we have split the acute directorate. So, you know, about two months ago I appointed the director for surgery as an interim and then the medical side of it as a substantive post to try to separate those two posts out. Certainly what I'm seeing since that happened is, because there's a greater concentration on the surgical and cancer side now as opposed to the whole 15:37 15:37

directorate, the flow of information, I think, is much faster and it is more robust, you know, as time goes on and they get those systems developed. So I can see that it is working better.

15:37

I think what we still have to test yet is the system. So I do think there's a process of clinical audit that needs to be undertaken with some of the patients who have come through that system to make sure that we do what we think we are doing and not falling into the same mistake again.

15:38

359 Q. I think you've mentioned -- or maybe it was when being consulted in advance -- that the 31, 62-day can act like a smokescreen, a bit like the waiting list, people fall off the end and, if they tick the box then, where do they go after that? So you're saying that that particular vulnerability in the system is through the tracking process, there's a safety net for that?

15:38

A. Yes.

360 Q. I just want to dip back into MHPS, just very briefly. The determination of Dr. Khan -- well, he made several, and I presume you are familiar with what he thought should happen?

15:38

A. Yes.

361 Q. Now, nothing did happen as a result of his findings or his recommendations. What's your view on that and why do you think that none of those were taken forward? We'll talk about the review of administration separately, but the other issues around the action plan

15:38

and things, why do you think there was a delay or reluctance or a freezing of everyone when he had set out a potential way forward?

A. So I think, as I understand it, the three elements of action, of the out workings of maintaining high professional standards, were to develop an action plan around Mr. O'Brien's administration, make sure he was properly job planned and make sure that, basically, there was an administration review at the process. Right. Mr. O'Brien launched a grievance against Maintaining High Professional Standards and the processes behind it which was lodged before I arrived. So when I arrived, my understanding was it had been paused because the grievance needed to be investigated. And that took quite a long time to get out the other end of appeal and everything else. But even with that, even though on one hand we were saying we have paused this, there was still work ongoing in relation to what came out out the back of Maintaining High Professional Standards. 15:39 15:39 15:39 15:40

So in the absence of the named action plan, we continued. My understanding when I arrived was -- and, you know, Dr. Khan was still involved, everybody else was still involved that was there and, eventually, the Associate Medical Director, when I brought him into it, was around monitoring those aspects of administrative practice that we had been concerned about. So those were in it. There were repeated attempts to obviously 15:40

get him job plans but I think, in retrospect, I and others should have been a lot more robust about that. I think I should have been on that a lot sooner.

Then the third thing in relation to the admin practices, I think that was in two parts. So the actual admin in relation to looking at systems and processes within urology, we made an attempt at it, I think, about August 2019. And, again, I had prompted Mrs. Gishkori to do that and I think that didn't happen. Then Melanie McClements came in as a director in the summer of 2019 and she did attempt to try to get that done. Then we didn't feel that terms of reference and everything else, it was robust enough, so then it was passed to Anita Carroll and she eventually got that done. But with COVID and everything else, that took a bit of time to get that finished. 15:40 15:41 15:41

362 Q. Can I just ask you why you think Mrs. Gishkori didn't do anything?

A. I don't know. I don't know. 15:41

363 Q. When you say that it was done in two parts, if I can just push you a little bit on that. Because the grievance that went in about the process of the MHPS, we already discussed at length that Mr. O'Brien was already subject to an action plan from February 2017. 15:42

A. Yes.

364 Q. In all possibility that could have been tweaked to reflect the findings or tightened or -- you know, do you accept that? I don't want to hammer the point but

I think you know the point I'm making, that there could have been something proactive done at that point given you had an existing -- in the Trust's mind anyway -- an existing action plan.

A. Yes, I think -- I mean I suppose what I did was continue on what was in place, what was there when I arrived -- right? -- because I had been through that process. Mr. O'Brien's performance and behaviour had been known to the Trust for three years before I arrived. It had been looked at in depth, it had been talked about a lot, tried to manage it. This is what had been produced out of that. And at the back of that, that's what I understood was working. So I continued on with that. Knowing what I know now, I should have tried something difference. That's my view. 15:42 15:42 15:42

365 Q. A grievance wouldn't have stopped that. I'll put that to you. You could have done more, and I think you've accepted that. The administration review, now that wasn't started until June 2020. It seems from the paperwork, just so you can answer the point I want to make, it seems from the paperwork that the GMC were knocking on the door trying to find out what was happening and that seemed to have triggered the action to carry out the administrative review as Dr. Khan had envisaged. Is that a fair enough comment? 15:43 15:43

A. Well, they were prompting me about it and I was prompting the system, I think is the way it worked. Obviously, there were two parts to it. So there was

the -- what we had got to was there was obviously the operational part in relation to what Anita Carroll eventually carried out in relation to urology. But then the other bit that Dr. Khan had mentioned in his deliberations was around that he felt it was lacking in terms of clinical and operational management. So basically that's what provoked me then to look at the clinical management and leadership structure along with all the noise I was hearing in the system about doctors not having enough time to do the job properly. That's what provoked that review at that point in time. And then, on the back of that, we revised the medical management structure and redefined the job descriptions for clinical directors, leads, everybody else in there. So actually there's now a clear line of sight on that. That was the out workings of that. 15:43 15:44 15:44

366 Q. That's a wider point.

A. It is.

367 Q. It is a wider point. And no doubt you had taken the view that that change was necessary. 15:44

A. Yes.

368 Q. Do you see why there might be a perception that, after all those years of concerns, having actually filtered Mr. O'Brien through the first formal investigation, nothing happened after it? You can see why that perception arises on the papers? 15:44

A. I can. I think it is partly down to the fact that actually what we did implicitly, we haven't sat down, taken the action plan and said: As a result of that

this is what -- you know, his deliberations -- that's what it looked like at that point in time and this is what we have done as a result. I don't think we expressed enough about it.

369 Q. Obviously it is specifically mentioned in the Terms of Reference the look-back review. I just want to ask you if you could just explain, in short form, why that was started. What was the reason behind that? What was it intended to do? Why was it considered necessary by the Trust and how was that done? I don't think we need to go into the figures. I know they are ever-changing and evolving. 15:45 15:45

CHAIR: I am sorry to interrupt, Ms McMahon. I am conscious that we haven't had a break this afternoon. I don't know whether people feel they need one or not or whether they are content to sit on until -- 15:45

MS. McMAHON BL: Sorry, Chair.

CHAIR: That's okay.

MS. McMAHON BL: I forgot about it.

CHAIR: Certainly, for my part, I am happy to sit on if everyone else is but I don't want to -- 15:45

MS. McMAHON BL: I'm on the home straight, if people want to hang in there.

This is the opportunity, I suppose, for you to tell us what the Trust did. No doubt you'll be back, but I want to give you the opportunity today to round your evidence off, having taken you through the pitfalls, perhaps you can give us the highs. 15:46

So the look-back exercise, we discussed that earlier. I would specifically, in relation to the early alert, ask you to address the concerns of Mr. O'Brien about why he wasn't informed. That's, obviously, an issue for him. I know the Trust got very short notice as well, but -- and the RQIA, the review. A small ask. 15:46

A. Just to get the chronology of this. On the back of what Mark Haynes had raised concerns about, the discrepancy in the lists in June 2020, what we found was that the two patients he was initially concerned about weren't the patients we had to be worried about. It was whenever Martina went in and started to deconstruct all of that, try to understand it, she realised that actually there was a gap in relation to the MDM connect with the rest of the system. That's essential where a lot of this came out to begin with. 15:47 15:47

On the back of that we called it a look back mistakenly. It actually wasn't a look back until March 2021. So the original part really should have been described as a scoping and review exercise. So really what we got to very rapidly at that point, within a week, was to pause the system and start to unpick all of his work to see if there were any concerns. And she and Mr. Haynes and various other people did significant amounts of work over a short period of time to identify that across the numbers of patients that they were looking at that there were 15:47 15:47

patients they were worried about had been missed but also had come to harm.

As we unpacked our way down through that, there were a couple of things about that. Given that we became really alarmed about what we were finding, our usual approach in relation to that then is to raise an early alert with the Department. So the purpose of the early alert is -- Northern Ireland has its own system. So basically, the purpose behind that is to alert the Department of Health and others to the fact that we have identity significant concerns in an area and it may be media worthy. The so that was put into the system on the basis of all of that. And then as well as that we started to try to take advice from various other people in terms of how this would be best managed. 15:48 15:48 15:48

Some of us then -- I think it was, to begin with, Stephen Wallace and myself -- met with the Royal College of Surgeons to get their advice on them. Because, I suppose, I used to chair the Invited Review Service for the Royal College of Psychiatrists. I was very familiar with the work of the RCS. We spoke to them because I thought, well, we need experts outside of the system who are used to undertaking this kind of work and could give us expert advice based on their own experience. So we went to them first of all. 15:48 15:49

They took this very seriously. Initially what they said to us was that given that we were exploring an individual practitioner's work they would need his permission to do it. I was fairly confident at that point he probably wouldn't give it, although I didn't ask him. But then, in discussion with him, we agreed that we could -- given that this was serious enough we could go ahead and start to look at this without his permission, so that's what we did. So they helped us think our way through that in terms of what we needed to think about. Also then, as the numbers grew and we worked our way through the end of 2020, to try and think about was the Serious Adverse Incident process really going to help us or just slow down our access to learning and awareness in relation to that? 15:49 15:49 15:50

So initially there were nine cases that were identified and those were the nine cases then that were taken on as a Level 3 Serious Incident Review by Dr. Hughes and were reported on in the following year. The other cases, then, that started to come through on that, because of the volumes of them, we went back to the Department of Health and in consultation with the Department and the PHA, we described that possibly it was best to use an historical clinical record review approach, which is a kind of derivation of the structured judgement review which is used commonly in England but had also been developed by the Royal College of Physicians for the Neurology Inquiry. So 15:50 15:50

we went back, we had discussions with the Belfast Trust, we had discussions with others to try to develop all of that. And on the basis of that, and then in consultation with our legal team, devised 10 questions for screening that would screen patients in into the structured clinical record review process and then start to identify learning at an early point. 15:51

So what rapidly started to come out of that were the concerns around the Bicalutamide prescribing. And what fell out of that was, obviously, Mr. Haynes's audit of Bicalutamide prescribing across Northern Ireland. And out of that was able to show that out of, I think 700-odd cases there were in and around 50 that there were concerns about. Two of those belonged to other doctors across Northern Ireland and all the rest remained with Mr. O'Brien in terms of prescribing practice. So that part was done. 15:51 15:51

Then there were other issues that started to come to light. For example, when Dr. Hughes realised about the nonengagement with the CNSs. You know, he had intimate working knowledge in relation to how MDM processes worked. He was able to unpick some of that as well. So as we built up that body of knowledge, then that's where we were directing our attention in terms of trying to get the information out. And that is what has informed our communication with UAG, which is a departmental oversight group. The Health and Social 15:51 15:52

Care Board, as was, which is now SPPG Strategic Group, and then latterly then our interactions with RQIA in relation to SCRR process. So to quality assure that, to make sure we were doing the right thing -- and a lot of these external systems are there -- a bit like the GMC and HS Resolutions -- are there for quality assurance, third-line assurance to Trusts in terms of their behaviour. We took that to our QIA to ask them about the SCRR process and whether they felt that was robust. They have now come back to us with an action plan in relation to that. At the meeting that I have been to in relation to that over the last week, we have worked our way significantly through that. There's a couple of areas that still have to be challenged. 15:52 15:52

370 Q. Is that family involvement? 15:53

A. Yes.

371 Q. I think there was some just general governance concerns around that because the SCRR is SAI light. It just doesn't have that filter in it. So have you adapted that to reflect those concerns? I think the Royal College of Surgeons had the same concern around it? 15:53

A. Yes. So the SCRR, unlike the Serious Adverse Incident approach, usually involves the families at an early stage and they are involved in terms of reference. SCRR doesn't have terms of reference, it is based on a very specific template. And the approach we had taken with this, because of the speed of it initially, was to try to get the learning out and get the SCRRs done. Then, when we identified harm/no harm, suboptimal care, 15:53

then we went back and communicated with the families and gathered more information at that point; right? I think we realised that that's not the way we want to engage with families. So we have now identified two patient experts, essentially, to work with us in relation to the oversight of all of this. Then, you know, take their advice in terms of operationally how we continue to manage some of this. Because, you know, we're now approaching the second phase of all of this in relation to where we're going and we have a huge amount of learning, I think, and information from the first part. And it is really important, I think, we have been able to pause, think about all of this, and then use RQIA recommendations and other people's recommendations to try and take this forward. 15:54

372 Q. The RQIA made a recommendation about the temporal scope, I think, of the look back, about extending the years. Could you just explain that?

A. So the Royal College of Surgeons initially suggested to us five years in the first instance; right? What we had asked them to do at that time was to take 100, which translated into 96 of Mr. O'Brien's cases, and carry out an audit on them. They did a very thorough piece of work. They have just recently reported on that. The very sad realisation in all of that is that the findings that they have from that mirror the findings we've had now since 2020 in relation to some of the findings about the patients; right? So that, I think, quality assures our processes in terms of, you 15:54 15:55

know, we're all on the same bake page with this. But I think there's a horrible realisation that this has been going on for a very long time.

I think the other part of it, then, is what we are in discussion with the Department of Health about at the minute is just the extent and scope of the rest of the look back. Because what we need to do is prioritise the patients that we think are potentially at risk of harm or where we can, you know reverse potential harm at this point in time and risk stratify all of that. So there's been quite a lot of work done over the last period of time in terms of working out all the different ways of doing that, the costs associate with the personal involved, etcetera. So we are hoping that between now and Christmas, hopefully, we will have a decision in relation to what the next phase of the look-back will look like. At this point in time we have looked back on 2,112 patients. This is a really high volume specialty. So in relation to this there's probably about 12-, 1300 patients a year. So for each year we go back, these are significant numbers of people.

373 Q. I know that was a quick run-through but is that us up to date as regards developments the Trust's perspective? I think we're -- you're also -- the urologists group you mentioned but we can deal with that again.

A. Yes. I think just to assure the Inquiry that we

have -- you know, we have taken all these concerns really seriously. I that what we have tried to -- certainly what I have tried to evidence in my statements around actually what -- you know, what we have learned and what we've done about it to try and improve on all of that so that, you know, hopefully reduce the risk of something like this happening again.

374 Q. Just a final question from me. It is just from left field, slightly. But when you worked in the Belfast Trust were you familiar with the doctor and dentist case review meeting? 15:57

A. Yes. So that was -- I was party to that on a regular basis. I was Deputy Medical Director for workforce and education, but mostly workforce. So I attended that on a regular basis. When I came to the Southern Trust, that structure wasn't there. It tended to be very reactive. So what happened was, if there were concerns, there was a director oversight group set up. So what we now have in place over the last -- I can't remember the start date of it but I know that we did a lot of work in terms of getting terms of reference and all those things sorted out -- but now we have a monthly meeting that has oversight from HR, the Medical Director's office and the operational directors, depending on who their doctors are, plus the divisional medical directors from each directorate, and all of that now systematically worked through and action plans developed. Then the out workings of that are now reported to me as Chief Executive. 15:57 15:57 15:58

375 Q. I have no further questions. The Panel may wish to ask you some questions. Thank you.

A. Thank you very much.

CHAIR: Dr. O'Kane, I'm going to hand over to my colleagues first of all and then I'll see if there's anything I want to ask you today. Dr. Sward, I know, does have some questions. 15:58

DR. O'KANE WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS: 15:58

376 Q. DR. SWART: I wanted to ask you about something that has come up in quite a few S21 responses from people. It's come up during Mark Haynes' testimony. It is associated with governance. And, appreciating the fact that you have taken on two very big roles in quick succession and have thought quite hard about governance, and it is a difficult job when there's a lot to do, what I'm not sure about is what the approach would be to improving the evidence base, the clinical outcomes, the different specialties, not just urology, particularly in the context of clinicians, particularly mentioned there hasn't been much clinical audit as a sort of general statement. You mentioned that one already. Also mentioned the fact that the search in national databases and so on which have caused issues in terms of Trust's participation. Mr. Haynes mentioned that there was a problem with the 15:58 15:59 15:59

hospital episodes statistics and the way that's used. From where I sit, all of those things make it difficult to have some pretty basic clinical outcome data that would help when you ask about a doctor. Because you haven't got that. You've got some nursing metrics, and you have harm events, but not data that says "this specialty is delivering care according to the recognised protocol according to this national audit", for example. 16:00

My question to you is there a difficulty with the hospital episode statistics? Is that on the Board's radar, if so? And how much of a problem do you think that is? That's the first bid. Then moving on to the information governance issues that the Health and Social Care Board raised with respect to some of these national audits. Is there a plan to get over those in any way? 16:00

A. So I'll answer it in reverse.

We do take part in some of the national audits that we can take part in when the GDPR audits allow. So snap audits, for example, around stroke are done. We have been part of, through the Royal College of Psychiatrists, some of their big audits and their accreditation programmes, but it is patchy. It's patchy across the specialties. Surgery, I think, is really hampered by not being able to nationally compare. I think that's really difficult. I think, 16:00

you know, particularly for high-volume specialties, sometimes when you get Serious Adverse Incidents coming through, you don't know whether, you know, in the scale of things that's to be expected or not because, obviously, it is not perfect. Unlike the likes of radiology, where there's an expectation there could be 6 percent default reporting, things like that. So I think it is really difficult to know.

377 Q. DR. SWART: Is there a plan to get over some of these issues? It was mentioned by Mark Haynes, in the context of the British Association of Urological Surgeons -- and I know there are others -- and I agree with your comment, one of the big issues in surgery is, is this a recognised complication or has something really gone wrong and how do we benchmark? Is the Board aware of the issue? Is there any plan to overcome it? Because other places do overcome it. I don't know exactly what the issue is, I do know we've had some, where I worked previously, that were eventually overcome. 16:01 16:01 16:02

A. I don't know if we ever had a specific discussion with the Board about it but I know at times we have mentioned about the limitations due to GDPR. In terms of sorting it out, that sits with the Executive because it's part of the process in relation to the UK-wide engagement and we can't -- I know that it certainly was raised with the previous minister and I was assured it was sitting on his desk. But, obviously, it -- I mean, I'm presuming it is 16:02

a difficult thing to sort out because it hasn't been done. So I'm not sure what the impediments are there.

378 Q. DR. SWART: You could perhaps ask the SPPG about that one.

16:02

Then the HES data issue? I wasn't clear what the problem with that was in the Trust that Mark Haynes referred to, Hospital Episode Statistics. He said you couldn't use it properly with CHKS and other things for some reason, but I wasn't clear.

16:03

A. He is a lot more familiar with this than I am. He would have been used to working with a different system in Sheffield, when he was there. As I understand it, the two don't align in terms of activity, consultant episodes outcomes. But in terms of the nuances of that, I don't know, but I will find out.

16:03

379 Q. DR. SWART: It is just something that, when you are looking from afar...

A. Yes.

16:03

380 Q. DR. SWART: Another quick thing. You mentioned that many of the urology patients hadn't complained even when they had come to harm. One of the issues we talked about with Mr. Hughes and also with Mark Haynes was the issue of copying letters to patients. It is our observation that many letters are not copied to patients and, hence, they don't have a summary of their treatment plan and they don't actually know what should happen. I think we were told

16:03

that there wasn't a hospital policy in this regard and there certainly wasn't a Northern Ireland policy. What's your stance on that? Do you have any comments about that?

A. It is certainly a conversation I've had with the clinicians before when I was Medical Director. Now, I would need to double-check, but I do remember putting -- certainly discussing it at a Divisional Medical Director meeting. But also I think there's a memo to the effect that what we were prepared to do -- now I will double-check because I know it was talked about at the time and I just want to make sure that I have actually done that, not just talked about it. But there was a discussion in relation to -- my own clinical practice was I would have written to the patient and copied it to the GP. That was standard practice. I think that goes on in certain parts of the Trust and isn't standard practice and, actually, that is what we should be getting to. So, I mean, absolutely, the patient should be king in their own management. 16:04 16:04 16:04 16:05

381 Q. DR. SWART: Just one quick point. It is about the Serious Adverse Incidents.

Looking through all the papers that we've had, which there are considerable numbers, it is quite hard to pull out a consistent Trust-wide eye level, Board level, director level learning from specific incidents kind of theme. I think you set up a new serious incident oversight process; is that right? 16:05

A. Yes.

382 Q. DR. SWART: Is it your view that a serious incident process should have director-level involvement and scrutiny before they are signed off? Or what does this oversight processes mean in terms of how things will be different? 16:05

A. This fell into abeyance over the summer just with me changing roles and the changeover in interim medical director. So now that we have a new medical director in place, along with a director of social work and director of nursing, what they will do is -- and I had a meeting before the summertime in relation to this, before I stopped being medical director, and they are going to continue on with the others, is taking oversight of the Serious Adverse Incidents as they come through to the Trust each week and then challenge them. I think there's something about, I think, giving feedback in relation to terms of reference and recommendations. Then the other part of that is around how, professionally, do you embed this learning down through the different systems. So, again, what I'm hoping is that develops back to our weekly governance meeting, that that will all get fed back down through all of that and then automatically then -- the governance meeting is done on a Thursday and then we have a senior management team meeting on a Tuesday -- that actually then that's followed through there. So that actually they have eyes-on all the time in terms of what the Serious Adverse Incidents are. 16:05 16:06 16:06

You know, the real importance of that is then to be able to see the themes across the Trust. You know, so that what is not working in paediatrics may not be working in psychiatry, may not be working somewhere else, and to pull all of that together. 16:07

383 Q. DR. SWART: Is your plan then to close that loop and perhaps do a themed report to the Board on occasions?

A. Yes, and to give them feedback in relation to that trail. Yes.

CHAIR: Mr. Hanbury, any questions? 16:07

384 Q. MR. HANBURY: We have heard about the long-term problem with capacity and demand, particularly long waiting lists for in-patients and day surgeries, up to a point with outpatients as well. It seemed to come to a head about 2016 or so. Mr. Haynes wrote quite an eloquent, 16:07 in tabular form, comparison of the urology difficulties compared to other specialties often who had much shorter waiting times, and I think there was frustration that nothing happened. If you had seen that -- that obviously predated your time -- but if you 16:07 had seen that, how do you think a senior manager should respond to that?

A. Well, I think what he outlined -- I think that was the Blue Sky Paper, wasn't it?

16:08

What he was highlighting in relation to that, I think, as you point out, was just the discrepancies in relation to this. Now, I know that in recent times, certainly, there have been discussions with the Board

as was and SPPG in terms of getting more commissioning in and around that to try to build it up. And they did, they have managed to build up the number of CNS's and urologists, but not at the pace we needed. Essentially, right from the get-go, I think what -- he was certainly raising it. I think it was being raised in different places, but I don't know whether we were forcible enough about that or whether we didn't go the right way around it. But it certainly took quite a period of time, really, for that to gain any purchase and to get some investment, as far as I can see. 16:08

385 Q. MR. HANBURY: In the same sort of line, obviously as surgeons we are very worried about patients being on the waiting list for a long time and, obviously, they had come to harm and they are not necessarily seen back in clinic to make sure they are all right. And there are initiatives for potential harm reviews after, say, a certain length of time, say a year or something. Is that something that you brought in or you would like to see happen? 16:09

A. I'm not sure whether they have -- I know that I hear mention -- and I haven't thought about this specifically -- I know that I hear mention of patients that they are concerned about as being long waiters that they have checked up on. So that definitely does get discussed. I haven't asked specifically is that done through the CNSs or is that done through other aspects of urology. But I can certainly check that out and see. But I know, certainly, those long waiters are 16:09

on everybody's mind, particularly -- I mean, the vast majority of what they do at the minute, almost entirely with the exception of stents, I think, is red flag. So a lot of those patients with long-term urology problems are waiting to be seen. And I know that, certainly in recent times, we have gone back -- and I will check whether or not it is specifically urology, but I know for some aspects in surgery we have certainly gone back to patients in writing to check with them that they are still on our waiting lists and that, actually, if there's anything that we need to do to engage with them. Again, that came out of the back of recommendations marked RQIA and others in relation to that. 16:10 16:10

386 Q. MR. HANBURY: Just one final question about waiting list management. We've heard potentially the problems that clinicians can run into if they are running it with themselves and their secretary. What's your view of maybe having a waiting list office where this is controlled, there's more of an independent look and people don't so get forgotten about and scheduled stent-change type patients don't forgotten about as we sort of mark the SAIs. There does seem to be a lot of the section, the consultants themselves, seem to have a lot of responsibility there with that particular administrational task. Do you think that could usefully go into more generalised administration system such as a waiting list office? 16:10 16:11

A. I know that the current interim director for surgery is

in the process of developing that, because that's been one of her concerns. I think what I hadn't appreciated until she brought that to my attention was the Southern Trust is the only Trust in Northern Ireland that doesn't have that. So, as you say, a lot of that is distributed across the secretaries rather than actually coming through a central booking office. So she is in the process of sorting that out.

387 Q. CHAIR: Dr. O'Kane, we will be looking in more detail on the Maintaining High Professional Standards operation within the Trust, particularly in relation to this case, obviously. But you weren't involved in that yourself and you then, once you had got on top of all the information, when you came into the Trust, you then must have formed a view on how that was handled. Is there anything you would like to say about that at this point?

A. Well, firstly, I don't think that -- I think Maintaining High Professional Standards as an approach for something as complicated of this, I think falls far short of what it needs to be. I think that's the first thing. I think, certainly, on the face of it, it was followed, albeit that it took quite a long time, but actually I think that probably the part of it that I gained most insight myself from in relation to the case was the case investigator's report. I think -- and, I mean, that's obviously why I went back to the GMC -- the part I was concerned about was the deliberation then in terms of referring him. I thought

he should have been referred.

388 Q. CHAIR: I won't press you on that any more today. I see it is quite late in the day and you have had a very long day with us, but it is something that we will be revisiting as to how that was handled. You might want to reflect on that and see if there's anything else that you want to let us know about. 16:13

A. Okay. Thank you very much.

CHAIR: Is that it, Ms. McMahon? 16:13

I think we have finished, certainly, this stage of Dr. O'Kane's evidence, but we will, I'm sure, be seeing you many times over the next few months and years, perhaps, at this rate. 16:14

We were due to start with Mr. Devlin, I think, tomorrow afternoon?

MS. McMAHON BL: I haven't heard from Mr. Wolfe so I wouldn't want to commit him to anything earlier at this stage. But, certainly, if that changes we can let people know, if that suits, Chair. 16:14

CHAIR: We plan to start then at 2 o'clock tomorrow. But if we have managed to get in touch with the witness, we will let you know. 16:14

THE INQUIRY WAS THEN ADJOURNED TO WEDNESDAY, 7 DECEMBER 2023 AT 1400