



Oral Hearing

Day 30 – Tuesday, 21st March 2023

Being heard before: Ms Christine Smith KC (Chair)
Dr Sonia Swart (Panel Member)
Mr Damian Hanbury (Assessor)

Held at: Bradford Court, Belfast

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I N D E XP A G E

Dr Neta Chada examined by Mr wolfe KC	3
Lunch adjournment	77
Dr Neta Chada examined by Mr wolfe KC	77

1 THE INQUIRY RESUMED ON TUESDAY, 21ST DAY OF MARCH, 2023
 2 AS FOLLOWS:

3
 4 CHAIR: Good morning, everyone. Ladies and gentlemen,
 5 forgive me for asking for a moment of your time to 10:06
 6 mention the sudden death of an esteemed colleague at
 7 the Bar, Mr. Ivor McAteer. He died suddenly last
 8 night. On behalf of those of us who knew him both as
 9 a colleague and a friend, I want to express my
 10 sympathy, and all the members of the Bar working in 10:06
 11 this inquiry, to his wife and family. Thank you.

12
 13 Mr. Wolfe.

14 MR. WOLFE KC: Thank you, Chair. If I can briefly add
 15 that we all have our own fond memories of Ivor, but 10:06
 16 your words faithfully capture the essence of the man
 17 and the relationship many of us had with him. I think
 18 I speak for many of us colleagues in the room when
 19 I say he will be much missed, and may he rest in peace.

20 CHAIR: Thank you, Mr. Wolfe. 10:07

21 MR. WOLFE KC: Good morning, Dr. Chada. Chair, your
 22 only witness today is Dr. Chada. I think she wishes to
 23 take the oath.

24
 25 NETA CHADA, HAVING BEEN SWORN, WAS EXAMINED BY COUNSEL 10:07
 26 AS FOLLOWS:

27 1 Q. MR. WOLFE KC: Dr. Chada, in advance of today, you
 28 provided the Inquiry with one substantive statement, an
 29 addendum, and something that's come in this morning

1 that's going to make its way into a further addendum
2 statement. Let me just draw your attention to those
3 and ask you to confirm whether you wish to adopt these
4 materials as part of your evidence. Your substantial
5 statement is in response to Section 21 notice 41 of 10:08
6 '22; the first page is WIT-23759. Have we WIT-23759?
7 CHAIR: Another technical Tuesday, Mr. Wolfe.
8 MR. WOLFE KC: Is there a problem with the system, can
9 I inquire?
10 MR LUNNY: [Inaudible] 10:09
11 MR. WOLFE KC: Thank you, Mr. Lunny, but I am more
12 concerned about --
13 CHAIR: The witness does have her own copy I see before
14 her, in any event.
15 A. With no annotations on it. 10:09
16 CHAIR: Do we have the WIT bundle in the system all
17 right?
18 MR. WOLFE KC: Okay, we will see how we go. If we run
19 into further problems, we might have to pause.
20 2 Q. So you recognise that document okay, I'm sure, 10:10
21 Dr. Chada?
22 A. I do.
23 3 Q. And the last page containing your signature, I believe,
24 is WIT-23788 and it's dated 24th June last year?
25 A. That's correct. 10:10
26 4 Q. And would you wish to adopt that statement as part of
27 your evidence?
28 A. I do.
29 5 Q. Let's see if we have the addendum which would have been

added very recently. WIT-91937.

CHAIR: No joy? Might it be better just to try to resolve this at this stage before we get much further?

MR. WOLFE KC: We will run into difficulties because there's sections of Dr. Chada's evidence that we need to see on the screen.

10:11

CHAIR: We will --

MR. WOLFE KC: We will rise for five minutes?

CHAIR: Yes, we will rise for five minutes.

10:11

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Right, everyone, let's hope that our technical difficulties are over for the week.

MR. WOLFE KC: Okay. So moving on to your addendum

10:16

statement, then, let's bring it up on the screen, WIT-91937, please. You provided that addendum witness statement in the last few days or so to correct an issue at 8.4 of your original statement. So where you have previously said, "I had no direct contact with the Medical Director other than when I was asked to engage in the investigation process when the previous case Case Manager had to be replaced", you have reconsidered that in light of what Dr. Wright has said. If we scroll on down, you say that, on down to paragraph 3, you say:

10:16

10:17

"I do not recall the discussion that Dr. Wright alludes to", until you had read his statement and now you

1 recall that you had a brief informal conversation with
2 Dr. Wright during the course of your investigation but
3 it was, in essence -- as we scroll down -- he was
4 asking you for a progress check and you were saying
5 that progress was slow and outlined the reasons for
6 that. That's the correction there.

10:17

7
8 Then, this morning, you have come in with two further
9 corrections which you will, in due course, place into
10 an addendum. If we go down to 11.3 of your statement,
11 please. I will try and get the page number up for
12 that, WIT-23778. At 11.3, you said in the penultimate
13 sentence:

10:18

14
15 "I am not aware of the parameters under which
16 Mr. O'Brien returned to work or whether they were
17 adhered to."

10:18

18
19 And you wish to change that to say:

20
21 "I am not aware of the exact parameters under which
22 Mr. O'Brien returned to work, but I was aware that
23 there was an action plan in place relating to the areas
24 of concern. I was told that the action plan was
25 adhered to during my investigation. Monitoring
26 adherence to the action plan was not under my role
27 under MHPS."

10:18

10:19

28
29 That's a change you wish to make to that paragraph?

1 A. Yes.

2 6 Q. And then at paragraph 18.4, which we find at WIT-23787,
3 the last sentence on that page reads:
4
5 "I am unaware of how he progressed on his return" -- 10:20
6 that is Mr. O'Brien's return -- "as I was not advised
7 of that" and you wish to change that to "I am unaware
8 of how he progressed, after I completed my
9 investigation as I was not advised of that."
10
11 That's the change you wish to make? 10:20
12 A. Yes. Yes.

13 7 Q. We can see from your statement, Dr. Chada, that you
14 obtained a medical degree in June 1988, assumed
15 membership of the Royal College of Psychiatrists in 10:20
16 1994, and appointed as consultant psychiatrist in the
17 Southern Health and Social Care Trust, which is the
18 name we now know it by, on the 1st February 1999. Is
19 all of that correct?

20 A. Yes, that's correct. 10:21

21 8 Q. And you retired from your role as consultant
22 psychiatrist in the Southern Trust on the 2nd March
23 2020. Is that also correct?

24 A. I retired from my permanent role on the 2nd March 2020,
25 and was contacted about three weeks later because of 10:21
26 Covid. I actually returned as a consultant then for
27 a further 15 months or so to help out during Covid.

28 9 Q. Very well, thank you. Thanks for that clarification.
29

1 Those details, Chair, just for your note, can be found
2 at WIT-23759 to 23760. We don't need to bring it up on
3 the screen.

4
5 Now, in the course of your employment in the Trust, 10:22
6 you've participated in a number of management roles.
7 You were Clinical Director within your Directorate,
8 which I understand was the Mental Health and Disability
9 Directorate?

10 A. Yes, that's correct. 10:22

11 10 Q. After that, from 2011 you were Associate Medical
12 Director within that Directorate?

13 A. Yes.

14 11 Q. Just to be clear, although you were asked to take up
15 the role of Case Investigator for the purposes of an 10:22
16 MHPS investigation concerning Mr. O'Brien in or about
17 February of 2017, you had no prior knowledge of any
18 concerns relating to his clinical practice or how he
19 carried out his job as a Consultant Urologist?

20 A. No, I did not. 10:23

21 12 Q. Did you have any prior dealings or knowledge of him at
22 all?

23 A. Mr. O'Brien was a consultant in the Trust when I was
24 a junior doctor. I would have been aware of him. He
25 was a very senior consultant and so I would have been 10:23
26 aware of the name, I would have been aware that he was
27 a urologist but I had no direct dealings with him at
28 all. He was a manager at one point and I did wonder
29 whether I might have come across him at management

1 meetings but I have no memory of doing so. I'm not
2 sure if he was a manager and my management overlapped,
3 but I had no direct dealings or contact with him
4 whatsoever.

5 13 Q. As we will hear in a few moments, you had some 10:24
6 experience of operating the MHPS and Trust guidelines
7 prior to taking up the particular role of investigator
8 in the case of Mr. O'Brien and we will hear about that
9 in a moment. Clearly, your evidence today, in light of
10 that experience, will hopefully assist the Inquiry on 10:24
11 two levels. First of all, obviously and specifically
12 the Mr. O'Brien investigation and your experience of
13 that, and some issues arising out of that which I will
14 need to tease out with you. But over and above that,
15 the Inquiry is charged generally with looking at the 10:24
16 MHPS process and any lessons that can be learnt from
17 both the Aidan O'Brien investigation but, more
18 generally, from witnesses in terms of their experience
19 will no doubt be very helpful. I will have some
20 questions on that at a second level for you. 10:25

21
22 You have told us in your witness statement that in
23 terms of training prior to taking up this role as
24 investigator, you attended a medical leadership forum
25 for NCAS training on the 24th September 2010. Let's 10:25
26 just have that up on the screen, WIT-23790.

27
28 we have heard already from Mrs. Toal, Chair, you will
29 recall, that this was training introduced shortly after

1 the development of Trust guidelines in 2010. If you
2 just scroll through that briefly, we can remind
3 ourselves of it. The objectives of the training were
4 to understand the Trust's guidance of handling
5 concerns, to discuss the internal and external support 10:26
6 available for Clinical Directors and Associate Medical
7 Directors and to clarify for them their roles in
8 applying the guidance.

9
10 Scrolling down, please, we can see that Dr. Fitzpatrick 10:26
11 of NCAS, amongst others, was one of the people
12 delivering the training, and also the Panel will recall
13 Mrs. Toal's evidence in that respect.

14
15 Any particular memories of that training and how it 10:26
16 assisted you in the work that you were to undertake
17 over the next few years?

18 A. Dr. Fitzpatrick was the most senior NCAS representative
19 in Northern Ireland at the time, and having his
20 training on that day was excellent. I have had the 10:27
21 benefit of further training from Dr. Fitzpatrick at
22 a later stage. I was still a Clinical Director at this
23 point, but I thought the training on that day was very
24 helpful in terms of understanding the relationship.
25 Maintaining High Professional Standards is the 10:27
26 overarching document and procedures that we would
27 follow in the Trust. Then this was really, I suppose,
28 the Trust guidelines were a derivation of that, but
29 really Maintaining High Professional Standards was the

1 overarching thing and Dr. Fitzpatrick talked to that.

2 14 Q. You also trained on the 7th and 8th March 2017 shortly
3 after you had been appointed to the role of Case
4 Investigator. I suppose before you got in too deep
5 into that investigation -- let's just bring that
6 training up, WIT-23794 -- it is described as Case
7 Investigator training workshop and it's a two-day
8 workshop. Is this the one that you attended?

10:28

9 A. It is, indeed. Yes.

10 15 Q. Yes. If you just scroll down. Learning objectives are
11 set out. Was this training attended by you because you
12 had recently taken appointment as a case investigator
13 or was it planned?

10:28

14 A. I believe it was already planned and I was invited to
15 attend. It was fortuitous that it happened to be at
16 this time. I was very grateful that I was getting an
17 update at this stage.

10:29

18 16 Q. In general terms, do you think training in the
19 operation of NCAS and the local Trust guidelines is
20 essential, or do you derive more from familiarising
21 yourself with the documents and doing the job of Case
22 Investigator or Case Manager?

10:29

23 A. I think the training is very important because there
24 would have been case studies and there would have been
25 examples, so an opportunity to understand how the
26 process is worked through, which, I mean Maintaining
27 High Professional Standards as a document is reasonably
28 lengthy. You will be aware, Chair, that the section on
29 Case Investigator is about a page, which isn't really

10:29

terribly detailed. Therefore, this type of training -- this was a two-day training programme -- really expanded a lot on that, which I thought was very helpful.

17 Q. Is there anything in particular about your training experience -- or your experience of training, I should say -- that has caused you to reflect that things could be improved in any way in the training that you receive, or were you basically content with it?

A. I thought the training was very good, and there was a mixture of people who attended this training which I thought was helpful as well. I think Maintaining High Professional Standards leaves a lot to be desired as a document. But the training, I thought, was very good. I thought it was well put together and I thought it covered a number of relevant areas.

18 Q. You have reflected in your statement that as an Associate Medical Director perhaps in particular, you had significant experience, perhaps, of managing performance amongst colleagues. You say in specific terms, if we can go to WIT-23773, that you have been involved in some six cases using the MHPS format. If you just scroll down. What you are setting out here is an e-mail that you received from Zoe Parks when compiling your witness statement. She says:

"To the best of my knowledge I have you down for the following six cases. There are also a few other investigations that I know you were involved with but

1 they weren't managed or investigated under MHPS as
2 such. "

3
4 And she gives an example. Then if you scroll down
5 slightly, we can see the six cases. I take it, and you 10:32
6 can perhaps help me with this, if we work from the
7 bottom, number 6 where it says "2013", that those three
8 cases, 4, 5 and 6, were handled by you as Case
9 Investigator in that year, or the issue arose in that
10 year? 10:32

11 A. In 2013?

12 19 Q. Is that right?

13 A. Yes, that's correct.

14 20 Q. Then there was a matter in 2016. So, in all of those
15 four matters you were Case Investigator? 10:33

16 A. Yes.

17 21 Q. Then there was a matter number 2 where you were Case
18 Manager?

19 A. Yes, that's correct.

20 22 Q. And then another matter more recently in 2021 where you 10:33
21 were Case Investigator?

22 A. Yes. Just for clarification, Madam Chair, the case in
23 2016 is not this case. That was a different case.

24 23 Q. It's, in essence, six cases plus Mr. O'Brien's case?

25 A. Yes. 10:33

26 24 Q. Yes.

27 A. Yes, that's correct.

28 25 Q. Looking at those four cases before you came to deal
29 with Mr. O'Brien's case, can you help us in terms of

1 the kinds of experiences or learning that you took from
2 your involvement in those cases before grappling with
3 the Mr. O'Brien investigation?

4 A. All four cases were very significant cases, I suppose,
5 so my experience of Maintaining High Professional 10:34
6 Standards was of its use in situations which were
7 complex and significant issues being raised. I found
8 Maintaining High Professional Standards difficult to
9 use in terms of time scales where -- and so I knew that
10 from even before being asked in relation to 10:34
11 Mr. O'Brien. Time scales were not met in any of those
12 cases, I remember that vividly. I think that's one of
13 the biggest issues for me in terms of learning, was
14 that Maintaining High Professional Standards really
15 very difficult to keep to the time scales. Very clear 10:35
16 in terms of what the Case Investigator role is but
17 again not a lot of additional information in relation
18 to guiding that role. I suppose that's...

19 26 Q. You seem to highlight that one of the main things you
20 take from those experience is managing the time scale. 10:35
21 I suppose by the time it gets to a formal MHPS
22 investigation, it involves a degree of seriousness or
23 gravity and, perhaps in very many cases, complexity.
24 We will look in due course at how time moved on in the
25 O'Brien investigation. 10:36

26
27 But at this stage of our discussion this morning, can
28 you see anything in terms of learning from those
29 experiences that either yourself, as the Case

1 Investigator, can do better, or is it a case of Trusts
2 who own these processes building a better
3 infrastructure and support network around the
4 investigations?

5 A. One of the things that I am minded of on reflecting on 10:36
6 those cases was the impact on the subject of the
7 investigation. I do think that that probably
8 influenced me in terms of the investigation into
9 Mr. O'Brien. You know, there's a difference between
10 being told you are being managed under the Trust 10:36
11 guidelines, which tends to be at an informal level,
12 although that is part of Maintaining High Professional
13 Standards still, and then being told that you are being
14 investigated under the auspices of Maintaining High
15 Professional Standards. 10:37

16
17 My memory of all four of those prior to Mr. O'Brien was
18 how anxiety-provoking it was for people. They were
19 afraid of the process and anxious about the outcome.

20 10:37
21 I'm so sorry, I have lost the track of your question,
22 Mr. Wolfe.

23 27 Q. Yes. I asked the question from the angle of whether
24 you, as the practitioner leading the investigation, or
25 the Trust who owns the process, if there is impact on 10:37
26 the practitioner as you describe, whether the delays
27 that seem to punctuate the process -- perhaps
28 inevitably because of complexity or whatever else --
29 can that be better managed by the investigator or is

1 there a need for better support by the Trust for the
2 investigation in order to move it along with greater
3 efficiency?

- 4 A. I think Maintaining High Professional Standards is not
5 fit for purpose. The reason I say that is because 10:38
6 Maintaining High Professional Standards requires really
7 that it should be a medic that undertakes the
8 investigation for, I think, very good reason. However,
9 medics have other responsibilities, either clinical
10 responsibilities or, in my case, both clinical and 10:38
11 management responsibilities. There's an onus on the
12 Case Investigator being somebody who is, I suppose, of
13 a reasonably -- in a reasonably responsible position
14 because you don't want an investigation carried out by
15 somebody who is, you know, at a lower level or the same 10:39
16 level in terms of perception. The difficulty with that
17 is that people in that position are people who have
18 additional responsibilities. As a consequence, you are
19 trying to undertake a complex investigation, maybe
20 interviewing lots of different witnesses, as was the 10:39
21 case in some of these other investigations as well, who
22 are very anxious. At the same time, you are running --
23 you are doing your clinical job, which, in my case --
24 I am not sure if this is helpful to the Panel -- but
25 I ran an acute service, so I essentially ran an 10:39
26 emergency service. I was the consultant for Home
27 Treatment Crisis Response Services. That is an
28 alternative to hospital admission. So, all my clinical
29 work is not work that can be put off to another time.

1 I can't cancel Outpatient clinics, I can't cancel
2 theatre lists, not that I would anyway. I have to be
3 honest and say I wouldn't do that anyway for an
4 investigation because I don't think putting other
5 patients' quality of service, impacting on that is
6 appropriate.

10:40

7
8 But all my work in any respect, in any way, in any
9 event, was acute work, and these are things that can't
10 be put aside. These are people who are acutely
11 mentally ill, who, if it wasn't for my service, would
12 have to be admitted to hospital. There aren't enough
13 beds in hospital and therefore it's very important that
14 we can safely manage those people who are acutely ill,
15 presenting with some risk, in the community. So, you
16 are doing that.

10:40

10:40

17 I was also the Associate Medical Director. Just to put
18 that in context, you are responsible for performance of
19 the biggest number of consultants, bar anaesthetists,
20 in the Trust. Mental health and disability has the
21 most significant number of consultants bar
22 anaesthetists, so it's a big consultant body, along
23 with junior doctors. Then there's the governance
24 issues that you are directly responsible for. In the
25 15 months that this investigation took, there were also
26 30 ongoing Serious Adverse Incidents in mental health
27 and disability, which I would have been aware of.

10:40

10:41

28 I chaired one SAI in mental health and disability. For
29 me to chair -- for the Associate Medical Director to

1 chair an SAI within the Directorate suggests that there
2 was something quite complex about it, maybe involving
3 outside agencies.

4
5 I also chaired an SAI in the Acute Hospital across, I 10:41
6 believe, ED and Children's Services, and Medicine was
7 involved in that as well. Again, for someone from
8 outside Acute Services to be asked to chair that
9 suggests a very significant degree of complexity. On
10 top of all of that, we had a double homicide in the 10:42
11 Trust in this period. I suppose the reason I'm
12 explaining this is that in terms of Maintaining High
13 Professional Standards, it's my belief that the
14 investigation is done to the best of your ability
15 within time constraints that are available, and I'm not 10:42
16 sure that that's the correct way to carry out an
17 investigation if you want a more robust outcome.

18
19 I'm not sure how much time this Inquiry has but
20 I suspect that time has been set aside -- in fact, 10:42
21 I know that time is set aside specifically for it. No
22 time is set aside for Maintaining High Professional
23 Standards investigations in terms of my job plan, or in
24 anybody else's. I mean, I was assisted by Mrs. Hynds,
25 and no additional time was set aside for her either. 10:43

26 28 Q. Mm-hmm. So, the picture emerging from your evidence so
27 far is that you, a senior practitioner, with perhaps
28 more experience than most in the role of an MHPS
29 investigator -- you have gone through four

1 investigations -- you are asked to do this; can you
2 refuse, in real terms --

3 A. Yes.

4 29 Q. -- or is it part of your nature perhaps to assist the
5 employer where you can, despite the pressures?

10:43

6 A. You can refuse. This is done as a voluntary additional
7 activity. It's not my nature to assist the employer.
8 It is, however, my nature to ensure that patient
9 service, patient care, quality of service to patients,
10 is considered and regarded with seriousness.

10:44

11
12 I felt that given my experience to date, and the fact
13 that I had very little contact with the Acute side, so
14 I was outside of a lot of these issues, I felt that
15 probably did lend to me being able to carry out an
16 in-depth and reasonably robust investigation. You want
17 to be helpful, and I suppose you want to be helpful
18 also because you feel that if an issue arises within
19 your own directorate that requires somebody from
20 outside it to come in and take an independent hands-off
21 look at it, that they will do that. You know, if
22 everybody said no, then we would never get anywhere.
23 Nowhere is that appropriate, you know. Complaints and
24 issues of concern need to be investigated and
25 addressed, so I felt a moral obligation to do so.

10:44

10:44

10:45

26 30 Q. If the likely candidate for Case Investigator is
27 a person like you, can one assume that the experience
28 that you face of other responsibilities, the need to
29 progress an investigation and the risk that, as you

1 have just pointed out, of a less than robust
2 investigation or less robust than you would like it to
3 be, if that's the experience of others, what is to be
4 done, in your view? You have described MHPS as not
5 being fit for purpose but assuming we need some form of 10:46
6 framework to look at matters of this nature, what is to
7 be done to avoid a situation where you aren't able to
8 devote all of your energies in a consistent way to the
9 investigation, risking delay and risking less than
10 robust outcomes? 10:46

11 A. I think to the Panel, I suppose I have a number of
12 comments in relation to this. An investigation which
13 takes 15 months is not helpful to the person under
14 investigation or to the Trust. I was aware that there
15 was an action plan in place, which I suppose lent some 10:46
16 degree of assurance that things weren't being allowed
17 to continue in the previous manner. That helped to
18 some extent. However, I think there's no doubt that,
19 having a shorter timeframe for an investigation, where
20 issues are looked at very quickly, recommendations are 10:47
21 made quickly and that the Trust can implement those
22 quickly is what's required.

23
24 In terms of how that happens, I don't believe that
25 anybody can be a Case Investigator -- and, as you have 10:47
26 indicated, Mr. Wolfe, I have some experience in this --
27 I don't think you can be a Case Investigator without
28 time set aside for it. Further, I also think -- and I
29 have reflected a lot on this through this experience

1 and coming here today -- I also think that not only do
2 you need time set aside, but I think identifying
3 specific people to be Case Investigators is helpful for
4 a number of reasons. I think building up expertise is
5 important. So, being familiar with guidelines, 10:48
6 frameworks, protocols, whatever it is that's in place,
7 is helpful so you are not constantly having to refer to
8 them. I think you develop learning from being involved
9 on a regular basis. I also think that it takes away
10 from this issue of, well, you know, maybe 10:48
11 I particularly like investigating other doctors and
12 being irritable and annoyed with other doctors.
13 I think if there's a pool of Case Investigators who are
14 specifically trained, who have time set aside, maybe
15 one day a week or whatever that is. 10:48

16
17 When I started in medicine, for example, I was the
18 Northern Ireland Medical and Dental Training Agency
19 Regional Adviser for psychiatry. That meant that I was
20 responsible for all postgraduate training in Northern 10:49
21 Ireland for five years. I resigned from that post when
22 I was made Associate Medical Director because I felt
23 that there was the potential for those two roles to
24 have a conflict. However, the reason I raise this is
25 because that role was also done under my usual clinical 10:49
26 responsibilities and being a clinical director at the
27 time. Now that's changed, so now if you have a college
28 role, there's time specifically dedicated for your
29 college role, which I think is absolutely correct

1 because you can't expect consultants to be doing all of
2 these other things. I mean, part of my consultant role
3 is teaching and training, for example. I have junior
4 doctors working with me; it's very important that
5 I ensure that they are appropriately trained. You have 10:50
6 that role, you have your clinical role, you have your
7 governance role and so on, and that's just as
8 a consultant, not including the management role.

9
10 Time set aside to ensure that things that are very 10:50
11 important -- teaching and training, governance, this
12 type of investigation -- I think is very important. I
13 have probably rambled, I do apologise.

14 31 Q. Don't apologise. A moment or two ago you used the word 10:50
15 "robust", a robustness. This is what I took from your
16 answer. I can't bring it up on front of me as I stand
17 here, but what I took from your answer is that these
18 pressures on your time often led to a lack of
19 continuity in the investigation process, leading you to
20 be concerned as to the robustness of this 10:51
21 investigation; is that right? Is that what you were
22 wishing to convey?

23 A. Yes. I think as doctors and lawyers, one of the things
24 that's difficult is setting things down and then
25 picking them up and then setting things down. None of 10:51
26 us, for example, like to be involved in proceedings
27 which, you know, go on for a week and then they
28 disappear and then you come back and in the middle of
29 that, maybe the next day, you are doing something else.

1 That made it very difficult. There were some delays in
2 this investigation which were of my own making because,
3 I was, as I have explained earlier, very busy through
4 this year. It was an unusual -- unusually busy year.
5 Some of it was of my making. Some of it was of other 10:51
6 people's making. But in the sum of it, you are looking
7 at something, something comes to mind, you think oh,
8 yes, I must look at that again but then you are not
9 looking at it again for maybe another month. I think
10 that isn't helpful, which is one of the reasons why 10:52
11 I think if there was, for example, a day a week set
12 aside, you would always be coming back to, right, how
13 far have we got, what are we doing with that? It would
14 help with time scales, it would help with prompts.
15 whereas, for example, when you are waiting for witness 10:52
16 statements to come in and so you are sort of, well, I
17 can't do anything further until those come in, I have
18 got all these 101 other things to do so I will go and
19 do those, you don't keep things to the forefront of
20 your mind in the same way, which I think is unhelpful. 10:52
21 32 Q. Within your witness statement -- I needn't bring it up
22 on the screen, I will read it to you -- it's at
23 paragraph 15.4 at WIT-23784, you say:

24
25 "I believe the processes and findings on this occasion 10:53
26 were robust, balanced and led to clear conclusions
27 which then generated and informed a clear action plan."
28

29 we will come, in due course, and look in some detail at

1 your report and the conclusions you reached. Do you
2 still stand over that view, that the process and
3 findings were robust, balanced and led to clear
4 conclusions?

5 A. I think the process was robust, balanced and fair 10:53
6 within the timeframe that we had. Perhaps I could have
7 added that clarification. But I do think that we --
8 I think I did as much as I could in the timeframe that
9 I had with the information that I had. I thought the
10 conclusions, therefore, were reflective of the 10:53
11 information gathered. From those points of view, I did
12 feel it was robust.

13
14 I feel it could have been done better if I had more
15 time, if I had freed up time. I think you reflect on 10:54
16 these things, and I suppose -- I suppose everybody
17 thinks things could have been done better. You know,
18 I would be very concerned about most doctors if they
19 said that they didn't think things could be done better
20 because I think that's the nature of our work. So, 10:54
21 I do think things could have been done better but I'm
22 satisfied that the findings from the report were robust
23 and reasonable on the information that we had, and that
24 we progressed, we progressed the report to the Case
25 Manager to make his decision. 10:54

26 33 Q. We will come and look at some of the minutiae of that
27 later. You have earlier pointed out that the very
28 concise description of the Case Investigator role which
29 is to be found in the MHPS document -- let's just pull

1 that up. WIT-18503. At the bottom of that page you
2 can see this is the description, I think, you were
3 alluding to earlier, that:

4
5 "The Case Investigator must formally on the advice of 10:55
6 the Medical Director involve a member of the medical or
7 dental staff with relevant clinical experience in cases
8 where the question of clinical judgment is raised
9 during the investigation process".

10
11 we will come on to look at the role of Mr. Young in
12 this investigation in a short time, but it's fair to
13 say that he wasn't appointed to your investigation as
14 a clinical adviser?

15 A. He wasn't appointed to the investigation as a clinical 10:56
16 adviser, but I was aware that he -- sorry, he came to
17 the investigation as a witness, and I was aware that
18 Mr. Young had been asked to look at some of the
19 evidence, along with some of the other urologists, that
20 was trying to be gathered for the investigation. So I 10:56
21 was satisfied that there was someone with the correct
22 clinical expertise who was looking into the evidence
23 that was being gathered.

24 34 Q. Yes. I don't want to go very much into that at the
25 moment. Is this a case that might have benefitted from 10:56
26 the involvement of somebody at your side or perhaps in
27 place of you with expertise in urology, given the kinds
28 of issues that were being raised?

29 A. The terms of reference that were raised were issues in

1 relation to, in my view, more administrative processes
2 which had the potential to lead -- certainly had
3 potential to lead to patient outcomes. However, I
4 didn't feel, looking through the terms of reference,
5 that there was a question of clinical judgment being 10:57
6 raised, so that wasn't an area that I had concerns
7 about. Therefore, I didn't feel that I needed either
8 to be replaced by somebody with specific experience in
9 urology or to be assisted directly by somebody with
10 specific experience in urology. My view was that any 10:57
11 consultant who has to carry out clinical
12 administration, which we all do, should have been able
13 to address some of those terms of reference -- terms of
14 reference 1, 2 and 3. I felt any consultant should be
15 able to look at whether private patients were being 10:57
16 jumped up the queue, to put it in that way. Therefore,
17 it was not my view that this required specific urology
18 guidance or advice or input.

19 35 Q. we will look at that. Just going through this job
20 description as such. 10:58

21
22 "Must ensure that safeguards are in place throughout
23 the investigation so that breaches of confidentiality
24 are avoided. Patient confidentiality needs to be
25 maintained. It's the responsibility of the Case 10:58
26 Investigator to judge what information needs to be
27 gathered and how".

28
29 Again, did you feel well-equipped to discharge that

1 element of your role?

2 A. Well, the terms of reference were very specific. The
3 terms of reference with which I was provided by the
4 Case Manager were very specific. I felt that the
5 process of gathering information in relation to those 10:59
6 Terms of Reference was being carried out and,
7 therefore, I was content that that information was
8 being gathered as required.

9 36 Q. There's then reference to the need to ensure sufficient
10 written statements are collected and this was, as we 10:59
11 will see, a process that you oversaw gathering witness
12 statements, or drafting witness statements maybe is the
13 right way to put it, after interviewing witnesses.

14
15 Could I just pick up on the last bullet point there? 10:59

16
17 "Must assist the Designated Board Member in reviewing
18 the progress of the case".

19
20 The Designated Board Member was a Mr. Wilkinson. Had 10:59
21 you direct dealings with him at any time?

22 A. No, I didn't. Mr. Wilkinson contacted Dr. Khan, who
23 was the Case Manager, directly, rather than me.
24 Because that relationship had already been established
25 before I was appointed Case Investigator, I felt that 11:00
26 that relationship could continue rather than directly
27 be involved in it, although I'm aware that these
28 guidelines suggest that it should be the Case
29 Investigator.

- 1 37 Q. what did you perceive, not only in this investigation
2 perhaps but from your experience. what did you
3 perceive to be the proper role for the board member?
4 A. My understanding is that the board member in some ways
5 is almost like a conduit between the investigation 11:00
6 that's being carried out and the subject of the
7 investigation; to provide support, to ensure that the
8 investigation is progressing as it should. So, to
9 provide support, sorry, to the subject of the
10 investigation I mean, and to ensure that the 11:01
11 investigation is progressing as it should. I believe
12 Mr. wilkinson did carry out that function, though, as
13 indicated, through Dr. Khan rather than through me
14 because both Mr. wilkinson and Dr. Khan had been
15 appointed prior to my involvement, as far as I'm aware. 11:01
16 38 Q. Paragraph 33. I suppose paragraph 32 first of all is
17 important but it's perhaps stating the obvious, that
18 you do not make the decision on what actions should or
19 should not be taken. But you, as paragraph 33
20 emphasises, have a wide discretion on how the 11:01
21 investigation is carried out, but in all cases the
22 purpose of the investigation is to ascertain the facts
23 in a unbiased manner.
24
25 In terms of the role that you were performing, did you 11:02
26 consider yourself to be independent of the person, that
27 is the Medical Director, who was in essence giving you
28 the instruction to perform this task?
29 A. Completely.

1 39 Q. Could you, had you seen fit, have required the Medical
2 Director to attend upon you as a witness?

3 A. Yes, the Medical Director can be required to attend as
4 a witness, if required.

5 40 Q. In terms then -- just scroll down -- of the Case 11:03
6 Manager's role, were you clear in the distinction
7 between your role and his, that was Dr. Khan's?

8 A. I was.

9 41 Q. Where was the division of labour as you saw it?

10 A. Dr. Khan had no role in the investigation. I would 11:03
11 have had meetings with Dr. Khan to discuss how the
12 investigation was going but not really to discuss the
13 detail of the investigation. Dr. Khan would have asked
14 about timeframes. Dr. Khan was an Associate Medical
15 Director, I was an Associate Medical Director. I would 11:03
16 have met him at monthly meetings and, you know, he
17 would have approached and said, look, how are things
18 going, how long is this going to take? So I would have
19 kept him up to date. But most of -- most of the, I
20 suppose, more formal/informal contact with Dr. Khan 11:04
21 would have been carried out by Siobhán Hynds,
22 Mrs. Hynds, who was assisting me in the investigation,
23 Mrs. Hynds is the head of Employee Relations, and so
24 she would have been the person who would have been
25 doing a lot of the e-mailing between me and Dr. Khan, 11:04
26 or copying me into e-mails that Dr. Khan had received
27 or Dr. Khan may have copied me into e-mails. So, some
28 of that sort of more formal, I suppose, on paper
29 contact would have been through that. But Dr. Khan had

1 no role in the investigation whatsoever.

2 42 Q. Yes. You have already indicated that you didn't see
3 the need for clinical input as such or a clinical
4 expert to assist you in any way. Paragraph 36 provides
5 that:

11:05

6
7 "If, during the course of an investigation, it
8 transpires the case involves more complex clinical
9 issues, the Case Manager could consider whether an
10 independent practitioner from another HSS body or
11 elsewhere would be invited to assist".

11:05

12
13 Did that ever arise for you or for the Case Manager at
14 any point?

15 A. During this investigation we had no clinical concerns
16 raised with us bar one. I think fairly early in the
17 witness statements, one of the witnesses, and I'm
18 afraid I don't recall which one but it was one of the
19 non-medical managers, indicated to us that one of the
20 difficulties with Mr. O'Brien is that, for example,
21 Mr. O'Brien contacted patients to put them on a theatre
22 list, he phoned them himself. So he put together his
23 theatre list. He wouldn't indicate the urgency of
24 patients on the theatre list. As a consequence
25 a theatre list would go ahead, say for Tuesday, and if
26 something urgent came in the night before, the nursing
27 staff and the staff who operated theatres and ran
28 theatres had no idea if there were patients on this
29 list who were urgent or could be moved off the list to

11:05

11:05

11:06

1 allow the urgent surgery to be carried out.

2
3 So, I raised -- I raised that with Mrs. Hynds because
4 it was raised at one of these interviews. I asked
5 Mrs. Hynds if she would contact Dr. Khan to let him 11:06
6 know that so it could be brought to the attention of
7 people who were supervising the action plan and
8 supervising Mr. O'Brien's return to work, because
9 I felt that was an issue that required some attention.
10 But other than that, everybody we spoke to went -- 11:06
11 well, most people we spoke to went to great lengths to
12 say that this was a good doctor, who, in fact, was
13 overinvolved with his patients and spent long periods
14 of time with them, wrote -- when he did write --
15 letters and notes, that they were very complex. So, at 11:07
16 no point did I have -- at no point did I feel there
17 were complex clinical issues to raise with Dr. Khan so
18 that he could have --

19 43 Q. I am going to explore that with you in the context of
20 Dr. Young in a moment, particularly around the private 11:07
21 patient debate that you had to resolve. I will be
22 asking you, just to flag it now, whether Dr. Young was
23 the appropriate person or whether other people should
24 have been involved to help you resolve that issue.
25 I just want to flag that now. 11:07
26

27 Before we reach that, if we could just scroll down to
28 paragraph 37, please.
29

1 "Time scale in decision: The Case Investigator should,
2 other than in exceptional circumstances, complete the
3 investigation within four weeks of appointment and
4 submit their report to the Case Manager within
5 a further five working days."

11:08

6
7 You have touched on the difficulty around that already,
8 and I want to explore that again in greater detail as
9 we go on.

11:08

10
11 Just in terms of the Case Manager's role, that's
12 Dr. Khan, did he at any point suggest to you any
13 methodology or assistance that could be brought to bear
14 to move this matter on quicker or more efficiently?
15 I know that he was kept in the loop in terms of the
16 timeframe and he asked questions about the timeframe.
17 My question is more specific: Did he make any
18 suggestion to you in terms of how this ought to be
19 progressed?

11:08

20 A. No, Dr. Khan did not. I think, in terms of time span,
21 there was discussion with Dr. Khan about some of the
22 things that were taking longer. For example, the
23 numbers of triage, those numbers were already
24 identified by the time my investigation started.
25 However, the lookback in terms of their notes and
26 records that were brought back from Mr. O'Brien's
27 house, that was taking a lot of time for the consultant
28 urologists. I did inquire through Mrs. Hynds whether
29 additionality could be used to try and get through that

11:09

11:09

1 process a bit quicker, but Dr. Khan didn't make any
2 specific suggestions. I think he shared that, I
3 believe he shared that suggestion but I am not sure
4 about that.

5 44 Q. If we just scroll back, I just want to underscore an 11:10
6 issue that we will come back to later. If we go back
7 to paragraph 35. You will note that it says halfway
8 down that paragraph:

9
10 "The practitioner must be given the opportunity to see 11:10
11 any correspondence relating to the case, together with
12 a list of the people whom the Case Investigator will
13 interview. The practitioner must also be afforded the
14 opportunity to put their view of events to the Case
15 Investigator and given the opportunity to be 11:10
16 accompanied."

17
18 Again, in due course we will look at how that played
19 out during this investigation, and in particular the
20 fact that you, when you first interviewed Mr. O'Brien, 11:11
21 he hadn't been provided with any witness statements;
22 isn't that correct?

23 A. Yes. Yes, that is correct. However, we had a lot of
24 discussion about the timing of interviewing
25 Mr. O'Brien; Mrs. Hynds and I did. Maintaining High 11:11
26 Professional Standards actually suggests that the
27 subject of the investigation should be interviewed
28 first. I knew that, I was aware of that. Having had
29 sight of a lot of the documentation from prior to my

1 involvement, I felt that it wouldn't be fair to
2 Mr. O'Brien for me not to at least be aware of some of
3 the things that other witnesses had to say, because
4 I felt that needed to be -- to be fair and equitable,
5 I felt that needed to be put to Mr. O'Brien. I mean,
6 I realised, of course, that we could always bring him
7 back again. So, for that reason -- so this issue of
8 not seeing the witness statements, absolutely,
9 Mr. O'Brien hadn't the benefit of seeing those. At
10 that time a lot of them weren't back --

11:12

11:12

11 45 Q. I think we will come to that in some detail and we will
12 explore -- sorry, I didn't mean to cut you off rudely.

13
14 In terms of your approach to this role, given your
15 experience and your training, did you feel yourself
16 well-equipped for it?

11:12

17 A. Yes.

18 46 Q. But that has to be set in the context of the strains, I
19 suppose, of your everyday professional life in terms of
20 fitting it in and doing it efficiently?

11:13

21 A. Yes. I mean, I think I had the appropriate training
22 and the appropriate approach and appropriate seniority.
23 If you are including in the appropriately equipped
24 whether I had the appropriate time and resource, then
25 no. I felt I was an appropriate person to do the
26 investigation and, if I was doing it again, I suppose
27 the issue would be of support.

11:13

28 47 Q. In terms of your, I suppose, initial briefing about the
29 issues that have given rise to the investigation, that

1 came from Dr. Wright, is that right? Is that correct?

2 A. Yes, that's correct.

3 48 Q. Your witness statement, if we just turn that up,
4 please, WIT-23760. You say at 1.5, if we can just move
5 through this fairly swiftly, that you were approached 11:14
6 by Dr. Wright in late February 2017. I should ask you,
7 there's no such thing as a formal letter of appointment
8 or letter of instruction setting out what you were --
9 I see you smiling as if that's pie in the sky. Why is
10 it pie in the sky? 11:14

11 A. No, no. It's not that it's pie in the sky but I would
12 bring you back to what I said earlier. This is
13 a voluntary role, this is a "Dear Neta, will you
14 please", and I think that's how that happens or at
15 least has happened to date. I am not saying that's 11:14
16 ideal. To date you get a phone call completely out of
17 the blue saying we really need somebody get senior and
18 away from the main hospital to deal with something. I
19 mean, all of the cases in which I was either Case
20 Investigator or Case Manager were outside of my 11:15
21 Directorate, so they are all cases where I'm felt to be
22 very independent. So this is a phone call. This is
23 usually a lengthy phone call but a phone call
24 nonetheless.

25 49 Q. Yes. I'm not sure we need to go through it all. You 11:15
26 summarise in 1.6, 1.7 into 1.8, the kinds of things
27 that you were told. You were advised that issues had
28 been first raised by clinical and non-clinical managers
29 with Mr. O'Brien in March 2016 in relation to his areas

1 of practice, or areas of his practice.

2
3 were you clear at an early stage that, in fact, the
4 issues of concern predated March 2016, went back some
5 several years? 11:16

6 A. I was aware that -- well, I don't know if it was an
7 assumption or that I was told -- but I believed that
8 issues had arisen or had been brought to the attention
9 of managers in 2015 such that there was a more formal
10 approach to Mr. O'Brien in 2016. That was the first 11:16
11 more formal approach. Prior to that, I was told that
12 there had been issues through 2015 which were raised
13 informally. I wasn't aware of it being raised or an
14 issue prior to '14, '15 maybe; certainly '15. I was
15 aware issues had arisen, you know, clearly had arisen 11:16
16 in 2015 and possibly before that.

17 50 Q. Mm-hmm. You were provided with paperwork and we will
18 come on and look at that paperwork in a moment. You
19 were told about an ongoing or a recently concluded,
20 probably, Serious Adverse Incident? 11:17

21 A. Yes. I'm not sure if that was concluded when
22 I started. I don't believe it was. I think it was
23 started in December '16.

24 51 Q. I think perhaps you are unsighted on the facts but it
25 was to be signed off in March 2017, having been 11:17
26 investigated through 2016?

27 A. I wasn't aware it had been completely signed off at
28 that stage. I was aware Mr. O'Brien wasn't formally
29 aware of the outcome of it.

1 52 Q. Yes. You were informed that Mr. Weir had been the
2 previous holder of the Case Investigator role but you
3 were being asked to come in in his stead?
4 A. Yes.
5 53 Q. In terms of that, you have explained -- I think it's at 11:18
6 1.11. Yes, on down the page -- over the page, I should
7 say -- that there was a concern that he might have been
8 required to be interviewed and, therefore, that was the
9 reason he should step aside. Who told you that, can
10 you recall? 11:18
11 A. Dr. Wright told me that in a phone call, and then
12 Dr. Wright had directed me to speak to Dr. Khan and to
13 Mrs. Hynds. I did so and they also advised me of the
14 same, that Mr. Weir -- and Mr. Weir was a clinical
15 director and was Mr. O'Brien's clinical director at the 11:18
16 time.
17 54 Q. You were also advised -- this is paragraph 1.10 -- that
18 Mr. O'Brien had been the subject of an immediate
19 exclusion from work, that it was felt that there was
20 a case to answer but that the immediate exclusion was 11:19
21 lifted, it being felt that a clear management plan put
22 in place might address the difficulties?
23 A. Yes, I was aware of that.
24 55 Q. In terms of the actual issues that were to make up the
25 terms of reference, did you get the detail of that from 11:19
26 Dr. Wright?
27 A. I believe in the phone call, Dr. Wright may not have --
28 I don't believe he went through the terms of reference
29 and the sort of A, B, C sections of them, but I believe

1 he outlined in general there were four terms of
 2 reference and what they related to. I was told that in
 3 the phone call, yes.

4 56 Q. Your appointment towards the end of February is the
 5 suggestion, you haven't given us a precise date for
 6 that, but your appointment was, if we factor in the
 7 normal time scales as suggested by the MHPS

11:20

8 arrangements, was coming almost eight weeks after
 9 a decision had been taken to pursue a formal MHPS
 10 investigation. Did you appreciate that? Did you
 11 appreciate that, if you like, the normal time scales
 12 had already expired by the date of your appointment?

11:20

13 A. Well, I appreciated that there had been a delay in the
 14 decision-making in terms of replacing Mr. Weir with me.
 15 I was aware that that decision, that the decision to
 16 progress an investigation, had been made sometime
 17 earlier. I was aware of that and I knew that from the
 18 e-mails as well that then subsequently arrived.

11:21

19 57 Q. Is there any discussion in your experience at the point
 20 where you are appointed as an investigator, that this
 21 four-week time limit - save in exceptional
 22 circumstances to give it its full read-out - is there
 23 any discussion of the importance of trying to meet that
 24 expectation or, if the expectation can't be met to the
 25 letter, that we really have to try to do this within
 26 the shortest time possible, or does that discussion
 27 simply not happen in your experience?

11:21

28 A. I don't believe Dr. Wright mentioned timeframes in the
 29 phone call. I did have telephone contact with Dr. Khan

11:21

1 and I believe I may have said, look, there's no way we
 2 are doing this in four weeks because it was perfectly
 3 clear from the information by e-mail that I had been
 4 provided with that this was a far-reaching, complex
 5 investigation. I think I was provided with a list of 11:22
 6 sort of six or seven witnesses that Mr. Weir, I think,
 7 had maybe put together. It was perfectly clear to me
 8 that that was just a small portion of people who would
 9 need to be interviewed. So I believe, and I do
 10 apologise but it may have been a flippant comment to 11:22
 11 Dr. Khan, that there was just no way that this
 12 timeframe was -- I mean, I felt the timeframe was
 13 ridiculous.

14 58 Q. Yes. I suppose my question is, and it's a general
 15 question, it goes even beyond this case and it's 11:23
 16 something the Inquiry will be thinking about, I
 17 suppose, this MHPS process inserts four weeks, save in
 18 exceptional circumstances, into its code, and yet you,
 19 as a relatively experienced investigator, are saying
 20 none of my investigations could have been done in that 11:23
 21 period of time. So, I suppose when you think about it,
 22 the draftsperson of that MHPS code is no doubt thinking
 23 there are good policy reasons - whether it's Patient
 24 Safety, whether it's the clinician's interests itself,
 25 the interests of the organisation - to get these things 11:23
 26 done in an expedited form, but you are saying just not
 27 possible?

28 A. I think, as I have said earlier, Mr. Wolfe, if there
 29 are patient safety concerns and if you are aware that

1 those are the subject of the investigation, well, then
2 you raise those immediately and say look, hold on, you
3 know, we need to address that immediately. I suppose
4 the analogy that I might use is that if we have
5 a Serious Adverse Incident in home treatment, for 11:24
6 example, that Serious Adverse Incident will go through
7 a review process, quite rightly, but we don't wait for
8 the review process. If something happens at a weekend,
9 at the next ward round on Monday or Tuesday I will
10 bring the team together and I will say - excuse my 11:24
11 language - what the hell happened, is there something
12 we have missed? what can we do differently? what
13 needs to happen here, what needs to change, even before
14 the SAI Review happens. The SAI Review is a formal
15 process undertaken by somebody else and that will take 11:25
16 a process and a period of time. But we need to fix --
17 if we think there's an obvious glaring issue, that
18 needs to be fixed now.

19
20 I think the same applies to Maintaining High 11:25
21 Professional Standards. If there's clear clinical
22 issues, then those need to be addressed. I was told --
23 I understood that there was a period of exclusion;
24 that, you know, patient issues/safety issues were
25 looked at; it was felt appropriate for Mr. O'Brien to 11:25
26 return to work after the four-week exclusion period;
27 and I was told that the main issues were in relation to
28 administrative processes, albeit that has an impact on
29 patient outcome, but there's an action plan in place.

1 So, whilst ideally these investigations should be done
 2 over a short period of time to ensure patient safety,
 3 if those are being managed anyway, and you are trying
 4 to make sure that you are fair to the subject of the
 5 investigation and trying to get interviews with 11:26
 6 witnesses who have -- I mean, I am saying I had
 7 competing demands; Mrs. Hynds had very many, probably
 8 more, competing demands. Other people being
 9 interviewed had all sorts of competing demands. I mean
 10 these are senior managers who have 101 other things 11:26
 11 going on. So, it was very difficult to get people
 12 together, and not just difficult, I think I have said
 13 in my statement impossible to do it in that time frame.

14 59 Q. What you are describing, whatever the rationale is for
 15 the four weeks, and it may be in most cases, patient 11:26
 16 harm is removed as being an issue because structures
 17 and safeguards are put in place. But the interests of
 18 Mr. O'Brien, he is a practitioner who is concerned, no
 19 doubt, and emotionally involved in this process and
 20 it's hanging over his head, for various reasons, for 15 11:27
 21 months, 18 months or whatever the precise timeframe is.
 22 What you are describing is an acceptance on the part of
 23 the Trust that it will just take however long it will
 24 take. There is actually nobody sitting and having
 25 a discussion with you, saying, right, how are we going 11:27
 26 to get this done in three months?

27 A. No.

28 60 Q. On the 2nd March, it appears, certainly from my reading
 29 of the material, that you receive a large number of

1 documents. This is your first, I suppose, detailed
2 briefing of what all of this is involved. Can we just
3 bring up that e-mail, please, TRU-283049. This is
4 Mrs. Hynds sending you -- if you could just look at the
5 attachments. If you look at the attachments, you can 11:28
6 see that you received this document - I don't mean that
7 pejoratively - of a lot of the background material. It
8 seems on my reading that, about two-thirds of the way
9 down, letter to A O'Brien from Eamon Mackle, 23rd of
10 March 2016, that's the earliest document in the 11:28
11 sequence. But you can see that many of the relevant
12 documents are provided to you, particularly those
13 documents that have been generated as a result of the
14 Oversight Committee decision on the 22nd December to go
15 with a formal investigation. 11:29

16
17 were you left to read that material yourself without
18 further orientation as to the issues?

19 A. I spoke to Mrs. Hynds. I think I spoke to Mrs. Hynds
20 before this e-mail arrived, who advised me that she'd 11:29
21 be sending me lots of different things to read and if
22 I needed any more sort of information about it, to
23 contact her. So I spoke to her before this and then
24 I spoke to her in a more lengthy conversation after
25 this. I mean, I had many meetings with Mrs. Hynds, 11:30
26 both in person and by -- and lots and lots of
27 conversations on the phone.

28 61 Q. Mm-hmm. In terms of Mrs. Hynds, she was appointed to
29 the process before your involvement; isn't that right?

1 A. Yes, that's correct.

2 62 Q. How did you see her role and your relationship with her
3 in terms of the division of labour for the conducting
4 of this investigation?

5 A. With no disrespect intended, my view was I was the Case 11:30
6 Investigator, Mrs. Hynds was there to assist. In terms
7 of gathering information, taking notes through
8 interviews, maybe pointing out if there were any areas
9 that I had missed, for example, but the interviews, for
10 example, and the pulling together. -- for example, 11:31
11 Mrs. Hynds, you know -- I undertook the interviews;
12 Mrs. Hynds would have typed them up, for example,
13 a first draft, and then she would have sent them to me
14 and then I would have corrected or made changes or
15 whatever and sent them back to her. She would have 11:31
16 done all the administrative stuff in relation to
17 sharing them with witnesses and gathering them together
18 and things like that. Mrs. Hynds would have done all
19 the sort of e-mailing people about audits and
20 information and those sorts of things, so she did a lot 11:31
21 of that administrative stuff that is imperative to an
22 investigation as complex as this.

23

24 I was the Case Investigator, she was my -- when I say
25 assistant, that sounds terrible but she was there to 11:31
26 assist me as Case Investigator. That's how the
27 relationship was. And she had carried out that role
28 previously.

29 63 Q. So unequivocally you led the investigation. You were

1 the investigator and she was in the support role?

2 A. Yes, yes.

3 64 Q. Just going back to this document, is that again typical
4 -- perhaps there's no typical MHPS investigation but in
5 your experience is that the way it's done, you received 11:32
6 the background documents and are invited to get on with
7 reading them and orientate yourself, perhaps with some
8 input from HR, and is that necessarily a helpful way to
9 do it?

10 A. I suppose investigations I have been involved with 11:32
11 before, I have been the Case Investigator from the
12 beginning. I suppose some of this information
13 I wouldn't have been provided with in previous
14 investigations because I started, you know, at
15 a different point. I prefer personally to read what's 11:32
16 happened before and orientate myself and then have
17 a meeting to discuss. So I would have met with
18 Mrs. Hynds and with Dr. Khan after I had sort of
19 understood what had happened to date because I think
20 rather than -- you know, this is - certainly for 11:33
21 Dr. Khan and myself - this is eating into clinical
22 time. This is the sort of thing that I would read
23 outside of work hours, you know, this is not something
24 you read inside of work hours because you don't have
25 time. But the meeting with Dr. Khan, for example, is 11:33
26 something that does happen generally within work hours.
27 You divide out the work that you can do that doesn't
28 eat into work hours and then the work you need to do
29 within work hours. My preference is to read it first

1 and then have an understanding of what it is I am being
2 asked to do and then meet with Mrs. Hynds and Dr. Khan.
3 Although I have to say, most of my telephone
4 conversations with Mrs. Hynds were probably outside
5 work hours, hers and mine.

11:33

6 65 Q. Just before we perhaps take a short break this morning,
7 I just want to ask you about something that appears
8 obviously missing from this list of documents. The
9 23rd March 2016 letter is clearly briefed to you. We
10 can bring that up on the screen. If we go to
11 AOB-00979. You will have read that letter as part of
12 your preparations. Were you advised at any point as to
13 the background to this letter?

11:34

14 A. I spoke to Mrs. Hynds, and I think Dr. Khan may have
15 been present for that as well, but I am not sure
16 because this was a meeting and it wouldn't have --
17 sorry, I can't be sure about that, who explained the
18 background to that letter and some of the difficulties
19 in relationships in terms of management with
20 Mr. O'Brien.

11:35

21 66 Q. Would you have been aware, for example, that the
22 Medical Director, Dr. Wright, had been approached by
23 Mrs. Trouton and Mr. Mackle to alert him in January
24 2017 that there were problems with Mr. O'Brien's
25 practice, and this led to the meeting and the
26 production of this letter?

11:36

27 A. January '16?

28 67 Q. January '16, sorry, yes.

29 A. I was aware that there had been meetings with senior

1 managers and I think I probably assumed with the
2 Medical Director, because if it's an issue which
3 involves a very senior doctor, the Medical Director is
4 usually involved. So I would have been aware that
5 there had been meetings which had led to this was an 11:36
6 outcome from a previous meeting.

7 68 Q. Yes. You comment upon this in your report, about this
8 letter not then generating any further action so far as
9 you were aware. You have described that, and we will
10 look at it later, as being a missed opportunity. When 11:36
11 we look at that list of documents that you received as
12 part of your briefing from Siobhán Hynds, there doesn't
13 appear to be any reference to the oversight meetings
14 that took place during 2016, of course until the 22nd
15 December meeting that led to the decision to have 11:37
16 a formal investigation. Nor, for that matter, do you
17 see in what is briefed to you the advice that NCAS
18 provided to the Trust in September 2016. Is it fair to
19 say that you didn't spot that as an issue at the time?

20 A. I didn't spot it as an issue at the time, that's 11:37
21 correct. I was aware that NCAS had been approached and
22 that that was one of the reasons why the investigation
23 was to be progressed under Maintaining High
24 Professional Standards as opposed to a more informal
25 route. But I was not provided with any written 11:38
26 correspondence or advice from NCAS.

27 69 Q. If we just briefly look at the NCAS advice that came in
28 in September 2016, AOB-01049. Again, conscious that
29 you have never seen that document; is that fair?

1 A. That document was included in the bundle that I was
2 provided for the purposes of this Inquiry --

3 70 Q. Yes, of course.

4 A. -- but I have not seen it prior to that.

5 71 Q. You didn't see it as part of your investigation?

11:38

6 A. No.

7 72 Q. Just scrolling down the page, this is the first advice
8 the Trust received in the context of Mr. O'Brien's
9 alleged shortcomings and what was to be done about
10 that. Just going over the page, the Trust is advised
11 that:

11:39

12
13 "The problems with the review patients and the triage
14 could just be addressed by meeting with the doctor and
15 agreeing a way forward. We have discussed the
16 possibility of relieving him of theatre duties in order
17 to allow him the time to clear this backlog. Such
18 a significant backlog will be difficult to clear and he
19 will require significant support."

11:39

20
21 In terms of your approach to your investigation, did
22 you know or have any appreciation that NCAS was
23 advising the Trust that, in terms of dealing with some
24 of the issues that were of concern, Mr. O'Brien would
25 require, and NCAS was endorsing, the need to provide
26 him with appropriate support?

11:40

27 A. No, I wasn't aware of this NCAS letter or of the
28 recommendations. I was aware that NCAS had been
29 approached. I have thoughts on providing additional

1 support. I am not sure if it's appropriate for the
2 Panel to hear.

3 73 Q. What I want to ask you is now that you see this kind of
4 thing - and we will come on to look at why you included
5 paragraph 5 in your terms of reference in just a short 11:41
6 time - but given that you did include paragraph 5, was
7 it not important that you had a full understanding of
8 what transpired during 2016?

9 A. I felt I had been provided with enough information. I
10 mean, terms of reference number 5 is about what 11:41
11 management did in terms of if they knew that there were
12 problems and how they tried to deal with them. So, I
13 suppose I was looking specifically at that. I wasn't
14 aware of this letter from NCAS. My understanding was
15 that NCAS had suggested that -- 11:41

16 74 Q. There was, and this Inquiry knows, a sequence of events
17 in or around the period between August and the end of
18 the year when the decision was taken in December to
19 have a formal investigation. I suppose what I wish to
20 look at with you in the course of this is, having 11:42
21 regard to the term of reference which you included at
22 5, should you have been able to investigate what
23 happened during those six months, there was a series of
24 oversight meetings, there was NCAS advice, there was
25 a conversation between the Medical Director and the 11:42
26 Chief Executive, the Medical Director and the Director
27 of Acute Services, Mrs. Gishkori, and none of that
28 seems to have featured as part of your investigation?

29 A. To my mind, term of reference number 5 was added by me

or suggested by me to the Case Manager. Really, what I believed I was looking -- the reason I raised it is because what I wanted to know is what had happened prior to sort of 2016 or the first half of 2016, I suppose. And I had no knowledge of what happened between August and December so I was really -- to my mind, I added that as well, what happened earlier in 2016, were there attempts to try and deal with it; what happened prior to 2016, were there attempts to deal with it? So I had no knowledge of what happened towards the end of 2016.

11:43

11:43

75 Q. Yes. Okay, we will come back and that will be one of the first areas we will look at.

CHAIR: 12 o'clock.

MR. WOLFE KC: 12 o'clock.

11:44

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

76 Q. MR. WOLFE KC: In terms of the e-mail we just looked at from Mrs. Hynds to yourself, 2nd March, there's just a brief point I want to draw your attention to. If we could have it back up, TRU-283049, and scrolling down. She suggests to you you should give Mr. O'Brien a call to introduce yourself, as the Case Investigator and to reassure him "we are moving forward with the investigation".

12:01

12:02

Did you speak to Mr. O'Brien?

A. I believe I did so but I can't completely recall.

1 I expect I did so because it would normally be my --
2 that's a normal thing that I would do in this case of
3 events. I believe I did so but I can't be entirely
4 sure of that.

5 77 Q. Have you any record of it?

12:02

6 A. No, I haven't. I haven't retained diaries, for
7 example, from my time in the Trust.

8 78 Q. Have you any memory of what was discussed?

9 A. No. I believe I did and I would have just said, look,
10 my name is Neta Chada, I have taken over as the Case
11 Investigator and we will be arranging to meet you and
12 I just wanted to touch base and say hello. Literally,
13 it wouldn't have been any discussion about the
14 procedure or about the investigation as such, it would
15 literally have been a courtesy sort of introduction
16 type call, so it wouldn't have been in any great detail
17 at all.

12:03

12:03

18 79 Q. So you don't recall a discussion of substance, more an
19 introduction?

20 A. Yes. I don't recall -- no, I mean, I know there
21 wouldn't have been any detailed discussion. The normal
22 thing I would do in this situation is introduce myself
23 out of courtesy and say, look, I have been asked to
24 take over, I am sure I'll meet you in due course and
25 I do appreciate this is difficult. You know, that type
26 of conversation but a very brief conversation.

12:03

12:04

27 80 Q. We know that you wrote to him through I think
28 Mrs. Hynds in June, suggesting a meeting, a substantive
29 meeting for the end of June, before the holidays. Are

1 you sure that that wasn't your first contact with him?

2 A. I don't believe so. I mean, I think if Mrs. Hynds had
3 suggested that I make a phone call, I think I probably
4 would have. I believe I would have. I know it's other
5 circumstances that would have been my normal course of
6 events, I believe I would have. I say by means of an
7 introduction but I absolutely can't be categorical
8 about that.

12:04

9 81 Q. Yes. You have said in your witness statement, dealing
10 with the terms of reference, that when you were
11 appointed - this is paragraph 1.12 of your statement,
12 if we could have it up on the screen. WIT-23761.
13 Bottom of the page, please:

12:05

14
15 "The Terms of Reference had already been formulated and
16 were shared with me".

12:05

17
18 And you go on at paragraph 120:

19
20 "When I took over as Case Investigator I believed I was
21 advised of four Terms of Reference as outlined in the
22 Trust's discovery documents. However as the
23 information was being gathered, it became clear to me
24 that a further term of reference needed to be
25 considered. ToR5 was to determine to what extent any
26 of the above matters" - that's the first four elements
27 of the terms of reference - "were known to managers
28 within the Trust prior to December 2016 when the
29 outcome of the SAI was shared and to determine what

12:05

12:06

1 actions were taken to manage any concerns".

2
3 I just want to look at the terms of reference for
4 a moment in this context. Let's look at the NCAS case
5 on this issue, WIT-41394. Scroll down, please. If we 12:06
6 go to 41407, sorry. It's understood that the Trust
7 guidelines are to be read in the context of this NCAS
8 document. Just if we scroll to the bottom of the page,
9 thank you. It says that:

10 12:07
11 "In terms of finalising the terms of reference, these
12 will have been agreed in outline at the time of the
13 decision that was made to carry out the investigation
14 but some final drafting may be needed. The Terms of
15 Reference as finally drafted should be agreed by the 12:07
16 organisation's relevant decision-makers. The Case
17 Manager and investigators appointed to carry out the
18 investigation would not normally be involved in this
19 process".

20 12:07
21 If we just scroll down and go over the page, please.
22 It says:

23
24 "It may be that as the investigation progresses, the
25 Terms of Reference are found to be too narrow or that 12:08
26 new issues emerge that warrant further investigation.
27 In such cases the investigator should inform the Case
28 Manager who should seek the agreement of the
29 responsible manager or the decision-making group to

1 a widening of the terms. Such requests should be
2 decided on promptly so that the investigation is not
3 delayed", et cetera.

4
5 I want to ask you about the process by which ToR5 was 12:08
6 added. Is it fair to say that it started with you?

7 A. That's my memory of it. I believe it went through the
8 information that I was provided with and felt that for
9 fairness and for an understanding of what had happened
10 to date, that a review or some information from people 12:09
11 about what had happened prior to this, should be
12 considered.

13 82 Q. We will come on to the rationale in a moment. I just
14 want to look at some e-mails in this context.
15 TRU-283121. Highlight the bottom, please. I will 12:09
16 check the reference. So, if we just go back a page,
17 please, and TRU-283121. This is the 3rd March, shortly
18 after your appointment. Siobhán Hynds is sending to
19 Dr. Khan, the Case Manager, copying you into draft:

20
21 "Terms of Reference for your agreement. These need to
22 be issued to Mr. O'Brien when agreed".

23
24 The last line is irrelevant for present purposes. If
25 we go to the next page, please, 283122, and so we can 12:11
26 see there are four matters to be investigated. Term of
27 reference 1 concerns the issue of triage. ToR 2
28 concerns the issue of patient notes being stored at
29 Mr. O'Brien's home. 3 is in relation to delay in

dictating outpatient clinics. 4 is to determine if Mr. O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their clinical priority.

That appears what you were sent at the outset. Then, on the 15th March, if we could look at TRU-283129, Siobhán Hynds writes to Ahmed Khan and copies you in.

"Please find attached final draft of ToR for the AOB investigation. Please also find the proposed witness list to date although it is likely Dr. Chada will need to speak to others. Once we have others determined, we will update Mr. O'Brien. If you are in agreement with the draft at ToR, can you please share with Mr. O'Brien. Dr. Chada and are starting the first of our meetings with witnesses this week."

If we scroll down again, we can see that that's the witnesses that have been agreed at that point. Then the terms of reference - scroll down through them, please - they have been expanded and they now add number 5. So, taking into account the e-mail that has been sent, there seems to have been some process undertaken perhaps between yourself and Mrs. Hynds to add a fifth, and that is being sent through to Dr. Khan for his agreement. Now, can you recall the process that was undertaken to come up with the fifth?

A. I would have -- after I had received the background

1 information and had read through it, I met with
2 Mrs. Hynds over a period of time, I'm sure over that
3 week. I felt that one of the things we needed to look
4 at is what management were aware of. So I suggested
5 that this fifth term of reference should be added if 12:14
6 Dr. Khan and the decision-makers were in agreement with
7 it. So I asked Mrs. Hynds to share that with Dr. Khan
8 to see. This was essentially a draft to see if he was
9 happy enough to progress with that.

10 83 Q. what was your understanding of the process for agreeing 12:14
11 any revisions or amendments to the terms of reference
12 at that time?

13 A. Normally, terms of reference are passed down to a Case
14 Investigator, and it's not up to the Case Investigator
15 to agree or to outline terms of reference. I think 12:15
16 there's good reason for that. I mean, as the NCAS
17 document outlines, you can't go on a fishing exercise.
18 But, however, having read through the information that
19 I had been provided with, I felt that it was important
20 that we understood what had taken so long to get to 12:15
21 this point. I felt that that term of reference was
22 relevant and fair to Mr. O'Brien as well.

23 84 Q. what did you understand Dr. Khan should be doing with
24 your suggestion?

25 A. well, I mean, I don't think -- the Case Manager is not 12:15
26 really supposed to set the terms of reference either,
27 but my understanding is that Dr. Khan either takes that
28 to the people who did set the terms of reference, which
29 would have been the decision-making group, or, if it

1 was in his remit to agree that, then it was up to him
2 to agree it. I mean I asked for permission to add it
3 and that's what I felt my role was.

4 85 Q. The e-mail was asking for his agreement, whereas, in
5 fact, the advice seems to suggest that it's within the 12:16
6 remit of the Trust decision-making group, which, in
7 local parlance, would have been the Oversight group.

8
9 Did you have an understanding that an Oversight group
10 had been in command of this case and that that's where 12:16
11 the issue of the terms of reference should have gone?

12 A. I knew that there was an Oversight group in command, in
13 charge in overseeing this, and that there had been
14 a scoping exercise done and that the terms of reference
15 had been set by that decision-making group. I suppose 12:17
16 I didn't consider whether the Oversight Group should
17 specifically have agreed this term of reference. I
18 suppose my view was my chain of command, if you like.
19 My line of communication was with Dr. Khan rather than
20 anybody outside of that, and therefore I shared with 12:17
21 Dr. Khan.

22 86 Q. In terms of the communication with Dr. Khan, did you
23 discuss this with him or did you get a green light back
24 from him?

25 A. I believe that -- I believe that there was a green 12:17
26 light back because the term of reference was adopted
27 and shared with Mr. O'Brien, as far as I'm aware. I
28 don't formally -- I don't remember specifically being
29 told yes or no. I think the e-mail was sent with,

1 look, if you agree with this, then go ahead and do
2 something with it and if you don't, well, I think --
3 I didn't say if you don't but the implication was to my
4 mind, if you don't, come back and tell me.

5 87 Q. Yes. So you got nothing affirmative but you got 12:18
6 nothing to the contrary back from him?

7 A. Yes, so I felt that that was an indication that it was
8 an appropriate term of reference to consider.

9 88 Q. In terms of the terms of reference, the term that you 12:18
10 have added and you took to be approved by Dr. Khan,
11 what was the spark for that? What did you see in your
12 documents that you had been provided with or in the
13 briefing that you had received that caused you to think
14 this is an important issue to look at?

15 A. I think originally there was the letter from Mr. Mackle 12:19
16 back, who was, I think, the Associate Medical Director
17 at the time for this Service in March 2016. I suppose
18 I sort of thought, look, somebody has tried to do
19 something. Prior to that letter being sent, there must
20 have been things happening before that, you know. The 12:19
21 implication was that we have tried to raise these
22 things informally was my understanding, and I sort of
23 thought well look, what has been done? So that was
24 really the start of it, was that letter from Mr. Mackle
25 which I felt this seems to suggest that the Trust knew 12:19
26 that there was something not quite right with
27 administrative processes at that stage.

28 89 Q. Just looking at how the term has been framed, it takes
29 as its lookback date December 2016, that being the date

1 when there was a formal MHPS investigation decision
2 made by Oversight. It's asking, I suppose, what was
3 known by line managers prior to that date and what did
4 they do about the concerns that they were aware of.
5 It's as simple as that, really?

12:20

6 A. Yes.

7 90 Q. Was the spark for that a concern perhaps that things
8 might have been done differently or better in terms of
9 the management of these issues?

10 A. Yes.

12:20

11 91 Q. Had you, in how you imagined this might be
12 investigated, a view that you would want to understand
13 the management knowledge and the decision-making that
14 they took in light of the knowledge of the concerns?

15 A. Yes. I suppose I wanted to understand what it was that 12:21
16 managers were aware of; what they had done to try and
17 manage that. From Mr. O'Brien's point of view,
18 I wanted to understand what support or assistance he
19 had been given to manage concerns. Or how I suspected
20 that, from the correspondence that I'd seen - I knew, 12:21
21 not suspected - I knew Mr. O'Brien wasn't happy that
22 this had been progressed to a more formal investigation
23 on the Maintaining High Professional Standards, and
24 I wanted to make sure that, you know, there weren't
25 earlier opportunities to have acted and to have done 12:22
26 something maybe in a more informal way. So, some of it
27 was about trying to gather that information in terms of
28 understanding what the Trust knew, what they did, and
29 what Mr. O'Brien's view about how he was managed was.

1 92 Q. In terms of your approach overall, you've indicated, I
2 suppose, that because of the pressures on yourself with
3 other commitments, you would worry about, I suppose,
4 the overall robustness or the overall quality that you
5 would be able to bring to this exercise. 12:22

6 Notwithstanding that, did you have it in mind that you
7 would need to adopt a fairly forensic approach in terms
8 of working through, perhaps on a chronological basis,
9 perhaps by imagining what witnesses are at all relevant
10 to each term of reference, how this would be done? 12:23

11 A. Well, you try and approach an investigation like this
12 as transparently, as inclusively, as completely as you
13 can. However, the use of the word "forensic" is
14 interesting because did I bring a forensic approach to
15 this? Doctors are not either lawyers or detectives. 12:23
16 You know, that's just not what we do and how we
17 function and how we deal with people. You know, an
18 example that I sometimes give in terms of medico-legal
19 approaches is that if a patient goes to a GP and says I
20 have a sore tummy, the GP doesn't say I don't believe 12:23
21 you; or my foot is still sore after an accident. The
22 GP accepts that.

23
24 I don't believe that -- I don't believe I could say
25 that I brought a forensic approach to this. I believe 12:24
26 I brought a transparent and inquiring approach. The
27 nature of the questions and the nature of the
28 investigation was an inquiring one rather than
29 a forensic one.

1 93 Q. I suggested to you, and I will maybe come to this in
2 another way later, but I have suggested to you already
3 this morning that some of what might be regarded as
4 important materials from 2016 didn't reach you - the
5 screening report of Mr. Gibson, NCAS advice, minutes of 12:24
6 Oversight Committee meetings during 2016 - which all
7 speak, I would suggest, to the knowledge and
8 understanding of managers around these concerns, and
9 all speak to the actions that they did or didn't take.
10
11 when I tell you about the existence of those pieces of
12 information in light of your development of term of
13 reference 5, would you accept that either you didn't
14 adequately investigate term of reference 5 to get to
15 those materials and to get to those issues, or, 12:25
16 alternatively, relevant managers were holding back?
17 A. I would disagree with both of those.
18 94 Q. Yes.
19 A. I don't think either of those apply. I think those
20 issues were, as far as I was concerned, part of the 12:25
21 investigation, I mean part of the process that led to
22 this investigation. Term of reference 5 was actually
23 looking at things that had happened more historically
24 from that point of view. That was my reason for
25 putting in term of reference number 5. Anything that 12:26
26 was part of that, of the process that was started, was,
27 in my view, part of the process.
28
29 By that point, by that point in late autumn 2016, this

1 process of what are we going to do, does this need an
 2 investigation, what's the level of investigation; as
 3 far as I'm concerned that's part of the process. I
 4 suppose my real interest in including term of reference
 5 number 5 was what had happened before that, really. My 12:26
 6 view was that was part of the process. I expected that
 7 the Case Manager would have knowledge of that, so
 8 I never had intended to include and never considered
 9 including anything that was already part of that
 10 process. 12:26

11 95 Q. What process?

12 A. Of moving towards a Maintaining High Professional
 13 Standards investigation and appointing a -- it being
 14 suggested that a Case Investigator was appointed and
 15 things like that. 12:27

16 96 Q. So you set the temporal provision, December 2016, you
 17 are looking back from there. Are you telling me that
 18 you had no interest, for the purposes of ToR 5, in
 19 understanding what flowed from the 23rd March letter;
 20 the advice that was given around next steps from NCAS; 12:27
 21 the decisions taken by managers, whether they were
 22 Mr. McAllister, Mr. Weir, Mrs. Gishkori, the Medical
 23 Director, the Chief Executive? None of that was of any
 24 interest to you for the purpose of ToR 5?

25 A. The gap between the letter in March 2016 and things 12:27
 26 that happened much later on that year was of interest
 27 to me for terms of reference number 5, but it was my
 28 view that once, if you like, the ball was rolling with
 29 information being sought from NCAS, decisions made to

1 exclude, I felt once those things were in process in
2 the autumn of 2016, my interest for term of reference
3 number 5 was what was done about this previously? Yes,
4 I mean that's really what I was thinking of when
5 I thought of term of reference number 5. I'm not 12:28
6 saying they are not of interest, I'm saying that's not
7 what I was considering when I suggested term of
8 reference number 5.

9 97 Q. If Mr. O'Brien, in the view of NCAS, should be
10 supported by his management team to address what 12:28
11 management saw as shortcomings, and if they knew all of
12 that and didn't act on it, is that not four-square
13 within your ToR 5?

14 A. As I have said, Mr. Wolfe, when I wrote ToR 5 or when
15 I considered ToR 5, it was really to look at what had 12:29
16 been done prior to this process. When I say "this
17 process", I do mean NCAS being involved and the Medical
18 Director being involved and all of those things that
19 sort of started a roll-on from the autumn, because
20 I think once that roll-on started, things moved on. 12:29
21

22 So when I wrote this -- I mean you are asking me about
23 did it fall within it. When I wrote it, I was really
24 interested in what had been done prior to all of this
25 to manage the situation before we got to this process. 12:29
26 As I said, I knew that NCAS had recommended that things
27 moved on to a Maintaining High Professional Standards
28 investigation. I wasn't aware of any of the rest of
29 the NCAS correspondence. I mean, I didn't know it and

1 therefore couldn't be referring to it, or...

2 98 Q. Well, the NCAS advice that you did receive, which was
3 dated 28th December 2016, did refer to the fact that
4 NCAS had been contacted before and had spoken to
5 Mr. Gibson.

12:30

6
7 I suppose the point I reach with you on this issue is
8 you are dismissing what I have just outlined as not
9 being relevant to ToR 5 because that was part of the
10 process. So, everything from March to the end of the 12:30
11 year, you are seeming to suggest, was not of direct
12 interest to ToR 5 because it was part of that process.
13 But is it not fair to suggest to you that you didn't
14 even gather the information around the issues I have
15 outlined, so it wasn't even known to you? So how could 12:31
16 you dismiss what was not known to you? Yes?

17 A. What I didn't know, I didn't know. As I say, my view
18 was that was part of a process which had already
19 started. I was much more interested in what supports
20 and what actions had been taken prior to that. I 12:31
21 suppose not really March but what flowed from the March
22 letter; did something happen after the March letter?
23 Did somebody support Mr. O'Brien? Was an action plan
24 put in place? I was interested in all those things.

12:31

25
26 Things that happened much later in the year, so from
27 the autumn onwards, I felt was the beginning of what
28 this investigation was about. Therefore, I didn't
29 regard that as part of term of reference number 5.

1 99 Q. Did you know that there had been an Oversight meeting
2 on the 13th September 2016?

3 A. I knew that there had been Oversight meetings and
4 I knew there was a meeting in the autumn. Without
5 referring to whether I was provided with information
6 about that, Mr. Wolfe, I can't answer that question.

12:32

7 100 Q. I can't see where you were provided with any
8 information in relation to events after March 2016.
9 So, it rather begs the question why that information
10 didn't come to you, or, in the alternative, why you
11 didn't ask for a timeline of events after March 2016 so
12 that you could begin to break down what was known to
13 managers after that event, the issuing of the letter to
14 Mr. O'Brien and what they knew?

12:33

15 A. I think I was given -- I mean, I stand to be corrected
16 but I believe I was given an overview timeline of
17 things that had happened -- of some of the things, by
18 the sound of it, that had happened in the autumn of
19 2016. I believe that I was given some information
20 about that.

12:33

21 101 Q. If we go to your report, there will be set out a
22 timeline. The report is to be found at TRU-00661. If
23 you turn to TRU-00666 and you refer to the March
24 meeting at the bottom of the page, you say that:

25
26 "Eamon Mackle and Heather Trouton met with Mr. O'Brien
27 to outline their concerns in respect of his clinical
28 practice."
29

12:34

1 It was, in fact, Mrs. Corrigan and Mr. Mackle who met
2 with him.

3
4 Over the page, TRU-00667, you outline the concerns that
5 were identified. Then in respect of the period April 12:35
6 to October 2016, you say:

7
8 "During the period April to October 2016,
9 considerations were ongoing about how to best to manage
10 the concerns raised with Mr. O'Brien in the letter of 12:35
11 the 23rd March 2016. It was determined that formal
12 action would not be considered as it was anticipated
13 that the concerns could be resolved informally.
14 Mr. O'Brien advised the Review Team he did not reply to
15 the letter but did respond to the concerns raised in 12:36
16 the letter by making changes to his practice."

17
18 In November you detail that he was on sick leave or was
19 going on sick leave. Then you refer to the ongoing SAI
20 investigation before December when the formal decision 12:36
21 was reached to have a formal MHPS.

22
23 The point I am asking you comes down to this, in
24 essence: You have charged yourself with the task of
25 investigating the knowledge of managers in the period 12:36
26 before December 2016 and the actions that they took.
27 Nowhere in this report is there to be found
28 a description of what managers knew within that period
29 and what action they took. We don't find out how the

1 Oversight Group grappled with the events with the
2 events after March 2016; we don't find out how they
3 might have grappled with NCAS advice. Is that not
4 a shortcoming in your report?

5 A. I don't believe so, Mr. Wolfe. As I have indicated, 12:38
6 you know, I added -- my understanding is that I added
7 term of reference 5 and it was really about how things
8 were managed before things gathered apace and started
9 to happen. So, perhaps an error on my part is that it
10 shouldn't have said December '16, it should have said 12:38
11 before the summer of 2016. You asked me why did I add
12 that term of reference; I added that term of reference
13 because it seemed apparent to me that people spoke to
14 Mr. O'Brien in March '16, and what wasn't apparent to
15 me was what was done as a result of that letter. So 12:38
16 that's why I added the term of reference. It was about
17 that period where I felt maybe something else could
18 have been done, both by the Trust and by Mr. O'Brien,
19 to address those issues. So anything that happened
20 beyond the summer of '16 was, to my mind - and I mean 12:38
21 perhaps I haven't been explicit enough and clearly
22 I haven't in the report - was to my mind out with that.
23 Once the process started, it started.

24 102 Q. Okay.

25 A. And that's not up to me to -- I didn't feel that that 12:39
26 was -- that wasn't my remit to have a look at that.
27 I felt it was about understanding what happened at an
28 early stage, and maybe I should have said that.

29 103 Q. In fairness to you, and I will put it out there now so

1 that you can address it, your report does, of course,
2 go on to say that the failure to address matters after
3 March was a missed opportunity. I will just find the
4 reference. If we go to TRU-00703, you say at the top
5 of the page:

12:40

6
7 "The above issues" - and that was dictation and triage
8 - "were raised in the correspondence in March 2016.

9 However, there appears to have been no management plan
10 put in place at that time and Mr. O'Brien seems to have 12:41
11 been expected to sort this out himself with no
12 arrangements for monitoring or changes to practice were
13 being made and sustained."

14
15 But is it fair to say it's no more than that; you don't 12:41
16 identify the managers concerned with this shortcoming.
17 You feel you didn't need to go to the NCAS advice or
18 ask questions around what was happening in September
19 and October, even if you didn't know directly about the
20 NCAS advice? 12:41

21 A. I mean, as you have indicated, Mr. Wolfe, I do later in
22 the conclusions indicate that management could have
23 taken action at an earlier stage. The investigation
24 was in relation to Mr. O'Brien rather than specifically
25 about the managers. I added that term of reference 12:42
26 because I felt that it was a fair, equitable,
27 reasonable thing to do. But NCAS advice and
28 Maintaining High Professional Standards advices around
29 doctors as opposed to, you know, shortcomings or

1 failings of other people, so I felt that it was
2 important that I highlighted this and then it would be
3 up to somebody else to have a look to see, you know,
4 what else needed to be done.

5
6 I still -- I mean, I accept everything you have said
7 and I still don't think I would have done it
8 differently. I still think I was looking for what
9 assistance was given to Mr. O'Brien after March, you
10 know; who did what in relation to that, and even prior 12:42
11 to that. That's what I was interested in and that's
12 the area that I covered.

13 104 Q. But it's about more than being equitable and fair to
14 Mr. O'Brien, isn't it? This term of reference was
15 formulated by you, assumedly with the approval of 12:43
16 Dr. Khan, in order to get to grips with whether things
17 could have been done better by Trust management in
18 light of the concerns that were identified?

19 A. Yes. And I think my report does highlight that things
20 could have been done better and there were missed 12:43
21 opportunities. I believe I concluded that.

22 105 Q. Although you have said I am looking back from December
23 2016, you, in fact, only looked back so far?

24 A. Yes. I mean, in effect - and I say that and I do
25 absolutely accept, I have said December '16 - I really 12:43
26 only looked back from -- anything that happened from
27 the autumn time to my view was part of this, and I only
28 looked back from before that. Absolutely.

29 106 Q. In terms of setting terms of reference, can I broaden

1 this out as I think it's probably an important issue.
2 The Trust has told the Inquiry through its witnesses
3 that, in 2020, a range of issues relevant to
4 Mr. O'Brien's practice were discovered; the Trust
5 considers those matters to be shortcomings of practice. 12:44
6 This was investigated through a number of processes,
7 including nine SAIs.

8
9 Now, the MHPS investigation set off in 2017 and didn't
10 identify the kinds of issues that were discovered in 12:45
11 2020. The question, I suppose, that arises is should
12 other aspects of Mr. O'Brien's practice have been the
13 subject of MHPS investigation when you took up the
14 reins? In light of your experience across a number of
15 MHPS processes, can you help us at all in terms of the 12:45
16 development of terms of reference; how is that done;
17 could it be done better? The public will want to know
18 why an investigation that took so long under your watch
19 didn't get to find what was there perhaps to be found,
20 and was only found two or three years later? 12:46

21 A. First of all, Mr. Wolfe, I didn't know about the
22 additional issues raised in 2020, I'd already left the
23 Trust by that point. I suppose what I would say is
24 that terms of reference -- so, how this process works
25 is that there is an initial screening process, and then 12:46
26 terms of reference are drawn up and then a Case Manager
27 is appointed and then a Case Investigator is appointed.
28 I have used the phrase earlier but I think it is
29 relevant, this is not a fishing exercise. You know,

1 terms of reference are clearly and specifically and
2 very often precisely written. Really, the Maintaining
3 High Professional Standards document indicates that
4 actually - and I think the NCAS document actually takes
5 that even further, makes it more clear - that you are 12:47
6 not there to start looking at every aspect of
7 a doctor's work, you are there to look at areas which
8 have been specifically raised as an issue.

9
10 However, during the process, if somebody comes along 12:47
11 and says something to you which rings bells, well then,
12 of course it's your responsibility as an investigator
13 to raise that with the Case Manager. I have
14 identified, I have highlighted already that on one
15 occasion that occurred and we raised it. But I was 12:47
16 quite shocked by the findings that came out in 2020
17 because we had no inkling through the investigation -
18 and I understand you will get evidence, you will
19 receive evidence from Mrs. Hynds as well, I expect she
20 will say the same - but I had absolutely no inkling. 12:48
21 In fact, quite the opposite. The information that I
22 was being given by almost everybody was that this was
23 a good clinician who, in fact, was overinvolved; spent
24 too much time with patients; wanted to do advanced
25 triage, you know, look up blood results, look up 12:48
26 imaging, send people off for other investigations, you
27 know, before, you know, progressing to seeing the
28 people, the patients. The information I was receiving
29 was that there were no clinical concerns.

1
2 I mean, the patient outcome concern was to do with
3 administration. You know, if you are not properly, you
4 know, reading triages and putting them into a filing
5 cabinet drawer, well, that has the potential to impact 12:49
6 on patient outcomes. So of course patient outcome was
7 something that we considered in this and we looked at
8 those, at the five cases that were highlighted. But
9 nobody at any point suggested that either there had
10 been any previous or other concerns or that there were 12:49
11 any clinical concerns in relation to how Mr. O'Brien
12 was performing as a clinician.

13 107 Q. I'm not suggesting to you, Dr. Chada, that at the point
14 that you entered the process as an investigator you
15 should have free rein to go wherever you want with the 12:49
16 investigation. I'm talking about the stage before
17 that. You call that stage, quite properly, screening.
18

19 Let's start with the proposition, would you agree with
20 me that what was known to the Trust was that 12:50
21 Mr. O'Brien had shortcomings on the administrative side
22 of his practice which had a clinical or a patient
23 safety dimension?

24 A. Yes.

25 108 Q. I mean that covers the triage issue; it covers the 12:50
26 dictation issue, doesn't it?

27 A. Yes.

28 109 Q. Now, as part of screening, is it not within the gift of
29 the Trust - and it is the people who instruct you so

1 it's the people in the Oversight Group, perhaps, or
 2 it's clinical managers - depending on how it's done and
 3 the Trust may have done it in a way that wasn't
 4 entirely consistent with the process written down.

5 However it's done, would you agree with me that there
 6 is an opportunity, indeed a responsibility, at that
 7 point to sit down and effectively screen the
 8 practitioner's practice to see what it is that should
 9 be investigated?

12:51

10 A. Yes, I think it's part of the screening role to decide
 11 what areas of practice need to be addressed or need to
 12 be investigated.

12:51

13 110 Q. Let's just look at what the NCAS guide says about this.
 14 If we go to WIT-41400. It asks:

15
 16 "What should be considered in making a decision to
 17 investigate? Before deciding whether a performance
 18 investigation is necessary, consider what other
 19 relevant information is available."

12:51

20
 21 Just before that, I beg your pardon, it says at the top
 22 of the page:

12:52

23
 24 "The purpose of screening is to identify whether there
 25 are prima facie grounds for an investigation and if
 26 there are, to set Terms of Reference which are
 27 sufficiently detailed for an investigation to proceed.
 28 It is essential that managers sets aside dedicated time
 29 to address initial screening so it can be completed

12:52

1 properly and quickly".

2
3 Then, at 1.3, it's essentially telling the Trust what
4 could be taken into account as part of screening, what
5 should form part of screening.

12:52

6
7 "This could include clinical or administrative records;
8 serious untoward incident reports or complaints;
9 earlier statements are introduced for people with
10 first-hand knowledge of the concern; clinical audit and 12:53
11 clinical governance data; the views of professional
12 advisers; earlier occupations health reports."

13
14 That's not an exhaustive list. It appears to be
15 suggesting that relevant decision-makers should 12:53
16 carefully think through what it is that should come
17 within the terms of reference of an investigation.

18
19 would you agree with me that if there are
20 administrative-type shortcomings in one area of 12:53
21 a clinician's practice, it would be within the
22 obligations of a Trust and its decision-makers to set
23 the terms of reference wide enough to enable you, as
24 the investigator, to explore whether those
25 administrative shortcomings exist elsewhere? 12:54

26 A. I suppose it's the balance between earlier things in
27 NCAS, which is about not making this so wide that,
28 number 1, the investigation is unmanageable, and number
29 2, that you are just saying I am going to look at all

1 practice and see if I can find something. I think it's
2 about -- my view is that, yes, of course screening
3 needs to be properly carried out, of course it does.
4 But I think if there are specific areas of concern that
5 have been raised by managers or by SAI reviews or by 12:54
6 complaints or by patients, well then, those are the
7 areas, and issues around those areas certainly. I
8 don't think it's a well, let's look at everything.

9
10 I suppose, Mr. Wolfe, and I have said earlier, you 12:55
11 know, Mr. O'Brien's colleagues and managers, certainly
12 who gave evidence to -- who I was involved in
13 interviewing, were certainly very clearly saying that
14 they had no concerns about his clinical practice, you
15 know, other than, you know, the potential for patient 12:55
16 negative outcomes because he wasn't doing things like
17 triage which he didn't agree with. You know, as I say,
18 people seem to think that other areas he was spending
19 lots of time on and those seemed to be clinical areas.

20 111 Q. They were answering questions within a particular 12:55
21 framework, the framework being your terms of reference.

22
23 Let me test you with this example. We know that in
24 2020, Patient 5 and Patient 8 were the subject of
25 Serious Adverse Incident Reviews because, at least in 12:56
26 part with regard to Patient 5, it was alleged that
27 Mr. O'Brien had failed to action a CT scan, the results
28 of a CT scan. With Patient 8, he had failed to action
29 the results of a pathology report. Now, I know this

1 is, in some respects, a foreign planet to you but that
2 was what was revealed in 2020.

3
4 If we rewind the clock to 2010 and 2011, there was
5 a never event; the never event involved a retained swab 12:56
6 in the cavity of a patient in respect of which
7 Mr. O'Brien was the surgeon. There was a scan produced
8 which would have suggested there was a pathology there
9 that needed further investigation, but the scan wasn't
10 looked at. Now, when Mr. O'Brien, and others, in the 12:57
11 urology team were told about the importance of
12 actioning the results of scans or looking at scans as
13 soon as they would be available, he responded in
14 a particular way. I will ask you just to look at this;
15 TRU-276805. 12:57

16
17 So, back in 2011 he is writing to his Head of Service
18 and he asks a series of questions which reveal his
19 concern that there may be an expectation that
20 investigative results and reports are to be reviewed as 12:58
21 soon as they become available. So, it's for others to
22 judge, but that might suggest that he was oppositional
23 to that notion that he should review investigative
24 reports and results as soon as they become available.

25 12:58
26 Given what we know happened in 2020, but given also
27 what we know about Mr. O'Brien's attitude to these
28 matters in 2011, which you might accept is broadly
29 within the sphere of administrative processing of

1 matters which could result in patient harm, would you
2 agree that, as part of screening, this is the kind of
3 thing that should have been considered by the Trust?

4 A. I suppose 2011 is a significant amount of time before
5 the screening was carried out. I don't know what the 12:59
6 people who were doing the screening would have been
7 aware of. I know that at the end of our interviews
8 with people -- you have made the point, Mr. Wolfe, that
9 we specifically asked questions in relation to a very
10 tight term of reference, which we did. However, at the 13:00
11 end of each interview, I would have said to the person,
12 you know, there will be a statement drawn up, if you
13 have anything else to add, if you think there's
14 anything else that is of relevance to this
15 investigation, please add it. 13:00

16
17 I have never been involved in -- I have to be honest
18 and say I have never been involved in a screening or
19 a scoping issue. I have always only ever been the Case
20 Investigator or a Case Manager, neither of which are 13:00
21 involved in those processes, so how screening is
22 carried out, I really can't give an informed opinion
23 about that because I really don't know.

24 112 Q. Have you anything to suggest to the Inquiry in light of
25 your experience about how a Trust operating within the 13:01
26 rubric of MHPS can ensure that when issues such as
27 those that were raised in 2016 and into '17, how they
28 can be translated into Terms of Reference which
29 encompass other areas of the practice that perhaps

1 aren't known?

2 A. I suppose, looking at this e-mail, which I've never

3 seen before, but looking at this e-mail and the case

4 that you have outlined in relation to the retained

5 swab, I suppose I would have assumed that when one was 13:01

6 screening, one would have looked at adverse incidents,

7 never events, things like that that had occurred in the

8 past, I would have made that assumption. But I do have

9 to preface that by saying I have no experience of

10 screening, I don't know if there are limitations to 13:02

11 time frames. I really don't know how screening happens

12 and, therefore, I really don't feel I am the best

13 person to comment on that.

14 113 Q. Very well. I think I have taken that as far as I can

15 with you. It's one o'clock? 13:02

16 CHAIR: Two o'clock, everyone.

17

18 THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

19 CHAIR: Good afternoon, everyone. Mr. Wolfe.

20 114 Q. MR. WOLFE KC: Good afternoon, Dr. Chada. I want to 14:05

21 spend the next few minutes just talking about your

22 approach to the witnesses who you thought were

23 important to speak to as part of your investigation.

24 Just if we could pull it up briefly on to the screen,

25 WIT-23762. It's the bottom of page 4 of the speaking 14:06

26 note, Chair.

27

28 At paragraph 1.13, just scrolling up, you say:

29

1 "A list of witnesses was agreed by Mrs. Hynds and
2 I after reviewing the terms of reference. I quickly
3 realised this would only be a few of the people who
4 would need to be interviewed. The list was shared with
5 Mr. O'Brien with the information that this was an 14:06
6 initial list and we may identify others in the course
7 of the investigation as it progressed. I am unable to
8 recollect exactly how the witness list was put
9 together. Certainly I am aware of having input into
10 the witness list in that I realised we needed to speak 14:07
11 to the current managers of the Service to begin with,
12 Ronan Carroll and Ms. Corrigan, as well as the Clinical
13 Director, Mr. Young..."

14
15 I think that should be Clinical Lead in the interests 14:07
16 of accuracy. The Clinical Director was Mr. Weir, as we
17 understand the position. In any event:

18
19 "... to understand how the Service functioned and its
20 account of the issues. Having read the investigation 14:07
21 chronology to date, I felt it was important also to
22 interview Mr. Eamon Mackle who had previously been the
23 Clinical Director and whom I had understood had raised
24 issues with Mr. O'Brien previously, as well as
25 Mr. Weir, who also had clinical managerial 14:07
26 responsibility more recently."

27
28 So, you don't have a clear recollection of how this
29 evolved. Were you to some extent dependent upon what

1 Mrs. Hynds knew of the intricacies of the issues?

2 A. I believe, Mr. Wolfe, by the time I was parachuted in,
3 if you like, there was some witness list had already
4 been put together by Mr. Weir and --

5 115 Q. Yes. Indeed just to help you, maybe we can bring that 14:08
6 up on the screen, TRU-283124. This is the first list
7 that was being circulated. I cut across you, sorry.

8 A. No, I was going to say I thought there was some list
9 that had already been sort of considered in terms of
10 who were the managers responsible sort of at that time. 14:08
11 And I think that was the point when it became apparent
12 that Mr. Weir couldn't remain as a case investigator
13 because he might be on this witness list or might be
14 asked to be on the witness list.

15 14:09

16 I think I got those names and then whenever I got the
17 information in terms of the background information and
18 what we were -- the terms of reference and what we were
19 tasked with investigating, I sat down with Mrs. Hynds
20 and had a discussion about who else would need to be 14:09
21 interviewed. Mrs. Hynds would have been very helpful
22 in terms of -- because I didn't work on the Acute side,
23 I probably had less knowledge of the sort of structures
24 around medical records and things like that. In Mental
25 Health and Disability we have our own medical records 14:09
26 system, which is a little bit separate because of the
27 nature of mental health notes which traditionally would
28 have been almost prioritised in terms of
29 confidentiality. Mental health notes are not included

1 with Acute notes, so they are two separate set of
2 notes. I would have had a lot of familiarity with
3 medical record staff within my own directorate but not
4 so within the Acute Directorate. So Mrs. Hynds --
5 I would have said, well, we need to speak to somebody 14:10
6 about, and we need to speak to Mr. O'Brien's secretary
7 but I wouldn't have known who these people were,
8 whereas Mrs. Hynds would have come back and said oh,
9 you need to speak to, that's the name, and that's the
10 name of that person that you have identified. 14:10

11
12 I would have identified probably roles rather than
13 people. Then, Mrs. Hynds very kindly would have found
14 out the answers to the questions and then come back to
15 me and said, look, this is who you mean. 14:10

16 116 Q. Yes. We can see, just by way of example of how this is
17 developing, TRU-283129, just. Scroll down six pages,
18 maybe, it might be quicker. 283129. It's maybe over
19 the other side. This is an e-mail -- back up again,
20 sorry. 283129. Yes, we have seen this e-mail earlier. 14:11

21
22 You are adding at this point, as you mention,
23 a proposed witness list. If we scroll down the page to
24 130, these are some additional names we now see.
25 Mr. Mackle has been added, and Mr. Weir. Then as we 14:11
26 are about to see, other names are added over time.
27 Ultimately, including Mr. O'Brien, you speak to 14
28 witnesses.
29

1 I want to ask you about your approach to those
2 witnesses in a moment. Before I do so, in fairness to
3 you, Mr. McAllister gave evidence and he was asked
4 whether he gave evidence or information to the MHPS
5 process, and he said that he didn't. This is when he 14:12
6 gave evidence to the Inquiry and the reference is
7 TRA-02803. He said:

8
9 "I would expect that they would give the reason that I
10 was on sick leave. However I wasn't on sick leave for 14:12
11 17 months and I wasn't asked. I presume they didn't
12 want to hear what I had to say".

13
14 Now, just in fairness to you, dealing with what
15 Mr. McAllister has said, did you ask to hear from 14:13
16 Mr. McAllister, who, as you know, was Associate Medical
17 Director covering Urology for a short period of time in
18 2016?

19 A. It's Dr. McAllister.

20 117 Q. Dr. McAllister. 14:13

21 A. But that's okay. Sorry, that's me. So Dr. McAllister,
22 as you have indicated, Mr. Wolfe, was Associate Medical
23 Director for quite a short period of time during 2016.
24 When we considered witnesses, Dr. McAllister was off
25 sick and I wasn't aware when he returned to work. Of 14:13
26 course, this process did take quite a long time but
27 I really felt that by the summertime, we needed to have
28 those witnesses interviewed that we were going to
29 interview. I wasn't aware that Dr. McAllister could

1 add anything more than what other medical managers had
 2 already told us so I didn't ask for Dr. McAllister to
 3 be present.

4
 5 As I say, my understanding was that he was an Associate 14:14
 6 Medical Director for a short period of time, there was
 7 a matter of sickness, there was a matter of other
 8 things that he was dealing with, and I felt that I had
 9 enough information from the medical managers that I did
 10 interview. 14:14

11 118 Q. He may have had relevant evidence to give around TOR 5
 12 again. Let me put it in this way: The Inquiry has
 13 seen from him an e-mail which he posted shortly after
 14 taking up the Associate Medical Director role. We can
 15 find that e-mail at TRU-14875. Rogue reference. Try 14:14
 16 14877. Thank you, Mr. Lunny. Just wait until we see
 17 the date at the top. So he has written, that is
 18 Mr. McAllister, on the 9th May 2016, and Dr. Wright is
 19 replying. If we just scroll down to see the substance
 20 at 6, please. 14:16

21
 22 "As regards Urology. . ."

23
 24 He is writing to Dr. Wright to say there's issues of
 25 competencies, backlog, triage and referral letters, not 14:16
 26 writing outcomes in notes, taking notes homes, and
 27 questions being asked regarding inappropriate
 28 prioritisation of the NHS of patients seen privately.
 29

1 So he has given evidence, it appears, that he, very
2 early in his role as AMD, he had a good handle on the
3 issues that were emerging in relation to Urology. You
4 will recall this is in the close aftermath of
5 Mr. O'Brien receiving a letter asking him to deal with 14:17
6 four issues.

7
8 If your concern in ToR 5 is to understand what was
9 known by line managers, and clearly Dr. McAllister was
10 a line manager, is he somebody you should have sent 14:17
11 inquiries out to on whether he was able to speak to
12 you?

13 A. Yes. I think Mrs. Hynds and I did have a discussion
14 about Dr. McAllister and, as I said, I think that he
15 was either on sick leave or just returning from sick 14:17
16 leave, and I felt that the issues that Dr. McAllister
17 would have been aware of at that time were similar to
18 the issues that were already outlined in the letters
19 from -- in the letter written by Mr. Mackle. So,
20 I wasn't sure if he had anything else to bring along. 14:17
21

22 But I absolutely accept that, in terms of considering
23 what the Trust did beyond or what -- beyond that letter
24 of March '16, it would have been helpful to have ...
25 I haven't seen this e-mail before but it would have 14:18
26 been helpful for Dr. McAllister to have been one of the
27 witnesses.

28 119 Q. Because plainly he took over from Mr. Mackle?

29 A. Yes.

- 1 120 Q. And if part of your interest is to see whether
 2 Mr. O'Brien was supported to make changes in his
 3 practice, a key person, arguably, the senior line
 4 manager on the medical side or on the clinical side, is
 5 Mr. McAllister? 14:18
- 6 A. Well, I did ask whether there was any action taken by
 7 Trust managers in relation to that letter from
 8 Mr. Mackle and I was told that there wasn't, that there
 9 was no formal action that came out of it, or action
 10 plan or further correspondence or contact with 14:19
 11 Mr. O'Brien. That's what I was told. And I don't know
 12 if Dr. McAllister gave evidence to the contrary.
- 13 121 Q. No, but what there was was a series of events through
 14 Oversight Committee and the NCAS advice leading to a
 15 decision to have an informal investigation, that 14:19
 16 decision being set aside and a decision being taken to
 17 approach it in a different way. But none of this is
 18 being drawn to the attention of Mr. O'Brien; no support
 19 being provided to Mr. O'Brien to enable him perhaps to
 20 avoid the formal MHPS, which came in December. It 14:19
 21 appears from what you are saying that you were
 22 unsighted at least in terms of the fine detail of that,
 23 although you were sighted on the fact that nothing was
 24 done essentially?
- 25 A. Yes, I was aware that nothing had been followed from 14:20
 26 the meeting in March 2016.
- 27 122 Q. Yes.
- 28 A. And I wasn't aware that Dr. McAllister had made any
 29 plans or had taken any action. I wasn't aware of that.

1 123 Q. Now, in terms of the witnesses you spoke to, 13
2 interviews were conducted between the 15th March and
3 the 5th June. If we just have up on the screen,
4 please, the timeline for that, TRU-00671. You started
5 with Ms. Corrigan and, just over a week later, 14:21
6 Mr. Young, and then a gap of just over a week,
7 Mrs. Graham and so on.

8
9 would it have been ideal, Dr. Chada, to have had, I
10 suppose, less gaps in terms of gathering 14:21
11 information/evidence from witnesses rather than
12 spreading it over a three-month period?

13 A. In terms of the overall timeframe, clearly it would
14 have been preferable to see people fairly close
15 together in terms of comparing what different people 14:22
16 have to say. That would have been helpful. The
17 timings relate to me providing dates to Mrs. Hynds
18 about when I was available; people were providing dates
19 to Mrs. Hynds about when they would be available.
20 Taking into account all of that, and I have to 14:22
21 absolutely acknowledge that one of the things that I
22 believe I advised Mrs. Hynds was that this
23 investigation would not impact on patient care, so
24 I tried very hard to facilitate timings around -- I
25 didn't want outpatient clinics cancelled, I didn't want 14:22
26 theatre lists cancelled, so things like that had an
27 impact. On reflection and in terms of the time that it
28 took, you know, perhaps that was a foolish aspiration
29 that I had, but -- but, look, that's what we did. Yes,

1 is the short version, I am so sorry. Yes, it would
2 have been preferential to have them all closer
3 together, of course.

4 124 Q. Yes. The format or the process that you adopted when
5 speaking to witnesses, was it essentially to interview 14:23
6 them, you leading the interview, both you and
7 Mrs. Hynds taking notes, Mrs. Hynds perhaps intervening
8 to ask for clarification on certain points, and then
9 Mrs. Hynds going away and producing a draft statement
10 to be considered by the witness out of the notes that 14:24
11 you and her had jointly assembled?

12 A. Yes. Mrs. Hynds would have written to the witness and
13 explained that this was an investigation under
14 Maintaining High Professional Standards, that this was
15 a confidential issue that they shouldn't discuss, and 14:24
16 that they would be asked questions in relation to the
17 terms of reference which were sent to them. Then when
18 the person identified -- when the witness attended,
19 sorry, we both would have taken notes. I am a prolific
20 note-taker, I write very quickly. I expect Mrs. Hynds 14:24
21 will give you evidence that I probably had twice the
22 amount of notes that she had because I tend to do that.
23 At the end of the interview, witnesses would have been
24 asked if they had anything else that they felt was
25 relevant, anything that we hadn't asked about. They 14:24
26 would have been reassured that a statement will be
27 drawn up that they would have sight of, and that if
28 they wanted to make corrections or additions, that they
29 could contact either Mrs. Hynds or me. Then,

Mrs. Hynds would have gone away with her set of notes and would have drawn up a statement. She would have sent it to me; I would have gone through my handwritten notes and compared it to the statement and if there's anything else that I felt was relevant, I added that, it went back to Mrs. Hynds and she shared it with the witness, who, if they had changes, then they got back to Mrs. Hynds and those were made. Then that was how the witnesses -- and then they were asked to sign them.

14:25

125 Q. Could we just look at the chronology around this. If we turn to TRU-283629. Let's try TRU-283635. So, this is an e-mail to Martina Corrigan on the 15th August from Siobhán Hynds, and you are copied in. It's telling her:

14:25

"Please see attached statement from our meeting on the 15th March. I would be grateful if you could review and sign and return a copy to me if you are happy with the content. If you wish to make any changes, please highlight them on the attached document and return them for consideration."

14:27

So, as appears from the chronology, several other e-mails go out to witnesses on the same date.

Mrs. Corrigan was the first witness to be interviewed, five months earlier?

14:27

A. Mm-hmm.

126 Q. What explains what I think you might accept was a very significant delay before the witness gets to see what

1 you have interpreted from the interview as being her
2 evidence?

3 A. I'm not sure when the original draft from Mrs. Hynds
4 came to me. I may have been responsible for some of
5 this delay. In fact, I suspect I was responsible for 14:28
6 some of this delay. For example, I know July there was
7 a lot of holidays. There was annual leave, for
8 example, Mr. O'Brien, myself, Mrs. Hynds. So, I know
9 July was difficult.

10
11 I do know that, and I have mentioned earlier, we had 14:28
12 a very serious event in the Trust in May, late May --
13 well, May 2017, so that may have delayed my input into
14 this. I'm not sure what other delays were caused and
15 whether those were Mrs. Hynds' responsibility or my 14:29
16 responsibility. I apologise, I don't know. But
17 I absolutely accept that that's a long period of time.

18 127 Q. All of those witnesses were interviewed in that
19 three-month period ending in June?

20 A. Mm-hmm. 14:29

21 128 Q. And even by the 31st October - if we just bring up
22 AOB-01766 - this is now the 31st October. Mr. O'Brien
23 had been first interviewed with you on the 3rd August,
24 more than two months earlier. We will look at that
25 interview in a moment, which, as we now know, went 14:30
26 ahead without the provision of any statements to him.
27 By the 31st October, three witness statements are still
28 outstanding to him in terms of sharing them with him.
29

1 Again, the delay in the process, was it simply down to
2 resources between you and Mrs. Hynds to get them in
3 a fit state to be disclosed to the witness in the first
4 place for agreement and then out, or were there other
5 factors at play?

14:31

6 A. I am not aware of other factors. As I explained, the
7 process was Mrs. Hynds would type it up the statement,
8 she would send it to me, I would compare it to my
9 notes, I would make changes, I sent it back to her.
10 All of that was being done without, for example, admin
11 support. You know, Mrs. Hynds, I'm aware, was typing
12 these herself, which I think I highlighted in my
13 Section 21 notice, that here was a very senior person
14 within the Trust who was spending evenings typing up
15 things, which I felt wasn't a good use of either her
16 time or my time.

14:31

14:31

17
18 Perhaps what wasn't helped was Mrs. Hynds doing it,
19 sending it to me, me adding bits to it because that, of
20 course, causes delays with every person that needs to
21 sort of look at it, and then it went back to the person
22 and then they had to check it and send it back with any
23 amendments. So, it was a slow process. I absolutely
24 accept that at least some of those delays were down to
25 me and some of those delays were down to lack of
26 administrative support.

14:31

14:32

27 129 Q. would you agree that the longer you get away from the
28 date of the witness interview, the more difficult it
29 is, at least for the witness, to try to remember and

1 capture in a pure and consistent form what they have
2 told you?

3 A. Yes. Yes, of course I would. Yes.

4 130 Q. It comprises -- it potentially at least comprises the
5 quality of the evidence?

14:32

6 A. Yes, I absolutely accept that the longer it takes.
7 I would also say, I suppose, that Mrs. Hynds had
8 handwritten notes, I had handwritten notes. Mine
9 certainly, as I have said, were really very
10 comprehensive. But yes, I absolutely accept that
11 asking somebody to remember what they said five months
12 earlier is not particularly helpful.

14:33

13 131 Q. Did any witnesses express concern about Mr. O'Brien
14 seeing their statement or were they otherwise reluctant
15 at any point to come back to you?

14:33

16 A. I mean, witnesses in general -- I think witnesses in
17 general who were non-medical witnesses find this
18 process quite difficult and I dare say intimidating. I
19 mean, we did our absolute best to reassure people but
20 I felt that they felt it was intimidating. I felt
21 non-medical managers, non-medics generally found it
22 difficult to be giving what they felt was evidence or
23 giving a witness statement about a doctor. I think
24 they found that difficult.

14:33

25 14:34

26 Some of the witnesses, I mean at least one of the
27 witnesses was shaking as she walked into the room and
28 I spent a significant amount of time trying to reassure
29 her that this wasn't about her and that nothing she

1 said was going to get back to Mr. O'Brien in detail,
2 but that obviously we were taking a statement and that
3 the information that she gave us for that statement, he
4 would have to have sight of. So, trying to --

5 132 Q. who was that witness?

14:34

6 A. Mr. O'Brien's secretary was really very anxious about
7 the whole process, and I think had felt that she was in
8 a difficult position in terms of divided loyalties and
9 those type of things. Doctors and secretaries tend to
10 have a very special relationship, and I think it is
11 difficult for secretaries that feel in some way their
12 -- I don't know, just not being loyal. Certainly the
13 secretary found it difficult.

14:35

14
15 Some of the managers, I felt -- I mean I couldn't tell
16 you off the top of my head but I felt some of the
17 managers found the whole process very
18 anxiety-provoking.

14:35

19 133 Q. Is there any work, do you think, to be done around the
20 culture that creates that kind of, I suppose, fear that
21 you are describing, or sense of foreboding? I mean, is
22 there a need for colleagues in this context come
23 witnesses to better understand and better buy into the
24 idea that performance issues need to be properly
25 investigated?

14:35

26 A. I think a lot of progress was made, I hope a lot of
27 progress was made after the Mid-Staff Inquiry because
28 I think it addressed exactly this type of thing, that
29 you have these very senior consultants who tell you how

14:35

1 it's going to be and that's how it's going to be.
 2 I think in medicine we have moved well towards working
 3 in teams and having a team responsibility for
 4 a caseload. In psychiatry we have done that much
 5 sooner, I suppose, than some of the others because of 14:36
 6 the nature of the work. I do think that helping people
 7 from the ground up to understand that this is not --
 8 this is not an awful experience and that it's very
 9 important to raise concerns, and that anything that you
 10 say will be taken seriously, and that actually you have 14:36
 11 a responsibility. I mean, I have been involved in
 12 governance work in the Trust beyond this where we did
 13 governance teaching in a multidisciplinary way.

14
 15 It was very interesting, as doctors, watching how 14:37
 16 difficult it was for secretarial staff and admin staff
 17 and even nurses to some extent to feel that they had
 18 a role in raising concerns. You know, it was very
 19 interesting to go along to some of those meetings where
 20 we were encouraging people from every level to raise 14:37
 21 concerns and to be aware of their responsibilities in
 22 doing so.

23 134 Q. Thank you for that. Your witness statement helps us to
 24 understand the extent to which your investigation was
 25 dependent upon progress being made by the Trust in what 14:37
 26 might be regarded as a parallel process. That is,
 27 a process of urologists in the Service working through
 28 the triage or the non-triage cases and the non-dictated
 29 cases and then producing results that were, I suppose,

1 fed through to your investigation and, in addition and
2 perhaps subsequently, Mr. Young's work on the private
3 patients.

4
5 I want to ask you about that. In your witness 14:38
6 statement at WIT-23762 - just scroll down to 1 of 16 -
7 you say that you realised that this work was creating
8 a lot of additional work for the urologists, and you
9 suggested via Mrs. Hynds that Dr. Khan should approach
10 Dr. Wright and discuss the possibility and discuss 14:39
11 further assistance to move that part of the
12 investigation on more quickly.

13
14 "I felt it was important we had as much information as
15 possible before we met Mr. O'Brien so that he would 14:39
16 know the extent of the issues and have an opportunity
17 to address those concerns. This information is all
18 included in e-mails from Mrs. Hynds to Dr. Khan".

19
20 Just on that, were you concerned that, in essence, the 14:39
21 process of looking at the dictation and non-triaged
22 cases was slowing up your work?

23 A. It was more that I felt that -- I suppose some of the
24 issues about patient outcome and whether there was an
25 impact on patient outcome. One of the things that 14:40
26 I wanted to be able to put to Mr. O'Brien in relation
27 to the terms of reference was not only did this happen
28 but was there an impact on patient outcome or
29 a potential impact on patient outcome. So, I was keen

1 to have that information.

2
3 I suppose, in retrospect, and again this is something I
4 have reflected over, you know, whether the exact
5 numbers made any difference, you know, now I look back 14:40
6 and realise that it probably didn't. If it was
7 anything more than a handful, it didn't matter whether
8 it was 400 or 200. No disrespect intended to those
9 patients, of course, but the fact is, if it was more
10 than a handful, then that was enough for me to have 14:40
11 been concerned and to put that to Mr. O'Brien. Now
12 I look back and think, you know, the fact that there
13 was an issue and that there was hundreds of people
14 involved was probably all that I needed to know.

15 14:41
16 what was helpful, as I said, was to know whether there
17 were actually any adverse outcomes that we could then
18 put that to him as well. That's what I thought was
19 important at the time. As I say, you look back and you
20 think, well, maybe I could have done it a different 14:41
21 way.

22 135 Q. Yes. well, thank you for answering that. I will go on
23 in due course to look at your report and look at the
24 information that Mr. O'Brien gave you around, for
25 example, numbers around the issue of the 13 sets of 14:41
26 notes that weren't ever recovered and issues like that.
27 would you be in a position, Dr. Chada, correct me if I
28 am wrong, if you were wholly dependent on information
29 coming to you from the operational and clinical side of

1 the Trust that was fed in to you and you had no means
2 to independently interrogate that information?

3 A. No.

4 136 Q. Is that --

5 A. Yes, yes, I was wholly dependent. And no, I had no 14:42
6 means to interrogate that.

7 137 Q. You drew our attention this morning to the situation
8 that occurred, you say, early in your investigation
9 whereby a witness drew your attention to
10 a clinical-type issue concerning the failure, as the 14:42
11 witness saw it, or the refusal as he saw it, on the
12 part of Mr. O'Brien to assign clinical priorities to
13 patients coming through theatre; is that the nub of it?

14 A. Yes.

15 138 Q. Just for the Panel's eye, let's just look at this 14:43
16 briefly. I think you fully explained it this morning,
17 your point being that the MHPS process allowed
18 witnesses to raise other concerns that were maybe
19 outside of the terms of reference which you would then,
20 in turn, communicate back into the system for remedial 14:43
21 action to be taken, if appropriate?

22 A. Yes.

23 139 Q. TRU-283201. Scrolling down, please. The witness
24 concerned was Mr. Carroll. He had been interviewed by
25 you and Mrs. Hynds the day before, on the 6th April. 14:44
26 He's writing to you to say:

27

28 "Please see attached the operating the theatre lists
29 for all urology consultants this week. In summary all

1 but Aidan O'Brien reference the clinical status on
2 their lists".

3

4 If we scroll down, I hope to the next page to
5 illustrate that. Perhaps not.

14:44

6 A. I am sorry, was that e-mail sent to me?

7 140 Q. It was. If you want to go back up again. So yes, he
8 is addressing both you and Siobhán Hynds.

9 A. Sorry, I am not Neeta Gupta.

10 141 Q. Sorry?

14:45

11 A. What I can see on my screen is Siobhán Hynds and Neeta
12 Gupta.

13 142 Q. You are right.

14 A. I don't know who that is.

15 143 Q. Yes, it's a later e-mail I had in mind.

14:45

16

17 I just want to illustrate to the Inquiry how this
18 filters through the system. If we go to TRU-268080.
19 Just before we leave this page, scroll up, please.

20 A. There I am there.

14:46

21 144 Q. That's what I had in mind, I beg your pardon. I think
22 it's the case that Siobhán Hynds copies you and
23 Dr. Khan in on the 11th May?

24 A. Yes.

25 145 Q. Could I ask you about another issue that was raised
26 with you. If we go to TRU-0787. TRU-7787? Thank you.
27 This is part of Mr. Haynes' statement which was
28 prepared for your investigation. If we scroll down to
29 paragraph 27, he says:

14:46

1
2 "I am aware the previous AMD, Mr. Mackle, raised issues
3 with Mr. O'Brien and that this had become very
4 difficult. Operationally Martina Corrigan knew of the
5 issues and I anticipate he escalated these concerns. 14:47
6 The problem were well known in medical records. Other
7 people must have known, such as anaesthetists, and he
8 says he was taking people to theatre without clear
9 notes and at times with no pre-op done."

10
11 So, that's an issue out with your terms of reference,
12 another potentially serious problem. Did you do
13 anything with that information; did that go back to
14 Dr. Chada or the Medical Director?

15 A. The issue about not having clear notes and notes not 14:48
16 being available was one of the terms of reference in
17 the Inquiry, so that was something that I felt people
18 already knew.

19 146 Q. Mm-hmm.

20 A. The issue about no pre-op done, I, perhaps wrongly, 14:48
21 assumed that that meant that the pre-op was done on the
22 day of surgery. So, there was a period when I was
23 a very junior doctor where pre-ops were done on the day
24 of surgery or when somebody was admitted the day before
25 surgery. Things had moved on since then, and perhaps 14:49
26 my lack of knowledge about this, I assumed that what
27 was being said here by Mr. Haynes was that pre-ops were
28 done on the day of surgery, so somebody comes in for
29 surgery, the anaesthetist comes and see them before

1 they go into theatre. So, the clear notes issue,
2 I felt was already one of the terms of reference. The
3 other issue, I didn't understand the relevance of that.

4
5 I look back now and I realise with hindsight with the 14:49
6 information that came forward in 2020, but at the time
7 I didn't realise the relevance of that at all.

8 147 Q. Did you seek to clarify it with Mr. Haynes?

9 A. If I had, it would have been in that statement.

10 I think I made an assumption about what that meant and 14:49
11 that's what was said and that's what was documented.

12 148 Q. You would agree that there's a particular onus on Case
13 Investigators to be vigilant when speaking to
14 witnesses, particularly clinical witnesses, where they
15 are drawing your attention to issues of concern about 14:50
16 the clinician's practice that maybe don't fall within
17 the terms of reference but, as we have seen with what
18 Mr. Carroll told you, are potentially significant for
19 the service and potentially significant for patient
20 safety? 14:50

21 A. Yes, of course, and that's what the Case Investigator
22 is tasked to do. I understood that an IR1 had been
23 raised in relation to this so that the Trust was aware
24 of it, but ...

25 149 Q. Do you know the name of the case? 14:50


26 A. No.

27 150 Q. When did that information come to your attention?

28 A. I think at the time. I thought Mr. Haynes mentioned
29 that he had put in an IR1. Perhaps it wasn't about

1 that. I thought he had mentioned in his statement that
2 he had put in an IR1.

3 151 Q. Certainly an IR1 was raised in respect of Patient 90,
4 you will see mentioned in your cipher list beside you.
5 But that was a case that came into theatre on the 9th 14:51
6 May 2018, after your investigation. In that case, we
7 can see -- just if we look at the SEA case for that
8 case, TRU-161137. The date of the incident was 9th May
9 2018. If we scroll down to the bottom of 43, page 43
10 in this series. I am very conscious, Dr. Chada, that 14:52
11 you won't have heard of this case, but Dr. 1 in this
12 case was Mr. O'Brien, and the patient was seen by
13 Mr. O'Brien and he was the surgeon. It records that
14 the patient was pre-admitted for surgery on Thursday
15 the 3rd May, and the Review Team noted that the patient 14:53
16 did not have a formal outpatient pre-operative
17 assessment as per Trust and NICE guidance. If we
18 scroll down the page, please, and go to the bottom of
19 the page and on to the top of page 44.

20 14:54
21 "The Review Team concluded, particularly in view of his
22 co-morbidities, that  should have had a formal
23 pre-admission pre-operative assessment with
24 optimisation of his clinical condition prior to
25 surgery. This assessment should have been organised 14:54
26 sufficiently in advance of the surgery to allow for all
27 appropriate investigations to be completed".

28
29 Mr. Haynes was drawing your attention to a pre-op

1 assessment issue just about a year before --

2 A. Mm-hmm.

3 152 Q. -- this incident took place, which, unfortunately,
4 after surgery, led to the death of the patient.
5 Obviously there were a multiplicity of factors involved 14:55
6 in that death, which were discussed in the SEA. When
7 you look at what Mr. Haynes said in his statement - if
8 I can bring that back up - was it simply a case of not
9 appreciating the significance of that because it was
10 outside your terms of reference, or did it just pass 14:55
11 you by as something that he wasn't raising as
12 a particular concern?

13 A. I don't think it was because it was outside the terms
14 of reference, because if a clinical issue is raised
15 outside the terms of reference, then it's a Case 14:55
16 Investigator's responsibility to raise that. I think,
17 as I said earlier, I genuinely didn't understand or
18 missed the significance of it and I absolutely accept
19 that that's because I don't work in surgery and,
20 therefore, I'm afraid, 30 years ago when I was a junior 14:56
21 doctor, pre-op assessments were done on the day of
22 surgery or the day before surgery. So, I just missed
23 the significance of it. You know, that's simply all I
24 can say on that matter.

25 153 Q. Yes. Could I bring you to the process of engaging with 14:56
26 Mr. O'Brien for the purposes of your investigation.
27 It's plain from the e-mails that are available to the
28 Inquiry, and we can bring those up at any point if you
29 wish, that there was some difficulty in trying to find

1 an agreeable date to sit down and discuss this.
2 Suggestions were made that you would meet at the end of
3 June 2017; Saturday the 1st July was suggested by him;
4 you agreed with that and then it seemed to fall away as
5 a date that could work, but it was agreed then that 3rd 14:57
6 August 2017 would be the date to meet. Have you any
7 reflections upon the difficulties associated with
8 meeting with him? Was that just one of those things,
9 trying to marry diaries?

10 A. Yes. I think at the time I thought, well, this is 14:57
11 a man who is under a lot of pressure. He wasn't well
12 the previous year. I knew Mr. O'Brien had had surgery;
13 I didn't know what was the reason for surgery. It
14 wasn't appropriate information for me to know. I knew
15 that he hadn't been well, and someone had mentioned to 14:58
16 me - I think it may have been Mrs. Hynds - that
17 Mr. O'Brien had reportedly lost ten pounds in weight,
18 so I was conscious that this was a man who was under
19 some pressure. So, at the time I felt that I was
20 trying to be accommodating. 14:58

21
22 On reflection and as things progressed, and as
23 a psychiatrist, I felt that there was a bit of passive
24 aggressive behaviour evident from Mr. O'Brien. I felt
25 that he -- on reflection, I felt he was trying to 14:58
26 manage the timeframe; there was a level of control
27 trying to be exerted. I didn't think about those
28 things in the initial period at all, I have to say, I
29 didn't really know Mr. O'Brien that well. But as the

1 situation progressed and as the year progressed, and as
2 things weren't returned on time or e-mails weren't
3 responded to, and then the situation worsened the
4 following -- the beginning of the following year,
5 I really felt that there was an element of control that 14:59
6 was trying to be exerted by Mr. O'Brien in the whole
7 process. At the same time, he was complaining about
8 the length of time the process was taking, so it was --
9 it was difficult.

10 154 Q. You have said quite a lot there and hopefully we will 14:59
11 come to much of it in the course of working through
12 this. In terms of -- I mean, if we look at some of the
13 e-mails, perhaps, because you have suggested that there
14 was a degree of passive aggression on his part, or
15 controlling behaviour when I asked you about the issue 15:00
16 of the dates. If we go to AOB 03942, so just at the
17 bottom of the page, please. Work backwards.

18
19 Evidently, Siobhán Hynds has written to Mr. O'Brien,
20 perhaps the day before. I think it was the 14th. I 15:00
21 can't at this point locate the starter e-mail but it's
22 not terribly important. So, it had been suggested
23 Wednesday the 28th as a meeting date. He is saying:

24
25 "It wouldn't be suitable for me to meet for two 15:01
26 reasons: Firstly, I would wish to be accompanied by my
27 son, Michael; however, he is in court that day,
28 a commitment he can't avoid. Technically he has
29 scheduled" -- that is Mr. O'Brien has scheduled --

1 "operating that day and is already committed to
2 a number of patients".

3
4 He has asked Siobhán Hynds, politely it seems, to
5 contact her to consider other dates. There's nothing
6 controversial about that? 15:01

7 A. No.

8 155 Q. Then if we scroll up to the next e-mail, please.
9 Siobhán Hynds tells Mr. O'Brien:

10
11 "There's no difficulty with rescheduling. Dr. Chada
12 has told me the 29th also and the 30th may be possible.
13 Would either of these dates suit you in the morning?"
14

15 scrolling up, we see his response. On up, please, 15:02
16 thank you. He is explaining that he becomes urologist
17 of the week from 9 a.m. on Thursday the 29th June for
18 the whole week; talks about the handover and the
19 importance of that. He says:

20
21 "I do not know how important it is that I meet with 15:02
22 Dr. Chada around that time rather than later. If it
23 is, then most suitable day to have the meeting would be
24 on Saturday the 1st July as one of my colleagues would
25 probably be available to cover my absence, particularly 15:02
26 with regard to operating, but I have not asked any of
27 them yet. Would that be possible?"

28
29 Otherwise, he will be on leave from beginning the 10th

1 July. So, other dates not suiting him because of his
 2 professional commitments, he puts forward the 1st July,
 3 a Saturday, giving up a weekend day, it might be said.
 4 Again, is there anything passive aggressive in that or
 5 objectionable in that?

15:03

6 A. I did wonder whether Saturday might have been suggested
 7 because it was felt that I might not agree to that. It
 8 did cross my mind. However, I was keen to progress
 9 this and decided that Saturday would do, so I said to
 10 Siobhán, if she didn't mind - because of course it's
 11 not just my time on a weekend, and I was aware that
 12 Mrs. Hynds has younger children and I wasn't sure if it
 13 would suit her - but I think I went back to Mrs. Hynds
 14 and said that's okay with me. I believe I had
 15 appointments on the Saturday morning, I said if
 16 necessary I would rearrange them.

15:03

17 156 Q. Mm-hmm. You hadn't met Mr. O'Brien before?

18 A. Not -- no, no. Yes.

19 157 Q. Except in a kind of vague circumstances you describe.

20 A. Yes. I was aware of him, yes.

15:04

21 158 Q. On what basis would it enter your head that he is
 22 playing a bit of cat and mouse with you - my phrase -
 23 by suggesting the 1st July? Why wouldn't you take that
 24 at face value?

25 A. Well, it did cross my mind that it was a very generous
 26 offer to meet at a time that suited me, yes. It also
 27 crossed my mind that it might not be. It wandered
 28 across my mind. It wasn't until a bit later that I was
 29 more concerned about some of the cat and mouse, if you

15:04

1 like.

2 159 Q. It's very honest of you to say that it crossed your
3 mind but what I'm asking you is why would it cross your
4 mind, never having had any dealings with him before,
5 that this might be a bit of a trick or on his part to 15:05
6 suggest the 1st July, thinking that you may disagree
7 with it?

8 A. Mr. O'Brien was a consultant psychiatrist when I was a
9 junior -- sorry, a consultant urologist when I was
10 a junior doctor. I suppose I knew of Mr. O'Brien, 15:05
11 I knew he was a very formal man and I knew he was
12 a very senior colleague. I suppose I did wonder how he
13 would -- these investigations are supposed to be
14 undertaken by somebody of a reasonable seniority in
15 terms of Associate Medical Director, or a Clinical 15:05
16 Director if you are investigating a consultant. I did
17 wonder whether he might feel that I was a bit of
18 a whippersnapper. I did wonder whether he might feel
19 that because of the fact that he was really quite
20 senior to me in terms of experience and years. So, 15:06
21 I did wonder about that. As I say, knowing that he was
22 quite a formal, proper gentleman, I did wonder whether
23 he -- it did cross my mind. I mean it really was as
24 simple as that. It crossed my mind, I dismissed it and
25 said yes, Saturday will do. 15:06

26 160 Q. I am sorry to press you on this, Dr. Chada. You had no
27 basis at all upon which to be suspicious of
28 Mr. O'Brien's motivations in suggesting this date?

29 A. No, no, not at that time. As I have said, it crossed

1 my mind but I had no real concerns at that time that
2 there were any other factors.

3 161 Q. If we just scroll on up, please, so that I can see the
4 start of the e-mail and I can read down.

5 15:06

6 So, Siobhán Hynds has been in contact with you. In
7 terms of when Dr. Chada can meet, he is passing on your
8 view that you would rather meet later in July when both
9 yourself and -- sorry, you are asking if you would
10 rather meet later in July when both you, Dr. Chada, and 15:07
11 Mr. O'Brien are back from leave. Alternatively --

12 A. Yes. I think the e-mail says if that was his
13 preference.

14 162 Q. Okay. Okay. The alternative is that you would be
15 happy to facilitate Saturday the 1st July if that is 15:07
16 Mr. O'Brien's preference. You have a number of
17 preplanned appointments on Saturday morning and if you
18 are unable to change these, you would be happy to meet
19 in the afternoon.

20 15:08

21 So, is there a degree of giving up to his preferences
22 around this?

23 A. Well, I felt so. I felt if it suited Mr. O'Brien to
24 meet at this time. Of course, I was mindful of how
25 long this whole process is taking. I really wanted to 15:08
26 meet Mr. O'Brien before the summer recess because
27 people do go on holiday. So I thought, look, if it
28 suits Mr. O'Brien, then I will try and facilitate that.

29 163 Q. Then if we scroll up the page. He says that he

1 appreciates your flexibility and he says he feels it
2 would be better to defer the meeting to later in July;
3 says the only date prior to the end of July when he
4 could have attended would be Thursday the 27th but his
5 son cannot, and therefore he proposed to meet with you 15:09
6 on Monday, during the week beginning Monday 31st July.
7 He is suggesting Monday itself because he has a clinic
8 which could be rescheduled. Ultimately, the date
9 that's finally arranged is the 3rd August.

10
11 But just going back to how you introduced your view of
12 the difficulties fixing dates, did you mean to say that
13 you observed from your psychiatric expertise, or
14 perspective, passive aggressiveness on his part around
15 the fixing of the date? 15:10

16 A. I said at the time I didn't. I said subsequently when
17 I reflected on this and as the investigation
18 progressed, I felt that there was -- I felt there was
19 a degree of wanting to control the process. Yes,
20 I felt there was a degree, at a later stage. At that 15:10
21 time, as I think I said earlier, at that time I didn't
22 reflect on that. At that time it crossed my mind that
23 maybe this date had been suggested on purpose thinking
24 I would say no. But I wanted to get moved on with it,
25 I dismissed that thought, I thought, look, you know 15:10
26 this is a very busy man, he has a number of other
27 commitments, he does need to make sure that his son is
28 available, that's fair enough. At that time I was
29 happy with this arrangement, I thought, well look,

1 that's okay. It was really at a later stage where
2 I started to wonder if perhaps there was some element
3 of trying to control. As I say, that was a later
4 stage.

5 164 Q. Did you ever give consideration to whether there was an 15:11
6 element of Mr. O'Brien simply trying to protect his
7 rights within the process; that he felt perhaps a need
8 to ensure that he was going to be fairly treated within
9 a process which, by this stage in June, looking towards
10 the July or an August meeting, hadn't facilitated him 15:11
11 with the provision of a full witness list, any of the
12 materials which you had been sent in respect of
13 dictation, in respect of triage and that kind of thing,
14 and no witness statements?

15 A. I think, as I said earlier, normally, in the normal 15:12
16 course of events, for a case investigation and in cases
17 where I've previously investigated, the subject of the
18 investigation is usually the first person to be
19 interviewed, so they don't have access to all those
20 other things. 15:12

21
22 In this case, I felt things needed to be done slightly
23 differently. That was more about feeling that, you
24 know, I needed to come from a more informed position
25 because the terms of reference were there. They were 15:12
26 there for a reason. You know, obviously the background
27 work or a certain extent of background work had been
28 done to produce these terms of reference. So, the
29 terms of reference were there; there were some detail

1 in the terms of reference. So I was very mindful, as I
2 have said earlier, that Mr. O'Brien was clearly under
3 a significant amount of stress; I was very mindful that
4 this Maintaining High Professional Standards is a very
5 distressing process for doctors. Nobody wants to get 15:13
6 a letter to say that they are a subject of this. The
7 concern is it progresses and you get another letter to
8 say you are the subject of a GMC Inquiry. These things
9 are anxiety-provoking, and as a psychiatrist of course
10 I am aware of that. 15:13

11
12 I felt that, you know, I was trying to be as fair as
13 I could. Some of these witness statements weren't
14 fully completed and so... I would have to say that I
15 didn't realise at the time of that initial interview in 15:13
16 August the extent of some of the documents that
17 Mr. O'Brien hadn't received. I actually hadn't
18 realised that until we started the interview and, for
19 example, Mr. O'Brien said well look, I don't have
20 a full witness list. I was quite taken aback by that. 15:14
21 Not only did he not have the witness statements, he
22 didn't have the full list. I didn't know that and
23 I did apologise to him and said look, I'm so sorry,
24 I wasn't aware of that, we will make sure you get that.
25 Anything else that he asked for, I said we would make 15:14
26 sure he got it. I also said to him that if he had any
27 other comments to make or any other issues to raise
28 once he got those, that he could of course do that and
29 we could certainly -- we would have to meet again

anyway but that we could do that. So look, I didn't realise the extent of the information he didn't have.

165 Q. Yes. It is possible, isn't it, and Mr. O'Brien can speak for himself, in terms of his engagement with you, which you have at least, looking back on it, judged to have been controlling, passive aggressive and the words that you have used, that he was perhaps just looking out for himself in a process that was both emotionally difficult, no doubt, and professionally difficult?

A. Yes. I would absolutely accept that, yes.

166 Q. Could I ask you to look at AOB-01690. Just scroll down the page, please. This is the 31st July, three days before he's coming in to see you. He says to Siobhán Hynds:

"In addition to my earlier request, could you please add the details of the nine private patients included in the investigation and the names or names of those who identified them".

Scrolling up the page, please. Two e-mails that day.
The first is:

"In preparation for the interview on the 3rd August I would be grateful if you could provide me with the following."

The last of the items is:

1 "A list of the witnesses and their statements."

2
3 So, you say you went to the 3rd August meeting not
4 knowing that he hadn't received items such as that?

5 A. Yes.

15:17

6 167 Q. Was there good communication between you and Siobhán
7 Hynds?

8 A. There was a lot of communication between me and
9 Mrs. Hynds but I wasn't aware that -- I wasn't aware
10 that he hadn't received that. I'm not entirely sure
11 that Mrs. Hynds, although Mrs. Hynds can speak for
12 herself, I'm not sure that she realised. I think she
13 may have believed that she had sent that but I'm afraid
14 you will have to ask Mrs. Hynds. But I know I was
15 surprised that -- and I think the statement might
16 reflect that but I'm afraid I just don't remember.

15:17

15:17

17 168 Q. The issue concerning a list of witnesses and their
18 statements was also fed into a complaint letter which
19 you sent to Dr. Khan on that day, the 31st July. Just
20 for the Panel's reference, it's AOB-01675. I don't
21 need to open it to the Inquiry but it draws attention
22 in its last couple of pages to these very same issues.

15:18

23
24 Did Dr. Khan not draw that to your attention?

25 A. Dr. Khan was on holiday at the time but that e-mail was
26 shared with me, maybe the day of investigation or the
27 day before the investigation. I can't quite remember.
28 It was a lengthy e-mail addressed to Dr. Khan; a number
29 of the issues related to Mr. O'Brien's concerns about

15:18

1 the process which had started back in 2016 and how we'd
2 ever got to this point.

3 169 Q. Yes.

4 A. So it was quite a lengthy e-mail, and I may have just
5 missed the fact that he hadn't been provided with some 15:19
6 of these things. But it was in the letter and I was
7 copied that letter prior to that meeting on the 3rd
8 August. I think I saw it but Dr. Khan didn't see it,
9 if you see what I mean.

10 170 Q. Yes, yes. You didn't pick up on the fact that he 15:19
11 hadn't been supplied with a witness list?

12 A. Yes. I didn't pick up on it on the letter, and then he
13 mentioned it in the interview and I apologised.
14 I wouldn't have delayed the interview anyhow. I mean,
15 I would have to be upfront and say that. It had waited 15:19
16 long enough, we needed to get moved on, and I really
17 felt that whatever documents weren't available, if
18 Mr. O'Brien had comments to make, I encouraged him to
19 do that either in written response or that that could
20 be raised at -- you know, if he wanted other meetings, 15:20
21 that we could arrange that but I really felt that we
22 needed to move on. I know it was in that -- I know
23 I got that letter, I know I saw that letter,
24 I definitely remember seeing that letter but I've maybe
25 just missed that. 15:20

26 171 Q. As you know, the meeting with Mr. O'Brien on the 3rd
27 August was covertly recorded. I take it to be covertly
28 recorded; you didn't know that it was being recorded?

29 A. I did not.

1 172 Q. We can see AOB-56226. Just scroll to the bottom of the
2 previous page, please. So, Michael O'Brien asked:
3
4 "Have you spoken to all of the other witnesses now that
5 you will be speaking to, that you have said you were 15:21
6 going to be speaking to?"
7
8 You say:
9
10 "I think it's really important that we are clear about 15:21
11 what this process is about. Okay. I am very happy for
12 you to be here to support your dad but really a lot of
13 this is for your dad and for Mr. O'Brien to raise
14 queries or to raise concerns. You are here primarily
15 for support really". 15:21
16
17 He says:
18
19 "If you prefer my dad to ask you the question, he
20 will". 15:22
21
22 So, you weren't prepared to hear from Michael O'Brien,
23 is that fair, or you wanted to control that?
24 A. Well, I felt -- I think the issue was complicated by
25 Michael O'Brien's -- about Michael O'Brien's 15:22
26 qualifications. You know, the MHPS allows for people
27 to be supported by somebody and it says that they can
28 be legally qualified, of course, but that really they
29 are not there in a legal environment. I felt this was

1 a question that if Mr. O'Brien wanted to raise, then
2 look, it could come from Mr. O'Brien. It didn't take
3 somebody else to be raising this. But ...

4 173 Q. Okay. So, you were concerned about what you might
5 describe as the thin line between him coming here in 15:22
6 a representative capacity and coming there to support
7 his father?

8 A. Yes.

9 174 Q. Leaving that point aside and looking at the point that
10 he is working up to. At the bottom of the page, he 15:23
11 said:

12

13 "Would you not have provided what day the evidence, all
14 the points that he wants, that is to respond to in
15 detail beyond the points in the Terms of Reference 15:23
16 before he would date his witness" -- I think that
17 should say "make" perhaps his witness statement -- "if
18 you like"?

19

20 You say: 15:23
21

22 "There will be an opportunity to do both so we will
23 provide -- we are in the process of agreeing all of
24 those statements and our -- so there is a volume of
25 paperwork going back and forth in terms of the 15:23
26 agreement of those", et cetera.

27 A. I didn't say that, Mrs. Hynds said that.

28 175 Q. Sorry, Mrs. Hynds. Do you agree with what Mrs. Hynds
29 was saying?

1
2 why did you get to the stage of convening a meeting
3 with Mr. O'Brien when he hasn't been provided with the
4 witness statements containing reference to some of the
5 issues he will have to address?

15:24

6 A. Well, as I have indicated previously, most case
7 investigations, the person who is the subject is
8 usually the first person. We didn't do that in that
9 case, and it was more about me feeling that I was
10 adequately informed. If there were issues that arose 15:24
11 in that, then I could certainly raise them with
12 Mr. O'Brien. I was happy for Mr. O'Brien to come back
13 and to discuss those again at a different stage. The
14 intention had always been for those witness statements
15 to be shared with Mr. O'Brien beforehand. Time was 15:24
16 moving on. I just decided, I'm afraid, that look, we
17 have to get on with this because the terms of reference
18 are there, they are very specific, a lot of them
19 already have numbers and figures attached to them. As
20 I said, you know, whether it was 400 records in your 15:25
21 house or 200 records in your house, you know, does that
22 really matter? I really felt in the interests of
23 progressing things that we needed to move on.

24 176 Q. What was the point of gathering witness evidence;
25 directing, in some cases, allegations and providing 15:25
26 information in support of allegations about Mr. O'Brien
27 if he is not going to be given an opportunity at this
28 meeting to deal with it?

29 A. Mr. O'Brien was given the opportunity to deal with the

1 witness statements, and indeed did so. I mean,
2 Mr. O'Brien responded with very specific points to
3 a number of the witness statements, and I saw those.
4 In fact, I believe they were appended in full so that
5 the Case Manager would be aware of that.

15:26

6
7 As I say, my view was that I was putting to Mr. O'Brien
8 some of the areas that had been raised. But most of
9 the areas raised, in any event, were included in the
10 terms of reference already. The point of the witness
11 statements was for me to get an understanding of the
12 extent of the issue, how it had been managed to date,
13 what attempts had been made to try and manage the
14 situation, what assistance had been given to
15 Mr. O'Brien to try and manage the situation. All of
16 those things, whilst not directly -- this came from
17 witness whoever, weren't put to Mr. O'Brien in that
18 format, but if there was anything additional to the
19 terms of reference that had come up from witness
20 statements, I did try to put them in that. And then he
21 was provided with all the witness statements and
22 encouraged to put any response that he had back to us
23 for us to consider.

15:26

15:26

15:26

24 177 Q. Of course that's right but my question was directed at
25 this meeting. This meeting was set up so that
26 Mr. O'Brien could be interviewed with a view to
27 providing a witness statement on each of the four ToR
28 issues. Now, you allowed him a dispensation of not
29 commenting on ToR 4, but he was being drawn into that

15:27

1 meeting, as it appears from the common correspondence,
 2 under some degree of protest that he hadn't been
 3 supplied with the material that you had in your mind
 4 and were able to address through questions; he hadn't
 5 had the preparation time to look at that to see what he 15:27
 6 was up against. Do you think that fair?

7 A. Mr. O'Brien was a witness.

8 178 Q. Yes.

9 A. Like everybody else.

10 179 Q. Okay. Was he not also primarily the respondent in 15:27
 11 a process which was directed at his professional
 12 performance?

13 A. Yes, of course. He was both; he was both the witness
 14 and he was the subject of the investigation. I felt
 15 there was enough information in the terms of reference. 15:28
 16 Ideally, I would have very much liked Mr. O'Brien to
 17 have copies of the witness statement before we spoke to
 18 him. That wasn't possible because of the timeframe to
 19 date, and, rightly or wrongly, I felt look, we need to
 20 push on and we will give you the opportunity to see 15:28
 21 these as soon as we can.

22 180 Q. You were in charge of the process?

23 A. Yes.

24 181 Q. As the investigator?

25 A. Yes. 15:28

26 182 Q. You had a degree of control or power in relation to the
 27 processing of witness statements. It was you who
 28 decided to push for a meeting before those witness
 29 statements could be disclosed to Mr. O'Brien?

1 A. Yes. I thought Mr. O'Brien needed to be given --
2 I think I felt he had waited long enough and I felt he
3 needed to be given an opportunity to respond to the
4 terms of reference. As I say he was both a witness and
5 he was the subject. I felt time was moving on. I was 15:29
6 aware that Mr. O'Brien was very unhappy about
7 timeframes and I felt duty-bound to try and move things
8 on.
9
10 I wasn't trying to be unfair to Mr. O'Brien or to 15:29
11 blind-side him in any way, if that's perhaps an
12 implication. I really felt he waited a long time and
13 this was pressing on and he was unhappy about the
14 timeframe as it was.

15 183 Q. You may not have been intended that. The question, I 15:29
16 suppose, is whether it was a fair process.

17 A. Yes.

18 184 Q. And you believe it was?

19 A. Yes.

20 185 Q. You are quite content that he was required to come to 15:30
21 this meeting in the absence of witness statements?

22 A. I think it wasn't ideal but I don't think that it was
23 -- I don't think it was going to cause significant harm
24 or affect the things that he had to say significantly.
25 I think it was a very lengthy meeting, I think it went 15:30
26 on for nearly three hours, so I felt Mr. O'Brien had an
27 opportunity to answer the issues raised. I'm not sure
28 that there were significant additionality from the
29 witness statements, in any event.

1 MR. WOLFE KC: Chair, it appears unlikely that we will
 2 finish Dr. Chada's evidence today. I am in your hands
 3 in terms of whether you wish to take a break, sit to
 4 4.30, or whether you wish to proceed until 4:00 or
 5 shortly thereafter and rise?

15:30

6 CHAIR: Just allow me to consult with my colleagues to
 7 see which they would prefer. I think we will take
 8 a quick break, Mr. Wolfe, and come back again at 3.45.

9
 10 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

15:38

11
 12 CHAIR: welcome back, everyone.

13 186 Q. MR. WOLFE KC: Thank you.

14
 15 Good afternoon, Dr. Chada. We will probably sit until
 16 4.30, if that's okay.

15:48

17 A. Yes.

18 MR. WOLFE KC: We are in discussions about the
 19 possibility of Dr. Chada coming back next Wednesday but
 20 we will finalise that after the hearing today.

15:48

21 CHAIR: It's becoming a feature unfortunately,
 22 Dr. Chada, that a witness gets a date to come and speak
 23 to us and has to come back, I'm afraid.

24 MR. WOLFE KC: Perhaps a feature of my advocacy.

25 CHAIR: I wouldn't go that far.

15:49

26 A. I probably talked too much.

27 187 Q. MR. WOLFE KC: It was agreed that Mr. O'Brien could
 28 speak to the private patients issue at a subsequent
 29 meeting with you, isn't that right? In other words,

1 you didn't draw him into detailed discussion about term
2 of reference 4, the private patients term, because he
3 was unsighted at that point in relation to the detail
4 of the allegations that he faced?

5 A. Yes. He hadn't received that information and I didn't 15:49
6 feel it was fair to expect him to comment on specific
7 patients and specific examples without sight of --
8 without having an opportunity to look at them.

9 188 Q. On the 13th September that year, Mrs. Hynds writes on
10 your behalf to Martina Corrigan in relation to the 15:50
11 private patients matter. I just want to have a look at
12 that and the role of Mr. Young in the time that's
13 available today. TRU-283681. I said the 13th
14 September, the 14th September. Sorry, scroll down the
15 page. 15:50

16
17 Mrs. Hynds is writing, asking on your behalf for
18 clarity around the process undertaken to address the
19 clinical priority of the TURP private patients.

20 15:51
21 "Who assessed the clinical priority and what was this
22 based upon? Can you please provide me with a copy of
23 the information pertaining to each private patient
24 assessed. Could I please have this information as
25 a matter of urgency? If you have any queries, please 15:51
26 come back to me".

27
28 So, eight months into the investigation, you don't even
29 have the basis for the allegation around private

1 patients; is that fair?

2 A. Yes. I think -- I think, and I can be corrected on
3 this, Mrs. Hynds may be able to inform you better, but
4 I think we actually got the information on the private
5 patients, or some information on the private patients, 15:51
6 at the beginning of August. I think I said to
7 Mr. O'Brien, look, we only got this today and I'm
8 sorry, I don't expect you to answer on this point.

9
10 I think one of the issues that Mr. O'Brien raised at 15:52
11 that first meeting might have been - or maybe it was
12 Siobhán and I discussing it - was this issue of the
13 fact that it wasn't just TURP patients that were looked
14 at. I never really understood that it was just to be
15 TURP patients but there was this issue of where does 15:52
16 this list come from? Who made this list? I felt
17 Siobhán and I needed some information about that that
18 we could share with Mr. O'Brien before we met with him
19 again.

20 189 Q. Mm-hmm. The assumption - and we will look at this just 15:52
21 in a slightly different context later - the information
22 conveyed to Mr. O'Brien on I think it was the 24th
23 January 2017, when he met with the then investigator,
24 Mr. Weir, was that they had concerns about nine private
25 patients who had undergone a TURP? 15:53

26 A. Mm-hmm.

27 190 Q. And he proceeded on the basis of an understanding that
28 that was the allegation to be faced. And as you are
29 pointing out to us now, in fact, the nine patients

1 became eleven patients that were scrutinised?

2 A. Mm-hmm.

3 191 Q. Only three of which were TURP patients?

4 A. Yes.

5 192 Q. If we scroll up the page then, please, and see what
6 Mrs. Corrigan has to say by way of return.

15:53

7
8 The process undertaken was that Ronan "had requested
9 Wendy Clayton, op lead to request a report to be run on
10 all Mr. O'Brien's surgery during 2016. Any patient
11 that had a short wait between being added to the
12 waiting list and being operated on had their records
13 checked on the NIECR to see if they had a private
14 patient letter i.e. a Personal Information
redacted by the USI letter. Out of this

15:53

15 list that were eleven patients for which all the
16 letters were printed off. I" -- that is
17 Mrs. Corrigan -- "then asked Mr. Young if he could look
18 at these letters and gauge from his clinical opinion
19 could they have been as soon as they had been or should
20 they have been added to the NHS waiting list to wait
21 and be picked chronologically. Mr. Young agreed. He
22 took the letters away and, using NIECR i.e. checking
23 lab results, imaging and any other diagnostics
24 available, made his decision on whether, in his
25 opinion, they were sooner than they should have been."

15:54

15:54

15:54

26
27 She is attaching letters with Mr. Young's comments,
28 "which he went through with me and advised which he
29 felt was reasonable or not".

1
2 So, what did you take from that e-mail? Did you
3 understand, firstly, that Mr. Young had been asked to
4 conduct an evaluation of eleven patients against
5 a particular standard, which seems to be a time 15:55
6 standard; which doesn't have any other particular
7 definition? But this was all being done without
8 reference to you?

9 A. Yes.

10 193 Q. You didn't know that it was Mr. Young, the witness, who 15:55
11 spoke to you earlier in the year about his knowledge of
12 Mr. O'Brien?

13 A. I didn't know at the time that this was undertaken that
14 it was Mr. Young that was undertaking this, no. But
15 obviously I knew subsequently. 15:56

16 194 Q. There were no instructions or directions given by you
17 in respect of this private patients issue?

18 A. No. The private patient issue was term of reference 4,
19 which was provided to me.

20 195 Q. Mm-hmm. 15:56

21 A. And it was a wide -- you know, it was private patients
22 whose wait times appear to have been shorter than they
23 might otherwise have been. I think it was quite vague
24 in those terms. I don't recall mentioning it being
25 specifically TURP patients. But I mean, I had no input 15:56
26 into developing term of reference 4 or how it was
27 worded. It was just one of the terms of reference I
28 was provided with.

29 196 Q. Did you give any thought as to whether a practitioner

1 colleague of Mr. O'Brien within the Service, within
2 Urology Service, was an appropriate person to be
3 giving, I suppose, expert evidence to you or evidence
4 involving an expertise around these matters in these
5 circumstances?

15:57

6 A. I considered that Mr. O'Brien was a very senior
7 colleague along with -- sorry, Mr. Young was a very
8 senior colleague of Mr. O'Brien's. I thought,
9 therefore, that he would have a good knowledge of
10 waiting lists. I knew that his practice in terms of 15:58
11 waiting times and waiting lists and the length of time
12 he had been in the Trust was lengthy; not as long as
13 Mr. O'Brien but certainly longer than some of the newer
14 consultants. And I feel there's an obligation on all
15 of us to act as independent practitioners in this 15:58
16 situation so I expected that he would do a fair
17 analysis. So, I didn't feel that it was inappropriate
18 for Mr. O'Brien -- or, sorry, for Mr. Young to do that.
19 I felt he would give a fair and balanced account. I
20 believed that he would give a fair and balanced 15:58
21 account. I felt because his practice and his length of
22 time and so on was similar, that that would be helpful.

23 197 Q. Is it fair to say that at no point did you speak to him
24 about his analysis on the private patients issue?

25 A. Yes, that's a fair comment.

15:59

26 198 Q. We will look at his product in a moment but he produced
27 a table. Or he produced, first of all, notes; then he
28 spoke to Mrs. Corrigan about what his notes meant; she
29 sent the product across to you?

1 A. Yes.

2 199 Q. Mr. O'Brien, as we will see in due course, challenged
3 the conclusions which were reached by Mr. Young across
4 nine of the cases, that there were eleven cases in
5 total but Mr. Young felt two of them were appropriately 15:59
6 dealt with -- two of the patients were appropriately
7 treated at the time they were treated, but there was
8 conflict or dispute around the nine.

9

10 You accepted Mr. Young's view on that and didn't put to 16:00
11 Mr. Young -- didn't ask questions of Mr. Young in
12 respect of what Mr. O'Brien was saying. Have I got
13 that right?

14 A. Yes, that's correct. So, Mr. Young -- I was produced
15 a list of patients. Mr. Young had made comments on it 16:00
16 and whether he was felt it was appropriate or not for
17 them to be placed on a waiting list when they were.
18 I put that to Mr. O'Brien and asked Mr. O'Brien, once
19 he had a chance to see these, to look at them and to
20 see if he had an explanation for that. I included both 16:00
21 Mr. Young's opinion and Mr. O'Brien's opinion in the
22 investigation report.

23 200 Q. In terms of Mr. Young's product on this, could we just
24 bring up on the screen, please, TRU-01069. That's
25 a table showing eleven patients who had been seen by 16:01
26 Mr. O'Brien privately, who were then treated on the
27 NHS, or received diagnostics on the NHS. Those are the
28 days since they were added to the waiting list in the
29 view of Mr. Young. Isn't that right?

1 A. Yes, that's correct, yes.

2 201 Q. As I have said, he found that two of the cases were
3 reasonable. Or in the case perhaps of the second one
4 down, perhaps "mandatory" is the word that Mr. O'Brien
5 uses, mandatory, treats that patient having regard to 16:02
6 cancer access times.

7

8 If we just scroll down, please. The main document,
9 just to orientate the Inquiry, is a letter in the hand
10 of Mr. O'Brien to a general practitioner. Then what 16:02
11 Mr. Young appears to have done, although we have no
12 direct evidence on this, it's not contained in any
13 statement from him, is his Post-it note setting out
14 what he thinks of the case. It would require
15 translation from him, perhaps. It sets out a series of 16:03
16 dates and then it ends with a query "urgent", and he
17 repeats that exercise across eleven cases?

18 A. Yes.

19 202 Q. That's what you were getting through the Trust from
20 Mr. Young? 16:03

21 A. Yes.

22 203 Q. Not a report, not a statement, a series of Post-it
23 notes produced into a table summarising his views.

24

25 Did you think that was an entirely satisfactory way to 16:04
26 deal with this issue in circumstances where you didn't
27 have access or you didn't seek to achieve access to
28 Mr. Young to further discuss these issues?

29 A. I think it was -- I felt that it was a very senior

1 clinician considering this, with a lot of experience
2 behind him to know what the waiting times were. It was
3 perfectly clear from every witness that we spoke to
4 that waiting times for Urology were -- well, I mean,
5 they were just, I suppose, unacceptable but of course 16:04
6 they were unacceptable but they were very lengthy. And
7 waiting times for Outpatients appointments were
8 lengthy, waiting times for surgery were lengthy, and
9 therefore it was clear to me that waiting times which
10 appeared short, therefore, were outside what one would 16:05
11 have expected, but I didn't interrogate this any
12 further. It was put to Mr. O'Brien and Mr. O'Brien
13 gave a full response to each one of these.

14 204 Q. One of the things that Mr. O'Brien said to you was
15 where is the comparative analysis? In other words, if 16:05
16 you looked at patients who had not been treated
17 privately, would you see cases treated by him with
18 similar conditions treated in a similarly short
19 timeframe? Do you recall he made that point to you?

20 A. Yes -- 16:06

21 205 Q. He also made the point that if you look at his private
22 patients in total, or patients that had been treated by
23 him privately before going on to the NHS list, you will
24 see lots of private patients sitting on the list for
25 a lengthy period of time. The question becomes, in 16:06
26 trying to assess this issue and where the proper
27 conclusions could be drawn, could you have done more by
28 way of investigation to effectively bottom this out?

29 A. I think we could have done more and I think that

1 applies to most things when you are investigating. It
2 was difficult because interrogating waiting lists, I
3 was told, was difficult because if patients were
4 formerly private and then went on to the NHS waiting
5 list, at times it was difficult to identify that they 16:07
6 had been formerly private. I think that was one of the
7 questions I asked Mr. O'Brien. I said would I, if
8 I went along and looked at a waiting list, know that
9 easily? So, I think there were a lot of matters that
10 complicated the situation. 16:07

11
12 The comparator for this -- the comparator that was used
13 was an average NHS patient. Not an average Mr. O'Brien
14 patient but an average NHS patient. Was Mr. O'Brien
15 putting private patients -- were private patients 16:07
16 waiting a shorter period of time for surgery than one
17 might expect for an average NHS patient. I understand
18 that was the term of reference and that's the
19 comparator that was used. Rightly or wrongly, that's
20 the comparator that was used. I do accept that 16:07
21 Mr. O'Brien felt that that isn't the comparator that
22 should have been used. But, as I say, the issue of
23 trying to establish who was a private patient who then
24 becomes an NHS patient and at what point that happens
25 and so on became very complex. So these were put to 16:08
26 Mr. O'Brien. As I said, he provided a full response to
27 this and, you know, that's what we took and we
28 progressed with that.

29 206 Q. I may want to come back to this issue just to tidy some

1 threads of it up, but I suppose I'm asking you about
2 the role of Mr. Young primarily. He was a consultant
3 and a manager; he was the Clinical Lead; he was
4 a witness to your investigation who may - certainly it
5 was open for to you determine whether any criticism 16:09
6 should be visited him upon, particularly around ToR 5
7 and what management knew about these issues and what
8 they did or didn't do.

9
10 I introduced this morning the NHS Framework and drew 16:09
11 your attention to whether there was any need in this
12 case to involve someone with clinical expertise. It
13 appears from Mr. Young's work in this particular issue
14 that he was being asked to apply his clinical expertise
15 in respect of whether patients should have been seen at 16:09
16 the time they were seen.

17 A. Mm-hmm.

18 207 Q. He was giving that information to you in a circuitous
19 route. He wasn't putting it into his statement, he was
20 putting it in through Mrs. Corrigan, and you didn't 16:10
21 have access to him or didn't seek to have access to
22 him, and you didn't instruct him in the alternative as
23 an expert. This was a case where expertise independent
24 of the Service should have been brought in; is that
25 fair? 16:10

26 A. At the time I felt that Mr. Young was an appropriate
27 person to do this. I felt he understood how the
28 waiting lists in the Trust -- how long waiting lists
29 were; what the process was for adding people; what the

1 processes that the Trust adopted were. At the time
2 I felt that he was an appropriate person. On
3 reflection, I think if I was doing it again, I would do
4 it differently.

5 208 Q. As we know, you met with Mr. O'Brien again on 6th 16:11
6 November and, by that time, he had been provided with
7 this information that Mr. Young had developed and he
8 was able to comment on the ToR 4 issue. As I say,
9 there's some threads in association with that that
10 I want to come back to you with. We can see that 16:11
11 there's a transcript again of that meeting. For the
12 Inquiry's note, it's to be found at AOB-56285.

13
14 At that meeting, at the very outset Mr. O'Brien advised
15 that his priority after the meeting would be to deal 16:12
16 with his appraisal in the remaining weeks and months of
17 the year. Is it fair to say that you agreed with him,
18 that he was entitled to focus on that, notwithstanding
19 that there were other elements of the
20 investigation-related work that he needed to fulfil and 16:12
21 complete?

22 A. Yes. He was saying it had been a very difficult year
23 for him and that he felt that he needed to focus on his
24 appraisal as a matter of priority. I had raised with
25 him at the meeting in August that, in my view, issues 16:12
26 that needed to be carried out at certain times needed
27 to be carried out. You know, the GMC just didn't allow
28 you not to do your appraisal or not to do CPD or
29 whatever. He felt that this was weighing heavily on

1 him. Bearing in mind how long this process had taken
2 to date, the fact that information hadn't been given to
3 him in a timely manner, I felt it was appropriate to
4 allow him some time to gather his thoughts on his
5 appraisal and on the things that had been provided to 16:13
6 him.

7 209 Q. I suppose you did that fully realising that this might
8 add some further time to what was already a lengthy
9 process?

10 A. Again, you know on reflection, you think, you know, 16:13
11 maybe I shouldn't have done that, but I really felt
12 that he made a heartfelt plea that this was not his
13 priority just now and he had had a very difficult time.
14 I was very conscious that that was indeed the case and
15 he was making that point. And it is a fine balance 16:14
16 between trying to be fair and accommodating and
17 understanding and trying to get a process completed.

18
19 Mr. O'Brien was the single-most vociferous voice in
20 terms of the timeframe of all of this, so he was asking 16:14
21 for this delay. I kind of felt, well, do you know, we
22 have taken a long time to get all this information so
23 in fairness to him, if he's asking for this delay, that
24 doesn't seem unreasonable.

25 210 Q. His purpose in seeking time, after completing his 16:14
26 appraisal, was to allow him to comment on witness
27 statements which you had gathered and sent to him, and
28 also to provide comments in respect of the witness
29 statements that he was providing. Is that right?

1 A. Yes. Well, the request for the delay was to do with
2 his appraisal --

3 211 Q. Yes.

4 A. -- primarily. He said, look, I want to spend the next
5 couple of months focusing on getting my appraisal 16:15
6 information and CPD information gathered and getting my
7 appraisal sorted out and then I will turn my attention
8 to this. The first, I suppose, couple of months of
9 that, November/December, the rest of the year I think
10 he said were for appraisal, and then my view was that 16:15
11 he was to put things together in January was, I
12 suppose, the time I had in my head.

13 212 Q. Yes. There was a job for yourself and Mrs. Hynds to do
14 and that was to compile his witness statement, isn't
15 that right, and to send it off to him for approval or 16:15
16 amendment arising out of the meeting on 6th November?

17 A. Yes.

18 213 Q. Let's just turn our attention to events in February
19 2018. TRU-269358. At the bottom of the page, please,
20 Siobhán Hynds is writing, commenting: 16:16
21
22 "It has been some weeks since we last engaged about the
23 ongoing investigation. When we last met with you,
24 Dr. Chada and I advised that we were at the conclusions
25 stage of our investigations and the meeting with you in 16:16
26 November was the last meeting we felt was required".
27
28 And ultimately she is telling him:
29

1 "I have the notes of our meeting in November to share
2 which will also require your agreement. We do however
3 have your written statement on those issues in full so
4 that was a small matter to be finalised".

5
6 The statement hadn't been sent to him at that stage;
7 isn't that right?

8 A. Yes, that's correct.

9 214 Q. Yes. If you scroll up the page, after being reminded
10 on the 22nd February to reply to the 15th February
11 e-mail, he says:

12
13 "It would appear that I have misunderstood the
14 arrangements and commitments agreed at our last
15 meeting. I was of the understanding that I would next 16:17
16 receive the note of that meeting in November '17 and
17 that then I would reply with suggested amendments to
18 both notes and comments upon witness statements".

19
20 He says he had been checking e-mails to ensure he had 16:17
21 not overlooked a further communication and had been
22 wondering why there had been such a long delay.

23
24 "I have not had time to attend to the process since
25 November '17", and he would be grateful if he could be 16:17
26 provided with a note of the meeting and any other
27 documentation.

28
29 From there, a statement is compiled and then sent to

1 Mr. O'Brien for signing off?

2 A. Yes.

3 215 Q. That was sent to him on the 4th March; isn't that
4 right?

5 A. Yes, I believe so. 16:18

6 216 Q. why had it taken from the November meeting to the
7 4th March to provide Mr. O'Brien with his statement for
8 checking and signing off?

9 A. I don't know the answer to that. I am not sure what
10 led to that delay. I am not sure if it was 16:18
11 a combination of delays with Mrs. Hynds and with myself
12 and with Christmas. So, I really -- I can't even
13 speculate. I am not sure of the reasons for that
14 delay. As far as I was aware, that was the only
15 outstanding piece of information for Mr. O'Brien. 16:19

16 217 Q. It is the case that that provision of the statement or
17 an outline statement to him or a draft statement,
18 however we describe it, was an essential part of the
19 process. That ball was in your court and the process
20 couldn't be completed until he saw that and agreed it? 16:19

21 A. I absolutely accept that. As I have said, I think he
22 had everything else that he needed. I think, as that
23 e-mail outlines, Mr. O'Brien has said he hadn't had the
24 time to attend to the process since November '17. I am
25 not sure whether he had looked at the other things but 16:19
26 certainly that statement should have been provided at
27 an earlier stage and I absolutely accept that.

28

29 May I add it does appear that Mr. O'Brien had

1 transcripts anyway, so although he didn't have the
2 statement from us, the information from that day was
3 available to Mr. O'Brien. That's not taking away from
4 the fact that we should have provided that statement at
5 an earlier stage, and that was a deficit. 16:20

6 218 Q. It's part of the picture that you weren't aware of,
7 obviously, but --

8 A. Yes.

9 219 Q. -- I think you agree with me that until he had
10 a statement set out, as you understood his position to 16:20
11 be in the November meeting, commenting on each of the
12 eleven private patients - that was the statement that
13 was produced for him arising out of that meeting.
14 Until he had that, you couldn't complete -- until he
15 had that and approved it, you couldn't complete your 16:21
16 process?

17 A. No, we couldn't complete our process and he couldn't --
18 and I absolutely accept that he couldn't progress his
19 side of it either. So I mean, I absolutely accept that
20 that was a deficit and that was an warranted delay. 16:21

21 220 Q. He wrote to you then on the 2nd April to complete his
22 engagement with the process in terms of his written
23 work; isn't that right?

24 A. Yes, that's correct.

25 221 Q. Is it fair to say that by this stage, you thought 16:21
26 Mr. O'Brien was deliberately delaying?

27 A. I was concerned about that at this stage. I felt when
28 -- I mean, you will see from the e-mail correspondence
29 that we would provide a date, he would go past it,

1 suggest a different date. So, I was concerned that he
2 was deciding when this was going to finish. I didn't
3 think that we were being -- whilst the delay was
4 entirely our fault in terms of the witness statement
5 that needed to be got to Mr. O'Brien, and I absolutely 16:22
6 hold my hands up to that, I felt that there didn't need
7 to be this period of time to draw things together
8 because a lot of the information was already available;
9 the appraisal time in November and December had gone
10 past. So I was starting to worry that we needed to get 16:22
11 this pushed on and that maybe Mr. O'Brien wasn't being
12 as accommodating as he could. However, having said
13 that it, you know, I acknowledge the comment that you
14 made earlier about, you know, perhaps Mr. O'Brien felt
15 that we were trying to push on without him being 16:23
16 provided with things, you know. So, I expect there
17 were issues on both sides.

18 222 Q. Yes. Certainly he replied to you on the 2nd April,
19 which was roughly a calendar month after you had sent
20 him his statement for consideration? 16:23

21 A. Yes. Well, I went back and said look, we were trying
22 to get this completed before the end of the month and
23 so -- I think he had suggested the 31st and I think
24 that's right, actually and I said look, if we get it
25 finished say the 29th or 30th, let's try and do that, 16:23
26 let's set a deadline. That was a day or two ahead of
27 what he had suggested. I only suggested that because
28 I think I was doing something, or there was some reason
29 why I sort of said let's try and get it done for then.

1 That was with a couple of weeks of warning, maybe more
2 than that. We said look, this is -- we are just going
3 to have to draw a line under this at this point. And
4 the lines kept being moved. So, originally I think we
5 said the 9th March and then I think we said the 26th
6 May and then the 29th May. Actually, on reflection,
7 that wasn't a good idea because perhaps Mr. O'Brien
8 took from that that we would continuously move the
9 lines. I do accept that the lines moved and that
10 wasn't ideal either.

16:24

16:24

11
12 I also would say that I don't know if Mr. O'Brien felt
13 that there was a hidden agenda. I certainly had
14 absolutely no hidden agenda. I wanted this done,
15 I felt it had gone on far too long.

16:24

16 223 Q. Could I draw your attention to some remarks that were
17 made by the grievance adjudicators that had considered
18 the complaint registered by Mr. O'Brien when it came on
19 for the first stage grievance hearing in 2020. If we
20 could bring up on the screen, please, AOB-02804. In
21 terms of the delay in the process, the Grievance Panel
22 at first instance found:

16:25

23
24 "It is our finding that Mr. O'Brien was not inclined to
25 progress and he controlled this by his inaction. We
26 observed with the benefit of hindsight now in 2020 that
27 there ought to have been a more assertive management of
28 Mr. O'Brien, even though he would have been unlikely to
29 have welcomed that. If he considered he had no time

16:26

1 and valued faster progression of the matter with the
2 certainty he expressed his grievance, he ought to have
3 asked if space could be create to allow him to progress
4 his inputs".

5
6 In light of what you have said in the short period of
7 time before I drew attention to this, would you accept
8 that any delay in this process was more the fault of
9 the investigating team, including yourself, than it was
10 Mr. O'Brien, because - and let me just illustrate that 16:26
11 - you couldn't meet with him until late June, which
12 didn't suit him for reasons you agreed were reasonable,
13 but you met quickly at the start of August when both of
14 you were available. Then the meeting in November
15 wasn't progressed until he had all available material, 16:27
16 and it was within your gift to supply him with that
17 material. Then we had the period of time which you
18 agreed he could take to complete his professional work
19 that he had to do during December. The investigation
20 team then, it seems, forget to send him the statement 16:28
21 that he needed signed off before you could complete
22 your process.

23
24 So, if there was any delay, would you agree that it
25 wasn't his fault at all? 16:28

26 A. I wouldn't agree that it wasn't his fault at all.
27 I think there were many factors which led to delays.
28 There was delays in getting information, delays in
29 arranging witnesses, delays in not having appropriate

1 support to get witness statements typed up and things.
2 So, I think there was a multitude of factors for delay.

3
4 I think Mr. O'Brien contributed to those delays,
5 I absolutely accept that I significantly contributed to 16:28
6 those delays. In retrospect, and having reflected on
7 this, I think I would have been wiser to have
8 considered having more time to be able to do this in
9 a timely fashion. I certainly wouldn't go through this
10 process again, I don't think any consultant would. 16:29
11 This is actually one of the reasons consultants don't
12 volunteer for investigations like this any more,
13 Mr. Wolfe, and I don't blame them. That's why, because
14 we are expected to do this in the middle of everything
15 else. 16:29

16
17 In fairness to Mr. O'Brien, Mr. O'Brien worked solidly
18 through this. You know, he was seeing patients, he was
19 doing Outpatients, he was doing extra theatre lists.
20 In fairness to everybody involved, I think there was 16:29
21 a multitude of reasons. But if you are asking me was
22 he not responsible for any of them, I'm sorry, I
23 couldn't agree with that, no.

24 224 Q. which part do you think he could have responded with
25 greater expedition? 16:30

26 A. I think if Mr. O'Brien didn't want this to be dragged
27 into the following year, he could have said well,
28 actually, do you know what, I will put my -- I mean,
29 his appraisal was already ten months late, you know.

1 Really, delaying it for another two months wouldn't
2 have made a huge difference. As I say, I was mindful
3 that this was something that he was indicating that he
4 was very stressed about. If I was doing it again,
5 I would say no, actually, I'm sorry, but your appraisal 16:30
6 is ten months late already, another couple of months
7 isn't going to matter. I do think that he contributed
8 to delays.

9
10 I think whilst we didn't get the statement to him in 16:30
11 time, and that is entirely our fault, you know,
12 I absolutely accept that, we had those notes and that
13 statement should have been got to him, and probably my
14 fault - clarifying that very specifically - but the
15 fact is other information was available by that time to 16:31
16 him, and he could have had a lot of his responses
17 prepared and drawn up and ready to go, waiting for that
18 statement. The statement was sent to him and there was
19 still a period of delay. So, I don't think it's
20 entirely fair to say that none of it was Mr. O'Brien's 16:31
21 fault. I don't think that is a fair comment.

22 225 Q. Do you agree with the opinion of the Grievance Panel,
23 and it's repeated, I suppose, a similar sentiment in
24 the review of the grievance -- maybe just in fairness I
25 will bring this up for your attention, AOB-50034. 16:31
26 There was a Grievance Panel and then that grievance
27 decision was reviewed. At 5.8 to 5.9, this is the
28 decision of the Review Panel. It comments on what the
29 Grievance Panel has said. It says [it]:

1
2 "... recognised that there's a contribution to the
3 delay by both the Trust and Mr. O'Brien in relation to
4 concluding the MHPS investigation. We find that this
5 should have been concluded in a timelier manner. If 16:32
6 this investigation were as serious as it was reported
7 to be, the investigator should have been given time out
8 of her normal commitments to carry out the interviews
9 necessary and have the reports completed. This did not
10 happen. It is not referenced. There was no one 16:32
11 pressing the completion of these matters, irrespective
12 of the breach of the published timeframes. While
13 Mr. O'Brien complains about the timescale of these
14 matters, he too contributed to this, and while some
15 delays are understandable and acceptable, others simply 16:32
16 are not. The Trust has contributed to this. While one
17 might argue that the parties are equally culpable, the
18 Trust, as the employer, has the responsibility to take
19 control of the process in the timescale for completion.
20 Its general acceptance of the slow pace and failure to 16:33
21 seek to have" -- this is the grievance closed out at an
22 earlier position deserves mention so perhaps that moves
23 on into the grievance issue?

24
25 But in terms of the analysis at 5.8 - just scroll back 16:33
26 so we can see it again - in terms of the progressing of
27 the MHPS bit, they are, I suppose, putting the blame,
28 as you have, across a number of factors and suggested
29 that a significant factor here was that you were not

1 relieved of your professional duties to enable you to
2 go about this more efficiently. Is that an analysis
3 you would have some agreement with?

4 A. Yes.

5 MR. WOLFE KC: Thank you for your evidence today. It's 16:34
6 just after 4.30. The Inquiry will speak to your legal
7 team with a view to having you back next week. Sorry
8 about that, but that concludes our business today.

9 CHAIR: Thank you. 10:00 tomorrow, ladies and
10 gentlemen. 16:34

11
12 THE INQUIRY WAS THEN ADJOURNED TO WEDNESDAY, 22ND OF
13 MARCH 2023 AT 10:00 A.M.
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