Urology Services Inquiry

Oral Hearing

Day 36 – Tuesday, 18th April 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

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THE INQUIRY RESUMED AT 10:20 A.M. ON TUESDAY, 18TH APRIL 2023, AS FOLLOWS:

CHAIR: Good morning, everyone. Welcome back. I hope everyone managed to get some downtime over Easter. 10:20
A special big welcome back to my colleagues here; it's good to see them in person again.

Mr. Carroll, good morning. Mr. Wolfe.

10:20

THE WITNESS CONTINUED TO BE EXAMINED BY MR. WOLFE KC AS FOLLOWS:

1 Q. MR. WOLFE KC: Good morning Mr. Carroll. Thank you for coming back to us. We're starting from page 5 of my 10:20
speaking note.

Mr. Carroll, we last heard from you on about the 2nd March. It was Day 29 of the Inquiry's hearings. The transcript, for the record, for those hearings is to be 10:20
found from TRA-03506 - we don't need that up - through to 03553.

When you were last with us, Mr. Carroll, we spent some time that afternoon looking at your input into the 10:21
events of September 2016. You'll recall that there was the first Oversight Committee or Oversight Group meeting that month that led to a certain decision; Mrs. Gishkori's unhappiness, if I can put it in those

terms, with that decision. We rounded off, I think, when you told me that Mrs. Gishkori didn't want to pursue the action plan that had been agreed by the Oversight Committee, and you said that it would be a lengthy process, or it was anticipated that it would be a lengthy process, and would not necessarily have a favourable outcome. The Chair picked you up on that and asked what you meant by a favourable outcome, a favourable outcome to whom? Thinking back on that you said: 10:21 10:22

"I suppose Mrs. Gishkori wanted an outcome that allowed Mr. O'Brien to work with us. And rather than being viewed as being some sort of sanction or some sort of punitive, that he would be happy to work alongside us". 10:22

That's where we left on the last occasion. Do you agree with that?

A. Yes.

Q. Thank you. I want to ask you some questions about whether you were aware of Mrs. Brownlee, the Chair of the Trust Board, seeking to have any input or seeking to make any intervention around what was going on either at that time o r later. Before I ask you some questions about that, can I put up on the screen some pieces of information or evidence that the Inquiry has received. If we can put up on the screen WIT-87673. This is the witness statement of Dr. Tracy Boyce who was pharmacy within the Trust? 10:22 10:23

A. She was the Director of Pharmacy, yes.

3 Q. And she had a governance role supporting Mrs. Gishkori within Acute?

A. Correct.

4 Q. She has volunteered to the Inquiry the following account: 10:23

"I would like to add information about a telephone call that I inadvertently witnessed, as it, I think, it may be evidence of some level of pressure on one of the 10:24 Acute Services directors who did not fully investigate Mr. O'Brien's practice. I cannot remember the date of the meeting and I did not make a note of the incident at the time. However, I know that it must have been after the concern in relation to Mr. O'Brien's triage 10:24 practice was identified as I understood the context of the call without it having to be explained".

Paragraph 44.3: 10:24

"I was in a one-to-one meeting with Esther Gishkori, Director of Acute Services, in her office on the Craigavon Hospital administration floor, updating her on my pharmacy responsibilities. The telephone rang and Mrs. Gishkori answered it whilst I was in the room. 10:25 I realised she was speaking to the Chair of the Trust, Mrs. Roberta Brownlee, and while I indicated to Mrs. Gishkori that I would leave the room to give her privacy, she told me to stay. I could not hear what

Mrs. Brownlee was saying, however I recall that Mrs. Gishkori did not say very much in response to Mrs. Brownlee during the call and that she became very flustered. When the call ended, Mrs. Gishkori told me that the Chair had asked her to "leave Mr. O'Brien alone" as he was an excellent doctor and a good friend of hers who had saved her life of one of her friends" -- that might be corrected to "or" one of her friends. We'll speak to Mrs. Boyce about that.

"I remember saying to Mrs. Gishkori that the Chair's behaviour was unacceptable and she should document the call and speak to the Chief Executive about it as her line manager. I do not know if Mrs. Gishkori escalated the telephone call and it was never mentioned to me again".

That quote ends at WIT-8674.

If I could put one other piece into the mix before I ask you some questions, Mr. Carroll. This comes from the statement of Martina Corrigan. If we can have up on the screen WIT-26225. She says:

"I have an awareness of at least two occasions where managers had been asked to step back from managing Mr. O'Brien. In approximately 2011 /2012 Mr. Mackle had been advised that he was being accused of bullying and harassment towards Mr. O'Brien and that he needed

to step back from managing him. I was not present when Mr. Mackle was told this but he came straight to me after this happened, told me about it, and was visibly annoyed and shaken and said to me that he would no longer be able to manage Mr. O'Brien". 10:27

More pertinently from your perspective, Mr. Carroll, she says:

"I also understand that in mid-2016, Mrs. Gishkori received a phone call from the then Chair of the Trust, Mrs. Brownlee, and was requested to stop an investigation into Mr. O'Brien's practice. Once again, I did not witness this but I was told later by Mr. Carroll that it happened as my understanding is that Mrs. Gishkori had told some of her team". 10:27 10:28

Just to finalise, Mrs. Brownlee, in her statement at WIT-95894, has said:

"I would never interfere". This is at 48.1. This is the quote from what I've just read out. Then, just scrolling down: 10:28

"This account from Martina Corrigan is third-hand. Martina states that she heard from some unnamed member of Esther Gishkori's team that I had asked Esther to halt an investigation into Mr. O'Brien. I would never interfere in due process in this way. Patient Safety 10:29

was always my top priority, and I have absolutely no doubt that Esther will confirm that this never happened. I never made any phone call to Esther Gishkori about Mr. O'Brien".

10:29

Now, Mrs. Corrigan's account, Mr. Carroll, suggests that you were an informant to her or other members of staff in respect of what has been described here. Do you recall anything resembling what I've described from these statements?

10:30

A. Yes. So, I would have an awareness that Esther had received a phone call from Mrs. Gishkori. I do think it was Esther - Mrs. Gishkori - who told me. When she told me exactly, I don't recall, or where she told me I don't recall. But certainly Mrs. Gishkori did tell me, and I think others possibly, but I wouldn't be too sure of that, that she had received a phone call from, allegedly, Mrs. Brownlee in regard to how Dr. Boyce describes it in terms of Mrs. Brownlee's -- again, I'm hearing - I'm getting this second, third-hand, I wasn't there - but it was something along the lines of Mrs. Brownlee speak to Mrs. Gishkori in regard to Mr. O'Brien and the management of Mr. O'Brien.

10:30

10:30

Q. Just to be clear because your evidence was perhaps a little uncertain in respect of elements of that. Can I just maybe drill down with you.

10:31

You had the conversation with Mrs. Gishkori?

A. Yes.

6 Q. Mrs. Gishkori told you that she had received a telephone call from Mrs. Brownlee?
A. Correct.
7 Q. Were you told that Dr. Boyce was present during that telephone call? 10:31
A. No, I don't believe so. No.
8 Q. Okay. And you're unable to date when Mrs. Gishkori told you about it?
A. Yes.
9 Q. And you're unable to date when the conversation between Gishkori and Brownlee took place? 10:32
A. Yes.
10 Q. Obviously, you took over the Assistant Directorship role in the spring of '16, and there are a number of important events which we know took place within 12 months of that, including the September Oversight Committee meeting, the December Oversight Committee meeting, leading then on to the MHPS investigation. 10:32

Are you able to help us at all, even approximately, as to when in the context of those events - before those events or much after those events - that Mrs. Gishkori spoke to you? 10:32
A. If I were -- I'm not certain by any means but I think it might have been in and around the September time. But again, I'm not certain. It would have been, yes, in and around September '16, I think. 10:33
11 Q. It would appear from what we saw on the last occasion that you had some dealings, perhaps in quantitative

terms quite a lot of dealings, with Mrs. Gishkori over that period of time. Is that fair?

A. Sorry, I interacted with Mrs. Gishkori?

12 Q. In terms of your engagement with Mrs. Gishkori in September 2016. 10:34

A. Yes.

13 Q. In terms then of what you were told about Mrs. Brownlee's conversation with Mrs. Gishkori, could you help us as precisely as you can in terms of what you were told? 10:34

A. I mean, I can't remember exactly but it was something along the lines of Mrs. Gishkori said that she had received a phone call from Mrs. Brownlee, and the content of that conversation was Mrs. Brownlee asking Mrs. Gishkori to - and then these are my words -- go easy on Mr. O'Brien as he was a good doctor. 10:34

14 Q. Okay.

A. But again, I didn't make a note of that meeting. I didn't register it.

15 Q. But is it fair to say is that, if you like, the broad memory -- 10:35

A. Yes.

16 Q. -- with all its frailties that you describe that you take from that conversation?

A. Yes. My memory is I was spoken with, Mrs. Gishkori did tell me, and I think there may have been others. And it was broadly along those line that Mrs. Brownlee had phoned her and asked her to go easy on Mr. O'Brien. But again, those are my words. 10:35

17 Q. In terms of Mrs. Gishkori's response to that, as she was describing it to you, did it have an impact on her, are you able to say? How did she react to what she had been told in terms of how she was describing it to you?

A. Again, I think she was annoyed. Yes, I think she was annoyed. Maybe upset. I genuinely can't remember her emotions, her reactions. So, I'm guessing she would -- well, she would have been upset to have received that phone call. 10:36

18 Q. Did you form the impression from your memory that you were being told about this shortly after the phone call happened? 10:36

A. Yes, I believe so. Yes.

19 Q. Was anybody else present when Mrs. Gishkori told you about it? 10:36

A. I have no memory of anybody else being present.

20 Q. How did you react to it in terms of your thought processes around it?

A. Again, I thought it was unusual in that the Chair would ring the Director and instruct her - again, those are my words - instruct her to go easy with Mr. O'Brien. I've never known it to happen. In my working career, I've never known it to happen. 10:37

21 Q. Now, Mrs. Corrigan, as I've said, indicates it was you that told her about it. Do you recall that? 10:37

A. I genuinely don't, no. I'm sure I did. I've no doubt I did, but when I did it, I have no memory of.

22 Q. Moving on. I want to look for the next short while at what happens after you emerge from September.

If we can put up on the screen TRU-257640. We saw on the last occasion, Mr. Carroll, how, on 22nd September, you had brought your assistance to bear on a letter drafted by Mr. Weir which was to form part of this alternative approach, alternative to the Oversight Committee, and led, it seems, by Mrs. Gishkori. You clarified that your approach was to try and add robustness in terms of the monitoring ability and the quantification of these issues. 10:39

Now, there was an Oversight Committee meeting three weeks later then on the 12th October. If you just bring that up on the screen, please. AOB-01079. At the bottom of that page, this is the 12th October - you're obviously not present at this meeting - the decision made, if we go to the bottom of the page, is that: 10:40

"Mrs. Gishkori has informed the Committee that Mr. O'Brien is going for planned surgery in November; likely to be off for a considerable period. It was noted that Mr. O'Brien had not been told of the concerns following the previous oversight. It was also noted that a plan was in place to deal with the range of backlogs within Mr. O'Brien's practice during his absence. Then Mrs. Gishkori gave an assurance that when Mr. O'Brien returned from his period of sick leave, that the administrative practices identified by 10:40 10:40

the Oversight Committee would be formally discussed with him to ensure there was an appropriate change in behaviour. It was agreed that this would be kept under review by the Oversight Committee".

10:41

I wonder if you can help us with this. Mr. O'Brien doesn't go on sick leave until the middle of November. You had contributed to finalising the letter that was to go to him on 22nd September; roughly a period of three months between those dates. What we see here in this decision, seemingly led by Mrs. Gishkori, that Mr. O'Brien would not be spoken to until after he came back from his leave of absence, his sick leave. Were you privy to her thinking in that respect or any discussions in relation to that?

10:41

10:42

A. No. I don't recall Esther and I having any discussion in regard to or leading up to this October Oversight meeting.

23 Q. So after contributing to the letters --

A. Yes.

10:42

24 Q. -- as we've just seen, was that, in essence, your final act or your final input around this?

A. Well, as I said the last time I sat here, I viewed this plan to be being controlled by Dr. McAllister and Mr. Weir. I had said if you needed assistance with any part or all, I was happy to do that. So, I was waiting on either of those senior doctors to come back, or Mrs. Gishkori to come back, but they never came back to me so I never progressed with anything. I don't recall

10:42

having conversations with Mrs. Gishkori leading up to this meeting.

25 Q. In terms of whether there was any awareness of continuing risk to patients, any discussion around that, you simply aren't in a position to assist us? 10:43

A. Well, I don't recall any discussions being had with me in regard to progressing Mr. Weir's action plan as of the 22nd. Now, I know Mr. Weir in his evidence said he was looking for the initial meeting with Mr. O'Brien to be with Dr. McAllister and they just found it difficult 10:44 to get dates between all three lined up. I suppose that's the only I can offer. But in terms of my input, I didn't do anything other than what I did to Mr. Weir's plan.

26 Q. In terms of your input, you are the Assistant Director 10:44 with responsibility, obviously with people below you and people above you, for this service. Did you not feel any inclination to push this towards commencing the process with Mr. O'Brien, it having been, if you like, on the agenda in one shape or form, one form or 10:44 another for most of 2016?

A. I know it's very difficult and hard to explain that for that length of period, no action was taken, but I suppose that's the reality. Again, my take on the meeting that we had with Dr. McAllister and 10:45 Mrs. Gishkori on the 14th September was Dr. McAllister and Mrs. Gishkori and Mr. Weir, they had a plan and they would take the plan forward to bring an outcome, a positive outcome, a suitable outcome in terms of the

management of Mr. O'Brien. Whilst I contributed to editing in some way the Mr. Weir plan, maybe naïvely I was leaving it to the senior doctors to progress.

27 Q. Could I put a perspective to you which goes something like this: Mr. O'Brien is, it appears, plainly in the dark that all of these events are taking place behind the scenes in respect of him. These matters directly concern him. On the one hand, we have NCAS advising that Mr. O'Brien needs significant support to be able to address these matters, and these matters are allowed to drift with no action being taken, no discussion with him. Then we get to the Oversight Group meeting on 22nd December, taking a decision to have a formal MHPS investigation and exclusion of him - and views may differ about his response to the letter of 23rd March - but he has not been engaged to do anything about his shortcomings and he has not been provided with any support to address his shortcomings. 10:46 10:46 10:47 10:47

Is he entitled to feel aggrieved about that, in your view?

A. Yes. With hindsight, absolutely. I mean, the whole process of any dispute or any member of staff who is underperforming, or viewed or deemed to be underperforming, is about two-way communication. So yes, with hindsight Mr. O'Brien should have been spoken with, should have been advised of what was happening; what had happened and what was happening. 10:48

I don't recall me being exposed to NCAS advice leading up to -- and I think I only read it in preparation for the Inquiry. But I take your point, Mr. O'Brien should have been communicated with.

28 Q. It may well be, as perhaps is implied by this minute, and we'll hear from Mrs. Gishkori this afternoon, that a decision was taken, perhaps from a welfare perspective or a soft-landing perspective, if I can put it in those terms, that Mr. O'Brien shouldn't be approached on the edge of going in for a procedure himself. That's not something you can comment upon, is it? 10:48 10:49

A. No. I just think as a principle of fairness, Mr. O'Brien should have been consulted with.

29 Q. Yes. Thank you. 10:49

Now, we know that when Mr. O'Brien was given the March letter, it provided that he should return patient charts to the hospital premises without further delay. Now, I just want to ask you some questions around what happens in October and November in relation to that issue. 10:49

If we could have up on the screen, please, TRU-251438. Perhaps just scroll down to the bottom of the page, and down maybe into the top of the next page and I can pick it up from there. 10:50

Pamela Lawson, is she in medical records?

A. Yes. She's the head of.

30 Q. So 17th October, five days after the last Oversight meeting, she has just learned that Mr. O'Brien is going off on sick leave and she would like to get any charts back into Records from his home. She notes that Martina Corrigan is off on leave until the end of the month, and she's asking is there anything we could do in the meantime. So, that issue is on her agenda. 10:51

10:51

If we scroll up to the top of the next page.
Simon Gibson is asking Martina, upon her return from leave:

"In the context of discussions held last month, do you know volume of charts Dr. O'Brien has at home?" 10:51

So, that issue hasn't gone away, some people are actually thinking about it. But perhaps the easiest knot to untangle arising out of the March letter should have been the "notes at home" issue. We'll see by January of 2017 the number of notes that return from his home. 10:52

Can you help us with this, and maybe you don't agree that maybe it was the easiest knot to untangle, there doesn't seem to have been any follow-up on even that issue, "please get your notes back into the hospital. You were told in March that we require them back 10:52

forthwith". Was that an issue that ever crossed your desk?

A. I suppose the short answer is no. I didn't progress any aspect of the March '16 letter, as I said on the 2nd March. I mean, I'm not being copied into these emails so that was going on without me knowing. Would it be possible to pull up the March letter? 10:53

31 Q. Indeed. It's to be found at -- I don't have the reference right to hand.

MR. BOYLE: AOB-00979. 10:53

MR. WOLFE KC: Thank you, Mr. Boyle.

32 Q. That's the letter of 23rd March. If we scroll down to the next page, please. "Patient notes at home". You were going the right way. Thank you. Just pause there. 10:54

He has been told:

"This has been an ongoing issue for years and needs addressed urgently. We request that all Trust charts that are in your Home or in your car be brought to the hospital without further delay". 10:54

I used the word "forthwith" earlier. Does that assist you with what you wanted to say? 10:54

A. Again, I'm just restating what I said earlier. I mean, I didn't progress any of the actions 1 to 4 on the March '16. I admit, as I said previously, with hindsight it's something I regret, and I should have.

33 Q. There's another development around this that I wish to put to you. If we just bring up on the screen, please, AOB-01226. We have here - just that so I can see the text - Mr. O'Brien is writing to Martina Corrigan on 14th November. He says that he's going to be having his surgery on Thursday morning, expects to be home again over the weekend. He says:

"I expect that I will be well enough to dictate correspondence concerning patients and have the charts delivered to Noleen's office", that's his medical secretary, "for typing". 10:55

"I would greatly appreciate if I could be afforded this opportunity to have all charts returned in this manner". 10:56

So, he is off sick. It's quite clear from the email that he intends to work while on sick leave or while convalescing, and it is quite clear that he has notes at home. 10:56

If we could just go on up. That's right, that direction. So Martina responds, saying: 10:56

"I'm more than happy with this plan. Please let me know if there is anything I can do to assist."

Then she asks about a particular chart which Governance

are seeking.

Again, you're not copied into this but it would appear on any analysis that Mrs. Corrigan is not only aware of the continuation of the charts at home saga, but she is giving her blessing to a plan which allows him to work at home while on sick leave on those charts and return them in the manner that he sees fit when he's done with the dictation, it seems. Again, is that issue something that you were consulted upon? 10:57

A. Again, the short answer is no. I only became aware of this email in the bundle. Martina and I -- I have no recollection of Martina and I discussing Mr. O'Brien working whilst on sick leave to catch up on his dictation. 10:58

34 Q. In light of what we know was the Trust's purported concern to get these charts back, and you have a situation where one of your managerial colleagues is seemingly, and for reasons we can explore with her, endorsing a continuation of the status quo ante, how does that sit with you? 10:58

A. Well again, it undermines the principle or the purpose of the March 2016 letter, in that the Trust felt it appropriate to formally write to Mr. O'Brien asking them to action the four elements of what was documented in the letter and for him to come back with a plan. In fact, Martina was a part author of that letter to Mr. O'Brien. I suppose what I would say to the Inquiry is that it undermined that letter and the purpose of 10:58

that letter.

35 Q. The fact that the letter had been issued... Just to focus on this issue of the notes - nobody had rapped his door again to say, 'March letter. You were told in clear terms, get these notes back'. The fact that that doesn't happen and then we have this, Mrs. Corrigan endorsing retention of the notes for the purposes of allowing him to dictate, it reflects an inconsistent practice at best? 10:59

A. I wouldn't disagree with you on that. It doesn't read very well. 11:00

36 Q. So October, we're into November. Is it the case, in terms of your role, because of the decision taken at the Oversight meeting in October to await Mr. O'Brien's return before this issue is going to be grappled with, that you're getting on with your many other tasks, and Mr. O'Brien's world and the concerns that the Trust had about him are not on your agenda any more until December? 11:00

A. That would be fair to say, yes. 11:00

37 Q. An email is written on the 6th December. Just pull this up on the screen. TRU-251827. We can see Esther Gishkori is writing to Dr. Wright, then Medical Director, copying Vivienne Toal. She is updating him that Mr. O'Brien has had surgery, and sick lines are being submitted. If we scroll down, she's referring here to the "SAI review continuing and will no doubt produce its own recommendations", and I want to turn to that SAI from your perspective in a moment. That's the 11:01

SAI concerning Patient 10. You know who I'm talking about.

She said in the concluding paragraph:

11:02

"I have been having conversations in relation to Mr. O'Brien's 'return to work' interview. We thought this would be a good time to set out the ground rules from the start. Since Colin and Charlie are both off sick, Mark wondered if you and I could do this. Since there are both professional and operational issues here, I feel that this is entirely reasonable."

11:02

So, this is the 6th December. Up the page, please. Richard Wright signals that this sounds very reasonable and asks "any ideas when that is likely to be?"

11:02

In terms of your engagement, this is the 6th December, do you have any understanding that this is how it is to be done, Mr. O'Brien would be spoken to after he returned? I suppose it is only reinforcing to some extent what had been decided in October.

11:03

A. Yes. That's what I was going to say, it sounds like a follow-on from what Mrs. Gishkori fed back to the Oversight Committee in October. Again, I'm not in those emails and I don't recall having discussions with Mrs. Gishkori about what she wrote to Dr. Wright.

11:03

38 Q. There's no sense at this stage, while the SAI is mentioned and there's an awareness that there is an SAI

working its way through the system, there's no suggestion at this stage that the SAI is going to affect the plan or the strategy going forward with regard to Mr. O'Brien?

A. The strategy in terms of Mr. Weir's... 11:04

39 Q. In terms of how Mr. O'Brien's shortcomings or perceived shortcomings would be managed?

A. No. I don't recall being party to any conversation in regard to -- I suppose from my mind, Mr. Weir's plan was still the plan that was on the table to be 11:04 progressed.

40 Q. Yes.

A. Now, I do appreciate Dr. McAllister in October, and then Mr. Weir, both went off on sick leave, and maybe with hindsight that was a missed opportunity to sit 11:04 down and have a discussion about Mr. Weir's plan and the possibility or the reality would it ever be -- would life be given to it, and should we have a rethink and revisit the decision of the September Oversight Committee meeting. But that never -- and that's just 11:05 me with hindsight. But those discussions never took place.

41 Q. Now, the sense that this could be left until after Mr. O'Brien returned to work and the rules would be set out to him at a return-to-work meeting, the strategy, 11:05 if you like, or that plan going forward was to change upon developments around the SAI. Do you recall that?

A. Yes. I think, from reading the evidence, Mrs. Gishkori received communication from Dr. Boyce in November,

I think the middle of November, where she gave I suppose a heads-up as to what the SAI Panel chaired by Mr. Glackin was saying. Then I think Mrs. Gishkori writes a separate email to Mr. Wright in regard to her concerns about the SAI.

42 Q. Yes. I can help you with that by putting up some of the documents. Maybe if we just help the Inquiry through this if we look just briefly at what you said in your statement on this, WIT-21122. At 14.1, you say:

"On 16th December I received an email from Dr. Tracey Boyce of Pharmacy with responsibility to Acute Governance, addressed to Mrs. Gishkori. The email had attached to it a letter of 15th December 2016 from Mr. Glackin expressing three concerns vis the default triage system, the patients' notes leaving the Trust and patients' letters not being dictated in a timely manner".

Then you go on to talk about the Oversight Committee meeting which was to meet within the week.

Let's just go then to what Dr. Boyce sent to you. It's a letter or a note marked "Dear Tracey". If we could have that up on the screen, please. It's AOB-01245.

While this isn't signed, it's your understanding that it's authored by Mr. Glackin, who was leading on the

SAI review for Patient 10; is that right?

A. That would be my assumption, yes.

43 Q. He's setting out in this document, is it fair to say, some findings and analysis and concerns arising out of the SAI review? 11:08

A. Correct.

44 Q. If we just scroll down the page, please. Further on down, thank you. Just back down, please, to the bottom of the page.

11:09

He's saying that upon conclusion, the Review Team have a number of concerns in relation to Mr. O'Brien's practice, it seems, which go beyond the instant case, that go beyond simply Patient 10's case. Is that your understanding? 11:09

A. Yes. Yes.

45 Q. If we scroll down further, please. He says that "these issues and themes concern the following", and he sets out three issues.

11:10

The first issue is the use of an informal process to monitor and manage urology letters which had not been returned with management advice, in other words they hadn't been triaged. That's the first issue.

11:10

The second issue is that a look-back exercise had been conducted and it revealed that a patient chart could not be found on the premises. Just scroll down, please. He says:

"On balance the Review Team agree there is sufficient cause for concern that Trust documentation may be leaving Trust facilities and the process of record transportation for this speciality does need urgently addressed".

Then, thirdly, the review Panel say that they have grave concerns, the third sentence: 11:11

"That other urology patient letters are not being dictated in a timely manner". They say that:

"The Panel have found that the Trust does monitor the number of charts needing audio-typing of dictation but there does not appear to be a robust process to monitor if post-consultation patient dictation has been completed". 11:11

That's a summary of what that "Dear Tracey" letter concerns. 11:12

In terms of your response to it, the SAI itself, Patient 10's SAI, when did you first become aware of that? 11:12

A. I think probably in and around this time. When I received this letter via Dr. Boyce, I remember speaking to Mrs. Corrigan and tried to dissect what Mr. Glackin was referring to see if we could understand and could

we quantify some of the issues. So probably in and around this time of Patient 10's SAI.

46 Q. We can see - and I don't need to bring it up on this screen, the reference for the Panel is PAT-000053 - that an SAI in respect of Patient 10 was notified in March 2016, and that was consequent upon an incident report having been raised by Mr. Haynes in January of that year. So, it's notified in March 2016 and it's reporting, as we can see from the "Dear Tracey" letter, towards the end of the year Dr. Glackin is saying we completed the SAI. Is it right to say that you have no awareness of it trundling through the system until that time? 11:13 11:14

A. Yes. I would not have been aware of, obviously in March of -- sorry, in January 2016, the Datix being completed. I know Mrs. Gishkori in her evidence does reference speaking to me and Mrs. Trouton in regard to it. In terms of Patient 10 registering with me and the gravity of it was probably when I received the "Dear Tracey" letter. 11:14 11:15

47 Q. Does that suggest in governance terms, an SAI being worked through the system isn't the subject of discussion in any forum in 2016 that you were a member of?

A. No. The normal process for any SAI would be the Datix, the screening, the investigation, and then the reporting at the end of investigation. That would have come to the Acute Governance meeting which was held on a monthly basis. It would not have been common 11:15

practice that an SAI would be referred to before the report had concluded, unless there was something extremely grave in it.

48 Q. This is a slight tangent to what we're talking about, but has that situation changed now? Is there a better ability in terms of the service that owns the SAI or is most interested in the SAI to keep tabs on it? 11:16

A. So, yes. We would have monthly governance meetings at which would be the governance coordinators, and they would update us as to progress or not of SAIs. That would be a normal practice now. 11:16

49 Q. As we can see from the "Dear Tracy" letter, it refers in the first bullet point to this method for dealing with triage that hasn't been done. It's referred to as an informal process for managing urology letters not triaged. 11:17

Can I ask you about something you've said about that to Dr. Chada. TRU-00763. Maybe bring it back up so the witness can see. At paragraph 8, you're referring us to the issues raised by Mr. Glackin. You say at paragraph 9: 11:17

"It came to my attention through this that because referrals from the booking centre were not coming back from Mr. O'Brien's office, it had been agreed that if referrals didn't come back, the secretary would put them onto the system according to the GP triage so they would not be lost in the system. Mr. Glackin wrote 11:18

expressing concern about that".

You say "I believe it may have been November '15" but you can see it is November 2016.

11:18

Is it the case that it's only when Mr. Glackin wrote the "Dear Tracey" letter, that it came to your attention that this default arrangement, if I can call it that, for the processing of untriaged referrals comes to your attention? 11:19

A. Yes. Yes. I mean, I don't recall having an understanding prior to that that the default system was in operation. I suppose my understanding is the default system came into operation in around 2014, and I would not have been aware of it in my previous 11:19 Assistant Director role. So when I came in in April, I don't recall Mrs. Trouton or Mrs. Corrigan advising me of the default system. Unless they're going to say something different, but that's my recollection, I didn't become aware of it until Mr. Glackin made 11:20 reference to it.

50 Q. You're obviously the Assistant Director within Acute. I know urology and the business around Mr. O'Brien is not the only item on your desk, and your involvement in that sort of peaked and troughed depending upon when 11:20 the issues came up. We saw on the last occasion you were in receipt of the March letter. If we just bring that up again, it is at TRU-274696. If we can look just under triage.

"There are currently 253 untriaged letters". It goes on to say: "Lack of triage means we do not know whether the patients are red-flag, urgent or routine. Failure to return the referrals to the Booking Centre means that the patients are only allocated on a chronological basis with no regard to urgency".

That is an indirect description of the default system, isn't it, that when triage isn't done, the system kicks in to allocate on the basis of chronology rather than any assessment of clinical urgency? 11:21

A. Yes. I mean, I accept that point. The patients were kept on whatever the GP had clinically prioritised them at. 11:21

51 Q. Is that something you didn't know? What did you think happened to referrals that weren't triaged?

A. I mean, in terms of registering with me, as I said, this letter I didn't act on in regard to when it reached my consciousness in terms of needing acted was around Mr. Glackin's "Dear Tracey" letter. I think you're being very fair in terms of I mean urology, and Mr. O'Brien particularly, was a very small element of my day-to-day work with many other challenges which would come across my desk on a daily basis. So yes, I accept reading that in the cold light of day it does make reference to the default system. 11:22 11:22

52 Q. But is it the case - and help me if you can with this - that for whatever reason, whether inattention to

detail, whether it's just the complexities of your working life, that you didn't fully appreciate, you didn't have a sensitivity to the implications of what you knew was going on with Mr. O'Brien's practice in terms of his failure to triage? 11:23

A. I think that's fair.

53 Q. If we go back to the "Dear Tracey" letter, AOB-01246. If we go to the top bullet point. Mr. Glackin records, about a quarter of the way down:

11:24

"The presence of this process implies that it was accepted that triage noncompliance was to be expected by a minority of consultants within the urology specialty. On 6 November 2015, an email from the AD of Functional Service formally implementing this process. 11:24 The Review Panel are anxious that the current process does not have a clear escalation plan which evidences inclusion of the consultant involved. In addition, this process has not been effective in addressing triage noncompliance. From 28th July 2015 until 11:25 5th October 2016, there are 318 patient letters which are not triaged".

I suppose that sets the problem with it in context. The failure to triage was not actually being grappled 11:25 with and there was no way of dealing with it, or the system seems to have given up on dealing with it. Is that a fair way to look at it?

A. I think I have reflected on this in my statement.

I think I said it was a flawed system. The default system was flawed for the reasons Mr. Glackin has just provided. It didn't address the underlying issue of non-triage or delayed triage.

54 Q. We'll go on and see in a moment that it appears to be, at least in part, the arrival on your doorstep of this letter and the implications of the failure to triage for a particular patient that was to be a trigger for the MHPS investigation. We'll look at that. This sense that failing to triage could place patients at risk, that would have been as obvious in -- it should have been as obvious in September, shouldn't it, as it appears to have become obvious in December? 11:26 11:26

A. I accept your point. I would also say it should have been as obvious when it was initiated in 2014 or '15, that the implementation of the default work-around did not fix the problem. 11:27

55 Q. Yes, I think that follows. I appreciate you for saying that.

11:27

In your statement you recall meeting with Mrs. Corrigan after receiving this "Dear Tracey" letter. I think you suggest that you received the "Dear Tracey" letter on 16th December but, in fact, we see action from Mrs. Corrigan on 15th December. So, it may well be that you received the "Dear Tracey" letter on the 15th. 11:27

A. Yes.

56 Q. Leaving that fine detail to one side, you say Mrs. Corrigan was asked to go away, as such, and report

on the various issues that arose from the "Dear Tracey" letter?

A. Yes.

57 Q. We can see, for example if we go to WIT-14348, that in respect of triage, these details are passed on to you on 22nd December. But if we just scroll down the page, please. Christine Rankin on 15th December is writing to Connie Connolly and Katherine Robinson. She is saying: 11:28 11:29

"As discussed please find attached spreadsheet containing 318 records which never came back from strategic".

It says: 11:29

"Copies of the letter for those highlighted in yellow have since been looked at by Mr. Brown and he has agreed the conditions are something he can see as opposed to whether or not the referral should be urgent or routine. We are currently booking these to Mr. Brown's clinics," etcetera. 11:30

Do you know whether that activity -- it was directed by Mr. Glackin; we can see that figure of 318 in his report. Was any other work done around triage at that time in terms of interrogating the issues, from your perspective? 11:30

A. No. Not at that stage, no. No.

58 Q. I suppose what stands out clearly from this email is that the Trust, through its staff, were clearly able to understand the extent to which triage wasn't being performed, isn't that right? The system enabled them to keep a track of this and produce the numbers. 11:31

A. Yes.

59 Q. This issue wasn't hidden?

A. I think what I could say or what I would offer is that with the default system in place, I suppose there was a false sense of security. I don't recall escalating 11:31 emails from the booking centre in regard to, for example these 218 records. Maybe everybody felt with the default system - and it had been in place since 2014 or '15 - that things were continuing on as had been for several years. 11:32

60 Q. Yes. What the Inquiry has seen is that up until introduction of the default system, there was a regular informal escalation process. So, emails would reach Mrs. Corrigan and she would then chase Mr. O'Brien to get the triage back. With the introduction of the 11:32 default system, that escalation process didn't occur. The cases, if they were left untriaged, simply went on the waiting list in accordance with the referrer's clarification?

A. Yes. 11:32

61 Q. Again, another flaw of the system; isn't that right?

A. As I said in my statement, I think the system was flawed.

62 Q. As regards undictated clinics, this "Dear Tracey"

letter seemed to have spurred some work around that. If we go to TRU-255968. Just scroll down the page, please.

Noleen Elliott on 15th December is e-mailing Andrea Cunningham. The subject is Backlog Report - No Clinic Outcomes. She says: 11:33

"Please find attached list of clinics with no outcomes completed as per 15th December...". 11:34

If we go back up the page, please. Keep going, thank you. Keep going. Katherine Robinson writes to Anita Carroll on this subject, and she says: 11:34

"See the attached list. This is a list of clinics that Mr. O'Brien has not dictated on and hence no outcome for some of these patients. There is a risk that something could be missed so I am escalating to you, although I know that a lot of the time Mr. O'Brien knows himself what is to happen with patients. Unfortunately, this was not highlighted on the backlog report. The secretary assumed we knew because there have always been issues with this particular consultant's administrative work from our perspective. 11:35 11:35

"As learning from this discovery, I have asked all secretaries to provide this information on the backlog report so that we fully understand the whole picture of

what is outstanding in each specialty. The secretary also advises that at present Mr. O'Brien is working on some of his backlog admin work as he is off sick recovering."

11:35

Just go on up the page, please. This is copied to you on the day of the Oversight meeting, which we'll come to in a moment. You then forward it on the day after the meeting, albeit I think it was the subject of discussion at the meeting.

11:36

Just go up the page again, please. Allow me a moment, Chair. If we could scroll down to TRU-255969. What we have here and on the subsequent page, 70 in this sequence, is 61 clinics which are said by Mrs. Elliott not to have been completed in terms of dictation. This is the origin of the 61 clinics which was to feature in Dr. Chada's report.

11:36

What was your understanding of the backlog report, Mr. Carroll? Was that something that you had a working appreciation of?

11:37

A. It was a report that I only came exposed to when I became Assistant Director for Surgery; it wasn't a report that was previously in the cancer and clinical services. My understanding was it was the backlog report described several aspects of the secretarial staff work. For example, ward discharges. I think there was two elements which referred to patients on

11:37

the ward, and then the third column referred to dictation, outpatient dictation. So clinics and the number of letters which were waiting to be dictated and typed.

My understanding, the development of that report was for the secretary, the RBC, to have an understanding of the working volume across all the secretarial staff to see was everybody up to date with their typing and, if they weren't, could resources be reallocated across the secretarial team. That's my understanding of the origins of the report. 11:38

63 Q. So, it was essentially a way of allowing managers to understand whether there was a typing backlog in any part of the system and, if so, whether it could be reallocated to any spare capacity amongst the typing pool? 11:39

A. Yes.

64 Q. The criticism which Katherine Robinson seems to suggest, if we go back to 67 in that series, two pages up, is that Mr. O'Brien's secretary was not highlighting on the report that dictation was not being completed. Was that the expectation of the secretary or, indeed, of the backlog report? 11:39

A. From my perspective, I mean the role of the consultant's secretary is to clearly undertake the typing associated with the work of the consultant in its totality, whether it be in-patient or outpatient activity. My expectation would be that any secretary 11:40

would be dictating the outcomes of clinics as they received them from their consultant.

65 Q. Of course. The point, I suppose, I'm asking is if Mr. O'Brien sees 12 patients at a clinic at the SWAH on a Wednesday afternoon but only two or three letters are dictated and come back to his secretary, what is she to do with her knowledge that he hasn't dictated on the remainder? 11:40

A. So, my expectation is that she would speak to Mr. O'Brien and say the clinic in SWAH, of the twelve patients seen, you've only dictated on three, where are the other nine? Then there would be an outcome from that. If there was no outcome, then I would expect her to have escalated that to her services administrator. 11:41

66 Q. If he's telling her, for example, I don't need to dictate on those now, they're not urgent or whatever, there's no expectation that she should take that anywhere else; her relationship is with Mr. O'Brien? 11:41

A. Well, yes, and I don't underestimate the relationship between the consultant and the secretary but also she has a responsibility to escalate to her superior, not least because if she's not dictating Mr. O'Brien's work, what is she doing. 11:42

67 Q. The point being she is dictating his work, he's not necessarily dictating on all of the clinical entries. She can't dictate if there's nothing to dictate. 11:42

A. What I'm trying to say, in your example if there's 12 patients and he only gives his secretary three, as opposed to 12, she is only doing a quarter of the work

that she should be typing.

68 Q. How is his failure to dictate, if we can call it that - and I know that that's not uncontroversial from his perspective - but how is that failure to dictate on a clinical encounter to be reflected on a backlog report? 11:43

A. It's not. I mean, I think that's one of the flaws in the system also. The report is only as good as the data that feeds it. If Mr. O'Brien is not dictating and there's a zero against Mr. O'Brien in the dictation column, you're lulled into a false sense - as we were - 11:43 you're lulled into a false sense that Mr. O'Brien is up to date with his dictation.

69 Q. We know from the March letter that the system was aware, through his clinical colleagues, his consultant colleagues, that he wasn't up to date with his 11:43 dictation. Obviously another source potentially for that might be the medical secretary, and we've looked at that.

Can I ask you to look at this document. It has been 11:44 drawn to our attention by Mrs. Elliott and we'll explore it more fully with her when she gives evidence. It is WIT-76603. I understand that she would describe this - and I shouldn't pre-empt her evidence too much - but this is a document which I understand is sent from 11:44 the Data Quality Team to medical secretary managers. Although we don't have any legends at the top to help us understand what the document is, if we can see, for example, when we first reach Mr. O'Brien about six

entries down and read across to the fifth column, there's a code, AAOBU1. That relates to an Armagh clinic. The clinic dates from 2nd November 2015. We understand that this report was run in April 2016. This is a method by which the Data Quality Team and the 11:45
medical secretary managers, as we understand it - and we can check this with Mrs. Elliott in evidence - it allows them to see where outcomes have not been finalised following a clinic. The shortcoming, for whatever reason, is that it doesn't deal with the SWAH 11:46
clinics, and again we can explore that.

Do you have any knowledge with this kind of report?

A. No, I don't.

70 Q. That's not something that ever crossed your desk from a 11:46
management perspective?

A. No.

71 Q. In terms then of the system that was in place or ought to have been in place to enable managers to understand whether dictation was happening, were you wholly 11:46
dependent, from your experience, on clinical colleagues identifying problems or medical secretaries identifying problems?

A. Yes, I think that would be fair to say. And, for what it was worth, the backlog report. 11:47

72 Q. The backlog report would tell you about --

A. Outstanding dictation.

73 Q. Well, it wouldn't tell you outstanding dictation, would it? It would tell you about the level of activity; it

would maybe tell you where dictation has yet to be typed, but it wouldn't tell you that Mr. O'Brien or any other clinician has failed to dictate?

A. No, and that's what I'm trying to say, is that the report had inherent weaknesses in it. If Mr. O'Brien doesn't dictate, you're not going to know that in the backlog report. So, yes, there's a shortcoming. 11:48

74 Q. Is that a shortcoming that remains to this day, or how do health service systems grapple with the possibility that a clinician isn't doing all the work in terms of dictation that is expected of him? 11:48

A. Yes. I do think that concern still remains in the health service. I'm not the most up to date in administrative dictation so I may not be the best person to give an opinion, but my understanding is we did move from audio typists to digital dictation, which improved, but we haven't gone beyond that, I don't believe. I know they tried to bring in another system; I can't recall the name of it. But I think digital dictation is as far as we got. I could be incorrect in that but someone more authoritative than me could tell you. 11:49 11:49

MR. WOLFE KC: Before we move to the Oversight meeting, can we take a short break, perhaps?

CHAIR: Yes. Five past 12, ladies and gentlemen. 11:49

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: Everyone. Mr. Wolfe.

75 Q. MR. WOLFE KC: Mr. Carroll, we've looked at various information coming into the system on triage, on dictation, in the days leading up to a decision to have a meeting of the Oversight group. What is your sense of the mood in those days following the "Dear Tracey" letter? Were you privy to conversations saying this is a development that needs to be grasped and that the intended track or the intended plan needs to change? 12:08

A. I have no recollection of being privy to any of those types of conversations. I have seen emails between Dr. Wright and Mrs. Gishkori in regard to Patient 10's SAI, and then Dr. -- 12:08

76 Q. Let me just bring one of the -- well, the email I'm aware of, up on to the screen. AOB-41585.

CHAIR: Mr. Wolfe, might that be 01585? 12:09

MR. WOLFE KC: Sorry, WIT-41585. My apologies. Bottom of the page, please.

Richard Wright is writing to Simon Gibson. Esther has rang, telephoned, Dr. Wright regarding worrying 12:10 developments in relation to what is described here as "AOB and lost notes". Do you understand that in the context in which you were working?

A. No, I don't.

77 Q. In any event, let's read on: 12:10

"Ronan is to report tomorrow with preliminary findings".

We know and we'll see at the Oversight meeting that you provided information around triaged dictation and notes at home. Is that what that refers to?

A. Possibly, yes.

78 Q. He says. 12:11

"I will come in tomorrow. If you're about could we set up a meeting with Ronan and if possible Mark Haynes to consider findings (Esther is off)".

12:11

She had some planned leave. It was coming up to Christmas; is that right?

A. I know she couldn't make it. Why she couldn't make it, I can't recall.

79 Q. He goes on to say: 12:11

"I don't think we can wait for the formal completion of SAI".

That's presumably a reference to Patient 10. 12:11

You were deputed to go to this meeting in place of Esther?

A. Correct.

80 Q. Do you recall any conversations with her - she was, after all, the Director of Acute - being, obviously, an important feature of September's interactions of the Oversight Committee and what followed. Any conversation with her as to how you were to represent 12:11

the views of the directorate at this Oversight meeting?

A. No, I don't recall having a conversation with Esther in terms of my attendance at the meeting or her giving me a brief as to a purpose of the meeting. No, I don't.

81 Q. We know that - and we don't need to go to these, the reference is AOB-01393 - Tracey Boyce sends through for the meeting a final draft of the SAI, a summary of the "Dear Tracey" letter, and a spreadsheet relating to triage. Then if we go to the meeting itself, AOB-01280. Just scrolling down to see how the context is described. It refers to the 13th September meeting where a range of concerns had been identified. It says: 12:12 12:13

"A formal investigation was recommended, and advice sought and received from NCAS". 12:13

Thinking back to that time - I know you weren't a member of the Oversight - did you understand that there was to be a formal investigation or was it to be an informal approach? 12:14

A. Reading the evidence bundles, my understanding was the September meeting was meant to be informal. I think Mr. Gibson's letter was 'and if things didn't improve, it would be formal'. 12:14

82 Q. It goes on to say then:

"It was subsequently identified" - as we've seen, we have looked at this this morning - "that a different

approached was to be taken as reported to the Oversight Committee on 12 October". Then: "Dr. O'Brien was scheduled to return to work on the 2nd January following a period of sick leave, but an ongoing SAI has identified further issues of concern". 12:14

Is that your understanding, Mr. Carroll, that it was the advent of the SAI and the conclusions associated with it that was the trigger for this meeting?

A. Yes, that's what I believe. 12:15

83 Q. Where do you obtain that belief from?

A. From the email that -- the "Dear Tracey" email which was sent to Esther and I, and then the conversations that were had between Mrs. Gishkori and Dr. Wright.

84 Q. We know, I've referred you to it, that there appeared to be a contentment or an agreement between Gishkori and Wright that these issues could be left until after Mr. O'Brien returned from sick leave. We saw the email earlier to that effect. What was your sense in association with the SAI of what had changed to trigger this matter being brought forward? 12:15 12:16

A. I think probably - and I could be wrong here, I could be wrong, could be incorrect - this was the first time there was a tangible evidence to senior managers that as a result of the review, that a patient, Patient 10, had come to harm. 12:16

85 Q. If we just scroll down slowly through this. Issue 1, this is Tracy Boyce, Dr. Boyce, summarising the SAI. He says:

"Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason".

"It is notes as part of this investigation that Dr. O'Brien had been undertaking dictation whilst he was on sick leave."

Then you report. You report that the triage count was 318 letters not triaged. We've seen earlier how that figure came to light. Sixty-eight were classified as urgent at that point. Do you know how that classification was arrived at? 12:17

A. More than likely I got it from Mrs. Corrigan. 12:17

86 Q. Do you know whether a clinician or someone else had made an assessment of urgency?

A. No, I don't.

87 Q. You have an action then arising out of that. What was required was a written action plan to address the issue of triage, isn't that right? We'll look in a moment at how you engaged with clinicians around this. 12:18

If we go to the top of the next page, please. The second issue is described as notes tracked to Dr. O'Brien, and it is said that a proportion of these may be at his home address. Is it fair to say that at this point, no work had been done to establish just how many charts might be in his possession? 12:18

A. That's correct.

88 Q. It is said that there is a concern that the clinical management plan for these patients is unclear or may be delayed. The action for you, again, is that tracking needs to be undertaken to quantity the volume of notes tracked to Dr. O'Brien, Mr. O'Brien, and whether these are located in his office. 12:19

Then issue 3. You, again, reporting that there was a backlog of over 60 undictated clinics going back over 18 months. Again, we saw earlier the figure was 61 based on what Noleen Elliott had sent through. You have said approximately 600 patients may not have had their clinic outcomes dictated so the Trust is unclear what the clinical management plan is for these patients. Again, an action for you, with Colin Weir, is to address this issue with a clear timeline. 12:19

Scrolling down. A further action was for Tracy Boyce to consider any previous IR1s and complaints to identify whether there were any historical concerns raised. 12:20

Just on that one, we'll come to the others separately, do you know whether work around that was ever performed? 12:20

A. The fourth action?

89 Q. Yes.

A. No, I've never seen any. I have never seen.

90 Q. Do you agree that in terms of trying to scope an MHPS investigation, consideration of that kind of material might be relevant?

A. Yes, on the basis that MHPS is about performance, and part of performance in its totality can be IR1s and complaints against the practitioner. 12:21

91 Q. We then come to the consideration of the Oversight Committee and essentially its decision. Just scroll down so we see all of that text. Thank you. 12:21

In summary, three broad decisions are reached. Mr. O'Brien is to be the subject of exclusion for the duration of a formal investigation. Secondly, there is to be a formal investigation under an NCAS approach, albeit it is recorded that Dr. Wright is to make contact with NCAS to seek confirmation of this approach. The third broad decision is the appointment of the case investigator, Mr. Weir, and a case manager, Dr. Khan. 12:21

12:22

I just want to ask you, Mr. Carroll, can you help us with this. Obviously, we have a very slimline minute here. Is it your recollection that the direction of travel throughout this meeting was always towards exclusion and a formal investigation; that that was the intended conclusion made obvious from the start of the meeting? 12:22

A. My memory of the meeting was when everything was discussed in terms of the data that was presented,

there was a feeling that the gravity of everything was more appreciated, and that, in order to understand it more comprehensively to enable operational managers like myself to determine the extent of it, that it might be best if Mr. O'Brien was excluded. That's my understanding of the meeting. 12:23

92 Q. In termination of options, because presumably there didn't have to be an exclusion, there didn't have to be a formal investigation, do you have a memory of options, alternatives, being discussed out loud by anyone at the meeting? 12:24

A. No, I do not have a recollection of that, no.

93 Q. Was it Dr. Wright who suggested exclusion and a formal investigation?

A. Yes, would be my... Yes. But am I absolutely sure that he said those words; no. But I suppose that it would be Dr. Wright who would have suggested it. He was the most experienced in the MHPS process. 12:24

94 Q. Can you remember options other than exclusion being talked through? 12:24

A. I don't, sorry.

95 Q. We've seen your role in the meeting up to this point. You're reporting on the facts as, I suppose, the preliminary investigations revealed to you. When it came to this point of the meeting when decisions had to be made on the way forward, were you a contributor to that part of the decision? In other words, were you part of the decision? 12:25

A. I would -- as I said when we first met, my knowledge of

MHPS, I had received no training, my knowledge was extremely limited in terms of the entire process. From my memory of this meeting, I think most of the discussion was between Dr. Wright and Mrs. Toal. I'm sure I contributed in a small way, but I suppose I didn't have the knowledge or experience to give any meaningful input would be my view. 12:25

96 Q. Go ahead.

A. But ultimately, maybe you'll come to it, when the decision was taken for exclusion, I agreed with that decision. 12:25

97 Q. The rationale, to the extent that we can divine it from what is said here, is that Dr. O'Brien's administrative practices have led to the strong possibility that patients may have come to harm. Was that the rationale for the decisions that were made? 12:26

A. Yes, yes. It was all -- well, my recollection was twofold. It was that patients may have come to harm as a result of, for example, the SAI, but also it was felt better that the investigation could take place by the operational managers if Mr. O'Brien was to be excluded for a four-week period. 12:26

98 Q. Mr. O'Brien, by this point, so far as we understand and we'll hear from him, was in the dark about the SAI. He certainly hadn't been given an opportunity to give a response to the SAI conclusions. Was that noted or was that a factor that was raised within this meeting, do you recall? 12:27

A. No. I don't recall it being discussed.

99 Q. When you think about it now, some of the key issues that were to be investigated under MHPS, so was Mr. O'Brien doing triage of urgent or routine referrals; well, that answer was obvious, wasn't it, he wasn't? 12:28

A. Correct.

100 Q. Is he dictating on all of his clinical encounters in a timely fashion, and is this causing some degree of uncertainty for the management systems. The answer to that again was obvious, wasn't it; he wasn't? 12:28

A. Correct.

101 Q. Again, is he keeping notes at home for extensive periods, again causing a degree of difficulty for colleagues and the system that relies on ready access to those notes. Again, the answer to that was obvious, 12:28 wasn't it? He wasn't. I assume all of that was realised at this meeting?

A. Yes. How you described it, I think when you put those three things together plus the yet to be fully reported SAI, then that made the decision. Helped inform the 12:29 decision.

102 Q. Yes. What from your perspective, given that the answers to those factual questions were perhaps obvious, what from your perspective directed the need for what became a fairly elaborate MHPS investigation? 12:29

A. Sorry, I don't understand.

103 Q. If you know these things are happening, what is there to investigate? What is there that merits an elaborate investigation?

A. So I think an investigation at this meeting, this Oversight meeting, I think an investigation in terms of MHPS, a formal one, was the right thing to do. Because, as you've just described, those four factors together did not paint a good picture in terms of Patient Safety.

104 Q. I suppose my point to you is this. Maybe I'm not being clear. You, as a committee, knew what was happening. Was it a question of we need to investigate to understand why? 12:30

A. I think it was to gather all the data. There were elements we still had to get data on. I think it was to do a bit of more reconnaissance so that we would have a better informed position of the totality of everything. 12:31

105 Q. The decision at that meeting was taken without NCAS advice. Again, you've described yourself being something of a stranger to the MHPS framework and its arrangements. Did it strike you as odd that advice was only being sought after a decision, whether in principle or however it might be described, had been taken? 12:31

A. No, because I didn't fully appreciate the systems and processes that needed to be followed.

106 Q. Did you appreciate what NCAS was? 12:32

A. No. At that point, no.

107 Q. You obviously set about some follow-up work after that meeting and we'll look at that just in a moment.

Shortly after the meeting, if we can bring up TRU-01366, you are referred to a further potential SAI in the case of Patient 16. You've seen the name in front of you, have you?

A. Yes. 12:33

108 Q. We'll call him Patient 16. Behind that email are documents related to concerns that had been expressed about Patient 16. I suppose the issue in the case was whether his care had been properly addressed. There was the need for a removal and, I think, replacement of 12:33 stent. Mr. O'Brien was the treating clinician, and you're asked by Dr. Boyce to give a view on that. If I just ask you again - slightly at a tangent to the MHPS process but it arises just after the Oversight meeting - should the issues associated with this one, 12:34 Patient 16, have fed into considerations associated with the MHPS process?

A. My understanding of Patient 16 originally came in as a complaint. As a result of working through the complaint, then Dr. Boyce sent this email to me. Then 12:34 we got into the -- the complaint continues on in terms of being investigated and reported and then it comes to be screened and was deemed to be an SAI. I think it was in April of '17. Its origins were as a complaint by Patient 16's daughter. 12:35

109 Q. What I'm really asking you is this. We've seen at the meeting of 16 December that Dr. Boyce is invited or requested to bring forward a report in terms of whether there have been any other complaints about Mr. O'Brien,

whether there have been any other IR1s, and here you have, immediately after that, information coming into the system that will ultimately lead to a decision to have an SAI in this case on the back of complaint?

A. Yes. 12:35

110 Q. What's at the heart of the complaint is, in essence, poor communication with the patient and his family, and delay in the provision of stenting, which leads to that complication. Why is that information not to be considered as part of the analysis of what needs to be 12:36 investigated around Mr. O'Brien's administrative practices?

A. So, looking in retrospect and knowing what we know now, yes, I think this complaint should have been part of the fourth item in terms of IR1s and complaints against 12:36 Mr. O'Brien. It should have been offered up but it wasn't and maybe Dr. Boyce can provide an explanation as to why that was. But I think you make a fair point, it was a complaint.

111 Q. Do you think enough work was done by the Trust and, 12:36 particularly, the Oversight meeting and those responsible for implementing the decisions which were ultimately to feed into the terms of reference for an investigation. Do you think enough background work was done to try to get to grips with all of the kinds of 12:37 perceived shortcomings in association with Mr. O'Brien's practice that were causing difficulty?

A. So I've thought about this quite a bit, particularly from March. I used the word that there was no coming

together of all views that everybody had. I think that was missing. There was no coming together of all the strands of information that everybody possessed. I think we were moving at quite a fast pace in and around end of December into January to collate the information. But with hindsight, should there have been weekly meetings of the Oversight meeting saying where are we now? Is there any more information that we have gleaned? How are we progressing with whatever actually needs to be done? That possibly would have been a much more robust system, but it didn't happen. Forensic is the word I'm looking for. 12:38 12:38

112 Q. Thank you for that perspective.

Let me ask you about the follow-up work which was clearly laid at your door to follow-up on after this Oversight meeting. First of all, what did you understand your role to be? 12:38

A. So, basically one of gathering information, gathering data to help inform the Oversight Committee. 12:38

113 Q. You've described that following the meeting you sent an email to Mrs. Corrigan and Mrs. Clayton to take some steps. If we can just look at that, TRU-258675. Hot on the heels of the meeting, just the next day 23rd December, you're writing to both of them to say we need an action plan to address the following, and you set out each of the four items. 12:39

Number 4 is the one I sort of picked up on earlier, Tracy Boyce had that action to complete. But you're asking Martina and Wendy, that's Corrigan and Clayton, to come up with some information around that. The other three, then, you're expecting information on the volume of notes tracked, what has been the outcome for the 318 patients, and what were the volumes of the patients where there's been no dictation and a plan to correct same. 12:39

12:40

On 28th December, if we look at AOB-01300, you become aware of what I will describe as the private patient issue. That wasn't an issue that was before the Oversight Committee on 22nd September, this was new information being fed in - I think if we look at the bottom email first - fed in by Mr. Haynes. Then if we look at what he's saying, he's referring here to a TURP patient. He attaches to his email some correspondence in respect of it. We don't need to look at that. But he's saying that there's a private patient letter from Mr. O'Brien. The patient was seen by Mr. O'Brien on 5th September and placed on the NHS theatre list on Wednesday the 21st, waiting a total of 15 days before a TURP procedure is performed. 12:40 12:41

12:41

If we scroll up to the top of the page, that issue is drawn to your attention. You say that you've asked Wendy - that's Wendy Clayton --

A. Right.

114 Q. -- to run a report on Mr. O'Brien's TURPs completed to see are there others who have been listed the same way.

You get each of those work streams moving and you report back on them at the 10th January Oversight Committee meeting; isn't that right? 12:42

A. That's correct.

115 Q. I'm going to come to that in a moment.

Obviously in association with what these preliminary investigations had discovered, there were obviously clinical issues to be addressed; isn't that right? 12:42

A. Yes. So we met with the consultant urologists, I think it was 3rd January, and we, I suppose, brought them up to speed with regard to what had been happening with Mr. O'Brien and the decisions that had been taken. We shared that with them and we asked them for their assistance to work through work that needed to be done. 12:42

116 Q. I needn't bring this up in ease of the time we have; you deal with that in your witness statement at WIT-1127. You say that the consultants were willing to work outside of core time or to displace SPA to assist with these investigations. They thought that the untriaged referrals were the greatest clinical concern and that this should be prioritised. Is that a fair summary of it? 12:43

A. That's fair, yes.

117 Q. They also said, according to your statement, that they would have preferred to accept Mr. O'Brien's opinion,

as it would be difficult for them to arrive at any other conclusion not having assessed the patient. Is that in respect of cases that hadn't been dictated, they were hoping to rely on or wishing to rely on the outcome sheets that Mr. O'Brien had completed? 12:44

A. That's correct.

118 Q. But they said to you that in the event that Mr. O'Brien's opinion led to a disagreement, that they would reassess the patients themselves?

A. That's right. 12:44

119 Q. I just want to get a sense from you about the impact of these large numbers of patients that were causing concern. What was the impact on the service, whether in terms of distraction from the heavy workload that was always there to be performed in terms of impact on 12:45 the other clinicians, impact on budget and finance?

A. Yes, you're right, this was a big impact on an already stretched urology service. But each of the consultants, all the consultants, were happy to contribute even with the pressures that existed on a 12:45 daily basis. Sorry, happy is not the right word but they understood the work that need to be done. They worked with us to address each aspect of that in terms of clinical prioritisation.

120 Q. One issue that they raised with you was the question 12:46 of whether Mr. O'Brien was entitled to do private work. Just have a brief look at that. If we go to TRU-00101. If we start at the bottom of the page, please. Thank you.

This is the 3rd January, as you correctly recall. You are writing to say that along with Mrs. Corrigan and Colin Weir, you met with urology consultants this morning, shared with them all the events that had taken place, decisions reached, and they had some questions. Number 4 is "What is the Trust's position on Mr. O'Brien undertaking private work and in particular Using Trust secretarial staff to type private patient work whilst off." 12:47

Just at the top of the page, Mrs. Gishkori purports to answer that by saying: "I'm sure Simon will be able to address the queries below". She wanted to comment on point 4. 12:47

"Mr. O'Brien is at liberty to do what he wants off ST premises but he cannot use the services of the Trust in the carrying out of his own private work, not unless the secretarial staff do the work outside core hours, and don't use any of the Trust's facilities". 12:47

She appears to have an understanding that Mr. O'Brien was at liberty, nevertheless, to carry out private work subject to those conditions. 12:48

If we go to the next page we can see that Mr. Gibson -- that's it, yes. Sorry, I'll have to give you the page reference. If we go to TRU-258674. If we go to

AOB-01344. Sorry, I've lost the reference. I can't find it.

The message that seemed to emerge from Mr. Gibson was that given Mr. O'Brien's exclusion under the MHPS process, he shouldn't be working privately. Was that your understanding? 12:50

A. Yes, that came from Mr. Gibson's correspondence. I think Dr. Wright, in his evidence, also held that view. 12:50

121 Q. Was that the subject of discussion between you and Mrs. Gishkori?

A. No.

122 Q. She seems to have adopted a different position.

A. No. 12:50

123 Q. Now, in terms of the other follow-up work that was being conducted by Mrs. Corrigan, as I've said you reported this into the Oversight Group meeting on 10th January. If we bring up the minutes of that, please, first of all. AOB-01363. We can see that you're in attendance at that meeting. If we scroll down a little, you explain that you have had a meeting with urologists; they were supportive of working to resolve the position. You then proceeded to update the committee on the three issues, plus the fourth, that is the private patient issue which was to emerge. You set out, in essence, some figures for them. It's recording you as reporting that from June 2015 there are 783 untriaged referrals, all of which need to be tracked 12:51 12:51

and reviewed to ascertain the status of these patients in relation to the condition for which they were referred. Four consultants would be participating in this review. We'll come back to that in a moment, I'm just summarising here. 12:52

Issue 2 is notes at home. At this point you are reflecting that 307 notes were returned from Mr. O'Brien's home and 88 sets from his office, and that there are 27 notes said to be tracked out to 12:52 Mr. O'Brien which were still missing. Again, we'll come back on that issue.

Thirdly, just scrolling down, please, the undictated clinics. Again it's coming through you, I assume, that 12:52 there were 668 patients with no outcomes formally dictated, and that's broken down, you say, across a number of clinics.

Issue 4 then. You say a review of TURP patients 12:53 identified nine who had been seen privately, then had their procedure within the NHS. You assert that the waiting times for these patients appear to be significantly less than for other patients. There's then discussion of what remuneration would be needed 12:53 for the clinicians carrying out the look-back work.

If I can work through in a bit more detail some of those issues that are raised. Let's go to the issue of

triage. You provided a written report which we have, I think in red ink. Let's just confirm that this is your work, AOB-257706.

CHAIR: Is that TRU, Mr. Wolfe?

MR. WOLFE KC: Is it? Try TRU-257706. Yes. 12:54

124 Q. This is how you presented to the Oversight Group your findings.

We've seen that prior to the Christmas period, the figure in terms of untriaged cases that was presented 12:55 was a figure of 318 cases. How did the figure of 783 emerge?

A. So, this was a physical search of Mr. O'Brien's office which Mrs. Corrigan undertook, and they were in Mr. O'Brien's filing cabinet, this number. So, it was 12:55 a physical search.

125 Q. We know that Mr. O'Brien directed Mrs. Corrigan to a drawer or a cupboard within his office where he had retained duplicates of the triage referrals or the referrals that were to be triaged. Are you saying that 12:56 the 783 was simply a physical count of that?

A. Yes.

126 Q. We know that previously we looked at the email this morning where a figure of 318 was given. In other words, that was the figure counted by the system that 12:56 had issued the referrals to Mr. O'Brien. Can you explain the disconnect? The system is giving 318 as a figure. Yet, for the purposes of the investigation we're working off this much larger figure based on a

count of the letters not returned.

A. I can't, really. The information came from the -- the 318 came from the referral booking centre, Mrs. Robinson, 318. 783 came from a physical search of Mr. O'Brien's -- the drawer in his cabinet. While there was a disconnect, I can't provide you with -- Mrs. Corrigan may be able to provide you with a better explanation, or an explanation.

127 Q. Can I ask you to take a look at TRU-257702. This, as can be seen, appears to be a count of letters waiting to be triaged taken from Mr. O'Brien's office, according to the legend at the top. Scroll down. It produces the figure of 738. Is Mrs. Corrigan the author of this document?

A. Yes.

128 Q. As you say, the title seems to suggest it is essentially a count of the letters.

A. Yes.

129 Q. If we go back then to TRU-257706. You describe the plan is to carry out an administrative exercise in association with these letters and ensure that these patients have not already been treated. Then, the remaining letters will be triaged by the four consultants and, after some discussion, it was agreed that in keeping with their normal triaged pathway, that these letters will need advanced triage, which will take quite a bit of time because of the volumes.

What does that mean, it was agreed that in keeping with the normal triage pathway, advanced triage would be necessary?

A. So, my understanding is that they would be sent for diagnostic tests in advance of being seen, if required, in the outpatient clinic. So ultrasound, CT, any blood work that would be deemed to be clinically appropriate, they would be sent for. The patient would be sent for.

130 Q. Is that to suggest that this advanced triage was normally performed by the four consultants? 13:00

A. I think Mr. O'Brien had a view of how he viewed advanced triage, and the other consultants had a different view of how they viewed advanced triage.

131 Q. Their view was that the approach was more like a traffic light system, it is either stay with the -- it's look at the referral coming in from the general practitioner and decide simply whether that's an accurate classification or not, whereas Mr. O'Brien went further, much further, and dealt with advanced triage. It is just how that sentence is written: 13:01

"After some discussion it was agreed that in keeping with their normal triage pathway, these letters will need advanced triage".

Is the "their" a reference to the other consultants?

A. Yes, the four consultants. I think the four consultants subscribed to a higher degree of triage than just simply a tick box. They would have, to

varying degrees, sent them on for other preliminary tests, whereas Mr. O'Brien had his own way of triaging.

132 Q. Which was even more developed?

A. Which was even more advanced.

133 Q. I understand. 13:02

In any event, is it your understanding that by virtue of this process with the four consultants doing the triage, 24 patients were upgraded to red flag, and four of those patients - perhaps it is four additional 13:02 patients, I need to check that point - but four patients were found to have cancer?

A. Correct.

134 Q. Those patients were 11, 12, 13 and 14, and those cases were the subject of another triage-related SAI? 13:02

A. Yes.

135 Q. A further patient, a fifth patient, was subsequently identified?

A. Yes.

136 Q. Thank you. 13:03

In terms of notes then, if we just scroll down the page and over into the next page. Your report indicates that 307 sets of notes were returned from Mr. O'Brien's home. This included 94 Southern Trust notes that 13:03 Mr. O'Brien -- perhaps 94 Southern Trust patients that Mr. O'Brien had seen privately but had written his private notes in these charts.

Is that the appropriate way to manage private patients at that time? Is that how it was done, if you see somebody privately, you put the private note into the Trust --

A. I could be corrected but I don't believe it is. The private notes should remain private. 13:04

137 Q. You go on to say that Martina, that's Martina Corrigan, ran a report from past and found there are still 27 notes tracked to Mr. O'Brien that were missing. 13:04

On 24th January you received information from Mr. Weir that Mr. O'Brien had provided explanation for what was ultimately to become 13 sets of notes that were missing. It is accepted by the Trust, isn't it, that Mr. O'Brien doesn't have those 13 sets of notes and wasn't responsible for their loss? 13:05

A. That's correct.

138 Q. The fact 13 sets of notes have gone missing without explanation, is that something that the Trust has worried about? Is it a source of concern, or is that put down to being just one of those things when running a busy hospital? 13:05

A. Well, obviously the Trust is tasked with keeping patients' information secure. So, to have 13 sets of notes not accounted for would be a concern. But I think these 13 were inappropriately assigned to Mr. O'Brien. I think we have referenced that in the evidence. But I suppose to answer your question -- maybe, if I think I understand your question is do 13:06

I know where those 13 sets of notes are, I don't.

139 Q. Yes.

A. I know we had discussions with the record people, Pamela Lawson and her team. They may be able to provide some more information to you. 13:06

MR. WOLFE KC: I see it is 1.10 nearly.

CHAIR: Yes. We have another witness due to start at two o'clock this afternoon, Mr. Wolfe. Are we going to manage?

MR. WOLFE KC: She is not likely to be starting at two o'clock. It is more likely, the way things developed, that she will be starting in the morning. We'll finish Mr. Carroll today. 13:06

CHAIR: Okay. It is probably too late to stop her coming this afternoon, but if we can get some message to her, I think we have to try. 13:07

Ten past two, everyone.

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS: 13:16

CHAIR: Good afternoon, everyone.

Mr. Wolfe.

140 Q. MR. WOLFE KC: Mr. Carroll, we were going through the report that you making to the 10th January 2017 Oversight Committee meeting. 14:10

Going now to look at your report on dictation. If we

could have up on the screen, please, TRU-257707. You say:

"Martina ran a report of all the undictated clinics from the Business Objects Group and found that this related to 668 patients dating back to November 2014". 14:11

Obviously we saw before lunch that Mrs. Elliott had provided a figure of 61 clinics in the pre-Christmas period. 14:11

Business Objects, is that a -- you're looking at me puzzled. Do you know what that is?

A. I do. I've never used it. It's a performance tool which exacts data from the information systems. I'm no expert. 14:11

141 Q. We'll have to ask Martina Corrigan how this 668 figure is arrived at, but it's not something you tested yourself?

A. No. 14:12

142 Q. Or challenged?

A. No.

143 Q. You were given the figure and that was the figure that was supplied to Dr. Chada's investigation?

A. Yes, yes. Mrs. Corrigan's background would be in administration and systems. 14:12

144 Q. Yes.

Now, obviously this is a report provided to the Oversight Committee. If we just scroll down, there's a plan of checks to be made with the lists of undictated clinics. It said that effort had been made to identify the 97 patients. That's relates to what's described as a shortfall in the handwritten outcome sheets coming from Mr. O'Brien?

A. Correct.

145 Q. Mr. O'Brien brought back the patient charts. Then it became known through Mr. Young, as I understand it, that Mr. O'Brien had indicated that he had retained patient outcome sheets, his handwritten outcome sheets and then they came back to the Trust on the 9th January. Counting them up, there were 272 outcomes from the SWAH clinic, 229 from other clinics, and out of the 668, there was 97 which hadn't been provided. On that analysis, do you know whether that was resolved in any way? 14:12 14:13 14:13

A. Yes. I think Mrs. Corrigan was able to work through the information she had so that when we get to June, by June 17th, all the patients had been accounted for. 14:14

146 Q. Yes. There was an email sent in June by Mrs. Corrigan to yourself which we can maybe look at in that respect. It's TRU-258863. Just so the Inquiry and everyone else knows and understands, you're reporting this information into he Oversight Group, and I'm taking you along the line to where this information, as part of your team's follow-up on it -- 14:14

A. Yes.

147 Q. -- where it takes you to.
A. Correct.
148 Q. It should be understood, I think, that the information that your team is gathering is then being fed into Dr. Chada's investigation in terms of, if you like, the statistics relied upon by the service -- 14:15
A. Yes.
149 Q. -- I suppose to support the allegations or concerns that have been identified; is that fair?
A. That's fair. 14:15
150 Q. So, the work that's been done in this, I suppose parallel investigation, by both your team and the clinicians who are tasked with looking at the undictated clinics leads to this conclusion, that there are 110 patients who are being added to a review outpatient waiting list. 14:15

Just help me with that. Does that mean that when these undictated clinics or undictated patients were being examined by the clinicians who were doing the work, 14:16 that they found that there was 110 patients who should have been on the review outpatient list if Mr. O'Brien had been doing it as you would have expected?
A. Yes, that's correct.
151 Q. It said a number of these should have had an appointment as per Mr. O'Brien 's handwritten clinical notes before now. They should have had an appointment issued to them; is that what it is saying? 14:16
A. Yes.

152 Q. Although the caveat that Mrs. Corrigan is offering is that Mr. O'Brien has a review backlog issues, that these patients, even if they had have been added timely, may still not have been seen?

A. Yes. 14:17

153 Q. So in a sense, no loss to patients?

A. No, they hadn't been disadvantaged in terms of being seen at the review appointment.

154 Q. Yes. 14:17

Then it is said there are 35 patients who need to be added to a theatre waiting list. All of these patients he has classed as Category 4, which is routine. Again, due to the backlog -- I don't think she finishes that sentence. Again, due to the backlog, they probably 14:17 wouldn't have received their theatre appointment by this stage?

A. Yes.

155 Q. But again, is the point here that the Trust doesn't have these 35 on the list? 14:17

A. Yes, exactly. For both the outpatients and the ins and days when you would be running the list, they would be short those number of patients.

156 Q. Just scrolling down, she has attached Mr. O'Brien's sheets. He's gone through all the charts that were in 14:18 the AOBs office and will be back in the records tomorrow.

Katherine Robinson's team are currently recording the outcomes and these will be backdated to when the clinics happened. Is this in order not to disadvantage the patients?

A. Yes. 14:18

157 Q. They will achieve a place on the waiting list --

A. At the correct time.

158 Q. -- at the correct time.

It says there are three patients consultants who have concerns on, and she has arranged appointments for them. Then she offers the following comments. Patients -- I think she's attempting to summarise there, is she, the broad findings? 14:18

A. Sorry, I think what Mrs. Corrigan is attempting to do is summarise the findings the consultants made when they reviewed the patients. 14:19

159 Q. If we scroll -- just if we go back in the direction we've come and go back to the top of page 63 in that sequence. You are here thanking Martina for this large piece of work. You say you accept that Mr. O'Brien had a long review backlog and routine waiting times are long, but you say the crucial thing is that the Trust was totally unaware of these patients in that there were no PTLs. 14:19 14:19

What's PTL, remind me.

A. Primarily target lists, so the waiting list.

160 Q. The implication you're describing here of the failure

to dictate is one of administrative distress or inconvenience for the organisation; is that it?

A. Yes, and for the patient in that the patient is not on the waiting list, you know. They haven't been advised of the outcome of their appointment and what the outcome of that is, in that you're going to be reviewed or you're going to go on the waiting list.

161 Q. I suppose, for that matter, their primary care --

A. The GP.

14:20

162 Q. -- their GP is unsighted on what's planned?

A. Yes, correct.

14:20

163 Q. Mr. O'Brien made the case to Dr. Chada that when you consider what dictation had or hadn't been done, the proper figure to arrive at is 189 cases, and we'll hear from him on this, perhaps. He says that he gleaned some support from Martina Corrigan's analysis of the patients. He thinks his 189 figure is consonant with what she has said in that email. I'll have to ask him to explain that.

14:21

A. Okay.

14:21

164 Q. Could I ask you this: It appears that he made that case about the much lower number, 189 as opposed to 668, very loudly and very clearly to Dr. Chada. She didn't come back to you or anybody in your service to ask you to test those figures?

14:22

A. No.

165 Q. Could I just ask you to look at your witness statement. WIT-13162, please. At paragraph 359, you're dealing with the issue of untriaged referrals. Then you go on

to say:

"The Undictated clinics were completed on return-to-work in February as Mrs. Corrigan had not scheduled Mr. O'Brien into any clinics until the end of July 2017".

Does that suggest that you believed that Mr. O'Brien was dealing with the dictation work? Or can you help us with the meaning of that? 14:23

A. I'm struggling to understand it myself. So, I am clear that Mr. O'Brien -- the number of 668, from our perspective -- Mr. O'Brien brought in clinical outcome sheets for the number, and there was a gap of 197. When Mr. O'Brien came back to work, because the work is planned six weeks ahead, there was no elective work or plan for Mr. O'Brien, so he was allocated time to do his administrative work. Thinking back, he could have helped in some way to help with those patients who there were no outcome. I suppose the total clinical outcome sheets needed to be recorded into the patient notes and into NACR. I think that's what I was trying to get at but we know the task wasn't finished until June in total. 14:24 14:24

166 Q. I suppose the point is, as I understand it, and we may hear some evidence on this, Mr. O'Brien would make the point that the records for these patients were not returned to him for dictation purposes. 14:25

A. This is when he returned to work?

167 Q. Sorry?
A. When he returned back to work?
168 Q. Yes. You seem to be suggesting that the undictated clinics were completed on his return to work in February. Two points: One, the records of these patients were not returned to Mr. O'Brien for the purposes of dictation and, secondly, he didn't return to clinic work until -- sorry, he returned to clinic work in March and not July, as suggested here. 14:25
A. Well, maybe I have -- the word "completed" is incorrect. 14:26
169 Q. The work on the dictation, looking through the cases that hadn't been dictated, that was done by his colleagues?
A. Yes. 14:26
170 Q. Not by Mr. O'Brien?
A. No.
171 Q. And he returned to clinic work in March --
A. In March.
172 Q. -- albeit on a managed basis? 14:26
A. Yes.
173 Q. The final issue that you were reporting into the Oversight meeting in January was in respect of private patients. That was an issue that, as we have seen, had just arisen after the December Oversight Group meeting. 14:26 Let's just look at the steps that followed.

If we go to TRU-257703. Scroll down to we see it. We have here from Mrs. Clayton an email where she says:

"All the patients had a" - and this is Mr. O'Brien's address - "private letter on the NIECR. It doesn't mean there could be more but no private letter on NIECR".

So, she sets out, I think, eight incidents. I think if that redaction weren't there, it would be in relation to six, possibly seven patients. They were all, at your direction, TURP patients. This was research into those who had had a TURP procedure; is that right? 14:28

A. That's correct, yes.

174 Q. Your interest in this was to see whether these patients who originated as private had received a quicker-than-usual procedure within the NHS? 14:28

A. That's correct. Yes.

175 Q. Do you know by which method she used to conduct this?

A. So, she looked at all the patients -- my understanding is, again, she looked at all the TURP patients that Mr. O'Brien operated on in 2016 and then looked to see which one of those patients had been seen privately, and she then produced this table. 14:29

176 Q. Yes. Unfortunately with this redaction, I can't illustrate the next point, but would you accept or would you have an understanding that only one of the patients on this list was to form part of the 11 patients that were ultimately considered by Dr. Chada's investigation? There was another patient, that was the patient referred initially by -- 14:29

A. Mr. Haynes.
177 Q. -- Mr. Haynes, who was part of the 11. But not all of these patients were to form part of the 11 that was considered by Dr. Chada; isn't that right?
A. That's correct. 14:30
178 Q. I just want to explore with you on how that came about.
A. Yes.
179 Q. She has produced that list. If we go to AOB-03164, I'm just going to jump about a number of entries. If we pull up the bottom entry. We looked at this briefly 14:30 earlier. A review of TURP patients; it says it identified nine. I don't see nine in that list that we looked at earlier. Some of the entries look to be the same patient in twice. We'll not worry too much about the nine. Then, had the procedure within the 14:31 NHS. "The waiting time for these patients appeared to be significantly less than for other patients".

Is that your language or is that hers?
A. I think this is the minutes of the note? 14:31
180 Q. Yes, this is you.
A. This is me feeding the information to the Oversight Committee and their recording of what I said. The table that you've just made reference to was the first table of patients at a very high level of what I had 14:31 asked to do, patients who had TURPs under Mr. O'Brien. What we were showing was there were these eight, plus -- although we make reference to the ninth, I think the ninth was Mr. Haynes' patient we were making

reference to. Just simply the waiting time and drawing the interference from that. So the column, I think it was the penultimate column, shows the number of days they were waiting before they were operated on.
I think what we were putting that against was the 14:32
waiting time for, the total waiting time for TURPs, which was, I think, 130/140 weeks. And these patients, I think the longest was 200 days.

We were just saying the waiting time is 130 weeks, 14:32
these patients seen privately by Mr. O'Brien are waiting considerably less.

181 Q. Yes. Well, that's the theory or the approach. Let's just work through what happens then. On 16th January, Ms. Clayton sends you an email showing 847 patients who 14:33
attended Mr. O'Brien for surgery in 2016. Let's get that up on the screen, TRU-263732. We can look behind that email if necessary, but she's sending you all of Mr. O'Brien's urological surgery for that year. At this point, was she being asked to expand her terms of 14:34
reference into other procedures other than TURPs?

A. I do not recall how we got from my request for TURPs to be looked at to all of Mr. O'Brien's surgery. I've tried to trace the emails to see how Ms. Clayton was given the instructions. I have no doubt it could have 14:34
been me that said it to her, but in terms of me recalling why I said it to her, I can't find any communication or evidence for the rationale behind that.

182 Q. It is fair to say, isn't it - and we saw the email this morning - that the initial interest is TURPs.
A. Yes.
183 Q. Or TURP?
A. Because that was the operation Mr. Haynes made reference to. 14:35
184 Q. If we pull up TRU-258862. Scroll down again, please. In response to the 16th January email, you say to her - just up a little - on 29th January you need to work through these patients to identify any who were operated on against chronological management. 14:35

How can you do that? What does chronological management mean in that sense?
A. I think we were, again, looking at those patients Mr. O'Brien had seen privately. I think there is somewhere in one of the emails where I had asked -- Mrs. Clayton had presented that 16th email data, and I had asked for guidance on how we should approach this. Should we look at all the patients, should we sample a few of the patients or none of the patients. I think I sent that to Dr. Wright and Mrs. Gishkori. I don't recall -- I can't see any evidence of getting a reply from them. 14:36 14:36
185 Q. Okay. We'll try to find that email. 14:36

The next step that we're currently aware of is on 8th March, Ms. Clayton has gone through all of the surgeries and she's identified 11 private patients.

We'll just pull that up, please. It's TRU-258769. She's telling you:

"I have gone through patients that had surgery under AOB in 2016. There were 11 patients with a [Personal Information redacted by the USI] letter who did not wait long for their surgery. See the below. There were 830 patients in total who had surgery in 2016". You have a hard copy of the [Personal Information redacted by the USI] letter". 14:37

Then scrolling up the page, you say:

"Wendy, thanks, and you will kill me (possibly) what procedures did they have? And then compare to the other patients classed as urgent awaiting the same procedure to see is there a difference. This would be important." 14:37

Does that suggest that you thought it important to compare like with like, there had to be fair comparative analysis? 14:38

A. Of course. I mean, we had to be fair to Mr. O'Brien that if we were -- yeah, we had to be fair to Mr. O'Brien. So I had asked Wendy to detail the procedure and what was the waiting time for those same patients who were not seen privately by Mr. O'Brien. 14:38

186 Q. Can you explain to us how the nine, if we can call it nine - I'm not entirely sure that it is nine TURP patients but let's work with that figure - how, at

least six and possibly seven of that original nine didn't then follow into the Chada investigation. They were, if you like, discarded; they didn't form part of this analysis going forward.

A. I don't think I can, except the patients we felt were appropriate, we asked Mr. O'Brien -- Mr. Young to review them from a clinical perspective to see what his views on the waiting time were against the condition. So, I don't know how the nine initial TURP patients were not then factored into -- or removed from the 11, the 11 which Mr. Young reviewed. 14:39 14:39

187 Q. Yes. It is fair to say, and we can see various examples of it, this minute to the Oversight Committee in January has you asserting that these nine appear to have been treated quicker than comparable patients who hadn't gone private. Similarly, when Mr. O'Brien meets Mr. Weir on the 24th January, again it's the nine TURP patients. He is being told the concern is these TURP patients have been seen -- these private TURP patients have been seen quicker. 14:40 14:40

A. Yes.

188 Q. I wonder can you help us with this, I don't have any analysis from Mr. Young showing how these TURP patients have been discarded from having been patients of concern to this investigation. How have they fallen out? 14:41

A. I'm unclear also so I don't have an answer for you, Mr. Wolfe, as to how the original TURP patients were then not -- did not find their way into the next set of

nine which Mr. Young reviewed.

189 Q. Yes.

A. I suppose what I would say is that the initial table that Ms. Clayton produced was simply waiting times for those patients. It wasn't whether or not they were clinically appropriate to be done, because we hadn't asked any clinician to review them. It was simply just stating a fact that on the face of these patients who had seen Mr. O'Brien, they had waited a considerably less time than the waiting time for TURPs. 14:41

190 Q. Nor does it seem you are able to clearly explain how you moved from an interest in the nine TURP patients into patients receiving other surgical treatments or diagnostics. There doesn't seem to be on the face of the papers or on your evidence so far a clear explanation as to how that turn was taken? 14:42

A. I know. I accept that. I am unable to provide an explanation as to why it went from TURPs to all surgery in 2016.

191 Q. The concern which was expressed by Mr. O'Brien to Dr. Chada and to Dr. Khan and in his grievance subsequently was that having realised as a service or as an organisation that the allegation in respect of TURPs couldn't be made out across the nine patients, a vexatious turn was made to look at other patients who might fit the charge. Do you follow? 14:42 14:43

A. Yes. I do follow and I have read Mr. O'Brien's view on that.

192 Q. In other words, he was suggesting - I'll choose my

words carefully - he uses the word "vexatious", to try to undermine, impact on his reputation by unfairly picking out patients who, to repeat the words, might look as if they better meet the charge of unfair advantage once you realise that the TURP patients couldn't bring the case against him home. Is that what happened?

A. In what respect, sorry?

193 Q. Was there some calculation made here that, well, Mr. Young won't stand over the allegation -- Mr. Young won't stand over the charge in respect of the handling of these TURPs patients so we better go and find some other evidence to hang Mr. O'Brien with? 14:44

A. No, definitely not. I mean, what we did was all in good faith. There was nothing other -- no other intention or purpose or reason behind. It was simply taking Mr. Haynes' email and investigating it. That's how it was set out. 14:44

194 Q. In terms of what has been done here by Mrs. Clayton - you sent her off to do a further body of work - can you explain the process which then led to these matters going to Mr. Young for consideration? 14:45

A. No, I can't. I mean, I think Mrs. Corrigan would be in a better position to answer that than I would be.

195 Q. Did you ever have a conversation with him in relation to this? 14:45

A. No, I never had a conversation with Mr. Young.

196 Q. Mrs. Corrigan may be the more appropriate recipient of these questions. If we pull up TRU-283681. This is

Mrs. Corrigan explaining in to Siobhán Hynds, copying the investigator, Dr. Chada. She explains - you have this high level explanation to the process that was undertaken - you had requested Wendy Clayton to produce a report or to have a report run on all Mr. O'Brien's surgery during 2016. That's correct?

A. Yes.

197 Q. "Any patients that had a short wait time before being added to the waiting list and being operated on had their record checked on NIECR to see if they had a private patient letter. Out of this list, there were 11 patients for which all the letters were printed off". 14:46 14:46

Obviously, the TURP patient issue came before that and you don't have an explanation as to why some of those nine were discard. Otherwise, that's a correct description of the process, is it?

A. Yes. 14:47

198 Q. It said she then asked Mr. Young if he could look at these letters and gauge from his clinical opinion should they have been seen - I think it says - "should be seen as soon as they had been or should they have been added to the NHS waiting list to wait and to be picked chronologically. 14:47

That conversation with Mr. Young, is that something you don't know anything about?

A. No.

199 Q. What was your understanding at that time - these are all 2016 cases, as we understand it - of how a clinician seeing a patient privately should manage that patient on to the NHS? How was that to be done? 14:48

A. My understanding is they fill in a form. They transfer the care of the patient from the private sector to the NHS.

200 Q. Was that the system in place in 2016?

A. I believe so, yes. 14:48

201 Q. Who would receive that form then?

A. So, it's the secretary. The secretary would fill it in. Where it would go to, I don't know is the honest answer.

202 Q. Is it the completion of that form which then places the patient on the HSC waiting list? 14:48

A. Yes. There is a process that is meant to be followed when a patient is seen privately and they are returned back to the NHS. There's a process that's meant to be followed. 14:49

203 Q. This, I suppose important, issue of chronological dealing or management of a patient, can you help us understand that; how does that work? Presumably, for example, not every TURP patient is as urgent as the next. Would there be gradations of clinical 14:49 complication with each patient that might affect how that patient is to be seen?

A. Yes. So if a clinician sees a patient and the clinician makes a decision as adding to the waiting

list, they do so by categorising them whether they are routine or urgent. If they are either of those things, then they go on at the date -- you know, the appropriate date. Then, they wait from that time that they're placed on the waiting list. 14:50

204 Q. Obviously Mr. Young conducted some work in relation to the 11. Again, just to be clear, that wasn't something that was overseen, considered or discussed by you in any way?

A. No. 14:50

205 Q. Mr. O'Brien criticises the exercise performed by Mr. Young because, he says, it didn't engage in a comparative analysis or an appropriate comparative analysis. In other words, he would maintain, it seems, that all of the 11 patients were treated at a time in 14:51 accordance with their clinical merits, and he would say it seems that Mr. Young didn't look at it in that way.

A. Well, all I can say is Mr. Young is an equally senior, experienced clinician, surgeon. He was the clinical lead. When Mrs. Corrigan asked him to review it, it 14:52 would be for his professional opinion.

206 Q. Dr. Chada, I think, accepts that having received Mr. O'Brien's quite detailed and comprehensive analysis of how he treated these 11 patients and why and his observations on the relevant timeframe, she didn't 14:52 check back with Mr. Young, didn't check back with the service to test Mr. O'Brien's response. Is that fair, you didn't hear back from her on this issue?

A. No, no. From Dr. Chada, no.

207 Q. Can you help me with this. Across all of these issues, plainly the Service - the Trust management is maybe another way of putting it - is through you and through your staff, sending information into the investigation. This parallel clinical investigation, if you like, is producing this data; it's going into the investigation. But it appears to be accepted without coming back to you or your staff to test it at any point; is that right? 14:53

A. Yes. The information that I would have received, I would have received from Ms. Clayton and Mrs. Corrigan, both of them equally competent senior managers who would be much more expert than I would be in systems and processes. So, the data that they gave, I didn't test it but I took assurance from their expertise in this field. 14:53 14:54

208 Q. A case conference happened in late January, 26th January. You had obviously attended the previous two Oversight Committee meetings. You didn't attend that one. Mrs. Gishkori didn't attend that one, that is the one on the 26th January. Do you have an understanding why you weren't asked to go? 14:54

A. I know now why I wasn't asked to go from listening to Mrs. Toal's evidence, that she sent an email to Mrs. Gishkori requesting that I would not attend as I was collecting the data, and so Mrs. McVey was asked to go. 14:55

209 Q. Mrs. McVey was another Assistant Director within the Acute Directorate?

A. Yes. So she was responsible for medicine on scheduled care.

210 Q. She had no prior background or knowledge, to the best of your knowledge or appreciation, of these Aidan O'Brien issues? 14:55

A. No, that's correct.

211 Q. Mrs. Gishkori can account for her own reasons for not attending. Could I ask for your observations on this. Was Mrs. Gishkori, to the best of your understanding, fully engaged on these matters? 14:56

A. I suppose at the time I didn't, but with reflection and looking at all the evidence and the data, Mrs. Gishkori seems to be arm's length in terms of communication and correspondence and moving things forward, would be my view now. 14:56

212 Q. The work that you were doing pursuant to the actions agreed at the Oversight Group in December and then again in January, were they issues that you just got on with, for example with Mrs. Clayton and Mrs. Corrigan, without any input from Esther Gishkori? 14:57

A. Yes. Yes, that would be fair to say.

213 Q. Did she seek to engage with you on them?

A. I don't have any memory of us actually having a meeting or a discussion about it. Now, she may have a different view but I don't recall having meaningful 14:57 discussions about being asked for updates as to where we were in terms of progressing the issues, would be my view.

214 Q. I ask that question from the perspective that the

information that you were generating in association with Mr. O'Brien's practice - failure to triage urgent and routine referrals; failure to dictate outpatient encounters in some clinics; the private patient concern; the sheer volume of notes retained at home, they raise, do they not, substantial governance issues and management issues for her directorate?

A. Yes. Absolutely, yes. Yes. But if the question is did Mrs. Gishkori act on that, well, I'm not here to answer for Mrs. Gishkori, she'll answer for herself, but I think the answer to that would be apparently no, in my view.

215 Q. The case conference - we can bring the document up in a moment - it raised a number of actions for you and Mrs. Gishkori. There was to be a monitoring plan in respect of Mr. O'Brien to facilitate his return to work following exclusion, and there was to be a comparison of workload activity. We'll maybe just turn that up and we can look at that. Sorry, just allow me a moment. We'll come back to that, I'll deal with it separately. Those were two issues that you were aware that you were required to take forward?

A. So, I don't think I was aware. I've looked. The minutes of the meeting, I didn't receive of the 26th. I've looked in the archives and I've looked in the evidence bundle. I don't recall receiving them.

216 Q. Let's just bring them up briefly at this point. TRU-00037. If we go to the bottom of the next page. It was indicated an formal investigation would take

14:58 14:58 14:59 15:00 15:00

place.

Then, scrolling down. As a condition of lifting exclusion, the minute records:

"It was agreed that the operational team would provide the detail for a monitoring arrangement. This would be provided to the case investigator, case manager and members of the Oversight Committee". 15:01

Over the page, please. It says: 15:02

"It was noted that Mr. O'Brien had identified workload pressures as one of the reasons he had not completed all administrative duties. There was consideration about whether there was a process for him highlighting unsustainable workload. It was agreed that an urgent review of Mr. O'Brien's job plan was required". 15:02

Obviously Mrs. McVey was the Directorate's representative, I suppose, at that case conference of the Oversight Committee. Are you saying that that information regarding those actions didn't filter back to you? 15:02

A. Yes. There was an email on the -- I think it's sometime early February from Mrs. Gishkori to Mrs. Hynds and then I'm copied into it, where she asks to meet with Siobhán and me to progress the first one, the terms of the monitoring plan. 15:02

In terms of the other one which has my name beside it, in terms of comparable workload activity with job plan sessions, I didn't action it because I don't think I was aware of it. 15:03

217 Q. Who should have been notifying you of it?

A. Well, Esther and/or Anne, Mrs. McVey.

218 Q. Clearly that was an important consideration or an important action from the perspective of the Oversight Committee in that they're trying to balance the need for exclusion as against whether the option of a safe return is something that could be contemplated, and they have to have a think about, or they're anxious to, it seems, consider whether there is anything in Mr. O'Brien's workload activity that would be unsustainable and lead them into further difficulty? 15:04 15:04

A. Yes. I suppose the timeline, I know from the note of the meeting in March, Mr. O'Brien and Mrs. Corrigan and Mr. Weir, Mrs. Corrigan was able to demonstrate to Mr. O'Brien in terms of inpatients and day cases that he didn't have the biggest volume or the longest waiting list among his peers. 15:05

219 Q. Let's just park this. We'll come back to this as a standalone issue in just a moment. I just want to pick up a couple of miscellaneous or separate-type issues that follow in the period after this case conference. 15:05

If we can pull up TRU-267904. This is you providing Dr. Chada's investigation with an update. Were you

conscious that the work of the Service and the conditions dealing with these look-back type issues - dealing with the triage, dealing with the undictated patients - that this was work that needed to be done in order to allow the broader MHPS to proceed expeditiously ?

A. Yes. These patients were the outcome of the 24 patients -- sorry, the 24 -- this is an update from the 24 patients who were upgraded, of the 783 patients.

220 Q. If we just scroll down to the bottom, please. I will just check my reference. If we scroll up. I have a reference but it doesn't appear to be in this document. 15:06

You're telling Dr. Chada, by the 3rd March I think, that the outcome of undictated clinics essentially has not started by this point. Now, as we saw from Mrs. Corrigan's email earlier, it was completed certainly by June. What was holding up progress on the undictated clinical issues? 15:07

A. You just couldn't scroll down to see the date on this email? 15:08

221 Q. This email is 3rd March, I think.

A. Okay. I suppose getting to June, where the undictated patients were finally addressed, generally there were only four consultants doing it. They were doing their day-time job. I also think they had committed prior to this to doing waiting list work. So, they were doing lots of work. They felt in terms of clinical prioritisation, the first tranche that should be done 15:08

was the 783 and then they would get to the 668 patients where there was no outcomes of the 97. So they would get to that. It was in the context of everything the Urology Service was doing.

222 Q. Simply you didn't have the capacity to do it as quickly as you would have liked to have done it? 15:09

A. Yes, correct.

223 Q. You mentioned just a moment or two ago the meeting that took place between Mrs. Corrigan, Mr. Weir and Mr. O'Brien in early March which looked at aspects of his workload. I just want to look at that briefly with you. TRU-258781. In the middle of the page, please. Mrs. Corrigan is writing to you, saying: 15:09

"Colin and I were to meet with Aidan on Monday to discuss SWAH and other issues that Aidan had on his return to work and Colin had intended to use it as a forum for discussing any issues such as nonattendance at MDT". 15:10

That meeting happens on the next day, the 9th March. What is your understanding of why that meeting was necessary? 15:10

A. I think it was just a return-to-work interview after him being off sick. I think that was the purpose of the meeting.

224 Q. If we pull up the minutes of it, TRU-269952. As you say, the minutes look at various aspects of Mr. O'Brien's workload. You say you weren't aware of

the requirement for a comparative or comparable exercise, but it does appear that this meeting sought to engage Mr. O'Brien in discussions about how he could better manage his workload.

15:11

Did you receive any feedback arising out of this meeting?

A. Mrs. Corrigan asked me to review it before she sent it out.

225 Q. The? 15:11

A. The note of this meeting.

226 Q. Yes. After the meeting, did you receive any feedback from it?

A. No. No, I don't believe so.

227 Q. One of the issues which was dealt with was in respect of the Enniskillen clinics, as we can see here, scrolling down the page. There was an emphasis on ensuring that Mr. O'Brien was in a position to dictate as efficiently as the service wanted it. 15:12

15:12

If we scroll down the page a bit further.

Mrs. Corrigan was going to check to see if Mr. O'Brien could use his laptop in SWAH to do his digital dictation. Mr. Young is going to SWAH on the 13th and has agreed to trial and report back. It was agreed that Mr. O'Brien would see 16 patients on these clinics and he would get one hour to dictate at the end of the clinic. 15:13

"Mr. O'Brien agreed to this and that he would not leave SWAH until all the charts had been dictated on. Mr. Weir asked Mr. O'Brien was this fair and Mr. O'Brien replied "Nothing about job plans was fair".

15:13

In any event, this grant of an hour to dictate at the end of a clinic day in Enniskillen, is that something additional to what he had had previously?

A. I don't know the answer in terms of what was detailed in his job plan. I suppose I read it that the clinics -- there are two clinics, an a.m. clinic and a p.m. clinic. So, he could be getting two hours to dictate, one for each clinic. 15:14

228 Q. In terms of how this is being described, I don't know if you can deal with it, it does seem to be something extra in recognition of the difficulties in dictating as contemporaneously or as quickly as the Service would like. 15:14

A. Yes. I'm not a clinician, a doctor, but Mrs. Corrigan and Mr. Weir were there, and Mr. O'Brien, notwithstanding his last comment, agreed. He agreed that that was a reasonable offer. 15:14

229 Q. I suppose the point being is it a recognition - and maybe it is fairer to ask Mrs. Corrigan this - is it a recognition that he hadn't been given sufficient time previously to get through all of the dictation requirements that these clinics throw up? 15:15

A. Well, yes. We would need to see what was in his job plan in terms of the admin time associated. Then also

you probably would need to assess that against his colleagues, how many patients they were seeing at the clinics and how much time they were given so that you were treating every consultant the same. But again, I suppose Mr. O'Brien had his own way of dictating or not dictating contemporaneously, and Mrs. Corrigan and Mr. Weir were trying to be of assistance to him. 15:15

230 Q. If we just pick up on one other thread in this meeting, which the Inquiry can look at it in some detail as it wishes. If we scroll on to the issue of MDT. Maybe just pause there. An issue arose in respect of whether Mr. O'Brien should be given dispensation from taking on any new outpatients. He made the point that he had the most patients waiting to be operated on with the longest waiting list and that it wasn't fair to him to see new patients and add them to his waiting list, he couldn't deal with him. Mrs. Corrigan clarified that Mr. O'Brien didn't have the most nor the longest waiting times for in and day patients, and the figures are set out there. 15:16 15:16 15:17

Any observations you want to make on that?

A. No.

231 Q. Moving down, then. In relation to MDT, a question arose as to whether Mr. O'Brien would continue to act in the role of lead for the MDT -- sorry, continue to act as one of the rotating Chairs of the MDT. He explained there that the demands on him after operating on a Wednesday, to prep for the next day's chairing of an MDT were significant. 15:17

In a follow-up note, Mrs. Corrigan said that she spoke with Mr. Young who felt that if Mr. O'Brien wanted to continue to Chair, then he should drop his theatre session once per month and give it to a locum consultant and this would allow him to do the preparation for the MDT.

Can I ask you about this. Was there a requirement for Mr. O'Brien to do additional surgery outwith the sessions required of him in his job plan? 15:18 15:19

A. There wasn't a requirement. I think again Mrs. Corrigan could talk to this better than I could. He was keen to operate, and any additional operating sessions that were available, he would be keen to take them up if he could. He also undertook waiting list initiative work, which is outside of core work, out of core job plan time. 15:19

232 Q. Is there extra remuneration for each of those tasks or each of those? 15:19

A. If it's in core time, no. If he is displaced, for example, in SPA or displaced in admin, he wouldn't be paid for that because he's already being paid for it. But if he did waiting list initiative work, he would be paid for that. 15:20

233 Q. Isn't it the case that whereas you describe Mr. O'Brien as being keen to operate, and we've seen the additional sessions of theatre work which he did through 2016, it appears to be almost double the sessions expected of

him in his job plan. But as well as him being keen, the Service was keen to have him do it; is that fair?

A. Yes. Yes.

234 Q. Because of the waiting list problems?

A. Correct. The length of the waiting lists, yes. 15:20

235 Q. Is it also fair to say that Mr. O'Brien was not prevented from doing these additional sessions of theatre notwithstanding the Trust's understanding that he was rarely completing his dictation, rarely completing his triage in the respects we have 15:21 discussed?

A. So, as I said in March time, that level of analysis or triangulation, that was not done. So, Mrs. Corrigan and Mr. O'Brien had a conversation and Mr. O'Brien was happy to do his operating either in core, however he 15:21 was going to do that, then that would have been permitted. It was based on the need to get the waiting list down in a small way. It wouldn't have made a big dint but it was going the right way.

236 Q. Here we have in front of us, I suppose, is a 15:22 realisation and a practical example of someone saying out loud - perhaps it's novel, it appears to be novel in terms of what we have seen so far in this Inquiry - of Mr. O'Brien's clinical lead, Mr. Young, saying, well, if Mr. O'Brien can't do what's expected of him as 15:22 MDM Chair, he should step back from doing theatre and the Trust should instead look to a locum to do it. In a sense that's refreshing, isn't it, we don't see that?

A. I agree with you. Mr. Young appears to be saying, you

know, we accept that you're under pressure; if you need some time, we can facilitate that time by using the locum to backfill the session, the theatre session that you drop.

237 Q. You provided your witness statement to Dr. Chada following an interview on 6th April 2017. At that interview you raised with her an issue that hadn't occurred or didn't appear to have occurred to anyone before, and that was that Mr. O'Brien wasn't putting the clinical status of his patients onto the form in association with theatre? 15:23 15:23

A. Yes.

238 Q. You drew that to her attention - maybe briefly put it up - in your witness statement, TRU-00765. At paragraph 24 you explain that this issue concerned you this week. 15:24

"That is when I checked regarding bed pressures, Mr. O'Brien has no clinician priority noted on the theatre list. He said that they are all urgent and 'they will all be done'. We need to be able to prioritise patients when there are bed pressures so we can know who can be cancelled if absolutely necessary. The only person who knows the priority is Mr. O'Brien". 15:24 15:25

Can you help us with that. That's an issue you brought back to Dr. Chada. Subsequently you sent her some documentation around that and then she would have

referred that to Dr. Khan, the case manager, for his information. Why is it significant for you?

A. Well, I suppose it makes -- let me try to explain. Pre-COVID when patients required operating on, they attended the day surgical unit. If they required an in-patient stay, they went back to an in-patient ward. At that time in Craigavon it was 3 South, 4 North, 3 South. But everybody knows there are more medical patients in the system than we have beds for. It was not uncommon that the surgical wards were used to accommodate the overflow of medical patients. So not infrequently we would come in in the mornings, thinking we had X amounts of beds to accommodate the post-operative surgical patients only to find out that the beds had been used to facilitate medical patients admitted overnight. 15:25 15:25 15:26

What we would do is we would look at the operating theatre list, see what specialists were using the theatres. Then we'd run our eye down to see the type of -- how the consultant had classified the patient, whether it was cancer, red flag, urgent, routine. So then when we knew what we were dealing with in terms of how many beds we would need, we would go to the consultant and say, you're operating today, Mr. O'Brien, you've got five patients and four of them are red flag, one is routine, could we cancel the routine patient, and he would say yes or no. 15:26 15:26

But Mr. O'Brien didn't put that classification down. It just meant that we didn't know what the -- we could have made a guess, an educated guess in terms of the operational they were having, but it just made it more difficult when you went to the clinician, he would say to you nine times out of 10, or frequently, what classification did I put against the operation? Mr. O'Brien didn't do that. That's the point I was highlighting. Whereas all the other urologists evidenced how they clinically prioritised the patient. It was just one small thing. 15:27 15:27

239 Q. A small thing that appears to have irritated you and had an impact on how you wanted to manage your service?

A. Well, it just would have been helpful if Mr. O'Brien had been the same as the other four consultants. 15:27

240 Q. Did you prevail upon him to change his practice?

A. No. Did I pursue it? No.

241 Q. I suppose that's the point. We've observed in earlier stages of evidence, operational managers seeking informally to orchestrate change or remedial action in terms of Mr. O'Brien's practice going back some years, triage being the most prominent example. But nobody actually, until 2016 in all of that, nobody actually sitting down with him, meeting and I suppose making him understand why these rules of practice are important and requiring him to comply. 15:28 15:28

A. I take your point, yes.

242 Q. Nothing had changed by reference to this particular example by the time you came into the role?

A. No.

243 Q. Why is that? What is the culture that is existent at the time? I suppose you may say this is a relevantly small issue, and I'm sure the Inquiry might accept that, but what is the difficulty that causes you to fail to sit down with the clinician and say listen, you have to do something different? 15:29

A. I suppose it's complex. If it was easy, we would fix it.

15:29

In terms of the life of anybody working in hospitals, there are many, many, many challenges that you face on a daily basis. I suppose everybody is guilty. If the issue isn't sorted there and then, it tends not to be completed, the loop tends not to be completed because there's something else very quickly falls in behind it. If Mr. O'Brien was the only thing that occupied my life, that would be one thing, but it wasn't. There were many other challenges, not least, you know, Dr. McAllister's state of the nation was only a small part of the challenges which we faced on a daily basis in the health service. 15:30 15:30

Two months of my working life each year was taken up on the role of the Assistant Director of the Week, where I stopped doing my AD of the week role and I was occupied looking after flow. That was one full week every six weeks. So, if you didn't sort out the problem at source there and then, unfortunately to get 15:30

back to it, sometimes it never happened because there was just so much more to be done with the resources that we had. Every morning we came in and we were faced with overwhelming patients in ED, trying to find the beds for them. Part of my role in finding the beds was, well, what surgery can we proceed today with. That is endless and draining. So, plenty of challenges. 15:31

244 Q. Thank you for that perspective.

15:31

Now let's move to the monitoring arrangements. You said that while unsighted on the minutes themselves, you did receive an email in relation to this. I think you are copied into this email. Let me bring it up and we'll see. TRU-267575. Scroll up so we can see the full timestamp. This is Gishkori to Siobhán Hynds, you copied in. 15:32

"Ann McVey has fully briefed Mrs. Gishkori and she has a number of questions. Is there a timescale for the development of the monitoring process which Ronan and her will assume responsibility for? Is it okay to involve other clinicians in developing this", and she suggests some options around that. 15:32

15:33

Who did develop the monitoring plan?

A. Following this email, we met on 6th February, myself, Mrs. Gishkori and Mrs. Hynds, and Mrs. Hynds then made a first draft of it. I think she sent it the next day

out for review. I had asked her would she include Mrs. Corrigan in it for her expertise, which she did. There was a few iterations back and forth in a chain of emails. Ultimately then it was shared on 9 February by Mrs. Hynds to ourselves and Dr. Khan and Mr. Weir for their approval.

245 Q. Then there was a meeting that day --

A. With Mr. O'Brien.

246 Q. -- with Mr. O'Brien. You didn't attend that meeting?

A. No, no. 15:34

247 Q. Just to observe it, put it up on the screen, please. TRU-00732. Just at the top of the page, please. It remarks in the second paragraph, "Urgent job review plan will be undertaken to consider any workload pressures". How did you interpret that? Was that to be 'let's work up a new job plan', or was it something like his current responsibilities have to be looked at to ensure appropriate supports are in place? 15:35

A. Yes. So, he would undertake the full role of a consultant urologist as detailed in his job plan, and then that would be surrounded by the monitoring plan. 15:35

248 Q. There's an expectation, it suggests here, of a review? The last sentence in that paragraph.

A. Well, I suppose that came out of the 26th Oversight meeting. 15:36

249 Q. Yes. What was your understanding of what should be done about that?

A. I think Mr. Weir was tasked with that undertaking, that action, so Mr. Weir was supposed to deal with it.

I didn't see myself as dealing with it.

250 Q. In terms of the monitoring plan itself, obviously - and we'll look briefly at them in a moment - there were flare-ups, if I can put it in those terms, of apparent noncompliance with the job plan in the summer of 2017, and you attended a meeting in early 2018, autumn of 2018, and in late 2019. 15:36

When you think about the monitoring arrangements that were drafted and then put in place, what's your reflections on how well they worked and how well Mr. O'Brien complied with them? 15:37

A. As you articulated, there were deviations in the length of time that we had been monitoring Mr. O'Brien. They varied in terms of which aspect of the monitoring plan Mr. O'Brien fell down in. But were they effective? I would say not, in that there were deviations over that four-year period, three to four-year period. But did we sit down again and say, look, this monitoring plan needs to be reviewed, this monitoring plan is not fit for purpose? That wasn't done. 15:37 15:38

251 Q. Obviously the mischief which the monitoring plan served to address was the question of can exclusion be avoided, can Mr. O'Brien be brought back to work and enabled to work his job plan in a way which the Trust considers to be safe. From that perspective, did the monitoring arrangements allow yourself and Mrs. Corrigan to have confidence that things were going in a relatively safe direction? 15:38

A. Yes, I think that would be fair to say. I think in the length of time -- and I would say we monitored him far too long, but in the length of time we did monitor him Mr. O'Brien, for those aspects that we were monitoring, largely they were kept in check. So yes, I would say -- and where there was deviations, bar the one in October, on October 18th, they were picked up relevantly quickly and dealt with and escalated to the case manager. 15:39

252 Q. You say he was monitored far too long. What do you mean by that? 15:39

A. Well, I suppose to have anybody on a monitoring plan from 2017 until you retire in June 2020 - although we stopped monitoring him when COVID hit in around March of 2020 - it has never been my experience that you monitor them essentially for three years, you know, and you are monitoring the same thing all the time. 15:40

Again, with hindsight and 20/20 vision, I think we should have brought the Oversight Committee meeting back, we should have met more regularly. There should have been greater oversight from the Oversight Committee in terms of, you know, what position we were at six months in, 12 months in. I know the parallel process was going on in terms of Dr. Chada and Dr. Khan, but I can't help but think, sitting here now, it may have been helpful and we could have brought about another way of monitoring Mr. O'Brien. I don't know what that was but I think to monitor someone, just 15:40 15:40

simply monitoring someone for three years can't be seen as a success.

253 Q. What were the aspects of it? You say we didn't meet to review the arrangements at any point. Thinking about how it did work in practice, what are your thoughts on it? If you had been given the tools to change it or revise it in any way, what would you have introduced? 15:41

A. Well, I suppose the first thing - and you've made reference consistently today to it - we didn't communicate with Mr. O'Brien. That's the first thing. This was consistently poor. We should have. I think there should have been, particularly after the 26th meeting, again there should have been oversight as to have all those actions been completed; and that wasn't done. Then I suppose just in terms of meeting with Mr. O'Brien, see how he was getting on. Then continue to monitor those aspects that we felt still remained clinically important. Also asking him, you know, his concerns, his stresses, his worries and what we could do as an employer to help along that. We didn't do any of that. 15:41 15:42 15:42

254 Q. I don't intend to take you to -- in the interests of time --

A. That's just my reflection.

255 Q. Yes, and that's very helpful. 15:42

You say you didn't meet with Mr. O'Brien. Of course, I know that's a general observation, there were meetings with him along the timeline that I've just

sketched out. There was a meeting with him, for example, in July 2017. In the early summer of 2017, issues were identified by Mrs. Corrigan in respect of retention of charts in his office which seemed to build up to 90 on 11th July 2017. Then, at or about the same time, a problem with triage. If we can just, by way of example, look at that interaction. TRU-25877. That is not what --

CHAIR: 8877, perhaps? TRU-258877.

MR. WOLFE KC: That's it. Thank you. 15:44

Down the page, please.

Obviously you are copied in, Mr. Carroll. That is the July. It sets out for Mr. O'Brien the condition of his work plan, including that red flag referrals must be 15:44 completed daily.

Scroll down, please.

"He has been advised by the booking centre that there 15:45 are 30 paper outpatient referrals not returned from your week on-call and this must be addressed urgently, please".

Then let's go to Mr. O'Brien's response. TRU-268995. 15:45 Scroll down. Just pause a moment. Sorry.

CHAIR: Might it still be the original page of 258877?

MR. WOLFE KC: I beg your pardon, AOB-01646. Another malfunction. Yes, sorry, it is right at the bottom of

that page. Hiding at the bottom.

Mr. O'Brien has just read Mrs. Corrigan's email in respect of the paper triage that hadn't been returned, and he tells her he finds this demoralising and provides an explanation. Scroll down, please. He says that he's deferred returning these referrals as each day's bundle included patients who needed to be contacted so that the appropriate triage decision could be made. He says that's proved difficult for a number of reasons. He gives an example. 15:47 15:47

"One such was a female patient who has a stone in her ureter, who returned my calls this morning to say she was in pain, which I had expected her to be. I had returned her triage referral to have an urgent appointment at a new clinic whenever that would have happened. However, I have arranged her admission today for that procedure on the emergency list. By virtue of the returned referrals not having been collected today, 12th July, I have been able to amend the triage decision. I came into the hospital today to review a couple of patients admitted since the referrals. Having done so, I thought I would do some work in my office, then I read your emails". 15:48 15:48 15:48

He then says:

"I know how referrals are triaged and returned on time.

It is most certainly not by taking the time to ensure that each patient's current state is most appropriately and expeditiously assessed and managed. As a consequence of my doing so, I have dictated letters to the referring doctors, and to the patients if I have been unable to speak to them by telephone, in over 50 cases, requesting scans, having conditions treated appropriately and so forth. By doing so, investigation is progressing and patients are hopefully deriving benefit from treatment. Having done all of that, I personally would have been better off ticking the box, being at home on my leave, and the patient, she would be at home with persistent colic, awaiting the urgent outpatient point." 15:49

15:49

What you see there, and I know you are not copied in this email, but from Mr. O'Brien's perspective, he is saying in this email there has to be some trade-off or accommodation to enable him in appropriate cases to do adequate triage to deal with the patient's real needs, even if that is at the expense of him devoting extra time and, I suppose, consequentially triage being done outside of the time limits expected by the return-to-work monitoring plan. 15:50

15:50

Is that a refrain that you understand?

A. You're right, I wasn't copied into it. I suppose my take on it is a sense of frustration from Mr. O'Brien. I mean, this type of triage, I don't know what term you

would apply to it other than maybe super triage. It is almost like an outpatient appointment. I think Mr. Haynes referred to it as a virtual outpatient undertaken by Mr. O'Brien. Whilst for the patient, it's an excellent service, there are other patients on Mr. O'Brien's waiting list who may not get the same level of advantage triage. I don't know, I'm just surmising. 15:51

I suppose I would also say, Mr. Wolfe, that he was met with by Dr. Khan on 9th February and the monitoring plan was shared with him, and I'm guessing he agreed or accepted in principle that he was now on a monitoring plan which required him to comply with that. Here we have, you know, several months down the road and he's slipping back into bad habits -- well, slipping back into his previous practice. 15:51

I can understand his frustration because that's the way he always done it but I don't know if he appreciated this was a new world he was operating in. He still wanted it to be the old world. That would be my take on it. 15:52

256 Q. Just to move along. In July you attended with Mr. Weir. The issue at this stage, the issues around triage having resolved during that period of time, was the question of charts in his office. This is, as I understand it, the first meeting with Mr. O'Brien to discuss a deviation from his work plan? 15:52

A. That's correct.
257 Q. Is that your understanding of the meeting?
A. Yes, that's correct.
258 Q. It's not a meeting that was recorded by you or anyone else from the Trust. Mr. O'Brien has surreptitiously recorded it, and we have the transcript from that. Why, in circumstances where this monitoring arrangement is supposed to be a serious effort to avoid excluding Mr. O'Brien and when serious issues are referred to within it, why is this meeting not granted the formality of a record? 15:53 15:53
A. It absolutely should have. The purpose of the meeting was to understand why the volume of notes were in his office, and if we understood, we could help. But yes, absolutely a record should have been made of the meeting, and that shared with Mr. O'Brien. 15:53
259 Q. He said at the meeting -- very briefly, if we can pull up AOB-56212, which is the transcript that's produced from the recordings. Essentially in that paragraph just below B, he's saying I don't ask for these charts, they are brought to my office by the secretarial teams, and while the numbers are decreasing as of last Friday, the number is still 25. But the rule is, according to the return-to-work monitoring plan, charts are not to be stored in his office, they're to be kept for the minimum period feasible. 15:54 15:55

This explanation that he has given to you, is that tested by you? Is it something to do with secretarial

preference or convenience?

A. Was it tested by me, no. When Mr. O'Brien provided this explanation, I think Mr. Weir replies, well, that's good, we'll get the notes and you have no need to get the notes. I think Mrs. Corrigan says that she would communicate with the service administrator, Marie Evans, in regard to the notes and the need for the notes to be there. 15:55

260 Q. 2017, the issue of triage arises again. TRU-275137. Martina is writing to Siobhán Hynds. She's explaining that red-flag triage was to be done within 24 hours and all other triage by the Friday. She, that is Martina Corrigan, has agreed with you that she is going to meet Mr. O'Brien to discuss this with him. This is, I suppose, the second incident of -- 15:56

A. Deviation.

261 Q. -- deviation from triage, at least as perceived by the Service in a little over six or seven months.

Do you think, looking back on it, knowing what Mr. O'Brien is saying about how he is still doing triage - you call it super triage or virtual outpatients - do you think that issue wasn't well understood or well responded to by you and Mrs. Corrigan to try and nip it in the bud? 15:57

A. So, this incident was highlighted by the cancer team, which we would not be monitoring as part of Mr. O'Brien's four elements. This was a separate team --

262 Q. I understand.
A. -- who were alerting Mrs. -- I think the email came to the urology team, there were seven red flags outstanding, and then it worked its way down to ourselves. It was resolved within a very short period of time. Within days it was fixed. I had asked Martina to share it with Siobhan - I think it was the end of January the red flags came - again, so that they were aware. In my mind my role and Mrs. Corrigan's role was to be the monitors of the action plan and then, where there was a deviation, to escalate that up to the manager and HR. So, that's why I asked Martina to share it with Siobhán, Mrs. Hynds. 15:58 15:58
263 Q. Is the sense to be gained from your evidence that overall - and we will come to some of the incidents later in 2018 in a moment - these instances are short-lived, they are identified, which is important from a safety issue, and when Mr. O'Brien is challenged or addressed in respect of them, they are resolved in a relevantly speedy fashion? 15:59 15:59
A. Yes, yes. So all the deviations, 17 and 18 and 19, they were resolved within a short period of time.
264 Q. In termination of accuracy, can I just bring one issue up with you? TRU-258902. Martina Corrigan is communicating with Siobhán Hynds, copying you in. We see in the Chada report reference to Mr. O'Brien, I suppose I think the word was "robustly" complying with the action plan. I draw a link between this email and the content of Dr. Chada's report in that respect 16:00

because what is being described here is:

"Apart from one deviation on 1st February when Mr. O'Brien had to be spoken to regarding red-flag triage, which he immediately addressed, I confirm he has adhered to his back-to-work action plan, which I monitor on a weekly basis".

Of course that's leaving out of account, to be absolutely accurate about it, the events of the summer of 2017, when we saw there was deviations in respect of referrals and you had to meet with him to discuss storage of charts in his office. 16:01

A. I accept that, that Martina's return is inaccurate in that since the monitoring started in February 2017, there had been two deviations, one in the summer of '17 and this one in February of '18. 16:01

265 Q. Is my point in respect of that pedantic in your view, or is this --

A. No, no. No, no. No, I think it's a fair point. 16:01

266 Q. But does this reflect perhaps - we can obviously ask Mrs. Corrigan about it - does this reflect perhaps a sense on the part of you and that team that things are going along relatively well in this respect?

A. I think you probably need to ask Mrs. Corrigan in terms of what her thought processes were. Maybe she misread it, I don't know. I suppose I would say in fairness to Mrs. Corrigan and myself, the July 2017 and the February 2018 were escalated to Dr. Khan and 16:02

Mrs. Hynds. They were aware that there were two deviations because we'd escalated them to them.

267 Q. You said earlier that you thought it was, in a sense, regrettable that this monitoring plan continued for so long right through into 2020. You know now, and I wonder did you know in late 2018, that Dr. Khan's determination following the MHPS investigation was that there should be, with NCAS input, a further action plan developed to ensure that Mr. O'Brien continued to work safely. Did you appreciate that at the time? 16:02 16:03

A. No. I was not aware of Dr. Khan's -- the outcome of Dr. Khan's recommendations in 2018. I didn't get to see them until much later.

268 Q. In terms of what was happening in the summer of 2018 which affected the monitoring plan, Mrs. Corrigan was off work for some time; isn't that right? 16:03

A. Correct.

269 Q. By the 4th October, it was drawn to your attention that Mr. O'Brien was not compliant with the monitoring arrangements. 16:04

A. That's correct.

270 Q. In that respect, concern was drawn to your attention about dictation and triage?

A. Dictation and notes.

271 Q. That's right, sorry. I'm just checking my note. Notes being held in his office and dictation. 16:04

The incident, if I call it that, generated quite a lot of correspondence. In summary, this was a situation

where, with Mrs. Corrigan going off on leave, there had been a failure on the part of the Service to recognise the gap created by her absence in terms of the need to monitor Mr. O'Brien; isn't that right?

A. That's correct. 16:05

272 Q. Do you accept responsibility for failing to fill that gap?

A. Yes.

273 Q. In terms of what emerged from that, we know that Dr. Khan wrote to Mr. O'Brien in October to ask him was 16:05 he adherent to the monitoring plan, but it doesn't appear that anybody at that time met with Mr. O'Brien to reinforce the need for compliance. Is that fair?

A. Again, that's fair. Yes.

274 Q. Now, these events were happening as the determination 16:06 from the MHPS process was being published, if you like, as Dr. Khan reached his conclusions.

The monitoring provides, in the preamble if you like, that it would be in place for the duration of the 16:06 formal investigation. Again, leaving aside Mrs. Corrigan's absence and what happened in relation to that, did you have a sense that it was felt that this monitoring plan had served its purpose and was no longer live, or did you understand that it remained in 16:07 place?

A. Do you know, I think in my Section 21 I said that I understood from, as you say, the preamble, that it would remain in place until the completion of the MHPS

process. I think in 2018 I did ask Dr. Khan was it to continue and he came back firmly and said yes, it was to continue. So I abided -- we complied with that.

275 Q. In terms of your own responsibility for ensuring that it was monitored during Mrs. Corrigan's absence, how do you explain the failure, I suppose, to deal with that? 16:08

A. Mrs. Corrigan went off on sick leave for a planned operation, and her and I discussed it. She was advised by her consultant that she would be off six to eight weeks, give or take. In terms of getting a replacement in, if you've ever tried to make an appointment in the Health Service, it takes much longer than six weeks to get someone in post. So, there was no opportunity to bring in someone to backfill her post. 16:08

16:08

I suppose two things: Mindful of keeping it within a small set of staff who knew the full totality of what was happening with Mr. O'Brien's monitoring exercise, I did ask the two other heads of service would they keep an eye on Martina's work. But I didn't ask them to continue on the monitoring exercise because in my head, Martina was coming back in six to eight weeks. Then genuinely it was -- and I suppose I was also mindful that Mr. O'Brien, bar the escalation from the red flag team in February, Mr. O'Brien had been compliant for over a year. That was also in my mind. 16:09 16:09

But when Martina's eight weeks became 18 weeks, it just -- I had forgotten about it is the only

explanation I can give. It was forgotten about in just the activity of working, of work.

276 Q. We can see that Dr. Khan, when he becomes appraised of this issue, describes this as unacceptable practice by both the clinician, Mr. O'Brien, and responsible managers. In Mr. O'Brien's case, the information as of 4th October was that he had 74 sets of notes in his office and 91 letters undictated dating from 15th June 2018. 16:10

If it was unacceptable practice on his part, that's Mr. O'Brien's part, can you explain why no one saw fit to meet with him to reinforce the need for compliance? There had been a meeting in July 2017, as we saw. It was to discuss the issue of notes in his office. Here was, I suppose, a more serious issue, perhaps, because it involved the issue of dictation. 16:11

A. Well, I did ask for the assistance of my senior medical colleagues, could Mr. O'Brien be spoken to.

277 Q. That's Mr. Young, Mr. Haynes and Mr. Weir? 16:11

A. Yes. Then Mr. Weir wrote to Dr. Khan saying what is it you want me to do; I'm happy to go with Ronan to speak to him. But the meeting never happened.

278 Q. Can you explain why?

A. I don't know why the meeting -- I can't explain why the meeting didn't take place. I think we were busy trying to bring particularly the dictation back into line. That was our focus. Which we did in a short period of time. 16:12

279 Q. Turn briefly to 2019 then. TRU-279848. Just at the bottom of the page, please.

Yes. 16th September, Martina Corrigan's writing to Dr. Khan. We're into late 2019. By this stage, as we know, MHPS has reported the year before, Mr. O'Brien continues to be monitored. Here again, we have Mrs. Corrigan spotting a difficulty. It doesn't appear that you are copied into emails by this stage? 16:13

A. Yes. I seem to be excluded out of quite a number. 16:13

280 Q. Yes. Is that because there had been some kind of step change in how monitoring was to be regarded, or had you fallen out with Mrs. Corrigan?

A. No, no. The only explanation is I wasn't in the first one and then reply-to-all, I'm not in the subsequent ones. That's what I'm thinking. 16:14

281 Q. Again, do you have a knowledge nevertheless of this --

A. Yes. I mean, I subsequently -- I'm sure Mrs. Corrigan then did share this with me or discuss it with me. My understanding for this deviation in September 2019, and it was acknowledged by Mr. Haynes, was that Mr. O'Brien's mother-in-law passed away in around this time, and he was preoccupied -- him and his wife were preoccupied by caring for Mrs. O'Brien's mother, and that was the reason for this deviation. 16:14

282 Q. Nevertheless, it was regarded as something that necessitated a meeting between the new clinical director, Mr. McNaboe, and Mr. O'Brien. You were aware of that?

A. Again, I'm aware of it now. In terms of real-time back then, I wasn't aware of it, that Mrs. Corrigan was meeting with Mr. McNaboe. I also know that the meeting didn't happen.

283 Q. Yes. I think there's two views on that, but certainly I think from Mr. McNaboe's view there was an encounter in a corridor as opposed to a formal meeting. 16:15

By this time there was discussion about the process of monitoring dictation used by the Trust. That was to give rise to a meeting at the direction of the Medical Director in January, the New Year, 2020. As we can see WIT-55822. You were in attendance at this meeting on 24th January. The purpose of the meeting is set out here. What's your reflections on that meeting, Mr. Carroll? It seems to arrive at a conclusion that the Trust's policy, if it had one, and its processes around dictation were not sufficiently fit to permit any challenge to Mr. O'Brien in terms of his compliance with the monitoring arrangements in that respect. Is that a fair comment? 16:15 16:16 16:17

A. Yes, yes. I mean, I think I read an email in the evidence bundle between Dr. O'Kane and Mr. Haynes in early November where Mr. Haynes is describing his concern about the whole backlog report to Dr. O'Kane, and about the robustness of it, and the fairness of it in terms of holding Mr. O'Brien to account to a certain standard and not holding any other consultant to the same standard, and basically we don't have a standard. 16:17

I think that may have helped - again, I'm only surmising - may have helped why Dr. O'Kane wanted this to be resolved. I could be entirely wrong.

284 Q. But a standard, whether it was inconsistent with what was expected of others, a standard had been arrived at for Mr. O'Brien, hadn't it? That was set in stone in the monitoring plan from February 2017, dictate contemporaneously with your clinical encounter. So, why was there this degree of -- 16:18

A. Concern? 16:18

285 Q. -- internal concern or deliberation about something that had been made clear to Mr. O'Brien and he wasn't always compliant with?

A. I think again - again, this is just my view - Mr. Haynes always shared or harboured concern about the robustness of the monitoring. There were emails in 2017 and 2019 and so forth, where he had written to the RBC asking how it was done, etcetera, etcetera. 16:19

I think it was his concern - again I'm just repeating myself - in terms of the backlog report and the monitoring of the backlog report and compliance with dictation if there was no standard available. Again, I could be entirely wrong, I just think Mr. Haynes felt it was unfair to hold Mr. O'Brien to a standard that didn't exist except... 16:19

Obviously in the cold light of day and with retrospect, a standard for Mr. O'Brien had been set in terms of the issues which we now know, in terms of his dictation,

his contemporaneous dictation and relating that to Patient Safety. But again, that wasn't connected -- the dots weren't connected to the monitoring report in 2017 and this meeting in 2020.

286 Q. Yes. One further area of questions for you, Mr. Carroll, you'll be pleased to know. The MHPS determination resolved that there should be an independent review of administrative processes. I want to ask you about that. If we could have up on the screen, please, AOB-01923. Just scrolling down the page, please. Under Final Conclusions/Recommendations, it said that: 16:20 16:20

"The investigation highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services directorate. The report identifies that there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr. O'Brien. No one formally assessed the extent of the issues or properly identified the potential risks to patients". 16:21 16:21

Is that a conclusion with which you agree?

A. Yes. I don't think that's unfair.

287 Q. Arising out of that and what he says there at the bottom of the page, he says: 16:21

"I recommended the Trust carry out an independent review of the relevant administrative processes with

clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes".

Now, we know that recommendation had not been addressed by 2020 and then there was, I suppose, a flurry of activity in the summer of that year to get the process moving. When did you first become aware of this recommendation? 16:22

A. It certainly was in 2020. Maybe early 2020. 16:22

288 Q. In terms of your contribution to it, can you help us understand what role you played in the review?

A. It was towards the latter end of probably 2021. This recommendation was picked up by Dr. O'Kane in terms of progressing it forward. Dr. Donnelly and 16:23 Dr. McCullough were asked to take this forward and to draft a model or a proposal which would meet this recommendation. So, I have to say what was done by Dr. McCullough and Dr. Donnelly, and subsequently by everybody else, did not, in my view - I haven't 16:23 listened to Dr. Khan - did not capture the essence of what Dr. Khan wanted to happen, even though despite many eyes and many fingers over it.

289 Q. We can see, just to bring it up, an email of 25th October 2021, pressing your input into it. 16:24 TRU-293812. Martina Corrigan is telling Siobhán Hynds that:

"As discussed at our last urology Oversight meeting,

Ronan and I have revised the administrative review process to anonymise/make it more generic to all areas".

What had brought this review to a stage where the managers, and you were one of them, who perhaps Dr. Khan thought your activities should be the subject of this review, looking back at what had happened in the context of Mr. O'Brien's work. What had brought this to a situation where an independent review, so-called independent review or requirement for an independent review, allowed you to be, on the face of it, contributing to it in this way? 16:25 16:25

A. So, nowhere in my thought processes or indeed anybody involved in this processes other than Dr. Khan viewed his recommendation as what he had intended. I suppose it wasn't helped where he used the word "administrative" and the whole way along we had referred to Mr. O'Brien's practices as administrative practices. So, I think there was an association between what Dr. Khan was writing in his recommendation to the history of Mr. O'Brien's administrative practices, and those were put together. Because the work done by Dr. Donnelly and Dr. McCullough was one of administration process, referrals in, how they were managed, etcetera, etcetera. And then that was viewed to be not a robust piece of work. Then it was assigned, I think, Steven Wallace. So I suppose it went from being Dr. Khan's macro written branch review 16:26 16:26 16:26

of administration in acute services, it had become a very micro specific urology review service. I understand Dr. Khan signed off on. I could be wrong on that.

290 Q. I think he challenges that. 16:27

A. Okay.

291 Q. He gave certain observations in respect of the terms of the reference and clearly set out his view that he didn't accept that. Leaving that aside --

A. Okay, leaving that aside. 16:27

292 Q. -- I suppose the question is did this, as it was produced, satisfy the review of independence?

A. No. I suppose did it satisfy Dr. Khan's review that he had in his mind when he wrote the recommendations, no, clearly not. Because was it independent? The Trust 16:27 did obtain independent input from a member of the senior administrative staff in the Belfast Trust, Denise Lynne in regard to the administrative processes, not the, I suppose, root and branch disciplinary review of senior managers. But the four aspects of 16:28 Mr. O'Brien's administrative practices, it was independent advice from Denise Lynne; she helped shape it. Then Martina was asked to progress with it and I helped her with it. But never in my contemplation could I read Dr. Khan's recommendation as one of 16:28 discipline, if that's not too strong a word.

293 Q. Yes. He doesn't use that word. He has explained himself what he anticipated would be done.

Who was leading on this from the Trust perspective, in your view?

A. It started off with Dr. O'Kane. Then, when it became under the work of Mr. Wallace, then it migrated into Acute Services and Mrs. McClements was involved in it and Mrs. Corrigan and Mrs. Carroll, and the referring booking centre also tried input into it and shaped it. I suppose at that stage the referring booking centre was part of Acute Services. When it became a micro urology issue, I suppose it was taken on by Acute Services, and not independent. 16:29 16:29

MR. WOLFE KC: Thank you. I have no further questions for you, Mr. Carroll.

CHAIR: Mr. Carroll, we can't release you just yet. I appreciate we haven't had a break this afternoon, ladies and gentlemen, but if you can bear with us, I'd rather we just continued on and get finished. I think if anyone does need to leave the room, then please do so, but I'm going to ask Dr. Swart, first of all, for some questions. 16:30 16:30

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

DR. SWART: Thank you very much for bearing with us today. These are general questions really based on your experience as a manager in the Trust. 16:30

Just to start with, in your role as Assistant Director did you get any regular reports that provided any kind of range of metrics about the performance of outpatients generally? So I'm thinking about time to first appointment, time to follow-up, dictation times, workload by consultant, complaints, patient feedback. Was that ever pulled together so that you could look at it by speciality and see what was going on?

A. I suppose the short answer is no. That level of detail we didn't -- was not provided. 16:31

294 Q. Would that have been helpful?

A. Absolutely, yes.

295 Q. A general question about private patients. Now, you have said that there is a form, which we have seen, that requires a consultant to indicate when a patient is transferred from private status to NHS status. You haven't said this but you've implied that perhaps isn't always done and you certainly don't know what happens to the forms. I think you said that. 16:31

Are you aware of any Trust guidance on the transfer of patients to and from the private sector? In other words, a patient who is seen in the private sector transferred to the NHS for an operation or a test, then seen again in the private sector. Is that common practice at the Southern Trust, do you know? 16:32

A. Some years ago the Trust made the decision not to offer operating time to private patients because it was so complex, it couldn't be tracked, a lot of purposes,

etcetera.

I suppose to answer your question, the Department of Health before - it could be six months ago, could be a year ago - they issued recent guidance on how private patients should be treated moving in and out of the Health Service. That is now available. 16:32

296 Q. Is that enforced in the Trust?

A. Sorry?

297 Q. Is it enforced or was it, in 2016, quite common for people to transfer back and forth? 16:32

A. I would say it was uncommon. We're not a big hospital for private patients.

298 Q. Okay.

16:33

There's very detailed monitoring arranged for Mr. O'Brien, and the standards are quite specific. Were there standards applied to the other consultants in urology in any way, or did you receive any data concerning things like numbers of notes in offices, numbers of notes at home, dictation times, any of those things? 16:33

A. Did we actively monitor the other consultants in that respect, the answer is no.

299 Q. You were, in effect, applying a standard to him that you couldn't apply to the other consultants? 16:33

A. It's not that we couldn't, we didn't because they weren't the source of the review. I suppose, if there's any consolation, in October of 2018,

Mrs. Corrigan, when she was reported an update of the amount of notes in the offices, she reported that there was zero notes in the offices of the other four consultants.

300 Q. With the benefit of hindsight, what is your view on this in terms of monitoring one individual in this way? 16:34

A. Well, as I said, I thought the monitoring was far, far too long. People were exhausted. I'm sure Mr. O'Brien was exhausted. But people were exhausted doing it.

301 Q. No, in terms of fairness, I mean. 16:34

A. Is it fair to have someone on a monitoring action plan for three years? No, I think it's unfair. As I said, I think the Trust should have - and I'm part of the Trust - we should have sat down and consciously at set points thought and revised and updated ourselves as to 16:34 have we reached a threshold for which we could stand it down.

302 Q. Was any of the data that you were looking at obtainable automatically in some way. This required conscious monitoring but it would be much easier if your business 16:35 objects and other systems could just generate this information for all consultants, actually.

A. I'm no expert in business objects but I'm sure it can be done. Digital dictation can be, I understand, run through a report. Triage also. But yes, our ability 16:35 to audit is very poor, in my view, and we need to strengthen that. We have processes in place, but do we audit them regularly to provide assurance? I think the answer to that, to be fair, would be no.

303 Q. That's kind of what I'm getting at.

If you were talking to a layperson, say you were at a dinner party and someone said, look, there are very long waiting lists for everything in Northern Ireland, 16:36
and particularly long waiting lists in the Southern Heath care Trust. Say someone asked you that, what would you say about what the Trust is doing to minimise the chance of harms to patients or in fact to assess whether patients are coming to harm? How would you 16:36
explain that to the man in the street?

A. What I will say is that in terms of triage, we now have E triage so that the referral now won't be lost; it's not paper and can monitor that. I would say that in terms of your outpatient point, if and when you are 16:36
seen by the consultant, we have made great inroads in our interactions, our contracts with the independent sector. We are sending large volumes of patients out to the independent sector. New patients. They stay out there for the whole patient journey as appropriate. 16:37
We have made significant roads in reducing the waiting volume. I don't know what they are now but we had made significant volumes.

I suppose we could always do more in terms of educating 16:37
GPS in terms of the referral pattern, identifying GPs which are high referrers and understanding why that is, etcetera, etcetera.

304 Q. How do you ensure that people on these waiting lifts

aren't coming to harm? Do you have a way of assessing that?

A. No, we don't.

DR. SWART: That's all from me.

CHAIR: Mr. Hanbury. 16:37

MR. HANBURY: Thank you. Just a few clinical things. Thank you very much for your evidence today.

I'll try the MHPS, the dictation ones first. Just to clarify, the original 668 patients alleged not to have 16:37 letters, did I understand that you said that that number came down to 189 in the end? Did you agree with Mr. O'Brien's assessment?

A. I haven't looked in much detail at what Mr. O'Brien has said so I wouldn't be in a position to say I agree with 16:38 it or not.

305 Q. Okay, thank you. Also, when the urologist went through those undictated patients and identified 35 needed to go on the waiting list, were they disadvantaged, do you think? 16:38

A. No.

306 Q. How were they not disadvantaged?

A. Because we put them on -- we put the patient on to the waiting time that they should have been put on. But our waiting times are so huge, the patients would not 16:38 have missed their slot, would not have missed their operating time.

307 Q. On the same theme, going back into the early part of the witness statement and looking at capacity for

operating time which Mr. O'Brien and his colleagues wrote to you about. You used a phrase when discussing expansion, you said "The physical theatre capacity would not be able to accommodate more sessions". When you were thinking about more urologists and whether that would help, how would having more surgeons help if you didn't expand the theatres? 16:39

A. Well, they could have done -- I suppose I was thinking two things. We have a huge emergency surgery. So, you know, they could help -- if we had more surgeons, they could help with the emergency side of the work because still there's always an emergency theatre. 16:39

We had a urology ward which had unscheduled urology patients, so having more consultants would help with that. They could also help with the outpatient work, and also they could help backfill. If we have five consultants, they're all taking leave, the additional person could use, for example, Mr. Haynes' operating list, Mr. O'Brien's operating list, Mr. Glackin's outpatient list if he's on leave. So, there was never any downtime in the urology because, as you know, each consultant works his job plan for 42 weeks, when you take out the emergency work, they actually only provide elective work 36 weeks. If we had more consultants, then we could have used the theatres more productively. 16:39 16:40 16:40

We did try extending the day, so a three-session day, but that has problems. Consultants didn't like it, people got tired, and the utilisation of the list went down.

308 Q. Thank you. 16:41

There was also something about the discrepancy between different departments in terms of waiting times. Did you sort of allocate sessions to the more needy departments? How did you respond to those sort of 16:41 figures? That is if, say, urology had a longer waiting time and other specialties a shorter one, was there a mechanism to reallocate either temporarily or --

A. No, no. We did always speak about that, so that the surgical specialist who had the longest wait got the 16:41 most operating sessions. We would have been faced with lots of resistance from the other surgical specialists who wanted to operate. They want their fair share of operating time. So no, we did talk about it but we never, I suppose, were brave enough to say, for 16:41 example to ENT, your waiting list is less. Apology, that would be unfair. Gynaecology, your operating time, your waiting time is less, we're going to take two sessions off you and give it to urology. We didn't do that. 16:42

309 Q. Should you have, do you think?

A. Pardon?

310 Q. Should you have?

A. Yes, if we're -- I'm not saying we weren't serious but

in terms of giving all patients the best service, then clinically to have one speciality waiting X amount of time and another surgical speciality X times three, then those patients waiting longer were disadvantaged.

16:42

But I don't know any theatre in Northern Ireland who operates like they do on the mainland. I remember going to a conference in London and I remember a hospital in Luton, and they operated on that principle. So, the longest waiters got the most operating theatre. 16:43

311 Q. Just one thing on outpatient times in the same sort of line. You elegantly displayed, I think it is 2016 we were talking about, that there was an average of between 300 and 425 new outpatient referrals a month but only capacity for about 300. So there was 16:43 approximately about 100 extra patients a month that you couldn't find slots for. Again, what was your response to that?

A. Again, we would have met with the HSCB. Well, we would have met with our own internal performance team and we 16:43 would discuss how we would have done that, how we would have managed it. We would have discussed it -- we also would have met with the HSCB, which is now the SPPBG and they wouldn't have given us nonrecurrent monies to run additional waiting lists -- sorry, additional 16:44 outpatient clinics. So, the consultants would have undertaken that additional outpatients waiting list. But it wasn't a permanent solution, it was nonrecurrent, so you couldn't do anything substantive

in terms of making substantive appointments based on nonrecurrent monies. It was a risky move. Some Trusts did it but our Trust, we didn't do it.

312 Q. Thank you.

16:44

Just one thing on the PP analysis. A slightly unusual situation that, from my reading, almost all the patients start as NHS patients and were put on a waiting list and then saw Mr. O'Brien in his private rooms. Were they already on a surgical waiting list? 16:44
That wasn't well demonstrated in the analysis. This has caused confusion, I think.

A. I am not sure. I don't know the answer, Mr. Hanbury, in terms of patients were initially seen as an NHS patient and subsequently went on to see Mr. O'Brien 16:45
privately, or they only saw Mr. O'Brien privately and then were transferred into the Health Service. I don't know the answer to that.

313 Q. But that would make a difference if they were?

A. Yes. 16:45

314 Q. Thank you.

Just lastly referring to Patient 16, sort of waiting list issues, especially for scheduled patients, stent change is delayed and that. 16:45

A. Yes.

315 Q. What mechanism did you have to oversee the waiting list of a patient who has to wait a certain length of time, but not shorter or longer, which is an unusual thing in

the case of a lot of urology patients?

A. So, Patient 16 required to have a stent removed in order to have his chemotherapy. I suppose, as Mr. Wolfe said, there was lots of miscommunication or noncommunication between the Regional Oncology Centre and the Trust. It was simply capacity to allow Patient 16 to allow to have the stents removed. He was caught up in our inability to provide timely stent removal. 16:46

316 Q. Is that rather than having waiting list, clerical office support-type factors in your thoughts? 16:46

A. I'm not too sure. Sorry?

317 Q. I was getting at the fact that Mr. O'Brien used to run a lot of his waiting lists himself rather than relying on clerical colleagues who may have assisted. Do you think that was a problem? 16:47

A. Well, I know consultants obviously do -- if they don't have the capacity and they're concerned about a patient, they would speak to their colleague and say would you operate on this patient for the following reasons, and I'm sure nine times out of ten that happens. I'm not aware that Mr. O'Brien made that request of one of his colleagues for Patient 16. 16:47

318 Q. Thank you.

CHAIR: Just a couple of questions.

16:47

In one of your answers to Mr. Wolfe, you said that you felt it was better that operational managers could investigate the issues of concern regarding Mr. O'Brien's practice if he were excluded rather than

him being there. Why was that?

A. I suppose -- and Mrs. Corrigan referred to that. Mr. O'Brien is a big presence. It was not uncommon that Mr. O'Brien would be in the hospital for many, many, many hours, you know, well into the evening. I met him when I was on-call sometimes walking the corridors at maybe nine o'clock at night. So it was generally felt his presence would just make things easier.

319 Q. His absence, not his presence? 16:48

A. Sorry. His absence, yes.

320 Q. I suppose the corollary of that is why do you think nobody sat down and talked to Mr. O'Brien about all of this that was going on in the background, the MHPS investigation? 16:48

A. I don't think anybody took ownership of it. I suppose the management of Mr. O'Brien was through the MHPS vehicle. That's a medically driven vehicle with support of HR. I suppose from my perspective, I was looking for senior clinicians to take the lead on it. 16:49 As I said, my knowledge of it was limited, very limited. It's been my experience, working in the Health Service many years, that senior clinicians always interact better and communicate better with their peers. Whilst I'm a senior manager and a nurse, 16:49 it's much more powerful and meaningful if an AMD or CD or the Medical Director, but that didn't happen. I suppose to answer your question why did that not happen, I don't know.

321 Q. Was one of the factors perhaps the changeover of staff in those roles?
A. In 2016?
322 Q. Hmm-mm.
A. Yes. Well, I think myself as one. Mrs. Trouton going the other way. 16:50
323 Q. I'm thinking on the medical management side. I think it went beyond 2016. There was a large turnover of staff on the medical management side here.
A. Yes, yes. I think losing Dr. McAllister so early in his tenure was unfortunate. I think that whilst we're never know, my knowledge and experience of Dr. McAllister would have made a difference or could have made a difference. Then Mr. Weir being off sick for extended periods of time over the next two years again didn't help. Mr. Haynes coming in as the MD in October 2018, and then his -- I think the term he used is "Mr. O'Brien is a challenge". So, you know, again he was a new MD finding his feet in the role. So yes, I agree with you, the turnover of senior medics. Also Dr. Khan, Dr. Wright, and the medical directors didn't help. Dr. O'Kane coming in lately didn't help either. 16:50 16:50 16:51
CHAIR: Thank you very much. I have no further questions for you. I'm sure you will be very relieved to know that we will hopefully not be asking you to come back and talk to us on another day. Can I also say I'm very sorry on your very recent bereavement as well. 16:51

Ladies and gentlemen, tomorrow morning, 10 o'clock.

THE INQUIRY ADJOURNED TO 10:00 A.M. ON WEDNESDAY 19TH APRIL 2023 16:51