Urology Services Inquiry

Oral Hearing

Day 27 – Tuesday, 28th February 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

INDEX

THE INQUIRY RESUMED ON TUESDAY, 28TH FEBRUARY 2023 AS FOLLOWS:

CHAIR: Good afternoon, everyone.

10:03

Dr. Wright. Welcome back.

A. Thank you.

CHAIR: Mr. Wolfe.

DR. RICHARD WRIGHT, HAVING BEEN PREVIOUSLY SWORN, CONTINUED TO BE EXAMINED BY MR. WOLFE KC AS FOLLOWS:

10:03

MR. WOLFE KC: Good morning, Mr. Wright. Thank you for returning for the second day of your evidence. You were last with us on Day 23, which was 2nd February. Your evidence has been transcribed and is available to the public and, of course, the Panel and Core Participants, and can be found at TRA02484 through to 02630.

10:03

10:04

You'll recall when you were last with us that we had brought the narrative in chronological fashion up to that point when, on 22th December 2016 the Oversight Committee had resolved to proceed by way of a formal MHPS investigation to consider what, at that time, looked like three issues of concern with regard to Mr. O'Brien's practice. What remains to be examined in your evidence is that portion after December 2016 when you had your hands on various activities associated

10:04

with MHPS, and we'll end this morning, or this afternoon, with some reflections on your involvement in the process.

Before stepping through those 2017 into 2018 issues, just, if we can for some time this morning, step back in time to go over some of the issues that arose the last time in light of some information the Inquiry has received through the evidence of others in the past few days and weeks since you were last with us. 10:05

Mr. Simon Gibson was with us on Day 25, 22nd February. He recalled that you asked him to do a discreet piece of work, emphasis on that word, in the form of what was to become known as a screening report. I asked him to explain what he meant by the word "discreet", and he suggested that there was to be, in essence, a confidential piece, not taking his enquiries all around the houses or into the canteen, as he put it, but to speak to a few people. 10:06

He told us he had done other work for you of that type but not in the context of an MHPS process. Is that fair?

A. That's correct. Yes. 10:06

1 Q. I asked him to comment in light of an understanding of the MHPS Framework and the Trust's guidelines, which I put to him to the effect that the screening process, or the preliminary enquiries, should be conducted by

a Clinical Manager. You'll recall we had a bit of debate about where you saw your operation of the process and whether it was compliant with the guidelines. What he said was:

10:07

"I think that Charlie McAllister and Colin Weir would have been clinically a lot closer and maybe would have been able to give a wider perspective of issues that they may have been aware of that I certainly wasn't, or maybe others weren't as well. Certainly there would be advantages in Charlie and Colin being there, for sure."

10:07

Just on that particular point. When you reflect upon the evidence that you've given and your awareness of the situation at the time, do you have any reservations about your decision not to involve Mr. McAllister and Mr. Weir in the process of preliminary enquiries?

10:08

A. Yes, I have reflected upon it and, clearly -- I mean, I would obviously support the guidance going forward in terms of involving clinical personnel where possible. But, I can give you my reasons for why I asked Simon to do it, Mr. Gibson to do it, if you wish. What was in my head. The first thing was speed. Both Dr. McAllister and Mr. Weir were very busy clinicians. I needed this done at some speed once we had to get ready for the Oversight Committee and I suspected they wouldn't be able to complete the job in the time frame. Mr. Gibson had been on an NCAS training programme. He was aware of the issues. He was very well placed with

10:08

10:09

all of the key characters to be able to speak to them. He had almost a unique breadth of experience within the organisation in terms of his involvement with the people involved in this. So, I was confident he would be able to complete this task in the time frame required and with a degree of professionalism and confidentiality.

In hindsight, yes, it would have been better to have involved a clinician, but I'm not sure they would have been able to complete the job in the time frame. 10:09

2 Q. I think those reasons you have set out are consistent with what you told us on the last indication.

I should say, Chair, and members of the Panel, the transcript from Mr. Gibson is not yet -- at least when I looked at it yesterday -- Bates numbered, but the quotation I have just recited comes from page 76 and questions 259 to 261. That should be easily married up when we have the transcription. 10:10

Is there any sense, Dr. Wright, that you may have thought that Mr. Weir, Dr. McAllister, were too close to Mr. O'Brien to provide you with the kind of clean, honest, straightforward analysis that you required for the purposes of taking this forward? 10:11

A. At the time that I asked Mr. Gibson to do the study I don't believe that was a factor in my mind. However, it may have been that they were too close, and that is

something, you know, as events unfolded could have been an issue. But, in all honesty, at the time of the decision it was simply I had confidence that Simon was able to deliver this in the time frame and he would do the job well. That was the overriding factor in my mind.

3 Q. Ultimately, and we'll come on later to look at Mr. Weir, who was removed -- I use that word neutrally -- from the process. He was appointed as case investigator, and that arose out of a sense that he was too close. Is that fair? We'll explore it in detail.

A. There were a number of factors, to be fair.

4 Q. Okay, we'll come to that.

10:11 10:12 10:12 10:12 10:13

Dr. McAllister's evidence, Day 24, 21st February, you spoke on the last occasion at TRA-02501 about the importance of the Associate Medical Directors, for your purposes as Medical Director. You say they were critical to the running of the professional system. It was the tenor of Dr. McAllister's evidence that there was a somewhat distant professional relationship between you and him. He said -- and this is, members of the Panel, TRA-2738 through to TRA-02739 -- it was the tenor of his evidence, as I said, that there was some distance between you. He was expecting monthly one-to-one meetings, which was the arrangement, give or take, before you came in in July 2015. He looked to have those meetings for support, information, a steer

on prioritisation and on the direction of travel for issues. You first met him after coming in in July 2015. You first met him one-to-one February 2016, and over a period of nine months he recalled that you only had two one-to-one meetings. Does that sound accurate? 10:14

A. I think that is accurate in terms of the one-to-one meetings, although there would have been lots of occasions when we would have been working together, and quite closely. I think it is fair to say that our relationship was not as strong as it would have been between some of the other Associate Medical Directors. I mean, I can expand on that if you wish. 10:14

Q. Please do. It's perhaps relevant in the context when he wrote you on 9th May, shortly taking over an additional AMD role in Surgery, and we saw his lengthy email of 21 points. We'll come to whether there was a meeting around that in a moment. Just in terms of the closeness of your relationship, which was different or lacked closeness compared to others? 10:14 10:15

A. Well, I set out my stall very much at the beginning of my tenure as developing a team of Associate Medical Directors who would work closely with each other and support each other and often help out on issues that affected the entire Trust as opposed to just their own specific area of interest. I think Dr. McAllister found that a difficult and a different approach to what he was used to before. So we differed quite significantly on our approach to that. 10:15

On one of the occasions quite soon after I began we took the team away for a number of days on a team-building exercise, and that was going quite well as far as I could see. We had external people in from the Leadership Centre to help us with that around this very issue of collegiate working. Dr. McAllister left that early, of his own volition, because I think he found the process very difficult. So, there was an issue of communication between the two of us that we worked through, I think, reasonably professionally. Then there were other complicating issues that arose as the tenure went on in that there was another process taking place regarding Dr. McAllister, which I was involved in, which made it difficult to have regular one-to-one meetings during that. So, it was a difficult time. But what I would say is we had lot of opportunities to discuss cases and issues on a regular and frequent basis, and those would have been availed of from time to time. It didn't prevent the working of the Department, but I realised there was an issue there that had to be addressed. 10:16 10:16 10:16

6 Q. The 9th May email, he gave evidence specifically around that at TRA-02745. Counsel was asking him about that. He says that he suggested that -- just at the bottom of the page. Thank you for bringing it up. 10:17

"Can you ever recall meeting Dr. Wright to discuss the email of 9th May?

I attempted to the following Friday.
You say you attempted to. Were you able to meet with Dr. Wright?
He suggested that it wasn't the time or the place and it should wait to the next one-to-one." 10:17

Does that effect your memory?
A. I honestly can't remember that situation arising. I'm not saying it didn't, but I have no recollection of that. I can't comment on that. What I would say is 10:18 the issues in that email, there were very many issues and virtually all of them already had a process in place that he would have been aware of and I was aware of, and we were working through those on an individual basis. So there wasn't one issue he was flagging up, 10:18 'I need to talk to you about this really urgently', in the way there might have been for other issues in the past. It was a general email of lots of issues going on and there were already processes in place for just about all of them. Whilst it was a significant email, 10:18 and I accept that, it wasn't one, 'I need to talk to you about this particular issue urgently'. I don't recall any attempt to get a sooner meeting than that. It may have been, but I have no recollection of that.
7 Q. I want to ask you, using the word "discreet" again 10:18 about a discreet issue concerning Patient 93. You should have a cipher list beside you. If you scroll to the fourth page you'll see the name of that patient towards the bottom two-thirds of the way down. Does

that name many anything to you?

A. No, not particularly. No.

8 Q. I want to show you some emails that were passing between managers within the Surgical Urological side in August/September 2016 and then ask you some questions about them. 10:19

If we go to TRU-754. Let's try TRU-274751.

A. Mr. Wolfe, this screen isn't functioning.

CHAIR: It is Tuesday. We tend to have technical difficulties on a Tuesday, Mr. Wright. Is everyone else's screen functioning okay? Can we just check it? 10:20

MR. WOLFE KC: There's nothing up on your screen?

A. No.

CHAIR: We've discovered loose wires and things can be an issue at times. 10:21

A. It may be just not turned on.

CHAIR: Easily resolved one, at least.

9 Q. MR. WOLFE KC: Just to contextualise this for you, Dr. Wright. You're looking a bit puzzled and I'm not suggesting for one minute you should have known about this issue or that you do know about this issue, but I want to set it out for you, nevertheless. 10:21

31st August 2016 Mr. Haynes writes to Martina Corrigan in connection with: "I can assure you Patient 93", and he sets out a history there in respect of the patient which, in a nutshell, says that this patient should have been triaged, having been referred as a routine by 10:22

the general practitioner. Had it been triaged, given the PSA results on repeat, it would or ought to have been red flagged. The triage didn't happen so the patient wasn't red flagged but he came back into the system after a delay of three and a half months with a metastatic disease from a prostate primary. Although the outcome for the patient, in Mr. Haynes' view, wouldn't necessarily have changed, he considered it of concern and put it into the system as "SAI?" Let's see how that develops and who knew about it. Ultimately, to give you a heads up, I want to look at this in the context of what you were looking at at the time: a screening process leading to an Oversight Group, decisions, then those decisions bypassed. I want to ultimately look at whether this kind of information is information that should have been drawn to your attention. 10:22 10:23 10:23

Mr. Haynes to Mrs. Corrigan, if we go up that page then. Mrs. Corrigan to Mr. Carroll. Then Mr. Carroll, scrolling up, to Mr. McAllister. Mr. McAllister is asked to consider the series of the emails. 10:24

"Suffice to say although the outcome for the patient would not be any different. This is, as you know, not the issue that needs to be dealt with. We await your thoughts." 10:24

That's going to Mr. McAllister, presumably in his role

as AMD. Then the AMD, Mr. McAllister: My thoughts are that this should go through Mr. Young, who is the Clinical Lead Urology, then Mr. Weir as the Clinical Director, then he is happy to become involved. Do you regard that as an appropriate process? 10:25

A. It would need to be done in a timely manner. But, yes, clearly the Clinical Lead and the relevant Clinical Director should be involved in that process, yes, that's correct.

10 Q. Then up the page it is back to Martina from Ronan, Mr. Carroll. Then it goes to -- up the page -- Martina to flag it for Michael, Michael Young. Up the page then, please. So Michael Young takes a view and comes back to Mrs. Corrigan. He's saying essentially that the GP got it wrong with the referral. 10:25

"The point here is that although noncurable I would have thought treatment would still have been offered in the form of ADT at some stage. To follow this, the next step means that if still following our current routine waiting time would have resulted in the patient not being seen for a year. Some clinicians would have regarded this as resulting in a delay in therapy". 10:26

What we have here is a live situation where a patient has been missed. It is also seen by Mr. Weir and he adds his comments through a meeting with Mrs. Corrigan, which I needn't bring you to. It does seem that both Clinical Director and Associate Medical Director were 10:26

aware of the case where the implications for the patient arising out of a failed triage were, potentially, quite serious. A delay of three and a half months, albeit the outcome may not have been any different.

A. Mm-hmm.

11 Q. This case joins the case of Patient 10, which was an SAI in the system. Is it clear to you that in August and September when Oversight were looking at Mr. O'Brien's practice, that you weren't aware of these issues?

A. I wasn't aware of this, certainly, no. No, I wasn't aware of that. At that point.

12 Q. Is it something that you ought to have been aware of or ought to have been drawn to your attention?

A. The process would normally be that the AMDs and the Governance Leads would meet within the Directorate to look at all the potential SAIs and consider. I would have expected that would have happened with this, and given this was connected with the case we were looking at, I would have wanted it to have been drawn to my attention.

13 Q. You were seeking, through Mr. Gibson's efforts, an update on the kinds of issues that were to be regarded as difficulties or, perhaps, shortcomings in Mr. O'Brien's practice?

A. That's right. That's correct.

14 Q. How was this information to come through that process if Mr. Gibson is only speaking to Martina Corrigan and

the lady -- I forget her name -- with responsibility for patient records? Those are the two people he spoke to.

A. I would have expected the Service Director to have been consulting with her AMDs and her Governance Team to bring any relevant information to the table, if you like, at the Oversight Meeting. That would normally be what would happen.

15 Q. In particular terms then, Mrs. Gishkori, knowing that an Oversight Committee had been convened to look at Mr. O'Brien's practice, should have been, I suppose, gathering appropriate intelligence from within her system to bring to the table at Oversight? 10:29

A. Yes.

16 Q. Obviously we can ask Mrs. Gishkori about that. She met, as you know, with Mr. McAllister and Mr. Weir, perhaps I think a question mark around that, on 14th September, the day after the Oversight. We can see from the dates of these emails that this Patient 93 issue was in their in-tray at that time, or had just left their in-tray, perhaps, with Mr. McAllister. 10:30

In the interests of full transparency and to enable senior managers to take appropriate decisions, would you have expected Mr. McAllister to have drawn this case to Mrs. Gishkori's attention if she didn't otherwise know about it? 10:31

A. That would normally be what happens in these situations and, yes, I would have expected that.

17 Q. The SAI concerning Patient 10 started life as an incident report in January. Maybe the Inquiry will do some work in terms of where it was sitting in September 2016. You say that wasn't known to you at that time? 10:31

A. Yes, I believe so. Yes, I wasn't aware of that at that time.

18 Q. I think you explained on the last occasions that perhaps the game changer in terms of why you had the 22nd December meeting leading to a formal MHPS was the 10:32 information coming through in respect of the SAI concerning Patient 10?

A. Yes, that's right. We received an interim report. Obviously the chair of that SAI was concerned enough to escalate that. He wasn't keen to wait until he'd 10:32 finished writing the report, and that was the appropriated thing to do. Obviously, at any one time there would be lots of incidents being investigated, most of them which don't come to very much so you wouldn't be aware of them all. But, yes, whenever he 10:32 raised that, that was a game changer for me in my mind.

19 Q. Reflecting back on that time now and trying to help the Inquiry generally with the process around this early stage of an inquiry in a practitioner's performance, have you any reflections to offer in terms of the kind 10:33 of questions or the Terms of Reference that should be set for the person conducting the preliminary investigations and, I suppose, the process for enabling information to flow in to Oversight from -- it's not

oversight any more, of course, but to flow into the system in respect of performance?

A. I think it makes sense, and clearly in this case this makes the case that specific information regarding any intelligence an organisation has around incidents that have been raised, or clinical concerns raised in other forums through complaints or litigation, or even as a result of a multi-disciplinary team discussion, which might be relevant to an investigation, would be useful to have at the table. That should be sought at an earlier stage proactively rather than waiting. 10:34 10:34

What had tended to happen was that the -- and the reason for having the Service Director at the Oversight meeting was they would usually be fully briefed about the relevant issues within their team and usually they would have brought any relevant information to the table or, if not actually at the meeting, they would have forwarded that soon after, once they realised what the issue was. I think, with hindsight, it would have been better to have proactively and deliberately asked for that information right at the start, if there was any. 10:34 10:34

20 Q. Of course if the Clinical Manager, be that McAllister or Weir, had been given the task by you of bringing to the table the results of a preliminary inquiry, we could say they were the people with that knowledge. Mr. Gibson didn't have that knowledge? 10:35

A. I think that's a reasonable point. I think the only

thing I would say is that going to the Oversight Meeting -- many of the issues brought to the Oversight Meeting don't go any further because they are deemed not to require an MHPS investigation or any other investigation, so that would happen from time to time. 10:35
I suppose in my mind, at what point does the MHPS procedure start? It could have been there wouldn't have been any further investigation after the Oversight, but with hindsight and looking back, yes, I think that's a fair point, that the local clinician 10:36
being involved at the start would have been more likely to have that information to hand. I think that's correct.

21 Q. You spoke on the last occasion at TRA-02611 about following the 22nd December Oversight decision you went 10:36
to speak, maybe you telephoned, Mrs. Brownlee in her capacity as Chair of The Trust Board.

A. Yes, I went to her directly in her office.

22 Q. Very good. Thank you. You remarked that you told her about the decision, and she listened professionally, 10:36
and there was no controversy in respect of that.

Could I draw your attention to what Mrs. Toal has told us in a witness statement? If I could have up on the screen, please, WIT-41056. Scrolling down. This is 10:37
a Section 21 response from Mrs. Toal. She's reflecting upon the time at which you first introduced her to the Aidan O'Brien issues. She places it somewhere between late August and early September. He says:

"I believe it was during this conversation that Dr. Wright made me aware that Mr. O'Brien was a friend of Mrs Roberta Brownlee, Chair of the Southern Health and Social Care Trust. Part of the same conversation, I can recall asking Dr. Wright if Francis Rice, Chief Executive, knew about the concerns."

Can I just ask you about that. First of all, do you agree with Mrs. Toal's recollection that at some point, possibly late August, early September, when introducing the Aidan O'Brien concerns that you, at the same time, referred to the friendship between Brownlee and O'Brien? 10:38

A. Yes. My wife and I had been invited to Mrs. Brownlee's 60th birthday party earlier in the year. It was the only time we were at a social event with her. Mr. O'Brien was there and it was clear they were friends. That's the only reason I would have known that. But I was aware that he was at her birthday party, as I was. 10:39

23 Q. That's helpful but it doesn't quite answer the -- why would you be, at the same time as relating your concerns about Mr. O'Brien, perhaps signalling that they would need to be looked at quite closely, and were being looked at quite closely, or about to be, by Mr. Gibson, why in that context are you mentioning the friendship with the Chairperson of the Board? 10:39

A. I was aware that other people would have been aware of

that friendship and it may have made them wary about how they interacted with the case, potentially.

24 Q. Mrs. Toal, an experienced HR professional, why did she need to know this?

A. To be honest, I'm not sure that she necessarily did need. She would have known this anyway. I think it's something she would have been aware of as much as I would have been. I don't think -- there was no other motive or intent. It was just an issue in the case that could potentially have been a complicating factor in how we dealt with it going forward, because I suspect that some people may have been reticent to become involved because of the known association, and we had to be aware of that. But I had no concrete evidence to say that that happened or would have happened otherwise. But it was an issue. It was a bit of the emotional intelligence around the case. 10:40 10:40 10:41

25 Q. Was it a suggestion that we have to be extra careful here to do this by the book, or was it a suggestion that by interference or implication that we might come under some pressure here in investigating this? 10:41

A. I don't think at that stage there was any of that, really. It was simply just a 'be aware of the issue'. I was certainly aware of that when I went to tell her about Mr. O'Brien, that she had a personal interest in this case and I just needed to be very factual, professional, about how I presented that to her. It was no more than that. 10:41

26 Q. Could I turn to the NCAS advice that had been sought in

advance of 13th September Oversight Meeting. You had directed Mr. Gibson, you will recall, to speak to NCAS?

A. Yes.

27 Q. He spoke to Dr. Colin Fitzpatrick on 7th September, but the report, or the written advice, I should call it, dated 13th September wasn't available at the time of the meeting and was, in fact, received later on the same day as the meeting. 10:42

A. Mm-hmm.

28 Q. You said on the last indication, TRA-02575, that you can't remember if the NCAS advice was discussed. You added you would have been wary of discussing advice not seen. This is just at the top of the page. Then at the bottom of that page you say: 10:42

10:43

"There might have been some mention of it" -- that's the advice -- "but without actually seeing the letter we couldn't have formally considered it, really."

Just to be clear, and to have your observations on it, Mr. Gibson, giving evidence on 22nd February, feels sure that the advice must have been raised verbally with him, although he cannot say specifically at this stage what he said and, of course, the minute or the record of the meeting is unhelpful in not mentioning it at all. 10:44 10:44

I'm not sure if I drew your attention to this email specifically on the last occasion but even if I did,

I'll do it again. WIT-41573. He is writing just over two weeks after the Oversight:

"You will recall that as part of the collation of evidence in relation to the above I sought advice from NCAS which was discussed when the Oversight Committee met. The written advice from NCAS has now come in and is attached."

Just on that, he's saying in specific terms, on the record, this is advice that's come in. I would have discussed this with you at the Oversight Committee. Nobody dissented from that email to say two weeks after the meeting, 'oh, no, you didn't'.

A. I'm sure if Simon remembers this that it could have happened. I don't recall it. It's not in the minute. I'm not being very helpful here. It's possible it was mentioned in passing but I can't recall the details of that. My only question would be why would that not have been minuted? Simon was doing the minutes but -- there was no reason. I mean from my perspective, if we had discussed it, there was no reason to not record that and make a minute of it, but it may have just been an oversight.

29 Q. Put it another way. As an experienced user of the MHPS process, you will be familiar with the indication within it which says at a preliminary stage make sure and take -- I'm paraphrasing here -- make sure and take advice from NCAS. Similarly within the Trust's local

guidelines, again, a difficult area, Clinical Manager, don't take this decision on your own, seek advice, including from NCAS.

Putting that into the mix, if you didn't receive advice from NCAS and had a think about that, you weren't acting in concert with your own guidelines? 10:47

A. Yes. I mean, I suppose we would have known the NCAS advice had come in. Perhaps Simon indicated we were broadly in line with it, I don't know. But we would have wanted to see that advice in as timely a way as we could, and would have considered it obviously if it had been in any way at variance with what we were suggesting. I honestly can't remember that conversation. I wish I could because it would help the situation. I don't dispute it could have happened, but I have no recollection of it. 10:47 10:48

30 Q. The advice -- if we can put it up on the screen, please, is AOB-01049. Just scroll down, please. Thank you. 10:48

An aspect of the advice that was given -- just scroll down. Thank you. Stop there. In the last paragraph there's a focus on providing support to the practitioner, Mr. O'Brien, including the possibility of relieving him of Theatre duties in order to allow him to clear his backlog. Such a significant backlog will be difficult to clear and he will require significant support. 10:49

It's fair to say, and we can go back to it if you wish, that the decision that emerged from Oversight did not deal with support for Mr. O'Brien. The letter that Mr. Gibson crafted on behalf of the Oversight Committee after the meeting didn't provide for support for Mr. O'Brien. Plainly, and I'm conscious you can't help us with whether there was a discussion of any advice, let alone this specific advice? 10:49

A. Mm-hmm. 10:50

31 Q. But the process moved forward, it seems, without any attention being given to supporting Mr. O'Brien through this process?

A. There would have been an expectation at Directorate level that there would have been a lot of support given. That usually, in my experience, was usually what happened, through informal and formal routes. We would have obviously had this letter in front of us and as the discussions ensued with Mr. O'Brien, I would have expected that that support would have been offered. As things developed, then, that letter was never sent so that wasn't possible to implement or look at. Again, we would have considered this letter in detail when we had it in front of us had the process ensued. But, in any case, the normal expectation would have been the Directorate would have managed the individual and supported them in whatever way was appropriate, and that would have been understood by everyone around that table, and that would have been 10:50 10:50 10:51

what we did with lots of cases in the past. This wouldn't have been a surprise and, yes, it would have been better to have been specifically outlined in that letter: I wouldn't disagree with any of the tenor of it or the discussions being made. 10:51

32 Q. Yes. Obviously things took a different turn. We've gone over that ground. Mrs. Gishkori coming with an alternative plan, drafted by Mr. Weir, commented upon and annotated by Mr. Carroll. Then we have the October Oversight. By October you have this advice in your 10:52 hands. It has been emailed to you at the end of September, as we've seen. But it's never taken out and made the subject of discussion in October.

In terms of NCAS, is NCAS a troublesome hoop that you 10:52 had to jump through --

A. No, not at all.

33 Q. -- or was it an organisation that was seen as central to a performance-related process?

A. No, no. I mean the letter should have been discussed 10:52 at that October meeting. That was wrong. I think, it should have been clearly formally discussed.

My experience of NCAS is generally they were quite helpful. I had quite a bit of experience with them, 10:53 a close relationship in the past. I found them to be very supportive. Their advice was usually very sound. Both in progressing an MHPS investigation and helping with the decision-making process around exclusion, but

also in looking -- sometimes at the end of an MHPS process the recommendation would be that NCAS would take on further work to support and assess a clinician further. I've used that in the past with some success to rehabilitate doctors who are in some difficulty. 10:53
So, no, NCAS was a very valuable organisation that performed very helpful work and it should have been considered at that October meeting, I think. I can only assume that by that stage -- I mean it should have been formally considered but we had seen the letter and 10:54
events were unfolding at a different rate. But, with hindsight, clearly, it should have been there.
I greatly valued and appreciated NCAS as an organisation, and their support and advice.

34 Q. Could I just then take you to a point which I think -- 10:54
I certainly have raised with you before but I just want to go back on it in light of what Mr. Gibson says.
Back up to the bottom of the page of this letter, please. You can see there that Dr. Fitzpatrick is recounting what Mr. Gibson accepts he must have told 10:54
Dr. Fitzpatrick. To date, you're not aware of any patient harm from this behaviour but there are anecdotal reports of delayed referral to oncology.

When we asked you about this on the last occasion, 10:55
TRA-02579 through to 80, you said that you didn't know the source of these anecdotal reports. You said it may have been tittle-tattle but, at that time, consistent with what you said this morning, you weren't aware of

complaints or SAIs at this stage.

Mr. Gibson, on Day 25, at page 54 of his evidence says:

"When thinking about this now, this issue" -- these last two lines -- "should have been further investigated". 10:55

He forwarded the letter to you and Esther Gishkori as we've seen. Maybe he said he is to blame for not flagging the issue when he forwarded it. But, nevertheless, if there were anecdotal reports of delayed referral to oncology there was an obligation on the process to better understand what that meant. Did you agree with that? 10:56

A. I mean obviously it would have been helpful to know where these were coming from and what level they were at. In a healthcare organisation there are always rumours and innuendos going around about every clinician. So there's a judgment call to be made about where that becomes significant. Without hard evidence it is very difficult to act on. But, yes, I think ideally that would have been bottomed out, one way or another. If there wasn't substance to it then it shouldn't probably have been in the letter at that point. If there was substance, it should have been investigated. 10:56 10:57

35 Q. I suppose the question worrying the Inquiry might be, in your role you have to gather the material which

might otherwise be available in order to make the judgment call, and that would start with, 'Mr. Gibson, what's this about?' In real-time he might have remembered what it was about. 'Where has that come from?' Then go back to the source for the anecdote, if that was feasible, to try to work it out? 10:57

A. That's where understanding where it came from would be helpful. It may not be possible to go back to the source. I think this type of information, obviously, would have been teased out. Once we decided we were doing a formal investigation this is exactly the sort of information you would like to gather. It's very difficult to do in the time period with the information given to make a preliminary decision that you were going to have an MHPS investigation. That's what the investigation is for, to get to the bottom of all these things. Yes, it is untidy, it is not helpful, but all I can say is that anecdotal stories about doctors are very commonplace, they are very difficult to get to the bottom of in the time frame that we were dealing with, and you would hope, though, that would have been bottomed out by the investigation proper, once it started. 10:58 10:58 10:58

36 Q. Yes. Obviously the investigation proper, once it started, didn't address this issue. Is it not reasonable -- 10:58

A. You say that, Mr. Wolfe, but I think the range of people that were interviewed and discussed if these issues -- I would have expected to have come out if

there was anything of substance to them. So I just don't totally accept that point.

37 Q. Let me argue that with you. You have Terms Of Reference which, as you see, identify five issues. We'll look at those presently. Certainly there was the 10:59
no issue within the Terms of Reference which would cause the investigator to look at delayed referrals through oncology. That's a long way round of saying having got this issue on the paper, whether there is any substance, it wasn't drawn up at the point of going 11:00
down the formal route in December 2016.

A. Yes.

38 Q. Nobody went to whoever was responsible for drafting the Terms of Reference to say, 'is this worth scoping out?'

A. Yes, and I would accept that. I suppose it, again, comes back to what's the level of these anecdotal stories? Is there any real substance to them? Is there any way of tracing them? It's a difficult area. 11:00

39 Q. Yes. Can I suggest to you that this line maybe was lost -- 11:00

A. Yes.

40 Q. -- in the process? It doesn't appear that it appears in any discussion or in any agenda subsequently.

A. Yes. I think that is a reasonable point.

41 Q. The next time you speak to NCAS was after the 22nd December decision and they provided you with some advice, and we looked at that on the last occasion. Just one other point, if I may, arising out of that. The advice is to be found at AOB-01327. Clearly it 11:00

isn't. Allow me a moment. AOB-01327. Just scroll to the bottom of that page, please? The last paragraph where the adviser, I think it's Dr. Fitzpatrick:

"As you are aware the concerns about a doctor should be managed in line with locality policy and the guidance in MHPS. We discussed that as the information to date noted no improvement despite the matter having been raised with doctor -- suggests that an informal approach is unlikely to resolve the situation, a more formal process is now warranted." 11:02 11:03

Just on that point. Were you advising NCAS in order to seek their advice about the appropriate process? Were you advising them that an informal approach had been tried and had failed, and therefore you thought that a formal approach was now necessary? 11:03

A. I had certainly advised them that an informal approach had failed, in my estimation, and was asking them for their advice. In my head I did believe a formal approach was now necessary. I don't think I would have gone on to say, 'and I think you should tell us that's the case'. What they advised was certainly what I was thinking was probably what they were going to advise given the situation. 11:04 11:04

42 Q. Just on the informal approach. In your own mind and by your own definition, what was that? Because the informal approach proposed in September, if we call it that, the informal MHPS investigation --

A. Okay. Well, I suppose -- I appreciate the language is confusing around this but. There would have been what I would call the informal informal approach which would have been at the beginning of March with the delivery of the letter where we hoped that this would have been resolved simply without any further investigation. I accept that that wasn't part of an MHPS process, but that, nevertheless, was an informal attempt as well as we now knew there had been many previous informal attempts to resolve this. I suppose that, in hindsight, was what I was regarding as the informal approach. We had planned to do the more formal informal approach under the MHPS guidance with the letter that was to be issued, but which never happened because of events that transpired and the attempts by the local team to resolve this differently. In the meantime then we had had this escalation with the SAI results becoming apparent to us. It was a complicated picture, I suppose, in my mind. There were lots of informal attempts made of various types and we got to the point, I think, where the only alternative was to handle this formally to move this forward, because the stakes had been raised, if you like. 11:05 11:05 11:05 11:06 11:06

43 Q. I suppose the point is that the process that Oversight had determined would be appropriate in December hadn't been tried because it had been sidelined because of Mrs. Gishkori's alternative, if I can put it in those terms.

The MHPS policy or framework in supporting local guidelines emphasises the need, first off, to try to deal with this locally on an informal approach, if possible. I just wonder, when you think about it, was NCAS provided with an accurate account of the efforts on the part of the Trust to try to resolve this?

A. I think they were. I would have had quite a lengthy conversation about this, I'm sure, with the adviser and explained the background to the elements. I can't say that every detail was shared, but I think they would have got a flavour of -- I mean a significant flavour of the situation we were in. 11:07

44 Q. Help us, if you can. Why do you go to NCAS after the decision has been made to go formal as opposed to before to seek advice? 11:08

A. A decision is it always open to change if NCAS were disagreeing with you. It's a big thing to consider, especially when you are considering an immediate exclusion. We felt that was required but we wouldn't have done it without the support of NCAS. 11:08

45 Q. Is it not putting the cart before the horse to make the decision and then go running to NCAS to confirm your decision?

A. I don't think so, because you would then be on the phone to NCAS about lots of cases that you might potentially consider an exclusion in but you weren't sure. It is a big thing. I think you have to be fairly sure that's the direction you're going in before you would be -- I mean this would be an unusual event 11:08

to consider immediate exclusion. I certainly wouldn't have been ringing NCAS about most of the cases that were on our books. I'm sure if I had they would have wondered why I was troubling them. I see where you're coming from. That was the direction we thought we should go in but we wouldn't have preceded unless NCAS had been in agreement with that. 11:09

46 Q. Of course NCAS can always give you advice to cause you to change your mind. Is it not much more logical to seek their advice in advance of any decision so that you can weigh up that advice and take up the various factors they are suggesting you weigh up and then reach your decision. Have you not done it the wrong way round? 11:09

A. Possibly. All I can say is, as I have said before, this was a Christmas holiday, New Year's holiday, things were moving very quickly. You know, it would have been difficult to have choreographed all the moves. This would normally have been the way, in my experience, we would have operated, both in this Trust and in other Trusts, that an intended direction was taken, then you would have consulted NCAS in the light of that. I could see it probably better to speak to them first, but that was not the normal way it was done, in my experience. 11:10 11:10

CHAIR: Is this an appropriate time to take a break, Mr. Wolfe?

MR. WOLFE KC: We certainly could do.

CHAIR: Let's take a break now for 15 minutes and come

back at 25 past.

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Mr. Wolfe. 11:29

47 Q. MR. WOLFE KC: Dr. Wright, let's turn then to the actions that then followed the decision to pursue this matter formally. One of the first tasks you have to undertake is to speak to Dr. Khan and let him know that you had a difficult situation and you required his 11:30 help. If we could just have up on the screen, please, WIT-31899. This is you on 28th December, just after the Christmas break, writing to Dr. Khan, presumably for the first time to advise him of this matter.

11:30

Hope you had a good break. Etcetera. You have a tricky situation you need help with. You were saying you would like him to act as case manager under the MHPS framework and you were going to ask Colin Weir to act as CD. 11:30

We'll come to Colin Weir in a moment and look at the various interfaces with him and the difficulties the process ran into. The Inquiry would be interested in your reflections on the issue of training with these 11:31 key officers within the process. If we could just look at something you've said about that. At WIT-18425 at para 5.1, you say that:

Training for case investigators and case managers was provided mainly through the Trust development programme for senior medical staff along with individually tailored NCAS training. This was the programme that you developed in association with the Human Resources Department and the Health and Social Care Leadership Centre.

"I partly delivered this although we utilised expertise from across the Trust and also expertise from NCAS. This would have been reviewed as part of a doctor's annual appraisal of their entire medical practice, including leadership and investigative roles."

Are you saying that was a programme you instituted after coming into your role --

A. That's correct. There were lots of issues about leadership and medical management but there was a desire from the medical staff and, obviously a need that I witnessed for further training on lots of areas of medical leadership. Certainly the MHPS process and NCAS were some of the things that featured on that. We took quite a while to plan that, taking feedback from the medical staff themselves and our HR Department. We got it up and running in, I think it was the spring of 2017 by the time it was instituted. It took a while to get going. It ran then for the rest of my time as Medical Director. During that time we got virtually all the people in senior medical

leadership positions through that. But it hadn't started until after this process began.

48 Q. Would you have appreciated when making these appointments that Dr. Khan and Mr. Weir were without training, at least at the point of appointment? 11:33

A. Yes. This was a widespread issue within the Trust. There were very few people who had appropriate training. I mean I did recognise that as an issue. However, Dr. Khan -- I'm assuming you're going to ask why I asked Dr. Khan, not somebody else. Dr. Khan had 11:33 some very unique -- well, not unique but qualities. He had demonstrated as AMD of the Child Health Directorate that he had a very good grasp of governance issues, of dealing with difficult colleagues, of understanding systems issues. He had won many awards for that. He 11:34 was the outstanding leader within the Trust in that area, in my judgment. I felt and believed that the training issues could be overcome by enhancing his training during the process. So, yes, I was aware of that. 11:34

The alternative really -- and the other issue for picking Dr. Khan is I felt it was important that the Case Manager had not been, in the recent past, working directly with Mr. O'Brien to be objective and not have 11:34 any baggage. Mr. O'Brien had been in the Trust a long time, so there weren't very many individuals in that situation that one could turn to within the Trust and Dr. Khan was one of the few.

49 Q. Yes.
A. The alternative would have been to have gone outside the Trust which is possibly something we could have done, I have done in the past. The difficulty with that is in reality that would have meant, in Northern Ireland, probably going outside the region because Mr. O'Brien would have been well known throughout the province, so to really get an objective view you would have had to have gone outside the region. I have done that in the past. My experience with that is that introduces a significant time delay to the process which, in hindsight may not have been a big factor here because the process was very lengthy, in any case, but it's not an easy thing to do. Khan introduced -- almost certainly will introduce significant time delays to getting the process started. That was my reasoning. But, yes, I suppose I was aware of the issue is the short answer to the question. 11:35 11:35 11:35
50 Q. As I understand, they did receive training after a fashion. It may well not be the kind of developed training which I understand Mrs. Toal is going to tell us something about today and tomorrow, which has been more recently introduced. 11:36
A. Yes.
51 Q. Notwithstanding Dr. Khan's attributes and the training that he did receive, can I put to you his reflection on his involvement? It's at WIT-32000. He says at A at the top of the page: 11:36

"I think the most important factor was that I had no previous experience of conducting such a complex MHPS investigations as a Case Manager. I reviewed all the relevant guidelines and the MHPS Framework document. However, with no previous experience I wasn't fully quipped to carry out such a complex MHPS case investigation."

He did receive training after the investigation had commenced. He is reflecting back that, really, this was, in general terms, new to him and he didn't feel well-equipped. Is there -- the Inquiry is interested in this generally in the context of MHPS -- in your experience -- obviously you had experience in Belfast Trust before reaching the Southern Trust. Is there a need for Trusts to build capacity, familiarity, and a degree of, I suppose, comfort with these processes among medical leadership so that those charged with these key responsibilities are able to do them, I suppose, more efficiently and with less stress? 11:37 11:37 11:37 11:38

A. Yes. Absolutely. It's a major issue, I think, in processing these investigations. I have to say I struggle to think of anyone who would have been comfortable with this particular one because it was quite complex and difficult. But, as a general theme, there are very few people who would have extensive training who are doing these investigations frequently enough. It is not just about training, it is then about updating your experience and keeping abreast of 11:38

developing issues. You may be fully trained, carry out one investigation, then not be asked to do another one for a couple of years. So that's a major issue. My own personal belief is there needs to be extensive training of a bank of People within the province. 11:39
I don't think going to England or Scotland is really an appropriate response. You shouldn't need to do that. But you do need people with the right skill set who have sufficient time in their job plans who are sufficiently resourced and supported with 11:39
administrative support, and have the opportunity to use those skills in various Trusts across the province with enough frequency to keep focused and sharp. It is a very big challenge. It is not unlike the challenge that is faced around the investigation of SAIs. I was 11:39
involved recently in developing a report for the Department around SAIs, and similar issues have emerged from that. There needs to be a bank of people with experience who have time to carry this out appropriately and who are adequately supported. That 11:39
just doesn't really exist at the minute. Even getting experts from other Trusts is difficult. You are relying on grace and favour and goodwill of individuals and it's often challenging for them to be released for the time required for them to carry these out. That's 11:40
a very long answer. But I clearly identified within our own organisation and we began to address it, but this is a systemic problem across the region, and I suspect across the UK.

52 Q. Thank you for that. I'm not going to extend your answer any further. The Inquiry may have other questions arising out of that. We know we're going to hear from Mrs. Toal in relation to it, updates and work around that the Trust has carried out more recently. 11:40

I want to move to your engagement with the Department in relation to the decision to exclude and formally investigate. I start by looking at the MHPS process. It is WIT-18503. It says at the top of the page, 11:41 paragraph 26:

"At any point in the process where the Medical Director has reached a judgment that a practitioner is to be the subject of an exclusion, the regulatory body should be 11:41 notified. Guidance on the process for issuing alert letters can be found in circular HSS (TC8) (6)/98. This framework also sets out additional circumstances when the issue of an alert may be considered."

11:41

Regulatory body in that sense, is that a reference to the Department?

A. No, that would be the General Medical Council, I believe.

53 Q. You wrote to the Department. You notified the General 11:41 Medical Council, did you?

A. Yes, we would have notified them and we would have had regular meetings with the local representative of the GMC to update them on the progress of any cases that

we had.

54 Q. We'll look at that. We'll go to what you say to Dr. McBride as Chief Medical Officer. AOB-01339.

Did you understand it was an obligation to inform the Chief Medical Officer? 11:42

A. Yes. Yes.

55 Q. You set out what the Trust had decided to do and the fact you were scoping out Terms of Reference. In terms of the Department's interest or engagement with the Trust or issues concerning MHPS when you have a situation like this, is it just a case of notifying them and they leave you alone and they don't engage, or is there engagement and conversations that are maybe not reflected in writing? 11:42 11:43

A. I think it depends on the specifics of the case. My usual experience is that there wouldn't be very much engagement after the initial notification. Obviously you keep them updated and if an exclusion was being lifted, you follow that up. Where there would be likely to be, for instance, a public interest or a patient callback that takes it to the next level. The Department are very interested then in how you are managing that and managing the anxiety that would be there within the public. We weren't at that stage with Mr. O'Brien. I wouldn't have expected at that point a lot of direct engagement from them, apart from what we had done. 11:43 11:44

56 Q. Taking this from the specific to the more general and

on the basis of your experience, does the relationship with the Department work generally well in the context of MHPS Trust and Department or Trust and senior officials within the Department or is that an area that, in light of your experience, you might suggest improvement or development? 11:44

A. All these things can always be improved. I have never experienced any particular difficulty with the Department in this relation. They have never given me a hard time. They have always welcomed any information we've shared with them. In the light of a public callback of patients there would be questions coming back about how that was being managed, and they may sometimes have suggestions how that could be changed, which I would have thought would be fairly appropriate. 11:44 11:45

I remember one occasion when after the notification of an incident, the Minister appeared in the Department about two hours later such was the public interest and, to be fair to him -- this is not in this Trust -- his interest in moving the issue forward. So depending on the issue, you get various levels of involvement. I've never personally experienced any difficulty with them. I always felt that if I had to pick up the telephone and ring the Chief Medical Officer, for instance if that was required, that I could do that. It wasn't something -- well, I did have to do it on one occasion but not in this particular case. 11:45

57 Q. Okay. The next significant item on your agenda was to

meet with Mr. O'Brien, which you did on 30th December.

A. Yes.

58 Q. I just want to look at that for some time. There was a controversy, if I can put it in those terms, about the accuracy of the note made at that meeting. 11:46
Mr. O'Brien, as we know, secretly or covertly recorded the meeting, and I will ask for your views on that. I introduce it that way because I'm going to use, as I understand it, the revised note that was put together, taking into account the concerns that 11:46
Mr. O'Brien had about the initial note that was produced. If we go to AOB-01340. You attended this meeting with some HR employee relations, advice or support?

A. Ms. Hainey. 11:47

59 Q. Ms. Hainey.

In general terms this meeting was to convey to Mr. O'Brien the concerns that had been identified, the decision that had been taken, which was to exclude and 11:47
to conduct an MHPS investigation, importantly, to ask him to return notes and to set out for him some aspects of the likely process going forward. Is that a fair summary?

A. That's a reasonable summary. Obviously also to share 11:47
with him, as you alluded to before, support that might be available to him during the process.

60 Q. Just on that, what support was made available to him either during the process or to enable him to remedy or

provide remedial steps in respect of his practice?

A. The support would have been fairly standard in this situation in that we would have offered him the services of our staff counselling service, which he had the opportunity to avail of. In his particular circumstances I also requested that before he returned to work he attend an Occupational Health assessment to ensure if his physical and mental well-being was satisfactory. We didn't always do that but I wanted that done in this case because he had been on a period of sick leave, so we offered that. 11:48 11:48

In terms of the support for his -- we were jumping the gun a bit here, he was going to be off for a few weeks, but on his return there would have been a discussion around what was going to be put in place around him to allow him to carry out his work and the requirements being made on him. But that would have been at a later stage. 11:49

61 Q. This was the monitoring plan? 11:49

A. Yes. Yes. He also would have had informal support network from his colleagues and from his Lead Clinician and Clinical Director, which is very important in these circumstances.

62 Q. We'll maybe come back to that in a moment. 11:49

Looking at this note we can see on this first page you begin to set out the three concerns. The first issue is triage, the second issue is the backlog of

dictation, and the third issue is notes at home. Could I ask you this, back in March 2016, the letter that issued to Mr. O'Brien from Mackle and Trouton referred to a fourth issue, and that was the backlogs at clinics or review backlog. That issue, again, formed part of the Oversight Group's considerations in September, it formed part of the screening report. Where did that issue go to and why was it no longer a consideration of the Oversight Group? 11:50

A. My understanding is there had been measures taken within the Directorate to redistribute much of Mr. O'Brien's work amongst his colleagues. In fact, I know there was a meeting held with them once this process began to evolve to begin to deal with that. It was, I suppose in our minds, a lesser pressing issue than it had been in that there was a system in place to start to pick up on that. 11:50 11:51

63 Q. It doesn't appear, ever, at least on my reading of the various records, that any assessment was made of whether that was a performance issue that required further investigation through MHPS. Is that fair? 11:51

A. I think we were taking advice that the issue was being managed within the Directorate and the systems were in place to make it a lesser issue. In our mind, it wasn't as significant a factor as these other issues. That may have been a mistake, but at that point it was a less pressing issue. 11:52

64 Q. We know from the letter that issued in March 2016 that a concern was expressed within this review backlog that

Mr. O'Brien was maintaining his own or a separate oncology patient waiting list. Again, there doesn't seem to be any particular analysis of what that meant and the implications of it in performance terms. Again, you say you were receiving advice that these were lesser issues. Who was providing that advice? 11:52

A. I think, with hindsight, it was probably a mistake to not include that in the initial Terms of Reference. I would accept that. I think we were taking notice of the NCAS advice that we had to keep this investigation focused on the main issues. Again, the more issues you investigate, the more difficult it is to run the investigation. So there is a balance to be struck. This was the judgment we made at this time, which, in hindsight, may not have been right. 11:53

65 Q. If we go over to the next page. On the second paragraph down you deal with the issue of exclusion. He is being placed on immediate exclusion with full pay. On down the page, I think. Maybe on to the next page, sorry. 11:54

Another matter, coupled with exclusion, was a requirement for him to deliver up patient notes. You have a bit of a debate around that, as we can see reflected in that paragraph: 11:54

"Mr. O'Brien stated he could not return them without processing them himself".

You held the line that the notes needed to be returned

by the above date. You were accountable and needed to deal with the matter. You go on to say that if there were notes missing this would be a major problem. Mr. O'Brien and Mrs. O'Brien queried what happens with the patients given that Mr. O'Brien has not processed them and would be the best person to process the cases? Dr. Wright advised that you would deal with this. 11:55

I'm just interested in this area about the implications for the patients of taking this material away from Mr. O'Brien and what was done by the Trust in relation to both the issue of triage, and there are many cases, it seemed, as well as the issue of dictation. 11:55

First of all, am I right to infer from that paragraph that Mr. O'Brien was concerned that there were Patient Safety issues if you took the case notes away from him and didn't let him progress them? 11:56

A. Yes. He was concerned at that. But I think it's also probably a reasonable call to say that he didn't seem to appreciate the Patient Safety issues that were already there, that we had identified of notes not being completed and the lack of tracking where they were in the system. So, yes, he did have a concern about that, but I don't think he appreciated the other concerns that were shared by, certainly, the Oversight team and his clinical colleagues. So, yes to a degree. 11:56 11:56

There were a number of reasons for wanting the notes back quickly. Clearly it was potential to get the patients back in the system and redistributed amongst his colleagues, but there was the other side of it in that there was the potential of what would be put in the notes subsequent to this potentially -- the investigation starting. I wanted to protect him from any potential accusation that the notes had been tampered with. In my experience in the past this had happened on a few occasions. It is a very difficult thing to unpick once an accusation has been made. So as much as protecting the patients, this was about protecting him. I don't think Mr. O'Brien appreciated that or saw it that way, but that's what was in my mind. 11:57

66 Q. In terms of what was done by the Trust with regards to this group of patients reflected in both the un-dictated work and in the un-triaged work, were you familiar with the work that was done on that?

A. I'm not over the detail of it, Mr. Wolfe. That was very much the responsibility and the domain of the Acute Services Directorate, and they obviously were reassuring me that they had that in hand, and I know they met with the urologists as a team to discuss how that would be done. 11:58

67 Q. Can you answer, for example, whether un-dictated entries were then dictated?

A. That would be difficult. I can't give you any definite information on that. Obviously what I would say is

it's difficult for someone who didn't perform a clinic to dictate notes on what happened at the time if they weren't there. So that is a difficult area.

68 Q. Mr. O'Brien would have established appointments with patients for January and February and March, anticipating his return to work. They were all cancelled, were they, because of his exclusion? 11:59

A. I know you're going to get frustrated at my answer. I can't tell you, put my hand on my heart and say what happened to them. That was very much an operational matter which I left with them, with the Directorate. 11:59

69 Q. I accept your answer.

Elevating it to the more general exclusion as an approach results in all sorts of difficulties, doesn't it? 11:59

A. Yes.

70 Q. It is not just a matter of Mr. O'Brien's concerns and the personal impact on him, it does have an impact on patients generally, you would agree with that? If that clinician would have been expected to be in Theatre or at his desk in clinic? 12:00

A. Absolutely it does, which is why we take a very serious view of it. We use it very rarely, and for the shortest possible time that we can. This was an immediate exclusion under the terms of the MHPS for a period of four weeks when, actually, Mr. O'Brien, incidentally, was already on sick leave. It was the least we felt we could do to get the measures in place 12:00

to ensure that he could safely return to work.

What I would say, obviously it is very regrettable, but cancellation of lists is day and daily part of the health service. It is not taken lightly. But you'll appreciate with waiting lists, with staff leave, with sickness, this happens all the time. There is a system in place for dealing with that and a four-week period would not be exceptional, put it that way, regrettable though it was. 12:01

71 Q. While you may not know the specifics of the consequences for patients and the number or the nature of the treatments or the encounters that may have been missed, when you reflect back upon it do you still believe that, weighing things up, exclusion was an appropriate approach? 12:01

A. Yes. What one has to balance is -- I mean it's also very well to say, yes, there are patients inconvenienced, but we were now aware there were serious issues going on here that had to be bottomed out rapidly. We were aware now that there was at least one SAI and potentially there might have been others, possibly. We had to get this bottomed out very rapidly. That is the judgment that a Medical Director sometimes has to make. It is a very difficult one. It is based on experience and taking all the factors into conclusion. If I was in that position again with Mr. O'Brien, I would have excluded him again temporarily until we had satisfied ourselves we had 12:02 12:02

measures in place that he could return to work in a safe system where he was able to work at a level that he could cope with, both to protect his patients but also as much to protect him from himself.

72 Q. One of the issues that came up at the meeting, I think introduced by Mr. O'Brien -- I would just need to check this -- concerned his ability to work with private patients. If we could scroll down AOB-01343? I think it is the next page. The penultimate paragraph. 12:02 12:03

"He queried if he can continue to work with private patients. Dr. Wright suggested he take advice from his union but he said as RMO he would discourage this. Dr. Wright suggested that Mr. O'Brien ask his colleagues to review any private patients that he has." 12:03

That last sentence is perhaps the clearest indication that you didn't want him working with private patients at that time?

A. That is correct. I was holding two roles here as his Medical Director as his employer within the Trust, which I had a lot of authority over what happened on that patch, but then also as Responsible Officer. So my advice would have been to him that he didn't. But I recognise that there are difficulties in managing patients outside of the system and he would have to make appropriate arrangements for them. That wasn't the Trust's responsibility, that would have been his responsibility. 12:04 12:04

73 Q. Let me just draw to your attention to the MHPS provision in this respect, or at least generally covering this area. WIT-18510.

"Where there is a concern that the practitioner may be a danger to patients" -- that's the test -- "the employer has an obligation to inform other organisations, including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons." 12:05

It goes on to say: "Where an HPSS employer has placed restrictions on practice the practitioner to agree not to undertake any work in that area of practice with any other employer." 12:05

Mr. O'Brien working in a private capacity doesn't have, in our circumstances, another employer, per se.

A. That's correct. You raise an interesting point. That is a difficult area. Had he been employed by a private clinic, for instance, then I would have written to the director of the private clinic or the RO responsible for that, or possibly the RO responsible for RQIA in that instance. But this was a situation where Mr. O'Brien saw his private patients at home and that is a very difficult area to monitor or police. There are less and less doctors doing that these days but there are still a few, of which he was one. So there isn't an employer to contact, you're quite right. 12:06 12:06

We did, however, contact the General Medical Council and the Department, so in that respect we informed the system.

74 Q. Just on this, and the framework is drafted as it is and the Inquiry has been charged within its Terms of Reference to look at any niggles or wrinkles that affect the likes of this Trust and others. Is that helpfully drafted or unhelpfully drafted in terms of the range of private sector engagements or commitments that a practitioner might be involved in? 12:06 12:07

A. In my experience these situations where a practitioner is working independently on their own -- where any practitioner is working independently on their own in the private or public sector there's always a risk where you don't have a team around you to challenge and to learn from. If it is a private situation, that makes it even riskier, I think, because of all the implications of that. Where it is being conducted in one's own personal premise without any employer oversight, that's even riskier. There is a lack of ability of the system to deal with such individuals, in my experience, and that is a risky area. It would be helpful if there is some sort of recommendation around that that comes out of this, to guide the powers that be to be able to police such situations. I think that is certainly -- we have quite good relations -- or we did when I was working in the health sector, with the larger private employers in this area, but the individual practitioners or those working for small 12:07 12:07 12:08

firms with one or two doctors is a challenge for the system, and any guidance around that that might emerge would be helpful, I think, in trying to tighten that up.

75 Q. Certainly, I needn't bring it up on the screen, but there does seem to have been even a confusion within the small area within which you were working. Mrs. Gishkori, for example, sent an email to, I think, Mr. Gibson to say that Mr. O'Brien is at liberty to do what he wants off Southern Trust premises, which wouldn't have been your interpretation of this? 12:08 12:09

A. No. It wouldn't have been, actually.

76 Q. Ultimately -- and I know this issue was raised with you by the GMC liaison officer, Ms. Donnelly -- was this issue of his ability or any restriction on his ability to practice privately from his home, where did that eventually reach? Was a solution found? Was a restriction imposed? 12:09

A. Not by ourselves. I'm not aware what happened down the line after I left the Trust. I wasn't aware of any specific restriction being imposed that I can recall, but there may have been something later in the process. 12:09

77 Q. Did you feel that it was the limit of your powers, I suppose, to say what you said by way of --

A. That was my understanding of what I could say. I did -- yes, that's correct. 12:10

78 Q. The issue of the Serious Adverse Incident review concerning Patient 10 and Mr. O'Brien's role within it, he said to you at this meeting that he had not been

engaged with that issue.

A. Mm-hmm.

79 Q. The report was at an advance at that stage of preparation. He was to have his say and wrote comprehensively on the issue. Was that unusual in your experience, by the time you were taking decisions which took into account the SAI, that he had not had an opportunity to make his input? 12:11

A. It was unusual but understandable. So, yes, it would have been much better had he been involved in an earlier stage. However, he was on sick leave for a significant period of this and when these serious issues emerged and became apparent, he was still on sick leave. I think the judgment was taken by the team that they would wait until he returned. It would be unusual to contact someone about an issue like this when they were on sick leave. It was certainly not an ideal situation, but I think it was an understandable one given the circumstances. 12:11

80 Q. You were to become aware, through this Inquiry, perhaps, that this meeting was covertly recorded. Any reflections on that? When you discovered that how did that make you feel? 12:11

A. Yes, I have a few reflections. 12:12

I was disappointed, I think, mostly. I mean we obviously had a very professional minute taker, Ms. Hainey, very experienced. It wasn't as if minutes weren't going recorded and there wouldn't be an

opportunity for those to be challenged if he didn't agree with them. So that would have been, and that was provided to him.

I'm aware and I have been involved in cases in the past where people have requested that interviews be recorded, and that can be accommodated if that is something they desire, but it would usually be done with liaison with the Human Resources Department where all sides of the conversation were recorded appropriately and there was no possibility the recording could be tampered with. I was disappointed in that if they felt they wanted a recording we could have facilitated that, and I have done so in the past. 12:12 12:12

I thought the covert nature of it was unprofessional and unnecessary. Sorry, I also should say unfair because the recording recorded, from what I can see, one side of the conversation quite well but was not complete in that there were bits of my own conversation that were not heard. So there are issues around the technical quality of it which are important. 12:13 12:13

81 Q. Maybe we'll follow up with you on that. Can you better explain that for us?

A. More in the second recording, which you'll probably come to later, there were parts of my conversation that were not audible on the recording. 12:13

82 Q. Is this the conversation you had with Mrs. O'Brien after your retirement?

A. Yes. I'm not saying there was any discrepancy in what was written, I'm just saying it was a poor quality recording and was incomplete and therefore not satisfactory for the purpose.

83 Q. The process by which you were looking at concerns around Mr. O'Brien had commenced in August. Before that we had the March letter. Between August and January you had had no engagement with Mr. O'Brien. Indeed nobody had direct engagement with Mr. O'Brien in respect of the concerns that were being explored, if you like, behind closed doors without his knowledge. Is it, therefore, not particularly surprising that trust of the process may have been a factor for him? 12:14 12:14

A. I can understand that. All I'll say was that we were -- the process is what it was. We had made attempts to meet with him. In the original plan from the Oversight meeting that was the intention. For circumstances that we have rehearsed before that didn't happen. Then Mr. O'Brien was on sick leave. So we were dealing with a very unusual set of circumstances. But I can fully understand why there was a lack of trust. So, yes. I personally would have been quite annoyed in such a circumstance. But I think I would have understood where we were with it, and I would have handled the recording side of it differently. But I do get the lack of trust and I appreciate that. It is not what anyone would have planned or wanted for such a process. 12:15 12:15 12:15

84 Q. Mr. O'Brien wrote to you after the meeting, wrote on

21st February, AOB-01433. I might have a rogue reference. Sorry. AOB-01443.

He writes to you 21st February and the purpose of writing to you is that he wishes to advise of a number of factual errors and omissions. There's some controversy about whether he received a response from you on this. Do you remember drafting a response?

A. He did receive a response but I think it was not an immediate response. It was a delayed one. 12:17

85 Q. There is a letter, WIT-14950. You can see 13th March you're writing further to his letter of 21st February concerning the notes of the meeting. We will hear from Mr. O'Brien, of course, and, as I understand the position presently, he would insist that he didn't receive a response. He didn't receive this response, it seems. 12:18

A. I can't explain that.

86 Q. You can't explain that. You think the letter went out?

A. Yes. 12:18

87 Q. As the Inquiry can see if it studies this letter, you responded to all of his points apart from one where you wouldn't agree a correction. If I can just bring you to that. Let me just go down to the bottom of -- I may not have it here. If we go to AOB-01342, it's Mr. O'Brien's letter. Just at the bottom of the page there was an issue raised with the notes as regards Mr. O'Brien's job plan, and you had queried with him if the job plan was unrealistic. Your note of the meeting 12:19

seemed to suggest that they were satisfied or he was satisfied with the job plan. Do you remember that issue?

A. Yes. I don't remember the exact words but I remember the issue arising, yes, and being discussed. 12:19

88 Q. You were satisfied with your note of how it was discussed?

A. At the time I was. I can't remember the conversation now. Yes, I remember the issue being raised and being surprised that it wasn't as big an issue as I thought 12:20 it might have been.

89 Q. The next step in the process was for the Oversight Group to meet on 10th January and, in advance of 10th January, some further work was done. If we can just look at aspects of this, please. 12:20

If we go to the record for 10th January meeting. It is AOB-01363. You chaired the meeting. If we scroll down, please. The various issues are being updated, isn't that right? Further work is being done around 12:21 getting up-to-date, figures or statistics on triage referrals, and it's set out there. Notes being kept at home. Over the page, un-dictated outcomes. Then a fourth issue, private patients. That issue hadn't been drawn to Mr. O'Brien's attention at the meeting on 12:21 30th December. Can you explain from your perspective why that issue, although it was known to the system as it had been drawn to Mr. Carroll's attention by Mr. Haynes on 23rd December, what was the reason why it

wasn't given to Mr. O'Brien as soon as you knew about it?

A. Do you know, I'll be really honest with you, I'm not sure. I think we were still working through it to see whether it was worthy of further investigation. Issues with private patient scheduling had been an issue in the Trust before, and it wasn't always related to the individual. I think we probably hadn't made our minds up this was worth pursuing until we had more information. We had done a lot of work around retraining people in how to process private patients and, in fact, I think subsequent to this we took a decision within the Trust to stop all in-patient private practice within the Trust completely because, to be honest, it was very difficult to organise, to schedule, and to separate out, and the amount of disruption it caused was in excess to any potential advantage to the organisation. I can only imagine it was an area we were trying to make sure there was a genuine issue with him as an individual as opposed to a systems area. But I can't put my hand on my heart and give you a definite reason. 12:22 12:22 12:23

90 Q. It has been suggested by one or other of your colleagues that the appropriate approach with this matter, new information having come into the system after the last Oversight Committee meeting, it needed a decision of Oversight, whether -- I mean the question was whether this was going to be taken forward. As we see here, a decision was reached that there is an 12:23

issue of Mr. O'Brien scheduling his own patients in nonchronological order. Perhaps that is the process.

A. I mean that would make sense then, yes.

91 Q. Just keeping our eye on what's said in the last paragraph then, I asked you in the context of the meeting with Mr O'Brien what work was taken forward with patients and it's clear, and I'll show you some documents in a moment and ask for your comments, that Mr. Carroll was leading the operational team in working through issues to reach clear outcomes for all patients. It was agreed by the Oversight Committee that this work would be recognised at WLI rates? 12:24 12:24

A. Waiting list initiative rates.

92 Q. Consultants undertaking 4-hour sessions to progress the issues identified. Was there ever a cost or an expense put on this exercise, to the best of your knowledge? 12:24

A. In terms of?

93 Q. Financial.

A. There was an agreed rate for waiting list initiative clinics which was established with the Health and Care Social Board. That would have been fairly standard and accepted by the consultants. How many of them one would have needed, I don't think at this stage we would have bottomed that out. This would be usual practice for any backlog or any extra work required. You're obviously depending on the goodwill and energy of the local team to facilitate this, so you wouldn't have known at this stage how many of these they were able to complete. I don't think there was a total price put on 12:25 12:25

it, but they would have known the price of the individual waiting list clinics.

94 Q. This was a cost to the Trust arising out of the failure to triage and the failure to dictate. Is that the way we're to understand it from your perspective? 12:25

A. I think that would be a reasonable assumption, yes. But I would say that actual waiting list clinics were not unusual. At this time this would have been a weekly occurrence for a multiplicity of reasons.

95 Q. I just want to look at some of the material that would have been available to this meeting in a slightly unusual fashion. The record of 22nd December Oversight Group was annotated to set out some of the steps that were being taken. If we could look at that. TRU-257705. This is the first page of the minutes of the last Oversight Meeting, but if we scroll down to the next page I hope in red. 12:26 12:26

A. Mm-hmm.

96 Q. The first issue was triage. I understand it to be Mr. Carroll is gathering information for the 10th January Oversight Group meeting by engaging with Mrs. Corrigan to provide this update to the meeting. As regards triage, it appears that the plan was to carry out an administrative exercise with the rest of the letters and ensure that these patients have not already attended, and then the remaining letters will be triaged by the four consultants who have advised they are willing to do this. Obviously there's quite a lot more detail there. I'm showing you this 12:27 12:27

acknowledging that when I asked you questions earlier I didn't put this in front of you. Does this help you to address particularly your understanding or recollection of the work that was being taken forward?

A. Oh, yes. This is the plan that Mr. Carroll, as the Acute Services Assistant Director was tasked with doing this and he produced this plan and it was very much what was adopted by the Trust. I would have seen this and been aware of it being done. It was very much an operational decision as to how it was processed and done. They were doing it appropriately, as far as I could ascertain. 12:28 12:28

97 Q. The Inquiry will look at the fine detail of that. I just want to put it on the screen so that we know it's there. 12:28

If we scroll down, for example. If there are any patients that need seen as urgent and are waiting longer than other patients then the consultants are willing to do additional clinics to see these patients again outside of core time and after the above about payment has been agreed. 12:29

Can I ask you this. Is it your understanding that concerns around this cadre of patients were being taken quite seriously by the Trust and that it was recognised that real action needed to be carried out to see what issues might lie below the surface? 12:29

A. Yes, very much so. This was a significant intervention

that would have caused -- I mean this would not have been done lightly by the rest of the urology team, who were already under a lot of pressure trying to deliver their core service. I think it is a tribute to them that they were in agreement to take on this additional work because they were concerned enough that there could potentially be problems with some of the patients in that group. So, I mean, yes, on every count.

98 Q. I won't bring the Inquiry to it in the interests of time, but on the next page there's a similar initiative or a not dissimilar initiative in respect of the dictation issue and work around that. 12:30

Can I ask you about the private patients issue. TRU-2557703. I'm going to have to check that. I'm not entirely sure that's ... TRU-257703. I think I had an extra digit in there. 12:30

It would appear that in light of Mr. Haynes' intervention some work was carried out in respect of patients who were identifiable of being in the private care of Mr. O'Brien who then came into the NHS system for TURP. Are you familiar with the work that was done around this to produce this analysis? 12:31

A. No. I saw the analyses. I'm not familiar with the background to it, the detail of it. Simply the report. 12:32

99 Q. Within your witness statement, it is WIT-18442, at paragraph 18.1, you refer to a review conducted by Mr. Carroll of nine TURP patients. I think there was

eight on that list who had attended Mr. O'Brien privately and who appeared to have had their operations performed on the NHS within a shorter period. In terms of this review, can you advise whether there are any other documents, apart from what we saw just now, that colourful table? 12:33

A. I would have seen the table. I don't have access to what lies behind that. To be honest, you'd have to ask Mr. Carroll and his team or Mr. Haynes how they produced that. 12:33

100 Q. Yes. In terms of Colin Weir and Dr. Khan, they didn't attend this Oversight Group meeting. Is that standard procedure, or now that they were appointed should they have been in attendance?

A. We were still working under the old Trust guidance, that was the three Directors. It wouldn't have been normal to have necessarily brought it to them. Sometimes we ask people to attend for different reasons but it wasn't, by any means, the norm. The requirement under the old guidance was for the HR Director, the Medical Director, and the Director of the Service. So it wouldn't have been unusual for them not to be there, is what I'm saying, under the old guidance. I think that was subsequently changed with the new Trust guidance. 12:33 12:34 12:34

101 Q. Let me look at Mr. Weir and his circumstances. We have seen the correspondence issued to Dr. Khan. I haven't seen any correspondence with Mr. Weir. Perhaps you spoke to him?

A. I spoke to him.

102 Q. To ask him to become involved. By 12th January he is writing to Siobhán Hynds to say that he is yet to receive any official confirmation to commence the investigation. Was there a slow pace in getting this started? 12:35

A. I can't explain why there wasn't anything more quickly. There was no delivered plan. I can only assume that's an oversight or related to people being on leave. The intention was that it would start, and it's regrettable there wasn't a formal letter at the time. I can't explain why that would have been. 12:35

103 Q. Yes. Who was responsible -- perhaps it was yourself -- for briefing him and explaining to him what was expected of him? 12:35

A. I would have spoken to him initially asking him to do it, but then thereafter the case manager would have taken on that role.

104 Q. Dr. Khan?

A. Dr. Khan. 12:36

105 Q. Was there a role for HR support to explain to him what was involved?

A. Both Dr. Khan and myself would always be supported by HR in any of those meetings. That would be the norm. So whether I was -- and we would certainly have taken advice from them. Sometimes they would have accompanied us, but not always, but usually after discussion with them. 12:36

106 Q. In his evidence to the Inquiry, Mr. Weir has explained

that he had, based on a previous experience, perhaps, of investigating a colleague, he had a reluctance, not to put too fine a point on it, to become involved again in investigating a close colleague. At TRA-02689, in his evidence on Day 24, he said that he spoke to you about that in, he thinks, January 2017. Maybe if we look at precisely what he has said: 12:37

"As far as I can recall I felt resistance to this, to doing this, to be a case investigator. As I said earlier, I had been involved in a completely unrelated and different style of an investigation of a colleague. I found that very challenging and difficult and here I was being put in this difficult position and feeling reluctance to doing that for the same reason". 12:37

Was that communicated to you?

A. I think that's putting it quite strongly. He certainly had some reservations about it. However, in light of many of the conversations we've had already, it was normal practice for the Clinical Director of the individual concerned to be the case investigator, and that was a core part of their job and their job description. It is rare that you get any case investigator wanting to do this. It is quite usual to have a degree of resistance. But I thought it was important that someone who understood the practice and the circumstances and the team that the individual worked in was the right person to conduct the 12:38 12:38

investigation. So, yes, there was some resistance but I wouldn't have said it was particularly strong, just the usual reservations about, 'this is a senior colleague, you know, this is going to be difficult'.

107 Q. You're saying in a sense that's understandable. 12:39

A. Absolutely understandable. On a human nature I have had to investigate colleagues, it is a very uncomfortable place to be and you have to put aside your personal relationships and go on your professional training. But it's a difficult, it's a very difficult 12:39 thing to do. But it is a core part of the Clinical Director's job. It would have been normal practice in our Trust from the Clinical Director to have been the case investigator.

108 Q. If you are putting your hands up to take on the role of 12:39 Clinical Director and receiving the salary or the pay, really it comes with the territory, difficult though it is.

A. It does. Mr. Weir had done this before and done it very well. I appreciated his reluctance, but I was, at 12:39 that point, convinced that the best person to conduct this investigation was someone with local knowledge of the team.

109 Q. You said, I think, on the last occasion you were with us, at TRA-2501 you were conscious of the need to 12:40 provide support through training and in other ways for the Clinical Director role which you described as being the most difficult in the health service. Did you tell us that you designed a Clinical Director training

programme around clinical management?

A. I think I've alluded to it before, it was the senior medical leadership training programme which most of them would have been Clinical Directors, but also the Associate Medical Directors and many of the Clinical Leads would have gone on that. I think eventually we tried to roll it out to most of the medical staff but it was targeted initially at the AMD, and Clinical Director level. 12:40

110 Q. Mr. Weir had to field a call, and then a letter came in, I think, directed to your attention from Mr. O'Brien on 17th January. We can see the letter at AOB-01365. I suppose, to summarise that letter, this is, I suppose, getting on for three weeks after Mr. O'Brien has been told he's excluded and he's saying that he's increasingly concerned regarding the procedural conduct of the investigation, flagging he has not been informed of the Board member who would take his part in the process. He hadn't yet received minutes from the December meeting, and the slow pace of proceedings which, to his mind, had to be completed within four weeks. 12:41 12:41 12:42

I know, Dr. Wright, that there's a lot of moving parts here and my slow process through the timeline here is perhaps highlighting that. Is it difficult to work this process in terms of joining up all the moving parts and ensuring that there is effective communication to all those who need to know, not least 12:42

the clinician concerned?

A. Yes. It's very challenging. Most of the people involved in these investigations are -- you know, this is not the only part of their job. They have other clinical challenges, many of them. So getting them all together at critical times is always challenging. The frustration that's felt with the slow progress of these is widespread throughout the organisation, and by me as much as by the individuals directly affected by it. So, yes is the answer. 12:43

111 Q. Again, taking into account that this Inquiry has to reflect and maybe make recommendations around this, have you any thoughts about that? Is there a need to streamline the process? Is there a need to -- I don't mean that you're not professional -- but a greater need to professionalize the process in the sense of making it somebody's specific responsibility? 12:43

A. Yes. I could share you a few thoughts on that. I mean, I mentioned before that for the individuals the Case Managers and case investigators have protected time in their jobs to do this, being expert enough to have received appropriate training to be appropriately resourced with administrative support, and HR support at the times they need it are all challenges within the health service at the minute. If that was improved, that would help a lot. 12:44 12:44

From my own office, at that point the Medical Director's office was essentially composed of myself

and, in relation to these matters, Mr. Gibson. It was very underresourced to provide this. I had highlighted this issue before I left the Trust with a paper to try and bring forward appointments of more staff to help with this, in particular, with Deputy Medical Director posts, one of whom would have a specific focus on this area. But it wasn't possible for that to be supported at the time for financial reasons. So, yes, absolutely. You were trying to do this on top of an incredibly busy and challenging job. At that time I seem to recall we had a -- I'm not making excuses for myself, I'm just painting the context in which this is being done -- we had a major issue with the Emergency Department in Daisy Hill Hospital which was having to be completely restructured and was at crisis level. There was a crisis in the breast care surgery system where we had to get a regional approach pulled together to try to ensure patients were not left wanting in the Southern Trust. There were so many issues going on. This was a relevantly small part of the Medical Director's job and, to be honest, did not have the manpower, the time, required to focus on this. But I think the main issue that would have made a difference would be protected time, training and admin support for the case managers and the case investigators, because they are the ones actually carrying out the investigation. It would have been helpful for me to have had a bit more support but, to be honest, I think the bit that would really make the

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difference would be the time and training for case managers and case investigators.

112 Q. I don't wish to belittle the importance of the flurry --

A. No, no, it's not an excuse. 12:46

113 Q. -- that seemed to be kick started by Mr. O'Brien's letter. There was correspondence from Mr. Weir on 20th January advising Mr. O'Brien who the nonexecutive director would be. There was the correspondence from yourself to Mr. O'Brien on 23rd January. The Inquiry 12:46 has those details.

Can we move along to the case conference that took place on 26th January? What was your understanding within the process, the Trust guidelines, of what the 12:47 case conference on 26th January was intended to do? What was its role?

A. That is the Oversight Committee meeting?

114 Q. Let's bring up the record of it. TRU-00037. You pop a question back to me of the Oversight Committee. Can 12:47 I put this interpretation on it and let me have your views? This appears to be with those present members of the Oversight Committee or in the case of Mrs McVeigh, the nominee of Mrs. Gishkori, receiving a presentation from Mr. Weir in connection with the 12:48 issue primarily of exclusion.

A. Yes.

115 Q. Where does this process sit within the MHPS arrangements or the local guidelines?

A. I would probably have preferred to call it another meeting of the Oversight Committee, but in this case about a single case. That's where I would have seen it, and we had invited, obviously in this instance, the case manager and case investigator to contribute. I suppose we were looking for reassurance that the investigation had begun, that it was being appropriately pursued, and to consider any issues that had arisen at an early stage.

12:48

116 Q. We'll come back to this minute in a moment. Let's just briefly look at the report that Mr. Weir had prepared. It's to be found at AOB-01397. Mr. Weir provides a preliminary report. If we just scroll through it. He sets out within it a bit of the background. It's probably all familiar territory to this Oversight Committee. It talks about the initial scoping of Mr. O'Brien's administrative practices. Just going on down. Yes. He conducts what he describes as an initial investigation which involves a meeting with Mr. O'Brien. He sets out what Mr. O'Brien was told. He was told, for the first time on 24th January, that this private patient issue had emerged and was also to be the subject of investigation. Scrolling on down, please. There we have the fourth issue. Then Mr. O'Brien sets out his perspective or his case, which was, in essence, a combination of work pressures and commitment to surgery in particular, and having to use SPA time to undertake Theatre activities and indeed notification to management that he didn't have capacity

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12:50

to triage. Then Mr. O'Brien's view on proposals for alternatives to exclusion are set out, and that involves telling Mr. Weir about the impact of exclusion on his health and his commitment to work to any monitoring arrangement in respect of his work, if that was thought appropriate. 12:51

Scrolling on down to the conclusion, please, in the next page -- or the summary. 12:52

I'll just draw your attention to this because it comes back to us in a moment. The investigation is at a very early stage.

"While initial indications suggest some patients have been potentially adversely affected or harmed as a result of failings in the practice of Mr. O'Brien, the case investigator is reliant on completion of the review by four consultants to determine the full implications." 12:52 12:52

He is uncertain about the full implications but he is telling you and telling the Oversight Committee that some patients have been harmed or potentially adversely affected. 12:52

That's the report that came to the case conference of the Oversight Committee on 26th January. If we can go back to that record then at TRU-0037.

Could I ask you this, Ann McVey came to this meeting instead of Mrs. Gishkori. Mrs. Gishkori had apparently planned leave for that day. Mrs. McVey had no prior involvement in this case. Did it surprise you that the Director of the Service had passed the role to someone who had no prior involvement in this process? 12:53

A. I can only assume that the people that would have -- she had a number of Associate Directors or Assistant Directors who were all very competent or capable of delegating for her. Usually she would have passed it to Mr. Carroll, and I assume he mustn't have been available on that day. It wouldn't have surprised me. It happened occasionally that you had to ask your immediate colleagues to deputise for you. It would have been good if she had there but she was on leave, and I can only assume that Mr. Carroll wasn't available for that meeting. 12:54

117 Q. This meeting had been lined up since 22nd December. I think the date was in a diary, give or take a day or two. Would you expect for an important meeting like this, which was to determine whether there was to be further exclusion in the direction of travel with the investigation, that your senior Director of Service would be in attendance? 12:54

A. I would have preferred her to have been there but the reason she wasn't there, you really have to ask Mrs. Gishkori. It would have been helpful had she been in attendance.

118 Q. I just want to show you the format of the decision making at this meeting. If we scroll down we will see that -- on to the next page -- Mr. Weir is speaking to the meeting. He is presumably summarising his report. Just scrolling down. You will note the word there in terms of advocacy, it says in his role as Clinical Director, Mr. Weir reflected that he felt that Mr. O'Brien was a good, precise, and caring surgeon. He is speaking with his Clinical Director hat here as opposed to his case investigator hat. Is that a helpful way to approach things or should the roles -- should he have considered himself in an entirely different role now he had the case investigator hat. 12:55 12:55

A. One of the reasons it is preferable the Clinical Director is the case investigator is because they can bring these particular insights to the table. I didn't see it as a problem at this stage. 12:56

119 Q. There's then a discussion about exclusion or continued exclusion. Over to the top of the next page. Maybe just -- can we go back? There's one point on the previous page that I want to address. Just if you pause there. 12:56

"It was noted that Mr. O'Brien had successfully revalidated in May 2014 and that he had also completed satisfactory annual reappraisals. Dr. Khan reflected a concern that the appraisal process did not address concerns which were clearly known to the organisation. It was agreed that there may be merit in considering 12:57

his last appraisal."

What do you take from that? Does that suggest that appraisal wasn't working as effectively as it should be in the sense that if there were concerns known to the organisation about this practitioner, they should be fed in through the appraisal process and solutions considered at that point? 12:57

A. I think appraisal is primarily about supporting the individual doctor. It is not a good way to identify concerns in the first instance and, in my experience, rarely is the means by which that is identified. It is not that you are relying on appraisal to pick up these issues. However, if there are issues they should be fed into the appraisal process. That is quite correct. If that didn't happen, that is something that we would have wanted to have considered, I would have thought. We did have, at that point, a relativity robust system of quality assuring appraisals, but I think it was well recognised by most people working in this area that it is heavily reliant on the individual practitioner bringing information to the table as opposed to the Trust sourcing that information at first sight, and that is a weakness in the system. I think that is realised nationally. 12:57 12:58 12:58 12:58

120 Q. Just going to where I was going to go to then. At the top of the next page, as case manager Dr. Khan is cast in the role of considering whether there was a case to answer following the preliminary investigation. He

felt that there was and that the process going forward would be formal investigation. The decision -- just help us with this if you can. There was a decision already taken, 22nd December, by the Oversight Committee in the absence of Dr. Khan, who was only appointed by -- or the recommendation was that he would be appointed, and that was a decision taken on 22nd December. Where does this -- I call it a new decision -- sit within the process? 12:59

A. In a bid to move the process forward we did indicate that direction of travel. But the case manager, once appointed, does have a lot of authority and say in how the process ensues after that. It would have been quite possible for Dr. Khan to have looked at that information and overturn our decision, and that would have been accepted, I think, by the Oversight Committee. Once appointed he had a lot of authority in this. It was only right and proper that he would have considered what was before him and come to his own conclusions and we were happy to accept that. In a perfect world you would have appointed Dr. Khan first and let him take all those decisions right from the start, but we were keen to move this forward in an expedient matter, given the amount of delays we had in the past. This was, if you like, Dr. Khan re-affirming the decision we had already taken. But it would have been his option to disagree with us, had he chosen to. 13:00 13:00 13:00

MR. WOLFE KC: I am conscious is 1 o'clock, Chair. I want to take 5 minutes to finish this discrete point.

121 Q. Going down the page, the decision moves into the issue whether there should be formal exclusion. Mr. Weir reflected there had been no concerns identified in relation to the clinical practice of Mr O'Brien, presumably drawing a distinction with the administrative practice.

Then: "Members discussed whether Mr. O'Brien could be brought back with either restrictive duties or robust monitoring arrangements..." 13:01

That was ultimately the decision, ultimately he could return to work with a monitoring plan in place. That monitoring plan wasn't before you at that time.

Just before we look at that issue, I just want to set this process in the context of what is on paper in the form Of Trust's guidelines. If we could have up on the screen, please, TRU-83700? I think this is important because, given the earlier decision, and now seemingly a new decision with Dr. Khan in the hot seat as Case Manager, if I can put it that way, it's possibly an area where there could be some confusion. This is Appendix 5 of the local guidelines. If we scroll down, please. It says if a case investigator is appointed, he produces a preliminary report for -- you didn't like the word, but it is called a case conference in the procedure. 13:02

A. Yes.

122 Q. Who enabled the case manager to decide on the appropriate next steps. I think this is describing what we've seen in the record just now. And arrow across. Case investigator, Mr. Weir, has provided a report. What should the report contain? It should include sufficient information for the case manager to determine if the allegation appears unfounded, there's a misconduct issue, or there's a concern about clinical performance, or if the case requires further investigation. It appears that he takes the latter bullet point. There's a case to answer, that's your understanding. 13:03 13:04

A. Yes. That's my understanding.

123 Q. Then, next arrow down. Case manager, HR case manager, Medical Director and HR Director convene a case conference to determine if it is reasonable and proper to exclude the practitioner. That's the conversation within the minute we have just stopped at? 13:04

A. Yes.

124 Q. Is this the procedure you were -- 13:04

A. Yes. Yes.

125 Q. -- following on 26th January?

A. Yes, it is.

MR. WOLFE KC: I think we could leave it there for lunch, if that is convenient to you? 13:04

CHAIR: Are you going to continue with this after lunch Mr. Wolfe?

MR. WOLFE KC: This document?

CHAIR: Yes.

MR. WOLFE KC: I didn't plan to.
CHAIR: Can we highlight that large box in the middle. It says there that the case conference is to include the Chief Executive when the practitioner is at consultant level, and the minutes don't show that the 13:05
Chief Executive was present at that case conference; is that correct?
A. That is correct. He wasn't there.
CHAIR: Is there any explanation as to why he wasn't?
A. I don't have one. 13:05
126 Q. MR. WOLFE KC: I think there's a general observation to be made about the role of Chief Executive in this process. For example, we know from the process that we've looked at that it is the Chief Executive's responsibility to appoint the Oversight Committee, and 13:05
I think we'll hear from Mrs. Toal that wasn't done by him or her, whoever the Chief Executive was, Mr. Rice, perhaps, at this time. The Oversight Committee was put together by you, essentially, albeit, perhaps, with the knowledge of the Chief Executive. But he wasn't making 13:06
the appointments?
A. I think the Oversight Committee was convened jointly by the Director of HR and myself in the full knowledge of the Chief Executive who delegated that to us. I can't explain exactly why he wouldn't have been present at 13:06
this particular meeting but -- sorry, I just don't know. This would not have been -- there were a lot of -- as I said before, there was a lot of fluidity in the Chief Executive's role around that time and it may

have been related to that. I'm not sure.

CHAIR: This is the Trust guidelines of course, this is not the MHPS process?

A. Yes.

CHAIR: Thank you very much. Ten past two everyone. 13:06

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

13:07

CHAIR: Good afternoon, everyone. Mr. Wolfe.

127 Q. MR. WOLFE KC: Good afternoon, Dr. Wright. Just taking you back to the case conference, 26th January 2017. I just want to share with you some reflections from Dr. Khan in respect of his role in this context. 14:10

We can see from TRU-00039 that it's recorded that he considered that there was a case to answer and that this was also the subject of agreement by the members of the case conference there present. In his witness statement, if we could have up WIT-31979 at f, if we can scroll down please. I just want to share some reflections about his involvement in the process. He says: 14:11

14:11

"As this was my first experience of being involved in an MHPS investigation, it wasn't very clear to me at the beginning what my role as Case Manager would involve. The Oversight Committee was comprised of the

Medical Director, Director of HR, and Director of Acute Services. The committee was already involved and had made some decisions for this case, so this blurred roles and responsibilities for me. I did have the benefit of the MHPS Framework and Trust Guidelines but my MHPS training was not until March 2017, which was a few months into the investigations." 14:12

I might have, on reflection, shared that with you this morning. 14:12

I will just put these two together. If we can go down to WIT-31981, elsewhere in his -- go to, yes, 10.6. Again this is Dr. Khan's witness statement:
"I received advice". He is asked "outline any advice which you received in relation to the decision" this is in the context of the case to answer. "Whether or not you accepted or applied the device. Identify the persons or bodies who provided that advice". 14:12

14:13

He says: "I received advice from the Oversight Committee members in the Oversight Committee case conference on 26th January".
And he sets out who was at that meeting.

14:13

"After considering the report from the lookback exercise" -- I think he must mean the preliminary report -- "all advised in favour of a formal investigation under the MHPS Framework."

Can I ask you, his uncertainty about the process is reflected in some of his comments. Is that to be expected from somebody who's new to these arrangements and hasn't had the training? Is that something to reflect upon as requiring improvement? 14:13

A. I could certainly understand why he was a little uncertain. This is the first time he had been at a case conference like this and there are big decisions to be made. At the same time, he did have the guidance and would have been aware of it and would have 14:14 understood his role from a written point of view. But, yes, ideally he would have received the full training before he was appointed to the post. I have already explained why that hadn't happened. Going forward, it would be appropriate that anyone in this situation 14:14 would have had formal training.

I think no matter what training you have in this role as a case manager, making a big decision like this, there would always be anxieties that you're doing the 14:14 right thing, and the more experience you have, the easier that would become.

128 Q. Just a reflection then on something you said and which Mr. Weir had an opportunity to comment on when he gave evidence last week. If I could ask you to take a look 14:15 at WIT-17885, paragraph 57.2. You say:

"I was reassured by" -- this was in the context of -- so you're being asked did you consider that any

concerns raised regarding Mr. O'Brien may have impacted on patient care and safety?"

You said at 57.2: "I was reassured by Mr. Weir's assessment that the issues raised were largely administrative and that no Patient Safety issues had arisen. The Acute Services Directorate had put a number of measures in place to triage patients appropriately and address the other administrative concerns raised. We believe in 2017 that the support measures put in place around Mr. O'Brien were sufficient to ensure safe working practices as the investigation continued." 14:15 14:16

The support measures, is that a reference to the monitoring arrangements? 14:16

A. Yes.

129 Q. Just on the assurance you took from Mr. Weir's assessment that no Patient Safety issues had arisen, put as bluntly as that, can I suggest to you that looks a little strange? Let me ask you to look at this. We've looked at it already this morning. AOB-01401. This is, again, Mr. Weir's preliminary report. In the summary he said: 14:16

"While initial indications suggest some patients have potentially been adversely effected or harmed as a result of failings in the practice of Mr. O'Brien, the case investigator is reliant on the completion of 14:17

the review by four consultants to determine the full implications."

If you are saying you're reassured there were no Patient Safety issues arising, and you have taken that from Mr. Weir's assurance, how does that sit with what he said in this paragraph here? 14:17

A. I think elsewhere, I'm not sure of the exact reference, he does state quite clearly there are no Patient Safety concerns. I just can't put my hand on where that is. But taking this as it is, he was saying there were potentially issues as a result of the failings in the practice before, but what we're saying is with the measures that we put in place to allow him to come back to work, that should have been sufficient to prevent further issues arising going forward. I was really focusing on his return to work and what was around him at that point. I mean, that was my thrust and the point I was trying to make. 14:18 14:18

130 Q. Let's just be clear. In terms of, for example, the failure to triage and the need to bottom out the implications of un-triaged patients, you must accept, do you, that that created patient risk concerns or Patient Safety issues? 14:18

A. Potentially. Potentially. And, you know, quite possibly. 14:19

131 Q. You saw that -- sorry to cut across you. You saw that in December?

A. Yes, that's right. But the point I'm trying to make is

what I was referring, and maybe I didn't make that clear in my statement, was that the results we were putting in place to bring Mr. O'Brien back to work should have been sufficient to have obviated and prevented further issues like that arising. That's what I was trying to say.

132 Q. Looking at what has been classified as administrative shortcomings which were to be investigated, you're happy to accept, are you, that -- introduce the word potentially if we need to -- placed patients at risk, and you saw Patient 10's SAI? 14:19

A. Yes.

133 Q. But going forward you were confident that if an adequate monitoring support arrangement was put in place, that would obviate risk? 14:20

A. I think that's an accurate reflection of my view.

134 Q. Very well.

If we could then go back to the record of the case conference, TRU-00039. We can see, towards the bottom of that page, that it was agreed that Esther Gishkori and Ronan Carroll would be responsible for producing the detail of a monitoring plan, and this would be provided to the case investigator, case manager, and members of the Oversight Committee. We're going to look, in a short while, at the issue of compliance with the monitoring arrangements and seek your views on that. Can you recall ever seeing the monitoring arrangements and, if you did, did you provide input on 14:20 14:21

their adequacy?

A. I didn't provide input into their setting up at the time. I have, obviously, subsequently seen the detail of it in response to this Inquiry. But that was delegated, if you like, to the operational team, Mr. Carroll, Mrs. Gishkori and her team.

135 Q. What was the thinking when it was recorded here that the operational team would provide detail of the monitoring to the Oversight Committee, amongst others? Was that intended that you would have input on the robustness or otherwise of the plan? 14:22

A. I think it was intended that we would see what the plan was ultimately. First and foremost the case manager, but then subsequently the members of the Oversight Committee. I don't think it was ever intended that we would be directly involved in setting it up. That wasn't the intention as I would have seen it. That was very much with the Acute Services team. 14:22

136 Q. You wanted, having made a decision that the test for further exclusion wasn't met, the other side of that coin was a sufficient monitoring arrangement to obviate the risk of patient harm, and yet you were fully delegating to the service the preparation of that plan and not seeking to have any input as to its adequacy? 14:23

A. I was hoping I was going to see what it was and we would be kept up-to-date with how that was progressing. But I wasn't intending to be hands on operationally directing it. That wouldn't have been the way of doing things. 14:23

137 Q. I don't presently see any link back to you or any member of the Oversight Committee apart from, perhaps, Mrs. Gishkori in respect of this monitoring arrangement, as at that time obviously. Mrs. Toal, for example, comments in subsequent years about compliance with it. Did it come to you at that time or was that missed?

A. It didn't come to me for quite a while, until much later.

138 Q. It was missed? 14:24

A. That was missed, yes.

139 Q. It's recorded that if the monitoring process identify any further concerns, then an Oversight Committee would be convened to consider formal exclusion. How did you envisage that working because there was deviation? 14:24 At least some managers considered that there was, other people might have a different perspective. But it never came back as an issue to Oversight?

A. I would have been in discussions, obviously, with the Case Manager from time to time during the procedure, so 14:25 we would have received some feedback from that mechanism. You're quite right, it didn't -- and the information we received by and large over the bulk of the investigation, any deviations were quite small and being managed. So, yes, it didn't come back for 14:25 consideration of exclusion, but we were receiving reassurances from the team at different times in different places that the process, by and large, had been working and there were -- I know that Dr. Khan

received several reports to that affect during the course of the investigation.

140 Q. It wasn't a zero tolerance test?

A. No.

141 Q. It was -- 14:26

A. No, I think -- I mean, it's unlikely you're ever going to get 100% with any clinician in this type of situation. But if the vast majority was working and there was cooperation and compliance to a degree that was reasonable, I think that's what we were looking 14:26 for. Every clinician will have outliers, for whatever reasons, and those have to be looked at in context.

142 Q. If we can go over the page, please. Top the page. It was noted that Mr. O'Brien had identified workload pressures there, highlighted in Mr. Weir's preliminary 14:26 report, and it suggests the need for an urgent review of Mr. O'Brien's job plan, and perhaps linked with that in the next action for Mrs. Gishkori and Ronan Carroll was a comparable workload activity process. Why were they considered important? 14:27

A. The job plan review, obviously if he was under a very onerous job plan and the Trust was requiring him to work excessive hours, that could well be a major factor in some of the issues that had been raised. As a matter of good practice it would have been 14:27 a responsible thing to have ensured the job plan was reasonable. The job planning process had fallen behind within the Surgical Directorate over the previous years so I was aware there was an issue generally. Then the

comparison with his peers was to people have -- the best way you can get a feel for whether a job plan is reasonable is to see what activity is being provided by people with similar job descriptions working in a similar environment and similar context. So a peer comparator would have been helpful to determine whether what we were asking Mr. O'Brien to do was unreasonable or within the abilities of a reasonable consultant working in the environment he was in. Those would have been fairly sensible and routine things to have done. There's no point asking someone to do more work if you are already are requiring him to do excessive amounts of work in the first place. That would make no sense and would be unsustainable. 14:28 14:28

143 Q. It would appear, taking those three components together, monitoring arrangement, work plan, comparative exercise, that the Oversight Committee at this case conference were in the business of trying to formulate a plan going forward that would satisfy itself that this was going to work; that, okay, there might be risk of Mr. O'Brien not complying but, doing our best, these are the components that are going to try to ensure a workable practice. 14:28 14:29

A. It was certainly to increase any chance of success. We know, from past experience, that if somebody did have a heavy job plan and they were working above the level of their peers it is more likely they are not going to be able to comply with any further requests. So that was -- yes, I think we wanted to make sure the 14:29

basic steps were in place to maximise the chance of success.

144 Q. You've told us that the first step is missed, the monitoring plan didn't come back to you, didn't come back to Oversight, but were these two further factors? Did they come back to you as having been completed? 14:29

A. No. Not directly. These are operational matters for the Directorate and I would expected it to be -- and then for the Director to have brought it to us, were there any significant problems they hadn't been able to address. Obviously, those issues would have been picked up during the course of the investigation by the investigator and the case manager, if those were still ongoing issues for Mr. O'Brien. 14:30

145 Q. But Oversight are seized of a very delicate and a very serious issue, risking potentially patient harm if the monitoring arrangement, and all that goes with that, isn't a satisfactory arrangement and if there's a risk of deviation from it. If these matters didn't come back to the very people seized under the process of dealing with it, can that be regarded as satisfactory? 14:30 14:31

A. I would have preferred if they had come back. We were still working on the basis that we were probably going to have an investigation that wasn't going to take anything like as long as it subsequently did. The norm would be to set the investigation going, keep in touch with the Case Manager, and his final report then would illuminate. What, of course, happened that we hadn't predicted was the length of time this took to complete. 14:31

I think, from my own reflection, given that we then became aware that this was grumbling on, we should have asked for further updates on a regular basis during that time.

146 Q. This was 26th January. The report was available to Mr. O'Brien and the Case Manager in the last week of June 2018. I'm not aware of any further Oversight Committee meeting in that period. These issues, as you've said, didn't come back to the Oversight Committee. You're not aware, for example, looking at the monitoring plan until much later. Had the Oversight Committee stepped down now that the matter was in the hands of the investigator? 14:31 14:32

A. I think, in effect, that would -- the normal practice would have been for the Case Manager to have taken over the management of the case from then on. We wouldn't normally have got involved thereafter. I do accept, however, that given the length of time and the gravity of this, this might have been something that we should have done, been more active about. 14:32 14:33

147 Q. We'll come on and look at the issue of delay presently. Is it right for the Inquiry to consider that while you have a Case Manager under the rules of engagement, he is leading the investigation in that sense of, essentially, having instructed the case investigator, that's the nature of the relationship as they are defined. But you, the Oversight Committee, sit perhaps in a tier above that. Is that an appropriate way of looking at it? 14:33

A. Yes. I mean the Director of the Service responsible and the team around that would have been receiving, obviously, feedback on how the various measures were running. In the past, the normal process would have been then if they felt that wasn't going according to plan they could have asked for the Oversight Committee to meet to consider such issues. On reflection, looking back, I absolutely can see that that was depending too much on people initiating that action and we should have been more proactive. But it was the case up to then that once the Case Manager started the case, we tended to step back. 14:34 14:34

148 Q. If, for example, there was difficulty, for whatever reason, in agreeing a job plan, once again, are you suggesting the onus is on the Service Manager to bring that back to you or the Clinical Director? 14:34

A. No. No. There was a well agreed process in the Trust for dealing with issues around job planning, in particular.

149 Q. I'm conscious of that, but in the context in which you are working, in seeing that the a job plan and the need for an agreed job plan to be revised and approved urgently, and the way that links into monitoring in the sense that you need a job plan that is fit for purpose, that is balanced in all relevant respects, any inability to reach agreement on that is something, surely, that should come back to you in Oversight Committee? 14:35 14:35

A. It should have -- whether it comes through the

Oversight Committee or not, it should have come back to me as Medical Director, I think, certainly, and I would have picked up on that.

150 Q. We'll come back to the monitoring arrangement in just a moment in a slightly different way. In terms of one final action on this list. If we scroll down. It was agreed that you would update NCAS in relation to this case. You've said in your witness statement, WIT-17834, that you informed NCAS of these developments by telephone over the next few days. We don't see any record of that and maybe you didn't make a record. Can you help us with who you spoke with? 14:36 14:36

A. I did notice that. I do recall having a phone call and I think it may have been with Grainne Lynn. The reason I think I recall it is because we discussed the conditions in which Mr. O'Brien would come back from work after his temporary exclusion, which is why I'm pretty sure that that happened. 14:37

151 Q. It is closing that circle?

A. Yes. But it is possible I mixed that up with another -- I mean, I did have that conversation. When that exactly happened I can't be sure. I know then the Case Manager would have taken over the liaison with NCAS after that. But I do have in my mind a conversation with NCAS about Mr. O'Brien's return to work. So, I'm puzzled, but I don't have a written record of it. 14:37 14:37

152 Q. To be clear, they don't have a decision making role and you weren't looking for further advice. The direction

appears to be from the Oversight Committee, in essence, report back to NCAS.

A. We would let them know we were bringing Mr. O'Brien back to work, yes.

153 Q. Could I ask you about the Terms of Reference? The Terms of Reference -- the commencement of a drafting exercise for the Terms of Reference appears to have been commenced, very promptly as seems to be his approach to things, Mr. Gibson, very shortly after 22nd December meeting. They go through several iterations. Looking at your witness statement, you say: 14:38 14:38

"The Terms of Reference were agreed by Mrs. Toal and I after being drafted by Mr. Simon Gibson after discussion with NCAS in early January '17. I have been unable to clarify the exact date or dates containing any iterations". 14:39

That's, for the Inquiry's note, WIT-18441. 14:39

The issue of drafting Terms of Reference is obviously an important one because it provides parameters for the subsequent investigation. Was Mr. Gibson left to his own devices to perform that task? 14:39

A. He was asked to pull it together initially and then for input after that. I wouldn't say he was left to his own devices but he was taking the lead on it.

154 Q. Yes. I think we spoke on the last occasion about

whether there was an opportunity, before setting off on this journey of a formal investigation, for pause and reflection and perhaps to apply some curiosity as to whether the issues that you were aware of, and that were to become 4 with Mr. Haynes' investigation on private patients, whether there were sufficient grounds on what we knew already to look around Mr. O'Brien's practice to see if we captured everything for the purposes of an investigation?

A. Mmm. 14:40

155 Q. Just on that point, is it your reflection that really that wasn't possible, whether legally or practically?

A. I wouldn't say it wasn't possible. I think we did consider the breadth of the investigation and we felt based on the evidence to date what we had was reasonable and achievable. My own personal opinion was I didn't feel we had sufficient evidence to go on a major lookback of his clinical work. In hindsight, and knowing where this ended up, it would have been better if we'd done that at an earlier stage. But genuinely I don't believe we had really got the justification for that at that point. I mean, I think the Terms of Reference, and it is for the Panel to say whether they agree or disagree, but they were reasonable, given the information we had and the primary concerns we had, in light also of NCAS' advice to not be going unnecessarily wide in terms of the investigation criteria. Put it this way, I don't think resource would have been the reason for not going

wider. But hindsight is a wonderful thing and where we know this ended up, I think we might have done this differently.

156 Q. I wonder whether it requires hindsight to reach the position which you've just articulated. If I can reflect what Mr. Haynes has said. WIT-53957. He has said: 14:42

"The fact that some aspects of good clinical practice were absent in Mr. O'Brien's working appearance, he feels" -- he does add, "in retrospect ought to have raised concerns that other deficiencies of good practice may also have been present." 14:43

I think we've heard from him in relation to that. I suppose what I'm anxious to understand from you, first of all; having gone through this process and knowing what 2020 revealed, would you, if you were to conduct a similar process again, knowing that this clinician had these four shortcomings, would it be sufficient to stop with those shortcomings or, in future if you were to do it, do you need to look at those shortcomings and see what else they might be indicative of? 14:43

A. Yes. I think if I was doing this again I would cast the net wider, that is based on the experience we've had, and particularly with this case I think that is right. I think it would be helpful if there was more clear guidance around that available to people in my 14:44

position and those similar members of the Oversight Committee around this because there is a tension there between casting the net widely and, to be honest, in managing resource, but more importantly in limiting collateral damage, if you like, to the public on the cases where it turns out you don't find anything but you have caused a lot of public concerns and anxiety. I think it is that tension which is very difficult in the light of this. We always try and learn from experiences, in the light of this, if I was doing this again, yes, I would have cast the net wider. Definitely. 14:44 14:45

157 Q. I don't get the impression -- correct me if I'm wrong -- that as a matter of process this Oversight Committee sat down and said, 'well, we have these four examples of shortcoming which are very much obvious to us and we can classify it and we can almost count it, and we do need to have an investigation to see what falls behind that'. It is obviously necessary to have an investigation as a preface to any further action such as disciplinary or what you have. But there was never a meeting which said, 'what are these shortcomings indicative of? Have we looked to see what the rest of his practice might reveal? Is there anything to link these shortcomings into other areas?' That kind of conversation was never started; is that a fair assessment? 14:45 14:45 14:46

A. It certainly didn't feature as part of the Oversight Committee. That would be correct.

158 Q. I'm conscious that the MHPS and the local guidelines say relatively little about Terms of Reference. I'm conscious, also, that NCAS said to you, let's not have an unfocused investigation in terms of the Terms of Reference. In term of the person or persons best placed to develop a Terms of Reference, was Mr. Gibson the best person for that role? Or, alternatively, should that have gone to somebody like the Case Manager? 14:46

A. It could have gone to the Case Manager. It probably ideally would have been done by the Case Manager with input from the Medical Director's office and the HR Department. That may have been a better way to have progressed it. 14:47

159 Q. There was this bit head added to the Terms of Reference. If we can just bring it up briefly? TRU-267983. It's number 5. 14:47

"Part of the terms of the investigation are to determine if any of the above matters were known to line managers within the Trust prior to December 2016 and, if so, to determine what actions were taken to manage the concerns." 14:48

Do you know how that ended up in the Terms of Reference and who authored it? 14:48

A. I can't completely remember but I would imagine it was a discussion between ourselves and the HR Department, but I actually can't absolutely be sure about that.

But my own feeling, and perhaps Mr. Gibson picked this up, was that we needed to make sure this was not just about Mr. O'Brien but that we were looking at more systemic issues. That's one of the advantages of carrying out an MHPS investigation as opposed to maybe going straight to a disciplinary procedure or a more focused one is that we do have the potential then to look at the systems in which the person is operating because virtually always they are a major factor in any failings for a given individual. I suspect it probably came from me indirectly, but I can't, honestly, quite remember the process for that. 14:49 14:49

160 Q. In ease of you, Mr. Gibson seemed to know nothing about the genesis of it. For that matter, Dr. Chada, at WIT-23761 says to the Inquiry: 14:49

"It became clear to me that a further Term of Reference needed to be considered TOR-5 to determine to what extent any of the above matters were known to managers within the Trust prior to December '16." 14:50

She says "I believe I added this". We will ask her about that.

A. Yeah.

161 Q. It does seem, if I may say so, a little unusual for an investigator to think that she might have -- 14:50

A. It would have been. She may have raised it with myself or Mrs. Toal as a potential issue and we presumably agreed. I mean, I was keen to make sure that we were

looking at more systematic and system errors as opposed to -- so it may well be that Dr. Chada raised that, and we agreed with her. I can't quite recall the detail of that. But I wouldn't, as a general thrust I think we would have been missing a trick if we hadn't looked wider than just Mr. O'Brien.

162 Q. The Trust Board. You went to The Trust Board, I assume it's normal meeting, it's normal monthly meeting, the day after the case conference, so 27th January 2017. You provide the Trust Board with a confidential update, and we can see that at TRU-158981. Mrs. Toal was a Director of HR at that point? 14:51

A. That's right.

163 Q. A member of the Board, as were you. Just scroll down, please. You're reporting the exclusion and the investigation process and identifying the officers who were going to be taking this forward. Nothing unusual in that. The Board was required under the process, as I understand it, to know about an exclusion, so in that sense this was routine? 14:52

A. Yes.

164 Q. Nothing in the minute to suggest any response, and maybe none was expected from the Board. Is that fair?

A. I think that is fair. I can't recall but I -- normally what happened is we just brought the information to the Board and that was noted. 14:53

165 Q. This doesn't come back to the Board in the sense that an investigation eventually reports and then we have the delay in being able to implement any aspect of what

flows from that. Should the Board be getting periodic updates from the Medical Director's office when there's a live MHPS process? Or, put another way, should the Board, as a Board member, be looking for periodic updates? 14:53

A. I suppose in an ideal world, yes, they would. There may be an issue of just the volume of information that they have to receive about so many things. It wouldn't have been our normal practice to have gone back regularly to the Board at that time, but I can see that 14:54 that would make good sense for them to receive regular updates. I would imagine for any Board business this might be a challenge because of the amount of information they are receiving reports on, but our practice, I think, at that time would have been simply 14:54 to have informed them that we were doing this and eventually they would have heard if there had been any significant findings from the investigation.

166 Q. In terms of your experience in the MHPS environment more generally, the role of the Board and its 14:54 connection with the Medical Director's office and its ability or its interest in keeping in touch with MHPS issues; is that something that doesn't need fixed generally or is there a need, in governance terms, to put something in to that system to ensure greater 14:55 connectivity and communication on such issues?

A. I think historically it would be factually correct to say there wouldn't be a lot of direct oversight of these processes by the Board. That would be my

experience. Whether that's something that would be helpful, it could be. It depends the way it is done. You wouldn't want the Board to be interfering in the management of an individual investigation, which would be very regrettable. But in terms of an oversight role of ensuring the investigation had reported in a timely way or that type of thing, that would be helpful, I expect. But the downside would be the potential for interference in the process of what is meant to be a confidential process run by the investigation team. I'm not sure is what I'm saying to you. I think it is something to be considered and that could be helpful. 14:55 14:56

167 Q. Let me put a specific to you. You already highlighted that one of the advantages of an MHPS process such as was adopted in the context of the fifth Term of Reference which allowed the investigation to look at management behaviours. There's obviously this tension between, if you like, the confidentiality and privacy of the clinician in a context which may could down a disciplinary route. But here we have a situation where the investigator's report and the Case Manager with his input is raising some concerns, if not criticisms, of management. In essence, to paraphrase, they are saying, 'listen, management were aware of these issues for quite a long time and their efforts to address it were ineffectual'. That's the kind of issue that really should get up to the Board through some mechanism or other, isn't it? 14:56 14:57 14:57

A. Yes. Yes, it should. There would have been various

mechanisms where that could have. One would be by a formal reporting of the MHPS process. You usually want to be waiting until the investigation has concluded and conclusions were reached. I suppose that would be one thing, but that could come through the normal Directorate system or it could come through my office if those concerns were appearing to be substantiated. It would be unusual for -- until an investigation has concluded it would be unusual for them to come through to the Board level because you don't know if they're going to be accepted or validated or not. Certainly, this type of issue does need to come to the Board in some form. That's absolutely right. 14:57 14:58

168 Q. Mr. Weir was relieved of his duties as case investigator. 14:58

A. Yes.

169 Q. Let me try to explore how that might have come about.

At TRU-01248 Mr. O'Brien writes a lengthy letter containing a series of questions or concerns in association with the investigation process. 7th February. They're addressed, or at least spoken to, at a meeting with Mr. John Wilkinson on that date. If I could pull up WIT-17883, (vi). You've said that you emailed Dr. Khan, the case manager, on 21st February referring to a discussion you had With Trust legal advisers after Mr. O'Brien had expressed concerns to Mr. Wilkinson about the role of 14:58 14:59

Mr. Weir as case investigator. Can you help us with that? What concerns was Mr. O'Brien expressing to Mr. Wilkinson about the role of Mr. Weir?

A. I think most of that was in that letter you're referring to, or the --

170 Q. We can go back to that. The letter is TRU-01248. It seems to me that these are concerns regarding the investigation process. Let's scroll through it. I don't believe that there's any particular concern raised about Mr. Weir's role. 15:01

A. I need to refresh my ...

171 Q. You take charge of the machinery.

A. Can you keep going down, please. Okay, hold there a second. Keep going. Keeping going again, please. Whoa. Keep going. Whoa, stop there. Keep going, please. 15:02

172 Q. That's the correspondence. I know that correspondence arrived on the same day as a meeting with Mr. Wilkinson, 7th February.

15:03

Let me direct you to another reference. TRU-267745. Go to the bottom of the page in case there's anything there, and then we can scroll up.

You are writing to Dr. Khan and you've said: 15:03

"Thanks for your help with the AOB investigation. On Friday last Vivienne and I" -- I think I know what that says -- "after AOB approached John Wilkinson, in short

we are content that we continue with the formal MHPS process...."

We have 7th February letter and meeting. We know from your statement that legal advice was sought and you're content to proceed with the MHPS process having lifted immediate exclusion. You said here:

"Given Colin Weir's role as his Clinical Director at the time this broke there is a potential conflict of interest even though from our perspective he was doing a great job. We need to reappoint a different case investigator who is not involved with AOB."

Does that make sense to you? 15:04

A. I remember having the discussion with our legal adviser from --

173 Q. Let me just frame the question. It says we are taking the Clinical Director out of the case investigator role. It seems to me that that's typically a role for a Clinical Director, but you're taking him out because, notwithstanding he is doing a great job, we need to find somebody who is not involved with AOB. The particular circumstances of this clinical director and his relationship with Mr. O'Brien. Isn't that the problem? 15:04 15:05

A. There were so many issues that were proving difficult to respond to without making a significant change to the process. We discussed it with our legal team who felt that the CD's role was a conflict of interest,

even though it has been something that we have done many times in the past.

174 Q. That's what I'm asking you. Please explain the conflict?

A. They had been involved as his CD for some time whenever some of these issues arose and, therefore, may have been involved in the administration of some of the systemic issues that may be relevant. 15:06

175 Q. He had only been appointed in June 2016.

A. Yes. But that was the view, I think, of the legal advisers at the time. They were very adamant that we had potentially a conflict of interest here. 15:06

176 Q. Did you see any evidence of the conflict in terms of how Mr. Weir was conducting himself?

A. No, not personally. 15:06

177 Q. I don't wish to ask you about what instructions you gave your lawyers but they appear to have, on the basis of your evidence, told you that this was the appropriate course. Leaving aside what you may or may not have told your lawyers, did you form a view that there was a conflict? 15:07

A. I think Mr. Weir was indicating this was proving to be a very difficult task for him, both personally and professionally. He had also had some periods of ill-health over that time. He was indicating it was an uphill struggle to conduct this investigation. 15:07

I wouldn't have said it was a direct conflict but it was apparent that it was becoming a problem for him and may have become a bigger problem down the line as the

investigation went on.

178 Q. You can't help us to understand what the conflict was?

A. I think the role of managing him going forward in terms of the implementing the package of measures to ensure that he was complying was proving to take a fair bit of their time and it was an onerous role. To do that as well as conduct an investigation into the same time when there may have been potential breaches of the measures in place, which the CD was responsible for implementing could have been a conflict at that point. The CD was responsible, on the one hand, for ensuring Mr. O'Brien complied with these various measures, but he was investigating, at the same time, that process. I think it was along those lines that that could have been problematic, where there were breaches of the measures put in place, because he would eventually then be investigate himself. 15:08 15:08 15:09

179 Q. Could I ask you whether the answer you have just given is speculative or conjectural on your part?

A. I'm trying to recall the conversation and I think it was along those lines, so I think it is more than speculation, but I can't remember the details of it. 15:09

180 Q. Very well. Where this appears to have started in one of the answers I brought you to was Mr. O'Brien was raising issues or concerns. Can you better help us with that? 15:09

A. I'm struggling, to be honest, to give you a clear answer to this. I think possibly he might have mentioned -- with Mr. Wilkinson I don't know, I'm not

sure. I'm not sure where I got that from. I thought it was in that letter but clearly not.

181 Q. Just in fairness to you, and I will draw your attention to something else you said in your witness statement, which possibly reflects one of the answers you've recently given to me. WIT-18427. At 7.43 you've said: 15:10

"As part of the Oversight team, I would recommend and appoint a case investigator. I told meet with them to explain the task in hand but then I would expect the case manager to interact directly with them. In this specific situation the initial case investigator (Mr. Weir) was appointed in this specific case as he was a Clinical Director with experience in managing difficult issues within the Surgical team and was already partly briefed on the relevant issues as he had prepared the preliminary report into the issues arising". 15:10 15:11

I am not sure what that means. That's he'd been appointed prior to preparing the preliminary report. "We believed this would help to produce a timely report." 15:11

Then you go on to say: "After representations from Mr. O'Brien to Mr. Wilkinson I agreed with Mrs. Toal to change the case investigator. After reflecting we believe that Mr. Weir, as Clinical Director, would be better utilised addressing the triage and other issues 15:11

identified within the Urology team whilst we would appoint a new case manager who had no other involvement in the case and one who was unknown to any of the key individuals involved." Etcetera.

A. Mm-hmm. 15:12

182 Q. Any further observations you wish to make in relation to Mr. Weir in his role?

A. No. I think that's a fair reflection of my understanding of the situation. I got a sense that Mr. Weir was finding it a very difficult procedure and 15:12 he had a lot on his plate, and that managing the mechanisms around Mr. O'Brien to ensure that he was complying was a substantial piece of work, and it was becoming apparent that doing the two together was going to be very difficult. 15:12

183 Q. Could I turn now to your engagement with the GMC. Just one discrete point arising out of that. You met with Joanne Donnelly GMC Employee Liaison Adviser on 8th February.

A. Mm-hmm. 15:13

184 Q. You told her that time -- we can bring it up on the screen, if necessary, the reference is TRU-161683 -- that as regards the serious incident adverse review report raised in relation to Patient 10, -- you know who that is -- you would send it to her as soon as you 15:13 receive it. Could I draw your attention to your meeting with her on 25th July? It's TRU-161700. Just scroll down, please. The next section you say, this is 25th July.

"The SAI investigation is not yet complete. There had been a delay at the start because of difficulties identifying a chair, and Julian Johnson is now acting as chair." 15:14

A. I think we were mixing up two different SAIs.

185 Q. Yes. You would have appreciated that Patient 10's SAI review under the leadership of Mr. Glackin, had reported in March 2017?

A. That's right. 15:14

186 Q. But shortly thereafter, under the leadership of Julian Johnston, a further series of SAIs grouped as 5 cases was to commence its work.

A. That's right.

187 Q. That one was unfinished and wasn't to report until the early months of 2020. 15:15

A. That's right.

188 Q. The Patient 10 SAI had completed and, as per your undertaking at the February meeting, should have been sent to the General Medical Council? 15:15

A. It should have been, yes, but I don't think it was.

189 Q. No, it wasn't. Can you explain how this confusion, if it was confusion, may have arisen?

A. I think we just did a lot of business on that day. The investigation is not yet complete. I was referring to 15:15 the one that Julian Johnston was embarking upon. That was the one that was foremost in my mind. It was a mistake, I think.

190 Q. Obviously Ms. Donnelly isn't privy to the information.

She's dependent upon you --

A. Yes.

191 Q. -- to provide her with an accurate update and where this SAI and any other SAI sits.

15:16

Was there not a checking mechanism within your office to ensure proper compliance with the GMC's requests?

A. This never happened before. Usually information was shared very freely without any hesitation. This is the first time I ever came across anything where has happened. It was simply an error, and I apologise for that. It should have been sent to them. There was no reason not to send it to them.

15:16

192 Q. Could I just share with you, going back to the monitoring plan, a perspective of Mrs. Martina Corrigan. If we can have up on the screen, please, WIT-26314. At paragraph 70.6, scrolling down, please, her perspective on Mr. O'Brien's return to work following the lifting of exclusion:

15:17

15:17

"I do feel that, in February 2017, Mr. O'Brien should not have been allowed back to work so soon and particularly he should not have been able to come back until after the investigation was fully completed. There were too many issues and I think that, by allowing him back so soon, there was not a proper plan in place to manage him. For example, I now think it was a mistake that the monitoring only took place for Outpatient dictation and outcomes, which was agreed by

15:18

the case managers through the Oversight Group as this is where the issue had been identified in December/January 2016/17. However, as I discovered when doing the admin lookback in June 2020 prompted you to two patients who had not been added after emergency surgery to the waiting list. There were patients who had been in under Mr. O'Brien's care as an emergency patient or as a day case that had either no letter dictated or had a delay in dictation. So whilst he changed his practice for outpatient attendances, he didn't for the rest of his practice, including the oncology multidisciplinary meetings." 15:18 15:18

I perhaps should have raised this when I was looking at this earlier, but your reflections on this; is this again merely hindsight working or does it reveal in a clear way some of the connections with other areas of his practice that were there to be deduced or obtained in real-time? 15:19

A. A similar answer to earlier. Obviously, this was detected in 2020. Knowing that now, yes, I wish we had looked at that at the time. I agree with that. But, again, we didn't have any evidence of that at that time. 15:19

I don't agree that we brought him back too early. I refute that. I mean we already had lots of people of the view that we shouldn't have excluded him at all. I think we brought him back in a measured and

controlled way that was reasonable given the evidence we had at the time. So I don't agree with Ms. Corrigan on that particular issue. I do, however, agree that it would have been valuable to have looked wider at the time.

193 Q. You can see neatly encapsulated in this answer that really what she's highlighting is -- just look across at a slightly different area of his practice, you can see the same administrative shortcomings which obviously create patient risk as well. 15:20

A. Yes. Although, in fairness, that was several years later.

194 Q. I must press you on this. It is several years later but it is the same species of problem, albeit --

A. No. No. I accept that. I accept that, yes. 15:21

195 Q. In terms of the role of the nonexecutive Director, Mr. Wilkinson obviously took up the mantle here. Can you offer some reflections on that role and how you imagine it should work in light of your experience? The proviso within the Trust guidelines suggest that his role is -- my words -- to ensure a sense of momentum in the process, perhaps to liaise with the clinician concerned. How do you think it worked in this instance? 15:21

A. This is very unusual. In previous cases I've been involved in I've actually never known anyone ever to contact the nonexecutive director at any time. I was never quite sure what the purpose of it was except if there was some major problem that wasn't being resolved 15:22

locally that they might ask the right questions. In this case it was very unusual in the amount of interaction. I never experienced that before. Usually if people had issues they would bring them first to the Case Manager and possibly to the Medical Director and, as I say, never before directly with the nonexecutive director. I think the system clearly wasn't working well here in that Mr. O'Brien felt he needed to go to an nonexecutive director on frequent occasions. So I don't think it worked particularly well here. He should have been able to bring those concerns -- as in fact he did -- to the Case Manager and the Medical Director in the first instance. He was bypassing the first mechanism. That probably was difficult for Mr. Wilkinson, I would imagine. So very unusual. I think the role needs to be looked at because it wasn't particularly clear what purpose. In the past, as I said, it hasn't served admit useful purpose. But I think there is a need for the Board to have oversight of what's happening, whether it is with an individual named person like this, I'm not sure how helpful that really is. 15:22 15:23 15:23 15:23

196 Q. We can bring up the correspondence if necessary. He did seem to have to field quite a number of queries, some multiple questions and meetings with Mr. O'Brien. 15:24

A. Yes. Yes. I mean I've never come across this before. It was very unusual. I don't understand what was behind that.

197 Q. Section 8 of the MHPS, I paraphrased it earlier but

just to put it in the mix formally, which is to be found at WIT-18499.

"The role is to oversee the case to ensure that momentum is maintained and consider any representations from the practitioner about his or her exclusion or any representations about the investigation."

It wasn't, I suppose, outwith what would have been expected of him to receive what he received from Mr. O'Brien. 15:24

A. Yes, I think as written down there it is quite possible that would have been an avenue he would have taken. I am just saying usually people raise those issues in the first instance with the Case Manager and usually get a satisfactory response from them. I'm not sure that necessarily Mr. O'Brien was giving the Case Manager the opportunity to respond in full before he went to the next stage. That's no reflection on any of them, it's just an observation that this was a very unusual way it manifested itself. 15:25

198 Q. I'm being asked to clarify that the quotation I read a moment or two to you from Mrs. Corrigan was clarified by her. It was a reflection and not something she said to anyone at the time. I think that's probably obvious. 15:26

A. I understood that.

199 Q. Okay. Thank you.

You retired from your position within the Trust towards late 2018?

A. Yes. I went on sick leave in, I think, around about February 2018 with a recurrent cardiac problem. When I came back I didn't come back as Medical Director. I was asked to do a few specific pieces of work for the Chief Executive until I retired officially then in August 2018.

200 Q. Before your retirement you understood that the monitoring plan was working fine without any significant divergence? 15:26

A. That was the impression I was being given. I would have discussed it occasionally with Dr. Khan and with Anita Chada, and obviously other people in the Acute Services Directorate. While it was taking a long time to get through the MHPS process, by and large, he was complying and was cooperating with the process in terms of his clinical activities. 15:27

201 Q. There was a deviation in the summer of 2017 when Mr. Carroll escalated to Dr. Khan that there were 90 charts in Mr. O'Brien's office when the rule of the monitoring was that there shouldn't be any, or if there were any they were for the shortest possible period of time commensurate with the work that had to be done, and there were outstanding referrals. Do you have any particular recommendation of that issue being drawn to your attention? 15:27 15:28

A. No, not I don't, at the time.

202 Q. Was it satisfactory that it wasn't drawn to your

attention or would you have expected the Case Manager and local management to try to sort it out first?

A. I would have expected them to sort it out first and, if there was a persistent problem or any evidence that there wasn't compliance on a deliberate basis, that I would have been informed. But I gather it was fairly rapidly corrected. 15:28

203 Q. In terms of your office and the authority of that office to try to ensure that the investigation progressed with greater expedition, first of all, did that office have any role in that respect? 15:29

A. I would have met both the Case Manager and the case investigator on an occasional basis and that their routine one-to-ones that I would have had with them for other issues and on those indications I would have asked about the progress of the investigation, whether they needed any further assistance, or whether they needed me to intervene. I was aware that time was drifting on and we had those discussions at that time. It was felt -- the consensus of those discussions was that whilst not ideal this was taking a long time, Mr. O'Brien was complying with the measures put in place to ensure Patient Safety and that they were content that they would eventually get to the end of the process and be able to make the recommendations. So they weren't looking for any intervention, but I did ask them if they wanted any. We did consider things we might have done. On balance we thought we had started this process far from perfect. It was taking 15:29 15:29 15:30

it longer than required but it was the most likely one to deliver us an outcome rather than by interfering with other measures in the middle of an MHPS process.

204 Q. Could I ask you do consider a reflection from Dr. Khan in this respect? If I can bring up on the screen WIT-32001. At 25.4 he says -- and this is referring to the non-engagement of Mr. O'Brien in the process. You'll recall, perhaps notably, that from around about November of 2017 until about March 2018 Mr. O'Brien may not have engaged in the investigation process in the way that the investigator may have wished. We'll look at that with her, but this is Dr. Khan's perspective. It says: 15:30 15:31

"The nonengagement of Mr. O'Brien for periods may have been avoided if the Medical Director, who was his Responsible Officer had intervened earlier. I, as Case Manager, had discussions with the Medical Director (Dr. Wright) regarding this. I believe Dr. Wright had spoken to Mr. O'Brien but Dr. Wright would be able to provide this information." 15:31 15:31

Your reflections on that? Did you speak to Mr. O'Brien to give him the hurry up?

A. I don't recall a specific conversation with Mr. O'Brien regarding this. I don't think so. 15:31

205 Q. Very well.

You touched on this morning your meeting post retirement with Mrs. O'Brien?

A. Yes, that's right.

206 Q. Which we know was covertly recorded. It can be found at AOB-56339. Any reflections on that you wish to share with the Inquiry?

A. Yes. This was, again, a very unusual situation. I had obviously been back at work for a number of months but not in the role as Medical Director. I think I retired around about the end of August. On the day of -- I think it was on the day I actually retired I got a message that Mrs. O'Brien wanted to speak to me. I don't know what prompted that. I appreciated she had been quite distressed by the whole procedure. I also appreciated that as I was no longer an employee, I probably didn't have any requirement to meet with her but I felt that whatever she wanted to say in the interests of being empathetic and understanding, I would facilitate that meeting. I came back into work -- I'm not sure, it was a few days later, I think, to facilitate that in Trust HQ. Obviously I had no idea this was being recorded. I was there simply to listen to what she had to say out of sympathy and empathy, which we did. I felt the meeting went reasonably well. She was obviously upset at how things had happened and I listened. I tried to explain why we had acted in the way we did, and we parted reasonably, I think. I was very surprised to hear it had been recorded. It was an informal meeting. I had kept no record of it. I said to her at the start, this is an informal meeting, I'm not an employee of

15:32 15:32 15:33 15:33 15:33

the Trust. I'm here to listen to your concerns just on a human level. And that was it.

207 Q. You've offered the Inquiry through your statement, finally, some reflections on the process overall.

A. Mm-hmm. 15:34

208 Q. MHPS as a process, clearly, from the Trust perspective for reasons we discussed earlier didn't seek to engage with all of the aspects of Mr. O'Brien's practice that, I suppose, theoretically could have been engaged with. You have offered your perspective on that. MHPS, it is 15:34 a difficult process, it seems, from the evidence you have given?

A. Well, it's difficult. On paper it looks very simple but, in reality, getting all the right people together at the right time is really difficult, and almost 15:35 impossible to carry out in the timeframe that the process itself suggests in most circumstances in the current climate in the NHS. I think it gives false expectations of what's possible. I probably mentioned before about ways I think it could be improved and 15:35 I know there were several pieces of work done in the past with the Department regarding this in terms of trying to identify a better process. But, as far as I understand, they were never brought to a conclusion.

209 Q. You have, if I could just mention, you've said in your 15:36 witness statement that when you think about this case, a clear, unambiguous escalation policy to Medical Director level would have facilitated earlier resolution of these issues. If I had known the

unresolved formal process would have happened much earlier. You said that at WIT-17893.

A. Yes.

210 Q. I want to ask you, do you think it was inevitable by December 2016 that a formal process had to be commenced? 15:36

A. I think it was inevitable by that stage. I think the problem with this is this had been a situation that had been allowed to develop over a number of years and, clearly, the more I found out about it, the longer back it seemed to go. It was never going to be fixed in a few weeks. I think the trouble with that then, the longer it has gone on, become embedded, the more difficult it is to resolve an issue like that. As a general rule, early resolution of problems like this and put into a more formalised process, it usually produces better outcomes. It is very unusual now for a case such as this or a situation like this to arise that has been let go so long through very informal routes. It used to happen a lot in the past, it hadn't been my experience in the last five years of my professional life. This is one that got away. 15:36 15:37 15:37

211 Q. Just on that. You can develop your answer, but if you could answer these as you go. What do you put that down to the fact it was allowed to drift through informal channels for so long? Was it deference to Mr. O'Brien and a reflection of how he was viewed as an experienced practitioner who was a good surgeon, an excellent surgeon, perhaps, and these issues were 15:37

perceived as being more on the administrative side and not likely to cause too much harm to patients?

A. I think that's part of it. I think also a reluctance for people to put themselves in the firing line of criticism by a very senior colleague is part of it as well. Perhaps a lack of experience and knowledge of the potential remedies that might have been available. As I've said in my statements earlier, that there was a great lack of knowledge amongst even the senior medical staff around MHPS and other processes and how they would function. So certainly an education component to how that could be improved. There was some experience in the Trust in the past, as I now know, some of these issues had been escalated but they hadn't been addressed formally. So there was a feeling of what's the point of doing that again? That's part of the reason, I think, why people were reluctant to escalate, because they had seen it hadn't worked in the past. 15:38 15:38 15:39 15:39

212 Q. Maybe that's a bit too oblique for me, what do you mean by that? 15:39

A. In years gone by some of these issues, as I now know, had been raised at different stages but they didn't seem to have been brought to a conclusion or definitively addressed. I think there was knowledge within the system and within the teams that had happened, so what's the point in trying again? I think that reflects a naïvety and a lack of knowledge about potential remedies that can be very effective when 15:39

implemented properly. That's where we'd like to be. I think earlier intervention would have potentially fixed these issues at an early stage and prevented us getting to this stage. In my experience, it is always a mistake to not intervene formally in these type of situations because they always get worse, they virtually never get better. 15:40

213 Q. Thank you.

MR. WOLFE KC: I have no further questions.

CHAIR: Thank you, Mr. Wolfe. We will have some questions. I will ask my colleague Dr. Swart to get the ball rolling. 15:40

DR. RICHARD WRIGHT WAS QUESTIONED BY THE INQUIRY TEAM AS FOLLOWS: 15:40

214 Q. DR. SWART: My questions will be quite general, I am sure you will be relieved to know. Just to preface them, to be clear, the role of Medical Director in a big Trust like this is a tough job. You had a lot to deal with and there was a lot going on. My questions are going to be more around the structure in which you work and your observations on that, which will be helpful for us in terms of going forward. 15:40

15:41

One thing that's come out from quite a lot of the operational witnesses and also from the medical witnesses and, to some extent, from our expert witnesses on the SAIs is this divide between the

managerial and the operational teams. Today, several times, you have said that's delegated to the operational team and, equally the operational managers have said, well, that goes over to the medical hierarchy. We have seen a few examples where things seemed to fall down between the cracks. Most particularly and most obviously in the monitoring of the action plan for Mr. O'Brien where a manager was put in charge of it and the Clinical Director of an AMD didn't have oversight of it and you didn't actually have oversight of it either. Now, none of that is intentional. 15:41 15:41

My question to you is, when you arrived at the Southern Health Care Trust, what was your observation of the way these structures worked in practice and how did this impact on you in your Board role? Do you have, on reflecting on that, any recommendations about how to overcome these problems? 15:42

A. There were lots of situations where the organisation of the arrangements of senior management within the Southern Trust worked really well within Directorates. I mentioned before, Paediatrics, Mental Health, and so on. 15:42

215 Q. You did, yes. 15:42

A. These were all where we had very good working relationships and they were perhaps smaller and there didn't seem to be issues in the same way we had with the Acute Directorate, which was, to my mind, too

big and unwieldily, and over number of acute hospital sites with Surgery, Medicine, ED, all in there in the mix. So communication about all those issues that were going on was very difficult.

15:43

It probably didn't help that the Director of Acute Services was located in one of the acute hospitals, we were physically in a different place. That made informal interactions more challenging. I think there was a lack of medical professional representation at 15:43
Board level. I mean there was me, and that was it. I think to be running an acute hospital of that size with one doctor at that sort of level is probably not enough. There was very little back-up for the Medical Director in terms of ability to delegate issues to 15:43
other team members because there really weren't any.

216 Q. That's evident from the structure as it was. It's too big a job for it to be for one person really, in your view, and I would agree with that. There have been some examples of that. 15:44

You formed a view on this quite early on and you set out to develop the senior medical leadership management capability, although I think you would agree nobody quite had enough time devoted in some areas? 15:44

A. Oh, yes.

217 Q. And you put some training in. What did you see your personal role as in terms of mentoring these people? Were you able to give some thought to how you could

actually set a sort of vision for that for the Trust at all?

A. On the very specific it issue of mentoring, we did establish a mentoring scheme within the Trust for all clinicians. It was quite well worked through in terms of what was available, and we had plenty of volunteers willing to take on the role. It was, however, a voluntary scheme. What we were finding was the people who availed of it were not necessarily the people we thought could have benefited from it. So it wasn't compulsory -- 15:44 15:45

218 Q. I'm thinking more specifically have you got some Associate Medical Directors who need a bit of help and guidance really.

A. Yes. 15:45

219 Q. Did you have enough time to spend with them individually to really talk them through these things? Because no training course really equips you, does it?

A. No. The short answer to that is no. We did, however, get our senior medical team, we offered them opportunities to train at a regional level on various regionally led training courses. It allowed them to network with colleagues across Trusts, and many of them availed of that. It wasn't something we could make them do. But the time in their own job plans and the time in my work plan to allow time for reflection was very, very limited, and that was a challenge. 15:45 15:45

220 Q. For example, you had an away day and you described Dr. McAllister as walking away from it. Did you pick

up the phone and say, 'come and talk to me, what's going on here?' Did you have enough time for that kind of thing?

A. Our one-to-ones often would have been an opportunity for that. They work better with some individuals than others. There were one or two who didn't really want to engage with that. 15:46

221 Q. On that vain as well, one of the things that strikes us as we look through the evidence and listen to people is that there seemed to be a reluctance for the senior medical managers to sit down one-to-one with Dr. O'Brien and talk to him about what was really going on, in his view, in terms of the issues he faced. Did you have a chance to sit down and have a conversation with him from his perspective about what this was all about? 15:46

A. Well, I met him on a number of documented occasions, but by this stage we were into a fairly formal process. I had met him on a number occasions before but not on a one-to-one. 15:47

I would have taken the opportunity to meet individually with consultants as they were coming up to revalidation, so it would have been my practice to meet with all those people who were coming towards that process at a fairly informal meeting. Mr. O'Brien had revalidated before I came, and then subsequently I was going through that again when I left so I didn't do that with him. 15:47

222 Q. Were you struck by the fact that people were reluctant to sit down with him and talk to him about these issues? What do you attribute that to. Normal medical management, such as we define it, I think people mean different things, but you would naturally want to speak to people. 15:47

A. I think they were wary of him because they realised there had been several attempts in the past made to deal with these issues that had not gone well from their perspective. It was well-known within the organisation about this accusation of bullying against one of the AMDs who would normally have been quite able to deal with issues like that, but found it particularly challenging. So there was a reputation there. There was also the known association with the Chair which may well have -- I don't know, may well have been overplayed, but that was in the back of people's minds as well. I think Mr. O'Brien, by and large, was not a great team player. 15:48 15:48

223 Q. Do you think other doctors in a similar position would have had the one-to-one meetings with their Clinical Directors and AMDs? Was that the culture in the Trust to deal with things? 15:48

A. Not enough. Not enough. There wasn't time. The patches the AMDs had and the time they had in their job plans were not comparable. I think time to do the job -- now that was partly, of course, historical because of busy jobs, but there was also partly a culture that the doctors themselves didn't want to 15:48

have more time removed from their clinical work. That was a major challenge. For instance, when I was in Belfast Trust as an AMD it was a 50% job. It was a bigger Trust, but nevertheless, whereas it was unusual for AMDs to have more than one or two PAs assigned to their job plan. 15:49

224 Q. Did you set out -- was your vision to try and help doctors understand why they needed to lead and manage in a more modern way?

A. Yes, that would be my own personal professional life. I think one of the most rewarding things about medical management is your ability to develop new services or to modernise or to improve at a level beyond your own individual clinical practice. I think that's the healthiest way for people to get into this side of things. We wanted to develop medical management as a role that people would aspire to as opposed to be forced into. Over the 20 years or so that I was involved in that there was a great move towards that, but still, I think, there is a big issue about recruiting good, capable people into roles like this because of how it drains them physically and emotionally and how underresourced it is. 15:49 15:50

225 Q. Your recommendation on that would be? How do we get over this? 15:50

A. There has to be realistic investment into the medical manpower in terms of the financial side of it, availability of resource to give reasonable numbers of PAs to do these jobs. But it's not just about the

money, it is about seeing how they are valued and their views expressed.

I do think there was a bit of a culture within the Southern Trust, as in the health service in Northern Ireland generally of keeping doctors out of positions where they could actually take decisions. That's my personal view. I think that's been unhelpful and we need to get a more mature view where they can feel engaged. I think that is beginning to happen. I know there have been a lot of changes within Southern after I left, as well. 15:51 15:51

The other extreme would be something like the States where some people train jointly in medical leadership and management as in medicine right from the outset as a career path. We're not quite there yet, but there are some things we are doing around the adept fellows, which have been very encouraging and rewarding in giving junior doctors experience of management and leadership roles at an early stage. 15:51 15:51

226 Q. There's a lot to do. I would agree.

The route into that will be, I think, through the Medical Directors and medical professionals responsibility for clinical risk, Patient Safety and quality. I think that's the toughest part of the Board position because there's so much to that. There are a lot of safety and quality issues that have emerged as 15:51

a result of this Inquiry. The most striking thing is people didn't realise the extent of the risk soon enough, or in enough detail and this has raised questions about the mechanisms by which assurance is provided or sought and the level of inquiry that's going on. You must have a perspective on that as Medical Director because I'm sure you would agree it's not enough to be told by a Clinical Director that doctor is a good doctor; that objective evidence was needed. What was your plan in terms of your role, in terms of improving on that? Do you think that need was realised at the time or is it, indeed, realised now even? 15:52 15:52

A. I think there would have to be the ability and the capacity to be much more proactive about seeking assurance. That requires manpower, training and expertise. And expertise not just on measuring data off a number of files lying in a cupboard but expertise in human factors training, root cause analysis, some of these analytical tools that have been shown to be so valuable but where the skill base is very weak, certainly in this part of the world. 15:53 15:53

227 Q. Did you recognise that that was a deficit?

A. Yes.

228 Q. Did you raise that with the Board at all? Were the Board aware this was an issue? 15:53

A. I raised it in terms of not specifically in that respect. I certainly raised the need to bolster the resource within the Medical Director's team for seeking

assurances in different ways. Not totally successful -- well not successfully at all, to be honest with you. Maybe that's a reflection of the way I raised the issue. I think the Board were aware of the challenges that there were. I think, to be honest, 15:54
we were hampered, particularly in the Southern Trust, by the multiple changes at senior levels which seemed to be endless and it never allowed any individual the opportunity or the time to make their mark on the system. I think that has been an ongoing issue for 15:54
some time.

229 Q. I think they recognise the need for governance improvements but really as Medical Director it must be uncomfortable to know you haven't got enough assurance, for example, cancer standards, you get 31 and 62 days, 15:54
did you know that the peer review standards were not being met to that extent in urology? I expect you didn't.

A. We would have had quite good data on regard to the simple figures on waiting times, but the detailed 15:55
analysis was lacking.

230 Q. The Board didn't get a regular update on standards in that way, did it?

A. They would have got governance reports on a regular basis through the governance subcommittee. 15:55

231 Q. Would that include compliance with peer reviews or compliance with obstetric reviews, whatever?

A. It partly did but not systematically enough, I think. There would have been various ways of external

monitoring of our quality. We had a quality report that was produced annually and it would be ongoing updating during the course of the year. We would have participated in peer review groups such as, you know, the top 40 CHKS-type system which measured quality indicators. So that would have been brought to the Trust Board but not as systematically or regularly as we required, really, to have an in-depth understanding of the issues. 15:55

232 Q. Job planning has been mentioned by quite a few people. I've looked at quite a lot of the information. It doesn't seem to me that the Trust job planning process included, as mandated, team objectives and individual objectives, and any kind of capacity information built in. Is that correct? Or was that a place where that happened? 15:55 15:56

A. I think that is largely correct.

233 Q. Why was that then?

A. Well, I think it was one of the things that had been allowed to slip. We had a quite highly developed electronic system for the application of job planning. 15:56

234 Q. I've seen it. I've had to use it.

A. I'm not sure it was that helpful, really, because it did away with some of the face-to-face interactions where you can have a more meaningful discussion around that. There was a review of job planning just before I left. We were doing a lot of work around that at the time. We had a job planning task force looking at various different ways to improve the process and to 15:56

improve the outcomes from it. That was still ongoing as I left. We had had a specific issue within Surgery, actually, because of the multiple changes again of the leadership roles in that Department, and the surgical job planning was probably the worst area in the Trust. 15:57
There were other areas where it was quite good and regularly done and meaningfully done. But I personally don't know that the electronic system we had was really much of a help. In some ways it was a hindrance.

235 Q. You mentioned that appraisal is a tool for individual development, not really for monitoring. But appraisal can be used effectively if there's enough intervention in terms of really looking at the data available and that being provided? 15:57

A. Yes. 15:57

236 Q. Was the barrier to that not having a specific Deputy Medical Director who could devote themselves to that? Was the barrier cultural? Your mechanics seemed to be working fine but meaningful discussion was not necessarily available for us to look at. 15:58

A. That's a very good question. The mechanics at the time I was there did work very well. Actually we knew when people were being appraised. We had almost 100% compliance. We did have a fairly advanced quality assurance check on appraisals, that the right questions 15:58
were being asked. What we didn't have was a matching up of agreed specific clinical data that was agreed within teams that were relevant to them. It was too much left to the individuals to bring data themselves.

So for peer comparison within urology, for instance, that was not robust enough. Part of that would have been simply the culture within Northern Ireland medicine. There has been a lot of resistance to introducing that type of data on a systemic basis. But I have no doubt that having someone assigned with a dedicated role as a Deputy Medical Director, for instance, with that as their role would have been very helpful. That's what I was trying to achieve. I don't think that by itself would have changed the culture but it would have been very helpful. 15:59 15:59

237 Q. It takes a lot of time to do it well?

A. It takes a lot of time to make it really work. I think the colleges could have a role in this, to be honest. For example, radiology, I was a radiologist. Getting hard data on a radiologist's performance is quite difficult but the colleges are best placed on what is reasonable to expect. I think they have sort of ducked their obligations there. They've stayed back from coming out. In something like surgery where they could say 'return to theatre, complication rate, mortality. There are indicators that could -- 15:59 15:59

238 Q. There's nothing to stop the Trust doing that either though?

A. There is nothing to stop, but it is much easier to introduce if you have the colleges saying, 'this is what you should do, folks'. 16:00

239 Q. One last question. NCAS, a really important tool. Why did you delegate the task of speaking to NCAS at the

beginning to Simon Gibson, because when I was Medical Director I would always have done that myself.

A. I think there was just too much going on at that time and I knew we had to inform them quickly. It wouldn't normally have been my practice. I would have spoken to them. In fact, I can't think of any other case where I would have done that. It was simply -- and I can't remember what it was, but there are other things going on that I just couldn't make that call on that day. 16:00

240 Q. In that context you would then normally seek some sort of assurance about the support being offered, would you, in the Directorate? NCAS always say 'support them through whatever you're doing'. People don't always know what that means. It can mean lots of things. Is that built into your processes now that you actually know what they're doing to support the doctor? 16:00 16:01

A. To be really honest, I don't know what the process is now within the Trust because I have been gone for quite a few years.

241 Q. I'm really asking for your view on that? 16:01

A. It is very important. Both the doctor who is the subject of the Inquiry but also the doctors who are the -- well, any staff who are involved in being interviewed or being involved --

242 Q. Correct? 16:01

A. -- and they people conducting the investigation where these things can be quite traumatising and very difficult for them.

243 Q. Would you recommend that that's always brought back to

something. Not the equivalent of the Oversight Group, I mean there has to be some group to discuss these things.

A. It would help if that was formally -- I mean we looked at this again, worked around SAIs with a similar sort of experience that it wasn't consistently reassessed, 'are we doing this? What is left that could still be done that we haven't done?' It happened very patchily. And I think the same applies for MHPS. 16:01

244 Q. You have to get the assurance back automatically, don't you? 16:02

That's all from me. I'll stop torturing you. Thank you.

CHAIR: Thank you, Dr. Swart. Mr. Hanbury, have you any questions? 16:02

245 Q. MR. HANBURY: Thank you. I've got not nearly as many questions, you will be relieved to hear, and some have been asked already. I have one thing on job planning. We heard evidence from Colin Weir that he didn't seem to have a lot of trouble doing the job planning for other surgeons, not necessarily urologists, and one of the sticking points appeared to be the large number of administration sessions that Mr. O'Brien wanted. Actually, having done a reasonable amount of job planning myself, the rest of his job plan was fine and standard, the number of clinics, sessions, etcetera. What do you think should have happened then? I think it went up the food chain once, but when Mr. Weir, his 16:02 16:02

CD, was struggling?

A. It should have gone to facilitation, I think. There is a facilitation process within the Trust where you take somebody who is not just so directly involved in the service but has experience of job planning to give a view. Potentially then, in my experience nearly always you can revolve that issue at a facilitation process, and there's always the potential for appeal. That should have been used. There was a culture within the Southern Trust that they didn't use those processes as quickly as, maybe, other organisations I have worked in would have used them. My view is you can't get agreement at job planning, you go to facilitation, if that doesn't work out you go to appeal and you sort it. You don't let it drift would have been the preferred approach, I think. 16:03 16:03 16:04

246 Q. Thank you. In retrospect quite a lot of the administrational things that could have been delegated might have been spotted at an earlier time. Would you agree? 16:04

A. Yes. I think that's quite right.

247 Q. Just a quick one, really. Both Dr. McAllister and the MHPS colleagues suggested taking the surgeon out of theatres for a period of time. Have you known that as an actual technique ever? I thought it was tongue in cheek when I first heard it? 16:04

A. I don't believe that the MHPS process should be used as a stick in terms to encourage people to change their behaviour. I think the only reason for taking someone

out of theatre is if you felt there was a clinical risk, I think. I wouldn't agree using it as a means of encouraging someone to change practice. That would not be appropriate.

248 Q. I agree with you. It sounds somewhat vindictive. 16:05

A. Yes.

249 Q. One other thing, changing tack. With respect to Patient 10, the serious incident report, I was surprised that Mr. O'Brien wasn't interviewed as part of the serious incident process. We see later on that 16:05 the operating surgeons and the senior clinicians weren't uniformly interviewed as part of the evidence gathering part of the SAIs. Was that a culture or was it deliberately done by other people for other reasons?

A. I think the specific issue, as far as I'm aware on that 16:05 one, is that Mr. O'Brien should have been interviewed as part of that process but they felt they were unable to because he was on sick leave at the time. So that's the reason that's been given. I think that genuinely was the reason and their intention was to involve him 16:06 in it when he came back from sick leave, but things escalated in the meantime.

In terms of interviewing the other people. No, I don't think it was a culture. I think they should have been. 16:06 What I can tell you, because I have been involved in the regional reviews of SAIs, and this is shortcoming across the piece and reflects a lack of training and experience of the investigators. Many of the same

issues apply about time, training, frequency of conducting SAIs, and the techniques that are available to them. It's difficult to get people with the appropriate experience available at the right time who would know that this is the way the investigation should be conducted. So there are multiplied failings, I think, with the current system around SAIs, and that was highlighted with this case.

250 Q. Thank you. I just have one more. 16:06

Coming forward to January '17, when, again, Colin Weir gave some evidence at one of the Oversight Meetings stating about Mr. O'Brien being a caring and precise surgeon. He was very complimentary about it. On reflection, do you think it is the behaviour of 16:07
a caring surgeon to not read letters from many general practitioners and not to be precise about his diagnosis and management in terms of letters and communication?

A. I don't think so. I don't believe so. I can see what Mr. Weir was alluding to. From what I have gleaned 16:07
from Mr. O'Brien's practice, if you were the person in front of him at any given moment in time you got his 100% attention, in some ways more attention than you might with another clinician. But he didn't appreciate, as I perceive this, the need to look at his 16:08
workload in its entirety, and the implications of not following through on that. For some reason, he didn't grasp that. The short answer is no, I don't think it is the sign of a caring surgeon, but I can see what

Mr. Weir meant, that if you were the patient sitting in front of him, you would have got his 100% attention both in theatre and at the outpatient clinic. But the rest of his practice fell far below what was expected.

251 Q. No more questions. Thank you very much. 16:08

CHAIR: Thank you, Mr. Hanbury. Just reflecting on that. I'll be corrected if I've got this wrong but I think it was Mr. Haynes who said that patients got a Rolls Royce service from Mr. O'Brien who managed to get through the door to him, but others who were 16:08 getting a clapped out old banger as a result, perhaps.

A. That's very graphic. But I think -- I've tried to struggle with this to understand the thinking behind this and whether it is just his personality or the way his mind works. I'm sure there's no deliberate intent 16:09 to not serve his patients well. I'm quite convinced he is very committed in that respect. However, he failed to appreciate the effects of his shortcomings and that is a key problem. I always think, when I'm doing appraisals with any doctors, the doctors you are glad 16:09 to see coming in are the ones who admit, 'I've got a problem here, I have an issue, I'm not coping with this'. I love to see them coming because you can always help them. The ones you fear are the ones who see they are doing no wrong, and there are 16:09 personalities like that and they are the most difficult ones to engage with.

252 Q. Would it be a fair comment or not to say most of those people would be surgeons?

A. In all honesty, no, I wouldn't say that. I met them in all walks of life. They are not all doctors either but I don't appraise them. You can meet them anywhere. I think the mistake of the system is to let that go unchallenged. If you challenge that at an early stage of their careers when they are trainees or when they are junior consultants or newly appointed GPS, you have the opportunity to change behaviours and to help them through that. I think the difficulty is when something has become entrenched for 25, 30 years, you're really going nowhere with it. 16:10 16:10

CHAIR: It is the old dog, new tricks situation really, is it?

A. It is really hard. And I know as I get older it is harder to change my ways. I think the system, never mind Mr. O'Brien, but the system has let people down here in that we've tolerated this for a long time before we really seriously tried to address the issues. And that has been a big mistake. I think if anything comes out of this, I hope that the system learns that that is not a good approach. 16:10 16:11

CHAIR: I've just digressed from some of the questions I did want to ask you.

One of the things I wanted to explore with you was we heard last week from Mrs. Gishkori, who you will -- well, we have seen all the evidence of the fact there was this first Oversight Committee which she attended and she said then she came away from that -- I think it 16:11

wouldn't be a misrepresentation of the impression that she gave, but in panic mode. Because if -- here was a surgeon on her watch, as it were, who she needed to deliver the service that needed delivered, and if he left, what might happen. But she felt unable to express any of that at the meeting with yourself and Mrs. Toal. I just wondered if you can maybe shed any light on her lack of ability to do that or to raise those issues with you at that meeting? She talked about coming to the meeting with just having been given Simon Gibson's report to you and not really having had much time to it digest it, I suppose. I just wondered what your reflection were on that position? 16:12 16:12

A. I would normally expect a director to come to a meeting like that fully briefed on what was going on on their patch, having considered the outcome they want from the meeting, and with a plan for resolving the issues. So, for whatever reason, Mrs. Gishkori didn't have the time to put that together. But that's usually what I would expect and usually that's what would have happened. I can't think of another situation where somebody would come to a meeting not knowing the degree of the problem and not knowing what their preferred potential solution would be. So I'm at a loss. But my normal experience would be the directors come knowing much more about the problem than I would. They have often asked for the meeting in the first place and they have a fair idea what they want to do about it. That was very different with Mrs. Gishkori. 16:12 16:13 16:13

CHAIR: Also, you've described how the Acute Directorate was the biggest if you like in the Trust and what she had on her plate.

A. It is a challenge for anybody. To be fair to Mrs. Gishkori, the preceding directors in that role had found it a very challenging role. And I understand there have been changes made to accurate directorate since then. The breadth and scope of it was enormous, and the pressure she would have been under would have been absolutely enormous. 16:13 16:14

253 Q. We can take it that she -- I mean I don't think she would be adverse to me saying she seemed ill-prepared for the meeting, the Oversight Committee meeting, given that ill-preparation, was it appropriate then for a decision to be reached at it if all three of you hadn't actually been apprised of all the issues? 16:14

A. I think it would have been within Mrs. Gishkori`s power to ask for another meeting, if appropriate, and I'm sure we would have considered that. It wasn't something I'd ever encountered before. 16:14

254 Q. Certainly, when she contacts you after speaking to Colin Weir and Charlie McAllister, she comes up with an alternative way forward which, to her mind, was protecting her directorate by not losing what was, to all intents and purposes, a very good surgeon from the team. 16:15

A. Well, I didn't agree with her.

255 Q. You didn't agree with her yet you did agree with her. You let it happen.

A. I think one has to be pragmatic in that we had the director of the service and the Associate Medical Director and the Clinical Director responsible for the service who were taking a particular tack. There's only so much one can do to impose one's will. It never had arisen before. So I was convinced that it was worth letting the plan run to see if it would be it of some benefit. I clearly was frustrated by the process. I did agree to a change of tack, which we subsequently reversed, and I wasn't have surprised when we had to reverse it, ultimately. 16:15 16:16

256 Q. Can I just ask a couple of other things. I'm just going back over to my notes now.

Yes, I suppose there were -- we've heard about blurring of responsibilities and how that contributed to the slow pace of getting to grips with the issue. Would you consider that by agreeing to go along this path that was presented by Mrs. Gishkori to you, that again was blurring the responsibilities? 16:16 16:17

A. I'm not sure. I think I was being pragmatic in that it was the only game in town, really, that was likely to work at that point. I was under no illusion that we may have to reconsider that approach if it didn't work fairly quickly. I think there is a tension between delivering a clinical service and maintaining high safety and quality standards. That is something that every director has to grapple with. And I think in this particular instance we were slow to appreciate 16:17

the necessity to put the safety and quality standards at the top.

257 Q. That leads me to, you'll be glad to know, the final question that I want to put to you.

16:18

As someone with the experience that you had of MHPS, and you described at the outset of your evidence to us that you were a founding member of the Faculty of Medical Leadership and Management, and that has been your career path, largely, if you had to sum up one thing, what do you think was the cause of things going awry here? Because it is quite clear to us that things did go awry.

16:18

A. Inappropriate deference based on status rather than ability.

16:18

CHAIR: Thank you.

Thank you very much, Dr. Wright. We do appreciate you had to come back on a second occasion. Just for the benefit of everyone here, in our down time next week we will be looking at our timetabling to try to avoid having to call people back on a second occasion, if at all possible. I have to say, we might not manage it, but we will make every effort so that people will only come and speak to us once.

16:19

16:19

A. Thank you very much.

CHAIR: Tomorrow morning, Mr. Wolfe, we have Mrs. Toal.

MR. WOLFE KC: She's here now. We could get started.

CHAIR: I don't think that would be fair on any of us,

never mind Mrs. Toal. 10 o'clock tomorrow morning. Thank you.

THE INQUIRY ADJOURNED TO WEDNESDAY, 1ST MARCH 2023 AT 10AM 16:19