



**Oral Hearing**

**Day 89 – Tuesday, 12<sup>th</sup> March 2024**

**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.

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**Gwen Malone Stenography Services**

I N D E X

W I T N E S S	P A G E
<u>DR. MARIA O' KANE</u>	
QUESTIONED BY MR. WOLFE .....	3

1        THE INQUIRY RESUMED ON TUESDAY, 12TH MARCH 2024, AS  
2        FOLLOWS

3  
4        CHAIR: Morning everyone. Mr. wolfe.

5        MR. WOLFE: Good morning, Chair. Your witness this 10:02  
6        morning is Dr. Maria O'Kane, who you will recall joined  
7        us for the first time on the 6th December 2022, which  
8        was Day 15 of our proceedings. And the transcript for  
9        that day's hearing is to be found at TRA-01412. I  
10       think in light of the fact that she has been away from 10:03  
11       us for so long and essentially technically has not been  
12       under oath during that period, she would need to be  
13       re-sworn.

14       CHAIR: Very well.

15       MR. WOLFE: I'm obliged. 10:03

16  
17       DR. MARIA O' KANE, HAVING BEEN SWORN, WAS QUESTIONED BY  
18       MR. WOLFE AS FOLLOWS

19  
20       MR. WOLFE: Good morning, Dr. O'Kane. 10:03

21       A. Good morning.

22       1 Q. We remind ourselves for the record that your employment  
23       relationship with the Southern Trust commenced in or  
24       about December 2018, when you were appointed Medical  
25       Director for the Trust? 10:03

26       A. Yes, that's right.

27       2 Q. I think -- I've have never been quite sure, I think you  
28       started in December 2018, but became responsible  
29       officer in January 2019, is that the way of it?

1           A.    That's correct, yes.

2        3   Q.    And you held that Medical Director's role through to  
3                   the 30th April 2022?

4           A.    Yes.

5        4   Q.    Is that correct? 10:04

6           A.    Yes.

7        5   Q.    You had, from the 14th February 2022, been appointed  
8                   Interim Chief Executive, is that correct?

9           A.    That's correct, yes.

10       6   Q.    And you continue in that role substantively or 10:04  
11                   permanently as Chief Executive to today's date?

12           A.    That's correct.

13       7   Q.    Again, we recall that we've troubled you to reply to  
14                   some, I think at the last count, eight Section 21  
15                   notices, and we have your response to all of them. 10:04

16                   After you gave evidence on the last occasion you were  
17                   served with Section 21 Notice No.4 of 2023, and I'm  
18                   going to ask you whether you wish to adopt that  
19                   statement? We didn't obviously get the chance to ask  
20                   you that on the last occasion because this notice 10:05  
21                   post-dated your appearance. So if we could have on the  
22                   screen please WIT-91953? In essence you will recall  
23                   this was a notice which interrogated you on an issue to  
24                   do with you're initial relationship with a number of  
25                   managers within Acute. You were pointing to your 10:05  
26                   evidence to I suppose a certain difficulty in what you  
27                   saw as the culture of Acute in relation to the sharing  
28                   of information, responsiveness to your inquiries, do  
29                   you recall that?

1 A. Yes.

2 8 Q. And we'll maybe touch upon that as we go on later this  
3 morning or into the afternoon. So that's the first  
4 page of your response. And if we go to WIT-91960, and  
5 that's the last page, and your signature, 18th April 10:06  
6 2023. Are you content to adopt that response as part  
7 of your overall evidence?

8 A. Yes, thank you. Yes.

9 9 Q. Thank you. Now, the primary purpose in asking you to  
10 return to give evidence is so that the Inquiry can hear 10:06  
11 from you in terms of, I suppose, the insight which the  
12 Trust has gained in respect of the issues, primarily  
13 governance issues, that have emerged in relation to the  
14 issues set out in the Terms of Reference, and to hear  
15 from you also in terms of issues of reform and 10:07  
16 improvement within the organisation, and I suppose to  
17 get a temperature check on how well that process of  
18 improvement has gone and, I suppose, a status check in  
19 terms of where it is at and what's still to be done.  
20 So that's the primary reason for your attendance. But 10:07  
21 I also, as part of the first section of your evidence,  
22 wish to ask you some questions about some evidential  
23 issues or factual issues that have emerged since we  
24 last heard from you. So that's the first part of your  
25 evidence which I'm going to commence now. 10:08  
26

27 Could I ask you to take a look at something you said in  
28 the transcript when you were last here? It's  
29 TRA-01441. This first set of questions, Dr. O'Kane,

just to be clear, relates to the impressions that you formed as Medical Director of Mr. O'Brien. I'm conscious that in your evidence you've said you never met him directly, you've never had a discussion with him?

10:09

A. That's correct.

10 Q. Yes. And what we are looking at here, if we go down to line 14, you're being questioned by counsel about your engagement with Mr. Carroll. Mr. Carroll was Assistant Director for surgery, isn't that right?

10:09

A. That's correct.

11 Q. And you're asked "Did Mr." -- this is line 14:

"Q. Did Mr. Carroll ever speak to you about Mr. O'Brien?"

10:09

And you answer:

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

10:09

So, just in relation to that, that sense that Mr. Carroll found him difficult to manage, could you help us better understand that? Was Mr. Carroll, to the best of your recollection, pointing to any specific

10:10

difficulties which he was able to give by way of  
example in terms of his management of Mr. O'Brien?

A. It's a long time ago since I've had these discussions  
with Mr. Carroll, but certainly, as I've said in that,  
my sense at that time was if I had asked about, you  
know, did he have any concerns, were there any concerns  
within the team, you know, made reference to what I had  
picked up from the Maintaining High Professional  
Standards Investigation in relation to, you know, the  
triage of records, tardiness in dictation, all of those  
things, you know, there was certainly a strong sense  
from Ronan that, you know, "that was just Aidan",  
everybody -- would have been the phrase that was used  
-- everybody would have known that you had to work  
round him and that -- I didn't ever pick up that there  
was any animosity between either of them in any shape  
or form, but just that in terms of helping Mr. O'Brien  
and the Urology Service stay in a straight line  
essentially, that that was definitely a challenge for  
Ronan Carroll.

12 Q. So, MHPS and those issues, but was he pointing to any  
particular example that you can recall at this stage of  
difficulties?

A. No. No, the discussions would have been purely in  
relation to what came out of the Maintaining High  
Professional Standards recommendations in terms of what  
had to be managed,

13 Q. Mmm. And did you get a sense that Mr. Carroll needed  
help or was he asking for help to manage Mr. O'Brien?

1 A. He wasn't specifically asking for help. I mean, I  
 2 think, you know, particularly whenever we were working  
 3 through the recommendations that came out of that to  
 4 understand if they were being implemented, I think what  
 5 he was describing was that it was difficult to keep a, 10:12  
 6 you know, it was difficult to make sure I think that  
 7 Mr. O'Brien was, you know, following the rules. And  
 8 certainly, mostly we got the sense that he did.  
 9 Although I mean in other parts of the statement I make  
 10 reference to, you know, the fact that he hadn't been 10:13  
 11 compliant over the summer of 2018 before I arrived, and  
 12 then 2019, but I think we approached this as a  
 13 collective team in terms of thinking about how this  
 14 could be managed rather than suggesting to Mr. Carroll,  
 15 you know, any particular changes in terms of what he 10:13  
 16 would have to do.

17 14 Q. If we can move forward in the transcript. If we go to  
 18 TRA-01458. And if we just go down to line 11. Again,  
 19 in terms of the impressions that you formed from your  
 20 discussions with colleagues about Mr. O'Brien, you say: 10:14  
 21  
 22 "The history that was given about Mr. O'Brien was that  
 23 he had always been problematic. That, basically, he  
 24 was difficult to manage. He felt that the system was  
 25 always to blame. Didn't take any personal 10:14  
 26 responsibility for anything going wrong at any point in  
 27 time. I think the sense I got from people was they  
 28 were hugely frustrated with having to manage him."  
 29



1 I don't need to bring this up on the screen, but you  
2 say in one of your witness statements, it's WIT-45034,  
3 that it was your impression that:

4  
5 "Mr. O'Brien's colleagues had developed ways of not 10:14  
6 confronting him for fear of having to deal with  
7 unpleasantness but had found ways of working around  
8 him."

9  
10 Do you recall saying that? 10:15

11 A. Yes. Yeah.

12 15 Q. Again, did anyone actually tell you they were  
13 frustrated trying to manage him?

14 A. It's quite a long time ago since these things were  
15 discussed, so I couldn't hand on heart say they used 10:15  
16 the word "frustrated", right, but I've certainly, as  
17 I've said there, I was left with a sense of this, and  
18 certainly when you look through, you know, the  
19 Maintaining High Professional Standards Investigation  
20 and the paperwork around that is fairly extensive and, 10:15  
21 you know, when you refer back to, you know, some of the  
22 comments that were made by Heather Troughton, Eamon  
23 Mackle, some of the others that were involved, there  
24 was certainly a sense that they were trying very hard  
25 to work with the system that they had and to improve it 10:15  
26 and that, you know, what was communicated to me in  
27 that, and then, you know, in discussions as we went  
28 along, was that sometimes getting Mr. O'Brien to  
29 understand the point of what the ask was, was

1 challenging, and that rather than actually take on  
2 board and deal with the things that should be his  
3 responsibility - and I think I made mention of it there  
4 - there was this tendency to blame the system and not  
5 take personal responsibility. And certainly that came 10:16  
6 through in Maintaining High Professional Standards  
7 documentation. And I think, and particularly in  
8 relation to not taking any personal responsibility, I  
9 have to say I was quite taken aback at the time when I  
10 read down through all of that, that there was no 10:16  
11 mention of apology for, you know, harm caused to  
12 patients, or in creating, you know, the challenges to  
13 the system, not bringing to the manager's attention,  
14 you know, the backlog of untriaged referrals, the lack  
15 of dictation - the way that was being managed, that 10:17  
16 lack of insight, and that's what I described it as  
17 being at the time, I think was the one overriding sense  
18 I was left with in relation to what had happened in the  
19 past.

20 16 Q. I'm struck by your evidence that you never actually met 10:17  
21 Mr. O'Brien?

22 A. No.

23 17 Q. And I wonder whether, when you reflect upon it now,  
24 whether you feel that, as Medical Director, when you're  
25 getting this sense from people you're speaking to or 10:17  
26 from what you're reading in the report, whether you  
27 should have deployed somebody from your team, or  
28 yourself, to taking a more direct interest in this  
29 difficulty by either sitting down with the Urology team

1 or, indeed, sitting down with Mr. O'Brien, or both, to  
2 try to see what exactly was the problem?

3 A. So my role as Medical Director was to professionally  
4 manage doctors and to support the governance systems  
5 within the Trust. And, you know, certainly in terms of 10:18  
6 my review of the Maintaining High Professional  
7 Standards Report, which was undertaken before I  
8 arrived, there had been numerous attempts at this by  
9 very able people from a variety of backgrounds, you  
10 know, through a series of medical managers, a series of 10:18  
11 operational managers, to try and address all of this.  
12 And I think as I've written in another bit of my  
13 statement, you know, we were trying the traditional  
14 routes in order to manage Mr. O'Brien. He was not --  
15 any other doctor who would be managed under Maintaining 10:19  
16 High Professional Standards would normally be subjected  
17 to the same process. You know, either in my role as I  
18 undertook it in the Southern Trust, or when I was  
19 involved in this work in my previous Trust, this is the  
20 way we would have approached this. And I think, and 10:19  
21 I've put it in as part of my reflection in relation to  
22 the Section 21s, I think what I came to an  
23 understanding of late was that the usual approaches to  
24 all of this did not address this problem. So I can't  
25 think of another case that I've been involved with over 10:19  
26 the years in relation to Maintaining High Professional  
27 Standards were there would have been that level of  
28 input from so many experts in terms of trying to manage  
29 the way an individual works that it would not have got

1 that person over the line, or got to a decision  
2 probably a bit sooner. So this is highly unusual. And  
3 you know, he was -- as I say, all of this was explained  
4 to him at various stages. He was asked about the  
5 management of all of this and, again, you know, when he 10:20  
6 was under review, when he was being closely monitored,  
7 we were able to see that that made a difference, it  
8 took that level of containment to actually get him to  
9 the point of delivering on what he was supposed to be  
10 doing, but in between times, you know, if there was 10:20  
11 distraction, for whatever reason, you know, when  
12 Martina Corrigan was off [REDACTED], or when, you  
13 know, the following summer whenever, sadly, [REDACTED]  
14 [REDACTED], it fell by the wayside and he  
15 didn't declare to us that he hadn't been undertaking 10:20  
16 the work that we had tasked him with.

17  
18 So, you know, I know that this has been extremely  
19 difficult in relation to manage, but I have to say in  
20 relation to all of the cases that I've managed over the 10:20  
21 years, this has been the most problematic of all.

22 18 Q. Yes. We'll go on in due course to look at the issue of  
23 idiosyncratic practice and the steps that the Trust has  
24 now got in place to, I suppose, focus on what might be  
25 described as low level concerns. So we'll look at that 10:21  
26 directly in due course. But just in light of what we  
27 have just discussed, do you consider that there are  
28 lessons to be learned here? Your last answer was,  
29 "Well, we were managing this in just the way we would

1 manage everyone else." There was a template there, "I  
2 had the experience from elsewhere of managing people  
3 successfully according to this pathway, but now I see  
4 that it didn't work here." So what's the lesson in all  
5 of that?

10:22

6 A. So, I have to say other doctors I have been involved  
7 with in a similar process have found this extremely  
8 humiliating and quite a shameful position to find  
9 themselves in and have been preoccupied with the impact  
10 that their behaviour has had on the patients, right. I  
11 was not picking this up with this doctor that was being 10:22  
12 managed in this process. And I think on the back of  
13 all of that, if we'd had better governance systems  
14 around this at a much sooner stage I think we would  
15 have got to the crux of this a bit sooner and realised 10:22  
16 that the difficulties probably couldn't be resolved  
17 using the usual means. So as a result of all of this,  
18 and I think I've spoken about it in previous evidence,  
19 I, along with the Director of HROD, we have completely  
20 revised our approach to managing doctors in difficulty. 10:23  
21 So, I set up oversight groups, we pulled in a lot more  
22 information in terms of a governance heat map, if you  
23 like, of how the doctors function, in relation to how  
24 all of that is reported through, and then certainly  
25 when it comes to re-validation and the different steps 10:23  
26 that doctors have to step through, that all of that is  
27 scrutinised in great detail. And I think we are a lot  
28 more assertive now in relation to, you know, pausing  
29 the system and going back and having a very thorough

1 look at, you know, the environment the doctor is  
2 working in and what their practice has been, you know,  
3 if presented with any difficulties now. And you made  
4 mention of the low level concerns works. So that has  
5 been started over the last six to nine months within 10:23  
6 the Trust in earnest. We've had over 60 of the medical  
7 managers through that, or people involved in medical  
8 management, whether they're medical or not, through all  
9 of that in terms of addressing those concerns and,  
10 again, we're beginning to see that we are getting in at 10:24  
11 an earlier stage in terms of supporting doctors in  
12 difficulty to help them through, and by and large that  
13 has been really successful in terms of how we get  
14 people through this system.

15 19 Q. I'll pull some of that material up later. Just in 10:24  
16 terms of the sequence it's a bit out of time to do it.  
17 Sorry to cut across you, I want just to move on to one  
18 sort of final observation you've made in respect of  
19 Mr. O'Brien. If we go to one of your witness  
20 statements at WIT-45033. And you're recording at 10:24  
21 paragraph 28.1 that -- sorry, 28.1 and 28.2, that prior  
22 to the concerns that were raised in June 2020 in  
23 relation to Mr. O'Brien, you had limited engagement  
24 with all of the staff in Urology Unit. Your main  
25 points of contact were through one-to-one monthly 10:25  
26 Associated Medical Directorate group meetings, and that  
27 was primarily with Mr. Haynes. And then over the page,  
28 or, sorry, down the page, regular contact with  
29 operational management including Mr. Carroll and

Mrs. Corrigan.

So, if we move forward in your statement just over,  
down the page please, at 30.1, you say:

"From my limited interactions with them..."

- and Mr. Haynes, Mrs. Corrigan and Mr. Carroll I think  
you're referencing there:

"...my sense is that they did and do work well  
together, with the exception of the working  
relationship with Mr. O'Brien."

You say:

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

So, are you intending to convey the message that  
exceptionally across the team of urologists,  
Mr. O'Brien did not work well with his colleagues?

A. Yes.

Q. And struck by the fact that your contact within Urology  
was limited, as you have described, what was, I

1           suppose, your source of information, and what was the  
2           information that led you to form that view that he  
3           didn't work well with his colleagues?

4           A.   well, in my discussion with, you know, meetings with  
5           Mr. Haynes in relation to concerns that he would have           10:27  
6           had, you know, primarily about medical staff, the  
7           person that would have been mentioned most frequently,  
8           you know particularly as we were working our way  
9           through Maintaining High Professional Standards was, or  
10          not working our way through it, in the aftermath of it           10:28  
11          - because it had finished before I arrived - was in  
12          relation to ensuring that the system worked reasonably  
13          smoothly. And, again, it was that it seemed to be that  
14          Mr. O'Brien had one way of working and everybody else  
15          worked as a team, was the way I was left with that.           10:28

16  
17          Now, again, I don't think there was any animosity there  
18          at all, I never picked up that this was aggressive in  
19          any shape or form, but it was just again this sense  
20          that Mr. O'Brien had to be worked round, whereas the           10:28  
21          others could function together really well as a team.  
22          And, you know certainly, you know, as my relationship  
23          with this team has continued, and deepened I think in  
24          the course of the Inquiry, I see that at large. They  
25          get on extremely well, they're very professional,           10:28  
26          they're very patient focused, and they embrace I think  
27          challenge and change and move on and get that done and,  
28          you know, are very enthusiastic about the work that  
29          they do. And I'm not now picking up any sense at all



1 that people are having to work round any individual in  
2 order to get the best outcome for the patient, they are  
3 working as a team, and I think that was always there  
4 but I think it's not now diluted by some of the  
5 workarounds that had to go on in relation to  
6 Mr. O'Brien. 10:29

7 21 Q. And just to be clear, your, I suppose, informant for  
8 these impressions was primarily Mr. Haynes on the  
9 clinical side?

10 A. It was. But it also came from the, as I say the 10:29  
11 extensive work that was done around the maintaining  
12 High Professional Standards work, the whole history of  
13 that, and then the discussions that I would have had  
14 with the series of managers who were involved with  
15 Mr. O'Brien in the course of all of this, whether that 10:29  
16 was Ronan Carroll, or Martina Corrigan or, you know,  
17 people who had previously been involved with  
18 Mr. O'Brien, such as Eamon Mackle, or Heather  
19 Troughton, or others, there was this sense that the  
20 team worked well but Mr. O'Brien did not work in the 10:30  
21 same way as everybody else.

22 22 Q. would it be fair to suggest to you that your sense of  
23 this, the sense that, as you suggest here, there wasn't  
24 much respect for Mr. O'Brien, has been to some extent  
25 exaggerated by your knowledge of, I suppose by what we 10:30  
26 know now, to put it in those terms?

27 A. Mr. O'Brien was, and I'm sure is, was incredibly  
28 popular among staff in the Southern Trust. And, again,  
29 you know, I had people who approached me at various

1 stages to say to me that they felt how he was being  
2 treated was very unfair, that he had always been very  
3 kind and very supportive, and all of those things, and  
4 I have no doubt personally Mr. O'Brien, you know, has  
5 always had great relationships with people. Right. I 10:31  
6 wasn't so much interested in that, I was interested in  
7 the professional side of this actually. How was this  
8 relationship impacting on the functioning of the team  
9 and the outcome for patients? And, you know -- and,  
10 again, as I say, there was never any animosity picked 10:31  
11 up in the midst of all of this. There were slight  
12 tensions that I noticed came through in terms of some  
13 of the reporting that was done in relation to  
14 maintaining High Professional Standards where there  
15 seemed to be this sense that if Mr. O'Brien was 10:31  
16 challenged, you know, he would take legal redress and  
17 all of that, and that seemed to be a threat that was  
18 around - rightly or wrongly, I don't know - but by and  
19 large Mr. O'Brien was very highly respected, very well  
20 liked by staff, but the bit I was interested in was 10:31  
21 patient safety.

22 23 Q. Again, getting back to what we can learn from this?

23 A. Yes.

24 24 Q. My sense from your evidence is that in terms of the  
25 time when you're hearing this stuff, it's before 2020, 10:32  
26 you're getting through Mr. Haynes, Mr. Carroll,  
27 Mrs. Corrigan, these impressions of a senior clinician  
28 who is difficult to work, isn't a team player, "we have  
29 to work around him", and yet there wasn't any

1 particular initiative, other than the monitoring plan,  
2 or the action plan as we call it, to get to grips with  
3 him. Is that the way it would be dealt with today?

4 A. The attempts that had been made were through job  
5 planning process, appraisal process, the usual 10:32  
6 governance procedures that are in place for doctors  
7 and, again, the history with Mr. O'Brien had been that  
8 there was delays in all of those systems, in that, you  
9 know, it took him a while to get to actually undertake  
10 his appraisal, the job plans he was very tardy in 10:33  
11 signing off, all of those things. So there was  
12 something about, you know, the conversations that were  
13 had with him weren't landing him where he needed to be.  
14 There was always more work to be done, there was always  
15 more information that had to be brought to bear to 10:33  
16 improve in all of this, and the deadlines just kept  
17 getting pushed back and back. Right. So that,  
18 together with the discussions that were there,  
19 suggested to me, you know, together with the fact that  
20 he had been through a Maintaining High Professional 10:33  
21 Standards Investigation...

22 CHAIR: I think we have a tendency to speak quickly,  
23 but if we can slow down, because not only the  
24 stenographer has to get everything you say, but we have  
25 to try and keep a note as well. So if you can slow 10:33  
26 down, please, doctor.

27 MR. WOLFE: So, yes, you were saying - you were taking  
28 us through the various conventional governance steps in  
29 respect of Mr. O'Brien and you were pointing out delay

1 or tardiness in respect of compliance with those.

2 A. Yes. So when I think about that history, and I suppose  
3 - and I appreciate they've only been recently  
4 published, but when you look at the recommendations  
5 that have come out of the Neurology Inquiry in relation 10:34  
6 to appraisal, those mirror some of what we were dealing  
7 with in relation to Mr. O'Brien. And in relation to  
8 job planning obviously, you know, very tardy to sign  
9 off in relation to that too. I had, you know, he had  
10 been part of a Maintaining High Professional Standards 10:34  
11 Investigation. As I became increasingly familiar with  
12 the case, you know, I became aware of other aspects to  
13 his practice that there had been worry about previously  
14 but had been closed off, and I had referred him to the  
15 GMC. So this was someone that I was concerned about. 10:35

16 25 Q. Mm-hmm. And I suppose the focus of my question is,  
17 you, and those employed at senior level within the  
18 system, knew about these shortcomings, the  
19 non-compliance, the team work issue, the delays in  
20 co-operating with job planning appraisal. That's your 10:35  
21 evidence, or your perspective on it, and I'm sure  
22 Mr. O'Brien may have a different perspective. But from  
23 your perspective, with the knowledge of those things,  
24 what was the reaction to it? What was the response to  
25 this knowledge? And do you think it was satisfactory, 10:36  
26 looking at it from today's standpoint?

27 A. So, the overall response to this has been, as I  
28 mentioned earlier, a revision in our systems and  
29 processes in relation to how we manage appraisal,

1 re-validation and job planning. We now have much  
 2 tighter structures around all of that. There's very  
 3 timely escalation in relation to any of the challenges  
 4 within all of that, and it's dealt with, you know,  
 5 personally and in groups to try and help people get 10:36  
 6 over the line. So, when I look at the history of the  
 7 appraisal and job planning before, the numbers were  
 8 low. I mean as of today we're sitting at over 90%  
 9 compliance with appraisal. And job planning we're  
 10 sitting at over 60% of compliance with that as we come 10:37  
 11 into the new financial year. That's much better than  
 12 it was previously. I think again with the training  
 13 that has been done, you know, in connection between the  
 14 Medical Director's office and the Director of Human  
 15 Resource's office in relation to bringing all levels of 10:37  
 16 staff to a greater understanding of their roles and  
 17 responsibilities in relation to speaking up,  
 18 whistleblowing, reporting low level concerns, you know,  
 19 how that's escalated. You know, we've done training in  
 20 relation to all of that to improve the visibility of 10:37  
 21 all of that, and the systems and processes that are in  
 22 place now are taken very seriously. I now get monthly  
 23 reports in relation to how all of that is progressing,  
 24 it's discussed at Senior Leadership Team, Trust Board,  
 25 it's through the whole organisation in terms of being 10:38  
 26 mindful that these systems and processes are there for  
 27 a purpose and that we need to take them seriously and  
 28 respond to them if we have concerns.

29 26 Q. But you're not saying - and we'll come later in your

1 evidence to look in more detail at some of those  
2 improvements - but just to be clear, you're not saying,  
3 are you, that how the Trust responded to this in  
4 real-time through those years until 2020 was adequate  
5 even by the standards of the day?

10:38

6 A. I think that, at the time any doctor who was coming  
7 through the Southern Trust would have got the same  
8 response. And my sense is, from the history of doctors  
9 in difficulty in the Southern Trust, that that approach  
10 that was used, even though it was light touch, actually  
11 was helpful in other doctors responding to it and  
12 improving. Right. The same approach as was prevalent  
13 within the organisation was used towards Mr. O'Brien at  
14 that point in time and did not deliver, you know, the  
15 improvement that was actually needed in any sustainable  
16 way, other than when he was constantly being monitored  
17 in relation to his performance to ensure that he  
18 delivered what he was employed to deliver.

10:38

19 27 Q. That doesn't directly answer my question. If he's  
20 getting, that is Mr. O'Brien is getting a response that  
21 would have been used with every other doctor...

10:39

22 A. Yes.

23 28 Q. - with success.

24 A. Yes.

25 29 Q. The impression I get from your evidence is that you  
26 were aware, and others were aware that he was, even  
27 though broadly complying with the action plan and the  
28 monitoring plan, he was still causing problems, and  
29 they went unaddressed. Is that fair?

10:39

1 A. In terms of the problems we were aware of that had been  
2 identified through the Maintaining High Professional  
3 Standards Investigation, those problems were being  
4 monitored. There was nothing else concrete coming  
5 through at that point in time in relation to his 10:40  
6 performance and behaviour. So it was when we got to  
7 June 2020 that we then realised that there were further  
8 problems in relation to the management of cancer  
9 patients, but none of that had come through in  
10 maintaining High Professional Standards and none of 10:40  
11 that had come through in various discussions that we'd  
12 had on the way through in terms of ensuring that he was  
13 compliant with the recommendations that came out of  
14 Maintaining High Professional Standards.

15 30 Q. But what was coming through? And we heard from you 10:40  
16 earlier on, this is through your conversations with  
17 Mr. Carroll, Mrs. Corrigan, Mr. Haynes, this sense  
18 still that he wasn't performing as the rest of the team  
19 would be expected to perform, you had to work around  
20 him, there was always this tension, is the impression 10:41  
21 from your evidence?

22 A. Yes, but that was a sense, but in terms of actually,  
23 you know, that translating into, you know, anyone  
24 saying "I have particular concerns about this patient",  
25 "I'm concerned that Mr. O'Brien isn't doing A, B and 10:41  
26 C", there wasn't anything concrete said in relation to  
27 that. I think the frustration certainly at that time  
28 was in relation to the monitoring of these different  
29 areas and making sure that he was compliant, and that's

1 where the focus was. But in relation to other concerns  
 2 that, as I say, those weren't clearly identified then  
 3 until June 2020. If they had been, you know, we were  
 4 very vigilant in the system and, you know, in relation  
 5 to all doctors at this point in time, because we did 10:42  
 6 realise that some, you know, that the systems and  
 7 processes in relation to appraisal and re-validation,  
 8 or leading into re-validation, and particularly job  
 9 planning, were not as tight as they could be. So, we  
 10 were really vigilant then to any concerns about doctors 10:42  
 11 in the system at that point in time.

12 31 Q. Let me take you to June 2020 and something you said on  
 13 the last occasion. If we go to TRA-01467. Just the  
 14 second half of the page, please. So it's from line 14,  
 15 and I'm asking for your observations on: 10:42

16  
 17 "When Mr. O'Brien retired from the Trust on 17th July,  
 18 when we had discovered..."

19  
 20 - sorry, I'll start again: 10:43

21  
 22 "Mr. O'Brien retired from the Trust on 17th July. When  
 23 we had discovered the difficulties after, I think I was  
 24 informed on 11th June in a clinical team, principally  
 25 Mr. Haynes and Mrs. Corrigan had been working on an 10:43  
 26 email that they had received that suggested there was a  
 27 discrepancy in two waiting lists, and that caused them  
 28 a bit of concern. When they worked their way through  
 29 that they realised there wasn't a discrepancy, but what



1 they also discovered on the back of those explorations  
2 were the concerns then around the cancer  
3 multi-disciplinary team meeting."

4  
5 So, what you appear to be saying is you were informed 10:43  
6 about a discrepancy on the 11th June by Mr. Haynes?

7 A. Yes.

8 32 Q. Mr. Haynes and Mrs. Corrigan worked their way through  
9 that at that time because there was a bit of concern,  
10 as you describe it. But when they worked their way 10:44  
11 through it they realised that there wasn't a  
12 discrepancy?

13 A. Yes.

14 33 Q. Can you explain to me just what you mean by that and  
15 what your knowledge of that was? 10:44

16 A. This is a clinical system that I haven't used in recent  
17 times, so I'm not familiar with all of the nuances of  
18 it. But, as I under - and I think it's a Cloud system,  
19 so as you update it, it changes. And the - sorry.

20 34 Q. I don't mean the technical information around the two 10:44  
21 patients concerned.

22 A. Mmm.

23 35 Q. It's the question of when they realised that there  
24 wasn't a discrepancy, what is your understanding of  
25 that? 10:45

26 A. I think we realised that there wasn't a discrepancy in  
27 and around late September, whenever they had gone back  
28 and revised all of this, looked at the comparisons  
29 across the different patient lists that they had, and

1 realised that the two patients that we thought weren't  
 2 on - were on one list and should been on another list,  
 3 weren't. So this was a red herring in terms of these  
 4 two patients, thankfully. But, you know, what was  
 5 fortuitous in all of that was that it provoked a review 10:45  
 6 of systems and processes in relation to the management  
 7 of cancer patients in relation to Mr. O'Brien's  
 8 practice, and that's when we then realised that there  
 9 was a problem in terms of the cancer multi-disciplinary  
 10 teams and in terms of those patients getting access to 10:46  
 11 that, being on surgical lists, all of that area, and we  
 12 had been - certainly in terms of the information I had  
 13 available to me in what was looked at in the  
 14 Maintaining High Professional Standards Review, I  
 15 hadn't been aware of that, until that point. 10:46

16  
 17 So these two patients were a red herring, but actually  
 18 they were - it was fortuitous that that was approached  
 19 in that way, because then that took us into realising  
 20 that there were much bigger concerns about other 10:46  
 21 patients.

22 36 Q. When you say "these two patients were a red herring",  
 23 the initial concern, as the Inquiry understands it  
 24 through Mr. Haynes's evidence, is that when he received  
 25 an email from Mr. O'Brien in relation to a set of 10:46  
 26 patients who were to come in for surgery, he initially  
 27 formed the view that the two patients weren't on PAS,  
 28 they weren't on the Trust's waiting list, and that then  
 29 caused him to report to you on the 11th June, and then

1 in turn with Mrs. Corrigan, they carried out I think  
2 what you've described as a scoping exercise to see if  
3 there were any other problems, and as you say  
4 fortuitously you got to that and that's why, in  
5 essence, we're here today.

10:47

6  
7 The red herring was identified as being a red herring  
8 by September 2020?

9 A. Yeah, in and around, yes. I think it was as we were,  
10 as we were working our way - as we went back to track  
11 what happened with those two patients in the context of  
12 what became known. Now, I became aware that actually  
13 then those two patients hadn't been part of that cohort  
14 of patients, that we then began to identify as nine  
15 Serious Adverse Incidents and then concerns about  
16 significant other numbers of patients, yep.

10:47

17 37 Q. And the person who spotted it as a red herring was who?

18 A. I think between Martina and Mark Haynes, I think -  
19 Martina Corrigan and Mark Haynes - I think when they  
20 revised the data and looked at the pathway through for  
21 those patients they realised that those two patients  
22 weren't patients that we should be concerned about  
23 based on the original information. So it would have  
24 been they who brought that to my attention.

10:48

25 38 Q. And it is the fact that the Department was briefed  
26 about the circumstances in which the Trust moved from a  
27 concern about those two patients into, if you like,  
28 this deeper dive, this scoping exercise in relation to  
29 Mr. O'Brien's practice, and I just want to look at what

10:48

1 the Department was told.

2  
3 If we go to SPP - we don't often use that prefix, but  
4 it's SPP-00629. And this is now 14th October 2020, and  
5 this is a report to the Department of Health in 10:49  
6 relation to Consultant A. And if we scroll down, some  
7 of the background is explained. If we just go down a  
8 little further, please, next page. So it's explaining  
9 that on 7th June 2020, the Trust became aware that two  
10 out of 10 patients listed for surgery under the care of 10:50  
11 Consultant A were not on the hospital's patient  
12 administration system at this time.

13  
14 "As a result of these potential safety concerns a  
15 review of Consultant A's work was conducted to 10:50  
16 ascertain if there could be wider service impacts."

17  
18 And then the wider service impacts are explained.  
19 Going back to the red herring point, I think you've  
20 explained it was discovered as being a red herring the 10:50  
21 previous month in September, the Department is getting  
22 an explanation here as to why further concerns emerged,  
23 or the trigger for those further concerns. The reading  
24 of that first paragraph suggests that the two out of  
25 the 10 patients were not on the patient administration 10:51  
26 system at the time, whereas, as I understand your  
27 evidence, that had been corrected, or understood to be  
28 wrong in the previous month?

29 A. In and around. So I think it was in the course of

1 preparation for this. And I think, you know, when I  
 2 reflect on this, this could have been more clearly  
 3 written, and a sentence could have been put in there to  
 4 say that, you know, something along the lines of, you  
 5 know, when we've undertaken this more comprehensive 10:52  
 6 review or scoping exercise, that we've realised that  
 7 those two patients aren't patients that we should be  
 8 concerned about, that actually they have been on the  
 9 right lists, but actually what we've discovered as a  
 10 result of all of this, you know, has been, as you say, 10:52  
 11 eventually what has led to this Public Inquiry.

12  
 13 So I could have put - Melanie and I could have put a  
 14 more clearly stated statement in there basically to  
 15 explain out the end of that, that those two patients, 10:52  
 16 as I say, were - and I don't like referring to anybody  
 17 as a "red herring", but I know that was my language,  
 18 but certainly fortuitously those patients were  
 19 discovered and led us into understanding about all of  
 20 these other patients. 10:52

21 39 Q. Yes. So just to be clear, what you had discovered in  
 22 September or thereabouts...

23 A. Yeah.

24 40 Q. - was that these two patients were in fact on the  
 25 waiting list and that the initial concern about it was 10:53  
 26 unfounded?

27 A. Yes, the initial concern was unfounded, but the rest  
 28 certainly hasn't been unfounded. Yes.

29 41 Q. Yes.

1           A.    Yep.

2    42   Q.    Do you consider that, when you look at this, the  
3                   Department may have been misled by how the situation  
4                   was described?

5           A.    I don't, I don't remember, because bearing in mind this 10:53  
6                   paper was prepared for what was to become the Urology  
7                   Assurance Group with the Department of Health, I  
8                   haven't looked recently at the minutes from those  
9                   meetings, but I am fairly confident that we would have  
10                  explained to the Department that those two patients 10:54  
11                  weren't patients we were any longer concerned about,  
12                  but that may or may not be in the minutes, but I do  
13                  know that that was certainly communicated at a point in  
14                  time.

15   43   Q.    Just to be absolutely fair to Mr. Haynes, who was I 10:54  
16                  suppose your primary informant around these issues.

17           A.    Mmm.

18   44   Q.    I think it's fair to say he cannot recall a precise  
19                  date when he discovered that the two patients were in  
20                  fact on the waiting list, but I think it accurately 10:54  
21                  characterises his evidence to say he's doing his best  
22                  in terms of his recollection, he thinks his discovery  
23                  of that issue came more closely to the date when he  
24                  came to give evidence to the Inquiry, which would have  
25                  been in or around November 2022. Your evidence by 10:55  
26                  contrast, both on the last occasion and today, is  
27                  unequivocal I think, that it was discovered - the "red  
28                  herring", as you put it, was discovered in the autumn  
29                  of 2020. Can I ask you just to comment on Mr. Haynes's

1 evidence in that respect? Do you think he is clearly  
2 wrong, in your view, to put a much later date on it?

3 A. I haven't had a specific conversation with Mr. Haynes  
4 about this, but my sense of the realisation, as I say,  
5 was in and around September/October time, and probably 10:56  
6 a bit more fulsomely after that, but I think that came  
7 out of discussions back and forth that I would have had  
8 with Martina at that point in time. So I - as I say, I  
9 haven't spoken to Mr. Haynes about when, you know,  
10 specifically, you know, did he think it was a different 10:56  
11 date, I don't know.

12 CHAIR: Mr. Wolfe I hesitate to interrupt but, you  
13 know, I think we're spending an awful lot of time on  
14 what is essentially an admitted point, that we had two  
15 cases that were identified as a catalyst that led to 10:56  
16 greater discovery, and the actual timing of when it was  
17 discovered that those two cases were in fact on the  
18 patient administration system and were not, are really  
19 not the issue here. The issue is what that led, the  
20 discovery that that led to. So I think we're spending 10:56  
21 an awful lot of time on what is, to my mind, a minor  
22 issue.

23 45 Q. MR. WOLFE: Let me move on then to the point that you  
24 make, that notwithstanding the red herring,  
25 notwithstanding what was in essence, let's call it 10:57  
26 neutrally a mistake of interpretation, Mr. Haynes, with  
27 Mrs. Corrigan, went on to discover issues or  
28 shortcomings with Mr. O'Brien's practice that you have  
29 no concerns about, is that fair?

1 A. That's true, yes.

2 46 Q. And when I say "no concerns about", you've no concerns  
3 about the accuracy of the conclusions which they drew  
4 from their investigations?

5 A. No, because I think, you know, their concerns have been 10:58  
6 dealt with through Dr. Dermot Hughes' Serious Adverse  
7 Incident reporting on the nine cases, and then the work  
8 that we have undertaken to date in relation to  
9 identifying more than 2,000, or reviewing more than  
10 2,000 cases and then identifying, you know, within 10:58  
11 that, the stratification of areas of concern. So I  
12 think that that work has shown to us that we were right  
13 to be concerned.

14 47 Q. Now, just briefly. One of the concerns that was  
15 identified and referred to Mr. O'Brien in 10:58  
16 correspondence in July 2020, was in relation to a  
17 concern about other patients not appearing on waiting  
18 lists. Let me draw that to your attention. It's at  
19 AOB-02534. So Mr. O'Brien is written to by Mr. Haynes,  
20 and he is in essence telling him to stand down from any 10:59  
21 clinical activity, and he sets out within the body of  
22 the letter the steps that were taken in light of the  
23 7th June email. And if we just move through that to  
24 page 38 in the sequence, it's four pages down, and just  
25 scrolling down. So one of the issues raised with 11:00  
26 Mr. O'Brien is that there were other patients on  
27 Mr. Haynes and Mrs. Corrigan's estimation who had not  
28 been added to waiting lists, as we can see here, when  
29 they should have, and were mostly done a few days



1 before Mr. O'Brien had the patients admitted. It goes  
2 on to say:

3  
4 "One patient re-admitted as emergency and had their  
5 stent removed under a different consultant. There had 11:00  
6 been no plan to admit them by Mr. O'Brien."

7  
8 Is that what you were aware of at the time? Were you  
9 aware that there was a concern that patients had not  
10 been placed on appropriate waiting lists? 11:01

11 A. Can you remind me what date this was from, please?

12 48 Q. This is July 2020. So your attention was drawn to what  
13 you now accept was a red herring on the 11th June.

14 Mr. Haynes, with Mrs. Corrigan, conducted certain  
15 further investigations by way of a scoping exercise 11:01  
16 leading to this letter to Mr. O'Brien in advance of his  
17 retirement date. So the question is: in general terms  
18 were you made aware that, quite apart from the two  
19 patients that you've said was a red herring, that there  
20 was nevertheless a broader concern that there were 11:02  
21 other patients who had not been added to waiting lists?

22 A. Yes, and I think I much prefer the word "catalyst" I  
23 think to "red herring" - I'm feeling anxious about  
24 having said that! I think that, you know, as I recall  
25 this, and in terms of how this process unfolded, on the 11:02  
26 basis of Mr. Haynes raising concerns about these two  
27 patients and then the work that he and Martina Corrigan  
28 undertook in relation to understanding or searching to  
29 find out were there any other patients missing, I think

1 this started to come to light, and then based on all of  
2 that they began, I think with the other people that  
3 worked with them, to understand just the implications  
4 of all of this in relation to these patients and how  
5 they were being managed. So I would have been - I 11:03  
6 would have been aware that that was the growing pattern  
7 or concern in relation to all of this throughout the  
8 summer, yes. Yes.

9 49 Q. Before we leave this area, can I just bring you to  
10 something you said in your witness statement about it, 11:03  
11 or one of your witness statements. WIT-45159. If you  
12 just look at - just scroll down. Scrolling down. You  
13 have recorded "Patients found" - these are concerns  
14 about Mr. O'Brien, and the left-hand margin:

15  
16 "Patients found to not have been added to lists for  
17 required surgery 7th June."

18  
19 And you go on then to comment on what was done, you  
20 say: 11:04

21  
22 "When this was discovered a review of Mr. O'Brien's  
23 clinical work was immediately commenced by  
24 Mrs. Corrigan to determine the extent of this problem.  
25 Ongoing discussions were held with the relevant 11:04  
26 directors throughout the summer until Mr. O'Brien  
27 retired on the 17th July. Progress to date in the  
28 timeframe 1st January 2019 until 31st May 2020 was  
29 formally reviewed by directors oversight on 6th July.

1 I discussed the unfolding concerns with Joanne Donnelly  
2 of the GMC, the Deputy Chief Medical Officer, and with  
3 the Department of Health."

4  
5 - the latter being on the 24th August, and then you go 11:05  
6 on to detail some further discussions.

7  
8 I'm struck that although you were aware at the time of  
9 finalising this statement that in fact these two  
10 patients, while being the catalyst for further 11:05  
11 investigations were not in fact the subject of any  
12 concern at all, but you don't take the opportunity  
13 within your statement to address that. Should you  
14 have?

15 A. Yes, I think I should have added that information at 11:05  
16 that point in time just as it unfolded, and I think,  
17 you know, we have been - there is the balance between,  
18 you know, looking at smoke signals and those two  
19 patients that I think who were the catalyst for this  
20 were definitely, you know, took us to other smoke 11:05  
21 signals in the system, and those have to be tested out  
22 to ascertain whether or not patients have come to harm  
23 in the process of all of that. And I think by that  
24 stage I wouldn't have been clear - by July/August I  
25 wouldn't have been clear if any of those patients had 11:06  
26 come to harm. I think as we got farther through the  
27 autumn and the winter that became increasingly obvious  
28 to us, certainly as Dermot Hughes pursued the Serious  
29 Adverse Incident Review. So, yes, in retrospect I

1 could have added in more information in relation to  
2 that.

3 50 Q. Can I then take you to a new issue? It concerns the  
4 events of the autumn of 2019, it was discovered that  
5 during a period of ill-health within Mr. O'Brien's 11:06  
6 wider family, he had not complied with what was  
7 expected of him in terms of dictation and triage, and  
8 it was determined that Mr. McNaboe would meet with him,  
9 and that's the context for what you say - if we go to  
10 TRA-01522, and at line, just line 9: 11:07

11  
12 "I think Mr. McNaboe and Mrs. Corrigan wrote to  
13 Mr. O'Brien offering to meet with him in November. He  
14 came back to say he didn't have enough notice and  
15 cancelled the meeting but that would have been 11:07  
16 Mr. O'Brien's pattern."

17  
18 Can you help us with that? You refer to Mr. O'Brien's  
19 pattern, which I think is intended to suggest that he  
20 didn't come willingly to meetings, or cancel meetings 11:08  
21 when he was expected to attend them, is that what you  
22 intended to suggest?

23 A. Well, I think this resonates with what happened during  
24 the Maintaining High Professional Standards  
25 Investigation, when I think it took Dr. Chada nine 11:08  
26 months to, you know, get through her investigation in  
27 relation to producing a report, and that was largely  
28 down to the fact - now bearing in mind this is the most  
29 important investigation any doctor can have in their

1 career. My experience of that always is that, you  
 2 know, if you had that hanging over you, you would  
 3 prioritise it above all other things. Right. But it  
 4 took Dr. Chada, who is very skilled and experienced in  
 5 this area, nine months to pin this down to get that 11:09  
 6 report developed because of Mr. O'Brien's approach to  
 7 meetings, and here it was again.

8  
 9 So this was, this was the outworkings of the 2017/2018  
 10 recommendations in relation to Mr. O'Brien. He knew 11:09  
 11 that the Trust was taking this seriously. There had  
 12 been a lot of work done around it. They wanted to  
 13 speak to him about it, and when they offered to meet  
 14 with him in a timely fashion, he came back again then  
 15 to say he didn't have enough notice and he cancelled 11:09  
 16 the meeting. That was his pattern, and that - when you  
 17 look at the process throughout Maintaining High  
 18 Professional Standards, when you look at the history of  
 19 any of this, that tends to be my sense certainly of how  
 20 Mr. O'Brien approaches what should be really important 11:09  
 21 meetings for any doctor.

22 51 Q. Okay. There's obviously more than one perspective on  
 23 all of this. Mr. O'Brien would no doubt say, and the  
 24 records perhaps bear him out, that he made himself  
 25 available at various times to meet Dr. Chada, but it 11:10  
 26 was sometimes difficult to get a mutually convenient  
 27 date. There were also issues about supplying him with  
 28 material that he needed to be aware of before  
 29 subjecting himself to an important, in fairness to him,

1 interview, which could affect his professional  
2 standing.

3  
4 On the McNaboe incident - I don't have the email  
5 reference to hand, but a date was suggested for the 11:10  
6 meeting that coincided with Mr. O'Brien's attention to  
7 cancer review clinics, if my memory is correct. So do  
8 you think it entirely fair to criticise his willingness  
9 to attend meetings in the way that you have just done?

10 A. I completely understand that there can be clashes with 11:11  
11 very important clinical work, but in that situation I  
12 think what most doctors would reasonably do, given what  
13 Mr. O'Brien has been through in terms of maintaining  
14 High Professional Standards, would realise that there  
15 should be an urgency about complying with the requests 11:11  
16 and that they should come back themselves. You know,  
17 if they're not being offered other appointments, come  
18 back themselves with suggestions around when that might  
19 be done. So for example, on a Tuesday morning I know  
20 that Martina Corrigan had arranged with him to have 11:11  
21 additional administration time above and beyond what  
22 the other consultants were being offered in order to  
23 help him get his paperwork done. That might have been  
24 a time, for example, he might have suggested to  
25 Mr. McNaboe and Mrs. Corrigan that he could have met, 11:12  
26 or any other opportunities within his diary. But I'm  
27 not aware that he would have offered those appointments  
28 himself. He would have waited for other people to  
29 suggest them to him.

1     52   Q.    We'll come to the issue of whether he was provided with  
2               support for his administrative work in a moment. But,  
3               why, upon reflection, was the meeting with Mr. McNaboe  
4               important or significant?

5            A.   That meeting was important because it was to ask Mr. - 11:12  
6               remind Mr. O'Brien that he was to complete I think both  
7               appraisal and job planning, but essentially job  
8               planning, that needed to be done.

9     53   Q.    And it didn't take place in a formal setting. We  
10               understand that there was a brief corridor conversation 11:13  
11               on Mr. McNaboe's account, or Mr. O'Brien's account - I  
12               can't remember which. So from a Trust management  
13               perspective, an important meeting didn't take place and  
14               the manager didn't make it take place, is that fair?

15          A.    I think it didn't take place in the way it was 11:13  
16               originally intended to take place, and I know that when  
17               I came back to ask about that, I think it was then in  
18               early 2020, it was still being pursued at that point in  
19               time.

20     54   Q.    Another issue. You've said, if you go to the 11:13  
21               transcript again at 01545, just scrolling down. Yes.  
22               You were asked about your recollection of the culture  
23               of the Board, and you recall that:

24

25               "At the end of Trust Board each of the executive 11:14  
26               directors were asked for any comments."  
27

28               This is during your time as Medical Director of course:  
29

"Up until that point I hadn't brought anything to the Board because it wasn't anything particularly outside the confidential section that needed to be raised, until August 2020 when I was asked the question and I raised it in relation to Mr. O'Brien. I think the feedback that I got indirectly at that point in time was that it shouldn't have been raised in that way."

11:15

Could you help us understand - I see there wasn't any particular follow-up on what you said. What were you told about the way that you had raised the O'Brien issue at the August 2020 Board meeting?

11:15

A. My recollection of that was I had a - I think it was with Shane - Shane and I had a - Shane Devlin, the Chief Executive at that point in time - and I think in my one-to-one soon after that he had mentioned to me that some of the members, now he didn't say who they were, some of the members on the Trust Board felt it was inappropriate that I had raised this, and my response to him was, "well, I was asked the question so I gave the answer, that's what that part of the agenda is for", and he said "I completely agree with you. I'm just making you aware that some people may not have been happy with that approach", and you know, I said to him "well, if I was faced with that again I would - you know, and I had concerns and I was asked the question, I would answer the question", and he said no - you know his view was the same, I think the same as mine, which was "Yes, you were asked the question, you gave the

11:15

11:15

11:16



answer, you had concerns about it." You know, it wasn't a surprise to either of us because we had some conversations back and forth that this was being pursued. But that's what that's in relation to, he had mentioned to me at that time.

11:16

55 Q. Yes. I must profess a little confusion about the process. So 27th August 2020 was the first date on which the Non-Executive Directors, and perhaps some of the Executive Directors, became aware that there was this Aidan O'Brien issue?

11:17

A. So, if you...

56 Q. The Early Alert - just to fill in some of the background.

A. Sorry.

57 Q. The Early Alert that went to the Department at the end of July/start of August, had, as we'll discuss later in more detail, only been copied to Mrs. Brownlee, amongst the Non-Executives. So if we bring up TRU-158997. There was a so-called Trust Board workshop on the morning of 27th August, leading into a full Board meeting, albeit remotely, in the afternoon. TRU-158997.

11:17

11:17

So this is the workshop. I don't need to bring you to the opening page. The Chair left the meeting at that point, Mrs. Brownlee - it's well worn ground. So you brought to the Board's attention - what's described here is:

11:19

"SAI investigations into clinical concerns involving a recently retired consultant urologist. Members asked that this matter be discussed at the confidential Trust Board meeting following the workshop."

11:19

Is that the point that you're getting at, that you were told that you should not have raised the issue in the way that you did? Is the point that it shouldn't have been raised at the workshop, it should have been brought to the Board meeting, or have I missed the point?

11:19

A. I think I was being asked at that point to bring it more fulsomely to the Board meeting, but it wasn't mentioned to me at that point in time that anyone thought it was inappropriate.

11:20

58 Q. Okay. And then if we just go to the Board meeting at WIT-90951. And, again, bottom of the page, it's again - do you know why it's being described as "SAI" when we know that an Early Alert, based on the catalyst event in June leading to the scoping exercise and the revelation of other issues, why it's being described as an "SAI"?

11:20

A. So I think probably the language around that would have been, we would have been describing what was ongoing as, you know, concerns about serious adverse incidents - I don't remember exactly. SAI means - using capitals like that particularly means something particular in Northern Ireland. So I think what was probably being, or would have been discussed at that point in time was

11:21

1 that we had concerns about there being Serious Adverse  
2 Incidents and we were undertaking a review at that  
3 point in time to understand just the depth and breadth  
4 of all of that. So that's what would have been  
5 discussed at that time and I - but at that point - I 11:21  
6 don't think at that - not on 27th August, I don't think  
7 we would have had that firmly, we wouldn't have been  
8 firmly of the opinion that these were all Serious  
9 Adverse Incidents and be getting into the realms then  
10 of approaching Dr. Hughes about undertaking the 11:21  
11 investigation.

12 59 Q. Okay.

13 A. I may have got the chronology wrong, but it is probably  
14 a misnomer in terms of how it's actually recorded.

15 60 Q. Yes. We'll come back to this issue in a slightly 11:22  
16 different way later, bearing in mind when the Early  
17 Alert was issued, and bearing in mind that the Early  
18 Alert isn't mentioned at this first opportunity  
19 meeting, if you like. But just going back to where I  
20 started in the piece that jarred with me in your 11:22  
21 earlier evidence, where you said that you were told  
22 that you should not have brought this issue in the way  
23 that you did, and that was a conversation with  
24 Mr. Devlin as you've now explained, and he agreed with  
25 you that it was appropriate to bring it to the Board at 11:22  
26 that time and in the way that you did, is that your  
27 evidence?

28 A. We didn't discuss - Mr. Devlin didn't form an opinion  
29 about whether it was appropriate or not.

1 61 Q. No, he was reporting what somebody else had said to  
2 him.

3 A. Yes. And, you know, the essence of our discussion,  
4 from my memory, was around essentially the  
5 communication of the information, that you know what I 11:23  
6 - I mean it was fairly concrete, I was asked the  
7 question and I gave the answer, you know. Do you - "As  
8 Executive Medical Director are there any concerns you  
9 wish to raise?", that would be the normal question.  
10 And I said "Yes, I've got a concern here." 11:23

11 62 Q. Right.

12 A. Yeah.

13 63 Q. And, again, just to be clear in the way that you have  
14 now explained it, does that suggest that you hadn't  
15 gone to that Board meeting or, indeed, the earlier 11:23  
16 Board workshop, with the intention of revealing what  
17 was, I would suggest to you an important event, the use  
18 of an Early Alert, and the investigation, the ongoing  
19 investigation of these initial concerns in respect of  
20 Mr. O'Brien, that wasn't your intention until you were 11:24  
21 asked the question?

22 A. If I had - it was certainly weighing on my mind because  
23 I was aware that this was a Board that, you know, I  
24 came in to, that should have been through the process  
25 of the Maintaining High Professional Standards 11:24  
26 Investigations and Report in relation to Mr. O'Brien  
27 previously. So they had - they should have had a whole  
28 history with Mr. O'Brien and what unfolded in relation  
29 to all that of before I ever arrived. I, I think,

1 would have assumed that they would have been familiar  
2 with that whole history, and I would have brought this  
3 by way of saying to them, you know - and it was an  
4 assumption on my part, which I probably should have  
5 tested out beforehand that - they would have been 11:25  
6 familiar with all of that, and what I was saying to  
7 them was the person who was, you know, essentially  
8 drawing their attention to the fact that the same  
9 consultant I now had concerns about again. But without  
10 formulating it all, without all of the information 11:25  
11 around it. Because, you know, at that point we weren't  
12 completely clear where this was taking us, we were  
13 still undertaking an excavation to try and understand,  
14 as I say, the breadth and depth of what was actually  
15 going on. So I hadn't anything fully formed at that 11:25  
16 point in time, but I did have a sense that they needed  
17 to know, because they had been - first of all they  
18 should know and, secondly, they would had been involved  
19 before, I would have assumed.

20 64 Q. Yes. As I say, I wish to come at this issue in light 11:25  
21 of Mrs. Mullan's evidence and about Board cultures in  
22 general from a slightly different direction later, but  
23 for now, thank you for that.

24 A. Mmm.

25 65 Q. Can I ask you to look at WIT-45070, and at 48A, again 11:26  
26 you're looking at concerns in relation to Mr. O'Brien.  
27 Just scrolling down, you say - just that paragraph  
28 beginning "On my arrival":  
29

1 "On my arrival I was aware that for patients about whom  
 2 there were concerns these could be placed in hot  
 3 clinics, that is same or next day clinics Monday to  
 4 Friday. Consultants had the opportunity to use these  
 5 hot clinics on their weeks as urologist of the week to 11:26  
 6 review any patient about whom there were imminent  
 7 concerns. "

8  
 9 And you go on to say - just scrolling over the page.  
 10 Yes. Sorry, at the bottom of the page: "It would 11:27  
 11 appear..." you say:

12  
 13 "...that despite having long waiting lists with the  
 14 propensity then for patients to deteriorate, these hot  
 15 clinics were not used as intensively by Mr. O'Brien as 11:27  
 16 they were by other consultants. "

17  
 18 Can I ask you just about that and the factual basis or  
 19 the information basis for saying that? First of all,  
 20 who led you to form this impression, if it was an 11:27  
 21 impression, that Mr. O'Brien wasn't using the hot  
 22 clinics as intensively as others?

23 A. Could I suggest I come back to you with the answers for  
 24 this, because this data is not at the front of my head?  
 25 So I will revise that and come back to you in the next 11:28  
 26 couple of days, if that's okay?

27 66 Q. Right. Certainly, by all means explore that. I think  
 28 that's fair if you don't have the answer. I'm  
 29 conscious that this witness statement was filed almost

1 18 months ago.

2 A. Mm-hmm.

3 67 Q. Just before we perhaps take a short break, could I  
 4 bring you to the conversations that took place in  
 5 relation to Mr. O'Brien's retirement. If we bring up 11:28  
 6 to the screen, please, AOB-56498. And just while  
 7 that's coming up - yeah, just scroll down to - thank  
 8 you. There was, I suppose, a bit of a lead in to a  
 9 conversation that took place on 8th June 2020 between  
 10 Mr. Haynes and Mr. O'Brien. Mr. O'Brien had indicated 11:29  
 11 in March 2020 his intention to retire from full-time  
 12 employment with the Trust, but he had had conversations  
 13 with colleagues about his wish to return on a part-time  
 14 basis in August 2020, and he certainly had formed the  
 15 understanding that there would be no barrier to that, 11:30  
 16 and he was getting, if I can summarise his evidence as  
 17 getting, I suppose, receptive or positive noises back  
 18 in terms of whether that would be possible. This  
 19 conversation with Mr. Haynes, again I paraphrase, takes  
 20 the rug from underneath Mr. O'Brien's feet. He's told 11:30  
 21 on 8th June, you'll not be coming back as a part-time  
 22 worker following your retirement, and Mr. Haynes at  
 23 item C, or number C on the left-hand margin, explains:

24  
 25 "I've taken that forward with a number of conversations 11:31  
 26 within the Trust, with HR, and at Medical Director  
 27 level. Okay. Unfortunately, the practice of the Trust  
 28 would be that they don't re-engage people while there's  
 29 ongoing HR processes."

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In terms of the discussions at Medical Director level around this subject with Mr. Haynes, can you recall participating in such discussions?

A. Yes. 11:31

68 Q. And was it explained to you that Mr. O'Brien had this intention or at least this wish to return following retirement on a part-time basis?

A. Yes, it was suggested to me I think both by Mark Haynes and I think at a stage Martina Corrigan, that 11:32

Mr. O'Brien had suggested that he would like to return post retirement. And my response was clear throughout, which was, this is a doctor who had been through a Maintaining High Professional Standards Investigation, who had not been able to comply, and by that stage, you know, what we realised was on a couple of occasions with, you know, the recommendations that were being made, that it was, you know, he was difficult to manage as a result of all of that, and in addition to that I had concerns about the fact that he hadn't been 11:32

complying with appraisal and job planning throughout, and that I also, I remember also speaking to Melanie McClements about this as well, to explain to her that if - the difficulty in this process was going to be that if he were offered a post that I couldn't 11:33 authentically stand over him being there as responsible officer, because I have a - I had a responsibility, obviously professionally, to sit between the doctor and the GMC to say that they were a person of good standing



1 and someone that we could rely on going into the  
2 future, if I decided to go forward with that, and what  
3 I was explaining at that time was that it would be  
4 difficult for me to be his responsible officer, given  
5 all that I knew about his past and the concerns I had 11:33  
6 about the present.

7 69 Q. You had of course by this time referred him to the  
8 Medical Council?

9 A. Yes. Yes. Yep. Could I just ask? This conversation  
10 looks like it was recorded? 11:33

11 70 Q. Yes, indeed.

12 A. Was Mr. Haynes aware it was recorded?

13 71 Q. We've dealt with that with him.

14 A. Okay.

15 72 Q. It would appear that he wasn't. 11:34

16 A. Okay.

17 73 Q. In terms of this phrase that "the practice of the Trust  
18 is not to re-engage people while there's ongoing HR  
19 processes", when Mr. Haynes was asked about that I  
20 think it's fair to say that he acknowledged that this 11:34  
21 was really a term of convenience, the reality being  
22 that, if you like, the difficulties being caused by  
23 Mr. O'Brien in terms of the management of him and how  
24 he was perceived as a colleague and a team player, and  
25 I paraphrase, were really at the root of the decision 11:34  
26 not to have him back, as opposed to any formal or  
27 informal policy on the part of the Trust not to have  
28 people back when there's ongoing HR processes?

29 A. Well, I think, as you've reminded me, I had referred

1 this doctor to the GMC at that point in time and, you  
 2 know, we had concerns about his behaviour and in  
 3 relation to how he managed patients. So it would have  
 4 been highly unusual in that circumstance for me, as  
 5 Medical Director, to agree to take a doctor who was in 11:35  
 6 this position back to work once they had retired.

7 74 Q. And is it fair to say that that's the sense of it that  
 8 you communicated to Mr. Haynes?

9 A. Yes, I think maybe not just as precisely as that. And  
 10 as you said, I think Mr. Haynes, you've just referred 11:35  
 11 to the fact that this probably was an economic use of  
 12 language in relation to how all of that conversation  
 13 was described, but essentially we are talking about  
 14 similar processes here, but the root of it all was  
 15 concerns about, you know, what I knew about this 11:36  
 16 consultant's previous and current practices and whether  
 17 or not I would be prepared to continue as responsible  
 18 officer knowing all of that, and I felt authentically,  
 19 I couldn't.

20 75 Q. Ultimately whose decision was it to take? Who owned 11:36  
 21 the decision, in your view?

22 A. Well it would be very difficult for any permanent  
 23 member of staff to work in a Trust if they hadn't a  
 24 responsible officer within that Trust, or as an  
 25 alternative they weren't being managed by a responsible 11:36  
 26 officer from another Trust or through the GMC. So what  
 27 I offered to Melanie at that point was my view that I  
 28 couldn't remain as responsible officer, given the  
 29 concerns that I had and, again, that would have

1 impacted then on the decision whether to continue  
2 employment or not. But certainly in my opinion we  
3 couldn't continue to employ this man given the  
4 concerns.

5 76 Q. Okay. Thank you for that. Chair, would it be 11:37  
6 convenient to take a break?

7 CHAIR: Yes. We'll take a 15-minute break and come  
8 back again at 11:55, ladies and gentlemen.

9  
10 THE HEARING ADJOURNED FOR A SHORT PERIOD AND RESUMED AS 11:37  
11 FOLLOWS

12  
13 CHAIR: Thank you everyone. Hopefully the injury has  
14 been resolved? There's a few doctors about the place  
15 just, you know, if needed! Mr. Wolfe. 11:57

16 MR. WOLFE: Thank you. Just a few minutes before the  
17 break I was asking you about the subject of hot  
18 clinics, and you had made the point in your statement  
19 that despite having long waiting lists it appeared to  
20 you that Mr. O'Brien did not use such hot clinics or 11:58  
21 the opportunity of such hot clinics as extensively as  
22 his colleagues, and you invited me to come back to that  
23 issue in due course.

24 A. Mmm.

25 77 Q. If I could show you WIT-48519? And it's an email to 11:58  
26 you, I think probably shortly before you finalised the  
27 statement containing the reference to "hot clinics",  
28 and you're being told by Martina Corrigan that here is  
29 the breakdown of patients to hot clinics during that

1 five-year period. Just scroll down so we can see it  
2 all. So your point was Mr. O'Brien didn't appear to  
3 you to be using the hot clinic opportunity as  
4 extensively as others. It would appear, just confirm  
5 for me, that it's on the basis of this information that 11:59  
6 you made that point?

7 A. Yes.

8 78 Q. And in what sense was that significant, in your view?

9 A. It gave me -- well, I think that those hot clinics, as  
10 I understand it, are where consultants, if they have 11:59  
11 particular concerns about patients, will bring them up  
12 for review, you know, to monitor their progress, all of  
13 that, and they use the opportunity of being urologist  
14 of the week to actually, you know, get these reviews  
15 done in the context of the rest of the busyness of 12:00  
16 consultant of the week. It struck me that - I suppose  
17 what my concern was that there was less, and given how  
18 busy Mr. O'Brien, you know, was constantly concerned  
19 about being, it gave me an indication that actually in  
20 terms of the volumes of patients that he was seeing 12:00  
21 through that, it wasn't as high as others, and if there  
22 were concerns about patients and, you know, if patients  
23 had been phoning in, if that was being, you know,  
24 communicated into all of this and those patients  
25 actually being reviewed. So it was an observation 12:00  
26 because, you know, as you can see there, it's as much  
27 as half, and at times, you know, almost a third of what  
28 some of the others were seeing, and it seemed to me he  
29 was an outlier in relation to that and just, I suppose

1 it raised concerns to me about concerns about patients  
2 essentially.

3 79 Q. I'm conscious that you put this information, or the  
4 conclusions you formed from this information into your  
5 statement in 2022. Was it an issue that came to your 12:01  
6 attention during the time that he was employed within  
7 the Trust?

8 A. Would you mind scrolling, because I would have first  
9 known about this whenever Martina sent me the email?  
10 So the 26th June. 12:01

11 80 Q. So, yeah, she's writing to you in 2022.

12 A. Yes, yep.

13 81 Q. And we can go back to your statement where this issue  
14 arises. It's paragraph 48A at WIT-45070, and it's an  
15 answer to question 48 which in terms: 12:02

16  
17 "What were the concerns raised with you? Who raised  
18 them? And what, if any, actions did you or others  
19 take?"

20 12:02  
21 Et cetera. And if we scroll down the answer comes -  
22 there's various aspects to the answer, but from halfway  
23 down the page you're dealing with the hot clinics. On  
24 your arrival you're aware that this hot clinic option  
25 was available to consultants, and you then say in the 12:02  
26 last paragraph - I think I used the word "extensively"  
27 earlier, but it is "intensively":

28  
29 "The opportunity to use the hot clinics was not used as

1 intensively by Mr. O'Brien as they were by other  
2 consultants."

3  
4 So my question to you is: was this a real-time concern  
5 for you, or was it only a concern or an issue drawn to 12:03  
6 your attention at the time of filing your statement?

7 A. I think the first I would have been aware of that so  
8 explicitly was when Martina sent me that email in 2022.

9 82 Q. So it wasn't something which was the subject of query  
10 or investigation by you during the course Mr. O'Brien's 12:03  
11 employment?

12 A. No. No.

13 83 Q. Martina Corrigan, for example, in pointing the  
14 information out to you, would appear to have been aware  
15 that this was an indicator of Mr. O'Brien not using 12:03  
16 opportunities that were available to him to deal with  
17 patients which might have caused concern?

18 A. I think this came about in the context of - Mr. O'Brien  
19 raised concerns constantly about the busyness of the  
20 urologist of the week experience and, you know, on the 12:04  
21 back of the history of all of that where, you know  
22 there were delays in getting triage finalised, because  
23 as I understand it, and I am not a urologist so forgive  
24 me if I don't get this precisely, but as I understand  
25 it, when the urologists take on urologist of the week 12:04  
26 they take all - they don't do outpatient or surgery  
27 unless it's emergency surgery, and they basically take  
28 on the referrals, they see any patients that they're  
29 concerned about in relation to hot clinics and they do

1 the triage. So they'll take the ED referrals, they'll  
2 take any urgent GP referrals, they'll do hot clinics in  
3 relation to all of those and any other patients that  
4 they're worried about, and they'll also do the triage  
5 then in relation to the work that's coming in, and I 12:05  
6 think they also have an in-patient ward presence. So I  
7 mean it's a busy intense week. And Mr. O'Brien, as I  
8 understand it, constantly stated that he couldn't get  
9 to completing triage as quickly as the others could  
10 because he was so busy during the urology of the week 12:05  
11 discussions, and I think then eventually when we  
12 drilled down into that to try and understand what that  
13 was about I was surprised that his activity during  
14 these hot clinics seemed to be so different from  
15 everyone else's, given that the volume of activity that 12:05  
16 would have been coming from other sources such as GPs,  
17 ED, you know, ward referrals, whatever, wouldn't have  
18 been that much different for the rest, but yet there  
19 was still delays in terms of him getting this paperwork  
20 done. 12:05

21 84 Q. And what conclusion do you, did you form in light of  
22 that analysis or that process of thinking, in terms of  
23 Mr. O'Brien's activity?

24 A. Well, I think it was an observation on my part, right,  
25 and I think that it struck me that, you know, 12:06  
26 throughout all of the concerns that Mr. O'Brien raised,  
27 you know whether directly with managers or when he made  
28 reference to it in his appraisal, it was in relation to  
29 how busy he was and about the demands of all the

1 waiting times, but actually whenever we have drilled  
2 down into this and looked at it, there isn't an  
3 evidence base to suggest that Mr. O'Brien was a lot  
4 busier than his colleagues.

5 85 Q. Thank you. Could we turn to issues arising out of job 12:06  
6 planning and whether Mr. O'Brien was provided with  
7 assistance by way of extra administration time, for  
8 example, to enable him to cope with what he has  
9 described obviously as a very busy clinical practice.  
10 If we go to your statement WIT-45086, and at paragraph 12:07  
11 53.3, just at the top of the page:

12  
13 "It was reported to me in October 2019 that the first  
14 sign-off of Mr. O'Brien's job plan was not completed in  
15 a timely fashion, as Mr. O'Brien would not agree what 12:07  
16 was being offered, despite the fact that he was given  
17 the administration time on a Tuesday morning that he  
18 requested."

19  
20 I just want to put that piece to you and let me join it 12:08  
21 with another piece in your statement further on.  
22 WIT-45158 at 62.4, and you say here:

23  
24 "I'm led to believe that in the course of the  
25 development of the 2017 Action Plan, Mr. O'Brien was 12:08  
26 given a Tuesday morning, four hours, as extra SPA  
27 [Supporting Programmed Activity], to allow him to  
28 complete his dictation from the Ennisillen Clinic on a  
29 Monday."



1  
2 So taking those two pieces of evidence together, it  
3 seems to be your impression that through the job  
4 planning process, more was being offered to him by way  
5 of hours to complete his administration, and you say 12:09  
6 here's a concrete example of four hours extra SPA being  
7 granted to him in a particular context. Can you recall  
8 who reported these matters to you?

9 A. Oh, Martina Corrigan and I had this conversation  
10 because I think she had, you know, reviewed all of that 12:09  
11 along with - I'm not sure whether it was Mr. Haynes at  
12 that point in time but, no, it was Martina I had the  
13 conversation with, because she drew to my attention  
14 that in order to support this Enniskillen Clinic this  
15 extra time had been given. 12:09

16 86 Q. Yes. And it's that concept of extra or additionality  
17 that I want to briefly explore with you. So it appears  
18 to be your understanding that take, for example, the  
19 Tuesday following the Enniskillen Clinic, that he was  
20 being given something additional to that which was 12:10  
21 otherwise provided for in his job plan, is that your  
22 understanding?

23 A. I am not - well I'm not sure whether it was that it was  
24 in place of something else or whether it was  
25 additional, but it certainly was ascribed time that was 12:10  
26 purely to deal with administration and it was out of  
27 keeping with what the rest were receiving. So,  
28 normally when any of us would have done clinical work  
29 you would expect that you would see your patients and

1 get the dictation done by the end of the clinic or, you  
2 know, you would have other administrative time in the  
3 week that would have been, you know, recognised for  
4 supporting clinical activity to get that done. My  
5 sense with this was this was four hours in his week 12:11  
6 that was carved out to get this completed, and I think  
7 I was left with the impression it was above what he was  
8 getting previously, but it might well be that it  
9 displaced something that he was doing previously, and  
10 I'm sorry, I can't remember the detail of it. 12:11

11 87 Q. Yes. I think Mr. O'Brien would say that rather than it  
12 being extra or additional SPA, that in fact the hours  
13 made available for this administrative work was in fact  
14 designated as direct clinical care. In other words, as  
15 I understand it, not additional, but regarded as part 12:11  
16 and parcel of what was required for the clinical work?

17 A. So I think it's probably a moot point, although I do  
18 appreciate it's important, whether it's described as  
19 SPA or DCC, but certainly the important part of it was  
20 that it was time identified in his working week to get 12:12  
21 his administration done.

22 88 Q. So is it your understanding, just to be clear, because  
23 it may be of some significance, that there was -  
24 however it is described, that there was a dispensation  
25 or a flexibility arrived at to enable Mr. O'Brien to 12:12  
26 progress the dictation work in this instance, that  
27 wasn't otherwise available to someone else or hadn't  
28 historically been available to him?

29 A. Yes.

- 1 89 Q. Just going back to the paragraph we left at WIT-45085,  
 2 at paragraph 53.3 - sorry, I'm just scrolling down.  
 3 There we are. So in terms of what was reported to you  
 4 October 2019, in addition to what I've just read out,  
 5 it was described for you that he was spending long 12:13  
 6 hours on the ward at times, that he was neither  
 7 required nor expected to be there, and then was asking  
 8 for additional payment in recognition for this. Again,  
 9 in terms of the request for additional payment, who was  
 10 telling you that? 12:14
- 11 A. I think there had been - and, again, I don't have the  
 12 dates in front of me - but I think in a previous  
 13 iteration of a job plan he had raised this as a concern  
 14 and he had been job planned to try and offset some of  
 15 this, but there - what was reported to me, I think 12:14  
 16 again through the operational managers, was that on  
 17 occasion he had said to them that he was doing this  
 18 extra work and that he felt that that should be built  
 19 in to his job plan for additional payment, even though  
 20 the Trust wasn't requiring him do it. 12:14
- 21 90 Q. I think there's certainly plenty of evidence before the  
 22 Inquiry of Mr. O'Brien working into the night, late  
 23 into the night perhaps.
- 24 A. Mm-hmm.
- 25 91 Q. Being seen on the wards. Never leaving the hospital is 12:15  
 26 perhaps exaggerated a little bit. But have you seen  
 27 actual documentary evidence, for example, of requests  
 28 for payment in those circumstances, or are you relying  
 29 on what you were told?

A. I don't think I have seen - I could be wrong, but I don't think I have seen a written request, but I can certainly go back and check on that, but I think it was communicated to me verbally.

92 Q. Thank you. Just staying with this paragraph, let me see if I can spot it. You seem to suggest, and I'm not quite sure if I can see the precise language, but was it your impression that there was a pattern of Mr. O'Brien agreeing to sign off job plans but then not following through? Yes, there it is:

"By the time I arrived in 2018..."

- it's about 6 lines down:

"...there was a pattern of him agreeing to sign off job plans and then not following through."

who created that impression for you?

A. well, again, I think certainly that was coming from the operational managers in that, you know, there was - I don't know how you would best describe it, but this sense that "well, you know, we've been trying that for a long time", you know, and again the example of the Tuesday morning was used, you know, "has promised to do it but actually then, you know, we never seem to get it tied down", and there just seemed to be - I wouldn't say it was hopeless or despairing, but there seemed to be a sense of inevitability around it I think and, you

1 know, what struck me, and I've put it into the bottom  
 2 of that, is then around the process for escalation. I  
 3 felt because it wasn't clearly delineated in the  
 4 Clinical Director and Associate Medical job  
 5 descriptions at those times, then it wasn't escalated. 12:17  
 6 Because in ordinary circumstances, if our governance  
 7 processes had been tight, you know, once there's a  
 8 failure for that to happen, then that should be  
 9 escalated up through the system. So that's now in  
 10 place, but it wasn't in place at that point in time. 12:17  
 11 So that shouldn't have allowed - as a system, you know,  
 12 we should have responded to that I think medically a  
 13 bit more strongly than we did in the past.

14 93 Q. what more generally is the impact for the organisation  
 15 of allowing delay and, as you suggest, some 12:18  
 16 prevarication and excessive debate around the content  
 17 of a job plan?

18 A. well I think that, you know, the importance of the job  
 19 plan is that it clearly delineates, it mostly focuses  
 20 on activity rather than quality of care, right. So it 12:18  
 21 should be about the activity that is expected from a  
 22 doctor at any given time, the hours that are worked,  
 23 the on-call, the responsibilities, all of that. And I  
 24 think, you know, it was suggested to me that, you know,  
 25 he was working to one interpretation of what was 12:18  
 26 already on paper and other people were finding it  
 27 difficult to get that contained in terms of having a  
 28 very clear expectation of roles and responsibilities.  
 29

1           So it should be - the job planning process is a  
2           partnership, you know, and as a consultant what you  
3           want to do is make sure that you're very clear about  
4           what your roles and responsibilities are, because from  
5           a medicolegal point of view that's important, from a 12:19  
6           clinical responsibility point of view it's really  
7           important, and the system and you should work in tandem  
8           to do that. But there just seemed to be an inertia  
9           around this in that it was suggested that he would say  
10          yes, then it wasn't followed through on. He would say 12:19  
11          yes again, and it wasn't followed through, and all of  
12          that just lingered on and on until we got to an end  
13          point with it.

14       94   Q.   Mmm. Yes. Of course, and maybe it's unfair to deal  
15               specifically with the substance of Mr. O'Brien's 12:19  
16               disputes, but any doctor can take the view that "I'm  
17               not being - my activity is not being fairly reflected  
18               in the job plan", whereas I think what you are perhaps  
19               suggesting is that in Mr. O'Brien's case he was taking  
20               an unreasonable or at least an unconventional view of 12:20  
21               the responsibilities that he held and which he expected  
22               to be reflected in the job plan?

23       A.   The job plan is a joint venture, it's between the Trust  
24               and the consultant to agree. So the Trust should come  
25               with the expectation of the work that is to be done, 12:20  
26               and then the consultant, you know, will negotiate  
27               within that in terms of what they feel is reasonable  
28               and fair and how much time they need for various things  
29               and, you know, that will get described then usually in

1 allocations of four hours in terms of roles and  
 2 responsibilities. So both parties have a  
 3 responsibility in all of that. And, again, you know,  
 4 where you have - and this is the vast majority of  
 5 doctors, you know, where a clinician is very engaged 12:21  
 6 with their clinical work, is very clear about what  
 7 their roles and responsibilities are, realises that,  
 8 you know, this is a really important contractual area  
 9 that needs to be tied down to enable them to do their  
 10 job safely, so they know what the Trust expectation is 12:21  
 11 of them, you know, that's something that normally I  
 12 would see consultants/doctors stepping forward to say,  
 13 you know, "I need to get this done."

14  
 15 From the Trust's point of view, and from Mr. O'Brien's 12:21  
 16 point of view, then in a very practical way it can  
 17 affect the amount that you're paid, because you can be  
 18 over or underpaid, you know, depending on what you're  
 19 contractually required to do, and of course then that  
 20 can create a whole tale in terms of, you know, catching 12:21  
 21 up with that, which, you know, can add burden and  
 22 stress to the individual and to the system.

23  
 24 Also then when it comes to understanding roles and  
 25 responsibilities in particular in relation to patient 12:22  
 26 care, that it is really fundamental in terms of  
 27 understanding what the consultant's activity should be  
 28 based around.

29 95 Q. Yes. Later we'll go on to look at job plan, appraisal

1 and re-validation, and the steps which the Trust has  
 2 taken in more recent times to try and make improvements  
 3 in that area.

4  
 5 Just one final point before leaving this paragraph. 12:22  
 6 You say that eventually the 2019 job planning process  
 7 with Mr. O'Brien moved on into 2020, and he only signed  
 8 off on the job plan before he retired to allow his  
 9 pension to be finalised. Again, could you just account  
 10 for that impression? Is that something that was said 12:22  
 11 explicitly, "I'm only signing off on this for these  
 12 reasons", or is it something you infer or somebody else  
 13 has inferred from the circumstances?

14 A. It was never explicitly said, but it struck me at the  
 15 time that the job plans were signed off at that point 12:23  
 16 in time so that the - so it's simply a statement of  
 17 fact, they were signed off at that point in time and  
 18 that coincided with his pension being processed.

19 96 Q. Let me move on to what you describe as your first  
 20 awareness of issues around Mr. O'Brien. It's contained 12:23  
 21 in your statement, if we move a few pages on to  
 22 WIT-45091. And, just before - sorry, just after you  
 23 commenced in the Trust you attended a meeting along  
 24 with Dr. Khan, who was responsible officer at that  
 25 time. You attended a meeting with the General Medical 12:24  
 26 Council's Employment Liaison Adviser, Ms. Joanne  
 27 Donnelly, isn't that right?

28 A. That's correct.

29 97 Q. And I just want to ask you about an aspect of that.



1 You have written into this section of your statement -  
 2 this is paragraph 55.4, as we can see. Mr. Gibson also  
 3 attended the meeting. He was Deputy Director within  
 4 the Medical Director's office at that time?

5 A. Yes. So he is - he was and he is Assistant Director. 12:24

6 98 Q. Assistant Director?

7 A. Yeah. For Medical workforce.

8 99 Q. Yes. Yes. And you record within your statement some  
 9 of the background that Joanne Donnelly was told through  
 10 Mr. Gibson, and it's recorded - just where you see 12:25  
 11 January 2019, towards the bottom of the page:  
 12

13 "Mr. Gibson reported that the doctor still had local  
 14 restrictions on his practice, the 2017 Action Plan, and  
 15 these were being kept under review." 12:25  
 16

17 The suggestion that Mr. O'Brien was the subject of  
 18 local restrictions on his practice, what were those  
 19 local restrictions?

20 A. So I think "restrictions" is probably not the right 12:25  
 21 word now that I reflect on this. I think it was local  
 22 supervisions on his practice, because he was  
 23 undertaking all of his clinical duties at that point in  
 24 time and he should have been undertaking all of his  
 25 administrative duties, but in a much more controlled 12:26  
 26 way in that there was oversight of triage, private  
 27 patients, you know, the areas that we're familiar with  
 28 out of that action plan. So "restrictions" is not the  
 29 right word, I think it should have been local

1 supervisions on his practice.

2 100 Q. Yes.

3 A. Or enhanced supervisions on his practice.

4 101 Q. If we go to TRU-264716. This is an email from 12:26

5 Ms. Donnelly on 9th January 2019. She had been

6 promised at the meeting with yourselves, the meeting

7 took place in I think it was 4th December 2018, that

8 she would receive the outworking of the MHPS process,

9 which had been earlier promised to her and hadn't

10 materialised. So she receives the report and makes 12:27

11 some observations on it, and she says, middle

12 paragraph:

13

14 "On the basis of the information you have provided

15 these concerns appear to me to meet the threshold for 12:27

16 referral to the GMC."

17

18 And then at the end of that section she records:

19

20 "I acknowledge that the doctor's practise is currently 12:27

21 restricted in the interests of patient safety and that

22 the doctor is complying with a Local Action Plan."

23

24 So it would appear on the basis of that, that the GMC

25 carried away from this meeting a belief that there were 12:28

26 local restrictions in place in the interests of patient

27 safety, albeit that the doctor separately was complying

28 with the action plan. When you look at these various

29 strands now, would you accept that the GMC should have

1           been more accurately informed about the situation?

2           A.    I don't know what -- until I joined the Trust, and I  
3                had never worked in the Trust before, in December 2018,  
4                being present at the GMC meeting on 4th December and  
5                then became aware of this doctor and then started to           12:29  
6                review his notes throughout January/February, I wasn't  
7                cognisant at all of any of the discussions that had  
8                gone on between the Trust and the GMC at that date.  
9                In, again, reviewing that, I think "restricted" is not  
10              the right word, I think it should have been                   12:29  
11              communicated that this was a supervision of some  
12              description, because as I understand it, you know,  
13              supervision and restriction are two different aspects  
14              in relation to medical practice. So the word is wrong,  
15              and the GMC - and I'm not sure whether they were           12:29  
16              mirroring what they heard from the Trust at a point in  
17              time, or whether that was their belief, but I think  
18              it's the wrong word on there.

19 102   Q.    Certainly I don't think I need to take you to the other  
20               documents, but certainly it is recorded that when           12:29  
21               Mr. Gibson spoke to the meeting it's Ms. Donnelly's  
22               record that he used the term "restrictions"?

23           A.    Okay.

24 103   Q.    Whether he did or not we'll have to go back in time and  
25               be there, but that's certainly what she recorded, and           12:30  
26               it finds it's way into the note. Nobody sees fit to go  
27               back to her, and I'm conscious that you're just into  
28               the job and trying to learn on your feet, but nobody  
29               goes back to her and says "Actually, restrictions isn't

1 exactly what we're doing, it's more in the line of  
 2 supervision", which is perhaps a significant  
 3 shortcoming in terms the Trust's relationship with the  
 4 GMC, particularly when she views the risks associated  
 5 with the doctor so significantly, so significant that 12:30  
 6 it, in her view, requires or suggests the need for  
 7 referral?

8 A. Well I think she came to that decision after she and I  
 9 obviously had had a conversation and I raised concerns  
 10 about what I was starting to read in the midst of all 12:31  
 11 of this.

12 104 Q. Sorry to cut across you, she forms that view on the  
 13 basis of reading the MHPS report, as we can see from  
 14 this email from her.

15 A. Mm-hmm. 12:31

16 105 Q. You're referral eventually comes through in April of  
 17 2019, isn't that right?

18 A. That's right, yeah.

19 106 Q. Could I move from there, please, to your witness  
 20 statement at WIT-45143, and at paragraph 58.10, if we 12:31  
 21 just scroll down, you're reflecting on the action plan  
 22 and Mr. O'Brien's deviation from it in 2019. You  
 23 record that he was offered support in clearing the  
 24 backlog, and it was understood that this had come about  
 25 at a time he had been supporting his family due to 12:32  
 26 illness in the family. Could you help us in terms of  
 27 the help that was offered, can you particularise who  
 28 was offering him and what he was offered in terms of  
 29 clearing the backlog?

1 A. I can't remember the - so this is more than four years  
2 ago, I can't remember specifically what was stated at  
3 the time.

4 107 Q. Yes.

5 A. But I think in relation to how I became aware of the 12:33  
6 information, that came through Martina and Melanie  
7 McClements at that point in time. And as I, and as I  
8 say, I cannot remember the specifics of it, but  
9 certainly the sense I was left with was they recognised  
10 with him that, you know, he had had this [REDACTED] event 12:33  
11 that had interrupted all of those, and they spoke to  
12 him about what would be needed to help him get this  
13 cleared, but I couldn't tell you chapter and verse  
14 exactly what that entailed.

15 108 Q. Certainly there's a record of Mr. Haynes writing to you 12:33  
16 at that time and saying, "Listen" - he doesn't touch  
17 upon the [REDACTED], but he says, "Listen, we  
18 tend to be somewhat flexible around triage, so if it's  
19 a particularly busy week we allow perhaps another  
20 couple of days for the triage to be completed", so 12:34  
21 don't hold the clinician to, you know, Friday evening  
22 or whatever the cut-off date is. But the question I  
23 suppose is, you're unable to recall any specific offers  
24 of assistance to Mr. O'Brien around his triage at that  
25 time? 12:34

26 A. Yes, I don't know - I can't remember specifically what  
27 those would have been. But in relation to Mr. Haynes's  
28 email, again that I think was not specific to this  
29 episode in September. I think he was drawing my

1 attention to that generally to say, you know, "We're  
 2 not completely hard and fast in relation to this being  
 3 on this date, because we appreciate that all of this  
 4 clinical activity can impact", and I think was making  
 5 me aware that they give an extra 48 hours in terms of  
 6 getting this work done. 12:34

7 109 Q. Could I bring you to the issue of appraisals? We've  
 8 touched on it briefly earlier, and your sense that  
 9 there was often delay in association with the  
 10 completion of that exercise in the case of Mr. O'Brien. 12:35

11 A. Mm-hmm.

12 110 Q. If we go to your witness statement WIT - let me just -  
 13 no, it's a few pages back. WIT-45095, and at 55.9, you  
 14 record that:

15  
 16 "There was no clear evidence in the appraisals that his  
 17 appraiser had been made aware of any concerns."

18  
 19 That's an issue I'll come back to later when we look at  
 20 appraisal. This is the point I want to focus on. You 12:35  
 21 say?

22  
 23 "In addition to this, his 2017 appraisal had not been  
 24 completed."

25  
 26 And this is by 11th March 2019, as appears in the  
 27 question. So by that date his 2017 appraisal had not  
 28 been completed nor had his 2018 appraisal, for which a  
 29 360 degree feedback was required, and this is 12:36

1 significant because his revalidation date was due for  
2 renewal on 4th April 2019. I just want to seek your  
3 observations on whether or not that is factually  
4 accurate.

5  
6 If we look at TRU-294256, and Zoe Parks is writing to  
7 Therese McKernan, post Mr. O'Brien's retirement, and  
8 presumably information is being gathered perhaps for  
9 Inquiry purposes or whatever. And she says:

10  
11 "I have spoken to our appraisal..."

12  
13 - this is the bottom of the page:

14  
15 "...our appraisal revalidation lead who has confirmed  
16 for me that Dr. O'Brien completed the following  
17 appraisals..."

18  
19 And it seems that in terms of the 2017 appraisal, which  
20 you were suggesting hadn't been completed by the  
21 revalidation due date in 2019, it had been completed in  
22 fact, according to this, in October 2018. I'm  
23 conscious that you're maybe seeing this for the first  
24 time, but that clearly appears to jar with what you're  
25 saying in your statement?

26 A. would it be possible, would it be possible for you to  
27 pull the appraisals up to have a look, or do you want  
28 me to have a look at it and come back because...

29 111 Q. we'll come back to that.

1 A. Yeah. Okay. Yeah.

2 112 Q. So on the face of it this jars with what you've said in  
3 your statement, but you'd like to check the appraisals  
4 themselves to see when they were finally signed off?

5 A. Yes. Yes. 12:38

6 113 Q. Very well. And you appear to be correct about the 2018  
7 appraisal. It didn't, according to this, come in until  
8 October 2019?

9 A. Yes. Now, again I'm only thinking out loud, but if I -  
10 there is something in my mind that the 2017 appraisal 12:39  
11 wasn't complete in that actually all the information  
12 wasn't there, rather than a signatory date, which is  
13 what that tends to be, but I will go and check.

14 CHAIR: I think in fact, in fairness to you doctor, you  
15 did say in that last paragraph that was read out, that 12:39  
16 the 360 feedback had not been completed.

17 A. Yes. Yeah. Yeah, on the 2018. Yeah, I think that's  
18 right. I'm not sure about the 2017.

19 114 Q. MR. WOLFE: I'm not quite sure. If we could just go  
20 back, because I think there is - there's an issue just 12:39  
21 to explore with the 360. If we go back to your  
22 statement WIT-45095. So what you're saying about the  
23 2018 appraisal, you're saying - you're saying his 2017  
24 appraisal had not been completed nor had his 2018  
25 appraisal. So the document that I just brought you to 12:40  
26 would seem to suggest that's right, the 2018 appraisal  
27 wasn't complete until late in 2019.

28

29 It would appear, if we can bring up on the screen



1 AOB-07937? This is a note from Dr. Scullion. He's now  
2 Assistant Medical Director, is that correct?  
3 A. He's Deputy Medical Director, yes.  
4 115 Q. Deputy Medical Director, yes?  
5 A. Yes. Yes. 12:41  
6 116 Q. So he is dealing with appraisal issues and he's writing  
7 to Mr. O'Brien just before this - actually on the date,  
8 I think, of the revalidation becomes due, and he is  
9 speaking to Mr. O'Brien about colleague feedback. Is  
10 this the 360 degree process or is it something that 12:41  
11 sits beside that?  
12 A. It's part of it. So in addition to colleague feedback  
13 there should also be patient feedback.  
14 117 Q. I see. So it appears in any event that the colleague  
15 feedback has been completed by that date. Of interest 12:41  
16 perhaps in this email is Dr. Scullion's observations on  
17 a respondent colleague who has scored Mr. O'Brien  
18 negatively against patient confidentiality,  
19 trustworthiness and ill-health, and what Dr. Scullion  
20 says is: 12:42  
21  
22 "Since all your comments have been supportive and  
23 commendable, I think this is a case of  
24 misinterpretation of the question. I think it is  
25 reasonable to ignore this outlier feedback. Otherwise 12:42  
26 an excellent colleague feedback survey."  
27  
28 Just on that point, do you think that's appropriate to  
29 take the view that the respondent to the survey didn't

1 know what they were answering and decide ultimately to  
2 ignore the negative feedback?

3 A. The colleague feedback questionnaire as part of the 360  
4 degree appraisal is an interesting concept, because  
5 within the realms of all of this you produce a list of 12:43  
6 colleagues that are then approached to give feedback.  
7 So there's - my concern about it is that there is  
8 already inherent bias because you get to chose. Right.  
9 That's the first thing.

10  
11 The second thing then is that in terms of the 12:43  
12 completely disagree statements, usually where you would  
13 expect to find that is in the patient feedback, because  
14 it's not, these are not particularly sophisticated or  
15 well constructed forms very often, but they are the 12:44  
16 standard that's used, and sometimes what you'll find is  
17 that, you know, if someone has read it really quickly  
18 they'll put one thing when they mean another thing, and  
19 you usually pick it up through the outliers and, you  
20 know, we might make comment about that. 12:44

21  
22 It will have depended - it may well be that that's what  
23 has also contaminated the colleague feedback  
24 questionnaire, and given that I mean he has said - it  
25 doesn't give any indication there as to how many 12:44  
26 colleagues fed back, or that because it's anonymised  
27 whenever it comes back to the appraiser and the  
28 appraisee, you've no idea what grades or where the  
29 colleagues were actually chosen from. So, I think

1 usually, or what would happen now I think is that there  
 2 would be some discussion about that particularly at the  
 3 revalidation meeting in terms of whether or not that  
 4 was a reasonable assumption, and the way revalidation  
 5 meetings work now is that Divisional Medical Directors 12:45  
 6 are all together, along with the Medical Directors and  
 7 the support from the Medical Director's office and HR,  
 8 to review all of that and understand actually in the  
 9 context of not just a standalone questionnaire but in  
 10 the context of all the information available, is that 12:45  
 11 reasonable or should there be further exploration of  
 12 that to understand.

13 118 Q. The earlier part of your answer, if I may say so, was  
 14 to I suppose criticise the weaknesses or point to the  
 15 weaknesses of the process, but I suppose the point I'm 12:45  
 16 making to you is that, this kind of response may point  
 17 to something that needs to be investigated, in other  
 18 words you shouldn't just cast it to one side as  
 19 Dr. Scullion appears to have done, without further  
 20 analysis. His analysis seems to be limited to "well, 12:45  
 21 your other colleagues say this, this person says that,  
 22 therefore they must be wrong"?

23 A. And in fairness to Dr. Scullion, this was on the back  
 24 of having being his appraiser and being presented with  
 25 all of the information that didn't include anything to 12:46  
 26 do with Maintaining High Professional Standards. So  
 27 already, you know, he had been given a set of  
 28 information in the context of this doctor that  
 29 suggested that there weren't any concerns. So, you

1 know, that - if you were thinking about cognitive bias,  
2 you know, you can see where all of that would come  
3 together easily to assume actually this is just an  
4 average score rather than actually something that  
5 should be a smoke signal.

12:46

6 119 Q. Yes. And I'm sure when we go on to look at it you'll  
7 be explaining to us that the material, such as SAIs,  
8 MHPS, that kind of material, will now go into the  
9 process?

10 A. Yes.

12:46

11 120 Q. And what Dr. Scullion had to put up with, if you like,  
12 or had to address, is unrecognisable by today's  
13 standards, is that fair?

14 A. I think that's fair. And I think very helpfully I  
15 think again when you look at the recommendations coming  
16 out of the Neurology Inquiry, I think it underpins the  
17 position that we've taken in relation to this in terms  
18 of providing very comprehensive information whenever we  
19 come to describe a doctor's practice.

12:47

20 121 Q. Just one further issue. If we go to TRU-266 - sorry,  
21 yes, TRU-266586. And a GMC officer is writing to you  
22 on 12th August 2020, and if we just go - he's seeking  
23 from you further information in respect of

12:47

24 Mr. O'Brien's employment and, indeed, some issues  
25 raised with the GMC, it appears by Mr. O'Brien in his  
26 dealings with them, and could I ask you just to go down  
27 three pages to 589 in the sequence. Thank you. He,  
28 in the left-hand margin is saying, he's dealing with a  
29 meeting which was lined up to take place in December

12:48

1 2018 between management and the consultants in the  
 2 Urology Department, and he's asking that you provide an  
 3 account of the circumstances of the cancellation of  
 4 both the September meeting and the December meeting.  
 5 And as regards the December meeting, it's recorded - I 12:50  
 6 think this is your answer, or The Trust's answer:

7  
 8 "The meeting schedule for December 2018 did not  
 9 progress as three of the six consultant urology staff  
 10 were unable to attend." 12:50

11  
 12 Just scroll down. Yes. You sign off on that letter.  
 13 This is an event, this December meeting, that didn't  
 14 ultimately progress with management attendance. This  
 15 was an event where the five substantive urology 12:50  
 16 consultants were available and did attend, according to  
 17 the evidence before the Inquiry, whereas you've said  
 18 the meeting scheduled for December did not progress  
 19 because three out of the six consultant urology staff  
 20 were unable to attend. Can you help us in terms of how 12:51  
 21 you formed the view that three of them were unable to  
 22 attend?

23 A. Would you mind scrolling back to the top, please?

24 122 Q. Sure. Of this?

25 A. Yes. 12:51

26 123 Q. The top of the letter?

27 A. The top of the letter, yes.

28 124 Q. Yes. So it starts at 586. So you're writing to Chris  
 29 Brammall.

1 A. Yes.

2 125 Q. And you're answering an email of the 30th July, and  
3 just in terms of how the letter is constructed. You're  
4 putting in the left-hand margin each of the queries  
5 raised by Mr. Brammall and then providing your answer 12:52  
6 on behalf of the Trust in the right-hand column?

7 A. Yeah. I think to set - the reason I'm asking just to  
8 see the date again was to set this in context. So I  
9 would presume I responded to this in early August 2020,  
10 which would have been nearly two years after that 12:52  
11 event, which I wouldn't have been aware of I think  
12 until I was asked for information from Chris Brammall  
13 to respond, because I was only just into the Trust and  
14 the information that I would have been relying on would  
15 have come from other people. And, again, I am not sure 12:52  
16 where that would have come from, but it presumably came  
17 from my correspondences with people within the urology  
18 service to ascertain whether or not the meeting  
19 happened and what it was supposed to be, who was  
20 supposed to be there. But I think until Chris raised 12:53  
21 this with me, I wouldn't even have been aware of the  
22 existence of that meeting.

23 126 Q. Yes. And just to be clear, the gathering of the  
24 consultants was the subject of recording on  
25 Mr. O'Brien's part. 12:53

26 A. So Mr. O'Brien recorded that meeting?

27 127 Q. Yes. And we can - just so that the Inquiry can see it,  
28 if we go to AOB-56478, and that's the title page, if  
29 you like, it's suggesting that Mr. O'Brien was in

1 attendance with Mr. Glackin, Young, Haynes, O'Donoghue,  
2 and with Mrs. Corrigan available, and the date is  
3 3rd December 2018, and if one works through the  
4 transcript itself, it certainly suggests that each of  
5 the people named on the title page were in attendance. 12:54  
6 The answer you gave on behalf of the Trust back to the  
7 GMC was three out of the six urology practitioners  
8 wasn't available. I think Mr. O'Brien's evidence would  
9 be that the sixth person, that is Mr. Tyson, was a  
10 locum at that point and hadn't been invited to the 12:54  
11 meeting, but certainly the substantives were available,  
12 and that was not accurately communicated to the GMC.  
13 And if this transcript, or this recording is right,  
14 that would appear to be the case. I'm conscious that  
15 you weren't employed in the Trust until around about 12:55  
16 that date and so, in real-time you wouldn't have known  
17 perhaps about the meeting, but who would have been the  
18 person giving you the information so that you could go  
19 back to the GMC some two years later?

20 A. It would be, it would be somebody within Urology. So I 12:55  
21 will track back and find out. But, again, I can't  
22 remember the specifics of it.

23 128 Q. Yes.

24 A. And can I ask, is there a sense that it makes material  
25 difference whether there were five consultants there or 12:55  
26 three?

27 129 Q. Well, it's - the suggestion is that that is the reason  
28 why the meeting didn't take place.

29 A. Right. Okay.

1 130 Q. That's what the Trust is communicating to the GMC as  
2 being the reason why it didn't take place?

3 A. Okay.

4 131 Q. And if that isn't the reason why it didn't take place,  
5 then the Trust - the Inquiry might think the Trust  
6 should explain what was the real reason for it not  
7 taking place?

12:56

8 A. Yeah. And I think what I also need to check is are we  
9 talking about the same meeting?

10 132 Q. Well...

12:56

11 A. Yeah.

12 133 Q. You can come back with whatever explanation you think  
13 is appropriate?

14 A. Yeah. Okay. Thank you.

15 134 Q. It's 1:00 o'clock, Chair. I think...

12:56

16 CHAIR: I think it's certainly lunchtime. We'll come  
17 back at 2:00 o'clock, ladies and gentlemen.

18

19 LUNCH ADJOURNMENT

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THE HEARING ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon everyone.

MR. WOLFE: Good afternoon, Dr. O'Kane. So we now move into the, if you like, the second area or the second section of your evidence and, as I indicated this morning, this allows the Inquiry to, in essence, have a conversation with you through my questions about the opportunities that the Trust has engaged in to improve, reform and develop in light of the shortcomings in governance and related issues that have been, I suppose, unveiled or discovered as a result of primarily the events of the summer of 2020 and what followed. It's also an opportunity for you to inform the Inquiry of any residual concerns, disappointments, challenges, that the Trust hasn't been able to address to date.

I think it's useful before looking into, if you like, the reform or improvement work, to take a moment for you to explain to the Inquiry what, on reflection, you would define or diagnose as being the problems that the Trust has had to address.

On the last occasion when you were with us you, I suppose, referred to almost two stages of insight. When you came into the role of Medical Director you, and you might comment on this, you very quickly realised that clinical and social care governance was

1           weak and you commenced a review through Mrs. Champion,  
2           isn't that correct?

3           A.    That's correct, yes.

4   135   Q.    And that was in large part looking at the governance  
5           structures... 14:04

6           A.    Yes.

7   136   Q.    Within the Trust, and she provided a series of  
8           recommendations, some of which were grappled with and  
9           developed immediately and some were put on the  
10          backburner for reasons that the Inquiry is familiar 14:04  
11          with.   Maybe we'll come back to that in a moment.

12

13          The second stage of knowledge for you, as you explained  
14          on the last occasion, arose out of the events of June  
15          2020, and particularly in relation to Mr. O'Brien and 14:04  
16          what that revealed.   Is that a fair way to put it, that  
17          there were these, if you like, two different avenues or  
18          two different stages to an awareness that things were  
19          not all that they should be?

20          A.    I think that's a good summation, yes. 14:05

21   137   Q.    And on the issue of Mr. O'Brien and all that came with  
22          that, I think you were asked to reflect on the last  
23          occasion on the weaknesses within the Trust which  
24          caused or contributed to a situation where shortcomings  
25          in his practice, which from the Trust's perspective 14:05  
26          placed patients at risk, you were asked to reflect on  
27          what caused or contributed to that, and I suppose the  
28          headline from your answer was that the Trust and those  
29          who were charged with responsibilities in the

1 governance area were unable to join the dots, and they  
 2 were unable to join the dots and therefore unable to  
 3 see what was, I suppose, hidden in plain sight, and  
 4 that led to a situation where you and others, perhaps  
 5 not deliberately as you suggested, were given false  
 6 assurance. Is that again a fair reflection of how you  
 7 see it?

14:06

8 A. Yes. Yep.

9 138 Q. So, you have problems with the governance structures  
 10 identified by you quite quickly, and then a whole raft  
 11 of other areas emerging from what you saw in June 2020.  
 12 Would you like to give the, I suppose, the Inquiry a  
 13 summation of looking back at it from today's  
 14 standpoint, bearing in mind all that you've heard in a  
 15 yet uncompleted inquiry. What's your key reflections  
 16 on the state of governance within the Trust, pick any  
 17 date, 2019/2020, which you have had to go about trying  
 18 to fix, what were the key problems?

14:06

19 A. Em, so I think in terms of my reflection of the stages  
 20 of all of these, I think that it is, you know, for any  
 21 of us who have been involved in this throughout that  
 22 period of time, I think it would be fair to say that it  
 23 is a source of regret to us that we didn't know in 2019  
 24 what we learned in June 2020. Okay. And hence the  
 25 reason that, as you say, it has been a two-stage  
 26 approach.

14:07

14:08

27  
 28 So in relation to governance, or in relation to the  
 29 state of play and what I see as the fundamental

1 challenges, it probably falls within the four areas of  
2 culture, governance - and within that I mean clinical  
3 and social care governance and corporate governance -  
4 how we've used data, and then the quality and safety  
5 within the organisation. And as I've mentioned in some 14:09  
6 of the previous submissions, we have brought on board  
7 an External Reference Group to help us with the  
8 thinking in relation to all of that, and I think, you  
9 know, in terms of those four main domains, then within  
10 all of that, if we apply, you know, a model for 14:09  
11 improvement such as, you know, the Vincent model, which  
12 looks at, you know, were we safe yesterday, are we safe  
13 today, will we be safe tomorrow, are our systems and  
14 processes sensitive enough to operations so that we  
15 understand that if things are going askew that we have 14:09  
16 the governance arrangements in there to pick that up at  
17 an early stage? And also the fifth leg of all of that,  
18 which is, then how do we drive improvement based on all  
19 of that? If I use that as the framework for thinking  
20 of this, this is my easiest way into it. 14:10

21  
22 So in relation to where we were in relation to  
23 corporate governance. As you have pointed out, the  
24 June Champion review was undertaken across the summer  
25 of 2019 and, again, that was in response to my concerns 14:10  
26 about the lack of framework and structure around some  
27 of the patient safety and quality issues that we were  
28 dealing with. As you know, there were 48  
29 recommendations in that report. We have filled out on

1 the vast majority of them. The first 13 were to do  
 2 with corporate governance at a point in time and,  
 3 again, I think in fairness, Eileen, as Chair of the  
 4 Trust, has really grasped those 13 now, but there was a  
 5 period of time when that took a bit of debate for us to 14:10  
 6 try and understand, and I think, you know, fair to say  
 7 before Eileen arrived a realisation and acceptance that  
 8 actually the corporate governance across the  
 9 organisation needed to be strengthened, along with all  
 10 of the other governance aspects that were there. 14:11

11  
 12 So I think that gave me a framework then in terms of  
 13 improvement in relation to the overall corporate  
 14 governance of the organisation and has, you know, been  
 15 helpful to me in developing then the operational 14:11  
 16 governance within the Trust. So we have concentrated  
 17 on completely reforming the way we undertake corporate  
 18 governance and, again, that has taken a lot of  
 19 engagement, reflection, discussion, and we now have a  
 20 revised corporate governance structure in place that 14:11  
 21 brings patient safety and the quality of care very much  
 22 into the minds of staff within the organisation, and  
 23 feeds into the Governance Committee and sits alongside  
 24 the Risk and Assurance Committee - or, sorry, the Risk  
 25 Assurance and Audit Committee - that basically then 14:12  
 26 quality assures some of that work that comes in. And  
 27 then the other committees that are developed, the other  
 28 five committees that are alongside that then are to  
 29 support the overall approach to corporate governance.

1 And I think the reflections that I'm getting back from  
2 the people that are involved in that now, is that we  
3 certainly have a bit of refinement to do in terms of  
4 how we report data and use data, but I think we feel  
5 that we have a stronger grip on the organisation in 14:12  
6 terms of understanding how all of the information flows  
7 throughout the organisation and we make decisions and  
8 drive improvement based on patient safety and quality.

9  
10 At the operational governance level then, as part of 14:12  
11 the reaction to what went on before and a realisation  
12 that the Acute Directorate was too big to function  
13 properly, when I became Chief Executive I split the  
14 Directorate into Directorate for Surgery and Cancer  
15 Services, and a Directorate for Medicine and 14:13  
16 Unscheduled Care. And, again, those two directorates  
17 in particular are more immature than the other  
18 directorates in the Trust because we've had to develop  
19 more staff to actually support some of the functioning  
20 in there to make sure that we capture, you know, 14:13  
21 patient safety and quality issues through the  
22 governance system as robustly as possible. Right.

23  
24 So, what we have done is to try and support all of  
25 that, and this was introduced when I was Medical 14:13  
26 Director, have a weekly governance meeting. So it's a  
27 live governance feed, half eight to half nine every  
28 Thursday morning, when, under all of the headings that  
29 are to do with patient safety and quality, there's a

1 report done through to the Executive Directors in the  
2 Trust other than me. So it comes to the Director of  
3 Medicine, Nursing, Social Work, but not the Finance  
4 Director either, and all of that is run through and  
5 then that is escalated on a weekly basis to the Senior 14:14  
6 Leadership Team. We challenge the information that  
7 comes in there, and this is reported every week, and  
8 then pursue, you know, the agenda around improvement in  
9 relation to that.

10  
11 We've now been doing that long enough I think that we  
12 have built up an awareness of some of the patterns.  
13 We've certainly driven improvement in some of the areas  
14 such as how we report out on incident reports. So  
15 Datix, for example, and the IR1 reporting system. We 14:14  
16 introduced additional software in May 2022 that has  
17 really bolstered that in terms of the usefulness of it.  
18 So I think that has given the Clinical and Social Care  
19 Governance teams, along with the operational teams,  
20 more information in terms of how we triangulate data. 14:14

21  
22 So, for example, at the beginning when I went along in  
23 January 2019 to look for the supporting evidence  
24 around, you know, where is the heat in the system in  
25 relation to quality and safety incidents? It was 14:15  
26 really difficult to pick it up, because the information  
27 wasn't speaking to itself internally. We have improved  
28 on that quite a bit in that there's a number of feeds  
29 now that go into Datix, including the reporting through

1 on Serious Adverse Incidents and the management of the  
2 action points out of that. But there's still a way to  
3 go in terms of really bolstering that. And, again,  
4 there's a direct feed, you know, comes into the  
5 governance feed, you know, a Thursday morning meeting 14:15  
6 in relation to that. Alongside other areas such as,  
7 you know, reports out in relation to, as I say, Datix,  
8 Serious Adverse Incidents, any workforce pressures that  
9 are in there in terms of us being concerned about the  
10 impact of workforce shortages in certain areas, 14:15  
11 standards and guidelines come in there, so that we make  
12 sure everybody in the organisation, you know, has  
13 access to information in relation to what the latest  
14 standards and guidelines are, you know, any feed that  
15 comes from RQIA as the Regulator, any college reports 14:16  
16 that are worthy of mention that come up through the  
17 various directorates, and so it goes on and on. It's a  
18 very comprehensive report. Plus, you know, a readout  
19 on any of the delays in the system, such as we're about  
20 to introduce the Ombudsman delays in respect of 14:16  
21 complaints, but we have readouts in terms of, you know,  
22 the timeframes around responding to complaints, Serious  
23 Adverse Incidents, those things. So it is basically  
24 live and in front of us every week and it gets talked  
25 about frequently. 14:16  
26

27 Now, I think in terms of galvanising what has come into  
28 that, and now that we have got the Datix system better  
29 embedded, I think our next phase then we have been



1 approaching learning I think probably through different  
2 systems and processes, but not - we don't have an  
3 overarching approach to learning and embedding some of  
4 this in the system. So the discussions I've been  
5 having with the governance team and the Medical 14:17  
6 Director have now been around how do we bring that into  
7 the body of the organisation?

8  
9 So one of the other things that has happened over the  
10 last 18 months or so since I was appointed Chief 14:17  
11 Executive is that I have replaced a lot of the staff  
12 who have retired or left to go to other places, by a  
13 new team of Directors. So we have just finished the  
14 last replacement of an Executive Director. And in  
15 addition to that, in order to make sure that we pursue 14:17  
16 the agenda of embedding improvement in the  
17 organisation, I have appointed for the next two years  
18 in the first instance a Director of Transformation and  
19 Improvement, who will take forward the outworkings of  
20 what we've learned, again under those domains that I 14:18  
21 mentioned earlier in relation to this Public Inquiry,  
22 but also to look at what is coming out of the Neurology  
23 Public Inquiry, potentially Muckamore Abbey, you know,  
24 any other learning that's there. Plus dealing with  
25 some of the issues within the Trust in terms of how we 14:18  
26 address specific areas in terms of concerns in relation  
27 to improvements, such as overcrowding, and all of the  
28 ED issues that you would hear about. So that's now in  
29 place.

1  
2 And now that we are moving out of the phase of the  
3 External Reference Group that has supported us in terms  
4 of thinking about how we take forward on those four  
5 domains, our last meeting with the External Reference 14:18  
6 Group is this Friday. Once that's closed off then we  
7 will be moving to the position of having essentially  
8 our own Internal Reference Group, which is essentially  
9 the oversight through the Director of Transformation  
10 and Improvement to really drive and quality assure then 14:19  
11 the impact of some of the changes that we're making  
12 across the organisation. So that is kind of the grand  
13 plan, if you like, in terms of how that comes together.

14 139 Q. Yes. Okay. Well thank you for that overview. I'll  
15 pick up on some of the aspects of that in more detail 14:19  
16 as we move on.

17  
18 But what I want to get clear from the outset, before we  
19 explore some of the improvements is, can you help us  
20 from your perspective to understand how below the 14:19  
21 acceptable standard was this Trust before this  
22 improvement work commenced and, secondly, and related  
23 to that, how could you have been standing in Craigavon  
24 Hospital - well not just you personally, but I mean you  
25 as a Senior Management Team, be standing in Craigavon 14:20  
26 Hospital in the early summer of 2020 thinking  
27 everything is working well, or working reasonably, and  
28 not understand that there were these raft of issues  
29 that we see addressed through the Serious Adverse

Incident reviews? So can you help us with those two points?

A. So, I think that in terms of the level of performance of the Trust, right, this was a Trust that probably up until there were a significant number of changes of Directors, or Chief Executives and Medical Directors over a relatively short space of time, I think was seen as a high performing Trust, right, and it was recognised for that on the basis of it's activity and the way it used money, so based on those two parameters essentially. And I think that then with all of the disruption that came with the constant churn in Chief Executives and Medical Directors, I think it lost its way a bit and, again, got stabilization back I think then whenever Shane Devlin was appointed and was there for that period of time, and then, you know, obviously I came as Medical Director, continued on and, you know, there has been less churn certainly in the meantime in relation to that. And the Directors who are now appointed to the Senior Leadership Team have been in the system either as Assistant Directors or have come in as very experienced people from other places and are very familiar with health. So that has been helpful to us.

So I think to some extent, and maybe this is - I think it probably rested on its reputation of the past, and I think didn't completely recognise that it was missing a lot of the governance processes that it required in

1 order to ensure patient safety and quality.

2 140 Q. Just - I'm anxious not to intervene too much - but how  
3 does that happen? How can experienced people fail to  
4 see that standards expected of Trusts in terms of  
5 governance are not being complied with, and why does it 14:23  
6 take an event such as, or a series of events such as  
7 what was unpacked from June 2020 onwards, to trigger  
8 that realisation?

9 A. Well, I think it was relying very heavily on really  
10 good clinical practitioners and people who were there 14:23  
11 as managers who were trying their best. I think it's  
12 difficult to describe, but the biggest parameter that  
13 we would tend to go to or, you know, it's not, it's a  
14 proxy for quality of care very often, rightly or  
15 wrongly, is the mortality review. It hadn't been 14:24  
16 reviewed for a number of years when I got there. So  
17 actually the evidence wasn't in front of people. Now  
18 we've since reviewed it and there wasn't anything out  
19 of kilter with it. But I think in terms of all the  
20 nuances of that, trying to understand actually, you 14:24  
21 know, where the serious problems were, you know, and  
22 these are common to all Trusts in terms of, you things  
23 like insulin prescribing, anticoagulation, you know,  
24 acts of violence and aggression and all of that. It  
25 wasn't robustly recorded and reported anywhere in terms 14:24  
26 of understanding about patient quality and safety.

27 Right. So I think it was relying on the fact that on a  
28 day-to-day basis people did what they always did, which  
29 was they turned up to work, they did a really good job

1 for each individual patient as they saw it, but in  
 2 terms of bringing the system together and the system  
 3 learning that we need it in order to know whether or  
 4 not, you know, where we were in relation to the mean, I  
 5 think that was difficult and the evidence wasn't  
 6 automatically there. It took quite a lot of work to  
 7 understand where we were in relation to other people.

14:24

8  
 9 At a point in time to save money the clinical audit  
 10 team had been stood down. Now we have, you know, as  
 11 part of the whole governance review we have reinstated  
 12 that and, you know, through the papers you will see  
 13 some of the outworkings of that and what they've done  
 14 with that in a relatively short space of time and,  
 15 again, not all of that information was available to the  
 16 organisation in terms of where it was, you know, in  
 17 relation to its own activity, but also then in terms of  
 18 driving improvement and being able to benchmark itself  
 19 locally and nationally. So...

14:25

14:25

20 141 Q. Sorry, again.

14:25

21 A. Yes.

22 142 Q. Hopefully I don't take you off your track of thinking,  
 23 but sometimes if I wait to the end of your answer I'll  
 24 miss an important point.

25 A. Sorry.

14:25

26 143 Q. And the important point I think that you've just made  
 27 is that at some point in history, I think from memory  
 28 it was '16/'17, some time around then, the audit  
 29 function was essentially sidelined, resources were

1 needed elsewhere, and this audit was seen as  
 2 expendable. So when we think about that, and this may  
 3 not be an entirely straight line, if we bring it to  
 4 what we know about the urology multi-disciplinary team,  
 5 but it could be any service in the Trust estate, you 14:26  
 6 have a practitioner, according to the SAI outcomes, who  
 7 is not complying with NDT recommendations. So patients  
 8 don't get the recommended treatment, they don't get  
 9 referred down the road to oncology and what you have,  
 10 but behind that it can't be spotted, it can't be 14:26  
 11 identified, or it's going to be difficult to identify  
 12 it because you don't have resources into audit or  
 13 tracking, or whatever label we put on it, it's - is it  
 14 as blunt as that in some respects?

15 A. Yes, I think so, and I think, you know, if people had 14:27  
 16 concerns in certain areas then they didn't readily have  
 17 the tools available to them to help them understand  
 18 what the problem was, you know. So if you were  
 19 concerned about, you know, some of the clinical  
 20 processes in relation to urology, it would have been 14:27  
 21 very difficult to have had an audit project down around  
 22 that because you didn't physically have the staff there  
 23 do it for you.

24 144 Q. And obviously the commissioning process, and we'll come  
 25 to that perhaps towards the end of your evidence, or at 14:27  
 26 least that's my plan, we can't forget as we go through  
 27 your evidence that you are existing as a Trust - in  
 28 terms of your income, very much dependant upon what is  
 29 allocated to you from the commissioners - but it

1 appears from what you're saying that those budgetary  
 2 considerations, and the emphasis which your  
 3 predecessors maybe put on delivery as opposed to  
 4 quality and safety in terms of audit and all that goes  
 5 with that, those were choices that are made because of 14:28  
 6 the context, the budgetary context in which the Trust  
 7 has to inhabit?

8 A. Yes, and I think, you know, there's an old adage which  
 9 is "What gets measured gets done". Right. So at a  
 10 point in time in the past what got measured was how 14:28  
 11 much money you spent and how much activity you did.  
 12 Right. There was less attention given to - and it's  
 13 difficult to put a figure to it - quality and safety.  
 14 So the two things that were easily measurable were done  
 15 extremely well in relation to that. But then behind 14:29  
 16 that, I believe that that was at a cost in terms of the  
 17 clinical governance construction within the Trust.

18 145 Q. So when we go back to my question about how the senior  
 19 leadership team - and maybe my premise is wrong? I  
 20 said Senior Leadership Team standing in Craigavon 14:29  
 21 Hospital June 2020, before Mr. Haynes and Mrs. Corrigan  
 22 do their scoping work, you think all is well, obviously  
 23 the June Champion Report freshly delivered late the  
 24 previous year, and you have to work through some  
 25 structural changes which are obviously very important, 14:29  
 26 but it doesn't seem to me that you or your colleagues  
 27 in the Senior Leadership Team had a sense of - and take  
 28 the cancer services as our primary example, you didn't  
 29 have a sense of how degraded the governance

1 arrangements had become?

2 A. I think that's a fair reflection. And if you think  
3 back to the Maintaining High Professional Standards  
4 Investigation, right, which I think at this point in  
5 time was misleading, you know there was a suggestion 14:30  
6 that a wide range of people were consulted with at that  
7 point in time and that the feedback they gave was - I  
8 mean, one of the ultimate decisions that came out of  
9 that was that there weren't any concerns about  
10 Mr. O'Brien's clinical practice and, again, that was - 14:30  
11 and what was presented through the Maintaining High  
12 Professional Standards Report suggested that this was  
13 about administration and about professional, you know,  
14 management, but actually wasn't about - there weren't  
15 any clinical concerns. And I think that reassurance, 14:31  
16 and it was a reassurance, it wasn't an assurance, I  
17 think blinded us to the fact that actually what really  
18 hadn't been looked at in there was the cancer side of  
19 the house. So in normal circumstances, you know, if I  
20 were, for arguments sake, asking for a dermatologist or 14:31  
21 a psychiatrist, you know, to be investigated, you would  
22 assume that all of the activity would be within their  
23 department. I think what wasn't appreciated within  
24 that investigation was the fact that there was a part  
25 of his clinical activity sat without the people who 14:31  
26 were spoken to and that there was information in  
27 interest, and that I think came to light very forcibly  
28 then in June 2020.

29 146 Q. Mmm.



- 1 A. So that side of the house, the cancer side of the house  
 2 was quiet until we got to June 2020, and then there was  
 3 a realisation that actually all of this was going on in  
 4 there. And, in fact, you know, the concerns about  
 5 workload, waiting times, triage, all of those things 14:32  
 6 were important but didn't completely map on to what we  
 7 found then in relation to cancer.
- 8 147 Q. That perhaps provides some of the explanation and  
 9 understanding about what was deficient.
- 10 A. Mm-hmm. 14:32
- 11 148 Q. You know from your reading, and obviously it's before  
 12 your time, that even amongst the triage dictation,  
 13 private patients, notes at home shortcomings, they were  
 14 known about for quite a long time?
- 15 A. Yes. 14:32
- 16 149 Q. So there was something deficient in the, whether it's  
 17 the systems of governance or whether it's the people  
 18 who work those systems in terms of their understanding  
 19 of what they do when they are aware of shortcomings?
- 20 A. Yeah. 14:33
- 21 150 Q. So we'll come back to cancer in a moment.
- 22 A. Yeah.
- 23 151 Q. But is that a fair observation to make, that it's not -  
 24 problems existed not just because stuff was hidden from  
 25 plain sight, the cancer stuff, or it hadn't come, but 14:33  
 26 there were problems on the other side of it as well  
 27 amongst the stuff you did know about?
- 28 A. Yes. So I think at a point in time it functioned like  
 29 two different departments almost, there was the urology

1 side and then there was the cancer side, and there were  
 2 assumptions made I think about both parts of that and  
 3 by each other, and I think that, you know, the  
 4 individuals involved I think were very caught up - I  
 5 mean these are really busy jobs, so I'm not - and I 14:34  
 6 mean the volume of cancer activity and urology  
 7 activity, you know, as you know from the statistics,  
 8 you know, just has mushroomed over the years, and I  
 9 mean the workforce hasn't kept up with that in terms of  
 10 numbers. But, you know, they were very busy. I think 14:34  
 11 they dealt with what was in front of them, and as you  
 12 say, in terms of the connection across the system I'm  
 13 not - it wasn't there at times. They didn't see the  
 14 big picture, they saw the piece that was in front of  
 15 them. And, again, you know, very busy jobs, people 14:34  
 16 preoccupied with trying to get the best out of what  
 17 they're doing, that's not completely unusual. But I  
 18 think as a system where we could have been much better  
 19 was actually taking a step back and understanding how  
 20 that system should fit together, rather than leaving it 14:34  
 21 always to the people on the ground to work that out for  
 22 themselves.

23 152 Q. Mmm. Because I mean one of the explanations here, and  
 24 perhaps the primary explanation that you've given so  
 25 far for the deficiency in the governance arrangements, 14:35  
 26 was the budgetary consideration forcing the Trust's  
 27 choices or choice to go down one route, and to  
 28 sacrifice, for example, audit and what flows from that.  
 29 But I suppose the Department would say that there is a

1 limited purse and you have to make decisions that are  
 2 balanced. You can't simply point to the person and say  
 3 "well, I can't do governance, or I can't do governance  
 4 to the extent that I'm going to shrug my shoulders and  
 5 put people at risk", I'm sure that's maybe to  
 6 exaggerate the point. But the Trust made a decision  
 7 here at one point in time to undernourish the  
 8 governance arrangements?

14:36

9 A. The way commissioning works in Northern Ireland, it's  
 10 different from Scotland, England and Wales, in that  
 11 you're given an allocation per Trust and it's based on  
 12 the activity that the Department buys from you on  
 13 behalf of the population. Right. So, there is an  
 14 increment built into that, usually about 10%, which is  
 15 about providing systems to support that. So there was  
 16 a tendency in the past when systems were commissioned  
 17 basically to work it out on the basis of activity, the  
 18 numbers of doctors and nurses for arguments sake that  
 19 would be needed, and then some finance given towards  
 20 administration. There was never a budget towards  
 21 governance. I mean what every Trust does is make,  
 22 internally make a decision about that in terms of how  
 23 much or how little they want to put to it. Right. So  
 24 when things tend to get tight, what happens is the  
 25 governance gets stripped away and it is put into the  
 26 patient facing activity to get the patients seen, but  
 27 it doesn't necessarily mean that the quality of that  
 28 activity is as good as it should be and, you know, it  
 29 restricts the ability to quality assure it. So there's

14:36

14:36

14:36

14:37

1 always a balance to be struck on that. So I think the  
2 reason that, with the best will in the world, I think  
3 that there was high levels of productivity, but  
4 actually in terms of the government support to that to  
5 provide the quality assurance, that that's the part  
6 that was missing. 14:37

7 153 Q. Yes. Another aspect of this, and interested in your  
8 views about whether the diminution in governance  
9 activities may have had some impact on attitude or  
10 behaviours or culture amongst the middle management 14:38  
11 staff, you talk in your witness statement about your  
12 exposure to some middle managers, and you were asked  
13 about them on the last occasion and you came back with  
14 a Section 21 response and identified Mr. Carroll and  
15 Mrs. McVeigh as being examples, I suppose, of what you 14:38  
16 saw as being a problem culture.

17 A. Mm-hmm.

18 154 Q. And I think it's perhaps a little unfair to focus on  
19 the two of them directly, but perhaps let me set it in  
20 the context of the evidence that you gave. So if we go 14:38  
21 to your witness statement at WIT-91953. Sorry, if we  
22 go - just scroll down. Sorry, it must be I think over  
23 the page, please, towards the bottom of this page,  
24 yeah. Okay. Thank you.

25  
26 This is setting out the question that counsel put to  
27 you on the last occasion. You were - just up a little  
28 bit - you were explaining in your evidence that coming  
29 into the Trust you got pushback from some staff, and 14:39

1 this is within the question, you felt that your queries  
2 - they felt your queries were criticisms, and you were  
3 asked about that, and the answer then towards the  
4 bottom of the page:

5  
6 "There was certainly a number of occasions when I was  
7 very robustly challenged by middle managers within the  
8 Trust, not Martina Corrigan and not any of the other  
9 people who worked to her, in relation to what my role  
10 and function was, why I was asking these questions, and 14:40  
11 were a bit alarmed, I think, about the level of  
12 curiosity in relation to how this worked. That didn't  
13 stop me asking the questions, but it did make it more  
14 difficult in that I had to keep coming back and back to  
15 try to get the answers that I needed." 14:40

16  
17 And then over the page. So just scrolling down, and  
18 not having perhaps refrained from giving the answers on  
19 your last occasion because of perhaps the sensitivities  
20 around it, you gave the names of the people here, and 14:41  
21 you go on then within your statement to set out some of  
22 your concerns.

23  
24 If we go, just to go forward in this to the bottom of  
25 page 57 in this sequence. So what you're saying is 14:41  
26 that within the Acute Directorate it was your  
27 experience that it held on to its information under the  
28 guise at that time of managing its own governance,  
29 which is a system that had been instigated in the past.

1  
2 "As a result of this it was very difficult for the  
3 Director of Nursing and me, as Medical Director, to  
4 access the governance information we required in order  
5 to provide accurate assurance to the organisation. By 14:42  
6 the same token, Acute regularly believed that it was  
7 left to fend for itself."

8  
9 And then just finally just scrolling down, when you:

10 14:42  
11 "...spoke to others in the organisation about these  
12 behaviours by the Assistant Directors, there seemed to  
13 be an acceptance that this was the way in which  
14 individuals behaved and business was done and everyone  
15 worked around them. I hadn't encountered attitudes 14:43  
16 like this from middle managers in previous  
17 organisations."

18  
19 So you gave those two names as examples of people who  
20 appeared to be oppositional towards your requests for 14:43  
21 information, and you've seen their responses, and they  
22 denied behaving in any way that could be considered  
23 untoward. But what I really, and you can comment on  
24 that by all means, what I really am interested in  
25 asking you is, is it your observation that as well as 14:43  
26 the systems being undernourished in governance in terms  
27 of resources allowed towards governance, there was also  
28 a people problem. The culture was such that  
29 management, relatively senior management, wasn't

1 sharing governance related information with those who  
2 needed to know it?

3 A. Yes, and just in relation to, you know, naming Anne and  
4 Ronan. As you know, I was quite uncomfortable about  
5 doing that, and I think in fairness to both of them, I 14:44  
6 think they ended up being the voices I think of what  
7 was the culture in that Directorate at that point in  
8 time. So, you know, they were fairly discrete  
9 examples, which was the reason that they were  
10 mentioned. But I think they did - they were the voice 14:44  
11 of it. And, you know, in fairness to the two of them  
12 as well, they had been through numerous changes, and I  
13 think had been there a long time, had been trying to  
14 manage in really difficult circumstances. But the  
15 approach that was taken towards me was - and this is a 14:44  
16 fairly crass way of describing it - but it was, you  
17 know, "get your tanks off my lawn, this is not your  
18 business, we manage this, why do you want to know the  
19 answers to these questions?", and I think that's  
20 because the way that - that was the way they had been 14:45  
21 used to operating for long periods of time, and without  
22 a realisation that this was a systems problem that just  
23 didn't belong to the Acute Directorate.

24  
25 So on the basis of that and, again, you know the 14:45  
26 changes that we have made in relation to operational  
27 governance have been to centralise it now. So it is  
28 all brought under the office of the Medical Director,  
29 and the governance leads and staff are business

1 partners along with the different directorates. Now,  
 2 it's on the premise that there has to be a really close  
 3 working relationship with these directorates, because  
 4 we are completely dependant on their expertise and  
 5 local knowledge to actually understand but also to try 14:45  
 6 and help us develop and standardise what's going on  
 7 there so that we're not getting these pockets where  
 8 actually business is done differently and runs the risk  
 9 of being unsafe.

10 155 Q. Yes. So you are no longer - so as an organisation 14:46  
 11 you're no longer isolated as a senior management team  
 12 from what is going on within each of the directorates,  
 13 because there is now an energy or a requirement  
 14 propelling the information out of the services up  
 15 towards the top table on a very frequent basis, is that 14:46  
 16 the position?

17 A. Yes. And I think, I mean I think the weekly governance  
 18 report helps with that, and there is an expectation  
 19 that we, you know, if anybody is worried about anything  
 20 that they raise it. And, again, it may not be 14:46  
 21 something that we're going to react to immediately, but  
 22 in terms of building up the knowledge level of, you  
 23 know, or taking, you know, a temperature check in  
 24 relation to the organisation, all of that information  
 25 is really useful. So, you know, we actively encourage 14:47  
 26 people to speak up. And, again, you know, back to the  
 27 piece of cultural work that we have started across the  
 28 organisation in relation to being open, which came out  
 29 of the IHRD Inquiry, and the work that Justice O'Hara



1 did, and the work then that we're pursuing in relation  
 2 to being open and developing an open and just culture,  
 3 all that of is embedded in that as we try to take that  
 4 forward.

5 156 Q. Okay. Well we've touched upon a number of strands, 14:47  
 6 hopefully with a degree of connectiveness by way of  
 7 overview over the last 50 minutes or so. I want to go  
 8 back a little. I want to ask you about, I suppose the  
 9 External Reference Group is my starting point, but I  
 10 think the Inquiry wants to get a sense from you about 14:48  
 11 where the Trust is going from now. Having completed  
 12 something of the journey, what are the next steps? So  
 13 in terms of the External Reference Group leading in to  
 14 the work that's been done around the Trust's vision  
 15 through, I think it's Mrs. Wilson, is that right? 14:48

16 A. Yes, she's Director of Performance and Planning and  
 17 Informatics.

18 157 Q. Yes.

19 A. Yes.

20 158 Q. And the work that's going to go into the five-year 14:48  
 21 strategy. Could you help us first of all in terms of  
 22 the External Reference Group. You've kindly supplied  
 23 the Inquiry with a lot of papers in relation to it.  
 24 The Inquiry is interested to know the origin of that  
 25 group, why it was brought together, and what has it's 14:49  
 26 role been over the past several months?

27 A. Okay. I think I was - I think we all where, but I know  
 28 that I was particularly shocked by the fact that we'd  
 29 had this blind spot that we discovered in the summer of

1 2020, and I felt that, you know, the history in recent  
2 times in relation to Mr. O'Brien and what had happened  
3 was full of blind spots and actually here was another  
4 one, and I had been, you know, inadvertently complicity  
5 with it and that troubled me, and I think that on the 14:50  
6 basis of that I started to have conversations with  
7 people, as, you know - I mean it resonated with some of  
8 the other members in SLT, just in relation to how we  
9 would take this forward. So I spoke broadly to, you  
10 know, trusted advisers around the system in relation 14:50  
11 to, you know, if you're faced with something like that,  
12 how do you develop a reflective mirror for your own  
13 organisation to spot things that you don't normally  
14 see, because, you know, there's a whole psychology of  
15 group think and, you know, finding yourself repeating 14:50  
16 mistakes and all of that inadvertently. So the advice  
17 I got back then was to maybe think about bringing  
18 together a group of experts, which I did. So I  
19 approached Dr. Frawley, who was Ombudsman for a long  
20 period of time, and a huge career in terms of NHS 14:50  
21 management throughout Northern Ireland, and has been  
22 involved, you know, nationally in various bodies, and a  
23 huge source experience and expertise, and on the basis  
24 of the conversations then with Tom Frawley then, you  
25 know, approached Mary Hinds who was previous chief 14:51  
26 nurse whenever I worked as a consultant in the Mater  
27 Hospital, and also, you know, had various other high  
28 profile roles across Northern Ireland, you know, very  
29 well regarded in terms of patient safety and quality.

1  
2 I had done the patient safety, the Scottish patient  
3 safety fellowship a number of years ago, and the focus  
4 of that for those 18 months/two years is around  
5 developing systems around safety and quality, and had 14:51  
6 met - Simon Watson was the person in charge of all of  
7 that at that point in time. He's Medical Director for  
8 NHS Improvement Scotland, and Robbie Pearson is the  
9 Chief Executive of NHS Improvement Scotland. So I went  
10 to Scotland to have a conversation with them, just with 14:52  
11 Robbie in the first instance, and his Chair, to find  
12 out if they would be interested in supporting this work  
13 with us, given that they are involved in regulation and  
14 improvement, and then Robbie suggested to me to bring  
15 Simon on board given his background. 14:52

16  
17 And then alongside all of that, Hugh McCaughey has been  
18 involved with us and, again, he, as previous Chief  
19 Executive of the South Eastern Trust, hugely recognised  
20 figure in relation to patient safety and quality, and 14:52  
21 was an NHS England lead director in relation to safety  
22 and quality in England in the last few years before he  
23 retired, and then Vervan Richards, who I worked with  
24 when I Chaired the Invited Review Service for the Royal  
25 College of Psychiatrists, and she originates from 14:52  
26 Northern Ireland but works, you know, across Wales and  
27 for Welsh government, and through one of the colleges  
28 in Oxford, she's an ethicist.

29 159 Q. Yes.

1 A. So that I felt gave us - and, again, that was built  
 2 over time and conversations, and that I felt gave us a  
 3 really robust group of experienced experts who wouldn't  
 4 be frightened to challenge us as a group in terms of  
 5 some of our thinking, had huge years of experience in 14:53  
 6 the NHS and understood it intimately and, you know, had  
 7 enough distance from the system at this point in time  
 8 to be able to see us a bit more clearly than we could  
 9 ourselves.

10 160 Q. Could I just - I think it might be helpful if we bring 14:53  
 11 up on the screen, Mrs. Toal, I think it was her attempt  
 12 to define or describe the group's purpose. TRU-303726.  
 13 303726. TRU. So this is taken from the record of the  
 14 External Reference Group's seventh meeting which took  
 15 place on 10th November 2023, and just scrolling down. 14:54  
 16 So I think in this instance Mrs. Toal is describing  
 17 what you said to a Trust Board meeting in describing  
 18 the work of the External Reference Group, she is  
 19 summarising a workshop or a talk you gave to the Board  
 20 on the subject, and so, it said - she said: 14:55

21  
 22 "She had explained to the meeting that the purpose of  
 23 the ERG is to fulfil the role of a critical friend by  
 24 providing independent challenge and support to the  
 25 Chief Executive and Directors who were leading the 14:55  
 26 Southern Trust's Improving Organisational Effectiveness  
 27 Programme."

28  
 29 She explained she had advised the subgroups - and we'll

come to this in a moment:

"...the subgroup representatives that the central aim of this programme is to improve organisational health, maximise safety, quality, and the experience for patients and service users and staff by identifying areas of concerns highlighted by the Inquiry into urology services. Heather continued that she also explained to the meeting that the External Reference Group had identified four themes which had led to the formation of the four subgroups."

And they are set out there as the Patient Safety and Quality Subgroup, the Governance Subgroup, Data Analytics, and Culture and Leadership.

So just help us to better understand this. So the External Reference Group, you've described it's membership, come together at some point in 2023.

A. Yes.

161 Q. And have a series of meetings, and it's due to conclude  
it's work this month. Is that right?

A. Yes.

162 Q. And we see, just scrolling back down, please, or back up, we see that it's being described as leading the Trust's Improving Organisational Effectiveness Programme, and also assisting the, as part of that, assisting the Trust to improve against the areas which are the subject of this Inquiry. So is it - tell us

1           how it works and what is the, if you like, the end game  
 2           for the External Reference Group? Is it, for example,  
 3           going to produce a report of recommendations or is it  
 4           not that kind of group?

5           A.   It's not that kind of group. And what it does is, it 14:58  
 6           has led - it has helped - it has led the thinking in  
 7           relation to this rather than the doing, if you know  
 8           what I mean? So it's there to stimulate us to think  
 9           and to guide us towards improvement and to think how  
 10          things might be done differently. 14:58

11  
 12          So in the spirit of all of this, and given that this  
 13          started out with concerns about a blind spot, what we  
 14          will do and, again, it's the end stages of development  
 15          at the minute, is we - those of us from the Trust, and 14:58  
 16          that's myself, the Director of Nursing, Heather  
 17          Troughton; Director of Medicine, Stephen Austin;  
 18          Vivienne Toal, who is the Director of HROD, and Elaine  
 19          Wilson, we will - and Jane McKimm who leads out in the  
 20          Inquiry; and Margaret Higgins, who is now Director for 14:58  
 21          Transformation and Improvement - we are putting  
 22          together a report on where, what our progress has been  
 23          over the last year with the involvement of the External  
 24          Reference Group to report back to them to say, you  
 25          know, "These are the problems that we brought to you in 14:59  
 26          terms of what concerned us in relation to the Inquiry  
 27          and what you heard yourselves", given that Veryan does,  
 28          you know, an update in relation to each of these  
 29          hearings, "this is what we heard from you and now we're

1 reporting back to you to make sure that what we said,  
 2 what we all heard actually aligns and that we've got  
 3 this right". So they won't produce a report, we from  
 4 the Trust are producing a report, and then we will  
 5 sense check it with them to make sure that we're all on 14:59  
 6 the same page and that we have, you know, heard their  
 7 suggestions and guidance in relation to this and that  
 8 they can see that we have taken that on board and are  
 9 enacting it as best we can as a bigger group.

10 163 Q. So can you put that to an example? We can see, and 15:00  
 11 maybe I'll bring it up now, it might be helpful to  
 12 assist the discussion around this, Veryan Richards, one  
 13 can see from the papers supplied that she's following  
 14 very intently the questions I'm asking of witnesses and  
 15 the answers that come back, and the questions that the 15:00  
 16 Panel is asking and the answers that are coming back,  
 17 and she has provided the External Reference Group with  
 18 extracts from the transcript, and a series, if you  
 19 like, provocative, "have you thought of this?", kind of  
 20 question, isn't that right? 15:00

21 A. That's right, yes.

22 164 Q. And I'll show the Inquiry some examples of that. So if  
 23 we go to TRU-303646. And this is a matter that was  
 24 discussed at the External Reference Group meeting on  
 25 the 29th September. And so, the aims, she said, I 15:01  
 26 think she's referring to this exercise, is set out  
 27 there, and then she does a transcript, notes and  
 28 analysis, and if we scroll down the page she sets out  
 29 the various themes that she's going to explore, or have

1           been explored in the Inquiry, and then over the page,  
 2           we can see, and this was I think Day 42 of the  
 3           Inquiry's work, so she records the questions and the  
 4           answers, and then in blue she extracts, as I understand  
 5           it, and you can correct me if I'm wrong, an issue which 15:02  
 6           the Trust will have to grapple with, or she thinks  
 7           might be wise to grapple with, arising out of the  
 8           evidence that has been given. Is that a correct  
 9           interpretation of her approach?

10          A.   Yes. No, I mean as I understand it, Veryan listens 15:03  
 11           very intently to all of this, and then I think, you  
 12           know, given her perspective, and particularly her  
 13           perspective as ethicist, she comes back to ask these  
 14           questions, you know. But she's very clear that this is  
 15           coming from her alone, it's not coming from the group, 15:03  
 16           and it is to feed into a development of the group's  
 17           thinking. But, yes, that tends to be the pattern of it  
 18           in terms of how it is done.

19   165   Q.   And if I could bring you to another document, because I  
 20           think it originates from her, but maybe you can clarify 15:03  
 21           it, if not today at some future point, TRU-304137. And  
 22           here we have across eight areas, here's the first one,  
 23           the Trust Board, and it goes into Senior Leadership  
 24           Team, workforce, quality, patient safety, MHPS,  
 25           communications, all of the sort of themes that the 15:04  
 26           Inquiry is interested in, and on the right-hand side we  
 27           have the Inquiry's Terms of Reference. So do you know,  
 28           is this document something that has originated from  
 29           her?



1 A. I think it has emerged from within that group and I  
2 think it was developed across herself and some of the  
3 other involved in the group, yes.

4 166 Q. Yes.

5 A. But I think it is bringing together some of the 15:04  
6 questions that she has put to us, yeah.

7 167 Q. Yes. Yes.

8 A. Yeah.

9 168 Q. The Inquiry Panel will no doubt look at this in its own  
10 time, but I think it sets out a series of questions 15:04  
11 under each, if you like, each of the themes to be  
12 extracted from the Inquiry's Terms of Reference. It  
13 doesn't answer the questions but sets them out as, if  
14 you like, issues to be thought about by the Trust. Is  
15 that right? 15:05

16 A. Yes, that's correct. Yeah.

17 169 Q. So, that exercise having been performed by her, where  
18 is that work going? What's the next stage of it?

19 A. So we have - we have - this is, in terms of the  
20 collation of all of this, this is being done in 15:05  
21 anticipation of the meeting on Friday, on the 15th. So  
22 we have been down through this as a Senior Leadership  
23 Team, you know, we've picked up the questions as we've  
24 gone through the meetings, but as a Senior Leadership  
25 Team now we've brought everybody together just to 15:05  
26 revise this to get this into everybody's consciousness  
27 again. And I think then as we go forward and we  
28 continue to improve, because a lot of our focus and  
29 activity has been about, you know, changing some of the

1 structures, you know driving up the quality of  
 2 governance, you know, running the lookback review in  
 3 relation to all of that, you know, against a whole  
 4 backdrop of what was originally Covid, you know, the  
 5 concerns about Daisy Hill Hospital, cytology, you know, 15:06  
 6 the Caudrey Review, all of those things that have been  
 7 going on in the background, sometimes involving the  
 8 senior staff. So against the backdrop of that, I think  
 9 this is now part of how we start to test our systems in  
 10 terms of some of the changes that we've made, to say, 15:06  
 11 "Actually, in terms of how we've put this together, is  
 12 this representative?" So when I look at those  
 13 questions, for example, in relation to Trust Board, you  
 14 know, I will file down through all of the committees  
 15 that are there, what actually gets discussed, and think 15:06  
 16 to myself "Actually, have we addressed these?", and I  
 17 can see areas where we need to improve and other areas  
 18 there where I think "yes, we're nearly there or we've  
 19 got there with them", and the same with each of these  
 20 sections. I think this is a good way for us to 15:07  
 21 challenge ourselves, you know, in terms of whether or  
 22 not we've delivered.

23 170 Q. Yes. Yes. So again just for clarity purposes.

24 A. Mmm.

25 171 Q. You've described it I think quite well there. Before 15:07  
 26 the External Reference Group came together, you had  
 27 done a lot of work in terms of changing structures, a  
 28 lot of focus on governance. This is related but a  
 29 different strand or a different exercise that the Trust

1 is now pursuing?

2 A. I think - so this was part of the reflection to us in  
3 terms of, you know, what we've done and what we need  
4 do.

5 172 Q. Yes.

15:07

6 A. Right. And I think the next step in this process then  
7 is the work that will be driven under the leadership of  
8 the Director of Transformation and Improvement in terms  
9 of taking the learning that we've got internally  
10 obviously, you know, and this is anticipating what this 15:08  
11 Inquiry will report on, because I, I completely accept  
12 we may not have got this right. But what we're trying  
13 to do is improve as much as we possibly can in the  
14 interim, because we felt this was too important for us  
15 to put to one side and wait, you know, part of this 15:08  
16 will be for us to continually consider this to drive  
17 the improvement within the organisation and to build on  
18 it. So, you know, in relation to this to think if we  
19 haven't got - if we're not answering these questions,  
20 if they're the right questions, then are there other 15:08  
21 things that we could do to try and improve in all of  
22 this? And we will keep going with that and keep  
23 reporting on it.

24 173 Q. Yes. Yes. So if we go - I just want to highlight some  
25 issues or some developments that have emerged through 15:08  
26 the external reference groups. If we go to the minutes  
27 for the 29th September last year, TRU-306 - sorry,  
28 303681. That is 303681. And Vivienne Toal is updating  
29 the meeting, and she's explaining - if we just scroll

1 down - that - sorry, it's just down on over the page.  
2 Just down a little further, please. Down to the next  
3 page. Sorry, I've lost my place. Could you go back to  
4 the bottom of page 81. So, Ms. Toal - I can't find it  
5 on the page - but she's explaining to the Reference 15:10  
6 Group that Elaine Wilson, as you've said Director of  
7 Planning?

8 A. Mm-hmm.

9 174 Q. Has been asked to develop a new organisational vision?

10 A. Mm-hmm. 15:10

11 175 Q. And to be under-pinned by a new five-year strategic  
12 plan. I hope if I can just take another look down a  
13 page, she sets out - just keep going. Yes. So just  
14 below that bullet point. Yes. Is that something that  
15 has been agreed now that's being taken forward? 15:11

16 A. Yes, and the purpose in me presenting that to Trust  
17 Board in September was to essentially get their  
18 affirmation in relation to this, because we needed to  
19 be absolutely sure that Trust Board was behind all of  
20 this, you know, us as collective, in order to deliver. 15:11  
21 So Elaine has started this week and essentially - and  
22 we see the five-year vision as being, you know, the  
23 vision for 2030 essentially, I know it's slightly  
24 longer, but, you know, within all of that, you know,  
25 she has - she and other members of the team have 15:11  
26 consulted widely across the organisation with our  
27 external stakeholders, she's working our way through  
28 that, with our public, with patients and carers, and  
29 service users, in relation to what they see we should

1 be delivering over that period of time, and then, you  
 2 know, internally with any of us who are Trust Board  
 3 members. So that's a work in progress at the minute.

4 176 Q. Is that, just to be clear, this work on vision and work  
 5 on strategic plan, is that something that comes up in 15:12  
 6 the calendar every five years and now is the time do  
 7 it, or is this, if you like, new thinking borne out of  
 8 the experiences of working through problems with the  
 9 External Reference Group?

10 A. So naturally in the lifespan of any Trust there will be 15:12  
 11 a refresh in some of these things, okay, but I suppose  
 12 in recent times because we haven't had a Stormont  
 13 assembly until recently there hasn't been a programme  
 14 for government renewed, and usually the corporate plan  
 15 and corporate strategy falls out of that and then each 15:12  
 16 Trust then designs its own interpretation of that in  
 17 terms of taking that forward. In the absence of -  
 18 although we don't imagine it will be terribly  
 19 different, but we will keep an eye to it - in the  
 20 absence, before this started, of a programme for 15:12  
 21 government and, you know, the usual steer from  
 22 Stormont, we went on ahead and started this anyway,  
 23 because whenever you look at, and again this was  
 24 pre-pandemic but, you know, has been a theme and was a  
 25 theme that came through in relation to the changes made 15:13  
 26 in Daisy Hill. One of the things that was constantly  
 27 said was "we don't have a vision in terms of where  
 28 we're going", and that was one of the reasons that  
 29 people felt at sea, which I completely agree with, I

1 think that wasn't clear. So built into all of this was  
 2 about us setting strategic direction so that, you know,  
 3 particularly staff and service users would understand,  
 4 you know, what it was we were trying to achieve. And  
 5 within that I think, and what we're modifying at the 15:13  
 6 minute are essentially the areas that we'll focus on.  
 7 So it's about quality and safety, about adding value  
 8 for money, and then about listening and acting  
 9 intentionally.

10 177 Q. Yes, and I'm trying to - I've been struggling to find 15:13  
 11 these key principles. I think they're just down the  
 12 page. Yes. And so Mrs. Toal is explaining that the  
 13 work to be taken forward in terms of the vision and the  
 14 strategy will be under-pinned by, or she hoped that  
 15 they would be under-pinned by these four principles as 15:14  
 16 you've outlined:

17  
 18 "safety and quality of care.

19 Investing our resources where they add most value.

20 A commitment to following through all actions that are 15:14  
 21 agreed, and all under-pinned by intelligent use of  
 22 data."

23  
 24 So has that work started?

25 A. Yeah. Well this was part of the consultation. So 15:14  
 26 based on what we learned in the process of the Inquiry,  
 27 you know, the staff cultural survey that had been done  
 28 at an earlier stage, and then some of the more recent  
 29 learning that had come out of our experiences with

1 Daisy Hill Hospital and, you know, the Covid review and  
 2 all of that, these are the themes that kept emerging.  
 3 So that shaped our vision in relation to that. And  
 4 they have been refined in terms of, you know, with the  
 5 presentations to the different groupings, you know, it 15:15  
 6 has been through various iterations, but essentially  
 7 this is getting close to what we will see the vision of  
 8 the Trust being.

9 178 Q. And we can see, jumping ahead to the next meeting of  
 10 the External Reference Group. If we go, for example, 15:15  
 11 to TRU-303732. And Ms. Richards is explaining that  
 12 it's essential that a protected resource is agreed to  
 13 support the process and also that an updated narrative  
 14 was developed on the Trust's website so that that could  
 15 be shared with the staff. In terms of the senior 15:16  
 16 leadership, and I include you in that obviously, and  
 17 the Chair of the Trust Board, to what extent is it  
 18 important to bring the workforce and, indeed, other  
 19 stakeholders along with you in developing the strategy  
 20 and the vision? 15:16

21 A. It's pointless do it without them because, you know, I  
 22 can stand at the front and talk about what we might  
 23 aspire do, but if the hearts and minds of, you know the  
 24 patients and service users and the staff who work in  
 25 the organisation aren't with us as well, then we won't 15:17  
 26 deliver on it.

27 179 Q. There is talk within the External Reference Group  
 28 papers, to the need for an engagement plan?

29 A. Yes.

1 180 Q. That is engagement with the staff, with external  
2 stakeholders as well. Is that something that is being  
3 developed?  
4 A. Yes, and that's ongoing at the minute.  
5 181 Q. Yes. 15:17  
6 A. So through the work that Elaine leads, she and her team  
7 lead in terms of these meetings with various groupings  
8 and getting their feedback on all of this, you know  
9 what they're doing is explaining the background to  
10 this, you know, what we're proposing to do and, you 15:17  
11 know, then modifying anything that they hear in there  
12 in relation to that. So she will come back to present  
13 - she gives us updates on that at the Senior Leadership  
14 Team, but she will come back I think with a draft  
15 proposal in relation to that over the next number of 15:18  
16 weeks, you know. So that will happen reasonably  
17 imminently.  
18 182 Q. And the principles that I outlined there, we saw on the  
19 page in front of us, patient safety and quality,  
20 accountability and - sorry, I was reading from 15:18  
21 something else. Sorry.  
22 CHAIR: Resources.  
23 A. The second one is adding value for money.  
24 183 Q. MR. WOLFE: Yes. Sorry, I'll just get my note to get  
25 it absolutely - I'm sorry, I'm causing confusion. 15:18  
26 Bottom of the page. So why were those principles  
27 selected? Do they, I suppose, give an indication as to  
28 where you and your team see the need for development  
29 and the need for clarity?



1       A.   Yes, I think so. These came out, you know, they came  
2       out of our experiences through the Public Inquiry, the  
3       work that we undertook as I say in Daisy Hill and, you  
4       know, some of the learning that came out of the Covid  
5       experience, plus we had a big review to do in relation 15:20  
6       to that at a point in time, and then the culture review  
7       that was done 2016/2017 in relation to where the  
8       organisation was and, you know, some of the feedback  
9       we've had recently has resonated with that. So it came  
10      out of that because - and then underpinned by - we've 15:20  
11      two statutory duties in Northern Ireland; one is to  
12      provide safe quality care and the other is to break  
13      even and, you know, I think, you know, we also have to  
14      be pragmatic in the midst of all of this and be  
15      cognisant of the financial environment we're in, that 15:20  
16      we cannot waste resource. So it is really important  
17      that we do these, but not in an unrealistic way, and  
18      that we realise that what we do must add value and we  
19      must change what doesn't add value. Then I think, you  
20      know, one of things - again, I was very struck by 15:20  
21      whenever I arrived in the organisation but I think we  
22      are getting better at is, you know, a commitment  
23      basically to listen and to act intentionally, because I  
24      think, you know, one of the things that was, you know,  
25      I heard whenever I came into the organisation, and I 15:21  
26      think led to that apathy around understanding the  
27      impact of the loss of governance in all of that, was  
28      this sense that, you know, "It doesn't matter what you  
29      say, nothing changes", you know, it just felt all a bit

1           hopeless and, again, I think, you know, what has come  
 2           through certainly in the consultations with  
 3           particularly our, you know, the staff within the  
 4           organisation, has been that we need to listen to what  
 5           is being said and then we need to respond, and  
 6           sometimes that response might be "I can't do anything  
 7           about it at the minute", but people need to feel that  
 8           they're being taken seriously. And then I think as  
 9           well, it is again this intelligence use of data. How  
 10          do we join the dots to actually make sense of all of  
 11          this and try and reduce our tendency towards blind  
 12          spots?

15:21

15:21

13   184   Q.   Yes. There is another group that, as I understand it,  
 14           has recently formed under Mrs. Toal's chairmanship, and  
 15           that's the People and Culture Steering Group?

15:22

16           A.   Yes.

17   185   Q.   The Terms of Reference for that group are to be found  
 18           at TRU-305063. And it's purpose is concisely described  
 19           there at the top. And if we just scroll down. The key  
 20           - just pause there. So the purpose of this group, it  
 21           appears, is to provide support to the Strategy and  
 22           Transformation Committee. Is that the Committee that  
 23           Mrs. Wilson is leading to bring forward the strategy  
 24           and vision or is that a different group?

15:22

25           A.   So, the Trust Strategy and Transformation Committee is  
 26           Chaired by Eileen Mullan as Chair of the Trust, okay,  
 27           and that is again about bringing forward into the body  
 28           of Trust Board by reporting, but also to hold within  
 29           the organisation, you know, the strategic changes that

15:23

- 1 are being developed within all of this and any of the  
 2 transformation that's made. So basically, I mean  
 3 you've heard the quote, you know, "culture eats  
 4 strategy for breakfast", and I mean we see at large all  
 5 over the place. So it was really important that 15:23  
 6 actually, you know, the people plan was developed last  
 7 year along the lines of wellbeing belonging and  
 8 growing, again completely evidenced based in terms of  
 9 how that was pulled out as being the things that are  
 10 really important in developing, you know, an excellent 15:24  
 11 workforce that enjoys doing its job and does a good  
 12 job. But in order to be able to do all of this, all of  
 13 this needs to be aligned. So the people plan was  
 14 developed and is developing, continues to develop  
 15 alongside the strategic work that's going on, and these 15:24  
 16 committees then report into this, or these steering  
 17 groups report into this Committee that's chaired by the  
 18 Chair of the Trust, to make sure it gets right to the  
 19 heart of the organisation.
- 20 186 Q. Okay. So just so that we're clear. The job of 15:24  
 21 bringing the strategy and the vision, it's being taken  
 22 forward by Mrs. Wilson under the auspices of a  
 23 Strategic Implementation Programme Board, is that  
 24 right?
- 25 A. Yes. That's right, yes. 15:25
- 26 187 Q. It's going to report into Mrs. Mullan's Committee, is  
 27 that right?
- 28 A. Yes. Yes.
- 29 188 Q. So that's the Strategy and Transformation Committee?

1 A. Yeah. Mm-hmm.

2 189 Q. But Mrs. Toal's group, it has an opportunity to connect  
3 into those processes, is that right?

4 A. Oh, yes. Yes. And that works hand in glove, because,  
5 you know, that's very much about how do we deliver what 15:25  
6 we've promised through the people plan, you know,  
7 strategically, in terms of making sure that staff are  
8 aligned with what this vision is going to be and see it  
9 as being worthwhile?

10 190 Q. Okay. So her committee, or her group, that is 15:25  
11 Mrs. Toal's group, is the conduit to ensure that your  
12 people, that is your workforce, are given an  
13 opportunity to have a say on the development of the  
14 strategy, the development of the vision?

15 A. It's the staff on the ground who are exploring all of 15:26  
16 this with the various stakeholders come through the  
17 Director of Planning's Directorate, their Directorate  
18 of staff from there, but they're supported by Vivienne  
19 Toal's HROD staff, okay. But both of them would say  
20 that that is very much about, you know, helping to test 15:26  
21 these concepts to understand if we are heading in the  
22 right direction with it, and we think we are, the  
23 iterations seem to be repetitively saying the same  
24 thing, which is good, in and around. But in terms of  
25 the delivery of this, this will be delivered out 15:26  
26 through each of the directorates across the Trust,  
27 because they can help shape it and describe it. But in  
28 terms of the delivery it has to come into the lived  
29 experience of staff every day, so that's the next bit

1 in terms of how do you make that transition so that  
 2 this becomes the way we do business.

3 191 Q. Okay. So to summarise, the Trust is about to embark on  
 4 a process where a five-year strategy and vision will be  
 5 prepared. There are opportunities for staff and other 15:27  
 6 stakeholders to contribute to the shaping of that?

7 A. Mm-hmm.

8 192 Q. And you have been supported in getting that project to  
 9 the starting line by the expertise and experience of  
 10 the External Reference Group, who have listened to your 15:27  
 11 ideas, to your senior leadership team's ideas, and  
 12 offered comment and advice?

13 A. Mm-hmm.

14 193 Q. How useful has been the engagement with the External  
 15 Reference Group? 15:28

16 A. I think it has been enormously helpful because, you  
 17 know, to have such ready access to so much expertise is  
 18 rare and, you know, they come - the people involved  
 19 externally I think come from a position of, you know,  
 20 having had experience of some of these things 15:28  
 21 themselves in previous lives, but come with, you know -  
 22 and the knowledge of other people going through some of  
 23 these things, and I think can provide us with a lot of  
 24 information, point us in the direction of finding  
 25 things out, that I think have given us the confidence 15:28  
 26 to function because, you know, I haven't been a Chief  
 27 Executive very long, some of the other people on our  
 28 senior leadership team haven't been directors very  
 29 long. I think in terms of providing us with the

confidence, you know, to be able to deliver out on some of these things, that has been enormously important.

194 Q. And in terms of looking in the rear view mirror and seeing the potholes and the problems that you're hopefully leaving behind, at least in terms of governance, but perhaps more broadly than that, what is your ambition for the strategic plan and the vision in terms of where it will take the Southern Trust as an organisation and the people it employs?

15:29

A. Well, I mean, we are embedding governance. I think, you know, in terms of growing our workforce, you know, we know that that has been a very unstable system over a period of time. So over the last year/18 months, I mean we have employed 155 international nurses, we have recruited 72 internationally trained doctors, I mean a huge piece of work in terms of bringing stability into the system and, you know, educating people to, you know, work in the NHS. I mean super colleagues, you know, really enthusiastic and ambitious, and very enthusiastic about the work that we do, and that has really opened up lots of possibilities. So there's all of that stabilization piece that has gone on. You know, I think we have developed ourselves in terms of just understanding our own business much better, being a lot more strategic and planned and purposeful in what we do. We're trying to get away from being reactive but, you know, you're constantly hijacked by horrendous winter pressures and overcrowding in emergency departments, which everybody had, which can very often

15:29

15:30

15:30

15:30

1 take you away from the business. But again I think,  
2 you know, as we - and we've had, you know, the concerns  
3 about Daisy Hill, which we've managed to stabilise in  
4 the medium term, you know, the cytology review, which  
5 was well documented as well, again that has all been 15:31  
6 about, you know, really making sure that all of these  
7 governance processes that we have in place now, which  
8 are sensitive to operations, are working well for us so  
9 we can get through these problems. So bit by bit, and  
10 I think as we encounter these difficulties we are 15:31  
11 approaching them with more confidence, we now have the  
12 armament in place to actually deal with them  
13 expediently and get them over the line and get  
14 stability back the system. So I can see, I can see  
15 from a maturational point of view that we are slowly 15:31  
16 but surely working our way through there and, you know,  
17 our intention each time that we're hit with a  
18 difficulty - and there will always be difficulties in  
19 Trusts - is that we touch at once and we make sure that  
20 what we leave behind is sustainable so that we don't 15:31  
21 have to keep coming back in crisis mode.

22 MR. WOLFE: Chair, I know we've been going for an hour  
23 and a half. Should we take a short break and aim to  
24 come back or can we sit to say ten past or a quarter  
25 past four. 15:32

26 CHAIR: Okay. So let's take a 15-minute break then and  
27 come back and ten to and then sit for a maximum half an  
28 hour after that.

29 MR. WOLFE: Very well.

1        THE HEARING ADJOURNED FOR A SHORT PERIOD AND RESUMED AS  
2        FOLLOWS

3  
4        CHAIR: Thank you everyone. Just before you start,  
5        Dr. O'Kane, can I ask you again to slow down slightly, 15:46  
6        please. There's a great desire to get it all over  
7        with, I understand!

8    195   Q.    MR. WOLFE: In the time that remains this afternoon,  
9        Dr. O'Kane, I want to break into some discussion about  
10       leadership issues, and we'll look at whether there was, 15:47  
11       if you like, a problem with leadership that brought us  
12       to the circumstances which give rise to the Inquiry,  
13       and we will want to explore what has been done to  
14       develop leadership both on the Board and among, in  
15       particular, the medical leadership. 15:47

16  
17       Is it fair to say, you were reflecting just before the  
18       break on what was the perfect storm of issues that have  
19       confronted the Trust in recent times. Is it fair to  
20       say in your view that the work that has been done in 15:47  
21       relation to building leadership, developing leadership,  
22       has allowed you as a Trust to approach some of those  
23       issues with greater confidence?

24       A.    I think so, but, you know, it's always in development,  
25       you know, just in terms of the learning that goes into 15:48  
26       all of that. So in terms of, you know, supporting the  
27       leadership of the senior team, we have partnered with  
28       Mersey Care, it's recognised as being a high performing  
29       Trust. You know, they recently again rated as



1 outstanding in terms of well-led review, you know, have  
2 given us some really robust support and help through  
3 their Chief Executives and their other senior leaders  
4 in terms of how we can develop ourselves. So, you  
5 know, we've taken that on board and used it.

15:48

6  
7 we have taken time out on a regular basis to review or  
8 progress ourselves in relation to what we actually do  
9 and then to work with an organisational consultant  
10 basically to help us, you know, develop confidence as a 15:48  
11 team to deal with issues, all of that. And a number of  
12 the senior directors have taken on national training.  
13 So, you know, with the support of the King's Fund, a  
14 number of them are, you know, have taken on top  
15 director training, all of that, to try and build that 15:49  
16 confidence and resilience.

17  
18 But we're not finished with that yet. We still have  
19 got others to help, you know, to develop their  
20 confidence just as they've come into the roles. And 15:49  
21 also, you know, we have been in the process of trying  
22 to develop and embed coaching in all of that to help  
23 people along.

24  
25 And then in relation to the staff. Throughout the 15:49  
26 organisation, particularly through the Director of  
27 Nursing's office, she has led in leadership development  
28 among nursing staff, particularly at Band 7, 8A, 8B  
29 level, to drive that up to give the nurses there the

1 confidence, I think, to be able to speak up and to  
 2 lead. And we appointed a cadre of divisional medical  
 3 directors about 18 months ago and, again, they are  
 4 being taken through, you know, a developmental process  
 5 with each other. But, again, what we're planning to do 15:50  
 6 now over the next financial year is to develop a  
 7 leadership programme that will take in the senior  
 8 leader - a collective senior leadership programme that  
 9 will take in the leadership and the organisation. And  
 10 then for the other disciplines as well, certainly 15:50  
 11 through social work, AHP and others, that's being  
 12 developed alongside, and they have a fairly strong  
 13 tradition of support and supervision and development  
 14 within all of that.

15 15:50  
 16 One of the areas I think that we noticed that certainly  
 17 was put under a lot of stress at various stages was the  
 18 administrative teams and, again, through the HR  
 19 Department they have run a series of trainings with  
 20 staff across the organisation, particularly those 15:51  
 21 involved in administrative roles, to encourage them to  
 22 step up and to start to think about the what the  
 23 leadership opportunities are there. Because, again, if  
 24 we are going to develop ourselves as a collective  
 25 leadership organisation, you know, it's really 15:51  
 26 important that everybody is given the opportunity to  
 27 lead in the area that they can and that people are  
 28 given, you know, the support to speak up. So all of  
 29 that's in progress. And, again, it comes down through

1 the work that Vivienne Toal has been leading on in  
2 relation to the people plan and the cultural  
3 development with that.

4 196 Q. Yes. I'm going to touch on some of those aspects in a  
5 moment. One issue that arose in Ms. Mullan's evidence  
6 concerned you and the pressures on your diary and the  
7 time that you can commit to attendance at various  
8 meetings that she regarded as important, and I'm  
9 anxious to have your view in relation to that.

15:51

10  
11 She explained that I suppose you face significant time  
12 pressures, perhaps not surprisingly given some of the  
13 issues that you outlined a few minutes ago, that no  
14 doubt required your personal and direct attention. But  
15 she explained - this is - I needn't bring it up on the  
16 screen - it's TRA-10154 and into 55, that as a result  
17 of the demands placed on you, you have not been able to  
18 attend four out of the five governance meetings, I  
19 think last year.

15:52

20 A. Mm-hmm.

15:52

21 197 Q. And you've missed two Audit Committee meetings in  
22 recent times, and this has caused a ripple of concern  
23 with the Non-Executive Directors. Albeit, in fairness  
24 to the evidence, and the balance in the evidence that  
25 she gave, she said it would be remiss of her not to  
26 acknowledge that whilst all this other stuff is going  
27 on there has been tremendous work done as a result of  
28 the outworkings of the Inquiry.

15:53

1 Do you have any concern that because you're perhaps  
2 being pulled in several different directions at the one  
3 time that there is a risk there in terms of your  
4 leadership role and the lead that you must give to  
5 staff and the assurances that you must find the time to 15:53  
6 obtain across the Trust? In essence, are you  
7 sufficiently resourced to do your job safely?

8 A. So, in relation to the Governance Committee and the  
9 Audit Committee, I think it's fair to say - well I  
10 don't want to give the impression that those meetings 15:54  
11 aren't important, they are. But, in terms of the  
12 papers do with all of that and my opinion going into  
13 that Committee either through the Deputy Chief  
14 Executive or other people, those are all discussed at  
15 the Senior Leadership Team meetings, and then the 15:54  
16 papers are passed in, and if there's anything of  
17 concern I bring those up in my one-to-one with Eileen,  
18 which happens every fortnight, or through the Executive  
19 Directors meeting which happens every fortnight, or,  
20 you know, bring it to the NEDs meeting which happens 15:54  
21 approximately every month or so in relation to me  
22 meeting with the Non-Executive Directors. So that's  
23 brought into there. I think - and the same with the  
24 Audit Committee. I think in terms of the  
25 non-attendance, I think the last year we've all been 15:55  
26 trying to catch up on annual leave that was stored up  
27 over Covid in terms of trying do that, and then in  
28 terms of some of the other pressures on my team, those  
29 have been regional meetings or training courses.

1  
2 So one of the things I've undertaken is a coaching  
3 course, and again that, you know, signed up for that in  
4 advance and then the dates clashed. The same with the  
5 PTED meetings, which tend to be the regional 15:55  
6 departmental meetings, clashes with the Area Integrated  
7 Partnership Board, which I Chair the pilot for for  
8 Northern Ireland. So there are significant demands on  
9 times. And I am also on a lot of committees.

10 15:55  
11 So, again, getting the balance with that I think is  
12 important. I think as we have come into this year we  
13 have planned more purposefully around that so that, you  
14 know, now that we've a longer oversight I think of the  
15 timetable of the committees and when those are actually 15:56  
16 happening, it makes it easier then for me to attend,  
17 you know, either virtually or in person, depending on  
18 what's going on and, you know, I actively encourage  
19 everyone else who is supposed to be involved to be  
20 there. 15:56

21  
22 So, I am very cognisant of the information that flows  
23 into that and I need to stay on top of that and, you  
24 know, I have nothing to suggest that I don't, but I'm  
25 also very aware of the example that it sets for other 15:56  
26 people if I'm not there and it is important that I do  
27 attend these things. And I think as we've got  
28 ourselves into a better system of planning that has  
29 improved.

1 Now some of the changes that we're making within the  
 2 office of the Chair and the Chief I think have been  
 3 important in relation to this. So we're in the process  
 4 of appointing new secretarial staff in there. There  
 5 have been, you know, there have been churn and change 15:56  
 6 for a variety of reasons. I've also appointed an  
 7 Executive Head of Office, which there wasn't one  
 8 before, to try and manage all of this better and to  
 9 make sure that, you know, everybody is in the right  
 10 place at the right time. So that appears to be going 15:57  
 11 to plan. And then in relation to again the  
 12 streamlining of some of these processes and the sharing  
 13 of information, you know, that's now being done.

14  
 15 So I would hope, you know, the aspiration certainly for 15:57  
 16 this year is that it should be a bit better organised  
 17 in terms of the use of my time in relation to that, and  
 18 I think one of the things that we - that I asked the  
 19 executive head of office to do was to do a review of my  
 20 time usage and, again, I think what, you know, what 15:57  
 21 really came to light in relation to that was the number  
 22 of meetings that I am involved in, in terms of trying  
 23 to attend. So, again, we had some internal  
 24 conversations in relation to how some of that work  
 25 could be delegated to free me up to, you know, give 15:58  
 26 attention to the really important things and, again,  
 27 that has helped in terms of re-organising that.

28 198 Q. Okay. So to summarise, you have this awareness of a  
 29 perception?

1           A.    Yep.

2   199   Q.    That not being present rings alarm bells?

3           A.    Yep.

4   200   Q.    But you're understanding of your role is such that

5                   you're using mitigations, whether alternative means to   15:58

6                   communicate, additional staffing resources as well as

7                   prioritising, what you do to ensure that you're there

8                   when you need to be?

9           A.    Yes.   Yep.

10   201   Q.    Let me move to the Board, Board membership, development   15:58

11                   and how it works, I want to briefly touch upon some of

12                   the issues that arise from that. Again, coming back to

13                   Ms. Mullan's evidence, she, I suppose makes two points

14                   which I want to have your views on. One is that at

15                   least until 2020 she was a member of a Board that, I   15:59

16                   hope I don't do injustice to her evidence by saying

17                   that it was a Board that wasn't asking all of the

18                   necessary questions. And, secondly, she was a member

19                   of a Board that didn't receive all of the information

20                   from the executive side that it needed to receive to do   15:59

21                   it's job effectively. Now, let me put meat on the

22                   bones of that.

23

24                   January 2017, the Board is told a doctor in Urology is

25                   to be the subject of an MHPS investigation -   16:00

26                   Mr. O'Brien, and she acknowledged in her evidence that

27                   they, the Board, should have been asking is there a

28                   patient safety risk? They didn't, to her recollection,

29                   ask any questions about that event, and nor for that

1 matter until you brought the issue to the Board in  
2 August 2020 did the issue or the issues around  
3 Mr. O'Brien, and in particular the conclusions reached  
4 by MHPS, come back to the Board? So a clear example of  
5 a problem I think, would you agree?

16:01

6 A. Yes, yep. The communication should have been more  
7 robust, yeah.

8 202 Q. Yes. So - and equally on the other side, a clear  
9 problem on the part of Board members, they weren't  
10 asking the questions?

16:01

11 A. Yes, and I - yes, no, I think across the piece the  
12 communication wasn't what it should have been.

13 203 Q. Another example, if we go to WIT-101964, and Stephen  
14 Wallace, 3rd August 2020, writing to Roberta Brownlee  
15 with a copy of the Early Alert in respect of the  
16 concerns that had arisen in relation to Mr. O'Brien.  
17 Just scroll down on to the next page. You're the  
18 author of the Early Alert, or the signatory to the  
19 Early Alert, which went to the Chief Medical Office  
20 four days previously. Only Mrs. Brownlee was sent the  
21 Early Alert. The other non-execs didn't know about the  
22 Early Alert it would appear until - on Mrs. Mullan's  
23 evidence - until September of 2020. So, again, and  
24 maybe you could help us with this, another example of  
25 important information not being shared with the  
26 entirety of the Board?

16:02

16:02

16:03

27 A. Yes.

28 204 Q. Is that something that was conscious and deliberate  
29 and, if so, what was the thinking behind it?



1 A. Well, I can't imagine for one minute that if Stephen  
2 wallace sent that to the Chair of the Board that he was  
3 thinking that the Non-Executive Directors shouldn't be  
4 included. I think it was probably about, you know, any  
5 wider conversations outside all of that because, you 16:03  
6 know, we all, you know, it would have been knowing that  
7 Mrs. Brownlee's and Mr. O'Brien knew each other really  
8 well, so I think that was the suggestion - I imagine  
9 that's what the suggestion was to her. But it wasn't  
10 about not sharing it with the Board. 16:03

11 205 Q. So why wasn't it sent to the Board through your office  
12 or whoever owned it, Mr. Wallace's office? Why was it  
13 - was the - is the implication of your answer that the  
14 expectation was that Mrs. Brownlee would share it with  
15 her non-execs? 16:04

16 A. Yes, because that would, you know usually if there was  
17 an Early Alert that was concerning, you would expect  
18 that the Chair would take that up with the  
19 Non-Executive Directors, yes. Now since that time, if  
20 we send Early Alerts we send them to the entire Trust 16:04  
21 Board.

22 206 Q. Yes.

23 A. Yeah.

24 207 Q. From the centre?

25 A. Yes. That's how it is done now. 16:04

26 208 Q. It doesn't rely on the Chair to further share it?

27 A. No.

28 209 Q. So the fact that Mr. O'Brien's MHPS process could  
29 continue through to a conclusion with the report and a

1 determination, and that would pass without either  
 2 information coming from the Medical Director's Office,  
 3 or pass without questioning by the Board itself, poses  
 4 clear questions about the governance instincts of the  
 5 Board and the governance instincts of those in the 16:05  
 6 Medical Director's office, or whatever level it's at  
 7 within the operations side. Has that culture, if it is  
 8 a culture, changed in your view? Is there a greater  
 9 appetite on the part of the non-executive members, and  
 10 indeed the executive members of the Board to ask 16:06  
 11 questions, and is there a greater willingness to share  
 12 information with the Board?

13 A. Yes, and I think, you know, I think there should be  
 14 anyway, but I think possibly based as well on the  
 15 outworkings of the Neurology Inquiry and, you know, the 16:06  
 16 attention that was given to Michael Watt, I think  
 17 certainly Boards are now - well, certainly our Board is  
 18 a lot more curious about maintaining High Professional  
 19 Standards and medical staff generally and, you know,  
 20 the flow of information is a lot better than it would 16:07  
 21 have been in the past.

22 210 Q. In terms of the Board that you inherited as Chief  
 23 Executive, and maybe even in the period before that, is  
 24 it your view that it wasn't, at least on - I'll focus  
 25 on the non-executive side, that it wasn't sufficiently 16:07  
 26 developed or attuned for the work that it needed to do  
 27 on the governance side, or the holding to account side  
 28 of their work?

29 A. I think that, you know, this was a Board that had been

1 through many changes and, again, hadn't had anything in  
 2 particular raised with them over a period of time that  
 3 wasn't good news, either in relation to financial  
 4 break-even or performance and, you know, understandably  
 5 thought they were presiding over a high performing 16:08  
 6 Trust that didn't have any particular difficulties.  
 7 So, on that basis I, I mean some of those Board members  
 8 have been with us now in the last year/18 months and,  
 9 you know, given the opportunity and the change of  
 10 environment they're very able to challenge and ask 16:08  
 11 questions and, you know, if the conditions are created  
 12 they certainly have, you know, have been quite  
 13 challenging to me and other people in a very respectful  
 14 way, but the questions still get asked. So I do think  
 15 that there was something about the cultural that 16:08  
 16 created this sense that actually everything was okay,  
 17 you didn't need to ask questions, it was all being  
 18 taken care of, and that probably then, I think unfairly  
 19 to them, I think lulled them into a false sense of  
 20 security. 16:09

- 21 211 Q. And, again, as an observer as well as participant in  
 22 some of this from 2019, where do you see the, if you  
 23 like, the culpability for that? Is it a case that they  
 24 were being fed the good news, "nothing to worry about  
 25 here", or is it a case that the information was there 16:09  
 26 and whether because of cultural issues or leadership  
 27 issues they didn't ask the challenging questions?  
 28 A. Probably a combination of both because, you know, Shane  
 29 Devlin had arrived in the Trust about - he arrived in

1 the Trust about six months before I did, and up until  
 2 that point they'd had a whole series of rapid turnovers  
 3 of Chief Executive and, you know, Medical Director. So  
 4 nobody really had had the chance I think to settle and  
 5 understand the organisation in the way it needed to be 16:10  
 6 understood, you know, after Mairead McAlinden left. So  
 7 I think that rapid turnover I think meant that, you  
 8 know, it was constantly, you know, and not through any  
 9 individual's fault, it was constantly about superficial  
 10 management and keeping the day-to-day going, but then 16:10  
 11 in terms of, you know, recognising some of these deep  
 12 rooted problems and actually moving them on and sorting  
 13 them out, I think there wasn't anybody there in post  
 14 long enough to have that view of it all and to bring it  
 15 together. 16:10

16 212 Q. Obviously the Chair of a Board is an important  
 17 function.

18 A. Mm-hmm.

19 213 Q. He or she should arguably lead by example, set the tone  
 20 for what is expected. You've had opportunity to work 16:10  
 21 with both Mrs. Brownlee and Ms. Mullan. Are there  
 22 differences in style and is there, as a result of that,  
 23 a difference in how the Board performs in terms of  
 24 holding the executives to account?

25 A. Well, I think that Mrs. Brownlee was Chair of the Trust 16:11  
 26 for a long time, most of, you know, she had been on the  
 27 Board in and around 10 years I think and, you know,  
 28 since the development of the Trusts in 2007, you know,  
 29 the nature of Board business has changed quite a bit,

1 and certainly whenever I would have started out as a  
2 consultant, you know, moons ago, you know it was  
3 largely an honorary position, you know, and that's not  
4 an unfair description of it, but it was very much, you  
5 know, about having, you know, an awareness of being 16:11  
6 accountable, but actually was very much about being a  
7 figurehead, about being out there selling the Trust,  
8 you know, doing all of those things, you know,  
9 presenting a very well formed optimistic profile in  
10 relation to what the Trust was. I think as health has 16:12  
11 become increasingly more complex and, you know, less  
12 able to meet demand, and difficulties have arisen, and  
13 as we have become more sophisticated in terms of  
14 understanding the business the Trust, I think the role  
15 of the Chair has changed. 16:12

16  
17 So, you know, I imagine whenever she started out that  
18 the role was different from how it ended up having to  
19 be and, again, you know, if you are an incumbent in  
20 that position it is difficult I think to realise that 16:12  
21 change if you're staying with one organisation.

22  
23 So, I think that, you know, there probably, you know,  
24 it was much - it was much a legacy of that as of  
25 anything else. And in fairness to her, you know, she 16:12  
26 was the one constant with all of these changes in Chief  
27 Executive and, you know, had to keep, you know, the  
28 public face going, if you like, in terms of business  
29 continuing. So I think it was probably lost in the

1           midst of all of that.

2   214   Q.   Yes. And I don't wish to have my questioning  
3           interpreted as suggesting Mrs. Brownlee was  
4           unprofessional, but is there a difference between her  
5           role as the figurehead and perhaps a more - a greater   16:13  
6           professionalisation of the role of Chair under  
7           Ms. Mullan in terms of their approach to the work?

8           A.   I think, I think over time the expectation of the Chair  
9           has changed in that there is an expectation of greater  
10          professionalisation. And if you think about the, you   16:13  
11          know, the composition of Trust Board, the majority of  
12          people who come on to Trust Board have never worked in  
13          health before. It's a very sharp learning curve. It's  
14          very different, I imagine, from many other Boards that  
15          I hear about and, you know, the level of responsibility   16:14  
16          and everything else tends to be much greater. So I  
17          think through necessity, in order to be able to make  
18          sense of the job and to, you know, be able to hold me  
19          to account, hold Trust Board to account, you know to  
20          report to the Permanent Secretary and the Minister, I   16:14  
21          do think there has had to be an increase in  
22          professionalisation of that over time, yes.

23   215   Q.   Yes. It has always been the case, and we saw this  
24           through the evidence provided by Mrs. Brownlee, that  
25           the Non-Executive Directors have received training, and   16:14  
26           there'll be different views as to how adequate the  
27           training was, et cetera. We can see that - if we bring  
28           up TRU-306058, and this is the, if you like, the Trust  
29           Board workshops for the past year. 306058. And,

1 again, covering a broad range of subjects. And just  
2 scrolling down, regular workshops, you see there "Risk  
3 appetite in September, Board governance,  
4 self-assessment tool". So, the training, maybe you can  
5 help us with this, has it changed to any great degree 16:15  
6 over the years, or how can you account - because I  
7 think your evidence has been this is now a Board that  
8 does hold you to account, is much more - "interfering"  
9 may be the wrong word, but certainly asking the hard  
10 questions? Is there a sense in your view that this 16:16  
11 approach of the Board has changed for the better, and  
12 what do you put it down to?

13 A. I am - I can see - certainly during the time I have  
14 been Chief Executive I can see the Non-Executive  
15 Directors who have been there being more assertive, you 16:16  
16 know, in terms of challenging me, you know, and other  
17 people. Not in an unfriendly way, but in a very  
18 constructive way. And then, you know, the other  
19 problem I think for Trust Board Non-Executive Directors  
20 has been that we've been short of some for a period of 16:17  
21 time. Now before Christmas there were public  
22 appointments, and more have been appointed and, you  
23 know, we have lost some recently, we've gained a few  
24 others and, you know, there will be more change before  
25 the end of the year, and certainly, you know, when 16:17  
26 Eileen has taken this forward and developed it, it has  
27 been with that in mind. Because previously the  
28 induction was very much about understanding the purpose  
29 of the Board, the Nolan Principles, you know, how all

1 of that fits together. This starts to take us into  
 2 more of actually the accountability arrangements in  
 3 terms of what Trust Board has to be responsible for in  
 4 terms of helping them think about, you know, the  
 5 clinical and social care governance, and the financial 16:17  
 6 governance, and how to understand how to join the dots  
 7 and, you know, ask all of those questions. Because I  
 8 think, I can certainly see that that is starting to  
 9 come through more strongly than it would have done in  
 10 the past. Yes. 16:18

11 216 Q. So is that a suggestion that the quality of the  
 12 training has improved in the sense that it is more  
 13 meaningful and directs the member more specifically to  
 14 the kinds of questions that they need to be thinking  
 15 about and raising in their work? 16:18

16 A. Yes, I think so. But bearing in mind that these  
 17 Non-Executive Directors are extremely part-time and  
 18 haven't come largely from a health background before,  
 19 you know, this is about equipping them to hold the  
 20 accountability and to understand health and social care 16:18  
 21 at speed.

22 217 Q. Yes. Is it possible, sitting in your chair, to assess  
 23 the effectiveness of the Board in terms of the  
 24 challenge and support that it provides? Ms. Mullan  
 25 referred to the assessment tool, which those who sit on 16:19  
 26 Boards, whether it's Board of Governors in schools or  
 27 wherever, are asked to complete - she described it as  
 28 something of a box ticking exercise, I don't know  
 29 whether that's fair or unfair, but how do you assess



1 the effectiveness of the Trust, of the Trust Board  
 2 sorry, in terms of the work it's expected to do?

3 A. I think it's increasingly effective, and I think when  
 4 we get the full compliment of Non-Executive Directors I  
 5 think that will give it even more scope. One of the 16:19  
 6 things that we have planned to do in this financial  
 7 year is to carry out a well-led review. Now, we don't  
 8 have that in Northern Ireland, but it is part of the  
 9 function of CQC in England, just to look at the  
 10 Governance structures and how the Board functions and 16:20  
 11 all aspects in relation to all of that. The Chief  
 12 Executive in Mersey Care certainly has helped us with  
 13 some of that and has been part of, you know, he has  
 14 visited our Board and watched it's functioning and  
 15 everything else and has given some really constructive 16:20  
 16 feedback in relation to that. So, you know, it is  
 17 something that we take seriously. But I think in order  
 18 to know if this is functioning as well as we think it  
 19 is, I think it will be helpful to have the well-led  
 20 review done so at least we get that reflective back to 16:20  
 21 us in terms of, you know, what's functioning and what  
 22 isn't.

23 218 Q. Yes. Just finally for today, in terms of Board  
 24 membership, I'm thinking again about the Non-Executive  
 25 side, what is the biggest challenge that your Trust 16:20  
 26 faces in terms of that part of its membership? Is it  
 27 recruitment issues and ensuring that you have a steady  
 28 stream of well qualified Non-Executive Directors ready  
 29 to step in to the shoes of the outgoing, or is it

1 finding the time to provide for their development  
 2 needs? Maybe they're not issues at all, but are there  
 3 any particular challenges in relation to the  
 4 composition of your Board that you regard as risks?

5 A. So, some of the membership have recently changed and 16:21  
 6 they do come from a variety of backgrounds, which I  
 7 think, you know, it's not yet as diverse, I think, as  
 8 it needs to be. But, you know, I know that that's the  
 9 aspiration. And I think that, you know, it's always  
 10 about getting the balance between having enough 16:22  
 11 knowledge about health and social care and  
 12 accountability mechanisms to be able to do that part of  
 13 it. But also then to be able to think differently so  
 14 that you can actually challenge the status quo, which  
 15 is also really important. So I think I am beginning to 16:22  
 16 see that in different ways in terms of the questions  
 17 that come through. I think they need to get to a  
 18 position of stability with full Board compliment and I  
 19 think, yo know, their time is always pressurised, you  
 20 know because there's a day of month - the most of a day 16:22  
 21 a month taken up with the Trust Board, you know there  
 22 are the statutory visits to children's homes which we  
 23 get feedback on which is really helpful, and then we  
 24 try to do the leadership visits around, and then  
 25 chairing committees and attending to committees. So 16:23  
 26 their time is really heavily used and I think, you  
 27 know, ideally if we had more of their time I think it  
 28 would bring even more value to the system, but the way  
 29 it's constructed at the minute that's not where it is,

1           you know.

2   219   Q.   Can the Department do anything to assist Trusts in this  
3           respect?

4           A.   It's possible. I know that certainly, you know, the  
5           foundation Trust structure in England is different in   16:23  
6           that there are councils and there are Trust Boards, and  
7           there's probably a lot more input from the public, you  
8           know. But again, you know, we're - I imagine one of  
9           the limitations on this is we are working in a really  
10          financially restrictive environment currently and all   16:23  
11          of these things obviously have to be accounted for.  
12          But certainly, you know, anything at all that can add  
13          to the breadth and depth of the expertise and the time  
14          allowed to the Non-Executives I think would be welcome.

15   220   Q.   Clearly a strong Trust Board, strong Non-Executive   16:23  
16          Directors, could have the potential, viewed from one  
17          perspective, to make life difficult for executive  
18          directors and leaders, such as yourself. From your  
19          answers you would wouldn't appear to see it that way.  
20          What do you see as the value of a strong set of   16:24  
21          Non-Executive Directors for the overall health of the  
22          organisation?

23          A.   I think it's the informed challenge position, and  
24          that's really important. And, again, back to, you  
25          know, the issue of blind spots, being able to see   16:24  
26          things that we can't see because we're caught up in the  
27          day-to-day business, that's really important in terms  
28          of, you know, helping us to stay safe as an  
29          organisation in terms of patients.

1 221 Q. And in terms of the journey, if it has been a journey,  
2 do you think, finally, that you would have greater  
3 confidence in the Board as it is equipped today to do  
4 that work of challenge and identifying blind spots,  
5 than perhaps was the case four or five years ago? 16:25

6 A. I think so, but, you know, I am also mindful that I  
7 have a responsibility in helping them with that. So,  
8 you know, I am cognisant of that, and I know certainly  
9 the other members of the Senior Leadership Team are  
10 cognisant of that, you know, we need to help them 16:25  
11 develop in terms of knowing what they need to know, but  
12 not actually, you know, influencing that so strongly  
13 that we just extend the group. I think they need to be  
14 separate and they need to be slightly separate from us  
15 to be able to hold us to account and to be able to 16:25  
16 challenge.

17 222 Q. Okay. I'm at risk of being told off if I ask another  
18 question! So thank you for that, and we'll commence at  
19 10:00.

20 CHAIR: 10:00 o'clock tomorrow morning. Thank you 16:25  
21 Dr. O'Kane, and thank you Mr. Wolfe. See you all in  
22 the morning, ladies and gentlemen.

23  
24 THE HEARING ADJOURNED UNTIL 10:00AM ON WEDNESDAY,  
25 13TH MARCH 2024 16:25

26  
27  
28  
29