Urology Services Inquiry

Oral Hearing

Day 32 – Thursday, 23rd March 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

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CHAIR: Good morning, everyone. I see some people have changed location to get a better view of Dr. Khan. Mr. Wolfe.

MR. WOLFE KC: Good morning, Dr. Khan.

A. Good morning. 10:07

1 Q. Sound and vision all okay?

A. Yes, it's fine.

2 Q. As you know, my name is Martin Wolfe and I'm counsel to the Inquiry. Thank you for joining us this morning. 10:07

Could I ask you, just before you take the oath, a couple of logistical-type questions. Are you by yourself?

A. I am.

3 Q. And where are you located? 10:07

A. I'm at home.

4 Q. And do you have access to the witness disclosure bundle and the core bundle?

A. I do. I have access on my laptop.

CHAIR: I think, Dr. Khan, there is an issue with the sound with the stenographer who has to record what you're telling us. We're just getting that sorted out. If you bear with us a moment or two. 10:08

A. Okay. I apologise not being there in person; just with the clinical commitments yesterday and tomorrow. 10:10

CHAIR: Mr. McInnes, would it be better if we rose for a short period to get this sorted?

Dr. Khan, I'm afraid we're going to have to rise for a

short period to sort out the sound difficulties.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: Everyone. Hopefully we're now ready to go, Dr. Khan, and we'll not have any further technical issues. 10:21

MR. WOLFE KC: Obviously, Dr. Khan, perhaps obviously the person speaking to you is Ms. Christine Smith, who is Chair of the Inquiry. Sitting alongside her is Dr. Sonia Swart and Mr. Damian Hanbury. If at any time during our communication today you can't hear me, it will probably be obvious to us, but just raise your hand. 10:21

As you know, you have two bundles. One is your personal bundle, and I'll refer to it as that. The other is the core bundle. I understand you can access those relatively quickly, albeit we appreciate there might be some delay. We'll work through that. 10:22

I understand, also, that you have your holy book beside you. Our secretary will administer the oath. 10:22

DR. AHMED KHAN, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS:

10:23

MR. WOLFE KC: I should have mentioned to you also, Dr. Khan, that within the recent short period of time, the Inquiry secretariat have sent you an email containing a designation list of patients with their

cipher or, if you like, code name, because we try to keep anonymous the names or details of patients. I think it unlikely we will refer to that in any great detail but it should be in your inbox in the event it becomes necessary. 10:23

The first thing we need to do is refer you to your witness statements that you have kindly forwarded to the Inquiry in advance of today. There are three documents I need to refer you to. First of all, we can 10:24 find at page 35 of your personal bundle, this is WIT-31069. You'll be familiar with that, Dr. Khan, that's the first page of your statement, your Section 21 response dated 29th April 2022. If we could scroll forward, please, to the last page. It is 10:24 page 91 for you, Dr. Khan, WIT-31125.

A. Yes.

5 Q. Subject to the correction document I'm going to refer you to in a short period of time, are you content to adopt that statement as part of your evidence? 10:25

A. I do.

6 Q. Thank you.

The second statement is to be found at page 864 of your bundle. The last page is 906. If we could have up on 10:25 the screen, please, WIT-31960. You recognise that document, Dr. Khan?

A. Yes, I do.

7 Q. And the signature is, as I say at page 906, WIT-32002.

A. Yes. That's mine.

8 Q. Again, are you content to adopt that statement as part of your evidence today?

A. I do.

9 Q. Then the third document is an addendum statement recently received by the Inquiry. Your reference is page 2093. If I could have up on the screen, please, WIT-9124. The last page, WIT-91930. It is page 2099 for you, Dr. Khan. Again, that deals with a series of corrections or clarifications particularly around the issue of the terms of reference. We'll look at that presently. Again, are you content to adopt that statement as part of your evidence today? 10:25 10:26

A. Yes, I am.

10 Q. I'm obliged. 10:27

Now, you, as we can see from your statement, graduated as a Bachelor of Medicine and Surgery from a university in Pakistan in 1993; isn't that correct?

A. That's correct. 10:27

11 Q. And we can see at WIT-31070 -- your personal reference, I believe, is page 93.

A. Yes, I can see that.

12 Q. We can see your qualifications. If we just scroll down in this room, please. Your qualifications are set out there at 4.1. If we go over the page, please, para 5.1, we can see your various post holdings. You first came to the Southern Trust in June 2008 as a locum consultant paediatrician. You obtained a consultant's 10:27

post from 1st June 2009 as a general paediatrician with a special interest in Community Child Health, based at Daisy Hill Hospital. Then, in November 2012 you took up a medical management role, is that correct, as a clinical director? 10:28

A. Clinical director.

13 Q. Subsequently, from 1st June 2013 through to 31st April 2018, Associate Medical Director within your directorate, which is the Children and Young People Directorate? 10:29

A. Yes.

14 Q. There was then a short interlude when you were Acting Medical Director, isn't that correct, from 1st April 2018 until December 2018?

A. That's correct. 10:29

15 Q. That period of time coincided with your role as Case Manager for the MHPS process which we're going to discuss in some detail today; isn't that correct?

A. That's right.

16 Q. Then you, from 1st January 2019, resumed your role as 10:29 Associate Medical Director; isn't that correct?

A. Yes.

17 Q. The Inquiry understands that you have a particular interest or had a particular interest in the whole area of medical leadership, and in September 2018 you were 10:30 the author of a report dealing with medical leadership and medical leadership review; isn't that correct?

A. That's correct, yes. It was part of one of my ambitions to complete my doing my Interim Medical

Director role, so yes.

18 Q. You will find that at page 498 of your bundle. I'm not going to open that now. If we have time later, perhaps, we will look at aspects of that. I understand that the Inquiry may have questions as well for you in relation to your interest and perhaps your concerns about medical leadership and how that function was performed in the Trust. For the Inquiry's reference, Dr. Khan's report is WIT-31352. 10:30 10:31

What is your current position, Dr. Khan?

A. So I was on a career break from Southern Trust from July 2021 until September 2022, whilst I wanted to do further skills and other things in my subspecialty in children with genetic disabilities. So I was working in Cork, I'm still working in Cork with a special interest in children with disabilities. In October, when my period of career break finished, then I resigned from Southern Trust, and I'm currently working as a substantive consultant paediatrician from July 2021 onwards in Cork University Hospital. 10:31 10:32

19 Q. Thank you. So, you have no present links on the professional side with the Southern Trust?

A. No.

20 Q. I'm obliged. Thank you. 10:32

Now, you were appointed Case Manager for the purposes of the MHPS formal investigation into the practice, or aspects of the practice, of Mr. Aidan O'Brien from in

or about December 2016 or January 2017. That is obviously the main focus of your evidence with us today.

I want to ask you some questions about your understanding of MHPS at or about the time that Dr. Wright approached you to ask you to take on this role. So, if you look at 877 of your bundle, and we'll turn up in this room WIT-31973. You tell us that prior to the MHPS investigation, you had no experience of implementing or applying formal MHPS investigations; is that correct? 10:33 10:33

A. That is correct. I had no previous experience of applying or implementing formal MHPS investigations in that investigation. Although I was aware this framework is available as part of my medical management learning and understanding, but I had no role in the previous implementation of this. 10:34

21 Q. Was that awareness or that knowledge just part of your general familiarity with the area of managing colleagues as an Associate Medical Director, but no active involvement in applying the framework prior to Dr. Wright's call to you? 10:34

A. That's correct. One of my interests, obviously, is the governance arrangement, the clinician governance and professional governance. As part of my AMD work, I made myself familiarised with the current policies and procedures in the Trust -- 10:35

22 Q. Dr. Khan, not your fault at all. If we can just slow

down the pace of your delivery. The stenographer has some issues of hearing which we'll probably try to iron out over the course of the day, and your pace. Just recap on that, please.

A. So, as part of my medical management role as Associate Medical Director and my interest in medical management and clinician governance, including the professional governance, I made myself aware of the -- the current policies and procedures, which included the current policy of The Trust of addressing doctors' performance, which was 2010. And I was aware there was a MHPS Framework there to look, if I require to. 10:36 10:36

23 Q. You've told us again in your witness statement - it's page 875 for you and WIT-31971 for us - that you received MHPS training on 7th to 8th March. It was a two-day course, listed at 4.4. If we pull up on the screen just briefly to observe it, page 1040 for you, WIT-32210, the certificate of your attendance at Case Investigator training; self-evidently not case management training. Obviously you will have appreciated the distinction between what was your role and what was initially Dr. Weir's role and then became Dr. Chada's role. The Inquiry will look at the content of the training you received, but can you reflect upon us, thinking back on matters now, whether you were sufficiently equipped in your view -- having regard to your lack of experience and the nature of the training you received, how well equipped were you for taking on this role? 10:36 10:37 10:38

A. So, this had started with my discussion with the Medical Director, when he approached me for MHPS Case Manager's role. I have indicated that I have no previous experience or training in this regard, therefore Dr. Wright asked me to go for the March training, which is the next training coming up. I did attend that training and I found it useful in the regard of general understanding of the MHPS Framework various roles. But the training was a workshop training specifically for case investigators. 10:38 10:39

I did reflect on that afterwards and subsequent to that as well. So, that training was directed towards the roles and responsibilities and the actions for a case investigator. Although I must say the training was very useful to me to understand the wider framework, how it should work, but the training -- I understood that there's another training after that for a case, or something for case investigator, but this training was mainly related to case investigator's training. I did gain knowledge and understanding of MHPS investigations and the current framework which was at that time. However, I felt that as the training was directed to case investigator, I felt that I did not receive what I was hoping or intending to do. I did discuss this afterwards and I've reflected on since then as well. 10:39 10:39 10:40

24 Q. When you think about it now -- let me ask you first: Have you had a subsequent MHPS role, whether in your current location or in the Southern Trust?

A. No.

25 Q. How useful do you think training is; how important is it for people taking on roles such as the role you took on? And have you any reflections to offer the Inquiry about how medical managers - because it is typically medical managers who take on these roles - how should they be prepared by way of training or familiarity with the processes? How should that be done if the Inquiry were thinking about making recommendations around that? 10:41

A. I think we need to understand the different process which we are going to train people. In case of MHPS, the training should be part of a suite of other things. The training was very useful but I don't believe that only going to a training will equip you to go through a complex, or even simple, case manager's or case investigator's role. 10:41

Training, in a way, is also very important but I think that developing skills, developing peers, developing competencies, and developing the expertise in this role requires more than just training. Training is one part of the expertise but there should be further elements to this whole, I say, a suite of tools available to people who are going to do the MHPS role. 10:42

No doubt training is very important, and the right training for the right time. Like, doing a training three or four years ago and if you are asked to do someone now, it is hard to remember or retain the

knowledge. So it's the ongoing training, it's the ongoing peership, it's the ongoing support, it is the ongoing elements of expertise development. And not necessarily a large pool of people because we know from clinical practice, the more you do something, you'll get more and more expert in that way. So it is one of those things.

I don't know whether I answered your question but that's what my view was, and still is. 10:43

26 Q. Thank you. That's helpful.

If we can drill down into that a little bit further. You talked about training being important but you also talked about the need to develop competencies. What are you thinking about in particular? So, for example, the Case Manager, you will recall, had a role, a significant role in terms of receiving the investigation report. Then the next step was to receive a statement from Mr. O'Brien, outlining, in his case, his concerns about the process. Then, you had to make a determination which contained three steps or three recommendations. Is there any particular competency or competence required around that that should be developed for case managers for the future that you thought might have been lacking in your case?

A. I think it's also important to have the background knowledge and expertise, clinical expertise in that particular area. Not necessarily specific in that

particular area, but an understanding of how the clinical, you know, clinical domains were developed and delivered would be useful having that competency within that kind of case training suite or tools.

27 Q. So in direct answer to my question, is there anything in particular about that part of the process where you as Case Manager have to do work around the investigation report and make determinations? 10:45

A. Yes.

28 Q. Do you think the bit that's missing in your case is a lack of direct knowledge of the area; is that the problem? 10:45

A. I don't see a problem there but I think that would be a useful add-on for a competency point of view, to have a greater understanding of the whole system or the service, or how the initial service was developed and delivered -- supposed to deliver. But I believe the understanding of GMC Good Medical Practice is the core principle which is available and which should be part of this development or expertise development tool. A lot of those performance or conduct-related issues are late to the GMC Good Medical Practice guidance. 10:46 10:46

I believe I implemented, I addressed those. But having a greater knowledge of that particular team or services would be useful. 10:46

29 Q. You've told us in your witness statement -- this is page 40 of your bundle, and WIT-31704 of ours. At paragraph 7.1, you say:

"During your role as consultant paediatrician and Clinical Director and Associate Medical Director in Children and Young People Directorate from 2013 until 2018 you had no operational governance and line management responsibilities for Urology Services or staff".

So that was a part of the hospital or a part of The Trust that was totally foreign to you; is that fair? 10:47

A. So Urology Services sits within the Acute Directorate. I was the Associate Medical Director for Children's Service. Because my directorate also had a part in Craigavon Area Hospital, so although I was based clinically in Daisy Hill Hospital, my role was mainly 10:48 to do with clinical -- for Children's Services, not to the Urology Services. I must say I would have had some understanding of the challenges within the AMD forum, various items discussed at the AMD forum and not specifically for the urology, but the likes of staffing 10:48 shortages and challenges and the waiting lists are discussed at the AMD forum.

But to answer your question, I wasn't aware or I wasn't having any role in governance or line management or 10:48 medical professional governance within Urology before this.

30 Q. Do you consider your lack of familiarity with Acute Directorate and how it operated as being something of a

disadvantage in terms of how you did your work as Case Manager?

A. I think there are elements of I felt that I was not disadvantaged but not knowing I had to look for some of the procedures and policies -- not policies, procedures and how it's done. But I felt it was also useful because I was coming with an independent mindset which was, again, very useful in drafting the MHPS.
I believe that was the reason that I was approached by the Medical Director to act as a case manager. 10:49

31 Q. Very well. Thank you.

Could we just look at what the MHPS Framework and the Trust Guidelines then say about the role of Case Manager. I'm going to ask you to have a think and reflect to the Inquiry whether the understanding of the role set out on paper matched your experience of performing the role, so if we look at it from that perspective. If we go to the MHPS document in the first instance. It's the core bundle now I'm referring to, not your own personal bundle. So it's page 16 of the core, and WIT-18504. There you can find, at the bottom of page 16, a description of the case manager 's role. 10:49 10:50

"He or she is the individual who will lead the formal investigation. The Medical Director will normally act as the Case Manager but he or she may delegate this role to a senior medically qualified manager in 10:50

appropriate cases".

So it was delegated to you, Dr. Khan.

What do you take from the description of you being the lead for the formal investigation? What was the distinction between that role and the role of, as it became, Dr. Chada? 10:51

A. So I reflected upon this a lot of times since. I think I have a number of reflections on this. First, I would like to go to the framework document itself. In the first line it says the case manager is the individual who will lead the formal investigation full stop. What my understanding was at that point in time was that I'm the person who is leading the formal investigation, and that's my role. When the formal investigation finishes, by role ceased. 10:51 10:52

Now, the second reflection I have is that when I started this role, I wasn't leading, it was already led by the Oversight Committee. I had previous experience of involving medical professionals performance-related issues on the basis of Trust Guidelines of 2010, where the Oversight Committee has a role and they were actively making decisions. So, I presumed at that stage that the Oversight Committee in this MHPS Framework was also leading because of that. There are a number of decisions which were made before and since I was appointed as a case manager. 10:52 10:52

I did reflect on that part as well. So, that's the framework and how it practically was happening.

My own reflection afterwards was that I wasn't leading at the beginning of the case, of the MHPS investigation. 10:53

32 Q. We'll come -- sorry to cut across you. We'll come to some examples of that in just a moment, but if I could ask you to perhaps focus at this time in terms of your relationship with the actual case investigator and how 10:53 that description of your function as leading the formal investigation, how did that work in practice with Dr. Chada? Did you see yourself as having a role to manage the formal investigation, albeit that Dr. Chada was carrying out the actual investigation, or did 10:54 you see yourself as having a role to, if you like, sit back more passively and await her outcome?

A. So, Dr. Chada came into the role after Dr. Weir was -- first it was Mr. Colin Weir and then Dr. Chada. I would have known Dr. Chada before from the AMD roles. 10:54 We were both AMDs. I would have met and discussed various issues in relation to other -- not necessarily this, before that. So I would have known her before already and I would have a good professional working relationship with her previously as well. 10:55

In this particular case, we would have met, spoken over the phone, discussed on numerous occasions, especially in the later part of 2017 when things were slipping

away in terms of the timeframe and everything. So I had, I would say, quite a good understanding and working relationship with her during the course of this. However, I did not feel that I need to or I should be interfering about an actual investigation, purely for the purpose of independence, letting the investigator do the job, and then I will take ownership of that investigation as my role of Case Manager, perhaps. 10:56

On reflection, I may have or I should have done a little bit more prompting. I did some. I spoke to Medical Director, I discussed with Dr. Chada, I spoke to Ms. Siobhán Hynds on a number of occasions. However, we know now it took up quite a lengthy period of time. 10:56

33 Q. Looking at paragraph 35, for example. It says:

"The practitioner must be given the opportunity to see any correspondence relating to the case, together with a list of the people whom the case investigator will interview". 10:57

We'll go on and look at some detail in terms of Mr. O'Brien's complaints about the process. He wrote to you, for example, on 30th July setting out some concerns. I don't wish at this point to go into the detail of those but when concerns arise in a process such as this, do you think the Case Manager has a role 10:57

to intervene and try to resolve those concerns, or do you think it's the role of the Case Investigator to simply address them so that the Case Manager, if you like, sits back?

A. I believe there are a number of reflections on that and there are a number of ways we can improve things. I believe that there has to be a clear understanding and distinction of supporting the doctor who is going through this process which was, in a way, not very clear in the framework and the implementation. On reflection to this case and among also a lot of learnings, I believe there had to be much clearer roles and responsibilities in terms of addressing those issues. For instance, the example you quoted there, I, as a Case Manager, wasn't aware actually that the doctor hasn't received all those information until he wrote to me, which I forwarded to the Oversight Committee and admin support from Siobhán Hynds to address that. 10:58 10:58 10:58

But I believe there is an element of lack of clarity within the framework but also lack of clarity within the roles and responsibilities among various peoples. There is a designated director, nonexecutive director, as well, and there is a Case Manager, and then there's a Case Investigator who is doing the case, who is trying to explore what's happening. I believe there needs to be much more clarity in roles and responsibilities. 10:59 10:59

34 Q. Thank you.

Paragraph 36 at the bottom of that page refers to the potential to involve an independent practitioner. It says: 11:00

"If, during the course of the investigation, it transpires that the case involves more complex clinical issues which cannot be addressed in the Trust, the Case Manager should consider whether an independent 11:00 practitioner from another health and social services body or elsewhere be invited to assist".

Now, as this case developed, a question had to be answered or a serious of questions had to be answered 11:00 about clinical aspects. For example, Mr. Young was charged with the duty of reporting on whether there was a clinical justification for the treatment of a group of 11 patients who had previously seen Mr. O'Brien as private patients. Just to take that as an example of a 11:01 clinical issue that couldn't be resolved by the investigator herself.

First of all, any reflections around that, whether by reference to this particular case or in general, about 11:01 the clarity in relation to the use of clinical advisers or clinical experts?

A. I think I go back to the point of very kind of fading or in line of interfering into the investigation of

Case Manager's or Case Investigator's role. For instance, I was getting updates from the Case Investigator and from the admin in terms of the timeframe and other things, but in the content or what's coming up on the investigation, I wasn't getting all of those informations, which I believe I will be receiving the investigation report when the investigation completed and I will make my determination. 11:02

I think there is a missing link there now, on reflection, that if clinical concerns are coming up, then escalation or discussion with the Oversight Group, Oversight Committee or the Case Manager may be a useful opportunity to manage or to mediate those risks. 11:03

35 Q. You have reflected in your statement - I don't need to draw your attention to the particular page - but you have reflected in your statement that no one in this process, least of all you, was granted any additional or dedicated time to the fulfilment of your responsibilities. We can see that that applied to the Case Investigator; it also applied to Mr. O'Brien who had to commit some significant time to preparing his responses and participating in interviews and what have you. 11:03

When you think about it now, in terms of the role of the Case Manager and the Case Investigator, do you consider that the Case Manager's role should be

more proactive in terms of understanding what the investigator is doing, at what time and in what period he or she is doing it, the particular challenges faced in terms of gathering evidence and receiving evidence and, to some extent directing, not necessarily the minutiae of the investigation but directing in broad terms where the investigation should go?

A. There are a couple of points in your question that I would like to address in sequence. I think the first thing is that resource allocation, the time, the protected time. I'm now aware that nobody has received any protected time for doing this MHPS investigation. I had a busy caseload. I was also a medical management role in my directorate. We were going through a major reconfiguration for Children. We were going through some other important pieces of work, which I can expand on, if you like, at some stage. But no protected time in my job plan or in my working day. I feel that was one of the important factors.

I believe that I did try to address that as a Case Manager. I believe I wrote to -- I asked, actually, this question from the Case Investigator and I did discuss with the Medical Director. I think we need to understand the line management structures of all those people are different. So, for instance, my line manager was Medical Director but my appraisal line manager was my Operational Director. The same as for the Case Investigator, she had her own operational line

manager and then professional line manager. The same works for the HR. I had no authority or responsibility in terms of providing that. All I was trying to do is to raise that issue with the Medical Director and the Oversight Committee to address this lack of understanding that this is a complex investigation and it takes more time than you think initially. Initially I was told that it would take three months and then it should be finished, and we know it took much longer than that. So, that the first point. 11:06 11:07

The second point you made about the proactiveness. I think there's a balance to be made there in terms of how much involved the Case Manager should be, or could be in my case at that time. I think I reflected on that, and I reflected in my statement as well, that I could have or should have been more proactive in terms of pushing this investigation through the process and getting it finished. I did try that, and I've put a number of elements in my statement what I tried in doing that, but not interfering with the investigator's role and not letting the investigator feel that the Case Manager is nearly taking over or addressing some of those. So, there is a distinction between those. And those fine lines between those balanced approaches, I believe, comes with experience and expertise. Also, developing competencies and training and understanding. 11:07 11:07 11:08

That is my reflection in terms of not knowing when you

should be addressing some of the issues coming up but not stepping into someone else's role.

36 Q. The Trust Guidelines, which you had some familiarity with, the 2010 document, just take a brief look at the definition of Case Manager, the description of Case Manager to be found there. It is page 99 of the core bundle at your end, and for us it is TRU-83702 at the top of the page. So, the role will usually be delegated by the Medical Director. We've seen that already in the MHPS document. It says: 11:08 11:09

"The Case Manager coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate timeframe. The Case Manager keeps all parties informed of the process and also determines the action to be taken once the formal investigation has been presented in a report". 11:09

Is that a description of your role which met the reality of it? Did you provide support; did you ensure that it ran to an appropriate timeframe? Or with the benefit of experience, do you think - and perhaps resources, most importantly - that that is a goal or an objective that the process should aim for but wasn't deliverable for you? 11:10 11:10

A. I think we need to look at, for any task or activity, what are we trying to achieve, when are we trying to achieve and what quality we are trying to achieve. I think in this case there were some resources but not

appropriate, not adequate. In addition to that, I feel that the appropriate timeframe and what should be the appropriate timeframe for an investigation; you cannot have a generalised rule of one week or two weeks or 10 weeks, it has to be on the basis of what the investigation looks like from the beginning and then how it is progressing. But having that clarity that this is important from the organisational point of view. It is an important piece of work which we are doing, and we will put resources into that, whatever required resources are, in order to achieve the timeframe, the quality, the outcome which we are hoping to achieve, rather than doing it on add-on jobs, add-on roles, and then on people who are already very busy in other roles as well, and trying to complete these things within a timeframe that is unrealistic, and trying to do it in a way that there's not only -- so we are talking about a complex piece of work. We need to understand it - we can do it quickly or we can do it right. There is a balance between those two things. If you put a resource, if you put an expertise, if you put all those sorts of required elements into that process, we should get a good outcome. 11:11 11:11 11:12 11:12

In my case I believe that it was an add-on on many, many people's job plans, roles and responsibilities. I also believe there's this element of still lack of clarity at many levels, including myself; I take the responsibility for that. But I believe that it's even 11:12

more senior people than me at that period of time had a lack of understanding of their roles. I think we are learning, and that this is the one learning we should be taking forward, the clarity of roles and responsibilities; who escalates it; who should be acting when. At the centre of all that - I think we're talking about so many other elements - but the centre of all this is our patients; people, you know, our community. So we need to work around that and the process has to be right, the system has to be right, the support, the organisation -- and I'm not talking about, I think this is not about Southern Trust, it's about our whole system. We need to work to improve our system. We need to see an improvement going forward. That's my impression. 11:13 11:13 11:14

37 Q. Thank you for that.

If you could pick one or two learnings from your experience and from your observations of the experiences of others who were participants in this MHPS journey, what would those learnings be? Would they be resources, for example? 11:14

A. Well, as I alluded earlier, I think there are multiple factors. My experience was everybody was trying their best but not working as a team. I don't think we were working as a team; which should be. Again, team not necessarily means one team has roles and responsibilities, who is the leader, who is taking ownership, and where it goes next. There's a system, 11:14

and processes weren't there to support us. When I say about the systems and processes, it's about the resources, it is about the environment; all of them were not there at that point of time.

38 Q. Very well. Thank you for that. 11:15

I want to ask you about two specific aspects of your role by reference to the guidelines and the MHPS Framework, which we will touch upon in greater detail in the course of today. The first role concerns the 11:15 issue of exclusion and how the Case Manager had a significant role in that, at least according to the guidelines. If we can bring up page 97 of your core bundle, and for us in this room it is TRU-83700.

A. It is my bundle? 11:16

39 Q. Sorry, it is the core bundle at your end. Page 97 and you should see Appendix 5 at the top. This is Appendix 5 of The Trust's 2010 guidelines. It concerns an issue we'll come on to look at in greater detail later this morning but since we're in this document now, it's 11:16 convenient to look at it.

You can see that the context here is whether the clinician should be the subject of formal exclusion. We know that following a case conference concerning 11:17 Mr. O'Brien, the decision was that formal exclusion was not necessary. But in terms of your role, you can see that in the process is that the Case Investigator, that was Mr. Weir, produces a preliminary report - this is

the left-hand box - for the case conference to enable the Case Manager to decide on the appropriate next steps. Then across the page, the report should include sufficient information for the Case Manager to determine if the allegation appears to be unfounded at one level or whether the case requires further detailed investigation. Then the next step is, again, a case conference to be convened by the Case Manager and others to determine if it is reasonable and proper to formally exclude the practitioner, to include the chief executive when the practitioner is at consultant level. This should usually be where -- that is "exclusion should usually be where, and it sets out some circumstances and further detail about the exclusion. 11:17 11:18

First of all, did you appreciate when you went to the case conference in January that this was the process that you were following?

A. Yes, I did. Just I think a day or two before that I looked at the framework, and I was also advised by Ms. Siobhan Hynds in relation to that as well, that it is your role to make two decisions at that point in time. The first one is going to be looking at preliminary investigation and about the formal investigation decision. The second role, I understood, was in relation to the formal exclusion after the period of interim or preliminary exclusion. So, I understood a couple of days before that. 11:19 11:19

40 Q. Yes. Plainly, as we saw earlier, you are entering into

this area of your role when you didn't have training. The training that you ultimately received was in relation to the Case Investigator's role, although it had some general application as you have described; the issues that you had to grapple with at that meeting, whether there was sufficient, if you like, material or evidence to justify a formal investigation and, secondly, whether exclusion, formal exclusion, was merited. 11:20

Were those issues easy to grapple with on the basis of your perhaps wider medical management experience, or did you find this junction troubling and difficult in the absence of training and the absence of experience?

A. I think I have reflected on that. At that point in time, it was challenging for me to make that decision. I did not make that decision on the basis of just my assumptions, I took the advice, and I can go through that. I did indicate in my statement what elements I took in consideration in relation to that decision. But there were two decisions to be made on that day. 11:21

41 Q. We'll come to the detail of those perhaps a bit later but the question at this point, I suppose, is just in terms of this part of your job description, in the absence of training, you found these issues challenging? 11:21

A. I did. Also, I felt that it was on the day, it should be given an appropriate time consideration in terms of knowing the report in advance, getting the report in

distance, considering that. I felt it was -- I still believe the outcome would not be different but it was challenging for me coming in to assist in this process, first time, really first formal meeting about this process, and being asked to make the call for the two more decisions.

42 Q. Yes. The second part -- and this is really just draw your attention at this point in the evidence to what the rule book says, what the guidance of the Framework says, if you like. The second aspect to bookend the process is the determination role that you held. 11:22

I just want to draw out some aspects of that. This is going back to page 17 of the bundle you're in, the core bundle, WIT-18505. At the top of the page, it talks about time scale. We've had your reflections upon some of the reasons why four weeks wasn't possible, it being a complex investigation. Your view is that it should be done properly as opposed to be done at a certain fixed time. 11:23

Moving on, it says that the report, that is the investigation report, should give the manager sufficient information to make a decision on whether no further action is needed or whether some other action should be taken, including a misconduct or a conduct panel, reference to Occupational Health, NCAS performance assessment, referral to the GMC, etcetera. 11:24

I'm just interested to hear from you, Dr. Khan, on

this. In your role as Case Manager receiving the investigator's report, is it simply your role to accept the investigation's findings or is it part of your role to interrogate those findings and, if you like, assess whether there are any flaws or weaknesses within the analysis, any gaps in the evidence, anything not taken into account? Do you understand the difference?

A. Yes. So, we're talking about the quality of determination, I suppose. Part of the Case Manager's role at the time of determination, which I understood and I reflected upon, is not necessarily taking all that evidence provided only in consideration. So, making sure that factual accuracy is being consulted upon, which we did in this case by receiving some comments - I made a long list of comments back from Mr. O'Brien - but ensuring that the evidence provided is also -- there's no discrepancies between the evidence provided in the report, the statements or appendices which are also included in that as well. If there are significant discrepancies coming up or identified, then further explore that.

I must say it's not very clear in the framework document, if you were to go as a Case Manager, how to do that. But the Case Manager is taking all that information and processing all that information in addition to including the standards required through the GMC, through the contractual agreements, through the policies and procedures available in the Trust, and

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making sure the other information is also included in that as well, in that final outcome of that determination. We're talking about the investigation which is going through a lengthy period of a number of interviews and statements, and also interview of the doctor, and collecting all that information. So yes, that was my understanding.

43 Q. If you had taken the view that there were discrepancies in the investigation report or issues not effectively covered, did you consider that a Case Manager has the power to send the report back for further work to the investigator, or is that something that didn't cross your mind? 11:28

A. I must say in this case, other than one of the terms of reference, which was the fifth term of reference - this was about, you know, the management role and the understanding of the issue, long-standing issue - that wasn't coming across to me that there's sufficient information available in order for me to make a judgment on that basis. Therefore, I have asked the further independent investigation to look at it individually. 11:28 11:28

I also felt that that requires independence, that requires a different set of skills, competencies, in order to gain what we are trying to achieve. In this case, it did not come across as a significant discrepancy to me. There was some comments back from Mr. O'Brien, and he was commenting about the number of 11:29

clinics and details, but I compared that standard, the expected standard, with GMC Good Medical Practice, the expected standards from the contractual agreement, from the policies and procedures, and I made my determination on the basis of that. 11:29

44 Q. I wonder could you help me with this particular point? The Case Investigator's report led you to the view that there should be a conduct hearing. Is that report the subject of any further comment or consideration at the conduct stage? Forgive me, I haven't asked this 11:30 question particularly clearly. What I'm anxious to learn from you is, at the conduct stage, is there a further investigation or does Dr. Chada's report serve as the basis for the prosecution of the clinician in the conduct context? 11:30

A. Yes. So, in drafting my determination, I applied all those guidelines and standards and considered all those. But I also received advice from key people within the Trust and from NCAS. I would have received advice and shared the investigation and the draft 11:31 report with three key people - the Chief Executive, the Director of HR, and NCAS.

I was already aware of the fact that this case is already known by the GMC Liaison Officer because I was 11:31 involved in my other role as a medical director. The intention was that once the report is released, then the report will be shared with the GMC and discussed in the next GMC liaison meeting, which is coming up in a

couple of months' time, or before. I was also aware that at conduct level, there are various avenues available to the conduct panel. You know, there are options available at the conduct level which includes GMC referral, NCAS, if you feel there's a further inquiry or investigation. So, I was aware of those. But at the point of when I was making the determination, I was satisfied that I have fulfilled the requirements as per the MHPS guidance, what I needed to do for the options available to me. 11:32

45 Q. Thank you.

Now let's look specifically at the circumstances of your appointment. If we bring up page 238 of your core bundle, and if we go to AOB-01280. We have here the -- 11:33

A. Sorry, what's the number you said?

46 Q. I beg your pardon. It's 238 of your core bundle. Not your personal bundle, but core bundle. It's the Oversight Committee meeting of 22nd December 2016. We find that at that meeting a decision was made by the 11:34 Oversight Committee. Can we just scroll down, please. The context is set out and the issues of concern are described. Keep scrolling, please. Various action is directed to various people. Keep going, please. So, it is said: 11:34

"In light of the above issues, it was agreed by the Oversight Committee that Dr. O'Brien's administrative practices have led to a strong possibility that

patients may have come to harm. Should Dr. O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr. O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach. 11:34

It was agreed for Dr. Wright to make contact with NCAS to seek confirmation of this approach and aim to meet Dr. O'Brien on 30th December... ". 11:35

On the exclusion issue, clearly by this date, 22nd December, you knew nothing about this case. Is that fair? 11:35

A. Yes. The first time I was contacted was, I think, after Christmas. I think it was 28th or 29th December.

47 Q. We've heard evidence from the Medical Director, Dr. Wright - we don't need to bring up the reference - but he said, "It would be the Case Manager's decision ultimately on exclusion but he would have been aware of our view. The final decision to do this has to be the Case Manager". The suggestion through his evidence, perhaps - it is for the Panel to assess - the exclusion decision was somehow your decision. Do you understand that? 11:35 11:36

A. I do. I don't see how it could be my decision when the exclusion was already decided. If it wasn't, which appears to be, before somebody is contacting me even to

say that you are Case Manager. So I don't see that -- so when I came to know more after New Year, when I spoke to Dr. Wright about the case on a number of occasions during the early part of January 2017, exclusion was already in place.

48 Q. We will come to that discussion in a moment but just one question in relation to it. During that discussion, did he set out to you the fact that Mr. O'Brien had been excluded, and did he seek your view on whether it was merited? 11:37

A. Obviously Dr. Wright has indicated that Mr. O'Brien has been excluded. I don't recall any discussion in relation to my view on that. It was more about providing information that Mr. O'Brien has been excluded and there is further preliminary investigation ongoing. 11:37

49 Q. Plainly, as we will see in a moment, at the case conference, the case meeting on 26th January, you did have a specific role in terms of the continuation of the exclusion, if you like, and we'll come to that. But certainly what you are saying to the Inquiry in clear terms is this decision of the 22nd December had nothing whatever to do with you and you weren't consulted upon it? 11:38

A. No. 11:38

50 Q. Now, if we scroll down then. May be back up, I beg your pardon. Pause there. This committee meeting also took the decision - I'm struggling to find the reference but we know it's there - that there would be

a formal investigation under MHPS. So, when it came to your discussion with Dr. Wright, was that something you were told?

A. I was told that Mr. O'Brien has been excluded from practice for a period of time; there is an investigation going, an ongoing investigation which has to finish within a few weeks, and there will be a case conference at the end of that before the exclusion period is over. I don't recall the specifics of those discussions but I can recall that Dr. Wright was indicating that it is highly likely there's going to be a formal MHPS investigation. 11:39 11:39

51 Q. We know from what you said in your statement that, following this meeting on 22nd December, Dr. Wright wrote to you saying - by email: 11:40

"It's a tricky situation. There has been an SAI which has highlighted serious potential issues and would you be prepared to act as Case Manager under the MHPS framework". 11:40

And I think you replied and suggested a meeting after the holiday period. At that meeting, as well as being told about exclusion and the process as envisaged going forward, to what extent were you briefed about the background to all of this? 11:40

A. I think we need to understand that the first time that I was contacted, I had no understanding or information what was going in the background. I had no clinical

contact or wasn't actually aware -- I had never met with Mr. O'Brien before. I had no knowledge what was going on the previous year or years. When I was approached at that time, I thought about that, I said I thought there's the request by my Medical Director, we need to meet and discuss it after the holiday period, which we did. I must say information was drip-fed in a way. There was some information on the first meeting, and then there was further information. But I don't think I have received the extent of background information before this Inquiry. 11:41 11:41

52 Q. Let me take, for example, the events of 2016. At some point you did discover that Mr. O'Brien had met with Mr. Mackle and Mrs. Trouton and received a letter dated the 23rd March setting out some concerns and inviting him to provide a plan. Were you told about that, do you think, at an early stage? 11:42

A. I was told about the summary of what has happened in 2016, that there's some concerns, and then the clinical managers met with the doctor and provided some action plan and follow-up. Then it fell out of follow-up then and the SAI has raised concerns, and now we are going into the formal MHPS process. 11:42

53 Q. I think we know from events in late 2018 that at that point you discovered that NCAS had an involvement in this case from November 2016; that is several months after the March letter. Is that the earliest point you would have heard about that? 11:43

A. I would have heard about the NCAS December contact by

the Medical Director. Dr. Wright indicated to me, in fact on a number of occasions, that we had discussed with NCAS - and this is the December discussion with NCAS - and they are also suggesting about the formal investigation. I considered that as part of my role on the day as a Case Manager in a case conference day, but I wasn't clearly -- I had no clear knowledge or understanding about previous NCAS meetings or consultations. 11:43

54 Q. Yes. Perhaps it was fortuitous or coincidence that term of reference 5 was entered into the investigation because it, on the face of it, was supposed to look at the events pre-2016 and all of that. We've heard from you already that you were unhappy, to some extent, as to the content of that aspect of the report. When you look back at matters now, knowing that there were, for example, exchanges with NCAS in September 2016, knowing that they endorsed an approach which would have been supportive of Mr. O'Brien in terms of addressing the shortcomings in his administrative practice, do you feel that you were in any way disadvantaged as Case Manager by not having a better and more detailed briefing of all of the events that predated the decision to formally investigate? 11:44 11:44 11:45

A. I think the complexity of this investigation has a lot of learnings. A learning for me was that I wasn't aware of so many events or happenings happening before I came into this process. It may not be intended for that, but I gradually gained knowledge as I went 11:45

through the process. Maybe one of the learnings should be that the Case Manager and the Case Investigator should be briefed in a more formal way, providing the information not only through verbal information but having a more formal structure that a Case Manager, Case Investigator, and others in that particular role, should receive.

55 Q. Just one final question before the break, Dr. Khan. Dr. Wright described this as a "tricky case". Perhaps all MHPS cases are complex and tricky. You were new to the world of MHPS, no experience and no training, as you described, albeit you were familiar with the documents. Did you feel that you had any option but to accept the brief from the Medical Director or could you have refused? 11:46 11:46 11:47

A. On reflection, it's actually I could have refused, yes. I could have said no, but I felt that I needed to -- at that point in time I needed to discuss more with Dr. Wright to understand better, and as a medical manager in the Trust, I have roles and responsibilities as part of my medical governance roles. My main purpose of my medical governance was in the CYP, in the Children's Directorate, but I was also part of the Trust part of the system, so I felt that I needed to be part of understanding more and knowing more and then taking it from there. 11:47 11:47

Obviously, in hindsight, I could have refused. Should I have? I don't know. I would have liked a better

supported environment and training and time, and protected time. But that was my thinking behind that at that point in time.

MR. WOLFE KC: Very well. Is now a suitable time for a break? 11:48

CHAIR: Yes. We'll come back again at 12.05, ladies and gentlemen.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS: 12:05

56 Q. MR. WOLFE KC: Hello again, Dr. Khan. Are we loud and clear?

A. Yes, yes. Thank you.

57 Q. Just before the break you were reflecting on the fact that based on your experience, a greater formality and 12:06 a greater level of detail, in your view, should accompany the briefing of the Case Manager at the commencement of an MHPS investigation. I can see from your statement that you recall having perhaps two meetings with Dr. Wright during January, but still and 12:06 all, you, upon reflection, seems to be dissatisfied, knowing what you know now, about the briefing that you received.

A. I suppose at that point in time, I had no further knowledge of what I have gained since, and at that 12:07 point in time I felt that -- I perceived that I was getting all adequate information, but in hindsight, with the information available to me now, there's a much greater knowledge I acquired, you know, now rather

than at that point in time. Yes, that's correct. I feel that if there was an element of more structure, standardised formal approach of hand-over or giving information would be very useful in providing adequate, sufficient, appropriate information for the people who are going to lead this further.

58 Q. Yes. I mean, obviously, by its very nature an investigation will reveal to you as Case Manager, and the Case Investigator, facts that you wouldn't know at the start. But can you think of any particular example of the kind of information that Dr. Wright should have been sharing with you, notwithstanding that an investigation was to take place, which would have put the investigation on a better footing, perhaps, from the start? 12:08

A. I suppose there are a number of elements to the information which would have been very useful. I suppose the greater detail of what has happened in March 2016 in terms of around that period when some sort of a letter or explanation or action plan was given without any follow-up. I did not see that. Then the screening exercise, or -- I don't know whether I'm calling it the right term. There was a screening exercise happened, I think, in around September time, 2016. I did not receive the details of that. I was aware that there was a screening done but I wasn't aware of the details of that, by whom, by what extent, where they're screening, what it led to. That would be something I would have reflected upon and I thought

would be very useful. Those are the elements that maybe different in another case, I think, but it is having that structured information available that these are the documents, these are the minutes, this is the information which have been already happened before you joined. You need to take control of that or being aware of this would be very useful, and that's my view on that.

59 Q. I want to ask you another question that builds on that about, if you like, the nature of the communication and understanding across the team generally. By that I mean yourself, at that stage Mr. Weir, and Siobhán Hynds, who was allocated to the investigation wearing a human resources hat. We can see that Mr. Weir emailed yourself and Hynds and Gibson on the 12th January 2017. This is at page 353 of your core bundle, TRU-267243. 12:09 12:10 12:10

Against the background where the MHPS Framework provides a four-week completion period from the date of the appointment of the investigator, save in exceptional circumstances to complete the formula, he is writing on 12th January saying that he's the lead investigator; "I know an Oversight Committee met this week", they met on 10th January, "to discuss the issues". He said: 12:11 12:11

"I have not yet received any official confirmation to commence the investigation but I have been forwarded

several emails explaining the issues.

My understanding is the process should be completed within four weeks of the suspension of the consultant concerned" -- I'm not sure that's entirely correct but there's a four-week period I think from the date of appointment. 12:12

"I also understand I would have assistance from Employee Relations". 12:12

Is it fair to say, Dr. Khan, that there was a slow and uncertain start to this process with key actors such as yourself and such as Mr. Weir not quite knowing what was to happen next? 12:12

A. I think that indicates the lack of clarity in terms of roles and responsibilities at that point in time. I had very little understanding of my role personally and what I am supposed to do at that point in time. I was aware of a number of Oversight Committee meetings happening in somewhere, and I wondered afterwards and now on reflection why I wasn't involved in those information or meetings. Perhaps there was a reason behind that as well. That also made the roles and responsibilities less clear because there is a group of senior professionals in the Oversight Committee making those judgments and decisions whilst I'm being appointed as a Case Manager. I'm going through the framework, I have no prior experience or understanding 12:13 12:13

of the MHPS, I have no training.

I understood since afterwards and since then that there was a lot of -- a lot of work was going on in the background. So, the preliminary investigations were going on and other things were happening but I wasn't aware of that. I had no knowledge of that. It's fair to say it may be intended at that point in time, I wasn't sure, but it should be better communication among the whole team which was appointed. 12:13 12:14

60 Q. If we take the team to be yourself, Weir, and Hynds, did the three of you sit down at any point prior to the case conference on 26th January to discuss "how are we going to do this?"

A. I think the first time the three of us met was in case conference, but I would have met with Siobhán Hynds before that. I would have received a number of communication, emails, phone calls, discussion with Siobhán Hynds. But I don't recall; I may have spoken to Mr. Colin Weir but I don't recall meeting him face-to-face with Siobhán Hynds before the case conference. 12:14 12:15

61 Q. Reflecting upon that important stage - the three of you have just received your appointments, I suppose, in January, sometime early January - do you think upon reflection if you were doing this again that there's a need for the three in the team to sit down and chart a course, bearing in mind the imperative of the timeframe set out in the framework; if we can't do it in four 12:15

weeks, perhaps how quickly can we do it; what are the stages to go through; that kind of charting the way?

A. I believe there is an element of everybody is busy with doing different things, but I believe there is to be a formal meeting of the team appointed to discuss where we are. I also believe this is not at the beginning; like I believe there has to be a formal discussion at various points in investigation to discuss face-to-face how are we keeping a track of where we are, how we're going, when we get there. 12:16

I don't think we had that at that particular time, but yes, that should be something which I would like to do. If I do it again, I would like to do it that way.

62 Q. Let's move to the case conference. The case conference took place on 26th January 2017. We looked earlier this morning at the flowchart in terms of the decisions etcetera that have to be taken at that meeting and who should take them. Feeding into that meeting is a professional or preliminary report from Mr. Weir. If we could have up on the screen, please, TRU-284981. For you, Dr. Khan, it's 1617 of your personal bundle. Your personal bundle, not the core. 12:16 12:17

A. Is that the email from Siobhán Hynds?

63 Q. It is, yes. Sorry, I should have said that. 12:17

Siobhán Hynds is writing to you at 11.25 on 26th January attaching a report from Dr. Weir, telling you that in line with MHPS the report is required to give

you sufficient detail to enable you to determine, firstly, if there's a case to answer, and also to enable you to decide on the next appropriate steps, including whether formal exclusion is required or whether there are alternatives to exclusion pending conclusion of the investigation. 12:18

"It is also a requirement to consult with NCAS where a formal exclusion is being considered", and you are provided with a phone number for Dr. Lynn. 12:18

Have you any recollection of when this meeting took place?

A. So, this email is important because I was doing clinic in Daisy Hill; I was with a complex patient. This email arrived in my inbox, which I didn't get to see until I finished the clinic at 1.30. I had to be in Craigavon, driving, and the meeting was at two o'clock. So I did indicate that I'm not going to be able to see the investigation report before the meeting and I will discuss it at the time. 12:18 12:19

That's what was happening in my life at that moment in time. I was seeing a patient, I had no time outside of clinic activity to see the report which is going to happen in a couple of hours' time, and then I had to reach that meeting. So the first time I saw that preliminary report was in that case conference. 12:19

64 Q. The Panel is familiar with the report and I suspect

we don't need to open it.

Plainly, as this email suggests and as the process we looked at earlier this morning suggests, plainly this meeting is focused on a number of potentially pivotal decisions: (A) is there a case to answer and, if there is a case to answer, then a range of possibilities including a formal MHPS investigation. And, secondly, again I think you'll agree with me, a pivotal decision in relation to whether exclusion is necessary. You agree with that, do you? 12:20 12:20

A. I do. I do.

65 Q. I suspect you would also agree, from what you've just said earlier, that receiving this report when you're in clinic an hour and a half or so, or two and a half hours prior to the start of the meeting, was far from ideal? 12:20

A. Yes.

66 Q. The suggestion that you might contact NCAS, was that something you thought you should do prior to the meeting? 12:21

A. I don't think so. I saw that email actually in practical terms until I reached to the venue of the meeting. My focus obviously was, first of all, to attend that important meeting which was happening. The two key elements of those meetings, I see that meeting was an important point in time, which was to decide two important elements. First of all, is a formal investigation under the MHPS Framework going to happen. 12:21

The second important element on that meeting, the outcome or the aim of that meeting was to decide whether formal exclusion was necessary.

67 Q. If I could just ask you to pause and we'll bring up the minute of the meeting. It's in your core bundle now, going back to the other bundle, as 403. We can find it at TRU-00037. That's the first page. You're in attendance, obviously as the Case Manager, with Mr. Weir also present and Siobhán Hynds. You've said earlier - I don't know if it was just based on that email that you received from Siobhán Hynds - that you had an understanding of your role at that meeting? 12:22 12:22

A. I had a discussion with Siobhán Hynds before that meeting on a couple of occasions. She would have explained to me my role at that point in time, so I had some understanding of my role before going into that meeting. 12:23

68 Q. Yes. If we just scroll down through the document, maybe end up at your page 405, the third page of the document. We can see from the format, this is a document the Inquiry is fairly familiar with at this stage, that Mr. Weir outlined what his preliminary investigation had established. He had previously met with Mr. O'Brien, I think two days previously. Yes, the 24th January, as we can see at the bottom. He was putting into the mix various factors, including the extent of his concern around the four issues. He was also putting into the mix at the meeting his view on whether exclusion would be appropriate. 12:23 12:23

Just back to the top of page 05, please. The historical attempts to address concerns was discussed. Did you get any sense -- it uses the word "advocacy" in association with Mr. Weir. Mr. Weir was an investigator. Was he putting a case on behalf of Mr. O'Brien in an inappropriate way in your view, or is the word "advocacy" used advisedly simply to say tat he was trying to put forward a balanced approach to these matters? 12:25

A. If you allow me, I'd just like to make a few comments on that day, on that minute.

69 Q. Yes.

A. I think it was an important meeting and we need to take account of the importance of that meeting, which was planned well ahead, whatever timeframe. From the Oversight point of view, Oversight Committee point of view, Mrs. Toal was there and she chaired the meeting because Dr. Wright was on the phone call. 12:25

Mrs. Gishkori wasn't available, so she designated or she nominated Assistant Director, Ann McVey, came along. At that point in time I clearly remember she had been apprised of but not very much aware of the information or background. Then in the meeting, Simon Gibson was there, who provided quite a lot of background, historical background in that meeting. I don't think the minutes really reflect on what discussion was happening because there was a lot of discussion happening on that point in time and the 12:26 12:26

minutes were not -- I don't think they are called minutes, probably action plan in some shape or form summary discussion.

My role, as part of the first element of my role, was to decide, as Case Manager, whether there is a case to answer. How I was going to reach to that point was a number of factors. The main factor was the preliminary investigation report which was still preliminary, which wasn't obviously completed because there was a lot of elements to be completed afterwards, and it took nearly four, five, six months before we got to know the extent of the untriaged letter sent, all those things. So, that was the evidence provided. 12:26 12:27

I was also made aware in that meeting that Mr. O'Brien had successfully completed appraisals. He was successfully revalidated. I queried that element of the appraisal and revalidation and the role of that in the medical -- professional medical governance, with my experience in my directorate. I was informed that these were important, these were important but they will be looked at. 12:27 12:27

Then Mr. Weir, after presenting the report, the discussion happened clearly in terms of the standards from the GMC Good Medical Practice. I was aware of that and I had read before, a couple of days before that, to freshen my memory. 12:28

So, we got a report, we have the GMC standards, we have an understanding or awareness of there's an SAI, which was not reported but there was highlighted concerns in December 2016. Then I was provided some, obviously again historical background, about going on for some time and the extent of all that information in the preliminary report, which I don't need to go through that. There was large number of untriaged letters, large number of undictated letters, large number of notes were sitting somewhere. And then a discussion about whether there was a case to answer. 12:28 12:29

So, with all that evidence available in front of me, I asked a simple question from the team, from the available people in that meeting, what everybody thinks what I am thinking, that this is a case to answer; what the steering committee, the three people there, thinks. I'd like advice. I would also like advice from a clinical director, who was Mr. Weir as well. He was the investigator; he had a greater knowledge and a greater understanding of the extent of the problem, which he investigated along with other people. On the basis of all that information, the decision was reached, and it was my decision, that there is a case to answer. I reached that decision on all the elements that I have explained there. 12:29 12:29 12:30

Then the discussion started to happen whether Mr. O'Brien can be brought back.

70 Q. Yes. Dr. Khan, you're saying an awful lot, and I don't wish to stop you. Can we deal with these issues in part? Before going to the exclusion, let me just come back on some aspects of what you've just said around case to answer. 12:30

I asked you a question about Mr. Weir's role. Obviously he is the Case Investigator but he was also at that time somebody who knew Mr. O'Brien quite well. He was the Clinical Director with some responsibility for Urology. The record, the minute, talks of his advocacy for Mr. O'Brien or in respect of Mr. O'Brien. Did you see that as appropriate, given that he was the investigator? 12:31

A. I didn't comment at that particular time. The term "advocacy" wasn't used as the advocacy. Mr. Weir did indicate that, in his view, Mr. O'Brien is a good, caring surgeon who put a lot of effort in patient care. He also indicated at a later part of the discussion that he is not aware of any clinical concerns of Mr. O'Brien. 12:32

71 Q. Is that part and parcel of taking a balanced approach to his role which is entirely appropriate in your view, or did you see anything amiss with it? 12:32

A. I suppose, on reflection, again that goes back to the understanding of roles and responsibilities; when we are in a role which is relevant to that point in

time that we need to act on that role. But I can see from Mr. Weir's point of view that he was giving his view or his opinion in that way. On reflection, perhaps maybe it would have been, you know, better if the advocacy role wasn't introduced at that point in time. I can only say on hindsight and on reflection, I must say I did not question, or I did not challenge at that point in time. Neither anyone else. 12:33

72 Q. Thank you. If we scroll down just to see the decision that you make on the next page. You have said that you're a person who likes to take advice, you took advice at this meeting, but the decision that there was a case to answer was yours. Now, you've also said in your witness statement that -- I'll just read it out to you. If you need to bring it up, we can. You say: 12:33 12:34

"As this was my first experience of being involved in an MHPS investigation, it wasn't very clear to me at the beginning what my role as Case Manager would involve. The Oversight Committee was comprised of the Medical Director, Director of HR, and Director of Acute Services. This committee was already involved and made some decisions for this case, so this blurred roles and responsibilities for me". 12:34

In terms of your autonomy and authority at this meeting to take a decision that there was a case to answer and a formal investigation should ensue, was that in your mind a decision that had already been taken by

Oversight in December, so that you were influenced by that? Or was this an entirely independent and different stage of the process where you were simply informed by what Mr. Weir was reporting and the advice that you were taking around the table? 12:35

A. I think there's a lot of information come to my knowledge since. At that point in time when I went to the case conference and I made that decision on the basis of information and evidence provided to me, in addition to the advice I received on at that point in 12:35 time. I still believe that that was my decision as a Case Manager for exclusion, with the advice from the Oversight Committee which was present there. I was aware of some indication/discussion with Dr. Wright that this was potential or likely - I don't exactly 12:36 remember the term - but there was some discussion already has happened, and this is a potential or likely case for formal MHPS investigation, for various reasons which we have already discussed. But I still believe that was my decision at that point in time in the case. 12:36

73 Q. Help us if you can with this. The notion that there was a case to answer is legalistic language. The Framework document and the Guideline document produced by the Trust isn't very helpful in allowing the reader to take a grip of what is meant by that phrase. What 12:37 was the task, as you understood it, and what factors did you take into account? Was there, in your own mind, an alternative to an MHPS investigation in all of the circumstances, even if there were concerns about

Mr. O'Brien's practice?

A. I think the first point I would like to make is the MHPS Framework document is not easy to navigate, it is not easy to understand. You have to go through several times to understand the terms and the analogy and pathways on that. I did go through several times to understand various things. But at that point in time when I went into the case conference, that was the framework in front of us; it was the MHPS Framework we were working from. So that point in time there was no -- I must say there was no alternative framework or the policy. The Trust Guideline 2010 for managing performance and doctors and dentists was alongside with MHPS, but we were on the MHPS Framework document and we were keep referring back to that in that discussion as well. 12:38 12:38 12:39

74 Q. I can maybe push on this. What test did you think you were applying? What did those words, "case to answer", mean to you?

A. "Case to answer" meant to me at that point in time we need to do a further investigation, a formal investigation, to understand; to allow for the doctor as well to make their comments, case, statements, representation. But also we need to look at in a formal investigation way by approaching, by gathering information, by taking the statements, by doing the interviews. That was my understanding a case to answer means in MHPS terms. 12:39 12:39

75 Q. Having taken a view at that point that there was a case

to answer, does that inevitably colour your view at the other end of the procedure when you receive the investigation report from Dr. Chada and have to make a determination?

A. I would say no, because the case to answer was a beginning of investigation, and when I received the investigation and making a determination, that is another point in time, and I have got details of the statements -- apologies, I just. 12:40

CHAIR: Just for the benefit of the transcript, Dr. Khan had to step away from the witness box briefly. 12:40

MR. WOLFE KC: Exit stage right.

Thank you, Dr. Khan, are you settled?

A. Yes. 12:41

So at two different points in time, I was making judgment but they were at the different types, levels; different information available to me. So I don't think that my judgment at the time of determination was in any way influenced by the time of the initial decision. 12:41

76 Q. Some other issues arising out of the meeting, then. On exclusion - if we just scroll down, please - the discussion was whether Mr. O'Brien could be brought back with either restrictive duties or robust monitoring arrangements. As we can see as we scroll down, the case conference members noted the detail of what this monitoring would look like were not then 12:42

available, but it was agreed that the operational team would provide this detail to the Case Investigator, Case Manager, and members of the Oversight Committee. So this monitoring arrangement, we've otherwise called it an action plan, was to be the responsibility, in it's formulation, of the operational members of management.

Did it niggle with you at all that there wasn't any clinical input into the formulation of this plan? 12:42 12:43

A. I think at that point in time we discussed what the action plan or what the monitoring arrangements should look like. There were various elements to that, that obviously the monitoring should focus on elements of preliminary investigation findings, and how and who is going to do it and the practicalities of the monitoring arrangements. There was no clear -- I suppose it was building up on various decisions at that point in time. So, the decision was made to make that monitoring arrangement within the Acute Directorate who knows the processes the systems and how to monitor those, along with, obviously, from the HR admin manager Siobhán Hynds, with the support of Siobhán Hynds, them together monitoring arrangement which they feel that they should be able to monitor. So, that was decided at that point in time. 12:43 12:43 12:44

77 Q. We'll come on and look at your views of how effective the monitoring arrangements and the action plan was later this afternoon. I know you have reflected some

concerns around that.

Just staying with exclusion, you were satisfied then that it was unnecessary, going forward, if a satisfactorily robust plan was put in place? 12:44

A. Again, on the basis of information I was provided at that point in time, with the assurance from both operational and I must say clinical, because Mr. Weir was a clinical director at that point in time. He felt in his view that Mr. O'Brien could be brought back with 12:45 the monitoring and support arrangements. So yes, it was -- with also -- actually there was information a couple of days before. I think number of professionals met with Mr. Weir about the process, I think, 24th - the 23rd or 24th - and he provided assurance that he 12:45 will follow whatever monitoring arrangements or he will adhere to the monitoring arrangements which will be put in place.

So yes, I was satisfied that a robust monitoring 12:45 arrangement can be put in place for that.

78 Q. And it was agreed that should the monitoring processes identify any further concerns, then an Oversight Committee would be convened to consider formal exclusion. 12:46

Were you the person charged with the responsibility of highlighting to the Oversight Committee if there were to be any further concerns?

A. I don't recall that I was charged to do that. Again, that goes back to the point of lack of clarity in terms of roles and responsibilities. There was a lot of links happening outside of the normal -- or I should say formal arrangements. There was lots of discussions and lots of emails from Ms. Siobhán Hynds to this Oversight Committee which, for various reasons, were happening. Then there was a lot of discussions happening through me, Case Investigator, and the Oversight Committee. So again it was back to the point that certainly it wasn't clear to me am I supposed to escalate to Oversight Committee if there is a formal exclusion required. 12:46 12:47

79 Q. What did you understand would be, I suppose, the trigger for bringing something back to Oversight Committee? 12:47

A. I suppose my understanding at that point in time would be that if -- a number of things, I suppose. The first element is if there are series of or major deviation from the action plan; if there are any other concerns, a patient safety concern or clinical concern arising from the investigation; or if there is anything else coming from the overall Clinical Governance system, such as complaints, such as, you know, SAIs, such as MM incidents. All of those would feed in the decision of do we need to meet as an Oversight Group or Oversight Committee and discuss again in terms of further formal exclusion. 12:47 12:48

80 Q. Did any issue come across your desk or to your

knowledge in the period between this meeting in January 2017 and the conclusion of your involvement with Mr. O'Brien that would have merited referral back to the Oversight Committee?

A. There were a number of occasions there was some deviation or departure from the action plan. We know now -- certainly I know more now, because on a number of occasions it wasn't escalated directly to the Case Manager in my case. But most of them were immediately addressed, immediately dealt with, immediately managed, immediately rectified. And it wasn't for a period of time or anything else. 12:49 12:49

Apart from that, as a Case Manager, I wasn't receiving any other figures from the Clinical Governance or Operational Governance point of view. As a Case Manager, obviously I wasn't receiving any other triggers from the Clinical Governance meetings or SAIs, so I wasn't aware of any of those. 12:49

81 Q. In one of your earlier answers when I rudely cut across you, you mentioned the issue of appraisal. We can see in the minutes of this meeting how that issue arose. If you go back to page 404 of your bundle and if we go back to TRU-00038, just a few pages back. It says just below the middle of the page, Dr. Khan: 12:50 12:50

"It was noted that Mr. O'Brien was successfully revalidated in May 2014 and that he had also completed satisfactory annual appraisals. Dr. Khan reflected a

concern that the appraisal process did not address concerns which were clearly known to the organisation. It was agreed that there may be merit in considering his last appraisal".

12:51

Now, you are probably familiar enough with the MHPS process which sets the MHPS arrangements in the context of other quality assurance, quality improvement and safety mechanisms, including appraisal. Just for the Inquiry's note, we can see that at WIT-18495. We don't need to turn it up. 12:51

Why were you raising this appraisal issue at this meeting? What was your interest in it?

A. Well, as part of my medical services role in Children's Services, I was actively and heavily involved in the professional medical governance. Appraisal, revalidation, job planning, are the cornerstones of medical professional governance. My instinct is the appraisal system, the revalidation system, the job planning system should indicate the need for further look at things if we join these systems together and look at them logically. That was my reasoning behind, when I heard that this is going on for a number of years but the doctor simultaneously is successfully revalidated, and a successful appraisal has been completed, I was a little surprised in a way that the system is there to identify, to pick, to address those things. 12:52 12:52 12:52

We know that the Southern Trust appraisal system over the last number of years has been improving and it's very proactive in that way. We also know that the appraisal system not only just brings the doctor's view, the appraisal system has a number of elements for addressing the concern. So, the doctor has to bring updated training passport, which is done by the Trust, which is updated by the Trust. The doctor also has to bring the previous year's PDP, which is discussed at the appraisal. Then there's a new year's or next year's PDP discussed. There is an element of the doctor has to provide the CPD details, the Continuous Professional Development details in the appraisal, but they also have to provide the clinical activity, so this comes from the Trust systems. The clinical activity of individual doctors are provided as part of the appraisal. Then there is a CLIP record, which is Consultant Level Indication of Performance, which is all provided by all the consultants -- 12:53 12:53 12:54 12:54

82 Q. If I could just slow you down, Dr. Khan. This is important evidence, I think, and we just want to get a careful note of it. You're talking about the CLIP.

A. So the CLIP report is provided to all doctors and it is an independent tool, in a way, which is produced by the Trust through an external agency and provided to all medical staff - not all medical staff, consultant level medical staff - and it is part of the appraisal. 12:54

As part of the revalidation, we are also aware that the doctors, in every five-year cycle, have to complete an anonymous feedback from our colleagues and an anonymous feedback from the patients. This is the requirement from the revalidation point of view. So, if a doctor who has successfully completed revalidation, he must have had all of these elements. The final year of the revalidation, the final year of appraisal which leads to the revalidation, has in a way enhanced appraisal which has some other elements to that as well. So, revalidation was an important point in time in 2014. Then there is 2015, '16 and '17 appraisals. 12:55 12:55

So, I was a little surprised about having all those and not linking the dots there and finding out what's going on. 12:56

83 Q. I know that this issue comes up again and I'll look at it a little later in the context of the terms of reference. You come back on this issue in a slightly different way. These being your concerns, that the appraisal tool is part and parcel of this debate about Mr. O'Brien and his performance that's going to be formally investigated, did you see to it that these appraisals were brought in to, if you like, the pool of evidence or the pool of issues that had to be considered? 12:56 12:56

A. So as I put it in my statement, before getting to the evidence, I had requested or asked that why should we not involve, or include, the appraisal into the terms

of reference or in some shape or form. I was very much hopeful that we will look into in more detail about not only the administrative practices which were coming to light, but looking in a little bit broader way of other tools available to us as an organisation, but also for the doctor as well. It is important that the doctor represents that evidence provided, that he was successfully revalidated in appraisals. I definitely asked for that to be included and I was assured at that point in time that this will be looked at as part of the investigation. 12:57 12:57

84 Q. Okay. We'll park that issue and we will come to it. Just I don't want to take it out of sequence from the terms of reference, and we'll see what you did at that point. 12:58

Just a couple of other points before our break. In terms of the work that was to be done after this meeting, Mrs. Gishkori and Mr. Carroll had to go away and come up with a monitoring action plan. In association with that, if we go to page something in front of you and we scroll down to TRU-00040. 12:58

It was noted at the meeting that Mr. O'Brien had identified workload pressures. They were articulated to Mr. Weir when he met with him on the 24th. It was highlighted that there had to be consideration given to a review of Mr. O'Brien's job plan as a matter of urgency. Secondly, the case conference members 12:59

considered it appropriate that there be a comparable workload activity exercise performed. Can you give us some indication as to the rationale for those steps?

A. I suppose the discussion around the point of fairness and supporting the doctor was ensuring that his job plan is comparative to his work colleague within the team, and ensuring that if there needs to be further support or other measures to put in place, that can be done. So looking at the job plan, not in isolation but looking in a more comparative way, that this should be done in a broader way, that was the indication or the discussion that happened at that time. 12:59 13:00

85 Q. Do you know whether, first of all, the comparable exercise was carried out, the workload activity exercise? 13:00

A. I'm not aware that it happened or not. I wasn't aware of that at that point in time, and I'm still not.

86 Q. Should you have sought assurances, the Case Manager, that it had been done?

A. I did discuss the job plan issue with the Medical Director on a number of occasions. I also discussed the job plan difficulties or challenges to sign off the job plan with his Clinical Director, which was Mr. Weir, Colin Weir. I also discussed the job plan issue with Esther Gishkori when I became the Interim Medical Director and we had established a one-to-one with her. This is the later part in 2018, essentially. 13:01 13:01

87 Q. You didn't follow-up, it seems, on the comparable exercise on the job plan. Presumably the thinking was

that if Mr. O'Brien is to be in a position to comply with the action plan, his job plan has to be appropriately balanced. [I see we may lose this in less than a minute].

A. Yes, yes. That was the reason, I must say. I did not -- can you hear me? 13:02

MR. WOLFE KC: He can see the panic in my eyes. We're going to lose you unless somebody presses the Sky button.

CHAIR: We have 24 seconds. Thank you. 13:02

88 Q. MR. WOLFE KC: What was intractable about the job plan, to the best of your understanding?

A. What my understanding was was that the job plan was discussed at various times and various occasions but it did not get signed off or agreed by the doctor, by 13:03 Mr. O'Brien. That was on various discussions with various levels, as I indicated - with Medical Director, Clinical Director, and with the Director of Acute Services later on. I must say, and I accept, I did not personally follow up on the comparative exercise that 13:03 was to happen. Again, that did not come to my mind, that I have to address that or follow that up. Perhaps on reflection that would be done by -- you know, at some point in time I should have reviewed that situation. 13:03

MR. WOLFE KC: Thank you, Dr. Khan. It is now just shortly after 1:00. We normally take a one-hour break.

CHAIR: Yes. If we come back at 2.05, ladies and gentlemen.

MR. WOLFE KC: Is that convenient Dr. Khan?

A. Thank you.

CHAIR: Thank you.

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS: 13:05

CHAIR: Good afternoon, everyone. Dr. Khan.

MR. WOLFE KC: Good afternoon.

89 Q. Good afternoon, Dr. Khan.

A. Afternoon. 14:06

90 Q. It was your task after the case conference to make contact with Mr. O'Brien and to tell him the decisions that had been reached; isn't that right?

A. That's correct, yes.

91 Q. As we can see from a letter dated 6th February 2017, 14:07 you followed that up with a letter, which is at page 417 of the core bundle at TRU-00730. In simple terms you tell him about the outcome of the case conference, that four concerns previously notified to him would be the subject of a formal investigation and 14:07 that the question of immediate exclusion had been resolved in favour of a clear management plan, described in the second page of the letter overleaf. On that basis, on the basis of the implementation of this clear management plan, he could return to work and 14:08 that there would be a meeting with him to discuss the monitoring arrangements on 9th February.

That prompted a letter from Mr. O'Brien which was directed to Mr. Wilkinson. First of all, just before reaching that, was that your first contact with Mr. O'Brien, the telephone call, and then the letter?

A. As far as I remember, yes, that was my first contact. 14:08

92 Q. How did he receive the news from you?

A. Over the phone.

93 Q. Sorry, yes, that was my fault for asking such a loose question. What was his response to the information that you were giving him on the phone? 14:09

A. I don't think the phone call lasted more than a couple of minutes. I informed him of the decision -- I first of all introduced myself, because we never met before. I discussed the outcomes basically in summary, and I did say I will be sending out a letter and then 14:09 we will be meeting soon. I think as far as I can remember, that was really the essence of our discussion.

94 Q. Yes.

14:09

If you go to 420 of your core bundle, of the core bundle, and if we can pull up TRU-01248. These are concerns that were directed to Mr. Wilkinson but it appears from -- if you just take a peek at page 441, AOB-01446 for us. 14:10

A. Sorry, what's the number for me?

95 Q. 441, please, for you. This tells us that the Trust legal advice from June Turkington was that the response should be issued by you and assumedly not

Mr. Wilkinson. Did you understand what was going on there?

A. At that point in time I had limited understanding. I understood Mr. O'Brien had met with Mr. Wilkinson and raised a number of objections or queries or concerns, and then it's also about the case investigator's role. So I was apprised afterwards by Dr. Wright and Siobhán Hynds.

96 Q. What was your understanding of the role of Mr. Wilkinson if he could not be permitted to respond to this correspondence?

A. I wasn't part of the discussion with the Trust legal advice, but my understanding, looking at the MHPS Framework document, was Mr. Wilkinson was point of contact from the doctor's point of view, and he was to, I suppose, address or respond in whatever is appropriate at that point in time. That was my understanding. But I was asked, and appraised -- first of all, informed about the details of the discussion and then I was appraised -- also I was informed that the letter has to go from you.

97 Q. Did you have any input into the drafting of the letter or was it simply a case of you putting your name to it?

A. I looked at the draft letter and I had a brief discussion with Siobhán Hynds about the content. I wasn't involved in a lot of other discussions so I wasn't aware of what else is going on. I did indicate that, obviously, this is a letter going from me so I would like to know a little bit more. I was

appraised by Siobhán Hynds and then also by Dr. Wright as well. So, yes, it's a matter of -- so Siobhán Hynds drafted it from the HR point of view. I did look at that as a draft letter. All the factual information I was told was obviously coming from the discussion and the previous elements to that as well, so I agreed to that.

98 Q. Just before looking at the letter - we'll look at the letter in just a moment or two - in terms of Mr. Wilkinson's role, we can see in the Trust Guidelines and the MHPS that the role of the nonexecutive director is described. If we take, first of all -- if you go to page 99 of the core bundle and if we pull up TRU-83702. Just scroll down, please. This is the description of the nonexecutive director which we find in Appendix 6 of the Trust's guidelines.

"The nonexecutive director is appointed by the Trust chair and he must ensure that the investigation is completed in a fair and transparent way in line with the Trust procedures and the MHPS framework. The nonexecutive director reports back findings to the Trust Board".

Then if we could look at WIT-18499. That's page 11 of your core, Dr. Khan. Definition of roles. Here, the designated board member is described in perhaps less elaborate terms than the Trust Guidelines, as being:

"Responsible for overseeing the case to ensure that momentum is maintained and consider any representations from the practitioner about his or her exclusion, or any representations about the investigation".

14:16

In terms of your relationship or interaction with Mr. Wilkinson, one can see from a flurry of emails over the period of the investigation that there's an effort to update him by you or on your behalf, and sometimes by Mrs. Hynds on behalf of Dr. Chada about the progress of the investigation.

14:16

Were you being challenged by Mr. Wilkinson at any time to move things along or to address particular issues or any concerns?

14:17

A. Yes, I had a number of communications with Mr. Wilkinson. On the other hand, he also approached me on various occasions inquiring about the current progress of the investigations. I don't think that there was an element of challenging but I believe there was more about keeping up-to-date and also to encourage, to move along and finish the investigations. But I wouldn't consider that as a challenge to me or to the Case Investigator.

14:17

14:18

99 Q. I don't mean that in any antagonistic way. Was he, if you like, a friendly challenger to the process? If you like, in answer to his job description as I've read it out from the two documents, is that what he was, in

essence, doing?

A. In fairness to Mr. Wilkinson, he was asking about and he was requesting the updates on regular intervals, and I was providing the information to him as well. That was the bulk, really, of what these communications were. I had some sideline meetings with him - well, not meetings, discussions or chat - when I became the Interim Medical Director and attended the Trust Board meetings and things. But apart from that, that was really what our discussions were. 14:18 14:19

100 Q. Yes.

In terms of the role, perhaps more generally, of the nonexecutive director within an MHPS process, are they well-equipped? Do they have any, I suppose, weapons at their disposal to ensure momentum in an investigation that's perhaps going slowly, or is it simply, as you have described, asking questions on a regular basis? 14:19

A. I think in my experience, in my view, the biggest weapon they have is the Trust Board. They are expected to update the Trust Board and the Trust Board can ask the Trust to update in terms of the follow-up or the update of the MHPS or any such investigation. So, I believe the biggest tool they would have is going through the Trust Board and the Trust Board is requiring further information. But in my experience, both as a Case Manager and with an addition to Interim Managing Director when I was a Trust Board member, I didn't see many ways of requesting other than that, 14:19 14:20

really.

101 Q. You became an attendee at the Trust Board upon assuming the Interim Managing Director's role. I'm not sure what might have been your first board meeting; presumably some time around February, March, April time - is that fair - 2018? 14:21

A. It was a little after that, I think. I started in April, so I think either it was end of April or May, the next board meeting I attended.

102 Q. Was the subject matter of the MHPS investigation brought to the attention of the board or was it the subject of any discussion, whether through Mr. Wilkinson or through you? 14:21

A. I'm afraid I can't provide that information. It's just I don't recall, and I don't want to be saying something which is not correct. Without looking at the minutes, because I did attend a number of board meetings, I can't recall at present time, no. 14:21

103 Q. Thank you. Now, the letter that you signed off, which went back to Mr. O'Brien, is to be found at your 443, that is the core, core 443, and TRU-01252. This is the letter going out to Mr. O'Brien. 14:22

He raised a number of issues. I don't need to deal with this letter in any particular detail, the Inquiry can read it for itself. Just go over the page, please. One issue that was raised in his correspondence -- just pause there, please. One of the issues he raised in his letter - and we'll just deal with this if we can 14:22

simply through your letter rather than jumping backwards and forwards awkwardly through two pieces of correspondence - but one of the issues he raised was the person who met with him on 23rd March 2016 and who provided him with the letter, and who, in Mr. O'Brien's 14:23
view, didn't provide any support for dealing with the shortcomings identified in that March letter was Mr. Mackle. Mr. O'Brien, to some extent, protested, if that's the right word, that Mr. Mackle and him had had a run-in historically, and Mrs. Rankin, or Dr. Rankin, 14:23
had decided that Mr. Mackle shouldn't be dealing with Mr. O'Brien any further. That was an issue drawn to your attention; do you remember that?

A. I was informed about this issue. It was historical and I wasn't involved. I did indicate in my letter that 14:24
I wasn't a party to that discussion and I'm unable to provide my opinion or view on that. But the facts were provided to me and I put that into the letter. But yes, I was informed about that issue. Not in greater detail but as an overall summary. 14:24

104 Q. Obviously the issue was touched upon in the investigation report; Dr. Chada subsequently.

When you saw that issue being raised, did that help to inform your concern that, historically, issues around 14:25
the management of Mr. O'Brien and, indeed, the attitude of managers towards Mr. O'Brien and the decisions that they reached was something that was worthy of investigation or consideration as part of the

investigation?

A. I think that was the first time I -- well, one of the -- I was aware of some of this background talking to Dr. Wright initially in January, but this came to my attention more, in greater detail at that particular time, and I was, let's say, mindful of the fact that this has been in the history and addressed but not possibly the right way or the completion of the whole process. So, I was mindful of that, yes. 14:26

105 Q. If we scroll down, please. Another issue that you have to come back to him on is that the role of Mr. Weir had now changed. He was coming out of the investigation and Dr. Chada is coming in. The explanation that you give there is that it's likely that Mr. Weir may be required to provide information to the investigation on this issue. 14:26 14:27

Sorry, Chair, I'm going to have to go and clear my throat. It is just I have a cold today.

CHAIR: Can we take 5 minutes? 14:27

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: Everyone?

MR. WOLFE KC: Thank you, Chair. 14:31

CHAIR: Just before we start again, Mr. Wolfe, just to say we probably won't sit past 4.30 today.

106 Q. MR. WOLFE KC: Very well. Thank you for the break and apologies for the interruption, Dr. Khan.

Just coming back to the letter, your page 444, can we have up on the screen TRU-01253. Second part. In terms of what you're telling Mr. O'Brien, you're saying in respect of Mr. Weir that you think it likely that Mr. Weir may be required to provide information on the issue, therefore you have asked Mr. Weir to step down from his role as Case Manager and ask Dr. Chada to take up the role of Case Investigator. Is the reality of that that you agreed with those decisions but somebody else had taken the decision and somebody else had asked Dr. Chada? 14:32 14:32

A. For that element, Dr. Wright had written to me. I think he wrote an email and then we also spoke over the phone as well. He indicated that due to these issues and Mr. Weir's inclusion into the possible witness list, then Mr. Weir has to come off, and he has already discussed with Dr. Chada. And he did ask if you are happy with that, I'll go ahead with that, and I was agreeing on that. I had no issue with this. 14:32 14:33

107 Q. There are obviously other issues addressed in Mr. O'Brien's letter and the Inquiry can look at those. One particular issue on the next page, if you go across and we go down, is the time scale of the investigation. It is notes that he - that is Mr. O'Brien - has raised those issues of the time scale with Mr. Wilkinson, and that the issue was raised also with Colin Weir on 24th January. 14:33

You have said to him:

"Given the vast scale of the concerns, the numbers of patients involved, the time period, the records that require needing reviewing, etcetera, a four-week turn around time is not practicable".

You say these are exceptional circumstances.

We will look at the reasons for the delay, perhaps, in a short period of time. Is it fair to say that there was no attempt to plot out in advance how the time scale required by the framework could be achieved or, if not achieved, how much greater time would be required? 14:34

A. I think at that point in time, the time scale was already thought to be unrealistic, the time scale which is prescribed within the MHPS framework. However, nobody at that point in time anticipated how long it's going to take. It took a greater length of time compared to initially anticipated. But at this point in time, what the intention was was to inform or to warn Mr. O'Brien just it may take a little longer than initially -- which is prescribed as per the MHPS Framework. That's what I was only referring to in this letter. 14:35

108 Q. You know - we don't need to bring it up - that the MHPS Framework talks about the need to provide an audit of the process, which assumedly is designed or included so

that those who need to know have an idea of what's going on; next steps; are we meeting reasonable timeframes. Was there anybody formally carrying out that role? We know, for example, that you were keeping an eye on things, writing regular emails, but there was nobody formally auditing the process to ensure that next steps were given some momentum?

A. I don't think there was a formal audit process in place. However, there was, especially in the beginning of the investigations I'm talking about - the first six months of 2017, from April onwards - there was an attempt to track or to chase or to make the completion as soon as possible. However, when there was nonengagement or whatever from Mr. O'Brien at that point in time, it was hard to know how long it's going to take. But there was no formal audit or process in place for to track the time.

109 Q. Let me move on to the terms of reference. Could I start by asking you to consider what NCAS say about that. If we pull up their document How to Conduct a Local Performance Investigation, which you can find at page 63 of your core bundle. That's the relevant page; obviously the document begins some pages before that. In terms of finalising terms of reference, the Inquiry is now familiar with this document, but it says:

"The terms of reference as finally drafted should be agreed by the organisation's relevant decision-makers.

The Case Manager and investigators appointed to manage and carry out the investigation would not normally be involved in that process".

I take it to be the process of finalising the terms of reference. 14:38

Over the page, Dr. Khan - 41408 for our purposes and page 64 for yours, it provides... As you can see from the first main paragraph on that page, Dr. Khan: 14:39

"It may be that as the investigation progresses the terms of reference are found to be too narrow or that new issues emerge that warrant further investigation. In such cases, the investigators should inform the Case Manager, who should seek the agreement of the responsible manager or decision-making group to a widening of the terms". 14:39

Now, in the context of this investigation, there was no need to -- or at least nobody saw the need to widen the terms midflow. But did you have an understanding when you took up the reins of Case Manager or as a result of your training in early March that the procedural route or signing off or finalising terms of reference was not the Case Investigator and not the Case Manager but the decision-makers within the organisation? 14:40 14:40

A. As part of my understanding and looking at MHPS Framework and doing the MHPS training, I was aware that

Case Manager had some role, but I was also aware that in most cases it's a collective decision between the Case Manager and the decision-makers, which could be Oversight Committee, it could be other similar type of groups. So, I was aware of that option, yes. Sorry, I missed your second part. 14:41

110 Q. I suppose the thrust of my question is the finalisation of terms of reference before the investigation starts is not the role of the Case Manager or the investigator taking that NCAS guide into account, but is the role for the relevant decision-makers in the Trust. That's not defined but it might mean the Oversight Group, for example. 14:42

A. Yes. To my understanding it was, obviously in this particular case, the Oversight Group was making the decisions in terms of the terms of reference. However, my input, and I understand Case Investigator's input, was there as well. 14:42

111 Q. On 7th February 2017 you are sent the terms of reference as they had been drafted at that point. If we just look at those. It's page 2080 of your personal bundle. If we could have up, please, TRU-267637. If we start at the bottom of the page and work up. Siobhán Hynds is writing to you and copying Toal, Gishkori, Wright and Weir. By this point Dr. Chada hasn't been appointed. 14:42 14:43

"Please see attached draft terms of reference for the AOB investigation for your comment/agreement. Once

agreed, we can share these with AOB at our meeting this week.

"Oversight Committee for your comment and agreement".

14:44

Scroll up the page, please. You reply:

"As discussed previously, should completing successful appraisals while these ongoing issues be part of investigation terms of reference". 14:44

So this, as we saw this morning, has hung over in your mind from the discussion at the case conference. Let's just see her response.

14:44

"The issue of how a successful appraisal has been signed off will certainly be part of the queries needing to be answered by some we interview. However, in respect of the terms of reference for this investigation, it is not a matter of concern for Aidan 14:44
O'Brien to answer necessarily, which is what the terms of reference for this investigation need to focus on".

Were you satisfied with that answer?

A. I suppose I started this conversation in the case 14:45
conference and subsequent to that with Siobhán - Siobhán Hynds - but also with the Medical Director.

In relation to the appraisal, I believed and I still

believe that is a significant amount -- an important, let's put it this way, an important, vital piece of information and tool available for professional medical governance. I would need to use this tool appropriately in order to gain and understand more. That was the reason when I received this terms of reference, the draft terms of reference, the only query I had at that point in time was why not include the appraisal into this? And I received the reply from Siobhán saying this will be -- essentially this will be part of the investigation. And I was -- in a way I was -- I wasn't satisfied completely, I must say, on reflection, I should have pushed more, but I was satisfied in a way that this is going to be looked at as part of the investigation. 14:45 14:46 14:46

112 Q. Because if you look back at it and think about the content of Dr. Chada's report, I think I'm right in saying - I can stand corrected on this - but there's precious little mention, and perhaps no mention, of appraisal at all; isn't that correct? 14:46

A. I think you're right.

113 Q. Yes.

In a sentence or two, if you had been asked to draft a term of reference around the issue of appraisal, what would have been the general focus of what you were saying? 14:46

A. In my mind, I suppose, I wasn't thinking of me drafting that. I was thinking of starting this discussion among

the relevant people, the decision-makers and others, to think about how we go about looking at appraisal in a wider term, in a professional governance tool term.

In simple terms, it would be a matter of reviewing the past four or five years' appraisals and coming up with what were the themes, how the organisation can miss some of the issues which were raised in the appraisal and how we can address those going forward in the investigation and beyond that as well. So, that was essentially my thinking of the appraisal part coming into this. 14:47 14:47

114 Q. Could I put it into these words and you can tell me whether you agree? You were seeing a situation where operational and clinical managers were alleging shortcomings on Mr. O'Brien's part. You were also seeing or hearing about successful appraisal, if I can put it in those terms, and revalidation. Your questions, presumably, were in circumstances where this clinician is said to have significant shortcomings in his practice, is our system of appraisal working appropriately or effectively. Is that what you wanted to look at? 14:48 14:48

A. I suppose it's even before that. The link of appraisal into the job planning and also beyond that, of linking appraisal into performance, management, clinical governance, all of that needed to be looked at. There was kind of joined-up working between the so many elements of professional governance and clinical 14:49

governance which we are aware now were not as robust as they should be. I was trying to indicate that although it's not an immediate issue which is obvious now, but in my experience -- I was heavily involved in appraisal and revalidation and job planning in my directorate, and I found it a very useful tool to be able to identify, to support, to make sure that the safety element is there. That was the thinking in my mind at that point in time.

115 Q. You received that response from Siobhán Hynds, which was, in essence, the focus of our terms of reference are on the clinician but we will raise, or these queries can be raised, with appropriate witnesses as we proceed. 14:49

If you were less than, I suppose, assured by that, did you take the issue to Dr. Chada to ensure that this matter was on her agenda when she sat down to interview relevant witnesses? 14:50

A. The simple answer is I didn't, purely because I didn't want to interfere in Dr. Chada's investigation. I was assured by Siobhán Hynds, who was supporting that investigation, that this will be part of the investigation in some shape or form. So I took that assurance and I didn't go to Dr. Chada. 14:50 14:51

116 Q. We know that the early iterations of the terms of reference contained four elements. On 15th March, if you can go to 2085, and if we go to TRU-267981. It says, to you:

"Please find attached final draft of terms of reference of Aidan O'Brien investigation. Please also find the proposed witness list to date although it is likely Dr. Chada will need to speak to others. Once we have others determined, we will update Mr. O'Brien.

If you are in agreement with the draft terms of reference, can you please share with Mr. O'Brien Dr. Chada and I are beginning the first of our meetings with witnesses this week". 14:51 14:52

So if we scroll down, please, and just take a look at the terms of reference. Just scroll on down, number 5. This number 5 is the addition. You were obviously asked to express your contendness or otherwise with that addition. Did you discuss this proposal for addition with Dr. Chada? 14:52

A. I don't think so. I can't recall talking to Dr. Chada about this specific term of reference. I do remember that there was some discussion. I think it was between -- not discussion as specifically for this term of reference but around the terms of reference discussion with Siobhán Hynds, saying this is known to -- this issue is known to the organisation before and Dr. Chada is also aware of that. 14:53 14:53

I was aware this issue in the background -- awareness of this issue in the background by Dr. Chada and

Siobhán Hynds. I must say I don't recall discussing this with any of the Oversight Group or Oversight Committee.

117 Q. You say you had an awareness of it being discussed in the background. Have you any understanding of whether the Oversight Group approved this element of the terms of reference or do you think that stage in the process was missed? 14:54

A. My understanding from the beginning of this process of terms of reference was that they were coming to me after the approval of Oversight Group, or the same time at least. So every time I was getting -- I got about two or three communication emails from Siobhán Hynds about this, and every time initially it was asking Oversight Group -- initially, actually, it was saying the Oversight Group to approve or comment. Then it came to me has a final version of that terms of reference. I am not aware that it was or it wasn't, but my understanding at that point in time was it was looked at and approved by the Oversight Group. 14:54 14:55

118 Q. We don't need to bring it up on the screen but we have at TRU-285787 you saying back to Siobhán, "I am happy with the attached terms of reference, can this be shared with Mr. O'Brien". So you expressed the view that you were content. 14:55

If Dr. Chada hadn't come up with this, is this something you might have come up with anyway? To put it another way or a slightly different way, is this

something that you embraced as being a valuable thing to explore during this investigation?

A. At the time of the case conference I was surprised by the fact that this issue was known to the organisation for a period of time, at least for 2016. I was also a little surprised about the appraisal and revalidation and all other things as well. So, yes, in my mind I don't think at that point in time I was thinking of admin or admin review or looking at this as a terms of reference, but there was something in my mind around that issue of organisational awareness of the issue for a period of time. When this final terms of reference came to me, I was satisfied. I agreed to that and I was satisfied this was part of the investigation now. 14:56 14:56

119 Q. Is this part of, I suppose, the inherent flexibility of the MHPS process in that issues like this - number 5 - not directly focused on the clinician's actions or conduct but forming part of the context in which he is working, including his relationships with management and their knowledge, is this part of the advantage of the MHPS process, that this kind of thing can be looked at alongside the actions of the clinician? 14:57 14:57

A. I'm afraid I'm not able to answer that because I don't have much of expertise. This was the only MHPS I was involved in in terms of looking at. In that instance, I felt it was useful to include that terms of reference. 14:57

120 Q. Yes. Because self-evidently, perhaps, it is important that if the clinician is struggling to perform to the

standard expected of him by his or her employer, it's necessary, isn't it, to understand that in its fullest context, including, amongst other things perhaps, whether adequate support is provided or has been provided, whether the job plan is perhaps too heavy, whether the expectations are too much. Would you agree with that? 14:58

A. I think it's a joint responsibility for the organisation and the doctor or the healthcare worker in the situation that both brings their responsibility together. Without one or the other taking their own responsibility, there are high risks of failure and, as a result, potential or severe harm. So in my view, both parties, organisation and the staff or the employee or the healthcare worker, need to take their responsibility. That's why I felt, when I was happy with the terms of reference, I agreed with that, that this part is in the terms of reference. 14:59 14:59

121 Q. We'll look a little later, perhaps, at whether you were satisfied that this element of the terms of the terms of reference was exploited, if you like, to its fullest potential during the investigation and the conclusions that emerged from it. 14:59

Just one other aspect of the terms of reference, and I quite take your point that you're not expert in this and not particularly experienced in this. An element of what the Inquiry is seeking to grapple with is whether the terms of reference were sufficiently broad 15:00

to look at other aspects of Mr. O'Brien's practice, issues that came to light some couple of years later.

The first thing that has to be done, I think you would understand, is a screening process. You referred to that earlier. The screening process has to be defined or have some parameters. Then what emerges from screening feeds into the terms of reference. Were there any clues in the evidence before you - or the information before you, I should say - at the early stage that would have led you to take the view that perhaps we need to look beyond what we already know? 15:00 15:01

A. So, at any point during the investigations there was no indication of clinical performance/Patient Safety issues, even at the part of investigation completion. I do believe in hindsight, with a lot of information since then available, it's my view that the terms of reference was narrow, quite narrow, and we would have gone to a wider terms of reference. However, at that point in time, the terms of reference was mainly dictated by the preliminary investigations and the screening process which happened before that as well. So that was leading to the formation and drafting of the terms of reference in a way. 15:01 15:02

122 Q. But if you have information before you which shows that a clinician's approach to administration is of concern in area X, Y and Z, should that not inspire some curiosity on the part of the decision-makers to open the drawer and see whether there might be concerns on 15:02

the administrative side, perhaps - or perhaps only limited to that - in other areas of his practice that have not yet been looked at?

A. Again, going back to the point of at that point in time there was only the administrative issues which were highlighted in the preliminary report and the screening process there. I was aware that as part of going forward in investigations, other elements can be included into the part of investigation. However, I can only reflect on now that we should have gone a little bit wider in terms of terms of reference. But this is with the benefit of a lot of information available to us now at this point in time. 15:03 15:04

However, I believe that the decision-makers, in our case the Oversight Committee, must have and should have thought about all those elements in agreeing to the final terms of reference. I can only say that at this point in time, it is quite obvious, but it wasn't at that point in time. 15:04 15:04

123 Q. I want to move on now and look at, I suppose, how you were viewing the investigation as it proceeded, and to an extent try to establish the extent of your awareness of some of the issues that were perhaps holding up progress. It's fair to say, isn't it, that there was a parallel information-gathering process being undertaken by clinicians in Urology Service in that they were working through the files of patients who had not been triaged where there were concerns there hadn't 15:05

been dictation, and that information was coming back into the system to assist Dr. Chada with her investigation. You understood that to be the scenario?

A. I was aware of that exercise going on by the clinicians and that's feeding into the investigation, but I wasn't very close to what exactly the information was coming through. 15:06

124 Q. Your document is 480 of the core. If we look at TRU-268080. Scroll down slightly so that i can see the address. Siobhán Hynds is writing to you on 12th April, Dr. Chada copied in. By 12th April, they had met with four witnesses, taken comprehensive statements, these are being typed for agreement; identified another 11 witnesses they are arranging to meet. 15:06 15:07

"We have established that all untriaged referrals have now been looked at and we've been made aware of a number of referrals which, in the opinion of other consultant urologists, designed to have been triaged at red flag or urgent but were dealt with as routine. We currently understand this number to be 24, and of those, three have been identified as SAI issues. A further five still unknown at present. 13 files remain unaccounted for". 15:07 15:08

Then: "There has been slower progress with the undictated clinics as the work required in the review of these cases is significant. We have asked for an

update on a sample of the patients to allow us to progress our investigation. As this work is slow, it may be prudent to discuss further with Dr. Wright the possibility of getting further assistance with this work to move it forward. Dr. Chada and I are happy to discuss further with you if it is required. It is unlikely we will have completed our investigation in the next four weeks, therefore you will be updated within that timeframe". 15:08

This issue of slow progress in this parallel investigation - no doubt understandable because the clinicians performing it have their clinical duties to pursue as well - but here was, if you like, a cry for help or a suggestion of your intervention to secure, through Dr. Wright, some further assistance with that. Was that an issue you pursued with Dr. Wright, can you remember? 15:09

A. I think I don't have any email trail. I can't find that. But I think I discussed with Dr. Wright two issues. One was about a protected time or additional time for the investigator, and also do we need to -- obviously we need to look at what other elements are coming out from the other clinicians looking at other referrals and triage, and is there anything which can be done in relation to further fast-tracking the process. 15:09 15:10

125 Q. Let me just assist you with an email you sent on 14th April, just a couple of days after this. You'll find

it at 1385 of your bundle. We have it at TRU-264370. Just scroll down to see if there's anything. You're being asked to meet with Mr. O'Brien to tell him of further SAIs. You respond by saying:

15:11

"I have spoken to Mr. O'Brien yesterday over the phone and informed him regarding the SAIs. He did raise concern regarding the time taken for the case so far".

15:11

You have also updated Mr. Wilkinson.

"Is there a possibility for some more dedicated resource for this case especially as it is becoming more complex". 15:11

So, relatively early stage in relation to the investigation in that only several interviews of witnesses had taken place, but you could see already from what you were told on 12th April that the clinical 15:11 aspect was slowing things up and that Dr. Chada had identified another potentially 11 witnesses to speak to. So, was this all in your thinking as you were writing to Dr. Wright?

A. I think I spoke to him as well. I think I did add into 15:12 to my communication with -- to Richard, I suppose, in terms of follow-up from our discussion, was there anything then. I don't remember really that there was something came back in a more substantive way in terms

of doing. What my recollection is a verbal discussion, myself and Dr. Wright, that the clinicians are doing it, they are doing their best; this is additional work, they are doing it, and they are doing outside of their usual time frame and their job plans, and they are doing it as fast as they can; so we will get through these and I can assure you, you know, I have spoken -- or I'm aware of this. Something in relation to that. But I haven't received anything -- I don't think I have received anything more than that after this discussion. 15:12 15:13

126 Q. I think we spoke earlier about the issue of dedicated time and just to perhaps go back on that again. Is it your view that an MHPS investigation of any complexity does require dedicated and focused resource, both in terms of the Case Manager and the Case Investigator, and perhaps also the HR support, in order to ensure that the process works itself through in the most efficient manner? 15:13

A. Yes. I have reflected on the whole MHPS process and I think this is one of the improvements we should make as a healthier system. These type of investigations require quite a lot of input both from the clinicians and from the HR point of view, and requires additionality. Therefore, it has to be recognised as an additional piece of work, and additional time and resources should be put in place, yes. 15:14 15:14

127 Q. Now, we know, if you look at page 512 of your core bundle and if we pull up TRU-66814, that Martina Corrigan, on 7th June, is able to tell

Siobhán Hynds that, I suppose, what we take to be the final outcome on the work on the undictated clinics is now known. Within a period of two months, you'll recall I showed you the document of 12th April, where it was said that the review of undictated clinics was a mountain of work and it hadn't yet started, it seemed. But by 7th June, the clinicians had obviously got through what they thought was necessary to get through, and they set the details out here. 15:15

It's worth considering, isn't it, Dr. Khan, that from this date, it takes a further 12 months, with all the clinical information have been collected and with Dr. Chada, it takes a further 12 months to get this report to the finishing line. What's your reflections on the reasons for that? 15:16

A. I think there are a number of factors. I suppose as we were going through the investigations, there were new emerging challenges. There were a lot of witnesses to interview, to type their reports, to confirm their statements, then to engage with Mr. O'Brien and get his statement on multiple meetings. I think there are a number of factors and I think the time was not -- I don't think we had a process or system in place to track the time. It wasn't going to be a quick run of investigation, it was going to be thorough and detailed and it will take longer time. I believe we were progressing at a fairly good pace in the first six months of the investigation until August/September time 15:16 15:17

2017. Then there were multiple attempts to engage with Mr. O'Brien and, for various reasons, the delay was happening to meet him and to get his statement, or the representation, or the comments back. The time was ticking and it looks like we lost track of time at that point in time. I take personal responsibility to that as well, that I should have been more proactive in terms of making sure that the investigation is pacing according to what it was initially intended to be. However, for various reasons it did not happen. 15:18

128 Q. It may be correct to say, just to clarify, that the private patient issue was a process that was still ongoing, it seems, at that time. When I suggested that all of the clinical information was with the investigators, it is with that caveat. We'll look, perhaps, at how that information was generated and when it was available. 15:19

You received correspondence from Mr. O'Brien, or at least it was sent to you on 30th July. You can find that at page 550 of your core, and it's AOB-01675. The letter is wide ranging in its nature. The inquiry is familiar with it. 15:19

A couple of questions. You didn't reply to this letter to Mr. O'Brien? 15:20

A. No. When I received this letter, I forwarded it to the Medical Director and the Oversight Committee and Siobhán Hynds to address because there were a number of

elements in the letter which were historic and previous elements to that. So, I wanted the Oversight Committee and the Medical Director to address those. I was happy to be part of that but I did not feel that - although it was addressed to me - I have sufficient knowledge of historic background to address from my letter. So I forwarded this letter -- sent this letter to the Medical Director and Siobhán Hynds and the Oversight Group. 15:21

129 Q. Mr. O'Brien had written you a letter. From his perspective, the absence of a response might have the absence of a response might have appeared concerning, not only discourteous, perhaps, but in the midst of an investigation which was obviously of concern for him given the nature of the issues he was raising, some of which touched directly upon the quality of the investigation itself and the fairness of the investigation, should you not at least have dealt with those aspects? 15:21 15:22

A. I think on reflection there were some elements of that letter which I could have addressed but I wanted, I think my thinking of sending it to the Medical Director and the Oversight Group was not just to forward it to someone else to deal with it, but more so getting advice and support in terms of addressing some of the issues raised in the letter and to reply for that. I am afraid I think it slipped out of the radar from many people and I certainly didn't reply to Mr. O'Brien. 15:22 15:22

If you turn to page 559 of your copy, and if we go to AOB-01684. You will know because the letter was telling you that Mr. O'Brien was due to be interviewed by Dr. Chada three or four days later on 3rd August and 15:23
he's making a couple of points. He's saying, at the bottom of page 559. For your purposes, the bottom of this page. On the private patient issue he was previously advised that he would be told of the source of this concern or complaint and six months later he 15:24
has still not been advised. He has requested the identity of the nine patients concerned. He's still not being advised of their identity. Now, when you read that, were you concerned for the fairness of the process? 15:25

A. I think it's a point he was making and I wanted to know more about the background of that issue which he was raising which I wasn't aware of or I wasn't informed of at that point in time. My thinking behind that was sending it to Siobhan Hynds and the Medical Director 15:25
either to come up with, you know, some sort of factual information for me to reply back to him, to Mr. O'Brien, or else give me some information so that I can start drafting some part of my reply back to him.

15:25

As I said, on reflection, I don't really know why I didn't reply to that. I know I was on annual leave around that time. But to there was something because I do remember sending it, making sure that someone in

the Oversight Group and the HR Team knows about this issue and we need to address it. But there may be a reason that I didn't get to reply to that and it went out of my radar.

130 Q. Yes. 15:26

Over the next page it's our AOB-01685, your page 560. Right in the middle of the page Mr. O'Brien expresses concern that he had been previously advised that he would receive a witness list. In other words, the 15:26 witnesses who had been interviewed by the investigation and he hadn't received that, and nor on the eve of his interview with Dr. Chada had he received any of the testimonies of the witnesses so that he could adequately prepare for the interview and understand. 15:27 I suspect he is thinking what people are saying about him in relation to the issues of concern.

Did you appreciate, Dr. Khan, that this investigation was being, I suppose, run this way for whatever reason. 15:27 You knew that interviews had been taking place since March. No doubt you knew that the last interview of a witness took place in the first or second week of June. It was now the end of July and yet none of these statements had made their way to Mr. O'Brien. 15:28 Did you know that?

A. I wasn't aware of that. In fact I wasn't aware that he did not receive the witness list. Because that was one of the things, one of the documents, he should have

received it at the beginning of the investigation, formal investigation from Dr. Chada and Siobhan Hynds. And I believe that he would have received it. I wasn't aware that he did not receive the witness list.

15:28

But I was aware that some of the statements, or a lot of statements in fact, were going through factual accuracy and correction and drafting and typing at that point in time. I was aware of that fact but I was not aware that he did not receive the witness list.

15:29

So there were a number of elements in this letter which I wasn't aware of, or I would have liked to address that but I had no background information or knowledge of those and, therefore, I thought the two best people to inform about the issues which are raised in this was the Medical Director who was also the Oversight Committee member, and Siobhán Hynds, who is the HR Case Manager.

15:29

15:29

Now, I do not wish to take off the responsibility what I had and I don't understand, I usually address these issues, I don't understand why I did not reply to him or; I must have done something about it. And I think all I can think about right now is I have forwarded this to the two people I mention to be addressed.

15:29

131 Q. We know and we have observed this week already with Dr. Chada that there was a drip-feed of information through to Mr. O'Brien over the next several months before he

was invited on 4th November to be interviewed again, it not having been possible to address all issues at the first meeting because the information around private patients had not been disclosed to him. But even as late as, I think it was 29th October, four or five days before he was due to be interviewed for the second time, he has had to take the initiative with Mrs. Hynds and Dr. Chada to say 'I am still outstanding four witness statements which you haven't disclosed to me'. 15:31

I hear you when you say "I accept some responsibility for this", but was there not a concerted effort on your part, rather than pass the message across, to actually try to inject some a greater efficiency or momentum into the disclosure process? 15:31

A. So, in October time, I can't recall that I had received something again from Mr. O'Brien. I may have. I can't recall that I had received again asking for the same information, or similar type or more information. I would have imagined at that point in time that this matter has been dealt with or its in the process of being addressed, you know, in a way of information or otherwise. I wasn't aware of the witness list until that point in time that Dr. Chada, obviously she had to apologise from the investigation team that Mr. O'Brien didn't get the witness list initially and then the statements. 15:32

But I think, again, coming back to the point that the

information or the communication within the team could be better on hindsight and on reflection, both ways, from Case Manager to case investigation, and vice-á-versa, and we can, I suppose learn from that element to that.

132 Q. You wrote to Mrs. Hynds on 7 February 2018. To be entirely fair to you, you are communicating with the investigative team to establish progress. This is page 581 of your core, TRU-269355, you say:

"I haven't heard any updates for this case in the last couple of months. Kindly let me know the progress".

We know that Mr. O'Brien was interviewed in early October and Dr. Chada saying:

"The last we spoke to the doctor he was to get back to us. He explained he wanted time out to sort out his appraisal. We are waiting for him to get back to us rather than any delay on our part".

Did you know between Dr. Chada and Mrs. Hynds that they had allowed or agreed a period of time out for Mr. O'Brien to turn his attention to appraisal, rather than concentrate on finishing the MHPS process and his role in it?

A. I became aware of that issue, not at that point in time but afterwards, so I think in, I think it's after Christmas, after New Year, I became aware that he was

allowed, Mr. O'Brien was allowed to focus on the appraisal in the meantime and to provide the statements afterwards. And then within a couple of weeks later I asked another update afterwards, I think in February-time.

133 Q. Now, the impression to be borne from this email is that the investigative team is waiting on Mr. O'Brien, and that is perhaps true in part, but as appears from emails that the Inquiry has looked at already this week, on 22nd February Mr. O'Brien replied to Mrs. Hynds, who was obviously chasing Mr. O'Brien to follow-up. But he was able to tell her that he had not received from the investigative team in the three months since November, getting on for four months, the Draft Witness Statement which was the responsibility of the investigative team to produce.

So interview early November, sitting then on 22 February, and Mr. O'Brien still hasn't received that draft statement for his consideration and approval. Again, did you know that?

A. I don't think so. I was aware of that at that particular time. I was aware that the investigation team is waiting for the statement or the representation or the comments back from Mr. O'Brien. But I don't recall knowing that issue that he has with this statement from the team.

134 Q. Then eventually it is sent to him on, do you recall, the 4th March and he takes a further four weeks to

sign-off on his works. So can you accept from that description, Dr. Khan, that the responsibility for the delay in this process was certainly not by any stretch of the imagination wholly Mr. O'Brien's, but a significant responsibility for the delay rests with the investigative team. And I think you'll probably accept yourself for not effectively managing that team to ensure that greater expedition was brought to bear?

A. I think on reflection there are a number of issues there. The most important thing was going through the process well into end of 2017. I was getting quite regular updates in the investigation, how it is progressing, and then in the later part, after Autumn 2017, around that time, there was a little pause or it was something about getting through Mr. O'Brien's statement. On reflection, maybe he shouldn't have been allowed to go for a further two months for the appraisal, which was already, now you know, quite delayed and this is an important part of the investigations, so on reflection, he shouldn't. But at the same time I think that the responsibilities lies across.

A lot of people, and I take my responsibility, absolutely, in terms of managing and keeping the momentum going, I was also providing updates to Mr. Wilkinson as we were going along in the investigation, in fact, in the second part of 2017. I was also requesting some updates from the

investigator and Siobhan Hynds in terms of how it was progressing.

But I think there are a number of factors which led to further delay and could have been avoided if we acted upon at that point in time. 15:41

135 Q. It is fair to reflect I think, isn't it, Dr. Khan, that this has to be viewed in the context of your day job and the duties and responsibilities that you had as a clinician, as well as an Associate Medical Director at that time, shortly to take up the reins as Interim Medical Director. Delays are almost an occupational hazard perhaps as a scheme such as this which doesn't, at least in terms of how the Southern Trust, and no doubt, other Trusts operated, provide for dedicated time and that's across both, yourself, Dr. Chada, and indeed Mr. O'Brien who obviously had others things in his in-tray, most obviously of all a busy clinical practice. No doubt the Inquiry will reflect upon those structural issues when it is looking at this. 15:41 15:41 15:42

I'm going to suggest a short break, perhaps, for comfort purposes and the stenographer and no doubt the witness.

CHAIR: Can we come back at five-to-four and finish by half? 15:42

MR. WOLFE KC: Yes.

CHAIR: Thank you.

(Short adjournment - 3:54 p.m.)

CHAIR: Thank you, everyone. Mr. Wolfe.
MR. WOLFE: Good afternoon again, Dr. Khan. We aim to finish at about four-thirty today. Regrettably, and I say this to almost every witness, you will have to come back to us on Tuesday, hopefully Tuesday morning is suitable. 15:54

Before we finish this afternoon there are just two discrete issues: The first is your engagement with the General Medical Council's Employer Liaison Officer. If we go to document 596 of your core to start with, we'll scroll down to 597. It is TRU-264001. 15:55

We can see that you, "AK", are meeting on 6th June 2018. At this point you are meeting because you're the Interim Medical Director. The MHPS report is about to arrive on your desk any day now. The GMC are aware of that and they're aware of an SAI, or a series of connected SAI reviews arising out of the triage issue. 15:56

One issue arising out of this engagement that I would ask you to deal with. At the bottom of the page you say you will update "JD", that is Joanne Donnelly, isn't it, on the MHPS investigation as soon as you can and on the SAI investigation as soon as you can. In the meantime you are assured that there are no Patient 15:56

Safety risks:

"...subject to the doctor providing a written undertaking that he will not work from his home, his own home or do any other private work which you will seek as soon as practicable." 15:57

You are asked to confirm to Ms. Donnelly that the undertaking is going to be provided and that you're confident that you can rely on it. That issue was the subject of a follow-up letter too. If you just glance at that, it is 601 of your core, and if we go down to 251519. She's reflecting on or summarising the meeting of 6th June. She sets out the fact that there are no clinical concerns and describes that the concerns relate to administrative delays, et cetera. Then you set out, it is set out on your behalf what was done when the problem was identified. 15:57 15:58

Then the next paragraph you also confirmed that: 15:59

"While the doctor does not work for any private organisation, he does do some private work from his own home involving triaging and referring urology patients referred by their general practitioner." 15:59

Ms. Donnelly advised that in their view, GMC view, it would be prudent for you to secure an undertaking. So he is repeating what was said at the meeting. Just by

way of orientation then, so what, if you can elaborate, was the concern here, can you recall?

A. I suppose at this stage I would be Interim Medical Director and have had contact with Joanne Donnelly as part of the ELA Trust meetings. GMC was already aware of this case. It was in the list of ongoing issues within Joanne Donnelly's emails and minutes before that. Dr. Wright would have been already updating her. So from the time, I understood from the time the MHPS investigation started the previous year, which was 2017, that there was some discussion between her and Dr. Wright in relation to private practice and undertaking of not doing private practice. 16:00 16:00

The reason behind this is, if there is an MHPS investigation and also an SAI which is still ongoing, until that is concluded and the report is available and discussed and assured, until then he should stop doing private practice at his home. We did indicate to Joanne Donnelly that he is, obviously Mr. O'Brien is being monitored under the action plan on the Trust, but there is obviously no monitoring arrangements at his home. So she requested an undertaking that Mr. O'Brien will not do a private practice, so that was the background of this issue. 16:01 16:01

Now, that would be my first-time meeting with Joanne Donnelly in the GMC ELA Southern Trust liaison meeting. I would have gone through the minutes before and

afterwards and then when this, again this request came, I discussed this issue with Mrs. Toal as HR Director, asking her advice and opinion in that regard. I also, obviously, discussed this with Simon Gibson who was the Assistant Director in the Medical Director's office and assisting me in those meetings.

So I think there is also another chain of communication which I have added in to my addendums as well in terms of how my reflection was at that point in time. I wanted to, obviously, understand better from the Trust point of view and position what we have to do and therefore I discussed this with Mrs. Toal. There was some lack of clarity in terms of what we are expected to do or what we are supposed to do from The Trust point of view and my personal view at that stage, I was leaning towards obviously to get the undertaking, but how we are going to do that.

136 Q. Yes, just to interrupt you by way of assistance, hopefully. If you go to page 621 of your core bundle and if we go to TRU-263996. So you've already alluded to your engagement with Vivienne Toal on this issue. This is 22 June. This is some two weeks after your meeting with the GMC ELA. You explained to Mrs. Toal that:

"JD is clearly requesting an undertaking from AO'B on the basis of Patient Safety risks. I know Trust haven't demanded this before from Mr. O'Brien, however,

on reflection, I would also be concerned and reluctant to provide assurance without an undertaking from him. Can we discuss this again early next week before I can go back to her?."

16:04

So it is framed as a Patient Safety concern against the background of what had triggered the MHPS investigation presumably?

A. Yes.

137 Q. Yes. The issue, as you say, had been raised with Dr. Wright before you, and we have seen that already through the records of engagement with the GMC. You're expressing your view that you're uncomfortable in the absence of an undertaking and you're inviting Mrs. Toal to discuss this with you. 16:05

Now, just before I ask you a question about that, we can see from the advice that you took from Grainne Lynn of NCAS in September following your determination, or in the run-up to your determination on the MHPS report, if we just pull this up to complete the picture. AOB-01902. If you can go to page 898 of your core, Dr. Khan. If we go down towards the bottom of the page, the penultimate paragraph. Thank you. She records, and we'll look at this document for other purposes later, this follows a telephone conversation between you and her on 20th September 2018, and she says: 16:06 16:06

"We discussed the current situation and the overriding need to ensure patients are protected. I note that you have a system in place within the Trust to safeguard patients." 16:07

Which is the monitoring arrangements:

"But we discussed that this needs to be mirrored in the private sector." 16:07

You explained that the doctor saw private patients at his home and did not have a private sector employer. She would suggest that as per paragraph 22 of Section 2 which states that: 16:07

"Where a HPSS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer." 16:07

Dr. O'Brien should not currently be working privately was their advice.

How was this managed within the Trust? I think we know 16:07 that by the date of his retirement an undertaking had not been obtained, his retirement period coming in June 2020?

A. I was reflecting on this issue. I think I added

another communication in my addendum as well. I had to go on urgent leave just after that week. I don't know whether; it should be in my addendum which I submitted, that email communication. I asked Simon Gibson to discuss with Vivienne Toal and Richard Wright and 16:08 inform Joanne Donnelly the outcome of that discussion.

138 Q. If we pull up page 2104 of your bundle, not the core bundle, your witness bundle, and if we could have up WIT-91935. So does that assist you, Doctor?

A. Mh-mmm. 16:09

139 Q. You were explaining, and as you can see in the top email that you hadn't got to speak to Vivienne Toal before she left for annual leave, but you make clear your view that you were personally leaning towards Joanne Donnelly's advice to request an undertaking. So 16:10 what's your understanding of what steps were taken?

A. My understanding at that point in time was I made it clear that this requires further discussion. I did discuss with Mrs. Toal and I was to discuss again before she goes on leave and it didn't happen. And 16:10 I had to go on leave for some family reasons soon after that, I think within a few days, or a couple of days after that. So I delegated this to Simon Gibson in order to close the loop and to address this issue because I knew I was going to be away for a number of 16:10 weeks, to draws this and to inform Joanne Donnelly in relation to that.

Now, when I came back I understood this was completed. It never came back to us again until quite later in terms of that undertaking, but that was my understanding at that point in time.

140 Q. It came back to you, obviously, in the NCAS correspondence. 16:11

A. Yes.

141 Q. In September. Do you know whether a decision was ever reached to approach Mr. O'Brien to ask for an undertaking, or did this issue, was this issue avoided and the view of GMC and NCAS effectively disregarded? 16:12

A. I'm not sure whether I was aware after that that this issue was either resolved or still outstanding. And I can't recall any further discussions in relation to this undertaking until the end of the year when my interim Medical Director role ceased. But I must say, was trying to figure out and I was trying to reflect on this, whether this issue kind of stayed or left after I left it with Simon Gibson and to discuss with this. 16:12

142 Q. Can you explain why you were sympathetic to the view expressed by Ms. Donnelly that an undertaking should be obtained? 16:13

A. Purely for the reason that we, at this point in time, we had very little information in terms of any further, obviously we knew that there were other SAIs started ongoing, they haven't finished. I was on the view that we should take an undertaking that Mr. O'Brien should not work until we know the investigation, the SAI and the MHPS investigations are concluded. 16:13

143 Q. From a validation perspective was it important?
A. For the revalidation?
144 Q. Yes. Did you need to have in your own mind, I'm not quite sure what the date was for the revalidation, but from your own perspective, if you were entering into the process of revalidating, is this something you would need to have assurance on? 16:14
A. Absolutely. You need to have assurance for many reasons but revalidation is one, yes. But even for the basic element of ensuring that you have a system in place for assurance in all areas of his practice. 16:14
145 Q. Can I move then to the issue we touched upon just this morning about the monitoring plan, its implementation and your role in superintending it. Overall reflections, first of all: How, looking back at this area, how well do you think the action plan with its monitoring arrangements worked, taking into account that the alternative that was under consideration was exclusion? 16:15
A. The monitoring arrangement was designed and drafted by the Acute Directorate to ensure robust monitoring in terms of the elements which needs to be monitored. And it was clear, elements to be monitored according to the action plan. I was getting regular updates and I was also requesting assurances at various points in time. On reflection, I suppose, the monitoring arrangement was not as robust as it should have been, purely because it was reliant on possibly one or two people and also the lack of any clinical monitoring, clinical 16:15 16:16

managers monitoring in that action plan. And I reflected on that issue when I was drafting the determination. And that was one reason I wanted to get the monitoring arrangements renewed or updated.

16:16

I feel that monitoring arrangement was started with a robust process but it did fall down on a number of occasions, purely because it was reliant on Head of Service to monitor it on various elements and when she was away, she was off, then it didn't, it wasn't picked 16:17 up by a replacement or there was no alternative arrangements in terms of how the monitoring should go along and the escalation.

146 Q. Could I just ask you about that element of it, the actual work of doing the monitoring, the escalation 16:17 requirement to you through the Assistant Director Mr. Carroll. You pointed up the absence of a clinical involvement on that role. Now, we do know, for example, that in the summer of 2017 Mr. Weir attended at a meeting which focused on the issue of case notes 16:18 being retained in Mr. O'Brien's office, and Mr. O'Brien proffered an innocent explanation around that. He said that his secretaries were responsible for putting files into his office. He didn't need them and it wasn't his system, but the secretaries' system. 16:18

So Mr. Weir was involved to an extent, but did you see, looking back on it or reflecting on it, that there was a greater role that should have been enshrined in the

process for the Clinical Director and perhaps, ultimately, for the Associate Medical Director?

A. I think reflecting on that action plan and monitoring arrangements I see there was a role for clinical line management structure in there, purely for the reasons of understanding better the clinical ins and outs of Mr. O'Brien's working and also the line management structure was already there. I was the aware that Mr. Colin Weir is also aware of the arrangement but not necessarily actively involved in the monitoring. 16:19

147 Q. Do I take it from your answer that you're suggesting that it's not sufficient to have simply operational managers looking at this area, that he needs either the support or the cajoling, in certain circumstances if there's divergence of his peers who are managers? 16:20

A. I think that is one of the elements in my mind I was thinking about when I was drafting my determination in terms of going forward action plan, that the role of Clinical Manager into the monitoring of all that.

148 Q. Can I ask you about a discrete issue and see if we can follow it through a little. The monitoring plan is to be found at your core 429. If we go to TRU-00732. We can see at the top, just look at some of these elements, we'll come back at it with questions perhaps on the next occasion. It is explaining the background, 16:20 16:21 first of all, of the decision to have such a plan and it is saying that this action plan will be in place pending conclusion of the formal investigation process under MHPS. Now that's explicit. I think you say

something in your statement that it wasn't made explicit in the plan. Maybe that was an oversight on your part, but you accept that it is seeming to say that the action plan is alive for the duration of the investigation. 16:21

Certainly from a Trust perspective it was to remain alive after the investigation, indeed after your determination; is that fair?

A. I think it's fair to say there is a variability in terms of understanding from what it should be in my mind and many other people in the Trust. We were of the opinion that this is alive and it's ongoing until the new action plan is in place. However, I understand there are other understandings or views in relation to that as well. 16:22

149 Q. Yes.

Did you, for instance, ever communicate directly to Mr. O'Brien your view that this plan remains alive? 16:22

A. I think I did at the October 28 communication. I think in one of the letters I asked him -- or one of the communications I asked him to make sure that, you know, you are still adhering to the action plan.

150 Q. Yes, I've seen that. We'll perhaps bring that up at another time. 16:23

The one issue I wanted to ask you about in this particular plan is, if we scroll down to the issue

concerning dictation concern, I think Concern 3. It says:

"All clinics must be dictated at the end of each clinic theatre session via digital dictation. This is already set up in the Thorndale Unit. This dictation must be done at the end of every theatre and a report by via digital dictation will be provided on a weekly basis to the Assistant Director of Acute Services to ensure all outcomes are dictated. An outcome plan record of each clinical attendance must be recorded for each individual patient and this should include a letter for any patient that did not attend as there must be a record of this back to the GP". 16:23 16:24

Now, just on the issue of the ability of the Trust to effectively monitor dictation and ensure that clinics are followed up with dictation, it was pointed out in December 2016 that the system depended upon the reports coming back from the medical secretary. Let's just look at that. If we go to your core 207 and if I could have up TRU-288967. If you go to 207 and scroll down to what Katherine Robinson has to say to Anita Carroll. This is 20th December 2016. She's telling Anita Carroll: 16:24 16:25 16:26

"This is a list of clinics that Mr. O'Brien has not dictated on and hence no outcome for some of these patients. There is a risk that something could be

missed so I am escalating to you although a lot of time I know Mr. O'Brien knows himself what is to happen with patients. Unfortunately, this was not highlighted on the backlog report. The secretary assumed we knew because there have always been issues with this particular consultant's admin work from our perspective. As learning from this discovery, I've asked all secretaries to provide this information on the backlog report so that we fully understand the whole picture of what is outstanding in each speciality. The secretary also advises that Mr. O'Brien is presently working on some of this backlog admin work as he is off sick recovering". 16:26 16:26

This seems to suggest, Dr. Khan, that this system depends on reports coming back from the secretary that the dictation work is all present and correct. Now, did you know at the time of the construction of the action plan and its attendant monitoring arrangements that this was the system in place for checking for compliance? 16:26 16:27

A. I suppose I wasn't aware of the specific issue, but working in the Trust I would have known that there is a system in place for secretaries to report back in terms of compliance of the digital dictation. Historically, it was analogue dictation but then most of the places were converting into digital dictation. I understood as part of the action plan, Mr. O'Brien's on his computer in his office should have the digital 16:27

dictation, and monitoring arrangement through his secretary by completing the backlog report.

151 Q. If we could then turn very briefly - we'll just finish this issue - to page 513 of your core bundle. If we go to WIT-55743. Here you'll find, several months after the introduction of the monitoring action plan, an email from Mark Haynes, 17th June 2017. He's thanking members of the support team for circulating a backlog report. But he's saying: 16:28

16:29

"I'm concerned regarding the robustness of this data, particularly in relation to 'results to be dictated'".

Then he asks:

16:29

"Could you advise me of the process whereby this data is collected. From recent experiences I would suggest that the date presented in this column is inaccurate. My concerns relates to how this information would be used in the event of a significant issue arising due to a delayed or not acted on result. Corporately are we kidding ourselves that all results are acted on, dictated on in a timely manner? That is the conclusion you could draw from the information, particularly in relation to some consultants. If a backlog were identified after an issue were to arise, are the staff who collect the data (I presume our secretaries) liable to be found culpable for not highlighting the backlog through this process? One could argue that the 16:29 16:30

information presented whereby some consultants seem to barely ever have any results to dictate is not untrue - not all of us dictate letters on results. An illustration of the inaccuracy of the data may be seen in last year's data in relation to a number of clinics to be dictated, which has been proven to be inaccurate".

I seem to recall Mr Haynes, when giving evidence on that issue, was directing attention to what he knew in respect of Mr. O'Brien. 16:30

Unfortunately, we have to leave this issue a little bit in the air but it is the case, Dr. Khan, that by October 2019, the Trust is still grappling with the issue of dictation in the context of Mr. O'Brien and, indeed it might be said, generally, and there was a meeting convened in January to 2020 to try to address this issue. 16:31

A. I think this is a long-standing issue in terms of dictations and how the dictations are typed and monitored. Various departments have various ways in terms of addressing those issues. But I think in the Acute Directorate, this was still quiet active and alive in terms of an ongoing challenge in terms of how to address the dictations backlog typing, printing out or sending it to the GPS or to the charts. 16:31

I think you are right, you are correct to say it was

still -- until quite recently, it was an alive and challenging issue.

152 Q. Very well.

MR. WOLFE KC: I think we'll leave it there for today. Maybe take up on the next occasion and finish the area of monitoring. Then we'll move into your determination in respect of Dr Chada's report. 16:32

So 10 o'clock, I think, on Tuesday?

CHAIR: Yes. 16:32

Thank you, Dr. Khan. We'll see you at ten o'clock next week.

10 o'clock next week, ladies and gentlemen. 16:32

THE INQUIRY ADJOURNED TO 10:00 A.M. ON TUESDAY 28TH MARCH 2023