



Oral Hearing

Day 33 – Tuesday, 28th 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.

Gwen Malone Stenography Services

I N D E XP A G E

Dr. Ahmed Khan	
Examined by Mr. Wolfe KC (cont'd)	3
Examined by the Inquiry Panel	105
Lunch adjournment	76

THE INQUIRY RESUMED ON TUESDAY, 28TH MARCH 2023, AT
10:00 A.M. AS FOLLOWS:

CHAIR: Good morning, everyone. I know my colleagues
are on the zoom call with Dr. Khan. You can't see them 10:01
this morning but they are both present.

Good morning, Dr. Khan. I'm sure you're rather
relieved you were joining us remotely last week when
we had all to test for COVID. I'm fit and well, my two 10:01
colleagues thankfully, although positive, have mild
symptoms so they're certainly fit to get on with the
work. So that's what we're going to do.

Mr. Wolfe. 10:01

MR. WOLFE KC: Good morning, doctor, and welcome back
and thank you for joining us. You remain under oath,
of course. You still have your bundles available to
you?

A. I do, yes. 10:01

1 Q. Very well.

You'll recall that at the conclusion of the last day of
hearing with you, I was exploring with you the action
plan and the monitoring arrangements attached to that. 10:02
Through the lens of the dictation issue, I was
examining with you how robust or reliable was the
information available to managers in order to supervise
that issue as part of the plan. I brought you,

1 I think, to a meeting on 20th January, if you like,
2 several years after the plan had been introduced, and
3 you were explaining to me at the end that within the
4 Acute Directorate there always seemed to be a problem -
5 I hope I'm not overstating it - but there seemed to be 10:03
6 a problem which was never fully resolved in relation to
7 the dictation issue. Is that fair?

8 A. I suppose, just to further expand on that, I never
9 worked in the Acute Directorate so I wasn't going to be
10 part of a clinician's experience in that way, that 10:03
11 I would have seen a patient and dictated in Acute
12 Directorate. I was aware there was an implementation
13 of the digital dictation process across the Trust,
14 including the Acute Directorate. Some parts were
15 already implemented and other parts were going through 10:03
16 the implementation of the digital dictation process.
17 But other parts - various parts, actually - had
18 challenges in terms of managing the dictations, not
19 necessarily just in Acute Directorate, there other
20 directorates would also be in that position. So it was 10:04
21 a process going through the digital dictation which
22 gives a more robust monitoring recording arrangements
23 for the dictations. That was obviously my impression
24 in that way, that the Acute Directorate was also going
25 through the implementation of the digital dictations. 10:04

26 2 Q. Yes. I just want to explore with you then the process
27 by which this action plan with its monitoring element
28 was put on paper and agreed in February 2017 so that we
29 can better understand how the various elements came

1 together.

2
3 Let's start by looking at something you said in an
4 email -- sorry, in your witness statement, I should
5 say:

10:05

6
7 "I attended the return-to-work action plan meeting
8 along with Mrs. Siobhán Hynds, Ronan Carroll and
9 Mr. Colin Weir".

10:05

10
11 Let me just put up an email from Siobhán Hynds in
12 relation to this, 22nd February 2017, your core 414 and
13 TRU-267574. At the bottom of the page, please.
14 Siobhán Hynds is writing to Esther Gishkori and
15 Ronan Carroll is copied in. It is explained that
16 Siobhán Hynds and yourself hope to meet with
17 Mr. O'Brien this week to outline the monitoring
18 arrangements, however Ronan's on leave, and you
19 notified Mr. O'Brien that you do not have the detail as
20 yet but will inform him as soon as possible. It's
21 important that this is done as early as next week
22 because he intends to return to work if passed fit.

10:06

10:06

23
24 Siobhán explains:

25
26 "Colin Weir is fully aware of this and it will be
27 necessary, I assume, to inform the other clinical
28 directors to ensure the monitoring is robust and
29 doable", and a meeting is suggested.

10:07

1
2 Can you help us, Dr. Khan, in terms of where was the
3 action plan developed and who developed it, and was it
4 in fact brought to a meeting of the several people
5 mentioned here to discuss its robustness?

10:07

6 A. The action plan was developed after the case
7 conference. At the case conference, one of the actions
8 were to develop an action plan by the Director of
9 Acute Services and her team. Ms. Esther Gishkori and
10 Ronan Carroll, or her team, was to develop an action
11 plan. Purely it was felt at the time of the case
12 conference that this is necessary in order to make sure
13 that the monitoring and the action plan and follow-up
14 and monitoring is robust within the Acute Directorate,
15 purely because they know the system within the Acute
16 Directorate in terms of the operational management and
17 how it best can be managed. So, that was the
18 background at the time of the case conference at the
19 end of January.

10:08

10:08

20
21 Subsequent to that, I understood there was a number of
22 discussions within the Acute Directorate. Now,
23 I wasn't party to that or I wasn't involved in those
24 discussions. Talking to Siobhán Hynds and looking at
25 other communication, I was aware that there was some
26 discussion happening within Acute Directorate in terms
27 of putting that action plan together. We were to come
28 together and meet before I and Siobhán Hynds would be
29 meeting with Mr. O'Brien in order to inform him and get

10:08

10:08

1 his agreement to that. So yes, it was devised,
2 developed and obviously drafted by the Acute
3 Directorate team.
4

5 Now, I understood at that time as well that
6 Siobhán Hynds was helping in supporting them in order
7 to put that together in more kind of a document format.

10:09

8 3 Q. We know that you met with Mr. O'Brien and you discussed
9 the action plan with him, and we'll come to that in
10 a moment. But before you reached that stage of meeting
11 Mr. O'Brien, did you sit down and meet with these other
12 people, study the action plan, and give your approval
13 for it?

10:09

14 A. I did give my approval for that. My recollection is
15 that a small group of people met. Now, I'm uncertain
16 who was -- I know it was myself and Siobhán, and there
17 was Ronan Carroll possibly. My recollection is that
18 a small group of people met to go through the action
19 plan before I met with Mr. O'Brien.

10:10

20 4 Q. You say in your witness statement - I don't need to
21 bring it up to the screen but if you need to look at
22 it, it's at your bundle at page 84 - where you say that
23 the return to work action plan monitoring arrangement
24 was drafted by the Acute Directorate Management and
25 agreed by the Oversight Committee meeting on
26 3rd February 2017. Now, I'm not aware of a record of
27 any such meeting. Are you saying the Oversight
28 Committee met on that date?

10:10

29 A. Now, I suppose on reflection this may be that the small

10:11

1 group of people when they met rather than the Oversight
2 Committee, as such. I was aware that the Oversight
3 Committee was aware of this action plan. I'm not sure
4 if this is the correct reflection what it was at that
5 stage. Maybe it was just that a small group of people 10:11
6 met, including myself and Siobhán Hynds and
7 Ronan Carroll. I'm just trying to think about whether
8 the whole Oversight Committee met. Maybe not. It was
9 this small group of people who met and then, obviously,
10 the Oversight Committee was aware of this action plan. 10:12
11 That was my understanding.

12 5 Q. So when this small group met, did you have it in mind,
13 for example, to discuss - take the example of the
14 dictation issue that we have gone through - how are
15 we going to be able to establish that Mr. O'Brien has 10:12
16 performed all of the dictation that we require him to
17 perform?

18 A. I think there was -- I don't recall that there was
19 a specific dictation issue was discussed at that point
20 in time. The understanding was it will be monitored by 10:13
21 the arrangement which is already in place, such as --
22 it wasn't actually mentioned about that, the secretary
23 or who else, but my understanding was that it would be
24 monitored within the Acute directorate Management
25 system, which is already in place for any other 10:13
26 clinician and tracking back and all those things as
27 well.

28
29 So, my experience in my department would be that my

1 secretary would be, you know, informing me or keeping
 2 me appraised of where the dictations are, or what
 3 we need to do if there is obviously a further clinical
 4 dictation or something required. That was my
 5 understanding at that point in time. As I said, 10:13
 6 I wasn't very close to Acute Directorate or especially
 7 with Urology Services at that point in time. In fact,
 8 I wasn't clearly appraised at that point in time about
 9 the lack of escalation of the dictation. So, it was
 10 felt that that would be the system which is already in 10:14
 11 place.

12 6 Q. Are you saying, in other words, that you were assured
 13 by what Acute managers were telling you about their
 14 ability to robustly manage this?

15 A. I suppose the assurance was not only just for the 10:14
 16 dictations, the assurance was for the whole action
 17 plan --

18 7 Q. Of course.

19 A. -- that this is drafted, this is performed and drafted
 20 by the Acute Directorate, a team who knows their 10:14
 21 system, and they will provide the assurance monitoring
 22 and escalation.

23 8 Q. If we can then just look at the action plan which also
 24 serves, it appears, as a record of your meeting with
 25 Mr. O'Brien. Page 429 of the core bundle, Dr. Khan. 10:15
 26 If we could have up TRU-00732.

27 A. Page 49?

28 9 Q. Page 429 of the core.

29

1 Could you explain to us the format of the meeting which
2 you held with Mr. O'Brien on the 9th February? Did
3 you lead the meeting with him?

4 A. Yes. It was a meeting with Mr. O'Brien and it was
5 myself, Siobhán Hynds. I led that meeting, explaining 10:15
6 the purpose of that meeting. Essentially the main
7 purpose of that meeting with Mr. O'Brien was to share
8 the action plan and get his agreement in order to
9 proceed to the return-to-work arrangement which was
10 already agreed in the previous month. So, we did go in 10:16
11 the details of the action plan with him, essentially
12 going in terms of what are the main elements of the
13 action plan and what is required from Mr. O'Brien's
14 point of view, and then how they are going to be
15 monitored. 10:16

16 10 Q. Just on this record, it doesn't appear to make any
17 reference to any contribution from Mr. O'Brien at the
18 meeting. Can one assume that he did contribute
19 a viewpoint at the meeting?

20 A. The action plan was already established and we shared 10:17
21 that action plan. I must say he did not contribute
22 into the formation of action plan. However --

23 11 Q. Sorry, just to cut across you. Did he contribute at
24 the meeting to your explanations of what was required
25 of him? 10:17

26 A. I don't recall the exact details of the meeting but he
27 did show his agreement that he will adhere to the
28 action plan. I was also aware that in another previous
29 meeting, I think end of January - I didn't meet him but

1 he met with a number of other people - he said, or he
2 agreed, that he will adhere to any monitoring or action
3 plan arrangements in order for him to come back to
4 work. So, in my meeting he agreed on the action plan,
5 that 'I will stick to or I will adhere to the action
6 plan'.

10:18

7 12 Q. If we just look through it. As it appears from the top
8 section, it is made clear that a condition of his
9 return to work would be monitoring around the four main
10 issues under investigation as well as an urgent job
11 plan review to consider any workload pressures. We've
12 heard evidence from you in relation to the delays and
13 the difficulties around that.

10:18

14
15 If we just scroll down then. His immediate workload
16 upon returning to work is set out there. Then in
17 specific terms under Concern 1, the issue for
18 investigation is highlighted at the first bullet point,
19 and then the action required of Mr. O'Brien going
20 forward, including the completion of red flags daily
21 when urologist of the week. Scrolling down, please.
22 Then it provides that a report will be shared with the
23 Assistant Director at the end of each period to ensure
24 all targets are met.

10:19

10:19

25
26 On that, were you satisfied that that met the
27 difficulty and provided adequate assurance in relation
28 to the triage issue?

10:19

29 A. I guess different elements of the action plan are

1 monitored by various peoples but they're all providing
 2 report to the Assistant Director of Surgical Services
 3 at that point in time. So, in this instance it was the
 4 central booking system who was monitoring and providing
 5 assurance to the Assistant Director, who obviously was 10:20
 6 to escalate or to inform other people if there is
 7 a deviation or otherwise. So in this case that was,
 8 again, established that this is going to be the
 9 monitoring arrangement for the triage part, yes.

10 13 Q. Then, with regard to the issue of notes being removed 10:20
 11 From Trust premises, it's made clear that that's not to
 12 be done at all. Notes tracked out to Mr. O'Brien's
 13 office must be tracked out for the shortest period of
 14 time possible for the management of a patient. How was
 15 that to be determined, Dr. Khan? Was there any 10:21
 16 particular thinking given to the issue of what is the
 17 shortest period of time, or was that to be on
 18 a case-by-case basis?

19 A. I don't recall the specific discussion around the
 20 period of time the notes can be kept in the office or 10:21
 21 outside. It was depending on the situation at that
 22 point in time, but there was no specific discussion
 23 happened in relation to that.

24 14 Q. Do you think there was clarity of thinking around that
 25 issue? 10:22

26 A. I think in hindsight we see some challenges there.
 27 However, at that point in time, that was felt to be
 28 appropriate and monitored by various people, yes.

29 15 Q. Then Concern 3 in relation to the issue of dictation

1 we've spoken about that at some length already.
2 we know, I think I pointed out on the last occasion,
3 that late in 2016 the issue of the frailty or the
4 weaknesses in relying upon the secretary to report
5 whether dictation had been done or not had been exposed 10:22
6 in an email from, I think, Katherine Robinson --
7 between Katherine Robinson and Anita Carroll copying
8 Mr. Ronan Carroll in.

9
10 Did he raise that issue with you at all as part of 10:23
11 this?

12 A. I don't recall that I was informed or appraised about
13 the issues. In fact I didn't know until much, much
14 later. In fact, I wasn't aware of those issues which
15 were happening in terms of monitoring and escalation 10:23
16 about the dictations through the secretarial services,
17 the secretarial team.

18 16 Q. We know, and we'll look at it in a few minutes, that
19 come January 2020 - you referred to this meeting
20 already - that you attended, convened at the direction 10:23
21 of the Medical Director at that time, Mrs. O'Kane, and
22 chaired by Mr. Gibson, that issues were raised at that
23 meeting about the lack of clarity in relation to
24 dictation generally across the Trust, whether there was
25 a set standard, whether it was known, when should 10:24
26 issues be escalated.

27
28 In terms of Mr. O'Brien and this specific action plan,
29 is it fair to say that the expectations of him,

1 regardless of the rest of the Trust, the expectations
2 of him were made very clear?

3 A. In the action plan there are obviously four elements
4 and one of them was dictation. Therefore, the action
5 plan was agreed by Mr. O'Brien, and it was expected 10:24
6 that he will -- that that's the standard which he is
7 expected to deliver and that was until there is some
8 change. So yes, you are right in saying that and that
9 was my understanding, that the action plan provides the
10 standard form for Mr. O'Brien, which he already agreed 10:25
11 to, in relation to the dictation and for other three
12 elements.

13 17 Q. Specifically it provides that dictation must be done at
14 the end of every clinic, and a report via digital
15 dictation will be provided on a weekly basis to the 10:25
16 Assistant Director to ensure all outcomes are dictated.
17 Then, it provides that an outcome, plan or record of
18 each clinical attendance must be recorded for each
19 individual patient, and this should include a letter
20 for any patient that did not attend as there must be 10:25
21 a record of this back to the GP.

22
23 So, it was designed to be specific in those terms; is
24 that fair?

25 A. I think it was going in much more detail in terms of 10:26
26 the dictation than other elements. I believed that the
27 specific reason of having that action plan in place,
28 and specifically for the dictations, is to ensure that
29 the multi-disciplinary way of working and making sure

1 the patient management plan is shared with the
2 multi-disciplinary team, both in hospital and in the
3 primary care team, for the main reason that some of
4 these patients attend multiple occasions by the primary
5 care team, including the GPs, in between when they are 10:26
6 attending the hospital services. So, I believe that is
7 a robust arrangement in order for that to achieve that
8 element of standards.

9 18 Q. Then, scrolling down, please, private patients is
10 addressed. I needn't go into the detail but specific 10:27
11 reference made To Trust policies, a guide to paying
12 patients and a specific reference to referral of
13 private patients to NHS lists.

14
15 Again scrolling down, it's made clear that, in 10:27
16 conclusion, any deviation from compliance with the
17 action plan must be referred to you immediately, and
18 the referral to you would come through the Assistant
19 Director. Was that your understanding?

20 A. That's correct, that's my understanding. In the vast 10:27
21 majority of cases or occasions, it did happen that way,
22 yes.

23 19 Q. Now, after this meeting there was some discussion, it
24 appears, within the Trust as to whether NCAS should be
25 advised of this plan. If I could just draw your 10:28
26 attention to your bundle at 2082. If we could have up
27 on the screen, please, TRU-267906. Siobhán Hynds is
28 writing to you, copying in Dr. Chada, attaching the
29 draft terms of reference for agreement. That's in

1 relation to the MHPS investigation. Then asking you,
2 Dr. Khan, "Did you get speaking with Grainne Lynn,
3 NCAS, about the action plan"? That precedes an email
4 earlier in the month which suggested that the legal
5 advice from DLS was that the action plan should
6 necessarily be shared and discussed with NCAS.

10:29

7
8 Did you get an opportunity to discuss that with
9 Dr. Lynn at NCAS?

10 A. My recollection is that I did try to speak to her and
11 I didn't get through to her. There was a training
12 coming up in a couple of weeks' time and there was an
13 indication that I could discuss with Ms. Grainne Lynn
14 in the sidelines of the training as well or around that
15 time. However, in the meantime I discussed -- I met
16 actually with Dr. Wright, the Medical Director, and he
17 indicated that he was going to. Subsequent to that,
18 I understood that he did discuss with Grainne Lynn from
19 NCAS. I don't recall seeing a correspondence in
20 relation to that, but my understanding was that
21 Dr. Wright discussed with Grainne Lynn.

10:29

10:30

10:30

22 20 Q. Did Dr. Wright feed back to you what NCAS had said in
23 relation to the action plan?

24 A. I don't recall that we had any such discussion, but
25 what he suggested that he did speak to Grainne Lynn.
26 But I tried to -- even afterwards as part of the
27 preparation of my statements, I was trying to identify
28 or find a communication in relation to that but
29 I couldn't find any communication.

10:31

1 21 Q. So are you saying that you made contact with Dr. Lynn,
2 it was agreed that you could discuss this issue on the
3 edges of the training that was coming up but in the
4 meantime Dr. Wright took over the issue, and it's your
5 understanding that he talked to her about it? 10:31

6 A. That's my understanding. I tried to speak to
7 Ms. Grainne Lynn on one occasion after this and
8 I couldn't get through to her. Something that
9 I couldn't get through to her. Then there was some --
10 I think Siobhán Hynds possibly suggested that you are 10:31
11 attending that meeting which Grainne Lynn is going to
12 be -- not that meeting, the training day, which is
13 Grainne Lynn going to be at, so if you wish to discuss
14 it at that point of time, which was in a couple of
15 weeks' time. However, Dr. Wright, when I met with 10:32
16 Dr. Wright, he indicated that he's going to speak
17 to her, and my understanding afterwards is he did get
18 speaking to Grainne Lynn.

19 22 Q. If you just go to 1498 of your bundle. If we could
20 have up TRU-268026. Mrs. Hynds is obviously persistent 10:32
21 on this issue and she's writing to you now at the end
22 of March, four weeks after her first email. The
23 training was the start of March as well, I think the
24 7th and 8th. Dr. Wright is absent. "Is there any
25 update for Dr. Lynn, NCAS, at this point"? 10:33
26

27 Can you help us on that, Dr. Khan?

28 A. I don't seem to remember this communication, looking at
29 any communication. I can see in this email there was

1 some sort of a communication came back because I know
2 the NCAS communication usually comes with encrypted
3 message. So, there must be an email communication came
4 back from NCAS at that point in time. I don't recall
5 seeing any letter or communication at that point in 10:34
6 time. I know this must be that Dr. Wright must be off
7 for a day or two and it was sent to me. But you
8 need -- to decrypt that email, you need another
9 password and other information as well, so everybody
10 can't open that. I don't recall seeing a communication 10:34
11 or a letter from Grainne Lynn.

12 23 Q. No. If I can preempt what we anticipate she might say,
13 drawing from her contact with the Inquiry to date
14 through statements. She has indicated that she wrote
15 several emails to the Trust after December 2016 when 10:35
16 her advice was sought. Her repeated emails didn't
17 receive any response from the Trust and ultimately NCAS
18 closed the file.

19
20 Is it possible, Dr. Khan, that this request or 10:35
21 direction that you should contact NCAS was either
22 missed by you or avoided by you for any reason?

23 A. I remember contacting her first when the first request
24 was made, I think at the beginning of March, and
25 I didn't get through to Grainne Lynn. I think I wrote 10:35
26 back to Siobhán Hynds asking is there another number or
27 something that I can contact her. However, in the
28 meantime, Dr. Wright indicated that he is going to, or
29 he is going to meet or talk or discuss with Grainne

1 Lynn. So certainly it wasn't intended to be avoidance.
2 It was possibly that I remember clearly Dr. Wright
3 suggesting -- he said, "I'm going to discuss with
4 Grainne Lynn anyway". I can't recall an email coming
5 back. Now, necessarily all those emails or
6 communications back from NCAS comes to the case
7 manager, they usually come to the Medical Director.
8 I presume this email was sent to me because Dr. Wright
9 was maybe off for a day or two. But you can't access
10 these encrypted messages without having your login
11 details and everything; you have to have that. I don't
12 remember trying to open it or maybe I didn't even try
13 to get to it.

10:36

10:36

14 24 Q. So you can't recall responding to this email?

15 A. No.

10:37

16 25 Q. Very well.

17
18 Now, I just want to look at some of the alleged
19 departures from the action plan and examine your
20 participation in the supervision and escalation of
21 that.

10:37

22
23 First of all, it appears that on 12th April 2017 you
24 had to write to Mrs. Esther Gishkori and Mr. Carroll
25 asking for an update. If you go to core 489, and if we
26 could have up on the screen WIT-40828. This is at an
27 early stage in the plan you find yourself writing,
28 asking for an update. Had it not been, I suppose
29 nailed down, at an early stage, how the process of

10:37

1 keeping you informed would be acted out?

2 A. I suppose I did write to the Acute Directorate just to
3 get assurance, in order to get the assurance for the
4 action plan. However, if you look at the action plan,
5 at the end of the action plan it suggests "any
6 deviation should be referred to should be escalated to
7 case manager". So on reflection, I don't know, that
8 may be the reason if there is any deviation, then it
9 will be escalated to case manager.

10:38

10

10:39

11 I must say, I did receive a number of assurances for
12 the action plan during the year and on occasions I also
13 requested some, but the action plan document actually
14 suggested for escalation rather than a regular update.
15 So, there may be this understanding in the Acute
16 Directorate.

10:39

17 26 Q. Yes. If you go two further pages on in your bundle to
18 491, and if we could have up on the screen TRU-251847.
19 If we just go down to the middle email, please. So
20 you're suggesting that - reading between the lines
21 here - that you want monthly updates; is that fair?

10:40

22 A. Yes, absolutely. What it says there, it's very clear
23 that I was requesting monthly updates. Now, this is
24 very early on in the investigations. I was trying to
25 get a more regular update if I wasn't receiving any.
26 But I must say in between, in some months I was
27 receiving twice a month and some months I wasn't
28 receiving. So, I was requesting I get a monthly
29 assurance report. And I was getting it; I was getting

10:40

1 it, initial investigations.

2 27 Q. I needn't bring this up on the screen but it appears
3 that the team on the ground, that is Mrs. Corrigan and
4 then the Assistant Director, they had set out a plan to
5 look at matters weekly and draw to your attention any 10:41
6 difficulty but, in any event, provide you with
7 a monthly report. Is that the understanding of how
8 things were to work?

9 A. I think that was the understanding, yes. I wasn't
10 aware of how they're working, on a weekly or monthly, 10:41
11 but I was getting it at least monthly, yes.

12 28 Q. Shortly after this email on 15th May, your attention is
13 drawn to what you might have suspected was a first
14 deviation or perhaps a first problem with compliance
15 with the plan. I want to ask you how you bottomed that 10:41
16 out. If you go to 118 of your bundle and if we can
17 have TRU-251855. If we scroll down, please. The issue
18 is in respect of Concern 2, that's charts in the
19 office. It is reported that -- it says apart from the
20 13 already identified missing notes - and that goes 10:42
21 back to the start of the investigation, if you like -
22 Mr. O'Brien has 68 further charts in his office which
23 are all recent and are waiting for results.

24
25 Then just scroll up, please. Just keep going. 10:43
26 You are, it seems, copied into this. By 23rd June,
27 it's reported by Mrs. Corrigan to Mr. Carroll that
28 Mr. O'Brien has 85 charts in his office. If you go to
29 1519 and if we go to TRU-268972, Siobhán Hynds is

1 advising you of this issue. If we scroll on down. You
2 can see that -- just on down, please. It is flagging
3 that there are 85 further charts in his office.

4
5 Can you help us just in terms of what you were thinking 10:44
6 at that time and what actions you took, or whether
7 you were content that these issues being drawn to your
8 attention by the team on the ground, that they had it
9 under control?

10 A. I think at that point in time there was some indication 10:45
11 of the charts coming in his office and also returning
12 back to the secretaries or the other admin staff.
13 I suppose what I was assured by that at the same time
14 the charts are coming in and going out from
15 Mr. O'Brien's office, that there is a management 10:45
16 arrangement, or how to deal with this issue is also
17 coming through. They were saying we will deal with
18 this by 30th June or returning to the previous
19 position.

20
21 So, I was assured with the arrangements already in 10:45
22 place and I wanted to ensure that we return to the
23 position. I did discuss this with Siobhán Hynds on one
24 occasion around that time when we were meeting for
25 something else, not necessarily specifically for this 10:46
26 issue. But there appears to be action plan, monitoring
27 arrangements were there and a management plan was there
28 when the charted were not returned on time, so
29 follow-up arrangements were already made. So, I was

satisfied at this point in time.

29 Q. I just want to tease that out with you. On 11th July -- and I'm conscious you've sent in an email to us with your amended statement or your addendum to your statement to indicate that you were on holiday when this email was sent. On 11th July, Ronan Carroll was writing to you. 523 of your core bundle and we could look at TRU-251860. Just scroll down. On Concern 2, which again is notes in the office, 90 further charts.

10:46

10:47

"This amount has been increasing each week and while some are moving on, there are now quite a few that haven't been actioned. I have emailed Mr. O'Brien today and I again reminded him that as part of the action plan, notes should never be stored offsite and should only be tracked out and in of his office for the shortest time possible", etcetera.

10:47

while there's some suggestion there that some notes are moving out, as you've suggested in your last answer, the picture is emerging of an increased volume of notes in his office at that point in time. I want to ask you why, in advance of going on holiday - and obviously this email was sent while you were away or on the day you went - why you hadn't taken any specific steps to meet with Mr. O'Brien and nip this issue in the bud?

10:48

10:48

A. I think before, the previous emails and the communication obviously suggest there was plans around

1 that to manage this. This escalation, when it came to
2 my attention, obviously I was off on annual leave.
3 When I came back from annual leave, I was assured that
4 the issue of charts had been resolved.

5
6 Now, on reflection, possibly it was going up from June,
7 end of May/June time, and on reflection and hindsight
8 with all that information available, I could have taken
9 a more robust arrangement, or meeting with the team or
10 even indeed meeting with Mr. O'Brien. But every time 10:49
11 with these issues were raised, it appears to be before
12 this email came that there was an arrangement in place
13 to address those.

14 30 Q. In fairness to the team, a meeting was arranged by them
15 with Mr. O'Brien in your absence. If you could look at 10:50
16 page 531 of the core, and if we could have up on the
17 screen AOB-56210. That's the first page after a
18 recording or a transcript of a recording made by
19 Mr. O'Brien of this meeting attended by the persons
20 named there, Weir, Corrigan and Carroll. 10:51

21
22 As appears from the content of this meeting, if you go
23 through to 533 of your core, and if we could go down to
24 AOB-56212, another couple of pages down. Just scroll
25 down. At this meeting, in fairness to Mr. O'Brien, 10:51
26 he's explaining that, if you just read that page, that
27 the notes that are in his office from his perspective
28 do not need to be there, that they are being brought
29 there by secretarial staff. He says at the top of the

1 page or about a third of the way down that page:

2
3 "I don't ask for them. I'm not the person responsible
4 for storing them. There's no need for them. It is an
5 obsolete system".

10:52

6
7 It seems, if you read the full account, and the Inquiry
8 can read the full account, that he's making the case
9 that notes are being brought to his office by members
10 of the secretarial team to draw his attention, for
11 example, to results relevant to the case, the results
12 are placed on the file and the file is left in his
13 office and multiple files are generated, but he doesn't
14 see the need for that kind of system.

10:52

15
16 Was that drawn to your attention up your return from
17 holiday or not?

10:53

18 A. When I returned from my annual leave, I was assured by
19 Ronan Carroll just that the issue of notes had been
20 resolved. I must say, I wasn't aware that they met
21 with Mr. O'Brien and the issue of the charts brought to
22 his office had been discussed in detail. But I was
23 assured that the issues had been resolved, you know, in
24 agreement with Mr. O'Brien and the team which is on the
25 ground.

10:53

26 31 Q. Now, I think it's fair to say that no other issue of
27 concern regarding the action plan was drawn to your
28 attention during 2017. I want to ask you about an
29 issue that arose in 2018. If you go to page 1389 of

10:53

1 your bundle. Your bundle, not the core. If we could
2 have TRU-264481. Just start at the bottom of the page,
3 please. Martina Corrigan is updating Siobhán Hynds,
4 assumedly for the purposes of the MHPS investigation
5 report that comments on Mr. O'Brien's compliance with 10:54
6 the action plan. She indicates that apart from one
7 deviation on 1st February 2018 when Mr. O'Brien had to
8 be spoken to regarding a delay in red flag triage, and
9 he immediately addressed it, she can confirm that he
10 has adhered to his return-to-work action plan, which 10:55
11 she monitors on a weekly basis.

12
13 Was your attention drawn to the February deviation, as
14 it's described there?

15 A. Not until -- I wasn't informed until Vivienne Toal 10:55
16 emailed me. I wasn't involved in any escalation or
17 communication prior to that.

18 32 Q. Yes. If we just scroll up the page. Vivienne Toal is
19 being advised in respect of this and Vivienne Toal asks
20 you: 10:56

21
22 "See below regarding Aidan O'Brien. Have you been
23 getting these updates on a regular basis in terms of
24 assurance?"

25
26 You say at the top of the page: 10:56

27
28 "I have been receiving it until earlier this year from
29 Ronan Carroll. Haven't received it in a few months

now. Have spoken to him recently and he will forward this to me. Is the report ready", and that's a reference to the MHPS investigation report.

Is this explaining then that you hadn't been advised of the triage issue in February which, on Mrs. Corrigan's description, seems to have been relatively quickly resolved, is that right? You didn't know about that?

A. That's correct. I wasn't aware of that, no.

33 Q. Plainly, as it's explained here, you had been receiving updates from Mr. Carroll but hadn't been receiving them recently. How did that happen; was that outside of your expectations from him?

A. So at that point in time there were a couple of things happening. I was preoccupied with my appointment to the Interim Medical Director. I was appointed after the recruitment and selection process in April of 2018. I was also talking or discussing the issues of the progress of the MHPS investigation report with Siobhán Hynds, with Dr. Neta Chada. I would have spoken to Ronan Carroll about the understanding and the management of action plan. So, I was assured by talking to various peoples that the action plan is monitored and the investigation is coming to -- the formal investigation is coming to an end. So I was assured on those bases.

But I must say I didn't go looking for a report, an assurance report. I was under the impression that

1 I will be informed, and I have been previous to that.
2 So I was assured on my experience in that.

3 34 Q. Did you interpret, if you like, the failure to send you
4 updates as being an indication that everything was
5 okay?

10:58

6 A. My understanding was that if there was an issue, it was
7 addressed immediately, and I will receive an escalation
8 if there are further issues, yes. That was my
9 understanding.

10 35 Q. Later that year shortly after the publication of your
11 determination, this is the autumn of 2018, you became
12 aware, I suppose, of a more significant issue in that,
13 as you will recall, Mrs. Corrigan, who was, if you
14 like, the person primarily responsible for the
15 monitoring and gathering the information in for
16 monitoring purposes, she was absent from work on sick
17 leave and monitoring of Mr. O'Brien's compliance with
18 the action plan did not happen for a period of months;
19 isn't that right?

10:59

10:59

20 A. I wasn't aware of Martina Corrigan being off for that
21 period of time. My understanding was that the action
22 plan has been monitored as it has been before, purely
23 because it was not only my - well, let's call it my
24 perception or understanding - it is not just based on
25 Martina Corrigan but it is the team. If someone is off
26 sick or off, then someone else takes on that
27 responsibility, and the Assistant Director was there.
28 So, my understanding was it was monitored. I wasn't
29 aware of Martina being off for that period of time

10:59

11:00

1 until much, much later, and I became involved when it
2 was escalated to me.

3 36 Q. Your previous answer regarding the start of the year
4 when you weren't receiving updates contained an
5 explanation that you were satisfied, perhaps through 11:00
6 word of mouth, that nothing was going wrong, things
7 were being monitored, and the absence of an update was
8 interpreted by you at the start of the year as an
9 indication that things were okay. Mrs. Corrigan,
10 I understand, was off from June until October 2018. 11:01
11 Did you seek assurances, word of mouth or otherwise,
12 during that period that monitoring was continuing to be
13 done?

14 A. I didn't seek actively any assurances at that period of
15 time but I was assured on a number of other elements. 11:01
16 After becoming the Interim Medical Director, I would
17 have some one-to-one with the Director of
18 Acute Services. I would have also had some discussions
19 with other people as well. For instance, my discussion
20 with the Director of Acute Services, it wasn't an 11:02
21 established meeting but I established it after becoming
22 the Interim Medical Director. One of the discussions
23 happening in that short period of time before
24 Esther Gishkori was off on sick leave, I think in June
25 or July 2018, one of the important elements were the 11:02
26 assurance of the action plan. I was assured that the
27 whole action plan was being monitored closely.

28 37 Q. We will hear from Mr. Carroll in relation to this
29 today. He seems to have been under the impression,

perhaps, that others in the team were doing the monitoring but, for whatever reason, the issue or the task was not performed. Who was giving you assurance that it was? Was it Mrs. Gishkori?

A. At that point in time I remember there were a number of discussions with Esther Gishkori. Not in October; I'm talking about in June. When I started Interim Medical Director in April, I realised there was no one-to-one discussion with the Medical Director and the Direct of Acute Service in terms of a predicted or dedicated time to discuss issues, so I approached Mrs. Gishkori and we established an informal discussion time, either after the Trust SMT or another time. During the period of from May until June -- May and June, certainly, I was getting assurances this was monitored.

Now, I must say she was off, I knew she was off in the summertime on sick leave. I had, I think, one meeting with Ann McVey, but I was getting -- my impression was that I will be informed of any deviation, and I was in October, but I wasn't informed of any deviation before that.

38 Q. If I could ask you to look at page 919 of the core bundle, and if we could have up on the screen, please, TRU-251526. At the bottom of that page, Dr. Khan, you can see that Mr. Weir is writing to you.

"Please for your urgent consideration and action.

See email correspondence below. Please see attached

1 Excel spreadsheet and go to the October tab or see
2 below in email trail".

3
4 If you go over the page then, please, to TRU-251527.
5 It explains to you that Mr. O'Brien has accumulated 11:05
6 a large backlog of dictated letters and a large number
7 of charts in his office. Mr. Weir explains "I'm his
8 clinical director", and he asks for instructions on how
9 to proceed.

10 11:05
11 If you just scroll down a couple of pages, please.
12 I'll tell you when to stop. If you go over a couple
13 of pages, you can see the details. Stop there, just
14 put it back slightly. This is all copied to you.

15 11:06
16 You are told, if you read through all this, Dr. Khan,
17 if you go through another couple of pages, you can see
18 that you're being told there are approximately 82
19 charts in his office. Scrolling down. By this stage
20 you can see across from Mr. O'Brien's name, 91 clinic 11:06
21 letters to be dictated, the oldest of which is dated
22 back to 15th June 2018, if you look at the right-hand
23 column.

24
25 If we could go back up the email trail in the direction 11:06
26 we have just come. Thank you. A number of people
27 contribute to these emails, I hope you are familiar
28 with them, Dr. Khan. Ultimately, if we just go on up
29 and see your input. Sorry, on up. Thank you. You say

1 this is clearly unacceptable practice from the
2 clinician and responsible managers; you're meeting with
3 Siobhán tomorrow regarding MHPS, and you're asking
4 a number of members of the team can they attend.

11:07

6 Did you get to the bottom of what had happened here,
7 and what steps did you take?

8 A. So, this is the time when I received this and I felt it

9 was clearly a departure from the action plan, so
10 therefore I did a number of steps. In fact, I first of 11:08

11 all informed the Chief Executive. I also approached
12 the Director of Acute Services in order to get

13 assurance or information. I also started discussing
14 with Siobhán Hynds and Ronan Carroll, asking where's
15 the break in all that; where was this, kind of as call 11:08

16 it, breakdown in terms of monitoring. I still wasn't
17 aware at that point in time, I think, that

18 Martina Corrigan was off for that period of time and it
19 had kind of fallen in between various people's

20 understanding and responsibilities. 11:09

21
22 Then I thought it be useful to have a face-to-face
23 discussion in order to understand better what's

24 happening. Unfortunately, Ronan Carroll couldn't meet
25 because he was out of the Trust for some other 11:09

26 commitment, but he did reply back and he informed about
27 the issues or what was the main issue in terms of

28 monitoring. I think there was an issue of initially
29 about 90 plus dictations and then, within 24/48 hours,

1 it was identified that it was much less, it was about
2 16 or 18 dictations left from the previous few weeks.
3 I was still wasn't clear how it happened, so I asked
4 that question. I think it's in the communication chain
5 somewhere that I asked the question about what exactly 11:10
6 that means, that you're giving me assurance that it has
7 been addressed and it's going to be monitored, but
8 exactly where it is? So I received the assurance,
9 again from Ronan Carroll, who was obviously the
10 Assistant Director and providing the assurance 11:10
11 throughout, that this has been addressed and it's
12 monitored.

13 39 Q. A meeting did take place - I think maybe just to assist
14 your answer with that - or it appears to have taken
15 place. If you go to 939 of your core, and if we look 11:10
16 at TRU-251531. Go to 940. Just scroll on down,
17 please. Ronan Carroll, 23rd October, a week or so
18 later, says:

19
20 "Regarding the outcome of today's meeting, can I ask 11:11
21 are we to continue monitoring Aidan O'Brien against the
22 four elements of the action plan"?

23
24 If we scroll up, please. Simon Gibson says that's
25 a matter for the case manager. Then you come in very 11:11
26 specifically saying:

27
28 "The action plan must be closely monitored with weekly
29 report collected as per the action plan. Can you also

1 clarify that yesterday, 22nd October, there were 91
2 outstanding dictations and today only 16"?

3
4 A couple of things there. One, you've had a meeting.
5 There was some clarification that the amount of 11:12
6 outstanding dictations is reduced. There seems to be
7 some uncertainty in the team about whether the action
8 plan should continue.

9
10 How could they have left the meeting with that 11:12
11 uncertainty?

12 A. Now, I was very clear at the time of this -- this
13 happened just after the determination report was
14 published. So I was very clear after that meeting,
15 even after that -- in that meeting and after discussion 11:12
16 with relevant professionals that the action plan should
17 closely be monitored. I was certainly very clear in my
18 mind that this action plan is still in place, and I was
19 conveying this information to the relevant
20 professionals who are supposed to monitor and escalate 11:13
21 that action plan is in place, and they should clearly
22 see that the monitoring arrangement should be in place
23 as well. I'm unsure why the uncertainty came but
24 I was, again in that communication, back to the
25 relevant professionals. I included actually in that 11:13
26 email Esther Gishkori, Siobhán Hynds, Vivienne Toal,
27 that this action plan is still in place and we need to
28 continue to monitor it.

29 40 Q. You have said, and we've seen your email which says,

1 this is clearly unacceptable practice, and you point
2 the finger at both management and the clinician. while
3 in any walk of life accidents and omissions can happen,
4 from the managerial perspective, given the concerns
5 that the Trust said that it had in respect of 11:14
6 Mr. O'Brien, at a time when the MHPS investigation had
7 reached a conclusion and there was a determination
8 issued, this doesn't reflect well on how seriously the
9 Acute team were taking the issue of monitoring?

10 A. I think at that point in time, the determination was 11:14
11 out; it was shared with the Chief Executive, with the
12 Director of HR. However, I must say that the
13 monitoring arrangements were fairly robust until that
14 point in time. There were a few elements of some
15 possible deviation but it was addressed, it was 11:15
16 managed, it was rectified immediately until this
17 information came to me. I was clearly mostly
18 disappointed and frustrated at that point in time, that
19 we have achieved such reasonably good compliance until
20 now, why can't we do it more? That was my frustration 11:15
21 and disappointment in terms coming out, that I was
22 saying it is unacceptable from both parties.

23
24 I recall, I think, also I wrote to Mr. O'Brien as well
25 for his responsibility to continue to adhere to the 11:15
26 action plan.

27 41 Q. Let's just come to Mr. O'Brien in a moment. In terms
28 of management, Dr. Khan, if I can ask you this: who do
29 you think bears the lion's share of responsibility for

1 this omission to effectively monitor over a period of
2 months?

3 A. I suppose it falls to many people. On reflection, the
4 action plan was heavily reliant on one person and that
5 should be a broader, much more robust monitoring of 11:16
6 arrangement for the action plan. I believe without
7 anyone's intention, it fell through the system in terms
8 of monitoring when one person who was mainly
9 responsible was off sick for a period of time. I do
10 believe as a system there would be an opportunity at 11:16
11 that point in time when Martina Corrigan was off, that
12 was someone else delegated or allocated this
13 responsibility. I don't believe that it was something
14 which was really appreciated, let's put it, at that
15 point in time. But what I was trying to say is that 11:17
16 we still need to keep this robust, and including the
17 key people into that, like the director of acute
18 service, the HR Director, just to make sure that
19 everybody is aware of their responsibilities.

20 42 Q. In terms of reports to you, on 23rd November we see 11:17
21 that you wrote to Martina Corrigan to say that you only
22 need monthly reports, or earlier only if issues arise.
23 So, notwithstanding the difficulties over the summer
24 months in October, you were still content to get
25 monthly reports? 11:17

26 A. I was content to get information if there is
27 a deviation in between. I wanted the deviation to be
28 escalated to the case manager at that point in time.
29 However, as regular monthly reports, now at this point

1 in time I would have completed the determination; it
2 was published, released, sent to the relevant people.
3 Now I was also kind of doing a transition, call it,
4 from the medical director's point of view to
5 Dr. O'Kane. At this time I wanted this to be any 11:18
6 deviation, but not regularly as monthly would be fine.

7 43 Q. In terms of Mr. O'Brien's behaviour and the concerns
8 that were expressed about the dictation issue and the
9 notes, how grave was that, in your view? Was it
10 serious or not serious when you got to the bottom of 11:19
11 it?

12 A. In relation to the investigation or this --

13 44 Q. In relation to what was reported to you in October
14 about the number of outstanding dictations, 91, and the
15 number of notes retained in the office. Was that 11:19
16 a serious issue or not?

17 A. I was concerned, yes. I felt it was a significant
18 deviation again. I was also concerned about the
19 patient outcomes and the sharing of information to the
20 Primary Care Team and other multi-professional teams. 11:19
21 I felt it was a grave or significant issue which
22 I needed to address in relation to that.

23
24 Now, we know that afterwards, within a couple of days,
25 I was informed at that point in time it wasn't that, it 11:20
26 was 16 or 18 dictations rather than 90 or 92 which was
27 previously reported. But at that point in time I was
28 concerned that this was significant and it can lead to
29 major issues with the patient care.

1 45 Q. We can see that you wrote to Mr. O'Brien. If you go to
 2 page 926 of the core bundle and if we could have
 3 TRU-261997. You're writing to Mr. O'Brien in respect
 4 of an information request that was generated out of
 5 issues he became aware of through NCAS and as a result 11:20
 6 of the MHPS process. Much of this is irrelevant for
 7 the purposes of the question.

8
 9 If you go to the very bottom of this page, please. You
 10 take the opportunity, you say in the last line, to ask 11:21
 11 if he is adherent to the agreed MHPS action plan, which
 12 you attach. This is 23rd October. Is that the only
 13 step you took in respect of Mr. O'Brien's deviation
 14 from the plan?

15 A. That was the step I took to Mr. O'Brien but I took 11:21
 16 other steps, as I already alluded, in terms of how
 17 I addressed that deviation, to informing the Chief
 18 Executive, making sure that everybody in the team is
 19 aware; addressing the understanding of the monitoring
 20 of action plan after the determination report is 11:22
 21 released and making sure that everybody is aware that
 22 we need to still monitor.

23
 24 However, on reflection, perhaps I should have tried to
 25 meet with Mr. O'Brien, or maybe going through a further 11:22
 26 discussion with him. That's on reflection, I suppose,
 27 yes.

28 46 Q. He wasn't told at any time by anyone that the deviation
 29 from the plan which was placed before you in October

1 was unacceptable; is that right?

2 A. Certainly I didn't speak to him but my understanding
3 was that he was -- the team in the Acute Directorate
4 would have spoken to him in relation to the deviation,
5 the charts, the dictations, and there was a management 11:23
6 plan around that. My understanding was that he was
7 spoken to but I didn't personally speak to him, no.

8 47 Q. As case manager, should you have been the one speaking
9 to him?

10 A. On reflection, yes, I could have just arranged 11:23
11 a meeting with him. Obviously, on reflection, it is
12 important that I could have. I didn't at that point in
13 time.

14 48 Q. Why, Dr. Khan, do you have to caveat your answer with
15 "on reflection"? Should it not have been blatantly 11:23
16 obvious that you were the person with the
17 responsibility to address this with him?

18 A. Just what happened at that point in time, I didn't.
19 It didn't come across to my mind.

20 49 Q. Now into 2019, roughly the same time of year, 11:24
21 September 2019, Martina Corrigan forwards information
22 to you to suggest that triage and dictation have
23 slipped in respect to Mr. O'Brien. If you go to 1031
24 of your core bundle and if we go to TRU-275344. She's
25 telling you, Concern 1, which is triage, not adhered 11:24
26 to. She's referring you to escalated emails.

27

28 "As of today, Monday 16th September, Mr. O'Brien has 26
29 paper referrals outstanding, and on E-triage 19 routine

1 and 8 urgent".

2
3 Then, scrolling down, she draws your attention to
4 a digital dictation issue as well, and she sets out the
5 details.

11:25

6
7 why, Dr. Khan, you, having presented your determination
8 in MHPS a year previously, are you still engaged in the
9 escalation process around the action plan?

10 A. At the end of 2018, when my determination was released 11:25
11 and I completed that formal investigation process, call
12 it, with the release of the report, my personal
13 understanding was that my role as a case manager ceased
14 at that point in time. Obviously, the MHPS Framework
15 does not assist you in relation to when the case 11:26
16 manager role finishes and who is responsible for
17 implementation of the recommendations. My
18 understanding, my personal understanding, was that my
19 role ceased at that point in time. The rest of the
20 couple of months until end of December 2018, I was 11:26
21 involved as an Acting Medical Director. In the later
22 part of 2019, in fact, I do not recall receiving
23 regular updates in 2019, but the deviation, this came
24 to light. My understanding at that point in time is my
25 involvement is on the advice or request from the 11:27
26 Medical Director as previous case manager. At that
27 point in time I received this and I discussed with
28 Dr. O'Kane, the Medical Director, about what action
29 should be taken.

1
2 I think simultaneously there was another process, was
3 more information was coming from the GMC, and
4 Dr. O'Kane was involved in that process as well,
5 finding out and extracting information for GMC. But 11:27
6 this information came and I discussed this with
7 Dr. O'Kane. But my understanding is my role has
8 finished a year ago nearly.

9 50 Q. What was your role then? Why was this being brought to
10 your attention? 11:28

11 A. I'm unsure why it was brought to my attention.

12 51 Q. We know, if you take a brief look at -- if you go to
13 1037 of the core bundle. If we can have TRU-275588.
14 We know that an attempt was made within the Directorate
15 itself to manage this. As you can see from this email 11:28
16 from Martina Corrigan to Mr. O'Brien, it was proposed
17 to Mr. McNaboe, who had become Clinical Director,
18 I think succeeding Mr. Weir at some point that year, or
19 perhaps the year before, they wished to meet with
20 Mr. O'Brien to discuss a deviation when he was on-call 11:29
21 in September. That's where we started this part of the
22 conversation with the email to you in September.

23
24 If we just scroll down to the next page, please. Go to
25 TRU-275595. You can find this letter at page 1038 of 11:29
26 the core bundle. It's a letter, 7th November 2019. Do
27 you have that, Dr. Khan?

28 A. Yes.

29 52 Q. Mr. O'Brien is writing to Martina Corrigan in respect

1 of the meeting that had been proposed with Mr. McNaboe
2 and Mr. O'Brien for that week. He is explaining here
3 that when he met with you on 9th February 2017, he was
4 advised in writing of the action plan. The case
5 manager explained that this plan remained in place 11:30
6 pending conclusion of the formal investigation, and
7 that concluded in September when you presented him with
8 the report or the determination which provided for
9 a further action plan. He says at the last line of the
10 third paragraph: 11:31

11
12 "The Trust has failed to implement this recommendation
13 to date".

14
15 He goes on to say: 11:31

16
17 "It is evidence that the issues you wish to discuss
18 cannot be considered deviations from a Return to Work
19 Plan which expired in September 2018".

20 11:31
21 we'll obviously have to ask Mr. O'Brien about his
22 thinking around that, but he's seeming to say that he
23 can't be held to an action plan that was now out of
24 date or no longer in force.

25 11:31
26 Did you, in any of your conversations with him, after
27 you published the determination, tell him that the
28 action plan from 2017 remained in force?

29 A. I met with Mr. O'Brien - Mr. O'Brien, and I suppose

1 there were other people there in that meeting - after
2 the determination to share the report. I must say it
3 was not an easy discussion. It went on on multiple
4 strands, and keeping the meeting focused on the
5 determination was challenging. I'm aware later on that 11:32
6 meeting was recorded, which I wasn't aware at that
7 point in time. However, I think we went into the
8 details of the determination and what came out of as
9 a report. I do not recall discussing the action plan
10 at that point in time. 11:33

11
12 This is happening just in October 2018, and the
13 anticipation was that three elements of the
14 determination will take place as soon as possible
15 straightaway, essentially, purely for the purpose of 11:33
16 getting the action plan, the Conduct Panel hearing and
17 the admin review. We know now it didn't happen for
18 a significant period of time, purely because the
19 grievance came in straightaway in November and
20 everything was put to hold, including the action plan 11:33
21 as well. But at that point in time when I discussed
22 with him the determination, I don't think that we went
23 into the continuation of action plan or there was even
24 any discussion around that. I think that was more
25 focused around the determination. 11:34

26 53 Q. We know, and we've just seen how you ended a letter to
27 him on 23rd October 2018, asking him whether he
28 remained compliant with the plan. When you think about
29 it now, by 2019 when he's writing this letter, do you

1 think Mr. O'Brien has every entitlement to consider
2 that he was no longer bound by the plan?

3 A. I think there is a variation in terms of the
4 understanding on various people from the Trust and
5 Mr. O'Brien as well.

11:35

6
7 First of all, I don't think anyone was anticipating
8 that the action plan wasn't put in place until then on
9 the basis of grievance and other related issues. My,
10 I suppose understanding, was that the action plan was
11 in place and is being monitored. When I received this
12 at that point in time, this information, I was
13 surprised, I was shocked that, first of all, the action
14 plan wasn't in place. I wasn't aware of that at that
15 point in time that that action plan hasn't been put in
16 place. In a way I was out of the loop of information
17 or awareness of what's happening around this case.

11:35

11:35

18
19 However, when I received this information, I had a
20 discussion with the Medical Director, Dr. O'Kane,
21 around the action plan and monitoring arrangements and
22 various other things, including the GMC referral and
23 the information. I was obviously told at that point in
24 time that the grievance hasn't been completed and all
25 the elements of the determination report is on hold.

11:36

11:36

26 54 Q. In direct answer to my question, Dr. Khan, do you think
27 that there's an understandable belief on Mr. O'Brien's
28 part, because the communication wasn't as clear as it
29 should have been, that he was no longer bound by this?

1 A. Well again, I can go by what my understanding was.
2 I can appreciate what Mr. O'Brien was thinking. Coming
3 back to the point, I did write even after the
4 determination that you are adherent to the action plan.
5 In that way I was indicating that the action plan is in 11:37
6 place. Perhaps if I could have met, or during that
7 meeting that happened after the determination if the
8 action plan was also discussed, would have been
9 a better understanding. But at that point in time,
10 everybody was thinking that this is going to proceed 11:37
11 now with action plan information. I did actually put
12 in the determination how the action plan should be done
13 in terms of all the details of the action plan, what
14 should be included, what style the action plan should
15 be formed, including the inclusion of Mr. O'Brien and 11:37
16 NCAS. I was very clear in my mind that this
17 determination is out now, the action plan should
18 immediately be put in place or updated on the basis of
19 a number of elements in the report.

20 55 Q. Just in order to bring this issue of the action plan to 11:38
21 a conclusion, I want to bring you to the meeting you've
22 briefly touched upon already in January 2020. I just
23 want to highlight the lead-in to that meeting. If you
24 go to page 101 of core, and if we could have up on the
25 screen, please, WIT-55824. We can see in the middle of 11:38
26 the page that Siobhán Hynds is writing to Dr. O'Kane,
27 copying you and others in, expressing the view that
28 Mr. O'Brien is clearly deviating from the action plan
29 that was put in place as a safeguard to avoid this type

1 of backlog. She is asking has there been any direct
2 discussion, and she suggests a meeting to decide on the
3 necessary next steps.

4
5 That then is taken up by Dr. O'Kane, if we scroll up 11:39
6 the page, please. If we go to WIT-55823, two pages up.
7 At the bottom of the page, please. Dr. O'Kane is
8 asking Simon Gibson to coordinate a meeting, which
9 should be minuted to describe in detail the management
10 plan around this, the expectation regarding compliance, 11:40
11 and the escalation.

12
13 "It will be important before all of you meet with
14 Mr. O'Brien that you have this process well-described
15 and documented. Process mapping this might be the most 11:40
16 useful approach".

17
18 If I can stop you there, Dr. Khan. If we look at the
19 action plan and the specific requirements around the
20 dictation of clinical encounters, Dr. O'Kane is saying 11:40
21 it is important before you meet Mr. O'Brien that you
22 have this process well-described and documented. Was
23 it not well-described and documented already by
24 reference to this specific action plan that
25 Mr. O'Brien, in your view, remained obliged to comply 11:40
26 with?

27 A. It appears to be that Dr. O'Kane wanted to explore
28 further, possibly, the management or escalation of the
29 action plan. But you're right, the action plan was

1 already describing all the elements of the monitoring
2 arrangements and the points. Obviously, she has asked
3 Simon Gibson to chair that meeting, coordinate and
4 chair. Simon Gibson did chair that meeting a couple of
5 months later to discuss the system or the arrangements 11:41
6 behind that.

7 56 Q. Yes. Then, just in fairness to the author of the
8 email, she writes another couple of lines at the end,
9 just in case it's not -- it doesn't change the meaning
10 or the direction of travel. So, there is to be 11:42
11 a meeting, and if you go to page 1039, Dr. Khan, you
12 can see the record of the meeting as set out by
13 Simon Gibson. If we scroll up the page, please. Keep
14 going. Keep going. Thank you.

15 11:42
16 So, this meeting focuses on the issue of the backlog
17 report and the area of dictation and, as you can see
18 from the agenda items at the top, expectation around
19 compliance and escalation. And it's to assist in
20 a meeting with Mr. O'Brien to discuss his deviation 11:43
21 from the action plan. It appears, and this is a broad
22 summary of what the meeting appeared to focus on, there
23 appears to have been a discussion more broadly about
24 the problems faced by Acute Service or Acute
25 Directorate in managing these issues of dictation. So, 11:43
26 for example, it said that as regards the backlog report
27 there was scepticism amongst some at the meeting about
28 the accuracy of the data regarding compliance. The
29 view was expressed that no one was aware of any written

standards in relation to what was considered reasonable for dictation of results or letters.

As regards escalation, again the word "cynicism" is used, along with the view that there was no agreed process for escalating any concerns regarding non-compliance.

11:44

It goes on to say at the top of the next page, just scrolling down, please:

11:44

"It should be noted that those present agreed that the weaknesses identified in the current process described above may cause challenges in taking forward this issue with Mr. O'Brien".

11:44

Then a series of conclusions are set out.

Can you help us, Dr. Khan, in terms of how you viewed these discussions at this meeting? This suggestion that there was an uncertainty or a vagueness around these aspects when compared with, as I've described it, and you may disagree, the certainty and the specificity of what was set out in Mr. O'Brien's own action plan. How did the meeting get into this description of a vague process when the O'Brien plan was anything but vague?

11:45

11:45

A. I recall the meeting started with the issue of deviation from the action plan. You can see the

1 meeting was attended by both operational and clinical
2 or medical leadership. So, Ronan Carroll, Martina and
3 Mark Haynes. Mark Haynes was AMD (Associate Medical
4 Director) at that time. Simon Gibson was chairing that
5 meeting. I attended that meeting, and my thinking 11:46
6 behind going into that meeting was that we are going to
7 discuss, in more detail, about the robustness of the
8 current action plan and monitoring and arrangements and
9 escalation. However, within that meeting it kind of
10 went into more broad discussion within the Surgical 11:46
11 Services or the Acute Directorate or the Urology
12 Services of monitoring, recording, escalation, of any
13 dictations or triage, and all those elements. So, it
14 was quite technical in a way and it ended up, the
15 meeting kind of ended up with a lot of discussion 11:47
16 around the wider elements of the system-wide
17 challenges.

18
19 I did indicate in that meeting that we have to focus
20 again on the current action plan and the deviation and 11:47
21 monitoring. I think I have -- I recall I have sent
22 a -- when I was shared the minutes I sent some sort of
23 communication back to the --

24 57 Q. If you want to pull that up, it's your own bundle,
25 1147. If we could have up TRU-251809. Do you have 11:47
26 that at 1147?

27 A. Yes.

28 58 Q. You do. So, you are writing back to Simon Gibson,
29 having received his record of the meeting. Just

1 explain what you have in mind here.

2 A. So, I was, again, trying to focus back to the issue
3 which was initially raised and this meeting was called
4 in for that purpose. And bringing my previous
5 experience of the Case Manager role, I was trying to 11:48
6 bring back to the focus this is about we have all the
7 challenges and all the issues but we have to focus on
8 the action plan and monitoring and escalation for this
9 specific issue. And that's what I was bringing back to
10 everyone's mind that, yes, there are challenges, but 11:48
11 the action plan is very clear. The monitoring
12 arrangement has been there before, so why can't
13 we continue to do that and focus on it? I know in that
14 meeting there was discussion about should we make
15 changes in terms of wider arrangements. That's why 11:49
16 I said I don't need to be part of the Acute Directorate
17 internal discussions about the wider arrangements, but
18 I was bringing back to the focus of action plan and
19 this monitoring and that was my discussion in the
20 meeting and afterwards as well. 11:49

21 59 Q. Can you explain to us why the meeting was seemingly
22 tying itself up in knots in relation to these broader
23 issue when there was a specific plan in place for
24 Mr. O'Brien, was it because he - in the correspondence
25 that I've shown you - was pushing back against the 11:49
26 current applicability of that plan?

27 A. I wasn't aware of that letter back from Mr. O'Brien.
28 I wasn't shared any information that he has even
29 written a letter back to. So I went into that meeting

1 being kind of nearly out of the loop for a good period
 2 of time and then I was asked about to contribute into
 3 that meeting. I wanted to bring focus to the action
 4 plan and its monitoring arrangement, however it did go
 5 into a lot of discussion about the wider challenges in 11:50
 6 the Acute Directorate in terms of monitoring and
 7 escalation and other almost to that. But I was still
 8 trying to bring that back to the point that this is the
 9 purpose of this discussion.

10 60 Q. Is it fair to say then, Dr. Khan, that was your last 11:50
 11 input in relation to the action plan and monitoring of
 12 Mr. O'Brien?

13 A. That's correct. Yes.

14 CHAIR: I think then if we can sit again at 12.05 and
 15 hopefully conclude Mr. Khan before lunch. Is that 11:51
 16 likely to be possible?

17 MR. WOLFE KC: It's very unlikely to be possible.

18 CHAIR: Perhaps we can talk in the break as to what is
 19 possible. Okay. Five past 12, everyone.

20
 21 THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
 22

23 CHAIR: Mr. wolfe.

24 61 Q. MR. WOLFE KC: Dr. Khan, I want to move to that part of 12:09
 25 the chronology where you have received Dr. Chada's
 26 investigation report and you received a submission from
 27 Mr. O'Brien. Just as a lead into that, the Inquiry is,
 28 of course, aware that by the summer -- by early 2018,
 29 but as you're commencing the process of looking at

1 Dr. Chada's report, you're also wearing interim Medical
2 Director hat at the same time. We can see from what
3 you've said in your witness statement at WIT-32000,
4 this is 904 of your own bundle, at paragraph 24.2(b)
5 you say:

12:10

6
7 "After my appointment as Acting Medical Director I was
8 very mindful of my competing demands as Senior
9 Management Team and Trust Board member and its
10 responsibilities, therefore, I requested to step down
11 by from the Case Manager role. However, this wasn't
12 accepted by the Oversight Committee".

12:10

13
14 Do you mean the Oversight Committee or do you mean
15 particular people?

12:11

16 A. Yeah, I suppose at that point in time I was working as
17 an Interim Medical Director and I can go through some
18 background on that in order to understand better. I
19 suppose I started this Interim Medical Director role in
20 April with no formal hand-over. My predecessor was off
21 sick for a period of time, so I ended up in that role
22 with a significant amount of outstanding matters to be
23 addressed in the Medical Director's Office. I think
24 I had the formal induction of the senior management
25 team or the Board member a couple of months later. So
26 I ended up in a situation when I was also a Case
27 Manager but also now wearing the interim Medical
28 Director role and with significant demand in the Senior
29 Management Team with very little understanding or

12:11

12:11

1 awareness of a lot of background information, with no
2 hand-over. So, I was aware of that and mindful of that
3 issue, therefore I discussed my inability to be
4 available for Case Manager role completely with the
5 Chief Executive who was my line manager. I did also 12:12
6 discuss with the Director of HR, Mrs. Vivienne Toal.
7 So, I suppose -- so that's what I probably meant by
8 saying "Oversight Committee". It wasn't really an
9 Oversight Committee to discuss at that point.

10 62 Q. You say in an email that you're not comfortable having 12:12
11 both roles, but was that purely down to your capacity,
12 the number of hours in the day to get things done? Is
13 that why you weren't comfortable or were you not
14 comfortable because you didn't regard the dual roles as
15 being compatible for other reasons? 12:13

16 A. No, it's to do with the capacity. So, I didn't feel
17 that I have enough hours in my day to competing demands
18 in terms of Medical Director and also the Case Manager
19 role.

20 63 Q. We can also see - this is TRU-288510, your core page 12:13
21 618 - that you in an email to Siobhan Hynds says:

22
23 "I've agreed to continue as a Case Manager for this
24 MHPS case on condition that I will not be in a position
25 to go through this report until after you've returned 12:13
26 from annual leave".

27
28 So, you basically said I'm taking my annual leave
29 before I'll be able to deal with this; is that fair?

1 A. Yes, that's correct. And I suppose I reluctantly
2 agreed to continue because I had a number of
3 discussions with the Chief Executive and the Director
4 of HR and Mrs. Toal, obviously, was encouraging me to
5 continue because it's too late in the process and for 12:14
6 various other reasons. I had my own limitations in
7 that way, for the capacity reasons. I was also aware
8 that this investigation is significantly delayed in
9 terms of the timeframe and I'm going to be away for
10 another nearly month or over that, and I will not be 12:14
11 able to address this until I come back, and then I will
12 have to do a number of other elements in order to
13 compile and draft the report. So, for that particular
14 reasons I suggested that.

15
16 And when I reluctantly agreed, I did agree to continue
17 on and finish this work, however I made it very clear
18 that on what grounds, really, I can do that.

19 64 Q. Yes. We will now look at the steps that you had to
20 take prior to issuing your determination. Amongst 12:15
21 those steps included a telephone meeting with Dr. Lynn
22 of NCAS as well as consideration of a submission that
23 Mr. O'Brien put before you.

24
25 Before we look at that submission, can we bring on to 12:15
26 the screen please, it's your core at page 17,
27 WIT-18505?

28 A. 17?

29 65 Q. 17. This is the stage of the process we have reached.

1 So, the report is submitted to you. It says:

2
3 "The Case Manager must give the practitioner the
4 opportunity to comment, in writing, on the factual
5 content of the report produced by the case 12:16
6 investigator. Comments in writing from the
7 practitioner, including any mitigation must normally be
8 submitted to the Case Manager within 10 working days of
9 the date of receipt".

10
11 Then it says:

12
13 "The report [that is the investigation report] should
14 give the Case Manager sufficient information to make
15 a decision on whether...", and then there's a list of 12:17
16 options.

17
18 Now, can I try to gain an understanding of your
19 thinking at this point? The role of Case Manager at
20 this stage is what? Is it to read the investigation 12:17
21 report in the light of the clinician's comments around
22 fact finding and to reach a conclusion taking the two
23 documents into account?

24 A. I suppose my understanding was the role of Case Manager
25 at that point in time was not necessarily just looking 12:17
26 at the investigation report which was provided by the
27 Case Investigation Team but looking in the statements,
28 all the appendices which were the statements from
29 various witnesses statements, the case investigator

1 report, getting the factual accuracy statement by the
2 doctor, in this case Mr. O'Brien, but also to discuss
3 all that investigations with the relevant
4 professionals. In my case I shared the investigation
5 report with the Chief Executive, also with the Director 12:18
6 of HR, and then I had a lengthy discussion with
7 Mrs. Grainne Lynn from NCAS. So, my determination was
8 coming from all that elements into coming together, and
9 then I also consulted the GMC's Good Medical Practice
10 and the MHPS Framework which gives me what options are 12:18
11 available as a Case Manager. So, I had took all those
12 elements in line together in order to compile my
13 report.

14 66 Q. Can you remember whether you read the report and the
15 appendices before you considered Mr. O'Brien's 12:19
16 submission on fact finding?

17 A. I think I read the reports at the same time as I read
18 Mr. O'Brien's statement. So it was around the same
19 time I read both of those, and the statements as well.

20 67 Q. Yes. We can see, if we turn to AOB-01879, it's your 12:19
21 core 878 - this is Mr. O'Brien's response to the formal
22 investigation. Did you recognise this at the time,
23 Dr. Khan, as falling within that part of the process
24 that I've just read out as being a response to issues
25 of fact finding? 12:20

26 A. So I received Mr. O'Brien's statement, which I read as
27 the part of the investigation. And it was a detailed
28 account of his involvement and understanding during
29 previous years. Yes, I did.

1 68 Q. But this document here, as distinct from the statements
 2 he gave to Dr. Chada, did you realise that this
 3 document here was his challenge, if you like, or his
 4 analysis of the fact finding contained in Dr. Chada's
 5 report?

12:21

6 A. Yes, I appreciated the number of challenges or number
 7 of points he raised in that statement in relation to
 8 the report and also in relation to the historical
 9 context of his involvement during previous years. Yes.

10 69 Q. And I want to explore with you the extent to which you
 11 took into account the points that he was raising.
 12 Could I ask you that as a general question first off.
 13 He raises a number of points in this document. What
 14 was your approach to that? Where you saw, for
 15 example - and I'll give you some examples - were you
 16 saw that he was taking a different view of the facts to
 17 Dr. Chada, what did you see as being your
 18 responsibility or your methodology to try to bridge
 19 that gap, if there was a gap?

12:21

12:22

20 A. So, there were a number of variation or differences in
 21 both statements. I obviously shared the investigation
 22 report with the Chief Executive and the Director of HR
 23 and I was advised to take the evidence as provided by
 24 the Investigation Team, because they have gone through
 25 the whole investigation. I did appreciate it at that
 26 point in time Mr. O'Brien was making comments on
 27 various elements of the investigation. For instance,
 28 he was making comment about the dictations or the
 29 undictated clinic numbers and so on. So I took

12:22

12:22

1 consideration on that. And I took close observations
2 of his statement. However, my conclusion was based on
3 the broader element of the investigation but taking in
4 account of his statements as well.

5 70 Q. But your advice from the Chief Executive was to go with 12:23
6 the evidence gathered by Dr. Chada and not try to
7 address the challenge to that coming from Mr. O'Brien.

8 A. The advice from the Chief Executive and the Director of
9 HR, was to go by the evidence but as a Case Manager
10 I felt I have to look at the both elements of the 12:24
11 statements. So, I did consider Dr. Chada's
12 investigation report but also looked closely and
13 considered Mr. O'Brien's statement as well.

14 71 Q. Okay, so --

15 A. Now, I must say the Chief Executive never said not to 12:24
16 look at or consider. He did advise me to take evidence
17 from -- as provided by the investigation report, which
18 I did.

19 72 Q. I'm not sure I'm following the distinction you're
20 making. If we think about it in terms of what's 12:24
21 written down in the MHPS process, Mr. O'Brien, the
22 clinician, is entitled to make a submission on fact
23 finding. If you are faced with a scenario where he
24 considers that the facts as written up by the
25 investigation are wrong and he can demonstrate that to 12:24
26 you, what are you to do about that?

27 A. So, I'm going back to the point of the terms of
28 reference of the investigation. So, the terms of
29 reference was set for the investigation and for this

1 process. So I looked at the specific -- in fact, if
2 you look at my Case Manager's determination, I started
3 putting together in a format that what's the Case
4 Manager's role in this part of the case, MHPS
5 Framework, then I put together the terms of reference 12:25
6 of the investigations, and then I further expanded on
7 what the investigations was reported to me. And then,
8 obviously, what are the options available as part of
9 the MHPS Framework. I also included in my own
10 determination about the advice I have received from the 12:26
11 Chief Executive, from the Director of HR, but also from
12 my discussion and advice from Mrs. Grainne Lynn from
13 NCAS.

14 73 Q. But what did you regard as the purpose of a submission
15 by the clinician in relation to the factual content of 12:26
16 the report? What was the purpose of that?

17 A. Obviously, Mr. O'Brien got an opportunity to provide
18 his view on the investigation, which I considered.
19 However, on the balance of what information was
20 available to me as a Case Manager, I decided on the 12:26
21 evidence provided by the investigation report.

22 74 Q. Okay. Let's explore aspects of that. If you go to
23 AOB-01889 at your core 888. If we scroll down a
24 little, Mr. O'Brien explains that on 3rd August, he
25 submitted to Dr. Chada's and Ms. Hynds detailed 12:27
26 documentation of all additional in-patient and day case
27 operating during the years 2012 to 2016; all additional
28 outpatient clinics during 2012 to 2016, in addition to
29 all additional time spent in the role of lead clinician

1 of Urology MDT and of Chair of Urology MDM in that
2 period. He refers to the appendix. He says:

3
4 "None of this documentation has been included in the
5 report of the investigation".

12:28

6
7 Plainly, his introduction of this issue to Dr. Chada,
8 and indeed to yourself, is to set out the full context
9 and circumstances in which he was required to work, so
10 it may at least in part being put forward as mitigation 12:28
11 for any shortcomings on his part. Whatever the reason
12 for putting it forward, he's making the plain point
13 that the investigator hasn't taken this into account,
14 hasn't mentioned it, hasn't even appended it to her
15 investigation.

12:28

16
17 First of all, did you recognise the thrust of what he
18 was saying? Did you appreciate it?

19 A. I did. I understood what he was making as the point.
20 However, I go back to the point of the investigation 12:29
21 was carried out for a period of time and he was
22 provided opportunity to make a statement, but also
23 provide all the documentation. When I received the
24 investigation report, there was obviously all the
25 statements, including Mr. O'Brien's information and his 12:29
26 statement and his account of his discussion with the
27 investigation team. So, I had all that information.
28 But he's making in that case some of the other
29 information which wasn't included, no.

1 75 Q. Did you think it your obligation to go back to
2 Dr. Chada and say, where is this appendix; why haven't
3 you mentioned it; why have you apparently not taken it
4 into account?

5 A. No, I don't -- I don't think I went back to Dr. Chada. 12:30

6 76 Q. I know you didn't, Dr. Khan. I'm asking did you see it
7 as part of your obligation during this fact-finding
8 aspect of your role?

9 A. I must say I did not think that it's my role now to go
10 back to the investigation team for more information. 12:30
11 I did obviously share the investigation and discussed
12 with the Chief Executive and Director of HR, and
13 clearly I was advised that you have to take the
14 evidence provided by the investigation team. That was
15 my point and context for making the determination. But 12:30
16 I did not go back and challenge Dr. Chada or challenge
17 the investigation team.

18 77 Q. Is it fair to say then that you didn't go back and look
19 at Appendix 11 or try to get Appendix 11 and see
20 whether it would have made any difference to your 12:31
21 determination?

22 A. No, I didn't go looking for Appendix 11 from this
23 letter.

24 78 Q. Could I ask you about the issue of undictated clinics.
25 If you go forward to core 889 and if we pull up 12:31
26 AOB-01890. He explains here that also on 6th November
27 he provided a spreadsheet addressing the issue of term
28 of reference 3, the dictated clinics issue. He said:
29

1 "This clearly established that not all the patients who
2 had attended 51 clinics had not letters dictated, not
3 61 clinics as the case investigator had been advised".
4

5 He goes on to explain:

12:32

6
7 "The total number of patients who attended those 51
8 clinics had been 450 patients. 261 had had letters
9 dictated. These 261 were those who were more
10 clinically urgent. This left a total of 189 patients
11 and not the 668 as had been advised by those who had
12 informed the case investigator and whose the data the
13 Medical Director found no need to validate. This
14 detailed information submitted on 6th November was not
15 included in the report of the investigation".
16

12:32

12:33

17 So, again he's making the point that Dr. Chada has
18 failed to take into account relevant information which
19 goes to the quantity of the outstanding dictation.
20 Again when you saw this, did you not consider that this
21 was an important factual issue that needed to be
22 resolved?

12:33

23 A. When I looked at this, I suppose that goes back to the
24 point of what I put together as part of my
25 determination. GMC Good Medical Practice is one of the
26 elements which I studied and applied in going through
27 the determination report. In either account, there
28 appeared to be a sufficient number of undictated
29 clinics. If you look at even Dr. Chada's investigation

12:33

1 or even Mr. O'Brien's, he himself agreed or accepted
2 that he didn't dictate any letters on every
3 consultation. He agreed that he would have done it on
4 the completion of the care. Whereas if you compare
5 that with the standard set by the GMC, that when 12:34
6 a patient is managed by a multi-disciplinary team, the
7 other healthcare professionals should be able to rely
8 on the information provided to them. Now, the whole
9 care could take weeks, months or years. In between the
10 patients are attending other clinicians, they are also 12:35
11 attending Primary Care Team, they are attending GPs or
12 other elements, and not having availability of clinical
13 information or the clinical management plan will make
14 the patients more prone to get adverse outcomes in
15 their care. This is about the GMC Good Medical 12:35
16 Practice. The GMC Good Medical Practice is based on
17 four elements, and three of them are --

18 79 Q. Sorry to cut across you, Dr. Khan. We understand
19 perfectly well the importance of dictation. The point
20 that I'm alluding to is simply this: Mr. O'Brien 12:35
21 challenged the factfinding of Dr. Chada by saying it
22 wasn't 666 clinics, or whatever the number was, or it
23 wasn't that number of outstanding dictation, it was
24 189. Yet when you write this up -- if you go to
25 page 906 and if we go to AOB-01917. Scroll down a 12:36
26 little, please. So when you're writing up the findings
27 of the investigation, what you say is:

28
29 "It was found that there were 66 undictated clinics by

1 Mr. O'Brien during that period. Mr. O'Brien accepts
2 this".

3
4 But, in fact, he had written to you in the document
5 we've just been looking at, saying I don't accept this, 12:37
6 and, what's more, I've told Dr. Chada in a particular
7 document that I don't accept it.

8
9 Is your answer the same - I was advised to take into
10 account the evidence received by Dr. Chada and, does it 12:37
11 appear, nothing else?

12 A. I think there are multiple elements to that but the
13 most important things are the GMC Good Medical
14 Practice. There appear to be a sufficient number of
15 undictated clinics on either version of the events by 12:37
16 Dr. Chada or Mr. O'Brien. However, going back to the
17 point of I was obviously advised that the evidence is
18 provided by the investigation team after going through
19 the whole investigation and this is in front of you,
20 you need to make determination on the basis of that, 12:38
21 yes.

22 80 Q. Private patients again, I needn't turn up the detail
23 because I suspect I'm going to receive the same answer.
24 Mr. O'Brien told you in this paper that he had prepared
25 a comparative analysis of TURP patients which showed 12:38
26 that the suggestion that he was giving advantageous
27 treatment to private patients, private TURP patients,
28 was wrong or inaccurate. He makes that point to you.

1 Again, do you simply follow the evidence and the
2 findings of Dr. Chada's report rather than take into
3 account any aspect of what Mr. O'Brien is saying to
4 you?

5 A. I believe that we need to understand the bigger impact 12:39
6 of these to the patients, both of the undictated
7 letters and the private patients, and how it impacted
8 upon the systems put in place, the waiting list, the
9 theatre list, and impact on other patients. I believe
10 at that point in time as well, going back for both the 12:39
11 undictated letters, no matter if it is 600 or 162,
12 every patient counts. It is important to understand
13 that, yes, it is less than what is reported in 600 or
14 642, but 150 or 160, every patient has a right to be
15 trusted by the doctor. That's again by the GMC Good 12:40
16 Medical Practice, that patients should be able to trust
17 the doctors. In order for that to achieve, doctors
18 must show the good medical practice as per the GMC Good
19 Medical Practice guidance. That includes not only the
20 compliance or the clinical ability, but also the safety 12:40
21 and quality, the interaction, the communication, the
22 team working, the partnership and the trust that other
23 professionals put in place for us as doctors to provide
24 our reports.

25
26 Going back to the point, yes, he was challenging the 12:40
27 number 600 and he is suggesting he is probably 100 and
28 something, but every patient is as important. It is
29 not about the numbers. There are sufficient numbers to

1 suggest he was failing in providing all that
2 information to the multi-disciplinary team, both in the
3 hospital and in the community in the Primary Care Team.
4 But it is also important to understand the impact it
5 had for each individual patient.

12:41

6 81 Q. Sticking with your example of the numbers of
7 undictated; we'll move to the private patients issue
8 then. But surely in terms of an investigation which
9 took into account the numbers of patients involved,
10 there is a factual significance to how many patients
11 were involved; would you agree, Dr. Khan? If
12 Mr. O'Brien is saying and putting evidence before you
13 which he says wasn't taken into account by the
14 investigator, why didn't you reflect that in your
15 report?

12:41

12:42

16 A. Yes, perhaps I could have added the reflection in my
17 report. However, I was provided, I was presented
18 a clear evidence of all those elements of the terms of
19 reference in the investigation.

20 82 Q. But with respect, Dr. Khan, this is the stage of the
21 process which you read and you understood that
22 Mr. O'Brien has a right to challenge the facts. And in
23 relation to the dictation issue, while you may have
24 read it, you didn't include in your report any
25 reference to the factual dispute or to the fact that
26 Dr. Chada had seemingly received evidence with respect
27 to this factual issue and apparently had not taken it
28 into account. Why did you fail to take those basic
29 steps?

12:42

12:42

1 A. I suppose I'm going back to the point of the evidence
2 presented to me in the investigations. So, I took that
3 investigation report information of the -- my
4 determination. Perhaps it would be good if I included
5 some of the elements which Mr. O'Brien has indicated. 12:43
6 I still believe that it wouldn't have changed the
7 outcome but it would be good to have included that,
8 yes.

9 83 Q. Is it fair to say that this element of the process,
10 allowing Mr. O'Brien to contribute in respect of the 12:44
11 factual aspects was simply removed from the process by
12 the approach that you took?

13 A. I believe that Mr. O'Brien received opportunity at the
14 time of investigation as well. He provided information
15 and he did respond to his statement to the 12:44
16 investigation team. So he already was provided at the
17 time of investigation. He did provide further
18 information to me as well.

19 84 Q. This is a wholly different stage. You are the Case
20 Manager, you're performing a different role to 12:44
21 Dr. Chada. You are expected, by the process, to take
22 into account his submission and if there are gaps in
23 the investigator's factual analysis, are you not
24 supposed to take some steps to address that?

25 A. Yes, I suppose I could have included his comments into 12:45
26 my determination, that he did not agree to the numbers.
27 It was reflected in the investigation. However,
28 I believe that there was sufficient grounds, the
29 sufficient numbers of undictated clinic letters on

1 either version.

2 85 Q. Did you seek specific advice on how you were to handle
3 and approach this submission from Mr. O'Brien?

4 A. I took the advice from the Chief Executive. I did
5 discuss with the Chief Executive about the report and 12:45
6 shared the report. I also shared my draft
7 determination with the Chief Executive as well. Then
8 I took advice from Mrs. Grainne Lynn from NCAS, and
9 I shared the investigation report with her.

10 86 Q. Yes. 12:46

11 A. And I asked the specific advice on how to draft or
12 compile the determination of the investigation and,
13 simultaneously I did with the Director of HR.

14 87 Q. But did you say to anybody: 'I've received this
15 submission from Mr. O'Brien. He's taken issue with the 12:46
16 facts. He's provided me with information which
17 suggests that Dr. Chada hasn't adequately taken into,
18 account or at all, on occasions his evidence. What do
19 I do about that?' Did you ever present that scenario
20 to an adviser and did you ever receive advice? 12:46

21 A. No. I don't recall that I have basically asked about
22 that particular element of the report.

23 88 Q. You can recall meeting with Mr. O'Brien, his wife and
24 his son to discuss the determination that you produced.
25 Let me refer you to the transcript of that. If you go 12:47
26 to 2067 of your bundle, not the core, your bundle, and
27 if we could have up on the screen, please, AOB-56441.
28 If we scroll down please. Michael O'Brien interjects
29 at the meeting and he says:

1
2 "Your position is you've read the investigator's report
3 and then you read my father's report and then you weigh
4 up and then the decision on which one you find to be
5 more persuasive on certain points. Is that what you're 12:48
6 saying?

7
8 Well, I considered both in making my final
9 determination".

10
11 Michael O'Brien says: 12:48

12
13 "I understand. But do you weigh up both, is that your
14 process?"

15
16 You say: 12:48

17
18 "There is a process behind that as part of the MHPS.
19 You know, I have Mr. O'Brien's, you know, his report
20 and also the investigation report. 12:48

21
22 Michael O'Brien: I understand that you have them both.
23 Dr. Khan: Yes.

24
25 I just wondered, is it your process then that you weigh 12:48
26 them up?"

27
28 And you say "yes". But in fact, Dr. Khan, you didn't
29 weigh them up, you did the opposite of that. You

1 failed to take into account Mr. O'Brien's submissions,
2 albeit that you read them and you preferred, based on
3 an element of the advice that you received, to simply
4 adopt the findings of the investigation report. Is
5 that fair?

12:49

6 A. I think it's important to keep that in mind that I did
7 consider the report. I did weigh up the information
8 provided by the statement. However, on the report on
9 my determination I put more emphasis on the
10 investigation report.

12:49

11 89 Q. Just finally on this point. If you think, again, about
12 the approach that you adopted while no doubt, as it
13 says in your report, you have received this document
14 from Mr. O'Brien, no doubt you've taken it into
15 account, you've taken Mr. O'Brien's statements to
16 Dr. Chada into account, but where you face a scenario
17 such as Mr. O'Brien put before you, where he says:
18 'I did not agree with Dr. Chada's calculation of the
19 number of outstanding dictations. The number is this,
20 and she says it's that.' And you then write into your
21 report "he agreed with Dr. Chada" when he's telling you
22 in black and white that he didn't agree. When you have
23 your time on this, would you agree that a better
24 approach to this, a different approach to this, was
25 appropriate?

12:50

12:50

12:51

26 A. I think it's important that we -- certainly there's
27 a lot of learning for me, personally, as a Case
28 Manager. There's a lot of learning for the system, the
29 organisation. I was in this investigation with very

1 little training or expertise. I did develop my
2 experience during the investigation. I think the
3 learning for me is that we, you know, ensure that the
4 whole element is included, the expertise are developed,
5 the training and support is there. I must say there 12:51
6 has been a lot of learning for me personally as well.
7 I have learned a huge amount of elements into this
8 process. But at that point in time when I was making
9 that determination, with all that investigation
10 available to me, the MHPS Framework was providing 12:52
11 limited assistance in that regard as well. So, yes,
12 there is reflection and learning for me as well.

13 90 Q. You sought advice from NCAS in respect of your
14 determination and if we could bring up on the screen,
15 please, AOB-01901. It's your core 897, Dr. Khan. And 12:52
16 you spoke to her on the 20th and she's writing to you,
17 I think it says the 21st. Scroll down slightly. The
18 21st, yes, thank you. So your purpose in speaking to
19 NCAS and Dr. Lynn was to seek advice from NCAS.

20 A. Yes. 12:53

21 91 Q. As appears from her summary - if just go further down
22 the letter, please - you explained that there were five
23 terms of reference for investigation, and those are set
24 out, as well as the considerations that you took into
25 account. She provided you with two broad aspects to 12:54
26 her advice. First of all, she explained that as
27 regards the GMC -- if we just scroll down to the top of
28 the next page. As regards the GMC, you explained that
29 the GMC is aware of the issue and she advised:

1
2 "You may wish to update the GMC ELA but in the majority
3 of cases the GMC prefers the Trust to conclude their
4 own procedures before considering referral".

12:55

6 Is that advice that you took into account when you were
7 making your determination?

8 A. So as part of my determination I was aware that the GMC
9 ELA is aware of this case and it has been discussed in
10 previous Trust and GMC ELA meetings. I was also aware 12:55
11 that we will be providing an updated position with the
12 determination report to the GMC ELA meeting, which is
13 coming up in a couple of months.

15 So, yes, I took an account of all that information and 12:55
16 the advice. In my report also I put together that
17 currently or at present there is no requirement for the
18 referral, however, I was aware that we are going to
19 discuss at the GMC ELA meeting about the threshold in
20 the next couple of weeks or couple of months. 12:56

21 92 Q. Yes. The second broad issue that you discussed with
22 her was in relation to Mr. O'Brien's work. Now, we saw
23 on the last occasion that she gave you advice in
24 relation to Mr. O'Brien's working privately. If you go
25 to page 898 of your bundle and if we could just scroll 12:56
26 back please to AOB-01902. Stop there. We can see in
27 the middle paragraph that she is saying to you that
28 Mr. O'Brien should not currently be working privately.
29 I think you accepted on the last occasion that that

1 issue wasn't particularly well handled. You thought it
2 was being dealt with by somebody else in the system but
3 in fact would you accept that as Interim Medical
4 Director that was an issue that really rested with you
5 to resolve?

12:57

6 A. Yes, it was -- part of my role was to address that. As
7 I previously informed the Inquiry, I did try to address
8 it by discussing with the Director of HR; by also
9 leaving this issue to be discussed with the previous
10 Medical Director and then the handing over to the
11 upcoming Medical Director. This point is
12 between October and December, so two months I would
13 have done a number of elements to ensure that this is
14 addressed. Unfortunately, it wasn't addressed until
15 much later in -- well, it wasn't addressed until a
16 long, long time, I suppose. I wasn't aware afterwards.

12:57

17 93 Q. Associated with Mr. O'Brien's working, albeit in
18 his Trust role, you were provided with advice. If
19 we just scroll down. If you go to page 899 of your
20 bundle; AOB-01903.

12:58

21
22 You were advised by Dr. Lynn that NCAS could offer
23 support, that that support would come from the SPSR,
24 the Professional Support and Remediation Team, and that
25 they could assist by drafting a robust action plan
26 which would involve input both from the doctor and the
27 Trust, and that the purpose of the plan would be to
28 ensure oversight and supervision of the doctor's work,
29 that the Trust could be satisfied that there would be

12:58

12:59

1 no risk to patients, and it would afford the doctor
2 sufficient support to enable him to meet the objectives
3 of the plan. She has spoken with the SPRS team and
4 they arrange and, in fact, do send the forms to you.
5 Is that right?

13:00

6 A. At the time of my discussion, I had a lengthy
7 discussion. Part of that discussion was what the
8 action plan can look like and how NCAS can support
9 that. I was previously unaware of NCAS can provide an
10 assistance in that regard. However, I was very much
11 encouraged, actually, by talking to Grainne Lynn that
12 there is a service available for the Trust to ensure
13 the independence or the expertise comes into the
14 formation of action plan. Therefore, I put specific
15 elements into my determination for that action plan.

13:00

13:00

16
17
18 To me, there were four elements actually on that action
19 plan. The first one was who should be involved
20 updating that or informing the action plan, which will
21 include the NCAS, this practitioner performance advice
22 team from the NCAS; the doctor, which is Mr. O'Brien;
23 and then the Trust coming together and making sure
24 everyone on board and in formation of this, drafting
25 the action plan going forward.

13:00

13:01

26
27 But the action plan, I have also gone into more detail
28 in the action plan in my determination. I just didn't
29 want the action plan to be just updated by three

1 people -- three parties, but having that action plan
 2 much more broader, going into further elements of the
 3 patient administration duties, perhaps looking at how
 4 it can impact the clinical outcomes, and involving the
 5 medical and clinical leaders in the team and this 13:01
 6 organisation to ensure the performance and also the
 7 monitoring of that. I indicated that this action plan
 8 should include all that. Perhaps you are going to come
 9 to that, I suppose, at some stage.

10 94 Q. Yes, just after lunch we'll look at that. But just on 13:02
 11 the role of NCAS, did you find that Dr. Lynn's input
 12 was helpful and - a second element to the question -
 13 were you, in a sense, of the same mind with regard to
 14 the particular importance of an action plan?

15 A. I did, I did. At that point in time I discussed with 13:02
 16 Grainne about how it can be challenging in terms of
 17 having a right kind of a balanced action plan, and how
 18 can we ensure -- therefore, she indicated we have
 19 a team where we can help you, we can advise you, the
 20 Trust, in terms of putting together the action plan. 13:02
 21 So I must say I was very much encouraged to involve
 22 NCAS in forming the action plan.

23 95 Q. We can also see from her advice that she recognised in 13:03
 24 what you were saying the fact that a conduct issue had
 25 arisen and that a formal conduct process was likely. I
 26 know that ultimately Mr. O'Brien disagreed with that
 27 and presented a different analysis for the purposes of
 28 his grievance. Just to be clear, did you interpret Dr.
 29 Lynn's advice as indicating to you that a conduct

1 approach in light of the findings of the
 2 investigation that you were reporting to her could be
 3 recorded as appropriate?

4 A. As part of putting together my determination, yes,
 5 I did obviously receive the advice and I considered 13:03
 6 that. That was my own conclusion anyway. But as part
 7 of that, yes, NCAS advice was very comprehensive and it
 8 was very useful in that regard.

9 MR. WOLFE KC: Okay. If we could break now for lunch.

10 CHAIR: We will sit again at 2.05. Thank you, Dr. 13:04
 11 Khan.

12
 13 THE INQUIRY THEN ADJOURNED FOR LUNCH AND RESUMED AS
 14 FOLLOWS:

15 14:09
 16 CHAIR: Good afternoon, everyone. It's not getting any
 17 less lonely up here!

18 96 Q. MR. WOLFE KC: Good afternoon, Dr. Khan. I'm going to
 19 bring you to your determination just now but just one
 20 point I think in fairness you might wish to comment on. 14:09
 21 The Stage 1 Grievance Panel which considered the
 22 grievance raised by Mr. O'Brien at a hearing in 2020
 23 produced a decision which looked at delays in the MHPS
 24 process. If I could bring up at -- if you go to Core
 25 1107 and if we can have up AOB-02803? 2.4.6 on down 14:09
 26 the page, please. Allow me a moment, Chair, just to
 27 find the reference. At 2.4.6, Dr. Khan, it says that:

28
 29 "In speaking to you, the Panel consider that you

1 clearly reflected on the report and the MHPS options.
2 However, they find that the 21 weeks you took to do so
3 unnecessarily protracted the process. After such
4 lengthy investigations, Dr. Khan's response, where no
5 exchanges with Mr. O'Brien were required, should have 14:11
6 been expedited. It required Dr. Khan's analysis and
7 reflection on the facts in the report and how it fitted
8 with MHPS decision-making. They say the time scale is
9 not explained sufficiently, but Mr. O'Brien's grievance
10 is not upheld in that respect". 14:11

11
12 A little clunkily worded, but you can take from it that
13 they feel that you could have expedited the process and
14 that the time you took was unnecessarily protracted.

15 14:12
16 Now, we've heard from you earlier in respect of the
17 condition you imposed, that you couldn't deal with this
18 until after your leave; you were acting Medical
19 Director at the time. Do you feel that this criticism
20 is warranted? 14:12

21 A. I don't necessarily agree with this. I did what my
22 role as case manager as per the MHPS Framework advised
23 me to do. I felt I needed to complete the process in
24 accordance with the MHPS Framework. I understand this
25 grievance panel commented on that. I don't necessarily 14:12
26 agree what the comments are, and I believe that
27 subsequent to that there was a further re-look of the
28 grievance panel report, and that did agree with my
29 conclusion as well.

1 97 Q. very well. Could I bring you to your determination,
2 then, just to orient ourselves. The covering page is
3 at page 903 of your core bundle. AOB-10194. We can
4 see the structure of your report over the early pages.
5 If we scroll down through it, you set out your
6 responsibility as case manager, set out the terms of
7 reference, and then you set out in your own language
8 the investigation findings. Or partly in your own
9 language. You set out other findings or context at
10 your page 907. Scrolling down to 918, please. Then
11 over the page at AOB-01919 you set out your
12 determination.

14:13

14:14

13
14 You highlight in the first bullet point, Dr. Khan,
15 there's no evidence of concern about Mr. O'Brien's
16 clinical ability with patients. Plainly, the
17 investigation wasn't focused on clinical ability. Why
18 are you drawing that point out? Does it imply that the
19 shortcomings that had been identified were somewhat
20 less serious because they didn't concern clinical
21 ability?

14:14

14:15

22 A. I suppose my determination was based on the evidence
23 provided to me. In fact, in the report and the
24 statements provided with the report, if there was
25 anything it was the compliments rather than any
26 criticism in his clinical ability. So, there was no
27 evidence -- I was presented to indicate there is
28 a clinical ability issue. In fact, in some statements
29 and in the report, it was that the patients who did

14:15

1 attend Mr. O'Brien provided a clinical ability of his
 2 level as a consultant. There was no indication of any
 3 clinical ability issues at that point in time.

4 98 Q. Yes, I understand that but my question is somewhat
 5 different. While your bullet points go on to develop 14:16
 6 an analysis or a report on Mr. O'Brien's way of working
 7 on the administrative side, how is one to read the
 8 first bullet point? Is it to suggest that the concerns
 9 about administrative aspects are somewhat less
 10 important because he is sound clinically, or how are 14:17
 11 we to read that?

12 A. I suppose in forming that report, I wanted to make sure
 13 that all elements of the evidence which is provided to
 14 me is presented in my determination. By no means that
 15 was undermining in any shape or form the shortcomings 14:17
 16 of the administrative practices and its impact. It's
 17 merely just adding up to the fact that I did not find
 18 any evidence in the report suggesting that there is
 19 a clinical ability issue identified at that point in
 20 time. 14:17

21 99 Q. Of course you do go on, as we can see here, to
 22 highlight the potential harm to patients because of
 23 Mr. O'Brien's administrative processes and what
 24 you describe as "actual harm" to at least five
 25 patients. 14:18

26
 27 Could we go down to the next page please, 01920. You
 28 make a remark at the first bullet point, where it says:
 29

1 "Mr. O'Brien did not adhere to the requirements of the
 2 GMC's Good Medical Practice specifically in terms of
 3 recording his work clearly and accurately, recording
 4 clinical events at the same time of occurrence or as
 5 soon as possible afterwards".

14:18

6
 7 Just on that, Dr. Khan, the concern that is expressed
 8 in the investigation report involves Mr. O'Brien's
 9 failure to dictate following certain clinical
 10 encounters. It doesn't make a criticism that he was
 11 failing all together to record clearly and accurately
 12 clinical events at the same time as occurrence. Do
 13 you understand the distinction?

14:19

14 A. Yes, and it's important that the distinction sometimes
 15 is very fine in terms of recording and providing that
 16 information to the wider healthcare system. That is
 17 going back to the point of the Good Medical Practice
 18 standards from the GMC. Having that unavailability of
 19 that recording or the clinical events in the notes and
 20 then having that supplied to the wider healthcare
 21 providers, the clinical encounters are important, and
 22 every aspect of clinical care provision by the
 23 multi-professional team. That's what I was referring
 24 to in terms of unable to provide the full standards of
 25 Good Medical Practice in terms of communication,
 26 partnership, and team working.

14:19

14:20

14:20

27 100 Q. Yes, but it is one thing to fail to dictate a letter as
 28 a general practitioner which may well also be kept on
 29 the patient's file, but it is quite a different thing

1 to suggest that Mr. O'Brien wasn't clearly and
 2 accurately writing a note into the patient's record
 3 following the encounter. They are two different
 4 things, are they not?

5 A. Yes. They are two separate things but they are
 6 interlinked in a way.

14:21

7 101 Q. You, with respect, have suggested that the offence or
 8 the shortcoming is the latter when, in fact, it was
 9 a dictation issue that was front and central of the
 10 investigation. Do you accept that?

14:21

11 A. Yes, that's the terms of reference. That's correct.

12 102 Q. Looking then at your determination, you have set out
 13 the advice that you have received. Let's just deal
 14 with the misconduct issue. If we go over the page,
 15 page 910 for you. If we scroll down, thank you. You
 16 decided that you don't consider an exclusion from work
 17 to be necessary. Let's deal with that, sorry,
 18 a restriction on practice. The top of the page.

14:21

19
 20 You set out the purpose of the action plan. As you
 21 were reflecting just before lunch, you considered that
 22 a fresh action plan was necessary; isn't that's right?

14:22

23 A. That's correct, yes. So as part of adding this into my
 24 determination, I was very clear in my mind what part
 25 would be necessary in terms of having a continuous and
 26 ongoing assurance. The action plan would have a number
 27 of elements. The first element is how the action plan
 28 should be developed in consultation with NCAS,
 29 Mr. O'Brien, and the Trust coming together, putting

14:22

1 together an action business plan which is, in essence,
2 a combination of, you know, minds and brain coming
3 together forming this action plan which will be owned
4 by the consultant as well, and the Trust in terms of
5 monitoring. That was the first element.

14:23

6
7 But then the monitoring of that action plan was not
8 necessarily an operational line manager's, but I wish
9 to add that into -- the clinical and the line
10 management structure to the monitoring support and
11 escalation. Then at the same time, I wanted to include
12 an agreed job plan, an enhanced appraisal element into
13 part of the action plan as well.

14:23

14 103 Q. In terms of the scope of the action plan, you've
15 described a need, in this second paragraph at the top
16 of the page, for continuing assurance about
17 Mr. O'Brien's administrative practice and management of
18 his workload. Did you anticipate that this action
19 plan, if it had been developed at this time, would have
20 scrutinised any other aspects of his practice, whether
21 other administrative issues or even clinical issues, or
22 did you think in the alternative that you would be
23 repeating the same issues that were the subject of the
24 existing action plan?

14:24

14:24

25 A. So my thinking of developing the action plan in
26 consultation with NCAS, and Mr. O'Brien as well, to
27 expand the action plan more a little bit wider to
28 include the administrative practice but which can lead
29 to poor clinical performance or poor clinical outcomes.

14:25

1 So, expanding that in a way that it will cover broader
2 elements of Mr. O'Brien's practice into the action
3 plan.

4 104 Q. The role of NCAS in providing professional support, how
5 did you anticipate that that might work? They had sent 14:25
6 you the forms, as we saw. They can be found at
7 page 900 of your bundle. I needn't bring them up on
8 this screen. Did you think that that element was going
9 to be important?

10 A. I felt that inclusion of NCAS into the action plan 14:26
11 formation and putting together would be very useful.
12 I had no previous experience of putting together an
13 action plan with NCAS, and I had no previous
14 understanding or experience of involving NCAS in
15 relation to that. It wasn't very explicit or clear in 14:26
16 my mind how, but I felt it would be necessary to
17 involve NCAS into the formation of a further
18 going-forward action plan.

19 105 Q. In terms of the ownership of this issue, who did
20 you understand would be responsible for taking this 14:27
21 forward?

22 A. So, as for the implementation of action plan, I suppose
23 the three elements in my determination were presented
24 and I provided this to the Chief Executive, the
25 Director of HR and the Medical Director. So, 14:27
26 I suppose, it was in combination with the Acute
27 Directorate with the Medical Director and the Director
28 of HR because the action plan included the appraisal
29 which is Medical Director's responsibilities, but it

1 also included the job plan would be the Director of HR
 2 in combination with Medical Director's responsibility.
 3 So, I felt that would be a combined effort by the
 4 Director of Acute Services, by Director of HR and
 5 Medical Director, I suppose, in -- and the Chief
 6 Executive as the overall, you know, in charge of the
 7 organisation.

14:28

8 106 Q. What is your understanding as to why this aspect of the
 9 action plan wasn't implemented?

10 A. Soon after the determination came out we had some brief
 11 discussions, not formally, but we wanted to get things
 12 moving. But soon afterwards we were informed that the
 13 grievance request has come in and everything is on hold
 14 until the grievance will be completed. Nobody, I don't
 15 think anyone contemplated how long it took eventually
 16 to complete that, but at that point in time the general
 17 advice coming back was we have to wait until the
 18 grievance is completed before we can take on further
 19 anything.

14:28

20 107 Q. And was that the view of HR? Whose view was it?

14:29

21 A. Mainly from HR, yes.

22 108 Q. So, it was your understanding that the grievance
 23 provided the obstacle to moving this forward?

24 A. That's correct. That was my understanding, yes.

25 109 Q. At that time there was concern, as we saw this morning,
 26 or there was to be concern within a number of weeks
 27 about aspects of Mr. O'Brien's compliance with the
 28 existing action plan, and mainly the investigation
 29 report from the Trust perspective, and accepted by you,

14:29

1 pointed up concerns, albeit historic, in relation to
 2 Mr. O'Brien's practise. Was any conversation given to
 3 whether, notwithstanding the introduction of this
 4 grievance, that it would be necessary, nevertheless, to
 5 develop a better action plan in light of your 14:30
 6 determination to address what remained as concerns for
 7 The Trust?

8 A. I suppose that was the intention when the determination
 9 came out, that we would move on and form this action
 10 plan and other elements of the determination. But at 14:31
 11 that point in time my understanding was that everything
 12 was to be put on hold until the grievance is completed.

13 110 Q. Yes. And you didn't challenge that view?

14 A. I suppose I didn't challenge it but it was coming
 15 from -- obviously it was coming from the HR Department 14:31
 16 and obviously it was coming with a view that this has
 17 to be put on hold. But I must say I had some
 18 discussions around that but I did not challenge that.

19 111 Q. In relation to misconduct, we can see at the bottom of
 20 page 910 for you - AOB-01921 for us - that you found 14:32
 21 that there was a case of misconduct that should be put
 22 to the Conduct Panel. Again, can you help us with your
 23 analysis around that? why did you see the issues in
 24 relation to your findings or Dr. Chada's findings. why
 25 did you see them in terms of misconduct as opposed to 14:32
 26 simply a clinician being unable to perform the tasks
 27 that were required of him because of, as he explained
 28 it, job pressures, particularly in theatre but also
 29 around the demands in other aspects of his practice?

1 A. So, if you look at my determination, I put together
2 a number of points there. Essentially, what it means
3 is that going back to the point of terms of reference
4 and looking at the investigation report, there were
5 failings from The Trust, yes, but Mr. O'Brien as 14:33
6 a senior clinician had an obligation to ensure there is
7 a proper -- and that this was properly known and
8 understood by his line managers. Obviously, there was
9 elements of failure to triage off red flags which led
10 to a number of -- we know from afterwards, failing to 14:33
11 take his other elements of his administrative duties.
12 So, there were a number of elements which was clearly
13 indicating that he was failing in regards of his
14 administrative duties, known, standardised practices,
15 policies and procedures, and also failed to maybe not 14:34
16 recognise or not, you know, inform the wider system in
17 relation to that.

18 112 Q. Yes. Before we get to the bullet points, you make the
19 point that - this is at the top of page 911 for you,
20 1922 for us - you make the point that at this time 14:34
21 there's no requirement for formal consideration, IPPA
22 or referral to GMC.

23
24 Again, just on the GMC issue, why do you think the
25 threshold for referral had not been met? 14:35

26 A. At that point in time I was aware that this case is
27 already known at the GMC ELA. We were going to discuss
28 the threshold meeting, and we did afterwards. But at
29 that point in time, taking the advice from NCAS, I was

1 satisfied that this is to proceed as a Conduct Panel.
2 I was also aware that a Conduct Panel, if required,
3 this can be referred to the GMC. So, GMC referral
4 was -- in my determination I said at that point in time
5 the GMC referral wasn't required. I wasn't saying it's 14:35
6 not required at all. Having that discussion with the
7 GMC ELA, we discussed that and seems to be meeting the
8 threshold, so he was referred.

9 113 Q. We'll look at that in just a moment. But the -- you
10 then set out the conduct concerns by Mr. O'Brien. You 14:36
11 say that they include the following. You don't mention
12 in that list his retention of multiple patient notes at
13 home. Did you decide that that was not worthy of
14 a conduct hearing?

15 A. I suppose I put a number of elements there. I did not 14:36
16 include all of them. But I included -- for example, as
17 a summary of some of the elements which are there but
18 in the report, if you look at previously in my report,
19 I did indicate these are the failings in Mr. O'Brien's
20 case and it was included previous to that. But this 14:37
21 was a list of some of the elements which were already
22 included in the report.

23 114 Q. Notably, if you look at the fourth bullet point, I took
24 you up on the issue of how you had formulated your GMC
25 concern around record-keeping and here you're - can 14:37
26 I suggest to you - more precise about the actual
27 alleged shortcoming of Mr. O'Brien, which was
28 dictation, a contemporaneous dictation issue as opposed
29 to record-keeping more generally; would you accept

1 that?

2 A. Yes. Yes.

3 115 Q. You then, then if we scroll over the page, in your
4 conclusion section you insert a fourth decision or
5 a fourth aspect of your determination, and that relates 14:38
6 to the actions of management - both clinical and
7 operational.

8

9 Tell us about that. Why did you formulate a binding or
10 a decision around that? 14:38

11 A. So, by looking through and reading through and
12 considering all the evidence presented to me in the
13 investigation report but also in the statements, it was
14 becoming quite clear that these issues were known by
15 many in the operational and clinical and medical 14:39
16 leadership roles. It was also becoming clear that they
17 were not addressed, they were not escalated, they were
18 not addressed to the full extent. They were partially
19 addressed, they were partially dealt with, and then
20 there was gaps. So, becoming very clear to me that 14:39
21 this issue requires more in-depth analysis
22 investigation by independent team. I also was trying
23 to find in the report, in terms of whether I can reach
24 to any conclusion in that part of the terms of
25 reference, and I wasn't able to reach to any specific 14:39
26 conclusion. Therefore, my determination was that this
27 area of the terms of reference required further
28 investigation by the independent team.

29 116 Q. The terms of reference of the investigation report at

1 number 5, as we recall, was directed to the knowledge
 2 of management in the period before 2016 and their
 3 actions. Did you find the report unhelpful in terms of
 4 its coverage of those issues?

5 A. The investigation report, you mean?

14:40

6 117 Q. Yes.

7 A. The investigation report was comprehensive in many
 8 areas, however, I felt that perhaps the investigation
 9 team or the investigation report did not provide the
 10 adequacy of the details of the report which I need to
 11 do make some conclusion on that basis. Therefore,
 12 I wasn't satisfied that this is just to finish the
 13 whole fifth element of the terms of reference.

14:40

14 Therefore, I asked for further -- I requested for
 15 further investigation by the independent panel.

14:41

16 118 Q. You say in your conclusions towards the bottom of 912
 17 for you, 01923 for us, that these are what you regarded
 18 as systemic failures by managers at all levels, both
 19 clinical and operational, to deal with those matters.
 20 What did you mean by "systemic" in that context?

14:41

21 A. I suppose the operational team and clinical teams --
 22 the operational and clinical management teams provide
 23 the governance, the professional governance assurances.
 24 So, what I meant was that there must be failings at
 25 many levels in order to reach to this stage, both
 26 operationally and professional governance point of
 27 view. I was aware that these issues were raised at
 28 multiple times and they were not addressed by
 29 professional, clinical, medical and operational teams.

14:42

1 So there must be -- I was trying to explore there must
 2 be other reasons and I wasn't finding that in the
 3 report. Therefore, I requested that there needs to be
 4 a further in-depth analysis investigation by the team
 5 which is independent, and they can do independent 14:42
 6 assessment and they should provide for learning for the
 7 organisation to go forward. That was my thinking,
 8 I suppose.

9 119 Q. Can I trouble you for an example of what you might have
 10 been thinking about, perhaps, for example, triage. You 14:43
 11 would have observed from your reading of Dr. Chada's
 12 report over a period of time, going back several years,
 13 triage was an issue being raised both clinically and
 14 operationally by management, but the issue was never
 15 resolved to the satisfaction of management so that a 14:43
 16 default arrangement was put in place whereby if triage
 17 wasn't performed, then the patient was placed on
 18 a waiting list in accordance with the general
 19 practitioner's designation. If that's a useful
 20 example, or pick another example of what you would seek 14:43
 21 to communicate in identifying this concern.

22 A. I suppose there were many examples, but more
 23 troublesome for me at that point in time was I could
 24 not find a valid reason that these issues were raised
 25 on multiple occasions and they were not addressed, so 14:44
 26 there might be a system-wide failure to get to that
 27 point. I was really troubled by thinking what's going
 28 wrong? why is the system not working? There is
 29 a professional governance structure, there's a clinical

governance structure, there are operational managers. There are so many levels of safety netting, so why we are not able to protect patients. That was troubling me quite a lot at that time, and still is.

120 Q. You were obviously a medical manager yourself. You were sitting with the Interim Medical Director's hat on your head at that point in time. Obviously you were an Associate Medical Director (AMD) at that time. I suppose that was in abeyance while you were Interim but you had that in the background. What, from your perspective, were you seeing when reading this about the shortcomings of medical management? What should they have been doing but weren't doing? 14:44

A. I suppose my experience as Associate Medical Director before and as part of the Interim Medical Director, I was mindful of the shortcomings in the succession planning, the resources, the roles and responsibilities of all of that. That was the reason why one of the three key priorities I took as part of the Interim Medical Director was to start a process of looking at the professional governance structures in the Trust and the whole medical leadership structure. As part of my role as Interim Medical Director, we produced a paper to the Senior Management Team, SMT, for reviewing medical management or medical leadership structure. 14:45 14:46

The other element was about the whole Clinical Governance and how it fits into the bigger picture of governance structures and supporting the clinicians and

managers. But also highlighting and raising and providing the assurance to the system was also something I was mindful of and entrusted at that point in time. Therefore, I started another piece of work which I put in the statement report.

14:47

121 Q. Yes, and that's your report on medical leadership review, which the Inquiry can find at WIT-31532. We're not going to have the time to deal with it today, Dr. Khan.

14:47

Just again glancing back at your conclusions in this respect, you had it in mind and, indeed, you recommended the Trust would carry out an independent review of the relevant administrative processes, with clarity on roles at all levels within the Acute Directorate and appropriate escalation processes.

14:47

"The review should look at the full system-wide problems to understand and learn from the findings".

14:48

So, a number of elements there. It was to be independent; does that mean out with the Trust or simply out with the Acute Directorate?

A. I suppose in my mind it was to be independent to the organisation.

14:48

122 Q. Why did you think that important?

A. It was important because whilst the learnings are mainly from the Acute Directorate, they were previously escalated to the corporate level as well. I felt that

1 it would be necessary to bring in a fresh pair of eyes.
 2 An independent view of finding out and learning from
 3 those findings are going to be more useful.

4 123 Q. Now, presumably you saw this matter as being of some
 5 significance to go to the bother of making such
 6 a recommendation. Was there any urgency about it in
 7 your mind?

14:49

8 A. I suppose the determination was to be implemented
 9 immediately. We know it did not happen. However, the
 10 intention or -- certainly in my mind when I was writing
 11 the determination, it was very clear to me that these
 12 should be implemented - all three of them - should be
 13 implemented immediately. So there was an emergency,
 14 not only the administrative review but also the action
 15 plan and the conduct panel, all three were to be
 16 reviewed immediately.

14:49

14:50

17 124 Q. Was any reason associated with the grievance given to
 18 you as an explanation for the failure to carry out the
 19 administrative review immediately?

20 A. I suppose the advice I received, that everything was to
 21 be on hold until the grievance is completed, I suppose
 22 in hindsight perhaps it would have been useful if some
 23 elements of the recommendations or the determination
 24 could be proceeded, and this is probably one of them
 25 which would easily be proceeded. Unfortunately it did
 26 not happen until much, much later.

14:50

14:50

27 125 Q. Did you understand then that the administrative review
 28 wasn't going to be taken forward until after the
 29 grievance, or did you assume it would be?

1 A. Well, at the time of determination, my understanding
2 would be all three -- all of the determination
3 recommendations will take place. But at the point of
4 grievance, we were advised that everything is on hold
5 now until the grievance is completed.

14:51

6 126 Q. You were approached in July 2020 by Mr. Stephen
7 Wallace, prior to the completion of the grievance, to
8 seek your views on a term of reference for an
9 administrative review. Can you remember that?

10 A. I do, yes. That was the time -- it was much later,
11 I was approached by Mr. Stephen Wallace from the
12 Medical Director's office for my view on the terms of
13 reference, and I did provide my views on that.

14:51

14 127 Q. I'll assist you with the e-mail. If you could look at
15 page 865 of your bundle. Not the core, of your bundle.
16 If we could bring you WIT-32073. Just at the bottom of
17 the page, please.

14:52

18
19 This presumably comes out of the blue to you, if I may
20 use that expression?

14:52

21 A. Yes.

22 128 Q. He sets out over several paragraphs the terms of
23 reference he is considering you should consider. First
24 of all, he sets out your recommendation. Then if
25 we scroll down, the purpose of the review, its
26 objectives, output, scope and timing, governance and
27 methodology. Various headings.

14:53

28
29

1 You write back to him. Just if we go back up the
2 direction we came. You say:

3
4 "It was clear during this investigation, system-wide
5 failure happened at many levels within Acute
6 Directorate. Therefore, my recommendation was to
7 provide for" - I am not sure the word "recommendation"
8 should be there - "for system-wide problems in Acute
9 Director and not just only focus on Urology
10 Department".

14:53

14:54

11
12 So, you wanted a broader examination across Acute, as
13 you say in the last few lines of your determination.

14
15 Let's just look at how this is handled by the Trust.
16 So you are presumably expecting, on the basis of that,
17 if they were to honour your recommendations, they would
18 broaden it out to consider an Acute Directorate
19 investigation or view, not just urology. Were you
20 contacted by Mr. Wallace beyond that?

14:54

14:54

21 A. I don't recall being contacted afterwards.

22 129 Q. Two days later he emails those terms of reference
23 round. You can go to 1043, and if we could look at
24 TRU-292694. If we go to the bottom of the page,
25 please. Mr. Wallace is copying that group in. You're
26 not part of the group. He says:

14:55

27
28 "Please see below terms of reference for the review of
29 administration processes as per MHPS recommendation.

1 These have been reviewed by Dr. Khan...".

2
3 we'll obviously ask Mr. Wallace about that, but is it
4 fair to say you had not reviewed the terms of reference
5 and approved them? You had reviewed the terms of
6 reference and suggested how they could be improved to
7 meet your recommendation?

14:56

8 A. That's correct, exactly. I was provided initial terms
9 of reference; I provided my opinion, my view on those
10 terms of reference. However, unfortunately I was not
11 being approached afterwards.

14:56

12 130 Q. It appears that after your intervention on 27th,
13 Ms. O'Kane - that's Dr. Maria O'Kane - commented. If
14 we look at WIT-91392. This is an annex to your
15 addendum statement. You can find it at 2101, Dr. Khan,
16 of you're bundle, not the Core. And so -- have
17 you highlighted it in yellow?

14:57

18 A. I didn't. I don't remember highlighting it myself.

19 131 Q. Okay. So, it appears that Dr. O'Kane will have seen
20 your observation as regards the terms of reference and
21 she says:

14:58

22
23 "For the purposes of what I require currently for the
24 GMC, Stephen please ask Mary and Rose to review the new
25 patient referral to urology process only and the
26 remainder then sits with Acute Services."

14:58

27
28 Again, we can ask Dr. O'Kane about that but she seems
29 to be limiting the scope of the review to be conducted

1 by Mary and Rose to what she describes was the new
2 patient referral to urology process. It's possibly
3 stating the obvious, Dr. Khan, but that's much narrower
4 a scope than you had conceived of?

5 A. I suppose my determination was to review the whole 14:59
6 Acute Directorate System in terms of the system-wide
7 failure and the learning from that. Potentially, this
8 information came to light to me, obviously, as part of
9 the preparation of the hearing. I did not obviously
10 highlight it or anything but I can see Dr. O'Kane must 14:59
11 be making it in two distinct parts and completing the
12 first part before the other. So that may be the reason
13 behind that. But I obviously was provided the terms of
14 reference and I advised on terms of reference to
15 Stephen wallace. 15:00

16 132 Q. Did you anticipate that the independent reviewer would
17 look at each aspect of the administrative arrangements
18 governing Mr. O'Brien's work and provide a critical
19 appraisal, not just of those administrative processes
20 but of the management, whether individual or as 15:00
21 a general managerial entity, such as AMD or CD or on
22 the operational side, the Assistant Director or the
23 Director. Did you anticipate that all of those things
24 across Acute Services but with particular reference to
25 Mr. O'Brien's activities and alleged shortcomings would 15:01
26 all be looked at as part of a review?

27 A. So, my thinking behind putting that recommendation
28 was to -- I wasn't, at that point of time, going to put
29 together a specific terms of reference for that

1 investigation or for that review. Perhaps, I was
 2 keeping it open for that team or people or decision
 3 makers to think and come up with appropriate terms of
 4 reference for the review. I was providing at that
 5 point in time really the direction or the guidance in 15:01
 6 terms of what should be done in order to achieve the
 7 understanding of why the operational team and whole
 8 professional governance were failing in terms of
 9 addressing this issue for a long period of time. So,
 10 not providing specifics about what but I provided the 15:02
 11 general guidance in terms of what it should be, who it
 12 should be done by, by the independent reviewers, it
 13 should look at the system-wide failures, it should look
 14 at, obviously, in context of this case but learning for
 15 the organisation going forward. 15:02

16 133 Q. On 5th October you were sent the draft findings from
 17 the review. You can see those in your bundle at 1033.
 18 If we could have up on the screen WIT-32141. That's
 19 the email sent to you. You're being invited to read
 20 this. As Siobhán Hynds says, it's only two pages. 15:03

21
 22 "If you get a chance, take a quick read for discussion
 23 at 1.30."

24
 25 So, if we scroll down the page, please. Do you 15:03
 26 remember getting this?

27 A. I do, yes.

28 134 Q. Do you remember meeting to discuss it?

29 A. Yes. I recall a short meeting with a number of

1 professionals discussing that. Certainly Siobhán Hynds
2 was there, I was there. I think there were possibly
3 a few other professionals discussing the outcomes.
4 Certainly, I was surprised or shocked to see the so
5 limited amount of outcome and whether there was really 15:03
6 any learning from this activity. And I did voice my
7 view on that, that it doesn't appear to be what
8 I anticipated as part of my determination.

9 135 Q. Thank you for that.

10 15:04
11 Just before we finish, a couple of threads, just to
12 tidy up. We know, and we saw a glimpse of your meeting
13 with Mr. O'Brien after your determination was released,
14 you met with him, and his wife and son. He sought
15 assistance from NCAS as well and I just want to ask you 15:04
16 about that. If we look -- if you go to page 961 of the
17 core bundle and if we could have up WIT-53469. That's
18 a letter to you from Dr. Lynn. And if we go to the
19 last paragraph on this page. Clearly, Mr. O'Brien is
20 explaining from his perspective what he thinks of the 15:05
21 determination. He indicates in the last paragraph that
22 notwithstanding advice provided to The Trust in
23 September 2016, he wasn't afforded any opportunity to
24 address the concerns which had been raised with him.
25 And his view is that had this been done, it might have 15:06
26 avoided a formal investigation. And over the page,
27 please. It is suggested at the bottom of the page
28 that -- at the bottom of the page. Thank you. Just up
29 a bit. In your discussion with Dr. Lynn, the issue had

1 been raised whether a meeting with all parties should
2 be convened. You took some time to think about this
3 and you say you were unsure of the purpose of any
4 meeting and in the circumstances it was difficult to
5 see what a meeting would add. And she was to inform 15:07
6 Mr. O'Brien of this.

7
8 Can you recall your thinking there in terms of
9 refusing, if that's not too strong a word, an
10 opportunity to meet with Mr. O'Brien, with NCAS input. 15:07
11 why did you think that meeting would not be useful?

12 A. I suppose when this letter came in I sought advice from
13 the HR. I also put together a reply back to
14 Mrs. Grainne Lynn. The reasons behind -- we did,
15 actually, offer to meet with Mrs. Grainne Lynn to 15:07
16 explore further what the meeting between The Trust
17 professionals, Mr. O'Brien and NCAS would bring to the
18 whole process. And because, the fact that the
19 determination and the formal investigation, MHPS
20 investigation was completed already with the 15:08
21 determination report out, we were not clear in our mind
22 what that meeting will bring, therefore I wrote back --
23 I think I wrote back to Mrs. Lynn requesting a purpose
24 and what the expectation from that meeting would be.

25 136 Q. would it not have been useful to meet to see whether, 15:08
26 for example, Mr. O'Brien could benefit from further
27 support or to see whether issues around an action plan
28 in respect of his work could be advanced,
29 notwithstanding the grievance which was to be issued?

1 A. Yes. So, this letter came in early November, 2018,
2 which is just a few weeks after the determination was
3 out. The intention was, at that point in time, that
4 the action plan will be formed. Three elements of the
5 determination will proceed in terms of the action plan, 15:09
6 the admin review and the Conduct Panel hearing. In
7 fact I did write to Mr. O'Brien advising that we will
8 be in the process of putting together a Conduct Panel
9 hearing in January, which is in a few months' time.

10
11 For the purpose of getting more information, I asked
12 Mrs. Grainne Lynn that we are happy to meet and explore
13 further what that meeting, if that goes ahead, what it
14 brings, what it looks like. So putting that --
15 requesting a little bit more information. 15:10

16 137 Q. You had to write to Mr. O'Brien on 17th November - this
17 is 971 of your Core, TRU-279201 - to caution him in
18 respect of members of his family, as it says here,
19 being in contact with Trust employees to discuss the
20 ongoing case involving him. which members of his 15:10
21 family are you thinking about?

22 A. So, number of Trust staff were approached by his family
23 members, including his wife and his son. And it came
24 to my attention so I wrote to Mr. O'Brien to cease
25 that -- you know, to immediately cease this type of 15:11
26 behaviour.

27 138 Q. why did you consider it inappropriate?

28 A. I suppose, it was mainly to protect the staff but also
29 to protect Mr. O'Brien's view as well. That was

1 inappropriate, in approaching Mr. O'Brien's family
2 members to a number of staff. And they were -- they
3 felt vulnerable in that way. So, it was important that
4 this was to be addressed.

5 139 Q. Into the following year a decision was made to make 15:12
6 a referral to the General Medical Council; was that
7 your decision or was it Dr. O'Kane's decision?

8 A. Dr. O'Kane took over the Medical Director role in
9 December. So, in December 2018 we were together. She
10 was coming in as a substantive medical director. I was 15:12
11 transitioning out, I was finishing my role. We had
12 a period of 2018, December, when both were there. At
13 that point in time, the MHPS report was shared with GMC
14 ELA and it was discussed around the same time. The ELA
15 has indicated that all that information appears to be 15:13
16 meeting the threshold. Therefore, Dr. O'Kane was in
17 the Medical Director's role and responsible officer
18 role at that point in time, so she provided all that
19 information and made a referral. I think it was in
20 March or April 2019. 15:13

21 140 Q. You were despatched to communicate this to Mr. O'Brien?

22 A. That's correct, yes. So I was informed by Dr. O'Kane
23 and I was advised to inform Mr. O'Brien about that.

24 141 Q. Was that in your role as case manager?

25 A. I presumed it was as my previous role as case manager. 15:13

26 142 Q. Just finally from my perspective. You've offered some
27 reflections on the MHPS process generally and your role
28 in it. One of the things you've said in your witness
29 statement -- this is at page 903 of your bundle, not

1 the core. WIT-31999. You say at 23.1 that on
2 reflection in your view, the MHPS process could have
3 been more proactive. Proactive in that context means
4 what? Proceed with greater expedition or efficiency?

5 A. I suppose I was thinking on my experience and my 15:14
6 reflection since then. The MHPS process was
7 implemented and there were a number of elements. My
8 reflection was that all of them or most of them
9 contributed into the MHPS process; the framework
10 document itself, then how it was implemented in the 15:15
11 informal stages, the formal investigation, and post
12 determination, but also how the resources were
13 allocated, what was provided, what was the training
14 element, the experience, the expertise going forward,
15 the interaction or the interface of the Trust own going 15:15
16 into the MHPS Framework, that was all part of my
17 thinking. In terms of proactive more towards clarity
18 of the framework or the document or the policy, but
19 also clarity of roles and responsibilities, clarity of
20 entry and exit points in the process, and clarity of 15:16
21 taking it forward. That's what I meant by proactive.

22 143 Q. I'm glad I asked because there was more to it than
23 simple efficiency. It's a wide-ranging concern you
24 have. You go on to point out the absence of dedicated
25 resources, and you give the example of your own role as 15:16
26 case manager being an add-on to your other day jobs,
27 which were more than one, as we know.
28
29

1 Anything further you wish to add to that?

2 A. I think the dedicated time or protected time is vital
3 in terms of doing these investigations. We know now it
4 took much, much longer and it's still was going on and
5 on. It was initially thought to be for a few months. 15:17
6 I was already doing a busy clinical practice but also
7 in a managerial role. Then I took over the Interim
8 Medical Director role, which was also very busy,
9 without any proper induction or hand-over. So, I felt
10 that in my particular role as case manager, it took a 15:17
11 significant amount of my time, not only just the time
12 but also it had a greater impact on other elements
13 going into the clinical and my managerial roles. So,
14 I felt that what needs to be put in place if this is to
15 be done in a correct way. 15:18

16 MR. WOLFE KC: Thank you very much for your evidence,
17 Dr. Khan. I understand that the Panel will have some
18 questions for you. The Chair, Ms. Smith, will speak to
19 you about the arrangement for that. There may be
20 a short break. 15:18

21 CHAIR: Thank you, Mr. Wolfe.

22
23 Dr. Khan, thank you for your evidence. As you're
24 aware, my co-panelists and assessor are not in the room
25 with me today, but I understand we can switch. They 15:18
26 are actually on the Zoom call with you. If we can
27 switch to them, I'm going to ask them first of all to
28 ask questions. I think it can be done relatively
29 quickly and we could see them on our screens in the

1 chamber. They are going blank so let's just hope that
 2 happens. I'm hoping you can see both of them, Dr.
 3 Khan, on your screen.

4 A. I can see.

5 CHAIR: I'm going to invite, first of all, Mr. Hanbury, 15:19
 6 who hopefully will have his voice operational by this
 7 stage, and he can ask some questions. Thank you very
 8 much.

9
 10 AHMED KHAN WAS QUESTIONED BY THE INQUIRY PANEL AS
 11 FOLLOWS:

12
 13 MR. HANBURY: Thank you very much, Dr. Khan, for your
 14 evidence. I hope you can hear me?

15 A. Yes, I can. 15:19

16 144 Q. I just have a couple of clinical things I just want to
 17 run past you, in no particular order.

18
 19 You said you were interested in appraisal and job
 20 planning. Out of interest, one of the delays of 15:19
 21 Mr. O'Brien's -- of the investigation was when he took
 22 two months out for appraisal. Do you remember that?

23 CHAIR: Mr. Hanbury, can I just ask you to make sure
 24 the microphone on your headset is at your mouth,
 25 because your voice is dropping slightly. 15:19

26 MR. HANBURY: Is that better?

27 CHAIR: Hopefully.

28 MR. HANBURY: I'll just repeat that. When Mr. O'Brien
 29 took those two months out to do his appraisal during

1 the investigation, did you ask to see the appraisal, as
 2 a matter of interest, which was happening in the middle
 3 of the investigation? It might have been quite
 4 enlightening.

5 A. No, I didn't ask for appraisal to be seen. I was 15:20
 6 interested in the appraisal and revalidation purely
 7 because when it come to me -- this information came to
 8 me essentially at the beginning of the investigation,
 9 that Mr. O'Brien was successfully revalidated and had
 10 appraisals. I was interested to know what was the 15:20
 11 process behind it and how was that not linked, why it
 12 wasn't linking to his job plan and other elements.
 13 I was interested in the bigger picture of the appraisal
 14 feeding into the professional governance, the
 15 revalidation, and also the job planning going into the 15:21
 16 whole process of not necessarily identifying just the
 17 identification of concerns but also supporting the
 18 doctor, making sure these are professional governance
 19 arrangements, and why they have not been coming
 20 together. 15:21

21 145 Q. Then there was a delay in the job plan as well. That
 22 never came through, I think; is that correct?

23 A. Unfortunately, I understand it never came through. It
 24 was progressed to the level to Mr. O'Brien for
 25 agreement but I don't think it was completely agreed 15:21
 26 and signed off from both parties.

27 146 Q. Thank you. This may be slightly unfair on you in
 28 contrast to Dr. Chada, I may ask her the same thing.
 29 When the colleagues did the dictation reviews as part

1 of her investigation, I think that took two or three
2 colleagues a couple of months to do, it was a good deal
3 of work. From my notes, there were about 35 patients
4 not added to the waiting list and about three who
5 needed urgent follow-ups. Did the report look at those 15:22
6 cases in a bit more detail because that looks a bit
7 like potential patient harm at that point. I'm not
8 sure if that got the weight it possibly deserved. Can
9 you comment on that?

10 A. I'm not aware of any specifics on those patients, but 15:22
11 I knew that there was a, call it a lookback exercise or
12 reviewing the triage was done, was completed and
13 appropriately escalated or managed. A number of
14 patients were to be escalated. So I was aware of that
15 point but I'm not aware of any specifics more than 15:23
16 that.

17 147 Q. All right. Okay. I'll just move on.

18
19 The next thing was the private practice review.
20 Mr. O'Brien came back to you about the way that was 15:23
21 done, with one of the urologists at Southern Trust
22 looking at old letters and just making an off-the-cuff
23 analysis in contrast to comparing that group with a
24 similar group of, if you like, pure NHS TURP or other
25 cases of similar priority. Did that not ring alarm 15:23
26 bells? Is it fair, in a way, to compare the one group
27 with a nonexistent other group in the way that it was
28 presented to you?

29 A. I must say, it didn't come to my mind at that point in

1 time. Again, that may be due to the fact that I am not
2 a surgeon, I suppose, and at that point in time it was
3 done by the surgeons, his colleagues. Also, I
4 was assured this was going to be looked at, you know,
5 robustly, and it didn't come across my mind that
6 I needed to challenge that. 15:24

7 148 Q. I have one final question. I appreciate you're not
8 a surgeon but this should link in with your physician
9 background. It is the charts in the office thing,
10 which was obviously part of the Inquiry. Secretaries 15:24
11 don't just put charts or notes in the consultant's
12 office for no reason. When the numbers went up, did no
13 one think, well, what was it about those charts or
14 notes that meant they went into the office? Was it
15 a patient or a GP query, or investigations, radiology 15:25
16 to be answered? It seemed the analysis was just on
17 numbers, not how or why they were there, which might
18 have actually answered a lot of questions and in fact
19 raised a few clinical concerns. Again, thinking back,
20 do you think that was maybe an opportunity lost? 15:25

21 A. Yes, absolutely. I think among the other elements of
22 our reflection, I think that was a learning for us that
23 we could have looked at a little bit more deeper at
24 that point in time. Absolutely. That was something we
25 could have picked up if we looked at. Secretaries are 15:25
26 usually bringing that information, and there is
27 a reason behind that and it happens in all departments.
28 So yes, I would agree with that. Yes.

29 MR. HANBURY: Thank you, Ms. Smith. That's all the

1 questions I have.

2 CHAIR: Thank you, Mr. Hanbury.

3
4 Dr. Swart? Again, move to Dr. Swart. If we can see
5 her on the screen, please. I don't think we can hear 15:26
6 you, Dr. Swart. I am not sure if you are muted. No
7 we can't hear you at all at the moment. We still can't
8 hear you.

9
10 I'm just wondering, we maybe should take a five-minute 15:26
11 break just to see if we can get the sound issues
12 sorted. I don't know if it's at our end or
13 Dr. Swart's, but we'll take five minutes and try to get
14 her in sound as well as vision.

15
16 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS: 15:27

17
18 CHAIR: We have resolved the issue. Dr. Swart, can you
19 speak so we can make sure we can hear me?

20 DR. SWART: Hello, can everybody hear me now? 15:31

21 CHAIR: Yes, we can. Thank you.

22 DR. SWART: Sorry about that. It was working fine
23 before, but there you are.

24 149 Q. Good afternoon, Dr. Khan. I just want to ask you a few
25 things. Just to start with, I do fully appreciate that 15:31
26 your first big case as a case manager was a complex
27 one. Taking on acting Acting Medical Director role
28 without induction is a difficult gig. I've been there
29 in these things and I do understand that. It is just

1 important to help understand a bit more from your
2 perspective on a few other issues.

3
4 One of the most important aspects of your case manager
5 determination was the failing of managerial processes. 15:31
6 Your account of that this afternoon has been quite
7 clear, I think. But the terms of reference was then
8 translated into a review of administrative failings.
9 Now, I don't think that quite covers it, really. Were
10 you under any pressure to adjust the terminology, or 15:32
11 why do you think that happened, that it got translated
12 into that particular phraseology?

13 A. So at the time of my determination, I was very clear in
14 my mind, I had no pressure in terms of how do I put my
15 determination. I did receive advices but it was my 15:32
16 decision. I felt, as I alluded earlier, that to
17 understand better what exactly happened at many levels
18 on both operational and medical professional governance
19 line management structures, I was puzzled, basically,
20 to understand what really went wrong there and how can 15:32
21 we learn and improve our systems in order to --

22 150 Q. I understand that but did you think further in terms of
23 what was it saying about the way the Trust was managed
24 and led in terms of its structures and development?
25 Now, you came from a different directorate, 15:33
26 I understand that, but clearly from the evidence we've
27 heard, the lines of demarcation between operational,
28 clinician, professional were not all working correctly.
29 Do you feel now that that's adequately expressed by the

1 term "administrative review"? I'm saying that because
 2 of the way it was interpreted when it actually
 3 happened.

4 A. At the time of determination, I was hoping to make it
 5 clear that this is not about just the administrative 15:33
 6 duties or the responsibilities, it is the overall
 7 responsibility of the whole system. I must say I was
 8 disappointed to see the administrative part just taking
 9 in that way and not necessarily learning from that.
 10 I am aware that a lot has been done since in the Trust 15:34
 11 in terms of improving the professional governance
 12 structure but also the Clinical Governance, and
 13 combining all that together, bringing it together in
 14 more learning format. Since then, in fact, I was
 15 reflecting on that as well. There were elements, 15:34
 16 environmental elements such as the processes, the
 17 policies, the overarching -- the frameworks which were
 18 not working together. So, there were competing demands
 19 on various elements. The targets or the waiting lists
 20 are always in the forefront of all that, but are 15:34
 21 we making sure that the quality of care is there? Are
 22 we making sure that the succession planning is there?
 23 We know now the senior management team was going
 24 through the turnover and how it impacted on various
 25 elements of the Trust, so the leadership, the medical 15:35
 26 leadership and the no succession planning -- well,
 27 I must say less focus on that. But also the culture,
 28 the culture of both of --

29 151 Q. I think you're quite right and we've heard that. All

1 I'm trying to ask you is would you agree now that the
2 term "administrative review" perhaps doesn't do justice
3 to the extensive thinking that you did around it and
4 that we can now see. It was just to make that point
5 because it is much more than that, isn't it?

15:35

6 A. Yes, it is.

7 152 Q. On another aspect, this lack of dictation of letters,
8 have you ever come across this particular degree of
9 problem in relation to that with any other clinician?

10 A. No, I'm not aware of any -- I am not aware of any other
11 clinic who would leave that length. The extent of that
12 was remarkable. It was unbelievable.

15:35

13 153 Q. There was a monitoring plan put in; we talked about
14 that extensively. But it is my perception, and you can
15 correct me if I'm wrong, that there wasn't any regular
16 standard or data presented in that regard for the
17 department. I can't see any evidence to the length of
18 time dictation was taking for the other consultants,
19 for example, or any regular report of that; is that
20 correct?

15:36

21 A. That was my understanding as well, yes.

22 154 Q. In that context, is it entirely equitable to monitor
23 only one consultant in a department and not put it into
24 the context of how their colleagues are performing?

25 A. I suppose if you take it in the count of this case,
26 there was a clear action plan around one consultant,
27 and that was to have -- that would be the standard for
28 that particular consultant's monitoring arrangements.
29 I appreciate your point is it was kind of not taking

15:36

1 broadly for the whole team or the whole system rather
2 than just one.

3 155 Q. I'm really asking you what your view on that is,
4 because I can see that from the point of fairness,
5 individual practitioners have a right to be treated, in 15:37
6 terms of standards, the same as other people.

7 A. Absolutely.

8 156 Q. Would you agree? Yes.

9

10 The other thing is in all of this, because of the 15:37
11 length of time the letters were taking, at various
12 times we've touched on the need to copy letters to
13 patients, patients being a key partner in the
14 multi-disciplinary decision-making process. Did
15 you consider that at all in any of this, and is it your 15:37
16 view that there are such standards at the Southern
17 Healthcare Trust?

18 A. There are such standards, and certainly in my
19 Directorate, I personally would have copied my letters
20 to the patients. That would be quite standard practice 15:38
21 in some teams, not all of the teams. But that would be
22 -- my view on that is that patients and carers are the
23 key player in managing patients, actually. So,
24 we should be keeping them informed and I do tend to.

25

15:38

26 So in the Trust, I'm going to give you an example:
27 Some teams would be doing it regularly, perhaps other
28 teams are not doing it.

29 157 Q. What's your view? You spent a period as Acting Medical

1 Director, what's your view on the role of the Medical
2 Director in setting the tone for this type of thing?

3 A. I think the Medical Director has a key role in the
4 quality of care and provision of the services across
5 the Trust. But the Medical Director is part of the 15:38
6 senior management team. I felt, when I was in the
7 Interim Medical Director role, I was the lone medical
8 voice in the senior management table and, in fact, on
9 the Trust board as well. Having that robust structure,
10 I'm aware that Southern Trust have it now and I'm glad 15:39
11 that they took the initial paper which I produced when
12 I was Interim Medical Director and further developed on
13 that paper. Having the right kind of structures around
14 you is vital as a medical director as well. I felt at
15 times very overwhelmed and lonely in that capacity and 15:39
16 not, you know, not the support which I would require to
17 do that. I understand it has improved since then.
18 I have gone through that, yes.

19 158 Q. When you were Acting Medical Director, do you think
20 there was an effective way of the Medical Director 15:39
21 being assured - not reassured - assured about the
22 quality of clinical services? Did you see enough
23 information as Medical Director to give you that
24 assurance?

25 A. When I was Interim Medical Director, I wasn't getting 15:40
26 assurance as I would have hoped, maybe because I had no
27 previous experience but I was coming into that role
28 thinking I should get more robust assurance. When
29 I wasn't getting that, the second key priority I took

1 in my role was to look at the Clinical Governance
2 structures. Not the structures, necessarily; it was an
3 exercise to understand better and I put my role in
4 that. We looked at the understanding of the
5 assurances, processes, the learning process behind 15:40
6 that, and how we can improve our provision of care to
7 the patients. One element we did was to establish
8 a lessons learned forum. That was bringing together
9 quite a lot of learning from complaints, from SAIs,
10 from M&M, and bringing together to the people which are 15:41
11 really the decision-makers, and perhaps taking it back
12 to the clinical floor as well so that the clinicians
13 are involved.

14 159 Q. I agree with all that and we've heard some of that.
15 That's definitely a positive development. 15:41

16
17 When you were appointed as Acting Medical Director, do
18 you think you really at that point understood the full
19 scope of the role?

20 A. When I was appointed to the Acting Medical Director, 15:41
21 I was already in the Associate Medical Director MD role
22 for a period of time. Before that I was Clinical
23 Director and before that I was Lead Clinician. From
24 the time I joined the Trust, I was always interested
25 about making positive change in the role of medical 15:41
26 leadership and how it can impact the positive outcomes
27 and the experience and the patients. It was my first
28 exposure into the Medical Director hot seat, I would
29 call it, and it was so much learning for me. I think

1 these roles require succession planning. Although
 2 I did complete, previous to that, a number of medical
 3 leadership training courses and other things, but
 4 I think this requires more succession planning and
 5 development.

15:42

6 160 Q. So, my experience is that nothing really prepares you
 7 for absolutely being in the hot seat, unless it's
 8 a very exceptional Trust. But once you were there, you
 9 will quickly have realised the scale of the problems,
 10 as you will have done with the Case Manager role. Who
 11 was there to support you and mentor you? What senior
 12 advice did you have, maybe outside The Trust? Were you
 13 signposted to anyone or did you seek any additional
 14 help?

15:42

15 A. So, I did reach out to other Medical Directors in the
 16 region. So we had a Medical Directors' forum. So
 17 I attended those. I had informal discussions with
 18 other Medical Directors in the region. I did receive
 19 some advices and discussions on similar issues. But
 20 there was no, call it a support mechanism in The Trust.
 21 I suppose the Medical Director is thought to be leading
 22 all that but not having the support sometimes could be
 23 really daunting.

15:43

24 161 Q. So, what I'm trying to get at is were you formally
 25 signposted to a specific mentor outside The Trust or
 26 did you have someone you could ring, for example, when
 27 you had the challenge from Mr. O'Brien about the case
 28 management determination and he gave you a lot of
 29 information. Did you think then, 'I need to ask

15:43

1 somebody what to do with this.' And was there anybody
2 to ask?

3 A. To answer your first question, no, I wasn't signposted
4 to any resources or mentorship outside. But I suppose,
5 unfortunately, when I started the Medical Director's
6 role there was no Medical Director so I had no link to
7 a Medical Director --

8 162 Q. I realise that.

9 A. -- which would be very useful advisory role in terms of
10 knowing what to and how to approach others. So,
11 I had -- I was disadvantaged in that way of that
12 having -- so I started with a vacant office with a lot
13 of stuff to complete.

14 163 Q. I get it. Yes. But did you not think: 'This is
15 a difficult issue, I need to ask advice on that
16 particular issue.' The letter from Mr. O'Brien, it was
17 a very, very comprehensive letter full of information.
18 What stopped you from thinking: 'Hang on a minute.'
19 Was it just you thought you should be able to do it?
20 Were you not sure who to ask?

21 A. I actually -- I don't actually know why I didn't.
22 I just -- it just didn't cross my mind. Probably there
23 was a lot else going on, a lot of competing priorities
24 in The Trust and I wasn't -- I suppose on reflection
25 I was thinking maybe if I was just the Case Manager and
26 had the Medical Director there at that point in time
27 I could have reached out to the Medical Director.
28 Unfortunately I was or whatever at that point in time
29 I was in both roles. And I didn't reach out.

- 1 164 Q. Aligned to that, during the investigation, which was
 2 very prolonged, there were Patient Safety issues coming
 3 up. You know, additional SAIs, various things to do
 4 with prioritisation of lists, the whole private patient
 5 thing. Whether or not that was properly investigated, 15:46
 6 it was an issue about policies and things which was
 7 disadvantaging, possibly, some patients. What did you
 8 think about those as they came along? Did you feel you
 9 needed to take any more action because, really, as
 10 Medical Director, patient safety has to be the biggest 15:46
 11 thing. There is a Medical Director to talk to at the
 12 beginning, as Case Manager you'd got the same
 13 responsibility. What worries did that give you?
- 14 A. I was -- yes, I was mindful of that and I was concerned
 15 about purely for the patient safety perspective. I was 15:46
 16 aware of this SAI is ongoing and I think it did not
 17 conclude until much later. What I was assured by was
 18 that there was an action plan, there is an assurance
 19 coming from various parts of the system to me.
 20 I wasn't -- I wasn't getting -- I wasn't hearing -- 15:47
 21 let's put it this way -- I wasn't hearing the patient
 22 safety risk to me coming through the Medical Director's
 23 office.
- 24 165 Q. Okay. So, I think the learning from that is probably
 25 one always has to look further. I think we've all 15:47
 26 learnt that over the years.
- 27
 28 One thing that's come through with you and with many of
 29 the other managers, clinical and operational is, there

1 seemed to have been a reluctance to sit down with
2 Mr. O'Brien and just say: 'Tell me how it is for you.
3 what is going on behind this? why are you behaving in
4 this way?' Is that fair; was there a reluctance to do
5 that?

15:47

6 A. I think it's a fair comment. There was reluctance, in
7 fact, from quite a long period of time by his senior
8 colleagues, even by his colleagues or his own immediate
9 line managers to sit down and talk about that as well.
10 So, I think it's a fair point, yes.

15:48

11 166 Q. And were you fearful of it? Did you feel vulnerable?

12 A. I didn't feel vulnerable but I thought that there is
13 a process going and I will make my determination when
14 I receive these. I did address those if I felt that
15 I needed to intervene. However, I think the learning
16 for me, personally, is that maybe we could have been
17 more reaching out in that way to Mr. O'Brien as well.
18 Even for his -- for the support to him as well. I was
19 assured that the support has been provided within the
20 teams, but in my role as Interim Medical Director
21 I possibly would have been more going out to him as
22 well, yeah.

15:48

23 167 Q. I think you were reassured rather than assured, weren't
24 you?

25 A. Yes.

15:49

26 168 Q. That he had the right sort of support from what I can
27 see so far. would you agree with that, that it was
28 people telling you?

29 A. That's right.

1 169 Q. That you didn't see it for yourself?

2 A. Yes.

3 170 Q. If you had to do the whole Case Manager thing again

4 from the beginning, what one thing would you do

5 differently yourself? Never mind the process and The 15:49

6 Trust, and all of that, but you as an individual,

7 what's the biggest learning for you?

8 A. I think the biggest learning for me is that I wanted to

9 make sure that I am properly equipped with myself, my

10 training, my experience. I wanted to make sure am I in 15:49

11 this role being properly supported? What are the

12 processes we are following? Are we clear in our roles

13 and responsibilities? Am I clear? Are others clear

14 for their roles and responsibilities? And also making

15 sure that this is an important process for one doctor 15:50

16 or others, or something. But is The Trust taking the

17 responsibility in terms of supporting all this, all

18 these processes. So there was a lot of learning for me

19 as well, but I think as a system we need to understand

20 this better and learn more. 15:50

21 DR. SWART: Thank you very much. That's all from me.

22 Thank you.

23 171 Q. CHAIR: Thank you, Dr. Swart. Dr. Khan, just a couple

24 of questions from me.

25

26 It's clear that you were drafted into this role without

27 any experience, expertise or training. On reflection

28 do you think - aside from the all the other skills you

29 may have - do you think you were the right person to be

1 asked to do this?

2 A. I think I wasn't equipped, I wasn't ready at that point
3 in time. Obviously I had no experience, no training.
4 So looking back perhaps it's -- I could have just said
5 no. Sometimes the clinicians, they don't take -- in my 15:51
6 experience as AMD and Interim Medical Director it's
7 very, very challenging to ask or to get the doctor or
8 senior clinician to do such investigation, purely for
9 the reasons which we know now, there are the add-ons,
10 there are the -- you need to start with something, and 15:51
11 it's something else, and at the end of all that you
12 look back and you thought you could have done a number
13 of things differently. So, yes.

14 172 Q. So, one of things that we have to do is obviously to
15 make recommendations about the whole MHPS process. 15:51
16 would I be right in thing, and correct me if I've got
17 this wrong, but do you think that there needs to be
18 greater clarity within the Framework itself as regards
19 the roles and responsibilities that each individual
20 who's asked to operate that Framework has? 15:52

21 A. That's right. That's correct. I think the Framework
22 requires update and the Framework document itself is
23 very difficult to navigate. You just need to read it
24 multiple times to understand the extent of it. I think
25 it requires a little bit of easier language as well and 15:52
26 maybe FAQs and perhaps further explanation on various
27 things as well. So the whole Framework requires an
28 update, I say, yeah.

29 173 Q. So, perhaps a simplified document with more clarity in

1 it, but what about the actual operation of the
 2 Framework itself. Is it appropriate for an
 3 individual Trust to operate the MHPS process in
 4 isolation or would it be better to have, perhaps, a
 5 regional team with experience and expertise coming in 15:53
 6 for these complex cases at least? would that have been
 7 beneficial?

8 A. I think, as we know now, complexity usually comes
 9 halfway or as a process going into the formal
 10 investigations. But I believe that there needs to be a 15:53
 11 capacity building. I believe there has to be an
 12 expertise which would be supported with other elements
 13 of the system. But also having a peer support.
 14 I would have experience of peer support in terms of SAI
 15 or M&M. So in my Interim Medical Director role I would 15:53
 16 have created an M&M peer support role in The Trust.
 17 So, yes, there needs to be an expertise -- build-up of
 18 capacity and expertise in that role, yes. whether it
 19 would be central or Trust-wide, it really depends on
 20 how many, really, in a year or in a timeframe is going 15:54
 21 to be carried out.

22 174 Q. So, it would be useful to have an analysis of the
 23 number of MHPS investigations there are across the
 24 regions, say, to inform that?

25 A. That would give us a good indication. Yes. 15:54

26 175 Q. Just in terms of, if I've got this right, the initial
 27 decision to go for an MHPS investigation in respect of
 28 Mr. O'Brien, as I understand it, to put it maybe in
 29 laymen's terms as well, here we've got a problem,

1 there's a problem with this particular practitioner not
2 doing all of these things and we need to look at that
3 in some detail, and that that problem essentially
4 dictated the terms of reference. Would that be fair?

5 A. I think the initial screening or initial preliminary 15:55
6 investigation provided some context to that. But maybe
7 it wasn't providing the greater clarity or greater
8 visibility didn't which was not clear at that point in
9 time. So, the importance of an initial screening and
10 initial preliminary investigations would be very useful 15:55
11 to have a greater understanding and then to develop the
12 terms of reference.

13 176 Q. How do you feel that they need to maintain the
14 confidentiality of any such screening process to
15 protect the practitioner, apart from anything else? 15:55
16 How do you feel that affects what then subsequently
17 happens?

18 A. As we know, it's a fine, very fine line between the
19 confidentiality and patient safety. So there has to be
20 a balance maintained in order to protect the 15:56
21 confidentiality of the individual. But at the heart of
22 that is our patients. So we need to keep a balance
23 right there. Not by protecting and too much protection
24 or going one way or other. So, there has to be a clear
25 balance on that which in the practice it's very, very 15:56
26 challenging and we know in this case it has created
27 a lot of challenges for The Trust. But I think we
28 should aim to keep a balance right. And I think the
29 Framework should give us more advice and assistance in

1 relation to that as well.

2 177 Q. So, it would be useful if the Framework set out, as you
3 described it, some frequently asked questions as to
4 where maybe the line should be drawn between protecting
5 a practitioner's confidentiality or the confidentiality 15:56
6 of the process per se versus patient safety?

7 A. That's correct. Yes. That's right.

8 178 Q. Thank you.

9

10 I'm just checking through my notes. If you bear with 15:57
11 me one moment, to make sure I've nothing else that I
12 want to ask you.

13

14 Yes, just one thing. In terms of this particular case,
15 you knew that there was an ongoing SAI in the 15:57
16 background, obviously we know it didn't conclude until
17 much later, but that seemed to trigger the formal MHPS
18 process in this case. At that point in time ought
19 there to have been a greater involvement of the
20 clinician at that stage, do you feel, when the two 15:57
21 processes are running in parallel lines, if you like?
22 Should they have been linked up more?

23 A. In my view, I think the clinicians should have been
24 involved, really from the very beginning. I think
25 there was a missed opportunity at that point in time 15:57
26 when the initial screening wasn't completed by the
27 clinician, per se, or part of that screening process.
28 I think there was a missed opportunity there.

29

1 The clinician should be part of this process, I
2 suppose, in terms of immediate line management, the
3 Clinical Director, the Associate Medical Director, and
4 the same thing for the operational line management.
5 I believe that the inclusion of clinicians at the 15:58
6 earlier stage would have given us maybe an earlier
7 indication of some of the facts which we come to know
8 at a later part.

9 CHAIR: Thank you very much, Dr. Khan. I think
10 Mr. Wolfe might have something that he wants to ask you 15:58
11 before we allow you to go today.

12 MR. WOLFE KC: It is not questions, it is just
13 a reference for you.
14

15 You'll recall that I was asking Dr. Khan about his 15:58
16 interaction with Dr. Grainne Lynn of NCAS. You saw her
17 letter to Dr. Khan of 6th November 2018 which was
18 reference WIT-53469. It was an email from Dr. Khan to
19 Grainne Lynn the day before, which explains his
20 thinking around whether he should meet with 15:59
21 Mr. O'Brien. That reference is TRU-251539. In
22 essence, he says in the email:
23

24 "We remain unclear as to the purpose of a meeting with
25 Mr. O'Brien at this stage. We're happy to be guided by 15:59
26 NCAS and if you feel it is useful to meet, we're happy
27 to do so".
28

29 I maybe didn't put it as fairly as that in my question.

1 That ties that up.

2
3 Thank you again, Dr. Khan.

4 CHAIR: Thank you, Dr. Khan. I think that concludes
5 your evidence. We appreciate you giving up the time to 16:00
6 speak to us on two occasions. Hopefully we won't need
7 you back. Thank you.

8
9 Ladies and gentlemen, it is now four o'clock. We'll
10 start again at 10 o'clock in the morning. I think 16:00
11 we have both witnesses tomorrow scheduled in person;
12 isn't that correct?

13 MR. WOLFE KC: That's right. We start with Dr. Chada
14 in the morning.

15 CHAIR: Thank you. 16:00

16
17 THE INQUIRY ADJOURNED UNTIL 10:00 A.M. ON WEDNESDAY
18 29TH MARCH 2023