



Oral Hearing

Day 26 – Thursday, 23rd February 2023

**Being heard before: Ms Christine Smith KC (Chair)
Dr Sonia Swart (Panel Member)
Mr Damian Hanbury (Assessor)**

Held at: Bradford Court, Belfast

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

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INDEX

	<u>PAGE</u>
Mrs. Martina Corrigan, sworn Examined by MS. McMahon, BL	3
Lunch adjournment	102
Mrs. Esther Gishkori, sworn Examined by Mr. Wolfe KC	103

1 THE INQUIRY RESUMED ON THURSDAY, 23RD FEBRUARY 2023 AS
2 FOLLOWS:

3
4 CHAIR: Good morning, everyone. Ms. McMahon.

5 MS. McMAHON BL: Madam Chair, members of the Panel, 10:01
6 this morning's witness is Martina Corrigan, who is the
7 Head of service for Urology Services from 2009 to 2021,
8 and I believe she's going to take the oath.

9
10 MRS. MARTINA CORRIGAN, HAVING BEEN SWORN, WAS EXAMINED 10:01
11 BY MS McMAHON BL AS FOLLOWS:

12
13 Q. Mrs. Corrigan, thank you for coming along. I know you
14 were here yesterday. Best laid plans. It didn't work
15 out. Apologies for that. Thank you for coming back 10:01
16 today. We have this morning until 1 o'clock to get
17 through your evidence. Obviously, because of the
18 duration of your employment and tenure in Urology
19 Services you have quite a significant amount of
20 information that might be relevant to the Inquiry. For 10:02
21 the purposes of today, I want to try and concentrate
22 solely on the MHPS period of time and your involvement
23 or your actions in and around that period. If we can
24 both exercise some discipline and try and stick to
25 that, hopefully we'll get everything covered this 10:02
26 morning.

27
28 As I said, you were the Head of Service, including
29 Urology Services -- I know you covered other part of

1 the hospital -- from 2009 to 2021 when you changed
2 posts. We'll look at some of your roles since then and
3 your job description. Just in relation to the evidence
4 you have provided so far to the Inquiry, you've sent in
5 four replies to Section 21 Notices? 10:02

6 A. Yes.

7 1 Q. Two substantive. One the bulk of the information to
8 the Terms of Reference and the second more substantive
9 in relation specifically to MHPS?

10 A. That's correct. 10:03

11 2 Q. And two further replies attaching supplementary
12 documents. I just want to take you to those and ask
13 you if you recognise them, confirm it's your signature
14 and if you'll adopt them as your evidence.

15 A. Okay. 10:03

16 3 Q. If we could call up, first of all, the Section 21 reply
17 dated 6th July 2022 at WIT-26146. Do you recognise the
18 front page of that notice 24 of 2022?

19 A. Yes.

20 4 Q. If we go to page WIT-26318. There is a signature just 10:03
21 at the bottom of that page dated 6th July 2022. Do you
22 recognise that as your signature?

23 A. That's correct, yes.

24 5 Q. Do you wish to adopt that as your evidence today?

25 A. Yes, please. 10:04

26 6 Q. The second Notice dated 29th April 2022 is at
27 WIT-39879.

28 MR. MILLAR BL: Excuse me, Chairman, I'm not seeing
29 anything on the screens here.

1 CHAIR: If we just take a pause, Ms McMahon. Is this
2 something that is readily sortable?

3
4 (Technical difficulties)

5
6 CHAIR: would you like us to rise so you can check it
7 all out? 10:04

8
9 THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

10
11 CHAIR: Hopefully we'll not have any further technical 10:04
12 difficulties and Mrs. Corrigan can finally start giving
13 us some evidence.

14 7 Q. MS. McMAHON BL: I think we were on to the second
15 Section 21 reply dated 29th April 2022 at WIT-39879. 10:12
16 That's Notice 40 of 2022. If we go to page 39933.
17 Just to confirm that's your signature. That one is
18 15th July. I've got the wrong date on my -- so
19 15th July. The next Notice -- I'll just correct that
20 for my note. You wish to adopt this in your evidence? 10:12

21 A. Yes, please.

22 8 Q. The next Notice is WIT-40945. This is a Notice in
23 relation to supplementary documents. we'll come back
24 to that one. we'll try the next one. WIT-41803.

25
26 we'll check the index on those two, but they're 10:13
27 documents that came in subject to your main Notices
28 giving us documents that hadn't been -- I think they
29 were discovered later on and provided to the Inquiry.

1 we'll come back to those. They're not substantive
2 evidence documents, for the purposes of the other
3 Section 21s. In relation to amendments, I understand
4 there are two amendments you wish to make?

5 A. Yes, please. 10:14

6 9 Q. The first one is at WIT-26205 at paragraph 20.1(d)
7 where it says:

8
9 "Mr. Haynes title should be changed to Clinical
10 Director of General Surgery and Trauma and 10:14
11 Orthopaedics".

12 A. Yes.

13 10 Q. You have put in ENT there?

14 A. Ayes.

15 11 Q. The next amendment is at WIT-26306 at paragraph 69.1. 10:14
16 I think that's six lines down where you've referred to
17 Dr. McAllister and you want to change your reference.
18 There you have written "he was interim AMD" and you
19 want to change that "Dr. McAllister started his role on
20 29th April 2016 and not in June 2016"? 10:15

21 A. That's correct.

22 12 Q. Just a date error there?

23 A. That's all. Yes.

24 13 Q. I also know from consultation that you want to make
25 reference later on to a meeting that you had with 10:15
26 Mr. O'Brien on 25th July 2017?

27 A. Yes.

28 14 Q. You haven't referred to that in your statement. we'll
29 deal with that when we get to that point.

1 A. Okay.

2 15 Q. Are there any other amendments or corrections that you
3 need to inform us about at this stage?

4 A. No. Thank you.

5 16 Q. Thank you. Just as a very brief outline in relation to 10:15
6 your role, and for the Panel's note, your occupational
7 history is contained within your Section 21 Notice at
8 WIT-26161. In brief terms, prior to taking up the role
9 as Head of Services in 2009 you worked in various
10 management roles in the Western Health and Social 10:16
11 Care Trust and its predecessor Trust?

12 A. That's correct, yes.

13 17 Q. Just to confirm that you're not clinically quantified?

14 A. No.

15 18 Q. Your area of expertise and your undergraduate degree 10:16
16 was in Public Policy --

17 A. Yes.

18 19 Q. -- and Management, and you have an MA in Business
19 Improvement?

20 A. That's correct, yes. 10:16

21 20 Q. You started your role for the Trust as Head of Service
22 in September 2009 and you were in that role right up
23 until June 2021?

24 A. That's right. Yes.

25 21 Q. I just want to briefly touch on your current role. 10:16
26 You're the Assistant Director for the Public Inquiry
27 and Trust liaison since June 2021?

28 A. That's correct, yes.

29 22 Q. I wonder, just in relation to that specific role, if

1 you could just explain what that role involves?

2 A. Yes. I suppose I applied for the job and was

3 successful in it in June 2021. At that stage it was to

4 be bringing together evidence and, you know, responses

5 to Section 21s and sort of being the Trust liaison with 10:17

6 the likes of the Inquiry. It became apparent that

7 there would be -- and my Director at that stage was

8 Mrs. Trouton, Mrs. Heather Trouton, but it became

9 apparent that there would be a conflict of interest

10 with regard to the fact that I had been working in 10:17

11 Urology since 2009 along with Mrs. Trouton, so they

12 appointed a Director, Mrs. Jane McKimm who has never

13 worked operationally with Urology, and also we have

14 Mrs. Margaret O'Hagan, who is an independent adviser

15 for the public Inquiry so that anything -- to make sure 10:18

16 there was no conflict of interest, that everything goes

17 through them. Basically, pulling together evidence

18 like your Trust policies and things like that wouldn't

19 have a conflict, but would have worked through it

20 making sure Jane and Mrs. O'Hagan were involved in 10:18

21 whatever was going through. But I will be fair to say

22 that really since I took up post and most recently,

23 a lot of my time has been spent trying to prepare for

24 my Section 21s and for today. It's my own personal

25 evidence. I've had no contact with anybody else with 10:18

26 regard to their Section 21s apart from if they ask me

27 a specific question about a document that is in the

28 evidence. So it wouldn't have been influencing anybody

29 or anything like that with regards to anybody else's

1 Section 21. I've seen nobody else's. I've been taken
 2 totally out of that loop with regards to independence,
 3 that there would be no conflict.

4 23 Q. The Trust have inserted a layer --

5 A. They have, yes. 10:19

6 24 Q. -- as it were, of two other individuals in relation to
 7 their engagement with the Inquiry because of the unique
 8 position that you and Mrs. Trouton are in, where you
 9 actually have evidence relevant to the Inquiry in order
 10 to ensure that level of independence? 10:19

11 A. Yes. I was just going to say, I suppose my
 12 knowledge then, because at one stage I thought I would
 13 better stepping totally back, but it's just the
 14 knowledge I had since 2009 just felt it would be
 15 relevant, so I've been kept in the post or remained in 10:19
 16 that post, I should say.

17 25 Q. I think you are probably unique in being the only
 18 individual who has been in post for the entire duration
 19 and also at the one level, as it were?

20 A. Yes. 10:19

21 26 Q. The key level in the middle operationally. Clearly you
 22 have lots of information that's relevant. Just in
 23 relation to that role, I just want to say a little bit
 24 about and discuss with you your responsibilities.
 25 Hopefully that will put in context the nature and level 10:20
 26 of your involvement in the MHPS time period and why you
 27 were engaged in that.

28
 29 For the Inquiry's note again, the narrative of your job

1 description is at WIT-26163. I just want to read from
 2 this before I can ask you some more information about
 3 it. I'll just read from the second line that's on your
 4 screen:

5 "This role entailed being responsible for the 10:20
 6 operational management and strategic development of
 7 ENT, Urology, Ophthalmology and Outpatients across the
 8 Southern Trust. I was responsible for Leadership,
 9 Service Provision and Service Development of ENT,
 10 Urology, Ophthalmology and Outpatients, and ensuring 10:21
 11 high quality patient-centred services. I was
 12 responsible for achieving service objectives through
 13 the implementation of national, regional, and local
 14 strategies and access targets. I worked in partnership
 15 with the Assistant Director, Associate Medical and 10:21
 16 Clinical Director to define a service strategy, which
 17 support the Trust's and Directorate's overall strategic
 18 direction and ensures the provision of a high quality
 19 responsive service to patients within resources. As
 20 a Head of Service I was a member of the division's 10:21
 21 senior management team and contributed to policy
 22 development within the division towards the achievement
 23 of its overall objectives."

24
 25 You're a member of the senior management team but you 10:21
 26 don't sit on Board committees; is that right?

27 A. I suppose what I mean by that is that it's the
 28 division. I would have sat within the Acute
 29 Directorate then you have the Surgical and Elective

1 Care division, so part of that was the Assistant
 2 Director and the Heads of Service, along with the
 3 Associate Medical Directors and the Clinical Directors.
 4 When I say there senior management team, I don't mean
 5 sort of your Directors, it's more the next tier down 10:22
 6 rather than, sort of the Chief Executive and all the
 7 other Directors.

8 27 Q. You reported directly to Assistant Directors?
 9 A. That's correct, yes.

10 28 Q. In your tenure, who was that? 10:22
 11 A. When I started in 2009, actually for about two or three
 12 days it was Mr. Simon Gibson. Then Simon moved post
 13 and it was Heather Trouton from that until 2016. In
 14 April 2016 then it was Mr. Ronan Carroll and
 15 Mr. Carroll was still my Assistant Director when I left 10:23
 16 post in 2021.

17 29 Q. In relation to Mrs. Trouton and Mr. Carroll, what was
 18 the nature of your engagement with them on a daily
 19 basis, for example, or weekly basis?
 20 A. On a daily basis I would have been in contact either 10:23
 21 sort of through e-mail or face to face. I suppose the
 22 nature of the job was it just varied from day to day
 23 depending on how many, perhaps, meetings we were at.
 24 I'm just thinking, for example, in the middle of winter
 25 pressures, it would probably have been within every 10:23
 26 hour because we were needing direction on whether
 27 we cancel patients or how we get our emergency
 28 departments cleared. I would have worked very closely
 29 with both Assistant Directors.

1 30 Q. Would you say your lines of communication with them
2 were good? Effective?

3 A. Very good, yes. Very good, yes.

4 31 Q. What about the Assistant Directors over the same period
5 of time? Who were they? 10:24

6 A. When I started it was Ms. Joy Youart but I had no
7 contact with her at all because she had left in
8 December. Then Dr. Gillian Rankin. I just can't
9 remember all the dates just off the top of my head.
10 I think she was 2013. Then it was Mrs. Debbie Burns 10:24
11 from '13 to '15, and Mrs Esther Gishkori from '15 until
12 '18, I think, to read Melanie McClements from '15 until
13 I left the post in June '21.

14 32 Q. What was your contact with Directors within the Acute
15 Services? 10:24

16 A. It varied. Ms. Youart I would never have had any
17 contact with her. Dr. Rankin, I would have had a lot
18 of contact with her because it was during the time of
19 the review of the Urology Services and we would have
20 had regular meetings, particularly on a Monday night. 10:24
21 Then there would have been meetings ad hocly to do with
22 the review. I also was involved -- Dr. Rankin would
23 have been there at the time that we would have been
24 going through the likes of the issues with regard to
25 the IV antibiotics and the benign cystectomy. 10:25
26 She would have come to ask for information, for
27 example. She was also involved with me when we were
28 doing an escalation with regards to Mr. O'Brien's
29 triage. We would have weekly meetings to do with

1 performance with Dr. Rankin, every Tuesday morning, but
2 that would have been with the teams as in each of the
3 divisions, not only Surgery and Elective Care. I would
4 have had quite a bit of contact with Dr. Rankin. The
5 same with Mrs. Burns, I would have had a lot of contact 10:25
6 with her. Regular meetings. We would have had
7 meetings with regards to if we had, for example, needed
8 more staff on the wards and sort of the whole
9 recruitment process also I would have been very much
10 involved. Mrs. Burns had a very good working 10:26
11 relationships with the ADs and the Heads of Service.
12 I'm not sure if you were able to come and see sort of
13 the layout of the admin floor, but she would have been
14 down, as we called it, the corner office. Both her and
15 Dr. Rankin would regularly walked into the Head of 10:26
16 Service if they needed anything, any information.
17 Mrs. Gishkori, I have to say, no, I didn't have any
18 contact with her. She was very clear at the start of
19 her tenure that she expected that any information she
20 needed would come through the ADs as opposed to the 10:26
21 Heads of Service which takes a bit of getting used to
22 because we would have had an open door policy with the
23 other Directors. If you think about it, from
24 day-to-day, all the stuff that might happen, the AD
25 mightn't be about so you needed to have that 10:26
26 relationship to go to speak to the Director if you
27 needed, if the AD was on annual leave or maybe offsite
28 in Daisy Hill, or something like that. Finally,
29 Mrs. McClements I had a very good relationship again.

1 Again open door policy, would have called down to the
 2 office and we would have been able to go into her for
 3 any issues.

4 33 Q. You have mentioned a lot of information that we'll deal
 5 with when we come back, because you know you will have 10:27
 6 to come back. I know your counsel has already advised
 7 you of that. Just in relation to Mrs. Gishkori,
 8 because her tenure is relevant to the period of time
 9 for MHPS. I just want to probe that relationship a
 10 little bit more, if you don't mind, both in relation to 10:27
 11 the communication aspects and also any impact her style
 12 of management or your style of engagement with her may
 13 have had on the culture of dealing with issues as they
 14 arose.

15 10:27
 16 When you say that her approach was different so that it
 17 perhaps wasn't open door that you had been used to, as
 18 Head of Service, what impact, if any, did that have on
 19 your day-to-day operation or ability to seek help or to
 20 make decisions? 10:28

21 A. Working with the previous Directors it probably did
 22 hinder because if you had something -- like you needed
 23 to give a heads up on something, for example, the
 24 Emergency Department was really, really busy and you
 25 needed to know was it okay to open -- you know, bring 10:28
 26 in extra staff to open a bay, you couldn't go in to her
 27 to ask her that. She had always said if you needed to
 28 highlight anything to me you just needed to go to one
 29 of the other ADs. If Mr. Carroll was not about I would

1 go find one of the other ADs I wasn't directly
 2 reporting to, for example Mrs. McVeigh, and sort of
 3 speak to them. I suppose I sort of got used to it
 4 because she had been there for a while but didn't have
 5 the same relationship and, you know, didn't feel that 10:29
 6 I could go to her if I had to escalate something.

7 34 Q. You mentioned there about having to free up beds or
 8 make some operational decisions which presumably
 9 directly relate to patient care.

10 A. Mm-hmm. 10:29

11 35 Q. If you weren't able to go to Mrs. Gishkori and you had
 12 to go to an AD, would that have resulted in, perhaps,
 13 delay or, in fact, a decision not being taken about
 14 that?

15 A. It could have, yes. Although the AD normally would 10:29
 16 have made the decision if she or he couldn't get to the
 17 director, you know, talk it through with me.

18 36 Q. If it wasn't your direct AD and another one from an
 19 ancillary Department, did you assume that they would
 20 inform Mrs. Gishkori of the conversation, or was it 10:29
 21 your view that you were getting your decision signed
 22 off, effectively at the level you needed to?

23 A. Yes, because if my own AD wasn't about the other AD was
 24 able to make the decision, so I would have taken it as
 25 their decision. 10:30

26 37 Q. Is it possible then that decisions made didn't reach
 27 the Director, the relevant Director, Mrs. Gishkori?

28 A. I can't really answer that but it could be possible.
 29 I don't know because I don't know sort of what would

1 have been discussed with Mrs. Gishkori with the ADs.

2 38 Q. Just from a perspective of how things operated, I know
3 you said that Mrs. Gishkori indicated that there was
4 a line of communication and there was someone between
5 you and her. Is it the case that you wouldn't have 10:30
6 felt comfortable just going to her door and rapping the
7 door and saying, 'this situation has arisen. I can't
8 get my hands on an AD, and I need to discuss that'.
9 Was there, in effect, a barrier to you for doing that?

10 A. Yes, I felt that. Not with the other Directors. 10:31
11 I suppose that was the difference because we said I was
12 there from 2009 to '21.

13 39 Q. How was that barrier presented to you? Was it said to
14 you that you shouldn't do this or that you did do it
15 and the response was not welcoming? What was it that 10:31
16 happened that made you reluctant or to know that you
17 couldn't do that?

18 A. Not long after Mrs. Gishkori started in the role, and
19 I was used to just popping in to the office to her
20 personal assistant, Ms. Stinson, I would have said to 10:31
21 Emma, 'are they free?', because you obviously wouldn't
22 just knock the door and then go in, which is what
23 I have done, you know, right from the start. This
24 particular day I just said I just need to give Esther
25 the heads up on something. I knocked the door went in 10:32
26 to Mrs. Gishkori. She said, 'I'd prefer this didn't
27 come from you, it came from an Assistant Director. I'm
28 clear that the lines of communication is Heads of
29 Service, Assistant Director to myself'. That was near

1 enough at the start of it. I was a bit taken aback
 2 because I had such a good relationship with the other
 3 Directors, so I was a wee bit taken aback. In saying
 4 that, I would have still been at meetings with her and
 5 Mrs. Gishkori would have been in the patient flow team 10:32
 6 room and was always polite. It wasn't that. It's just
 7 when it came to actual, I suppose, decision making.

8 40 Q. Do you think that culture, when we look later on at
 9 what happened during the period of time '15 to '18, do
 10 you think her approach to management had a detrimental 10:32
 11 impact on governance?

12 A. I don't know how to answer in the sense of that I am
 13 confident that the governance within the AD to the Head
 14 of Service lead nurse level was taken very seriously.
 15 Obviously, both Heather and Ronan would have had weekly 10:33
 16 meetings. They had weekly meetings but one of them was
 17 dedicated to governance. I don't know -- like,
 18 obviously, there was Acute Governance meeting on the
 19 second Friday of the month with the Director and the
 20 ADs. 10:33

21 CHAIR: I think, as I said to Mr. Wolfe yesterday, this
 22 is an issue for the Inquiry to determine, rather than
 23 the witness.

24 41 Q. MS McMAHON: Just as you were saying that, I was
 25 thinking it might be a better question to ask when you 10:33
 26 take you to the e-mails you sent during '16, '17 and
 27 '18 escalating breaches, and you can answer that in
 28 context of anybody replied to you.

29 A. Okay.

1 42 Q. We can do it that way.

2

3 Your role in governance, you deal with at WIT-26225 in
4 your witness statement at paragraph 31.1:

5

10:34

6 "My role in governance for all my areas was to promote
7 and ensure that there was high quality and effective
8 care offered to all patients and to ensure that

9 services were maintained at safe and effective levels.

10 I can confirm that I didn't have a direct management

10:34

11 role regarding the consultants and other clinicians in
12 the Thorndale unit."

13

14 The evidence presented to the Inquiry and from witness
15 statements would seem to indicate that there were two
16 almost separate lines of communication within Urology.
17 One was operationally, and one was the medic side.
18 Would that have been your experience?

10:34

19 A. That's correct, yes.

20 43 Q. In some ways those two lines coalesce with you in some
21 respects. Would that be a fair description?

10:35

22 A. That's fair, yes.

23 44 Q. On the medic side, and if I include the nursing staff
24 in that, the lead nurses reported to you?

25 A. Operationally to me and then professionally to the AD,
26 with me not being a nurse or a clinical person. For
27 example, annual leave, and things like that would have
28 been to myself, but anything professionally wise would
29 have went lead nurse then direct to the AD.

10:35

- 1 45 Q. The other operational aspects, booking, referrals,
 2 people like Katherine Ford, you would have been dealing
 3 with that side of the branch of the day-to-day running
 4 of the unit?
- 5 A. That's right. Yes. Yes. Yes. All the operation 10:35
 6 clinics, theatre lists, and things likes that, yes.
- 7 46 Q. We will go through it on the next occasion in your
 8 evidence, but you have had a significant involvement
 9 with matters and issues of concern around Mr. O'Brien's
 10 practice from, I think, 2009, almost since you started 10:36
 11 in the unit?
- 12 A. That's correct.
- 13 47 Q. The person in post prior to that in Head of Service was
 14 a lady called Louise Devlin?
- 15 A. That's correct. 10:36
- 16 48 Q. When you started in the Service in 2009, did she give
 17 you an indication of her experience with issues arising
 18 from the practice of Mr. O'Brien before you took up
 19 your substantive post?
- 20 A. Louise was responsible for Outpatients as opposed to 10:36
 21 Urology. The Urology and ENT post was a new post that
 22 had been created. But Louise was the other Head of
 23 Service then for Trauma and Orthopaedics so we would
 24 have shared an office. She advised me of an occasion
 25 whenever she'd been in charge of Outpatients been 10:36
 26 tasked to go to Mr. O'Brien's office to get the some
 27 letters that was in his drawer because he was on annual
 28 leave. She removed the letters and Ms. Devlin said he
 29 came to see her, he was very confrontational and cross

1 with her, and that he said she had no right to remove
 2 the letters. She tried to explain that they needed to
 3 be added to the patient administrative system at that
 4 stage. But she basically said she never really
 5 communicated with him again. She had a hard time on 10:37
 6 that occasion. That was to do with letters in his
 7 drawer.

8 49 Q. Just in general terms, what was your experience and
 9 your relationship with Mr. O'Brien from the start of
 10 your taking up post? 10:37

11 A. I have to say I had a very good relationship with
 12 Mr. O'Brien. He was a wee bit off with me when we were
 13 introduced. I think he just seen me as another
 14 manager. But after that initial meeting I have to say
 15 I had a very good working relationship with him. 10:38
 16 I suppose I was the person that was able -- I would
 17 have been in regular contact with him and all the
 18 escalation, et cetera, would have been through myself
 19 to him.

20 50 Q. Again, it is not for today but I just want to take 10:38
 21 a brief trot through the issues that you ultimately had
 22 to deal with under the MHPS banner, and your knowledge
 23 of them over the years. If we just start with triage.
 24 That was something that was first raised with you in
 25 2010 by the booking staff? 10:38

26 A. That's correct. Yes.

27 51 Q. The patient notes at home was first escalated to you in
 28 2013?

29 A. Yes.

1 52 Q. The issue around non-dictation, again that was first
2 raised in 2014 with you?
3 A. Yes.

4 53 Q. The issue of not conforming with booking patients, you
5 don't specify the date but there seems to be 10:39
6 correspondence with you and Heather Trouton and other
7 staff on that issue over the years. Then you mention
8 in your statement what you call clinical issues that
9 you weren't aware of around IV fluids, benign
10 cystectomies and an issue around notes being placed in 10:39
11 the bin in 2011?
12 A. That's correct, yes.

13 54 Q. You also were aware of an issue around the allegation
14 that private patients were being given priority towards
15 the end of 2015? 10:39
16 A. Yes, that's correct.

17 55 Q. The issue around no access to key worker for oncology
18 patients. You say that you became aware of that
19 in November 2020?
20 A. That's correct. 10:39

21 56 Q. The issue of not following up on results, you say you
22 became aware of that in June 2020?
23 A. That's correct, yes.

24 57 Q. The same with the bicalutamide issue?
25 A. Correct, yes. 10:40

26 58 Q. We will go in depth into those particular areas on the
27 next occasion when you give evidence. I think it would
28 be a fair summary of all of that to say that there are
29 many, many e-mails, either from you or you're copied

1 into, in which you raise issues or respond to issues on
 2 all of those topics?

3 A. That's correct, yes.

4 59 Q. I just wonder if I could ask you, generally, on those
 5 issues, given the length of time over which you had an 10:40
 6 awareness -- you and others had an awareness of varying
 7 degrees of concerns around those issues. Was there
 8 ever a point from 2010 when it was realised that these
 9 had the potential to impact on patient care and safety?

10 A. I've had quite a bit of reflection on this. I suppose 10:41
 11 pre -- the notes at home, the un-triaged, un-dictated,
 12 was always classed as being admin issues, wrongly for
 13 me now. On reflection, I didn't associate that with
 14 Patient Safety up until probably 2016, and it really
 15 hit home with me personally whenever, in 2017, 10:41
 16 I recovered the 783 letters and one of the patients,
 17 I think Patient 13 maybe, one of the patients actually
 18 was just a couple of weeks younger than my own husband,
 19 and the first line of the letter just rang alarm bells
 20 with me. Even though I'm not clinical, the fact 10:42
 21 I worked for 35 years in the Health Service I have sort
 22 of picked up some clinical terms. It was that
 23 realisation that because of what had been classed as
 24 admin was really Patient Safety and, you know, that
 25 patient became part of the 2016 -- sorry '17 SAIs. Up 10:42
 26 until that I would have said they were admin issues.
 27 When you read the report it says "admin issues" but it
 28 was obviously a Patient Safety, on reflection.

29 60 Q. You just mentioned the SAIs. You first became aware of

1 those in January 2016?

2 A. 2017. Yes, there was one SAI in 2016.

3 61 Q. The final reports, you weren't aware of until 2020.

4 They were shared with you --

5 A. I was aware of Patient 10's SAI because it sort of was 10:42

6 what started everything in December '16. But, no, the

7 SAIs, the sort of the five SAIs that came out of the

8 un-triaged I didn't know about until 2020.

9 62 Q. You didn't have anything to do with the SAIs,

10 effectively? 10:43

11 A. No.

12 63 Q. If we look at the MHPS period, and you deal with that

13 in your second Section 21 Notice. Just for the Panel's

14 note, it's at WIT-39879. There's been a lot of

15 evidence about the MHPS Framework and you tell us in 10:43

16 your statement that you didn't know of its existence.

17 When did you first become aware of it?

18 A. I became aware of it, I think it was because it was

19 mentioned as sort of from Mrs. Hynds and Mr. Gibson in,

20 probably, the latter end of 2016, December time, when 10:44

21 everything, sort of, had come to a head. Pre that,

22 because it isn't part of my responsibility, and I would

23 not have been managing doctors, I never knew -- it's

24 obviously in the Trust policies but I never would have

25 any occasion to read it or need to use it. 10:44

26 64 Q. In relation to Trust policies, you also say you weren't

27 aware of the Trust guidelines around doctors?

28 A. That's correct.

29 65 Q. It was only discussed with you in the context of MHPS?

1 A. Yes.

2 66 Q. The two formal mechanisms, if we could call them that,
3 that were available, you didn't have any awareness of?

4 A. That's correct.

5 67 Q. Was it your understanding then, as the Head of Service, 10:44
6 that if there were issues with doctors, then those
7 issues were dealt with by other doctors?

8 A. Yes.

9 68 Q. Was that an expectation that you had for those in 10:45
10 senior management, the medics in senior management in
11 urology, that you would have assumed or hoped that they
12 would deal with the issues arising from other medics?

13 A. I did, yes. Because I would have had a, again, good
14 relationship with all of my CDs and AMDs and Clinical
15 Lead. Any issues that I would have brought to them, 10:45
16 I wouldn't feel that I was cope fit to deal with it.
17 So, yes, I expected that.

18 69 Q. You referred in your witness statement the way you
19 considered that things should be escalated or, in your
20 experience, were, at WIT-39882, paragraph 7.1 where 10:45
21 you've said:

22
23 "I can confirm that I had not previously implemented or
24 applied the MHPS Framework or Trust guidelines in my
25 role but my understanding, and what I confirm I did 10:45
26 during my tenure, was that, if there was a concern with
27 a member of clinical staff highlighted or brought to my
28 attention, I raised with this with either the clinical
29 lead of Urology, which was Michael Young, and/or the

1 Clinical Director, Mr. Brown, and/or the Associate
 2 Medical Director, which is Mr. Mackle from '09 to '16
 3 Dr. McAllister from April '16 to October '16, and
 4 Mr. Haynes from 2017 to 2021, and with your Assistant
 5 Directors Mrs. Trouton from '09 to '16, and Mr. Carroll 10:46
 6 from '16 to '21, and they would have addressed the
 7 concerns or issues raised."

8
 9 was it your expectation that if you brought anything to
 10 them that they would tell you what the resulting 10:46
 11 outcome of that was?

12 A. It was my expectation. Usually, depending on what the
 13 issue was, it would have closed the loop. They would
 14 have come back to me on it.

15 70 Q. Did that happen? 10:46

16 A. On some things, yes. On others, no.

17 71 Q. Could you give us examples of the things that it did
 18 happen and those that it didn't? If you can recall any
 19 at the moment?

20 A. For example, the notes in the bin that you mentioned, 10:47
 21 it was escalated to me by the ward sister. I shared it
 22 with Mrs. Trouton and Mr. Mackle. Then I know it went
 23 to HR, and until the Inquiry started I wasn't aware
 24 that there was actually a disciplinary process with
 25 regard to that, so I didn't get closed in that loop. 10:47
 26

27 with regards to other issues that I maybe have raised,
 28 say, for example -- I'm just thinking the time I would
 29 have raised with regards to un-triaged back in

1 Dr. Rankin and Mr. Mackle's time, Mr. Mackle did come
 2 to me to advise me that he went and spoke to
 3 Mr. O'Brien, he had triaged all the letters. I do
 4 remember that one distinctly because it was the time he
 5 was supposed to be going to a conference in Barcelona 10:48
 6 and then he had done the triage and didn't get because
 7 of the ash cloud. On some occasions, yes, on other
 8 occasions, no.

9 72 Q. Would it be fair to describe that as a bit of an
 10 inconsistent approach? 10:48

11 A. Yes, that would be fair.

12 73 Q. Do you have any explanation as to why there was that
 13 inconsistency? Do you think it was lines of
 14 communication with individuals, personalities, or
 15 people were busy? Is there any basis for that that you 10:48
 16 think the Panel would be informed by hearing?

17 A. One of the things, sort of thinking about things like
 18 this, is I think everybody about, and this process and
 19 all, is the confidentiality of it for the doctors.
 20 With regards to even all the investigation and then the 10:48
 21 monitoring and all, which I know we'll talk about, it
 22 was all to be kept confidential to protect the doctor.
 23 In, for example, the likes of the disciplinary,
 24 probably didn't need to know because that's a HR
 25 confidential issue between HR and the Consultant. 10:49

26 I suppose it depends on the circumstances and nearly
 27 feel there was also the busyness of it as well because
 28 sometimes you would see the AMDs or the CDs maybe
 29 a couple of times in the week and then you mightn't see

1 issues, and we'll discuss that. Do you think if the
 2 same approach had been taken earlier on on some of the
 3 other issues that it might have galvanised people to
 4 take action earlier?

5 A. I suppose the only thing about the IR1s for the notes 10:53
 6 at home -- I'll be honest, they don't seem to have went
 7 anywhere because, obviously, there was the ultimate in
 8 January 2017, the amount of notes that came back from
 9 home. But the triage, yes, I think potentially, if
 10 we had been getting every time there needs to be an 10:53
 11 escalation, it was just via e-mail as opposed to doing
 12 an IR1 about it.

13 83 Q. The reason I ask that question generally is because the
 14 Panel is obviously interested to look at the governance
 15 systems that were in place, why they weren't used, what 10:53
 16 happened when they were, and what might have made
 17 a difference?

18 A. Yes.

19 84 Q. Apart from the IR1 process and the Datix, obviously the
 20 resulting Datix, there doesn't appear to be any other 10:53
 21 formal way in which the issues that ultimately became
 22 subject to MHPS and this Public Inquiry could have been
 23 made known through the governance system. Is that
 24 a fair description, or do you think there are other
 25 ways it could have come through the governance route? 10:54

26 A. There is e-mails in the system where people have raised
 27 concerns. I think if they had have gone through the
 28 IR1 route, that probably would have ultimately led to
 29 maybe more SAIs because, like just to put it in

1 context, one particular day I was looking for an e-mail
 2 for evidence for the Inquiry and I had received 375
 3 e-mails that day. You know, so e-mail wasn't the right
 4 way of doing things. I think ultimately the IR1
 5 process is the best process to raise it. I suppose the 10:54
 6 problem with IR1 is it's quite a complicated system and
 7 I know when you would have spoken to consultants about
 8 raising stuff, they just didn't feel they had the time
 9 to actually sit and put all the information in. If it
 10 was just to put in what had happened, but you have to 10:55
 11 go through a number of pages, so I think the learning
 12 from this is to make the process a wee bit easier.

13 85 Q. Is the process the same now for passing any concerns
 14 along? Is the IR1 system in place at the moment?

15 A. It's still the IR1, although there seems to be more use 10:55
 16 of it now than previously.

17 86 Q. Is it "one form fits all", whether it's a patient fall
 18 or a potentially catastrophic incident?

19 A. Yes.

20 87 Q. Is there a way in which that IR1 is graded so if you 10:55
 21 have 375 e-mails, then that's brought to your attention
 22 at the top of the e-mail that this is a significant IR1
 23 as opposed to perhaps one that requires system change
 24 rather than patient risk?

25 A. It doesn't in the e-mails highlight it. You just read, 10:55
 26 it gives you a synopsis of what the issue is. You
 27 know, you sort of can read it and you automatically --
 28 like, if says a patient fall -- and I'm not
 29 underestimating that as not being serious but maybe

1 "patient fall" or, you know, "bed sore" or something
2 like that, or somebody nips their fingers in the door,
3 whereas if you start to read through and see there's
4 a significant issue, then you go in and it will be
5 categorised by the author of the IR1, whether its 10:56
6 major, minor or catastrophic.

7 88 Q. That sounds like a triaging of IR1, is that right?

8 A. Yes.

9 89 Q. Who deals with that then?

10 A. It is part of the governance of the division led by the 10:56
11 Assistant Director and either the Associate Medical
12 Director or the CD, and somebody from governance. So
13 governance will bring the cases that has come in as
14 major catastrophic to the meeting and then they will
15 read (as in the group) will read through and determine 10:56
16 then if more action is needed.

17 90 Q. In your experience, just before you left post for the
18 Inquiry's information, was it your view that IR1s were
19 effective in both dealing with the issue and responding
20 appropriately in a governance way? 10:57

21 A. They were effective to a certain extent. But I think
22 the fact that there was never any -- again, going back
23 to what we were saying -- any loop closed. So, for
24 example, if an IR1 went via SAI, if I put in an IR1
25 today and it actually went as an SAI, most likely 10:57
26 wouldn't know that unless it was discussed, you know,
27 because it was me put it in. So I don't know the
28 effectiveness of it for the users because they don't
29 know whether they've put in an IR1 whether -- what the

1 ultimate end is of the IR1.

2 91 Q. So no-one goes back to the staff member and says: "The
3 outcome of the IR1 or training has been identified" or
4 "This is the actual result." It goes into the machine
5 and they don't know what happens? Is that a fair 10:58
6 description?

7 A. A fair description, yes.

8 92 Q. Now just back to the MHPS timeframe. In December 2015
9 there was an issue in relation to clinical letters not
10 being dictated and some of the clinicians drew that to 10:58
11 your attention. You spoke to Mrs. Trouton at that
12 time?

13 A. That's correct.

14 93 Q. This was escalated to Mr. Mackle and Mrs Gishkori.
15 That triggers then the January 2016 meeting. Now a lot 10:58
16 of information that I'm going to speak through is just
17 really to jump through the chronology but I do want to
18 stop on some points where you have a particular
19 involvement.
20 10:58

21 There was a meeting on the 11th January, I know you're
22 aware of that meeting, that Mr. Wright had with
23 Mrs. Trouton and Mr. Mackle.

24 A. That's correct.

25 94 Q. Now this seems to be the start of the process that 10:59
26 would lead to MHPS that ended three years later. But
27 Mr. Wright -- did you have much contact with Mr. Wright
28 as Medical Director at that point?

29 A. To be fair to Dr. Wright, we would have -- when he took

1 up post, he was the first Medical Director that
 2 actually approached the Heads of Service to say that
 3 he would like to attend the speciality meetings so to
 4 get introduced to the consultants. So I knew him from
 5 his taking up post because I had facilitated him 10:59
 6 attending a urology and an ENT consultant meeting. But
 7 day-to-day dealings or escalations of any issues like
 8 that, no, I wouldn't have worked closely with him at
 9 all.

10 95 Q. Now you weren't at that meeting. Was the contents of 10:59
 11 the meeting or discussions or outcomes discussed with
 12 you afterwards?

13 A. They were, yes. It was a discussion where both
 14 Mr. Mackle and Mrs. Trouton came to me to say they had
 15 had the meeting, I don't recall the actual total 11:00
 16 conversation, but I do know that they requested me to
 17 do a draft letter covering some of the facts and the
 18 figures around four areas, four areas un-triaged,
 19 review backlog, charts at home and -- I'm taking
 20 a blank -- oh, un-dictated letters. 11:00

21 96 Q. Now, that letter was provided to the Inquiry yesterday?

22 A. Yes.

23 97 Q. I know that after consultation, you went and sought
 24 that letter and we received a copy yesterday. We have
 25 managed to Bates number it and it can be found at 11:00
 26 TRU-164660 to 164663, for the Panel's note.

27
 28 The first page, we can move past that. That's a letter
 29 from Ms. Frizell, Solicitor, yesterday sending this to

1 us. The next page should be your e-mail with, your
2 cover to the draft letter, 164661, on the next page.
3 So that's an e-mail that you have sent on the 18th
4 January 2016 to Mrs. Trouton and Mr. Mackle:

5 "Dear both, 11:01

6
7 Apologies for not getting this to you sooner but
8 I wanted to rerun and update the information before
9 including this in the correspondence. I wasn't sure if
10 this was a joint letter but I have put it from a plural 11:01
11 perspective, so this may need changed.

12
13 Hope it is okay and if there is anything else needed,
14 please do not hesitate to give me a shout."

15 11:02

16 And you have attached a draft letter. Now there are no
17 notes of the conversations with yourself and
18 Mrs. Trouton and Mr. Mackle.

19 A. No.

20 98 Q. But the contents of the letter would seem to indicate 11:02
21 that they have given you a steer as to the sort of
22 information not only they want you to cover but the
23 data they would like you to put in the letter?

24 A. Yes.

25 99 Q. I just want to look at some aspects of this. Now the 11:02
26 reason why I want to take you through this is because
27 the letter that was subsequently presented to
28 Mr. O'Brien differs from the contents of this letter.

29 A. That's right, yes.

- 1 100 Q. So this draft, the 18th January 2016, and the ultimate
 2 letter handed on 30th March 2016 have been altered,
 3 just in detail, and I want to identify that. But did
 4 you do another draft of this letter or is this the last
 5 draft that you sent to Mrs. Trouton and Mr. Mackle? 11:02
- 6 A. This is the last draft I sent. I did update the
 7 figures but I didn't do anything with the draft of the
 8 letter. That's this last one.
- 9 101 Q. We'll look at that in a second. I think you updated
 10 the letters on the day of the 30th March, is that 11:03
 11 right?
- 12 A. That's right. Yes.
- 13 102 Q. Okay. So the first part of this, I just wanted to read
 14 some of this out, as I say, because it has just been
 15 received by the Panel. The first paragraph in that, 11:03
 16 you speak to un-triaged outpatient referral letters.
 17 And you have said:
 18
 19 "There are currently 253 un-triaged letters outstanding
 20 from the period of time when you were on call. These 11:03
 21 are dating back to November 2014."
 22
- 23 I just want to ask you about that. Where did you get
 24 those figures from for this letter? Where was the
 25 source of your hard data, as it were, for this 11:03
 26 correspondence.
- 27 A. For the un-triaged letters, I would have got that from
 28 the Referral and Booking Centre, so most likely through
 29 Mrs. Robinson. I would have asked her and she would

1 have provided me with that data.

2 103 Q. I'm just inquiring if it is possible to put the two
3 letters side by side. It would perhaps make this
4 process a bit easier. The letter that was given to
5 Mr. O'Brien is at TRU-274672.

11:04

6
7 I'm trying to find the east way to do this without
8 moving to move back and forward. Perhaps the easiest
9 way at the moment is if I read out the parts
10 that didn't find their way into the final draft, ask
11 you the motivation for including them and then we can
12 ask others why they were removed, is that a fair enough
13 thing to do? If we go back to the original.
14 TRU-164662. Okay, back on track.

11:05

15
16 So we're under the heading: "Un-Triaged Outpatient
17 Referral Letters". I'll read out the bits that have
18 been left out.

11:05

19
20 So the second line:

11:05

21
22 "We have been advised that whilst the booking centre
23 does not book these patients on to clinics as their
24 date comes up..."

11:06

25
26 You had put in your original, which isn't in the
27 ultimate letter:

28
29 "There is a clinical issue for us in that we do not

1 have assurance that these patient letters have been
 2 read so as to give an indication on their priority.
 3 Therefore, the Trust do not know which waiting list
 4 they should actually be on. For example, do they
 5 remain on routine? Should they have been updated to 11:06
 6 "red flag" and "urgent". "

7
 8 Now that information isn't in the original letter. Now
 9 when you put that in, you specifically mentioned about
 10 there being a clinical issue? 11:06

11 A. I suppose when I was drafting the letter, really it was
 12 under the four headings and the actual information, the
 13 data. I just put everything down knowing that when
 14 Mr. Mackle and Mrs. Trouton would get it that they
 15 would consider it. So it's just one of those things of 11:06
 16 putting as much in as I possibly could, whenever I was
 17 drafting it.

18 104 Q. Now the next part of your letter that doesn't find its
 19 way in is the line that begins:

20
 21 "We have been informed that none of the original 253
 22 letters have not been returned from you to the Booking
 23 Centre." 11:07

24
 25 Then the bit that's not in the next letter, the rest of 11:07
 26 that sentence:

27
 28 "The integrated elective access protocol which governs
 29 the turnaround time for triage states that this should

1 be done within 72 hours (although we recognise that
2 this is not always possible, the maximum time to return
3 letters is 1 week). At the moment, the longest
4 un-triaged letter is now 60 weeks."

11:07

6 Now, again, you will appreciate the next line, and it
7 is a matter for the Inquiry and for the other witnesses
8 to explain why they removed this and if it has any
9 significance or any bearing on the element of risk that
10 you seem to have identified in the body of your text.

11:08

11 The next part is the next paragraph:

13 "You will appreciate.."

15 And almost all of this I think didn't find its way in.

11:08

17 "... the issue for us is that we do not know what is
18 within these un-triaged letters, as you are the only
19 consultant to have seen these, and whilst we have been
20 given assurances that they will be seen within their
21 timescales (therefore not disadvantaged), we are not
22 sure if the priority given by the GP is correct and
23 then from this end the patient is disadvantaged in that
24 their treatment has not been started at an earlier time
25 if that was what had been agreed if the letter had been
26 upgraded."

11:08

11:08

28 Now I wonder if I could just ask you to talk me through
29 that? where did you get that information from in

1 relation to there may be outcome issues for patients?

2 A. I suppose it's just -- it was just my knowledge that,
3 because I have been working with un-triaged letters --
4 like, even pre working in the Southern Trust I would
5 have worked as an outpatient manager so I was familiar 11:09
6 with the whole concept of referral letters and triage.
7 So I would have known that there was a potential amount
8 of patients that maybe needed to be upgraded, and
9 that's basically where I was coming from. Now when
10 I started in 2009, waiting times were nine weeks for an 11:09
11 outpatient appointment. So if the letter wasn't
12 triaged it still would have been seen within nine
13 9 weeks. Potentially, yes, if there's a cancer patient
14 in it, that wouldn't have been good, but there was
15 always a potential of only nine weeks. Before I left, 11:09
16 it was up to four years, I think, the waiting times.
17 So we don't know that somebody in there was graded as
18 a routine would end up as maybe an urgent or a red flag
19 missed if they weren't seen for four years.

20 105 Q. But even in the drafting of this letter, with your 11:10
21 nonmedical background, you realised that that system
22 alone could disadvantage patients?

23 A. Yes. Yes.

24 106 Q. would it be fair to say that that disadvantage, for
25 you, presented a clinical risk? 11:10
26 A. Yes.

27 107 Q. The next part of the letter, it is more the wording,
28 I think. Now the information in boxes was updated for
29 the letter, I think you were asked to update the

1 figures before sending it through.

2 A. Yes.

3 108 Q. Just the second line where you've started the paragraph
4 saying:

5
6 "Aidan, we need assurances that there are no patients
7 contained within this backlog are cancer surveillance
8 patients." 11:10

9
10 Then you say: 11:10

11
12 "We have been advised that you have now a separate
13 oncology waiting list."

14
15 I just wonder if I could ask you about that sentence 11:11
16 was not framed in that way in the ultimate letter. It
17 sounds as if you just found out about a separate
18 oncology waiting list, that may be wrong but certainly
19 reading that at face value, it seems to be the case.
20 Could you explain that? 11:11

21 A. It used to be all the consultants had a general waiting
22 list that everything went on. Now Mr. O'Brien was
23 Chair of the NICaN and part of Peer Review and part of
24 our oncology DT business meetings. It was advised that
25 we would be better to separate out any patients that 11:11
26 were oncology so that they -- because if you think
27 about it chronologically, if you have somebody waiting
28 back to 2013, which I can assure you it wasn't cancer
29 patients, but if you look at that, we have no way of

1 knowing how to pick out a surveillance patient. So
 2 there was a new oncology list. So it was CAOBUO for
 3 Oncology. It meant that when the booking centre were
 4 sending for patients they would probably take -- they
 5 were instructed to take from that list first for 11:12
 6 a review clinic. So yes, and that was a fairly new
 7 thing, and it went across the Board, all the
 8 consultants ended up with an oncology review waiting
 9 list.

10 109 Q. So that was a way in which it was trying to be 11:12
 11 effective and targeted?

12 A. Yes. Yes.

13 110 Q. So it was a beneficial approach, was it?

14 A. It was a beneficial approach, yes.

15 111 Q. You also say in that paragraph, third line from the 11:12
 16 bottom:
 17
 18 "We have no assurances that those patients in the
 19 'older' backlog are not clinically urgent patients."
 20 11:12

21 Then under: "Patient centre letters and recorded
 22 outcomes from clinics", just the last three and a half
 23 lines of that first paragraph:
 24
 25 "The lack of a record means that no decision can be 11:12
 26 made on whether a patient needs to be reviewed,
 27 discharged, et cetera, and when they do come to clinic
 28 they have to be treated as a new patient because there
 29 is no previous information to base decisions on."

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Okay, that's not dictating outcomes. That information wasn't reflected in that way. And then the next paragraph:

11:13

"We have also had it escalated that there are no outcomes recorded from your clinics and as there's no letter dictated, staff are not able to record a decision on the patient."

11:13

Then you have said:

"Example: "

And this wasn't included.

11:13

"Should they be add to a review list, should they be added for urodynamics, flexible cystoscopy, inpatient day procedure or actually discharged back to the GP, I am sure you would agree that this lack of documentation is not fair on the patient nor on the admin staff who are trying to manage this."

11:13

Then patient notes at home issue, the last two sentences weren't reflected in the final draft:

11:13

"We have been advised that you are being requested a few times a week to bring patient notes in from home. These are needed for clinics, patient admissions or

1 filing. This is a big governance risk and needs
 2 addressed and ceased immediately."

3
 4 So in your detail in the letter, you have identified
 5 both clinical risk and governance risk. There's 11:14
 6 probably more of a context detail in your draft. Did
 7 you ever get any direct feedback on that draft or asked
 8 to look at another draft after you sent that through.

9 A. No. The next thing I had heard was on the 16th March,
 10 I think it was, when Heather requested me to update the 11:14
 11 figures and then on the 30th March, the day that we met
 12 with Mr. O'Brien, I got a copy of the final letter,
 13 a hard copy, because it was printed off, and I copied
 14 it for Mr. Mackle and a copy for Mr. O'Brien.

15 112 Q. The 16th March Heather Trouton e-mailed to you -- 11:15
 16 we don't need to go to this, it's just for the Panel's
 17 note -- TRU-277940, and then your e-mail to Mr. Mackle
 18 on 30th March is at TRU-282021. Now in that one,
 19 you didn't copy Mrs. Trouton in, just Mr. Mackle. Was
 20 he the one dealing with the final version? 11:15

21 A. He was, yes, and I think it was because I think both
 22 him and I were going to the meeting, and it's
 23 possibly -- because none of us can remember why it was
 24 me, it was possibly Mrs. Trouton must have been on
 25 annual leave or something because it was coming up to 11:15
 26 the end of financial year. So that's probably why
 27 I didn't copy her in.

28 113 Q. Now Mr. Mackle in his evidence, about the 23rd March
 29 letter, seemed to indicate that you principally drafted

1 read the letter in detail. I do recall Mr. O'Brien
 2 folded up the letter and asked: "what am I going to do
 3 with this?" And I can't recall whether it was myself
 4 or Mr. Mackle but I definitely know that we said we had
 5 four weeks, we needed a response. Now I do know from 11:17
 6 reading -- from information in preparation for this
 7 that there was a -- Mr. Mackle is supposed to have
 8 shrugged his shoulders and rolled his eyes. I honestly
 9 can't say if that happened or not, but I could have
 10 just been looking at Mr. O'Brien at the time. And 11:17
 11 I did offer Mr. O'Brien, as I would have always done,
 12 if you need any help give me a -- my phrase is, as you
 13 can see from e-mails, "give me a shout".

14 121 Q. Just to deal with the shrug issue, that's a contention
 15 of Mr. O'Brien's where, when he was asked about what's 11:18
 16 expected, he was met with shrug of the shoulder and he
 17 says that at AOB-1367. That's not your recollection?

18 A. No.

19 122 Q. So going back to your recollection, that's the first
 20 time that it had been written in a formal way, the 11:18
 21 letter to Mr. O'Brien, about issues that had sought to
 22 be addressed, at least informally by you over the
 23 years?

24 A. That I'm of aware, yes.

25 123 Q. Now the Panel have seen the letter. I don't need to go 11:18
 26 to it but I don't think it is contentious to say that
 27 there's no mention of a plan or timeframes or specific
 28 actions that were expected from Mr. O'Brien?

29 A. That's correct.

- 1 124 Q. Was your understanding of that letter that he was to
 2 triage, to get on top of his review backlog, to dictate
 3 the letters and not store notes at home?
- 4 A. I suppose my view was, yes, that we would get
 5 a response back to say that he had done his triage, 11:18
 6 maybe tell us how he was going to address the review
 7 backlog and to let us know that he had returned the
 8 charts. I assumed we would get a response back.
- 9 125 Q. At that stage, were you aware that you would have any
 10 subsequent oversight of Mr. O'Brien's actions after 11:19
 11 this point at all?
- 12 A. I wasn't. I didn't think -- wrongly, I didn't follow
 13 up on it because I think it was -- in my head it was
 14 the Assistant Director and Associate Medical Director
 15 who were leading on it. My role was originally just to 11:19
 16 provide the information, the data, and then ultimately
 17 it just happened to be that I attended the meeting with
 18 Mr. Mackle because of previous encounters, Mr. Mackle
 19 couldn't attend a meeting on his own. So with Heather
 20 not being available, it's obviously the reason why 11:19
 21 I was there. So it was being led by the AD and the MD
 22 so I, wrongly, didn't follow up on it.
- 23 126 Q. Was there any reason why Mrs. Trouton didn't go to the
 24 meeting instead of you?
- 25 A. I really can't recall why that happened. 11:19
- 26 127 Q. Did you know well in advance you had to go to the
 27 meeting or was it something that you were informed of
 28 just before?
- 29 A. I think I was just informed relatively before it,

1 whether it was that day or the day before, that I had
 2 to attend.

3 128 Q. You've said about previous encounters with Mr. Mackle.
 4 Could you just give us some context to that, why he
 5 couldn't be alone, as you say, with Mr. O'Brien? 11:20

6 A. Yes. I'm not aware of the time scales but I think from
 7 reflection, it was sort of later on in the evening of
 8 a working day, Mr. Mackle, after theatre or clinical,
 9 would have popped up on to the admin floor. Again,
 10 that's in context of sort of he would walk right round 11:20
 11 from the Director's office right rounds to ourselves.
 12 I was in the office on my own, which is why I think it
 13 must have been later evening. Mr. Mackle came in,
 14 closed the door and put his back against the door and
 15 looked visibly shocked and actually looked very unwell 11:20
 16 and said to me: "I've just been accused of bullying.
 17 I've just been pulled into an office and been accused
 18 of bullying." He didn't tell me which office it was so
 19 I know, listening to Mr. Mackle's evidence, he did
 20 contact me when the inquiry was announced and said to 11:21
 21 me did I remember who it was. I really don't. I said
 22 to him at the time it had to be either Dr. Rankin's
 23 office, which was the first one, or Helen Walker who
 24 was the AD for HR, before he would have come round to
 25 me. He just said: "It has come from down the hill", 11:21
 26 which is what we would call Trust Headquarters and
 27 I was more concerned that evening for his actual
 28 health. I was trying to get him to sit down and take
 29 a glass of water because he was very distressed, and he

1 definitely said: "I've been accused of bullying by
 2 Mr. O'Brien."

3 129 Q. Just in relation to time frames, we're on to 2016. Do
 4 you have any idea when that conversation directly with
 5 Mr. Mackle occurred? 11:21

6 A. I think it was in and around 2011/12. I can't be more
 7 precise than that. I know at the time Mr. Mackle's
 8 late wife was quite unwell. So I do know it was in and
 9 around that time, but I can't be more precise.

10 130 Q. So just in summary form, he spoke to you directly about 11:22
 11 an allegation of bullying. His reference to "down the
 12 hill" you took to mean headquarters?

13 A. Headquarters, Yes, Trust headquarters. Yes.

14 131 Q. You think it was possibly either Gillian Rankin or
 15 Helen Walker who brought the allegation to his 11:22
 16 attention?

17 A. Yes.

18 132 Q. Now the Panel have heard from Helen Walker that she has
 19 no recollection of that but Dr. Rankin will be giving
 20 evidence so that can be brought up with her. So that's 11:22
 21 the context you were saying earlier in your evidence
 22 that Mr. Mackle didn't attend meetings alone with
 23 Mr. O'Brien?

24 A. Yes. And I suppose after that meeting with me there
 25 was a decision, which was shared with us all, that 11:22
 26 Mr. Mackle would take a step back from managing
 27 Mr. O'Brien and that it would be Mr. Brown who was the
 28 Clinical Director of General Surgery in Daisy Hill
 29 would have direct responsibility then in any meetings

- 1 he would take forward.
- 2 133 Q. Just having brought up that issue with Mr. Mackle, that
 3 allegation that was made, did that become more widely
 4 known among staff?
- 5 A. I'm sure it did, yes. It would have sort of ruminated 11:23
 6 through the -- a bit like what Dr. McAllister said,
 7 they all talked in theatre to each other so I'm sure
 8 that it did, yes.
- 9 134 Q. Did you perceive that as having, or did it have any
 10 actual impact on how people dealt with Mr. O'Brien? 11:23
- 11 A. I think it did. I think it did, because people knew,
 12 as was described by Mr. Mackle, when you sort of try to
 13 hit it head-on that something -- an allegation is made
 14 that just makes you run scared.
- 15 135 Q. I see the time but I wonder if I could just be indulged 11:24
 16 to just finish off just another couple of sections on
 17 this? Now there's nothing in the letter that said it
 18 had to be responded to within four weeks but that's the
 19 evidence being given to the Inquiry. Did you or anyone
 20 else follow up after this meeting with Mr. O'Brien 11:24
 21 about plans that he had to try to address some of those
 22 issues?
- 23 A. Not directly with Mr. O'Brien, no. Not me, and
 24 I assume just looking at everybody else's evidence over
 25 this last few days, nobody else did either. 11:24
- 26 136 Q. Would it be usual to ask -- to draw to a Consultant's
 27 attention concerns around issues of governance and
 28 clinical risk and not provide him with some kind of
 29 framework of support to address those concerns?

1 A. I would say yes. I know I offered support, as I always
 2 did, but it wasn't formal support.

3 137 Q. When you say it wasn't formal support, what's the
 4 difference between the support you've offered in
 5 previous years to the support that you might have
 6 offered at this time? 11:25

7 A. I suppose always my support was sort of informal, you
 8 know, but Mr. O'Brien never took up any offers in all
 9 the years. He still maybe -- I would say to him, you
 10 know, will we spread the likes of the triage maybe out 11:25
 11 with others or -- he would always still want to do it.
 12 Now I do know Mr. Young did help out on two occasions
 13 but, you know, Mr. O'Brien had a way of working that
 14 was probably inefficient. So it was his way or no way,
 15 sort of thing. So it was probably very hard to offer 11:25
 16 support. But, you know, if we would have been able to
 17 sit down, there might have been things like the review
 18 backlog, we maybe could had the nurses do a validation
 19 on it, for example, the CNSs, clinician nurse
 20 specialists. 11:26

21 138 Q. Just at this key point in April 2016 there were staff
 22 changes?

23 A. That's correct.

24 139 Q. Now those staff changes were as a result of a decision
 25 by Mrs. Gishkori, is that right? 11:26

26 A. That's correct. Yes.

27 140 Q. Would staff changes have been unusual in your
 28 experience or was it something that was routinely done
 29 by directors?

1 A. Well, I had worked from 2009-2016 without any change.
 2 I know Mr. Gibson, but that had been done before --
 3 Mr. Gibson and Mrs. Trouton, but that had literally
 4 been done before I had taken up post. But, no. And
 5 from '16 to 2021, I still had the same AD. So it 11:26
 6 wasn't normally...

7 141 Q. So at this point the two individuals who were tasked by
 8 Dr. Wright in dealing with this issue, Eamon Mackle and
 9 Heather Trouton, both changed roles?

10 A. Well, Heather changed roles but Eamon resigned from his 11:26
 11 role as AMD in April. So that was his choice.

12 142 Q. Yes, but they were replaced by other people?

13 A. Yes, they were.

14 143 Q. Who had no history with this issue?

15 A. No, that's correct. 11:27

16 144 Q. And the Inquiry has heard evidence from Mr. Weir and
 17 Mr. McAllister in relation to that. Were you aware of
 18 the staff changes at that point?

19 A. We knew they were happening and I actually didn't know
 20 sort of the reason for it until, actually, yesterday 11:27
 21 Mr. Gibson's -- when he was giving his evidence,
 22 actually, had given the reason why the changes -- why
 23 Mrs. Gishkori wanted the changes and that she wanted
 24 clinical people in the operational AD roles.

25 145 Q. Would that have been a significant issue ongoing that 11:27
 26 a consultant had been given a formal letter? Would
 27 that have been something that was pretty significant
 28 within the unit at that time from a management
 29 position?

- 1 A. It would have been, because it hadn't happened
2 previously.
- 3 146 Q. Are you aware if there was any hand-over in relation to
4 that for the people coming into the roles of Mr. Mackle
5 and Mrs. Trouton? 11:28
- 6 A. I'm not aware of if there was a hand-over. I did
7 myself, because I was concerned that we didn't have
8 a Clinical Director and Associate Medical Director.
9 Towards the end of April, I updated Mr. Carroll on --
10 there was a three areas I had to update him on 11:28
11 clinically-wise.
- 12 147 Q. And in your statement at WIT-39890, you have accepted
13 that the change in personnel meant that the letter of
14 2016 was not followed up as it should have been. Do
15 you think that the change in staff was the only reason 11:28
16 that it wasn't followed up or was there a general
17 reluctance to follow it up?
- 18 A. I think the change of personnel was probably the
19 most -- it was the biggest thing with regard to that
20 because this was the first time since I had started in 11:29
21 2009 that anybody had actually, you know, addressed it
22 in writing and seemed prepared to take it on. Then
23 I don't know then about the subsequent post holders,
24 whether there was a reluctance there or not.
- 25 148 Q. The Panel will be aware while you e-mailed Mr. Carroll, 11:29
26 nothing really was done until August 2016?
- 27 A. Yes.
- 28 149 Q. -- in relation to this issue. Because I'm going to
29 move on to that and a new topic, I wonder if that would

1 be an appropriate time to take a break?

2 CHAIR: we'll take a break now and come back at quarter
3 to 12.

4

5 THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 11:40

6

7 CHAIR: Ms. McMahon.

8 150 Q. MS. McMAHON BL: Just before we move on to the rest of
9 the timetable, I know we spoke about Mr. Mackle telling
10 you that it had been alleged about bullying, obviously, 11:48
11 that's an allegation that Mr. O'Brien denies completely
12 and he can deal with that in his evidence. The other
13 issue we touched upon with the SAIs, and you mentioned
14 about harm coming to patients, obviously that's
15 a matter for other witnesses to deal with, so the 11:48
16 particular phraseology used wouldn't be accepted by
17 Mr. O'Brien in relation to harm but, as I say, you
18 weren't involved in that. So I'm just putting that on
19 record.

20 A. Okay. 11:48

21 151 Q. Now when we talked about Mr. O'Brien had been asked to
22 respond within four weeks, although it's not in the
23 letter --

24 A. That's correct.

25 152 Q. -- there is an e-mail to that effect, and again, it's 11:48
26 just for the Panel's note, 28th April 2016, an e-mail
27 from you to Ronan Carroll at TRU-274671. This is where
28 you inform him of the letter that was given to
29 Mr. O'Brien and you mention that he had been asked to

1 respond within four weeks but nothing had been
 2 received. So just to tie that point up, that's
 3 a record of the four-week turnaround being recorded at
 4 that point.

5 A. That's correct, yes. 11:49

6 153 Q. Now there were steps and stairs along the way later
 7 through 2016 and you weren't necessarily involved in
 8 a lot of discussions that were ongoing. I don't want
 9 to take you to all of the ones that you were involved
 10 in because I want to get to the Return to Work Plan and 11:49
 11 your involvement in that?

12 A. Okay.

13 154 Q. But I just want to point out a couple of e-mails and
 14 I'll give references for the Panel and for core
 15 participants to note where your level of involvement 11:49
 16 sat.

17

18 There was an e-mail from you on 15th June, it was
 19 discussed I think with previous witnesses, to Colin
 20 Weir, where you have updated -- you have provided the 11:50
 21 letter of March 16th and just said "as discussed"?

22 A. Yes.

23 155 Q. I presume that was on the back of --

24 A. Yes, it was on the back of -- I do know I updated
 25 Dr. McAllister and then he's obviously updated Colin. 11:50
 26 I don't recall the conversation but as you say, I said
 27 "as discussed", so he must have asked me for it.

28 156 Q. And were those conversations, could they be described
 29 as a hand-over of the issues that were currently being

1 aired in relation to Mr. O'Brien?

2 A. They could be, yes.

3 157 Q. Again, on 9th August 2016, and the Panel will find this
4 at TRU-274723, Mr. Wright sought an update from you.

5 I'll just quote from that:

11:50

6

7 "Did we ever make progress with regard to the issues
8 raised re urology which Eamon had been dealing with?"

9

10 This is just in advance of him asking Mr. Gibson to
11 undertake his scoping exercise. Is that the first that
12 you had been directly asked about an update since the
13 meeting with Mr. O'Brien?

11:51

14 A. Yes, that's the first.

15 158 Q. You had never thought to follow up from that meeting?

11:51

16 A. I suppose in my head because there was sort of informal
17 conversations with Dr. McAllister and Mr. Weir that it
18 was being followed up but I personally didn't follow
19 up, and that is a regret that I probably didn't sort of
20 bring it to their attention more, that we needed
21 a response from it.

11:51

22 159 Q. Well, just to be balanced on that in relation to the
23 evidence you provided, it had been dealt with by Eamon
24 Mackle and Mrs. Trouton?

25 A. Yes.

11:51

26 160 Q. You discussed earlier in your evidence that the
27 hierarchy of the medics, dealing with medics, was
28 something that was custom and practice, if I can put it
29 that way, within the unit, and so the people who

- 1 replaced those posts, Mr. McAllister, Mr. Weir, was it
 2 your expectation they had taken up the mantle in this
 3 regard?
- 4 A. Yes. Yes.
- 5 161 Q. So you provided a letter to Mr. Wright that you had 11:52
 6 given to Mr. O'Brien on the 30th. There then is
 7 a period of time when Mr. Gibson is carrying out his
 8 work. There's an oversight meeting then on 13th
 9 September. Now did you have any knowledge of the
 10 oversight meetings? 11:52
- 11 A. No, I had no knowledge of any of them until the
 12 December 1st.
- 13 162 Q. And you didn't know that they were being planned or
 14 that they had happened?
- 15 A. No. 11:52
- 16 163 Q. Did anyone approach you in advance of the meetings to
 17 just get a further update on figures or facts or
 18 anything about practice?
- 19 A. Well, Simon, Mr. Gibson had actually asked for -- when
 20 he met with me with regard to figures -- but it was 11:52
 21 never in the context that there was an oversight
 22 meeting. I assumed it was just from follow-up of
 23 Mr. Wright's e-mail.
- 24 164 Q. But Mr. Gibson had informed you that he had been tasked
 25 with undertaking the work by Mr. Wright in order to get 11:53
 26 what could be described as a global view of the
 27 situation as it was at that moment in time?
- 28 A. Yes.
- 29 165 Q. And did you give him any information to inform his

1 report or did he just let you know he was doing it?

2 A. I would have given him some information. Yes, probably

3 give him an update on the situation with regard to the

4 triage, the review backlog and I couldn't do the

5 un-dictated on the chart at home and he did ask 11:53

6 a specific question from Ms. Lawson with regards to

7 records, did we know how many charts were at home.

8 I didn't see any responses to that and I didn't respond

9 because it wouldn't be my area of expertise to know

10 that information. 11:53

11 166 Q. Now when you come back to given evidence, we'll go into

12 some detail about the systems that were in place to

13 give you data and how reliable that data may have been

14 and how you relied on it operationally outside of these

15 issues. But just you've mentioned there, and I think 11:54

16 you're probably in a unique position that you can reach

17 out to different parts of The Trust?

18 A. Yes.

19 167 Q. Like Katherine --

20 A. Katherine Robinson. 11:54

21 168 Q. Katherine Robinson, I'd just forgotten her surname,

22 apologies?

23 A. Yes.

24 169 Q. Asked them for information that was fed in to you

25 obviously to inform you? 11:54

26 A. Yes.

27 170 Q. But you touched upon the un-dictated clinics issue and

28 I just wanted to ask you briefly about that. From

29 reading your Section 21 and others, was that

1 a particularly difficult issue to get proper
 2 information on because is it fair to say you don't know
 3 what you don't know. If a clinic hasn't been dictated,
 4 how do you find that out?

5 A. I suppose its easier now with digital dictation, but 11:54
 6 before it used to be the hand-held Dictaphones. So the
 7 only person who would probably know if a tape hadn't
 8 arrived back with the charts is the secretary.

9 I suppose there would have been -- it was never
 10 escalated. And the other thing would have been that 11:55
 11 the charts needed to come back so the secretary would
 12 know there had been no dictation. So it would be very
 13 difficult to know.

14 171 Q. So you were dependant on an individual then to alert to
 15 the absence of information. 11:55

16 A. Yes.

17 172 Q. And you say that's different now with digital
 18 dictation. Does that mean that there's a system that
 19 flags up the absence of dictation rather than an
 20 individual or is there still individual involvement? 11:55

21 A. There's still individual involvement. I know they are
 22 looking at a system to try and -- that when there's
 23 a clinical and a patient arrive at the clinician that
 24 it automatically flags up there needs to be a letter,
 25 but they're looking at the technology of that. The 11:56
 26 health service system are all full of fire walls so
 27 I think it's just trying to get -- and I am not at all
 28 and I will never claim to be technically knowledgeable,
 29 but I have been advised that it will. But at the

1 moment the answer to your question is it still depends
 2 on individuals.

3 173 Q. Is it still -- well, if I can frame the question this
 4 way. In your experience, do you see that dynamic or
 5 that particular system to be as vulnerable now as it 11:56
 6 was then?

7 A. Not as vulnerable because there is a lot of audits goes
 8 on from -- it's a different division, but they will
 9 ensure that everybody who has been to a clinic gets
 10 a letter. The downfall, and I'm sure we'll get to 11:56
 11 this, for me, was that there's 10 patients in the
 12 clinic and when I asked the question about the
 13 dictation, they told me there was 10 letters on the
 14 system. But I did spot checks but towards whenever
 15 there was a big deviation, when I went in and 11:57
 16 discovered there was 10 letters, the 10 letters weren't
 17 for the 10 patients. It might be one had three letters
 18 and one had none. So there is still that vulnerability
 19 in the system. And I really -- I know you're hoping to
 20 address this, I don't know if anything more has moved 11:57
 21 on because obviously I haven't been in that post
 22 since June '21.

23 174 Q. We can explore that, the Panel can explore that with
 24 other witnesses.

25 11:57
 26 The other issue about the notes at home, is that
 27 another particular issue that requires on reporting
 28 from individuals? Notes not being where they should be
 29 rather than just being at home with an individual.

- 1 A. Yes, the system that we have, the patient
 2 administrative system is very, very dependent on human
 3 input in the sense of that -- so I have a chart but you
 4 come up and lift that chart out of my office. If you
 5 don't case note track that chart, it is still, 11:58
 6 accordingly, to me, in my possession. Whilst charts
 7 may have been case note tracked out to
 8 Mr. O'Brien's office, they might not necessarily --
 9 well, as we know, weren't actually in his office, but
 10 people -- and it was a lot in the system and it's only 11:58
 11 now we're discovering how much, but basically if they
 12 couldn't find a chart that was case note tracked out of
 13 the office, they would go looking for it in the
 14 different areas; the ward, outpatients, the secretary's
 15 office, and then if it wasn't, we would contact 11:58
 16 Mr. O'Brien and he would bring it but we didn't know
 17 the extent of how many charts were at home.
- 18 175 Q. Is that system still flawed in that way?
- 19 A. It is, yes. There's a business case has been done up
 20 for a system called I-Fit that basically barcodes and 11:58
 21 tracks the chart wherever they move around the
 22 hospital, but that hasn't been implemented yet.
 23 I can't comment on why or whatever, but I do know that
 24 they are hoping to move to paperless within Compass
 25 say, which is quite imminent. 11:59
- 26 176 Q. Thank you for that slight deviation, but it will
 27 explain some of the e-mails you subsequently sent
 28 during your monitoring of Mr. O'Brien's return to work.
 29

1 You said you were aware of the 22nd December 2016
 2 Oversight Meeting?
 3 A. That's correct.
 4 177 Q. Were you informed in advance of that, that it was
 5 taking place? 11:59
 6 A. No. No. It was after the meeting that I knew about
 7 it.
 8 178 Q. Who they you about it afterwards?
 9 A. It would have been Mr. Carroll, the system director.
 10 179 Q. What was the context in which he discussed that with 11:59
 11 you?
 12 A. Because there had been a letter received in from the
 13 Chair of the Patient 10 SAI which raised issues with
 14 regards to non-triage. I am aware now that the 22nd
 15 December meeting was called and there were a number of 12:00
 16 issues raised. Mr. Carroll approached me and
 17 Mrs. Clayton to help gather some of that information
 18 up.
 19 180 Q. That was the period between 22nd December and the end
 20 of January? 12:00
 21 A. That's correct, yes.
 22 181 Q. You were involved with Mr. Carroll in another scoping
 23 exercise, really, to --
 24 A. Yes.
 25 182 Q. Was that to try to fine tune the figures that you 12:00
 26 wanted to rely on, or?
 27 A. Yes, to fine tune the un-triaged letters was really
 28 sort of towards the end of December up until 30th
 29 December. January was more to do with the fact that

1 the notes had been returned and there was 307 case
 2 notes from home, and the fact that there were 783
 3 letters in the drawer, and I think 66 clinics not
 4 dictated. It was quite a substantial piece of work had
 5 to be done after the December. 12:00

6 183 Q. All of this work eventually became the preparation for
 7 the subsequent MHPS investigation and provided the hard
 8 data for that. What's your view as to whether more
 9 could have been done in preparation for that
 10 investigation or for the areas that were actually 12:01
 11 explored? Do you think that, number one, enough was
 12 done to look at what was currently current issues and,
 13 number two, do you think it should have gone a little
 14 bit wider than what was already known?

15 A. My personal issue, it should have went a lot further 12:01
 16 because as we know now from 2020, at the time I thought
 17 it was quite targeted, small areas looked at. I do
 18 believe that outpatient, for example, outpatient
 19 dictation should have went to include, ultimately the
 20 day case discharges and also the MDT. Dictation wasn't 12:02
 21 only for outpatients only.

22
 23 I do believe that -- and I can understand why they
 24 needed Mr. O'Brien -- wanted to come back to work but
 25 I think the investigation should have went on a wee bit 12:02
 26 further, a bit more as, to coin a phrase, deep dive,
 27 because if it had been anybody else, in the sense of
 28 a nurse or an admin person, potentially wouldn't have
 29 been allowed back until the investigation was

1 completed. But that's my personal view.

2 184 Q. It's your opinion. What's the basis for that? Why do
 3 you think that's the case, that it was, as you have
 4 suggested, was treated differently?

5 A. Like on reflection I think, and it is no criticism of 12:02
 6 the people that's at the Oversight Meeting, but I think
 7 it should have been expanded to be nearly -- and I know
 8 the directors is operational, but at the end of the day
 9 a director has quite a wide remit. For example, the
 10 likes of the systems and processes, whilst I am in, 12:03
 11 probably, a wee bit of more unique position in that all
 12 of my experience has been admin and systems, like the
 13 patient administrative system, and case note tracking
 14 and my background, outpatients, things like that, most
 15 other people wouldn't have the wider view of it. 12:03
 16 I think more experts or people of specialism in the
 17 admin systems should have been brought in and asked,
 18 'is this workable?'

19 185 Q. We'll talk in a minute about the monitoring and where
 20 you say the deficiencies are in that. In this period 12:03
 21 early January 2017 Mr. O'Brien returned patient notes
 22 from home as a result of a request from you. Was that
 23 as a direct result of you being asked to do that or was
 24 that just part of you identifying that the notes were
 25 missing? 12:04

26 A. That actually came from Dr. Wright. Dr. Wright
 27 requested that he brought all the notes in and left
 28 them with me. Mr. O'Brien did contact me and said that
 29 they would be leaving them in his office, which is on

1 the second floor, and he had said that he would be
 2 doing it over the weekend of the New Year bank holiday.
 3 I arrived in on the Tuesday, I think it was the Monday
 4 was the bank holiday, and I went to his office and
 5 retrieved the notes from there. 12:04

6 186 Q. This is at TRU-257707 for the Panel's note. There were
 7 307 sets of note returned?

8 A. That's correct.

9 187 Q. Including 94 Trust patients who had been seen privately
 10 by Mr. O'Brien. Is that just you collecting the notes 12:04
 11 rather than -- in total numbers, rather than breaking
 12 down whether he should have returned them all, or was
 13 he able to hang on to some because they were private
 14 patients?

15 A. No. These were actually -- what it was, Mr. O'Brien -- 12:05
 16 and it was only at that stage in 2017 that I realised
 17 that this was happening. He was going to see me as
 18 a private patient, for example, on the Saturday, he
 19 actually brought my hospital notes home and wrote in
 20 the hospital notes of the private consultation. 12:05
 21 I suppose he needed -- I don't know, Mr. O'Brien will
 22 have to be asked. I am assuming he needed the hospital
 23 notes to find more information, I don't know. They
 24 were NHS notes but for a private patient consultation.

25 188 Q. There was a process undertaken in relation to 12:05
 26 un-dictated clinics --

27 A. Yes.

28 189 Q. -- that involved the other consultants becoming
 29 involved in looking at that?

1 A. That's correct.

2 190 Q. That was a process that was not completed. It started
 3 in January but not completed until June 2017. That was
 4 due to the number of patients involved. Was that
 5 something that was passed on to other consultants on 12:06
 6 top of their own workload to look at, or what way was
 7 that organised?

8 A. Dr. Wright agreed that they would get a waiting list
 9 initiative payment to do them outside of working hours.
 10 Obviously we couldn't displace clinical activity 12:06
 11 because Urology, as we know, their demand capacity is
 12 through the roof. But that was outside of hours, so
 13 evenings, weekends.

14 191 Q. Although that wasn't completed until June 2017,
 15 Mr. O'Brien came back to work in the February. 12:06

16 A. That's correct.

17 192 Q. In your witness statement, for the Panel's note at
 18 WIT-26315, you expressed a view that you don't think
 19 that Mr. O'Brien should have been allowed back to work
 20 so soon and you called that a mistake. Can you give 12:06
 21 a bit of context to why you have that view?

22 A. It's just back to what I had said previously. This is
 23 in hindsight, I didn't say this at the time, but it is
 24 a reflection when I was doing my Section 21, I think
 25 the investigation should have been a wee bit further. 12:07
 26 At that stage it hadn't even really started. I think
 27 there needed to be more of a -- you know, to extend it
 28 to talk to the likes of the people I'm saying there to
 29 say what other areas do we need to look at. It was

1 a decision made inside a confined group of people
 2 without actually expanding it out. It's a bit like
 3 everything -- just back to what I said there, you
 4 know -- any of the rest that go through disciplinary,
 5 they would be properly investigated before allowed back 12:07
 6 to work.

7 193 Q. When you say it was a confined group, who do you think
 8 made the decision to allow Mr. O'Brien in?

9 A. I think from reading, ultimately it was the Case
 10 Manager, Dr. Khan. 12:07

11 194 Q. Did anyone ask your views about the appropriateness of
 12 Mr. O'Brien coming back to work, or was that something
 13 you wouldn't have expected to be done?

14 A. No, I wouldn't expect it. I think it was, albeit
 15 a senior manager was too junior to make a comment. 12:08

16 195 Q. You said in your statement at that point that
 17 Mr. O'Brien's return to work was not accompanied by
 18 a proper plan to manage him. Did you have sight of his
 19 Return to Work Plan at that point?

20 A. The plan was shared with me by Mr. Carroll and 12:08
 21 Mrs. Gishkori because it had come out from one of the
 22 Oversight Meetings. It was the four areas that
 23 Mr. O'Brien was to be monitored on as part of his
 24 return to work.

25 196 Q. When you say that it wasn't a proper plan, I suppose 12:08
 26 what I'm asking is did you look at the plan and say,
 27 'that's not a proper plan', or did you form that
 28 opinion because you were left to try and help implement
 29 it?

1 anyone's attention, to say, 'well, we may ostensibly be
 2 covering this potential lacuna, but the work I have
 3 done or the work that's been undertaken shows
 4 a vulnerability for emergency and day case patients'?

5 A. To be honest, I didn't actually look at the ins and the 12:10
 6 days at that stage. I was concentrating in the midst
 7 of a very operationally challenged busy job and trying
 8 to make sure that the four areas that I had been tasked
 9 with, that I monitored them. In hindsight, yes,
 10 I should have thought of that, but I didn't. 12:11

11 202 Q. Might it have been something that the medics involved
 12 in both the work to prepare for the Return to Work Plan
 13 and looking at the work that had completed in
 14 June 2017, might it have been something that they
 15 noticed and could have adapted the plan to reflect? 12:11

16 A. Yes. I think because the people that would have been
 17 seeing -- as in medics -- would have been seeing
 18 patients without that information on them, if they had
 19 escalated then we would have known, but nobody every
 20 said there was -- at that stage, in between the '17 12:11
 21 and, sort of, '19, that there's letters missing. An
 22 in-patient discharge wouldn't be so bad because
 23 obviously there is electronic discharge from the ward
 24 so the juniors would have done that, it would be signed
 25 off. It was more to do with the day cases. They 12:12
 26 weren't dictated on, but nobody every said they were
 27 missing. It's one of those things, unless you're told,
 28 you don't really --

29 203 Q. Does it go back to your point that this was an

1 opportunity at this point to perhaps delve a little bit
 2 more deeply into what was happening as regards
 3 Mr. O'Brien's practice and also procedures in place?
 4 Do you see that as a missed opportunity now?

5 A. I do, yes. 12:12

6 204 Q. For the Panel's note the Return to Work Plan can be
 7 found at TRU-00732. It was given to Mr. O'Brien at his
 8 Return to Work meeting on 9th February with Dr. Khan.
 9 How did you end up in the role of monitoring that plan?
 10 Can you just explain the process or who spoke to you 12:12
 11 about it?

12 A. It would have come from Mr. Carroll to say it has come
 13 from the Oversight Meeting that it needed to be
 14 monitored. I suppose I was the best placed to do it
 15 because I knew the systems and processes and I worked 12:13
 16 in Urology so I just done it.

17 205 Q. When you say you were the best placed to do that, do
 18 you think that was based on a belief at the time that
 19 this was an administrative problem?

20 A. Yes. 12:13

21 206 Q. Was that something that you were happy to accept given
 22 your clear identification of clinical risk issues in
 23 your draft letter the previous year?

24 A. I suppose I accepted it, but I had the knowledge that 12:13
 25 if there was going to be any issues it would be
 26 escalated to medical, as in the CD and the Case
 27 Manager, who was also Clinical. But for a medic to
 28 actually do the work that I ended up doing for the
 29 monitoring, it was probably suited to an admin person

1 but with the knowledge that it could be escalated --
 2 which I did -- to the medical.

3 207 Q. The Inquiry has heard evidence from Colin Weir and
 4 Charles McAllister, and the tenure of both of their
 5 approaches to dealing with Mr. O'Brien, if I could 12:14
 6 summarise as saying, they both were reluctant to do
 7 that alone. Also they indicated that they felt more
 8 comfortable if they had back-up, that there was
 9 somebody else involved in the process of overseeing
 10 with them. Did you have that sense that you needed 12:14
 11 that comfort?

12 A. Comfort from? Sorry? The?

13 208 Q. Somebody else helping you monitor, oversee
 14 Mr. O'Brien's practice?

15 A. I think one of the faults with all of this is that for 12:14
 16 Oversight and MHPS, it's a very confined group of
 17 people. It was discreet. You were told it had to be
 18 discreet, confidential, it was very sensitive. It
 19 couldn't be spoke outside of the people, nearly on
 20 a need-to-know basis. My comfort was I was able to 12:15
 21 escalate any concerns to Mr. Carroll, my AD, and then
 22 my CD. I never would have went direct to Mr. Khan
 23 because I wouldn't have seen that in the chain, but
 24 would have expected Mr. Weir to pass it on to Dr. Khan.
 25 In hindsight, there was a vulnerability there in the 12:15
 26 sense of -- for me -- because it was nearly on
 27 a need-to-know basis and so few of us actually knew.

28 209 Q. Did you feel any discomfort at the time about having to
 29 take this role on alone?

1 A. The stuff I could do from afar I had no issue with.
 2 For example, the electronic triage I was able to do
 3 that from my desk. It didn't matter whether I was in
 4 the office or at home. The dictation, I got that
 5 information from the -- basically Katherine Robinson's 12:16
 6 team, her service administrators, and that was fine.
 7 Private patients was fine as well because I did that
 8 monitoring again from my desk. The one that gave me
 9 the most discomfort was the case note tracking or the
 10 case notes in the office, because that was a physical 12:16
 11 thing that I had to do that I felt I was sort of --
 12 kind of nearly sneaky doing it because I used to have
 13 to go up to Mr. O'Brien's office and it was -- him and
 14 I would always have said we're at the opposite ends.
 15 I was a morning person and he was a night person. 12:16
 16 I always would know when I would be in the office at 6,
 17 half 6 in the morning the likelihood that he wouldn't
 18 be in the office. It just made me uncomfortable.

19 210 Q. Just so I'm sure of your evidence. Are you saying that
 20 you made a point of going to the office when he wasn't 12:16
 21 there --

22 A. Yes.

23 211 Q. -- because you just wanted to have a look at the notes?

24 A. Yes.

25 212 Q. Was that more to do with the practicalities of two 12:17
 26 people being in the office at once or did it reflect
 27 your discomfort of having to do that job at all?

28 A. It reflects my discomfort of having to do the job at
 29 all. You know, I go back to Mr. O'Brien and I had

1 a very good working relationship, so much so that
 2 usually it was me who was the person sent to talk to
 3 him about any of the issues. I always was happy to do
 4 that because I kind of seen that as my role as Head of
 5 Service. But I just felt that -- and I know 12:17
 6 Mr. O'Brien probably would have challenged me if he
 7 knew when I was in the office. I have since read when
 8 I was off on extended sick leave after shoulder surgery
 9 that he took exception to some of the staff being in
 10 the office looking, counting the notes, what I would 12:17
 11 have done.

12 213 Q. Part of your strategy in going earlier when he wasn't
 13 there was because you didn't want to be -- and correct
 14 me if I'm wrong -- there for a confrontation, or if one
 15 took place, you didn't want that to happen? 12:18

16 A. Correct.

17 214 Q. would it have been possible for someone else more
 18 junior -- I know you are the Head of Service and you
 19 have a very significant workload, as the Inquiry will
 20 see later on, was there any way possible for another 12:18
 21 more junior member of staff to undertake going to
 22 a consultant's office and counting charts, or was there
 23 a reason why it was someone of your seniority asked to
 24 do that?

25 A. A very fair point. I suppose, yes, anybody probably 12:18
 26 could have done that, but I think it was back to the
 27 need-to-know, trying to keep it confined to a certain
 28 amount of people to protect Mr. O'Brien, the
 29 confidentially of what was happening. There would have

1 been very few people -- well, that's my view of it,
 2 I don't know what was talked about outside of it, but
 3 they wouldn't know the detail of what I was actually
 4 doing.

5 215 Q. Two of the issues that you had to engage in in the 12:18
 6 oversight of the Return to work plan, the dictation and
 7 the notes, they also would have involved, perhaps,
 8 Mr. O'Brien's secretary, the dictation issue?

9 A. The dictation issue would but we didn't involve her
 10 directly. That would have been through the service 12:19
 11 administrator. The service administrator have access
 12 to the digital dictation, so they didn't even have to
 13 ask. They would just be able to go in and look at the
 14 clinics and see did the number of letters match up.

15 216 Q. They fell foul to the analysis that the number of 12:19
 16 letters, the number of clinics, and the number of
 17 patients weren't reflective of what was outstanding?

18 A. Yes.

19 217 Q. Was that something the secretary might know?

20 A. She would have known, yes. 12:19

21 218 Q. Would it have been appropriate perhaps to have gone to
 22 her and say, 'what are the clinician numbers?' I know
 23 you speak about confidentially, it could have been
 24 perceived as an audit across all consultants, which is
 25 something the Trust may have considered doing in any 12:19
 26 event, given your views on the level of analysis they
 27 undertook to outstanding work. Would it have been
 28 appropriate at any point to go to her and ask directly
 29 at source, 'what's the situation with dictation?'

1 A. It did happen because there is the e-mail with regards
 2 to the backlog report. I know Mr. Gibson was
 3 questioned about it yesterday. That originally had
 4 been set out for -- it actually was more the purpose
 5 for using the secretary's workload to sort of make sure 12:20
 6 that everybody had an equal amount of work to do. As
 7 we know now, that came foul to the fact there was
 8 underreporting with respect to Mr. O'Brien. With
 9 regards to that they did ask but, as we know now, they
 10 weren't given the information. I know she has said 12:20
 11 since because I've been shared in the e-mail of
 12 un-dictated clinics, she just assumed everybody knew
 13 that Mr. O'Brien didn't dictate but she didn't report
 14 it either. To answer your question the long way round
 15 is yes, the secretary would have known and yes the 12:21
 16 secretary had been asked.

17 219 Q. There was a return to work meeting with Mr. O'Brien,
 18 Mr. Weir and yourself on 9th March 2017. That can be
 19 found, just for the Panel's note, at TRU-267952. If
 20 we do put that up because I want to refer to a specific 12:21
 21 part. TRU-267952. This follows up from a meeting on
 22 24th February that you had as well with Mr. O'Brien?

23 A. I was off on leave on that actual date. Mr. Weir met
 24 him on his own. It was me has done these notes.

25 220 Q. It says at the top of this: 12:22

26
 27 "The purpose of the meeting was as a follow on from
 28 Mr. O'Brien's return to work meeting that took place
 29 with Mr. O'Brien and Mr. Weir on Friday, 24 February."

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You were on leave. In advance of this meeting had you spoken to Mr. Weir about expected outcomes after this?
A. I can't recall but I'm assuming we did. We would have met, or we would have spoken about the agenda for what we needed to discuss with Mr. O'Brien. 12:22

221 Q. We don't need to go into the detail of this meeting but what is discussed at this is that Mr. O'Brien gave assurances in relation to outpatient clinics and turn around. Do you recall that? 12:22

A. Yes.

222 Q. He also indicated at that meeting that he didn't want to take on any new patients?

A. That's correct. Yes.

223 Q. Was that the first time that had been raised? 12:22

A. That was the first time it had been raised and I had come back to say that that wasn't possible because, at the end of the day, at that stage five or six consultants, I can't remember how many in post, and to take out on an already growing waiting list that Mr. O'Brien, you know, had quite an opinion on that we needed to make sure the people who were on that, advanced triage, enhanced triage, and that we couldn't just stop him from seeing new outpatients. He did say that it was to do with his theatre list being long, but in comparison everybody else's was the same. It would have been very difficult to argue that we were taking new patients from him and then not expecting the rest of the team to pick them up. 12:23

- 1 224 Q. In fact at that meeting it was clarified to Mr. O'Brien
2 that he didn't have the longest waiters I think they're
3 called?
- 4 A. The longest waiters, yes.
- 5 225 Q. In relation to the review backlogs of that meeting, 12:23
6 Mr. O'Brien assured that all patients were on the PAS
7 system?
- 8 A. He did, yes.
- 9 226 Q. Did that give you some sort of reassurance that he was
10 up-to-date with reviews, or what was your view when 12:24
11 he said that?
- 12 A. I was assured because, understandably, he had spoken to
13 me that this whole process was very stressful,
14 understandably. At that stage he said he was
15 determined to get back on track. That was a verbal 12:24
16 conversation outside of the meeting. Him and I walked
17 to the Departmental meeting, I think, together. So,
18 I was assured from that.
- 19 227 Q. He mentions in this as well, and I think you said in
20 your evidence, in your Section 21 you didn't have 12:24
21 anything to do with job plans?
- 22 A. That's correct, yes.
- 23 228 Q. That was entirely on the medic side. Mr. Weir asked
24 Mr. O'Brien was this fair about the hours he had for
25 dictation at the end of a clinic, and he said nothing 12:24
26 about jobs plans was fair. The Inquiry will see
27 evidence and hear evidence in relation to job plans.
28 would it be fair to say that the job planning issue did
29 seem to take up quite a lot of time and discussion

1 among medics?

2 A. It did, yes. It did. I suppose my only thing thing,
3 just to clarify that, is they would have come to me to
4 say, 'we want to do three outpatient clinics in a week
5 and have you got the accommodation to do that?' But 12:25
6 I wouldn't have been agreeing anything apart from that.

7 229 Q. If I ask you to look at TRU-251846. This is an e-mail
8 from 8th May 2017. The one is from 5th May from you to
9 Ronan Carroll where you are giving a case update.
10 Well, you're not giving a case update, I think you are 12:25
11 providing your update on the oversight?

12 A. Yes.

13 230 Q. In this you said that Dr. Khan wants monthly updates as
14 opposed to weekly, which had been previously; is that
15 right? 12:26

16 A. That's correct, yes.

17 231 Q. Was there any reason Dr. Khan asked for the updates to
18 change frequency at that point?

19 A. I don't know why he asked for that. I think it was
20 because he was getting an e-mail from me every week 12:26
21 that there was no issues at that stage. That's only an
22 assumption, sorry. I don't know.

23 232 Q. What was your view when he asked for that? Did
24 you feel that that was in any way premature at that
25 point or were you content to go along with that because 12:26
26 there had been no particular issues at the Oversight?

27 A. I did think it was a wee bit soon, yes. But I did
28 give, and Mr. Carroll asked me to continue doing it
29 weekly, which I did continue to do.

1 233 Q. Did you copy Dr. Khan and Mr. Carroll into your weekly
 2 updates, or just Dr. Khan monthly?
 3 A. Dr. Khan monthly. I didn't with Mr. Carroll because
 4 I only started to do it by exception, but I did keep it
 5 on my calendar the monthly updates with all the 12:27
 6 information on it. It is just, as I said earlier, we
 7 get so many e-mails, it's just I need to escalate when
 8 there's an issue.

9 234 Q. When Dr. Khan decided it was by exception, only if
 10 there was a problem arising, did that give you any 12:27
 11 reassurance that that meant if you were to let him
 12 know, something would be done about that?
 13 A. It did, yes.

14 235 Q. When did you subsequently let him know of concerns, was
 15 something done? 12:27
 16 A. Concerns with regards to the charts in the office when
 17 it started to -- there were two concerns. First of
 18 all, there was a slip in the triage, the length of time
 19 of triage, but we had a conversation, Mr. Weir and
 20 I had a conversation and we had then had the caveat in 12:27
 21 on a busy week that as long as it was done by the
 22 previous Monday. But I don't know if that was
 23 discussed with Dr. Khan or not, but it was definitely
 24 with Mr. Weir. Then the one with regards to the
 25 charts, it was Mr. Carroll, Mr. Weir, and myself. 12:28
 26 Again I don't know, even though Dr. Khan would have
 27 been informed, I don't know whether he'd asked us to do
 28 anything. It was actually on the instructions of
 29 Mr. Carroll and Mr. Weir.

1 236 Q. Did you know Dr. Khan to have done anything when
2 breaches were identified at any stage?
3 A. No, I don't. I'm not aware.
4 237 Q. Is that based on your belief that once it went to him
5 it was a matter for him to deal with from the medic 12:28
6 side?
7 A. Yes.
8 238 Q. Does that also reflect the tradition, if I can call it
9 that, that you spoke about earlier of when people raise
10 issues, nobody generally comes back to tell them how 12:28
11 they was resolved?
12 A. That's correct, yes.
13 239 Q. You not being informed about that was usual practice,
14 I suppose, was it?
15 A. It was usual practice. Again, I didn't feel it was my 12:28
16 place to actually contact him direct.
17 240 Q. You didn't feel it was your place to follow up as well?
18 A. Exactly.
19 241 Q. I want to take you to a couple of your reports of
20 breaches around at this time. The first one is at 12:29
21 TRU-268966. This is an e-mail 21st June 2017 that
22 you have sent to Mr. O'Brien and you have copied in
23 Mr. Weir:
24
25 "Dear Aidan, as you are aware I have been asked to 12:29
26 monitor the points that were discussed with regards to
27 your return to work.
28
29

1 One of the points was that notes should never be stored
 2 offsite and should only be tracked out and in your
 3 office for the shortest time possible. I have been
 4 monitoring this regularly and noted that the amount of
 5 notes in your office has increased, and therefore the 12:29
 6 length of time they are being kept is increasing."

7
 8 Then you provided a list of patient names and dates of
 9 when notes were missing. You have copied Colin Weir
 10 into that. Is that something that might helpfully have 12:30
 11 gone to Dr. Khan at that point?

12 A. I think it was probably -- my assumption would have
 13 been that Mr. Weir would have forwarded it to Mr. Khan.
 14 It was one of the first breaches and it was
 15 operational. It was me directly contacting 12:30
 16 Mr. O'Brien, but copying Mr. Weir in.

17 242 Q. would Mr. Weir have been aware that Dr. Khan had
 18 changed the procedure for alerts for exception only?

19 A. He was, yes.

20 243 Q. If I can ask you to look at TRU-258877. This is 12:30
 21 another e-mail from Ronan. That is an e-mail to
 22 Mr. O'Brien. Move it up so we can see the detail. You
 23 have reminded Mr. O'Brien, it seems, from this e-mail,
 24 of the terms of the action plan?

25 A. Yes. 12:31

26 244 Q. which is now the Return to Work and the action plan,
 27 same thing, effectively. You have provided him with
 28 the detail of that. What prompted that particular
 29 e-mail to set that out like that; do you recall?

- 1 A. Yes. This is one about the triage. I recall, if
2 we move down, I think there was 30 paper referrals that
3 hadn't been returned. I could monitor the triaged
4 referrals. Still some of the GPs hadn't been using the
5 GP system. I could monitor them. It had obviously 12:32
6 been escalated to me from the booking centre that there
7 were still 30 outstanding.
- 8 245 Q. Colin Weir, again, is copied into that, as is
9 Mr. Carroll?
- 10 A. That's right, yes. 12:32
- 11 246 Q. Do you recall did these e-mails result in a back and
12 forth with you and Mr. O'Brien about his explanation
13 about why, or what was your experience when you did
14 identify potential divergence from the action plan?
- 15 A. With regards to the notes, it was a verbal conversation 12:32
16 where he said to me he would action any of the notes
17 that were sitting in the office. This one in
18 particular I think from memory he did respond to me.
19 He had said about coming in from leave and he had sent
20 me a long e-mail about the 30 paper referrals and it 12:32
21 would be better if he had done a tick box exercise
22 instead of enhanced triage with regards to that. He
23 had sent it and I had forwarded it on to Mr. Carroll,
24 I think, and Mr. Weir.
- 25 247 Q. You have mentioned two things there and I just want to 12:33
26 touch on them briefly, because they will be mentioned
27 again.
- 28
29

1 The first one is the idea of enhanced triage.

2 Mr. O'Brien had a particular view on how triage should

3 be carried out. That was something that he engaged in

4 with you?

5 A. Yes. 12:33

6 248 Q. In e-mails?

7 A. Yes.

8 249 Q. Your understanding of the way medics should do triage

9 was in accordance with the Trust protocol, effectively,

10 of GP designation and then being reviewed by the 12:33

11 consultant on call?

12 A. That's correct, yes.

13 250 Q. When you were indicating problems with triage you were

14 working from your framework?

15 A. Yes. 12:33

16 251 Q. Mr. O'Brien was articulating his adherence to a system

17 he had developed which he considered to be more

18 effective for patient care. Would that be a fair --

19 A. That's fair, yes. I suppose, just to say, the other

20 consultants did a form of triage or advanced triage 12:34

21 because of the long waiting times. If they seen

22 somebody that had come in with a stone, they might have

23 sent them for, sort of, a CT scan, they ordered it

24 there and then. They would have done that.

25 Mr. O'Brien took his enhanced triage a step further in 12:34

26 that he would potentially ring the patient and go

27 through the detail with the patient on their symptoms.

28 Obviously that then was like an actual scuttle so it

29 took longer. He was counselled, and the rest of the

1 team said to him he didn't need to do that, just do
2 what they had done.

3 252 Q. The other consultants worked on an enhanced triage
4 basis only if it was triggered by clinical
5 presentation?

12:34

6 A. Yes.

7 253 Q. If I can put it that way. Then they fell back into
8 place with the rest of the expected way of doing
9 things?

10 A. Yes.

12:35

11 254 Q. You mentioned again about Mr. Mr. O'Brien being on
12 leave?

13 A. That's right, yes.

14 255 Q. Doing some of the catch-up on his admin duties on
15 leave. Was there an expectation from the Trust at all
16 that Mr. O'Brien should be doing that while he's on
17 leave?

12:35

18 A. Absolutely not. The amount of times, you know, we
19 would have said, 'but you're on leave, take your
20 leave'. Early on Mr. O'Brien would have said to me,
21 'you know, it's my choice. If I do this work outside
22 of working hours, it's the only time I can do it'.
23 I suppose it was like everything else, it nearly became
24 custom and practice. You knew, and you'll see from all
25 the evidence in the e-mails that's been sent in,
26 he would come back and say, 'well, I'm on leave
27 tomorrow and I'll address that'. I would have said to
28 him, and I can nearly hear people saying kettle calling
29 pot black, because I'm inclined to do the same thing

12:35

12:35

1 when I'm on leave. He would have insisted that it was
 2 his choice. For example, Sunday afternoons were spent
 3 contacting patients for the following few weeks'
 4 theatre lists, but again told not to do it or advised
 5 not to do it. Mr. O'Brien had strong views and it was 12:36
 6 very hard to turn him from them.

7 256 Q. From the Trust's perspective is there any suggestion
 8 that the fact he was having to work on leave was a bit
 9 of a warnings sign to the Trust that he just didn't
 10 have the capacity to do the work that was expected from 12:36
 11 him?

12 A. From the Trust perspective, no. There was lots of sort
 13 of warnings that that was the case, but Mr. O'Brien had
 14 more or less the same job plan as everybody else. The
 15 expectation was that he should have been able to see 12:36
 16 less patients, for example, at Outpatients. He should
 17 have been able to do it within the allocated time of
 18 the job plan if he had listened to the areas that just
 19 took him longer.

20
 21 For example, when he did do an outpatient letter it was
 22 pages and pages and pages long; great detail but, you
 23 know, GPS would have said a paragraph will do. I just
 24 want to know what's happening with my patient. Instead
 25 of dictating three or four pages, one page would have 12:37
 26 been fine.

27
 28 From the Trust's perspective, again custom and
 29 practice, and I've slipped into it as well, I've often

1 heard people saying, including myself, 'sure, that's
 2 just Aidan, that's the way he works'.
 3 257 Q. We will look at AOB-01646. This is Mr. O'Brien's
 4 response on 3th July 2017 to your reminder of the terms
 5 of the action plan. This gives the Panel an indication 12:37
 6 of where Mr. O'Brien was coming from in his view of how
 7 he could operate as a clinician within the expectations
 8 of the action plan.
 9
 10 This one is dated the 12th and Mr. O'Brien sent an 12:38
 11 e-mail to you where he's explained his view, but he's
 12 also indicated that he finds the e-mail about the
 13 action plan and his need to adhere quite demoralising.
 14 Do you recall this particular correspondence?
 15 A. I do, yes. 12:38
 16 258 Q. If I mischaracterise it, because you know more about
 17 the background of this that's not written down, so if
 18 I mischaracterise either you or your experience with
 19 Mr. O'Brien, please just say. He's explained the
 20 reasons why he returned referrals. One of the points 12:39
 21 I want to show is that he makes a point of saying that
 22 he takes the time to ensure patients are contacted.
 23 You'll see near the bottom of the screen he says:
 24
 25 "I know how referrals are triaged and returned on time. 12:39
 26 It is most certainly not by taking the time to ensure
 27 that each patient's current state is most appropriately
 28 and expeditiously assessed and managed."
 29

1 This is the one where he said, the quotation you relied
 2 on earlier:

3
 4 "I personally would have been better off ticking the
 5 box being at home on my leave" -- then a redaction -- 12:40
 6 "should also be at home with persistent colleague
 7 awaiting the urgent outpatient appointment."

8
 9 Just the tone of the reply to you, if I could just and
 10 their styles, if I can put it like that. I don't mean 12:40
 11 to be pejorative, but you, with your administrative
 12 oversight of the action plan, have indicated some
 13 divergences or potential breaches of what had been
 14 agreed. Mr. O'Brien has come back with clinical data
 15 really, and clinical information to patients who are 12:40
 16 named in order to respond to you. It does read, from
 17 this remove, as being very different tones in e-mails.
 18 Would that have been your experience of a typical
 19 response from Mr. O'Brien?

20 A. Normally, at the beginning, Mr. O'Brien, his e-mails 12:40
 21 would have been always quite courteous and there would
 22 have been no sort of -- nothing like this. This is the
 23 start of -- and that's why I know that it was
 24 a difficult time for him. It just goes back to the bit
 25 the part I was monitoring him made me feel 12:41
 26 uncomfortable because he is basically telling me I know
 27 how to triage. I was doing my job. He seen himself
 28 doing his job, but he missed the point that he was
 29 supposed to return his triage within a given period of

1 time and he still sat with the 30 referrals. This
 2 e-mail is a change in tone and, I suppose, going
 3 forward this was what I was faced with.

4 259 Q. Was there an underlying suggestion in this, and I know
 5 when we go to your evidence on another day you've said 12:41
 6 in other Section 21s, the fact that you weren't a medic
 7 was an issue for Mr. O'Brien when pressed on his
 8 particular practices. You would agree that was
 9 reflected in this reply?

10 A. Yes, that is reflected in that. On two occasions at 12:42
 11 least that I recall, Mr. O'Brien did say that to me,
 12 'you're a non-clinical person challenging my clinical
 13 decision'. To be fair, the two occasions, I will say
 14 that stands out in my mind, on both them occasions
 15 I hadn't made the decision on my own, I had spoken to 12:42
 16 one of his colleagues. It wasn't me as a non-clinical
 17 person coming to him, but that was his phrase of
 18 terminology to me.

19 260 Q. Some of the detail provided in that letter, would it
 20 also be fair to say that it is impossible for you to 12:42
 21 reply to because it is based on his clinical
 22 assessment?

23 A. Absolutely.

24 261 Q. And the justification for his actions based on
 25 information that either you couldn't possibly know or 12:42
 26 couldn't comment on, not being a medic?

27 A. That's correct. Yes.

28 262 Q. On reading that reply, and you said this seemed to be
 29 a change in tone in the replies, did you think at that

1 point that you needed assistance with monitoring
 2 Mr. O'Brien so that these sorts of responses to your
 3 oversight could be dealt with by, for example, one of
 4 the medical managers?

5 A. I did share the e-mail with Mr. Weir and Mr. Carroll 12:43
 6 and I know as a result of this, we had the meeting --
 7 the meeting that I had forgotten about. So it was led
 8 by Mr. Weir. So at that stage I had -- the reason
 9 I had passed that on was, number one, Mr. Weir was the
 10 case manager but also I knew I needed help with this 12:43
 11 one. This was something I couldn't deal with on my
 12 own.

13 263 Q. We'll go on to that meeting just in a moment. But
 14 whose idea then was it -- did you ask for help or when
 15 you copied them in, they thought; 'Okay, Martina needs 12:43
 16 help here' or 'We need to get behind her.' what was
 17 the sense of response among your managers to this
 18 reply?

19 A. Well, there was probably no e-mail response back to
 20 this but I do know Mr. Carroll was very supportive and 12:44
 21 any issues that I would have had with regards to this,
 22 I could have spoken to him, and depended on him taking
 23 it forward. And I do know then that's when he asked
 24 for a meeting to deal with both the slippage in the
 25 triage but also the slippage in the amount of 12:44
 26 notes that was in the deviation that was in the office.

27 264 Q. Just before we go to the meeting on 25th July, there
 28 are two references I just want to give the Panel.
 29 We don't need to go to the documents; AOB-01652.

1 That's an e-mail of 19th July 2017, when there is
 2 a reduction of 30 notes in the office at that point.
 3 So there was compliance. I want to point out these
 4 e-mails were the monitoring provided information that
 5 Mr. O'Brien was making changes to his practice. Then 12:45
 6 AOB-01660. That's a reply from Mr. Carroll to that on
 7 the same date when he said all notes need to be
 8 returned. I think the expectation was that it would
 9 get to zero, but there's obviously a movement in the
 10 right direction evidenced on those e-mails. 12:45

11 A. That's right, yes.

12 265 Q. So the meeting on the 25th, which seems to have been
 13 triggered by the tenure of that response, the 25th July
 14 2017, now you haven't referred to that in any of your
 15 Section 21s, and that was a meeting with Mr. Weir, with 12:45
 16 yourself, Mr. Carroll, and Mr. O'Brien.

17 A. That's correct. Yes.

18 266 Q. Is there any reason why that wasn't included in your
 19 original evidence at that meeting?

20 A. It's just a true -- it's just truly an omission; 12:45
 21 I forgot. And I genuinely had forgotten about that
 22 meeting. I usually would pride myself on having a good
 23 memory. I do recall at the time speaking to
 24 Mr. O'Brien about the notes and he said to me that he
 25 was clearing them. Then in my mind, that was it 12:46
 26 sorted. And it was only when I received the transcript
 27 of an audio -- a transcript from an audiotape that
 28 I remembered the meeting.

29 267 Q. For the Panel's notes, that's at AOB-56210 to

1 AOB-56221.

2

3 So you're making reference to the fact that Mr. O'Brien
4 recorded this?

5 A. That's correct, yes. 12:46

6 268 Q. Did you know it was being recorded?

7 A. I didn't. No.

8 269 Q. Do you know if Mr. Weir or Mr. Carroll were aware of
9 it?

10 A. No, none of us were aware. 12:46

11 270 Q. Now you became aware of it as a result of the Inquiry?

12 A. Yes.

13 271 Q. What was your view or your feeling, knowing that had
14 been recorded without you being aware?

15 A. Well, there was actually four recordings. Three of 12:47
16 them, I was with other colleagues. Initial reaction
17 was quite angry, but I suppose the one that annoys me
18 the most is....

19 272 Q. If you need to take a moment. If you need to stop for
20 a moment, we can do that, just to give you a short 12:47
21 break. There's no problem. Do you want to take
22 five minutes.

23 A. Yes, thank you.

24

25 THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 12:47

26

27 CHAIR: Ms. McMahon?

28 273 Q. MS. McMAHON BL: Are you ready to continue?

29 A. Yes.

- 1 274 Q. As a general point, you mentioned that there were
 2 several meetings with Mr. O'Brien that had been
 3 recorded without your knowledge.
- 4 A. That's correct.
- 5 275 Q. I just asked you what your views were on that? 12:54
- 6 A. That's right. Yes. Sorry about that. I suppose the
 7 three with the colleagues, I was angry about, but there
 8 was other people in the room with me. The one that
 9 annoyed me was on the 9th January when I agreed to meet
 10 Mr. O'Brien outside of the hospital. I facilitated 12:54
 11 a meeting in his car when he was handing over the
 12 outcome sheets and advised me of the letters in his
 13 drawer. So I actually feel quite violated about that,
 14 that a colleague would, on a one-to-one basis record me
 15 because I don't know what he expected me to say or do. 12:54
 16 The other three meetings, it's very obvious from
 17 listening to them that there was an agenda of
 18 Mr. O'Brien's because the meeting is steered to the
 19 areas that he wanted to talk to us about.
- 20 276 Q. Okay. The Panel have those transcribed and they can 12:55
 21 take a view on that.
- 22 A. Okay.
- 23 277 Q. But that's your view on what you consider to have
 24 happened.
- 25 A. It is, yes. 12:55
- 26 278 Q. I just want to give a list of e-mail references to
 27 either potentially what could be construed as breaches
 28 of the action plan or compliance with the action plan
 29 so the Panel have a note of that and the core

1 participants are aware that I'm bringing them to the
 2 attention of you in your evidence.
 3 The first one is TRU-258891 to TRU-258892. And that's
 4 an e-mail of 31st July 2017 when all charts had been
 5 removed from the office. So there was no more can 12:55
 6 compliance, effectively, with the requirements of the
 7 plan.
 8
 9 TRU-275133 to TRU-275134, and that's a breach of the
 10 action plan and a failure to triage. TRU-275148, 12:56
 11 that's an e-mail of 22nd February 2018, confirmation
 12 that triage issue had been resolved again. And
 13 TRU-258902, e-mail of 22nd May 2018 where you confirm
 14 that the plan has been adhered to, save for triage
 15 issues. 12:56
 16 A. Yes.
 17 279 Q. Then you had a planned period off sick from the
 18 25th June 2018 that went on a bit longer than was
 19 anticipated and you didn't come back to work until
 20 5th November? 12:57
 21 A. That's correct.
 22 280 Q. 2018.
 23 A. That's correct.
 24 281 Q. During your period of absence, did you hand over to
 25 anyone on the oversight role regarding the action plan 12:57
 26 before you went off sick?
 27 A. I didn't because, originally, it was shoulder surgery
 28 from the result of a car accident and I was advised by
 29 the consultant I would only be off for about a month.

- 1 So a month out of the system is probably not -- it's
2 just like being on annual leave because I have said in
3 my statement to the Inquiry that, you know, monitoring
4 happened every Friday apart from being on leave. So,
5 unfortunately, the surgery turned out to be much more 12:57
6 major and I ended up off for 18 weeks. I didn't hand
7 over and, I think, two things there. First of all, it
8 was getting back to the need-to-know basis. My
9 colleagues wouldn't have known the detail of what I was
10 doing, they knew I was doing something with regards to 12:57
11 return to work but they wouldn't have known the detail
12 because we had to keep it confidential.
- 13 282 Q. But given the fact that you were able to do some of
14 this, if I can say remotely?
- 15 A. Yes. 12:58
- 16 283 Q. We were given information from Katherine Robinson, for
17 example, was that something that Ronan Carroll could
18 have arranged to have sent to him directly?
- 19 A. Yes, that could have, yes.
- 20 284 Q. So there were aspects of the action plan that could 12:58
21 have been followed up without there being any potential
22 breach of confidentiality as regards Mr. O'Brien's
23 practices?
- 24 A. Probably.
- 25 285 Q. I don't think from the e-mail chains that are available 12:58
26 that anyone was monitoring, was that your understanding
27 when you came back?
- 28 A. That's correct, yes.
- 29 286 Q. Did you then pick up that in November 2018 when you

- 1 everything was quarantined, and then obviously no
 2 clinics and no theatre lists. But I had continued up
 3 until March 2020 monitoring.
- 4 291 Q. Again, for the Panel's note and for core participants,
 5 there are e-mails during your absence of breaches. You 13:00
 6 won't have any information of this but I just want to
 7 put it on record. So the first one is an e-mail of the
 8 18th October 2018, TRU-251525 to 251530, TRU-28888,
 9 I think that is, three eights. 19th October 2018
 10 e-mail, again about slippages. Then WIT-55773. This 13:01
 11 is when you are back again, 30th March 2019. That's an
 12 e-mail about Mr. O'Brien not triaging.
- 13 A. Yes.
- 14 292 Q. TRU-275324, and that's dated 12th September 2019, an
 15 e-mail we escalate to Siobhán Hynds, that Mr. O'Brien 13:01
 16 is not doing the red flag triaging.
- 17 A. Yes.
- 18 293 Q. TRU-275331. That's an e-mail from 5th September 2019
 19 and you e-mail Mr. O'Brien about outstanding
 20 dictations. 13:02
- 21 A. Yes.
- 22 294 Q. TRU-275344 is an e-mail from 16th September 2019 where
 23 you've e-mailed Dr. Khan and Siobhán Hynds with
 24 updates, including backlog in dictation. Another
 25 e-mail on 24th October 2019, WIT-55763, where you have 13:02
 26 e-mailed Dr. Khan, Siobhán Hynds, Mr. Gibson and Marie
 27 O'Kane. At that point, was she the Medical Director?
- 28 A. She was Medical Director, yes.
- 29 295 Q. Noting letters not dictated from Mr. O'Brien's clinic.

1 E-mail of the 6th November 2019 at TRU-275587. E-mail
 2 from you to Mr. O'Brien. And you've copied in
 3 Mr. McNaboe about the deviations and MDM
 4 recommendations not followed up.

5 A. Yes. 13:03

6 296 Q. Do you recall that? Those give a flavour, both in your
 7 absence and when you come back, of issues still
 8 arising.

9 A. That's correct, yes.

10 297 Q. Just from all your involvement with Mr. O'Brien 13:03
 11 throughout the years before this more formalised
 12 process began or more intensive of him began, do you
 13 feel you offered him support as and when necessary to
 14 allow him to try to change practices to fit in to what
 15 the Trust expected he would do? 13:03

16 A. I do think I offered it to him. I think, perhaps,
 17 sometimes I was, on reflection, possibly, you know
 18 a wee bit lenient in that he wouldn't do something and
 19 I would go and cajole him, and he would do it. I never
 20 would have escalated that because he would have done 13:04
 21 it. I think I have said in my Section 21, one of the
 22 things is I should have been more formal, now in
 23 hindsight, because, you know, we ended up where we did.
 24 And I would have always said to him, as I said, you
 25 know; 'If you need me to do anything, I'm more than 13:04
 26 happy to help', whether it was printing off letters or,
 27 you know, maybe getting some of the other doctors or
 28 junior doctors or CNSS to help him out with regards to,
 29 perhaps, triage. I think I was more than helpful to

1 him over the years.

2 298 Q. Now you have said in one of your statements at
3 WIT-26290, just for the Panel's note, that you felt
4 there was an overreliance on you as you had an already
5 demanding operational day-job and that the system 13:05
6 failed when you were on sick leave, seemed to fail when
7 you came back as well, but do you feel that you weren't
8 supported in trying to take on this role as well as all
9 the other things you had to do as Head of Services?

10 A. I suppose I'm the sort of person that just says, 13:05
11 probably, yes, and just gets on with it. I do think
12 there was always an overreliance on me in the sense
13 that everybody perhaps used the working relationship
14 that I had with Mr. O'Brien to get things sorted rather
15 than people tackle it because we did get on -- we were 13:05
16 amicable to each other. I could never change him
17 because he was sort of very set, stubborn in his ways.

18

19 with regards to support, I probably -- it's my own
20 fault, I probably didn't reach out for, you know, to 13:06
21 say; "I'm struggling with this", I just did it. I had
22 a demanding job, would have worked easily 15 hours
23 a day, and then on call, acute on-call on top of that,
24 but, you know, always tried to get it done. So from my
25 point of view, I probably didn't reach out and ask for 13:06
26 support, but I do think there was an overreliance on
27 me, on reflection.

28 299 Q. The Panel will see from your Section 21, and we'll
29 speak to it again when you come back, you did try to

1 still breaches and we ultimately ended up in 2020
 2 having the issues that we did, that brought us here
 3 today.

4 302 Q. If I can just give the Panel two brief extracts from
 5 Section 21, just for your note WIT-39930, at
 6 paragraph 24.1 where you have said:

13:08

7
 8 "The investigation was, in my opinion, a very long,
 9 drawn out process and therefore in the time it took to
 10 complete it Mr. O'Brien was deviating from good
 11 practice in other parts of his practice. In my
 12 opinion, because of the length taken to reach
 13 a determination it would appear that more patients have
 14 been exposed to potential harm."

13:09

15
 16 That's just your view on because of the length of the
 17 process.

13:09

18 A. Yes.

19 303 Q. You also said at paragraph 24.2 in relation to
 20 Dr. Khan's determination that it was: "Vague and quite
 21 wide-reaching, and I feel had been difficult to
 22 implement"?

13:09

23 A. Yes.

24 304 Q. That's a summary of what you said just previously, but
 25 do you think that the process undertaken by MHPS and
 26 the outcome on this occasion didn't result in any
 27 practical outcomes for you as a manager to make changes
 28 to the areas that had been established as being
 29 vulnerable?

13:09

1 A. I agree with that.

2 305 Q. Just in summary form, for the Panel's note, WIT-26299
3 to 301, you have set out what you consider to be
4 failings generally --

5 A. Yes. 13:10

6 306 Q. -- in your Section 21. You've indicated you felt there
7 was a lack of respect for non-clinical managers in
8 doing this role?

9 A. Yes.

10 307 Q. Is it still the situation at the moment? Do you know 13:10
11 if non-clinical managers are still expected to
12 undertake this kind of oversight and monitoring role?

13 A. With being out of the role now, the operational role
14 since June 2021, I couldn't comment on that at all.

15 308 Q. Was it up until that point, June 2021? 13:11

16 A. Up until that point, yes.

17 309 Q. You've also said nothing had been done about
18 Mr. O'Brien for years. Just in relation to any
19 potential outside influence, was it your view that
20 there was even the perception that there was an 13:11
21 influence over how Mr. O'Brien should be treated? Did
22 you have any experience of that, personal experience of
23 that?

24 A. Not direct experience but, yes, there was a perception.
25 There was the close working relationship with the Chair 13:11
26 of the Trust Ms. Brownlee, and Mr. O'Brien would have,
27 if you like, name dropped at meetings that he had been
28 out at a dinner the night before, or that he had met
29 her maybe down in Trust headquarters, and that he had

- 1 filled her in with regards to the likes of the waiting
 2 times in Urology. Because I would say I had another
 3 area as well, obviously you know that, ophthalmopathy,
 4 and ENT, and they have as long a waiting list as
 5 Urology, so I just wanted to put that on the record. 13:12
 6 He would also have, on occasions, just mentioned his
 7 legal connections, but they would never have been used
 8 in a context of making you persuade not to do
 9 something, but the inference was there.
- 10 310 Q. Mr. O'Brien would say that those perceptions of 13:12
 11 influence were entirely matters for others, that was
 12 never a matter for him. Also Ms. Brownlee would reject
 13 any suggestion that she in any way advocated for
 14 Mr. O'Brien. On one analysis, a consultant speaking to
 15 the Chair of a Board about wanting funds may not be 13:12
 16 that unusual, but I just want to put that context, that
 17 slight balance there?
- 18 A. I suppose just to say I had 13 consultants and none of
 19 the rest of them ever would have been sort of speaking,
 20 as we say, about the Trust Board. 13:13
- 21 311 Q. I think we have covered all of the issues, the main
 22 issues that are required for the purposes of the MHPS
 23 module?
- 24 A. Okay.
- 25 312 Q. Just while you're here, in relation to that time frame, 13:13
 26 is there anything you feel we've missed or you might
 27 want to say about that process and about your part in
 28 it that you haven't already covered in your evidence?
- 29 A. I think I have covered it in most of my evidence

1 because I took a long time to try and make sure that
2 I went through the years, did a lot of reflection
3 before I put it on paper.

4 MS. MCMAHON: I have no further questions. The Panel
5 may wish to ask you questions. 13:13

6 CHAIR: we will have questions for you but we're not
7 going to ask them today.

8 A. Okay.

9 CHAIR: we will save them up and spend some time with
10 you in due course. 13:14

11 A. Okay.

12 CHAIR: But not day. Thank you very much for coming.

13 A. Thank you.

14 CHAIR: It is now a quarter past one. The next witness
15 Mr. wolfe is taking, I think. It will be a quarter
16 past 2. 13:14

17 MS. MCMAHON: Madam Chair, may I clarify to release the
18 witness from her oath or do you want her to remain
19 under oath? It might be some time before she's back
20 and she may want to consult with her legal team. Just 13:14
21 to confirm if you want to release her from her oath.

22 CHAIR: If she is happy to take the oath on another
23 occasion I can release her from her oath. we'll have
24 you sworn in again next time.

25 13:14

26 THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

27
28
29

1 CHAIR: Good afternoon, everyone.

2 MR. WOLFE KC: Chair, your witness this afternoon is
3 Mrs. Esther Gishkori. I understand that she wishes to
4 take the oath.

5 14:23

6 MRS. ESTHER GISHKORI, HAVING BEEN SWORN, WAS EXAMINED
7 BY MR. WOLFE KC AS FOLLOWS:

8

9 313 Q. MR. WOLFE KC: Good afternoon, Mrs. Gishkori.

10 Now let's start by looking at the witness statements 14:24

11 that you have kindly prepared for the Inquiry in
12 advance of today. The first one is number 7 of 2022.

13 We find the first page. If we can have it up on the
14 screen, please, WIT-23366. You're, of course, familiar
15 with that, Mrs. Gishkori? 14:24

16 A. Yes.

17 314 Q. Just scroll through to the last page to see your
18 signature, WIT-23385. I know that you're going to tell
19 me about some corrections in a moment, but subject to
20 anything you wish to correct, do you wish to adopt this 14:24
21 witness statement as part of your evidence?

22 A. Yes.

23 315 Q. Then your second statement is number 35 of 2022. First
24 page is WIT-23400. Again, you're familiar with that
25 Mrs. Gishkori? 14:25

26 A. Yes.

27 316 Q. We will scroll through to the last page of this
28 statement. It's WIT-23412. You've signed on
29 27th June. Do you wish to adopt that as part of your

1 evidence?

2 A. Yes.

3 317 Q. Now just before we came in, you mentioned that you had
 4 communicated some changes to the Inquiry, or proposed
 5 changes. I'm sorry, I'm unsighted on those but can you 14:25
 6 highlight those for us?

7 A. Yes. It was just on an e-mail I sent to Owen yesterday
 8 or the day before, and it was in relation to some dates
 9 that I think were wrong, just sick leave dates and
 10 things. 14:26

11 318 Q. Okay. We'll perhaps try to adjust that later.

12 A. Yes. That will do.

13 319 Q. I think I've explained to you that the expectation is
 14 that you might have to come back to give evidence to
 15 the Inquiry. 14:26

16 A. That's okay.

17 320 Q. But just on the dates of your sickness, and this might
 18 be a way of dealing with the issue in the alternative
 19 to your e-mail, we have obtained from The Trust some
 20 indication of your sickness absence. 14:26

21 A. Okay.

22 321 Q. Over the period from 2017 through to 2020. I'll just
 23 bring those up on the screen now and ask for your
 24 observations. TRU-164659. You can see in the table in
 25 the middle of the page the dates of various sickness 14:27
 26 absence. We're taking the precaution of taking out the
 27 reason for your sickness, we've blacked that out on the
 28 right-hand column.

29 A. Okay.

1 322 Q. So you can see from that document that the longest
2 periods of sickness were three months in the summer of
3 2018.

4 A. Yes.

5 323 Q. 14th June to 14th September? 14:27

6 A. Uh-huh.

7 324 Q. And then going into the following year, you didn't
8 return to work after 6th June.

9 A. That's right.

10 325 Q. Yes. 14:27

11 A. That's right.

12 326 Q. It says "end date 30 April 2020." But as we'll discuss
13 briefly in a moment, you didn't return to work after
14 the 30th April.

15 A. That's right. 14:28

16 327 Q. Are you satisfied that that is an accurate account?

17 A. Yes, I, am. Perfectly. Thank you.

18 328 Q. Thank you. Now if we can go to one of your witness
19 statements, WIT-23366. Just scrolling down, please.
20 You are telling us here that you came to work in the 14:28
21 Southern Health and Social Care Trust in August 2015,
22 isn't that correct?

23 A. That's right.

24 329 Q. You took up a job at Director level, isn't that right?

25 A. That's right. 14:29

26 330 Q. You were Director of Acute Services?

27 A. Yes.

28 331 Q. This was your first job in the Southern Trust?

29 A. It was.

- 1 332 Q. And prior to coming to that role, you'd occupied
 2 several roles in the Health Service, particularly with
 3 the South Eastern Health and Social Care Trust?
- 4 A. That's right.
- 5 333 Q. Within your statement, you've described those roles as 14:29
 6 being across several operational and governance roles
 7 and management roles?
- 8 A. That's right.
- 9 334 Q. Your employment with the Southern Trust in the Director
 10 of Acute Services role ended on 30th April by way of 14:29
 11 mutual agreement, isn't that correct?
- 12 A. That's right.
- 13 335 Q. Now you've said -- just scrolling down the page,
 14 please. Can we go to the top of the next page. Your
 15 predecessor in the role of Director was 14:30
 16 Mrs. Debbie Burns?
- 17 A. Yes.
- 18 336 Q. You had an opportunity to shadow her on occasions prior
 19 to taking up the position?
- 20 A. That's right. 14:30
- 21 337 Q. But you didn't have a hand-over?
- 22 A. No.
- 23 338 Q. Does that mean that even though you were shadowing her
 24 you didn't have an opportunity to discuss, whether
 25 formally or informally, the kinds of issues that you 14:30
 26 might face in your role as Director?
- 27 A. That's right, yes. I had a chance to shadow Debbie but
 28 most of the time she was just going over performance
 29 templates with the staff. I didn't really -- she

1 walked me around the hospital but in terms of the
 2 issues that were going on at the time, in terms of, you
 3 know, things that were happening, other things that
 4 I might have needed to have known, just a formal or an
 5 informal hand-over, I didn't have one. The only thing 14:31
 6 she said to me when she was leaving was: "You'll never
 7 stick it." But that was it. Nothing more.

8 339 Q. Did you enquire as to what she meant by that?
 9 A. I did, yes. Yes.

10 340 Q. Did she explain? 14:31
 11 A. No. She was moving -- she was staying within the Trust
 12 herself, she said, so she didn't want to discuss much
 13 more. She was going back to the role I think that she
 14 had occupied before she became the Director. So when
 15 the Director's post came up, she decided she wasn't 14:31
 16 going to apply for it and she said it was a very
 17 difficult post. She said: "I think you'll find it
 18 difficult too." That was all.

19 341 Q. Yes. And you've described in a summary sense your
 20 role. "Mine was an operational role". And you go on 14:32
 21 in that paragraph to describe it. Do you see there?
 22 A. Yes.

23 342 Q. Stepping through this relatively quickly this
 24 afternoon, was it a challenging role?
 25 A. Very much so, yes, extremely. 14:32

26 343 Q. Why did you find it challenging?
 27 A. Well, first of all, as I said before, I was completely
 28 new to the job. I didn't know what -- you know, the
 29 "elephant in the room" always is; what is the

1 organisational culture, who's who, what's what, who are
2 the -- I knew nothing about it. But into the bargain
3 I was in charge of seven divisions, probably upwards of
4 14,000 staff. I honestly turned down more meetings
5 than I attended because I just simply couldn't go to 14:33
6 everything that was -- so I just had to juggle, you
7 know, decide at that time, send people in my place if
8 it was important, me go every other month. Things like
9 that. I always tried to communicate as well as
10 I could. I had an excellent secretary, she helped with 14:33
11 that. But probably I was expected and did go to about
12 three or four meetings every day. Then after that you
13 had to follow up with the actions, the outcomes of what
14 those meetings were, probably 120 to 200 e-mails were
15 done at home because I just simply couldn't do them. 14:33
16 There was never a day when there wasn't some sort of
17 firefighting or an issue. As you can imagine in acute
18 services, it was a very old hospital and that brought
19 all of its own challenging. You know, we had to
20 replace pipes at one point, you know, move patients 14:34
21 around, there was always building going on, new
22 pharmacy. It was one of the busiest roles I've ever
23 had and I do note that there are now two people doing
24 that job.

25 344 Q. Yes. 14:34

26 A. So, you know, I assume that the Trust understands how
27 big it was and have put two people into the post of the
28 job. But it was almost as though I was setting myself
29 up for failure because I couldn't do the job properly.

1 345 Q. Yes.

2 A. There was always something at the end of the day that
3 you knew hadn't been done. It was always a worry
4 a lot.

5 346 Q. Did you feel well supported by the staff that you had, 14:34
6 whether at Assistant Director level or below, even
7 though you may feel that you were under resourced?

8 A. Yes. I would have to say yes. All of my ADs I met on
9 a regular basis, and all of them, as well, were on the
10 admin floor where my office was, so it was very much 14:34
11 I could go and find them and seek them out at any time.
12 But all of the information that I got about the Trust
13 came from my Assistant Directors, or the AMDs, or just
14 walking around. But, yes, I did feel supported by my
15 Assistant Director, I would have to say yes. 14:35

16 347 Q. Obviously you have, below you in the management chain
17 the ADs, the Assistant Directors?

18 A. Yes.

19 348 Q. Then across on the professional --

20 A. That's right. 14:35

21 349 Q. -- medical side you have AMDs, CDs and Clinical Leads.

22 A. Yes.

23 350 Q. Do you think communication was good both on the
24 operational management side and medical management
25 side? 14:35

26 A. Yes. The AMDs, again, I met on a regular basis, some
27 of them, and I completely understood some of them
28 couldn't always make the meetings because their
29 clinical job was so busy, so I understood that and took

1 the hit for that. Sometimes it wasn't just as easy to
 2 get them into the room. But any time I went seeking
 3 information or asking them for the AMDs were also very
 4 supportive. Yes, I would have to say yes.

5 351 Q. You speak in your witness statement, at paragraph 5 14:36
 6 WIT-27300, of having monthly meetings with the
 7 Associate Medical Directors?

8 A. Yes. The AMDs had a monthly meeting and sometimes they
 9 were joined by the AD, depending on what was on the
 10 agenda. 14:36

11 352 Q. What was the focus of those meetings?

12 A. Mostly anything that was operational. It was a lot to
 13 do with waiting lists, and theatre lists, things going
 14 on around the hospitals. Too many medical patients in
 15 the hospital, and therefore not a lot of time to do the 14:36
 16 surgery that was planned. We had an orthopaedic ward,
 17 for example. The orthopaedic staff didn't like any
 18 medical patients in there because of the risk of
 19 infection. For bones, you can imagine how hard that
 20 would be if someone got -- so there were a lot of 14:37
 21 operational -- even just the hospital was getting built
 22 around all the time, bits added on. Sometimes that
 23 encroached on, for example, the Day Procedure Unit or
 24 Theatres or Daisy Hill, you know, what would go down to
 25 Daisy Hill and what would have to stay because 14:37
 26 they didn't have laminar flow theatres and they didn't
 27 have -- all those operational types of things.

28 353 Q. Yes.

29 A. There was plenty.

1 354 Q. You had two AMDs or three AMDs, but for present
2 purposes I wanted to speak about Mr. Mackle and
3 Mr. McAllister. Mr. Mackle stepped down from his
4 role --

5 A. He did.

14:38

6 355 Q. -- in March April of 2016 --

7 A. Yes.

8 356 Q. -- to be replaced by Mr. McAllister for a short time.
9 Then there was a gap --

10 A. That's right.

14:38

11 357 Q. -- through to the following year before Mr. Haynes took
12 up the role?

13 A. Yes.

14 358 Q. In terms of what we are going to be looking at today,
15 and that's performance issues in association with
16 a particular clinician's practice, Mr. O'Brien, what
17 would be the meeting or the mode of communication to
18 bring issues around clinical performance affecting the
19 service to your attention?

14:38

20 A. That would have been brought -- sometimes they would
21 have -- it was always brought to the AMD meeting, no
22 matter what that was. I would have recorded it in my
23 red book and whenever we obviously would have needed to
24 take further steps, whatever that may have been,
25 involved probably the Medical Director, very probably,
26 the Chief Executive, but depending what the problem and
27 the issue was, we decided at the one-to-one what we
28 would do and how we would take it, if it was brought to
29 me.

14:38

14:38

1 359 Q. Yes. Did you find you had a good relationship with
 2 both Mackle and McAllister in communication terms?
 3 A. Yes.
 4 360 Q. If there's a caveat to be added to that, may I ask --
 5 I put the two names together but please feel free to -- 14:39
 6 A. Yes. To be fair to both of them, yes, they brought
 7 what they believed to be the main issues of their
 8 Directorate at that time every month. They didn't hide
 9 anything, hopefully.
 10 361 Q. You've said in your witness statement, if you go down 14:39
 11 to WIT-23369, just the second paragraph there. In
 12 terms of the Medical Director it was arranged that you
 13 would meet fortnightly but this was difficult to
 14 arrange with ongoing time pressures and the meeting did
 15 not always take place. 14:40
 16 A. Yes.
 17 362 Q. The Medical Director, for the purposes of today,
 18 I suppose, is Dr. Wright?
 19 A. That's right.
 20 363 Q. Does that suggest that your meetings with him more 14:40
 21 often than not did not take place fortnightly, or?
 22 A. Yes. It would be fair to say yes, that is the case.
 23 364 Q. Did that create any particular communication
 24 difficulties for you?
 25 A. Yes, it would have. Although Mr. Simon Gibson very 14:40
 26 often assumed responsibility for Dr. Wright and
 27 I assumed that he was delegating the job. Quite often,
 28 you know, Simon would have come and asked me for
 29 whatever, but it was the very, very difficult for the

1 Medical Director. I think at a point in time he worked
 2 four days a week only and during those four days, a bit
 3 like myself, he had an awful lot of others things to
 4 do, so our meetings quite often went on the back burner
 5 it is fair to say.

14:41

6 365 Q. You've said at WIT-23370, just at the bottom of the
 7 page, please. Maybe it isn't there but I think I've
 8 got the -- I can put the point to you in this way.
 9 There was no governance team in place when you joined?

10 A. No. Well, there was one person, one 8B.

14:42

11 366 Q. Who was that?

12 A. Her name was Margaret Marshall.

13 367 Q. When you say no governance team was in place, what does
 14 that mean? So within the Acute Directorate --

15 A. Yes.

14:42

16 368 Q. -- there was nobody looking at governance issues apart
 17 from her?

18 A. If I can just explain probably what I mean. If you
 19 don't mind I'll just explain it through. In my view,
 20 governance is actually everybody's business because
 21 governance runs through all of what all of us do:
 22 documentation, standards and guidelines evidence-based
 23 practice, risk management, complaints, audit research,
 24 all of that is good governance, so it is everybody's
 25 business. The governance team for me draws everything
 26 together. For example, with the Serious Adverse
 27 Incident, that would have been reported by the staff on
 28 the ground, but the governance team drew together the
 29 team to look at that Serious Adverse Incident and, you

14:42

14:42

1 know, to report back on it. Or they would have looked
 2 at -- I was very keen at looking at trends and
 3 patterns, for example, in relation to incidents or near
 4 misses, because that will tell you if there's something
 5 wrong in an area around one particular person or 14:43
 6 whatever. When I say a governance team, I mean that
 7 that team would have dealt with all of those things
 8 being pulled together. Good governance, as I said
 9 before, is everyone's business and we should all,
 10 everyone who practices, make sure that they deliver 14:43
 11 good evidence-based practice.

12 369 Q. You've explained in your statement that there was
 13 resource available for you to --

14 A. Yes.

15 370 Q. -- to fill that gap? 14:44

16 A. There was. That's right.

17 371 Q. What exactly did you do?

18 A. Governance was the only thing that I didn't have an
 19 Assistant Director to report to me on, and I felt that
 20 was very important because I wanted to keep all of my 14:44
 21 service the same. So actually Kieran Donaghy, who was
 22 the previous Director of Human Resources, told me -- he
 23 was very helpful in the beginning, and he told me that
 24 Tracey Boyce, who was the Director of Pharmacy, had
 25 just done a Diploma in Governance, a postgrad Diploma, 14:44
 26 I think, I am sorry, it may have been a postgrad, but
 27 it was a postgrad, anyway, qualification in Governance
 28 and he said: "You know, you should use that as
 29 a starting point." So I spoke to Tracy and she was

1 happy enough to do it, based on the fact that hers was
 2 a very busy job as well. But she then was able to
 3 appoint an 8B and then, more importantly, three Band 7s
 4 who did the "legwork", if you like, of the governance
 5 team. They were the people who went and gathered the 14:45
 6 information and brought it together and got the review
 7 team sorted out, et cetera. Then there was a team
 8 below that of, you know, 4s, 5s, 6s, and they were
 9 admin and all those people.

10 372 Q. Can you give us a practical example of a governance 14:45
 11 shortcoming that existed when you came into post that
 12 you were able to solve and pursue a better course as a
 13 result of the action that you took?

14 A. Well, there was a few that I didn't manage to crack
 15 and, to be honest with you, those were important, 14:45
 16 I felt, but I did speak to the two medical directors in
 17 turn. But, for example, when I came in to my position,
 18 there were more than 200 Serious Adverse Incidents that
 19 hadn't been reported on, more than 200. So this team
 20 began very quickly to look at those Serious Adverse 14:46
 21 Incidents, get teams together. It was difficult
 22 because there had to be one of the surgeons or
 23 physicians, whoever it was on the team. So by the time
 24 I pulled the team together and then they sat, they
 25 looked into it and they followed the SAI procedure, and 14:46
 26 by the time I left, most of those SAIs had been
 27 reported on or were being dealt with. I resurrected
 28 the Friday morning governance meeting that had been set
 29 up by Dr. Gillian Rankin, because it had sort of gone

1 by the wayside. Actually, governance was one of my
 2 passions in both prison healthcare and in the South
 3 Eastern Health and Social Care Trust. So I was looking
 4 forward to getting on with doing more audits or, you
 5 know, taking "near misses" and looking at them and 14:46
 6 seeing what we could do. But I wasn't able to really
 7 get into some of the more enjoyable side of governance,
 8 the prevention side of it, because every Friday, the
 9 completed SAIs were brought to my governance meetings
 10 so, really, that's all we did during the time I was 14:47
 11 there. But at least it was done.

12 373 Q. Okay. And on the operational side, if we focus on the
 13 role of Assistant Director and then below that, within
 14 each service, the Head of Service.

15 A. Yes. 14:47

16 374 Q. How did information come up from the Service, Urology,
 17 to you if there was a problem?

18 A. The information would have come up -- again, I was very
 19 clear, it's not that I wouldn't have spoken to anybody
 20 on the team, but I needed it to come through a proper 14:48
 21 line. The information would have come from the ground
 22 to the Head of Service, to the Assistant Director, and
 23 then to me. From the medical side the same thing. It
 24 would have been probably the Clinical Director to the
 25 AMD and to me. In essence, the two people that brought 14:48
 26 the information to me were the Assistant Director and
 27 the AMD. If they weren't there or, you know, somebody
 28 else quite often came in. I mean if Ronan Carroll
 29 wasn't there, for example, Martina would have stood in.

1 But I don't ever remember, actually, an occasion when
 2 it happened. In anaesthetics, for example, or
 3 medicine, the Head of Service would have stood in for
 4 AMD at times. But that's how it came, how information
 5 came. 14:48

6 375 Q. Listening to Mrs. Corrigan's evidence this morning, she
 7 was Head of Urology for all relevant periods -- this is
 8 page 13 of the current stenography or stenographic
 9 reproduction, we may not have it on the screen?

10 A. Okay. 14:49

11 376 Q. I'll read it out to you. She says that you were very
 12 clear at the start of your tenure that you expected
 13 that any information that you needed would have come
 14 through the Assistant Directors as opposed to the Head
 15 of Service, and that took her a bit of getting used to 14:49
 16 based on her previous experiences, perhaps with
 17 Mrs. Burns and before that.

18 A. Yes.

19 377 Q. She said that she didn't feel that she could go to you
 20 if she needed to escalate. Do you recognise that 14:49
 21 description in terms of the framework of management and
 22 communication that you sought to implement?

23 A. First of all, I have to say I really am disappointed
 24 that she felt she couldn't come to me at any time.
 25 However, the only way that I felt that everybody who 14:50
 26 should know did know was by coming through the
 27 Assistant Director. If I can give you an example. If
 28 Martina had come in to me and said something to me
 29 about urology, and Ronan didn't know, I might have gone

1 off and done -- it creates all sorts of problems if you
 2 don't follow the proper lines of communication. I got
 3 along very well with Martina, and I hope she said that.
 4 But in terms of communicate the business of the
 5 Directorate, then I did prefer everything to come up 14:50
 6 through the Assistant Director. I couldn't manage it
 7 properly any other way.

8 378 Q. Yes. When you think back now, do you think that caused
 9 any difficulties in terms of your ability to manage?

10 A. I don't think so. The ADs had, in turn their -- I mean 14:51
 11 I had meetings separately with my Assistant Directors
 12 and a Tuesday afternoon SMT of my own meeting, that was
 13 all of my Assistant Directors. The Assistant Directors
 14 did the same with their Heads of Service. I cannot --
 15 unless there was something, and I don't remember this 14:51
 16 happening -- but unless there was something that the
 17 Heads of Service didn't feel that the Assistant
 18 Director was taking seriously, I would have expected --
 19 but I would always have had them and the Assistant
 20 Director in the room and say, 'can we talk this 14:51
 21 through? what are the barriers to communication?'
 22 Communication is one of the biggest issues in the
 23 Health Service anyway, you know.

24 379 Q. You're here today, Mrs. Gishkori, primarily to focus on
 25 the issue of the MHPS process. 14:51

26 A. Yes.

27 380 Q. You've told us in your witness statement, WIT-23407,
 28 just to have that up, please, at paragraph 5.
 29 You didn't receive any training on either MHPS or the

- 1 Trust guidelines during your time in the Trust?
- 2 A. No, I didn't receive any formally training. However,
- 3 because of my two previous jobs and because I sat on
- 4 every single consultant interview I was quite -- it was
- 5 almost like, for want of a better word, osmosis. AS 14:53
- 6 I went along in my previous two jobs I understood MHPS.
- 7 When I went to look at it, it reminded me very much of
- 8 the previous Leadership and Qualities Framework and the
- 9 holding to account was actually quite similar, so
- 10 I kind of was able to grasp it and look at it. The 14:53
- 11 answer to your question is no, I didn't get any
- 12 training.
- 13 381 Q. But you had a working knowledge --
- 14 A. I did.
- 15 382 Q. -- of MHPS and something similar to the 14:53
- 16 Southern Trust's local guidelines from previous work?
- 17 A. That's right. And NCAS too, because the South
- 18 Eastern Trust were employing GPs at the time, so there
- 19 was a lot of work in relation to doctors.
- 20 383 Q. You used an acronym there N? 14:54
- 21 A. NCAS. That's the National Clinical Advisory Service.
- 22 384 Q. Yes. We've been calling it NCAS.
- 23 A. Sorry.
- 24 385 Q. Don't worry. Entirely my fault.
- 25 A. Sorry. 14:54
- 26 386 Q. You had familiarity with that organisation?
- 27 A. Yes, I did.
- 28 387 Q. Had you occasion to contact that organisation yourself?
- 29 A. I didn't ever contact them but the senior doctor -- and

- 1 I notice Colin Fitzpatrick he actually worked with us
2 in prison healthcare, I don't know if it's the same
3 person or not, he would have been the person who dealt
4 with them a lot because he was the lead, but I was
5 always involved with them as well. 14:54
- 6 388 Q. When it came to September 2016 --
- 7 A. Yes.
- 8 389 Q. -- and you were a member of the Oversight Committee,
9 the Oversight Group of the Southern Trust dealing with
10 an issue concerning Mr. O'Brien and, indeed, other 14:55
11 clinicians during the meetings but focusing on him
12 today, this wasn't a foreign planet to you. You knew
13 what that MHPS processes involved?
- 14 A. Yes.
- 15 390 Q. Had you read the local framework document, the local 14:55
16 guideline document produced by the Southern Trust?
- 17 A. Yes. I always --
- 18 391 Q. If we could have that up on the screen, please? It is
19 TRU-83685.
- 20 A. There was a flowchart I found very useful. I had it 14:55
21 here but I don't know where it is.
- 22 392 Q. That's the Trust's guidelines. Did you have a copy of
23 those?
- 24 A. The guidelines were there for everyone to see on the
25 Trust's website. I don't know if I had it in hard copy 14:56
26 or not, but they were there, yes.
- 27 393 Q. Would it have been something you consulted?
- 28 A. Yes.
- 29 394 Q. In terms of your awareness of Mr. O'Brien,

1 Mr. Aidan O'Brien --

2 A. Yes.

3 395 Q. -- did you know him before you became employed in the

4 Trust?

5 A. No. 14:56

6 396 Q. Starting your employment in August 2015 --

7 A. Yes.

8 397 Q. -- did you become aware of him?

9 A. No, not at all.

10 398 Q. When do you think was the first time that you became 14:56

11 aware of him and of concerns, however those concerns

12 might have been described, with his practice?

13 A. Yes. The very first time I became aware of him was in

14 March 2016 at one of the one-to-ones. Heather Trouton

15 and Eamon Mackle were there. 14:57

16 399 Q. That's March 2016?

17 A. That's right.

18 400 Q. I want to test that with you, because other people, you

19 might imagine, have come and give evidence about that

20 and I want to work through that with you. 14:57

21 A. Okay.

22 401 Q. We'll get to March 2016.

23

24 Could I have up on the screen, please, WIT-12130? At

25 paragraph 425, this is an extract from Mrs. Trouton's 14:57

26 Section 21. She's here talking about the concerns such

27 as triage, patient notes held by Mr. O'Brien at home,

28 review backlog. She's being asked did she have

29 discussions with anybody about that. She said:

1
 2 "These discussions directly with Mr. O'Brien were
 3 primarily via the Head of Urology and ENT but on
 4 occasion by Mr. Young, Mr. Brown, Mr. Mackle,
 5 Dr. Rankin, Mrs. Burns, Mrs. Gishkori or myself. 14:58
 6 Following discussion with Mr. O'Brien his practice
 7 would improve for a period. However, this improvement
 8 was not sustained and through alert systems we would
 9 have been alerted to delay, triage, missing notes which
 10 was then followed up for action. Review backlog 14:58
 11 numbers were also constantly monitored."
 12

13 we know from the evidence that we've heard that triage
 14 was a problem in late 2015 --

15 A. Yes. 14:58

16 402 Q. -- and for several years before that.

17 A. Mm-hmm.

18 403 Q. We know from evidence that we've heard that a new issue
 19 came on the Services agenda towards the end of 2015
 20 because recently appointed consultant clinicians were 14:59
 21 discovering that Mr. O'Brien was, on occasions, failing
 22 to dictate clinician encounters, those kind of things.
 23 Of course, notes at home was seen to be a constant
 24 battle. Can you remember, as suggested here by
 25 Mrs. Trouton, participating in a meeting with 14:59
 26 Mr. O'Brien and her to discuss any such issues?

27 A. Never. I never met Mr. O'Brien with Heather Trouton,
 28 not ever.

29 404 Q. Can you remember, prior to March 2016, discussing

1 issues such as this with Mrs. Trouton?

2 A. No. I saw on one of the documents that was provided to
3 me that in December 2016 that Heather Trouton had
4 discussed at one of her one-to-ones. But the first
5 time, according to my recollection, and it is 15:00
6 five years -- it's a long time ago, Mr. Wolfe, and
7 I hope I'm being correct here, but the first time
8 I remember Mr. O'Brien being discussed was in
9 March 2016.

10 405 Q. Can I just deal with that December meeting that you 15:00
11 refer to?

12 A. Yes.

13 406 Q. If you go to Mrs. Trouton's statement at WIT-14811. At
14 paragraph 11, please, she says:
15 15:01

16 "Following the emerging concern relating to the lack of
17 clinic outcomes recorded on patient centre in 2015 and
18 following verification of this concerned by
19 Mrs. Corrigan, advice was sought by Mr. Mackle from
20 Dr. Richard Wright as to the best next steps. As I 15:01
21 recall, it was notification of another concern
22 regarding Mr. O'Brien's administrative practise that
23 prompted a request for a direct meeting with the
24 Medical Director.
25 15:01

26 I also alerted my Operational Director,
27 Mrs. Esther Gishkori, of this latest concern and I have
28 a note of a one-to-one meeting with Mrs. Gishkori which
29 records same."

1 So that note, if I can just ask for your comments on
 2 it, is at TRU-277934. If you can highlight the top
 3 section, where it is highlighted in pink, please.

4
 5 Now this, as you can see, is a note dated 21st December 15:02
 6 2015. It is described as a one-to-one with Esther.
 7 We have evidence that it's in the hand of Mrs. Trouton
 8 and she recalls meeting with you in December to discuss
 9 Mr. O'Brien as per that note. Are you saying that
 10 meeting didn't take place or you simply don't have 15:02
 11 recollection of it?

12 A. No, no. It is highly possible -- I mean, I had monthly
 13 one-to-ones with all of the ADs, of which Heather was
 14 one. It is possible that yes, we met. My red books,
 15 as you know, weren't able to be retrieved so my 15:03
 16 one-to-one would have been recorded in it. And all of
 17 the other things on Heather's note there I can remember
 18 about. So those are things that would have been
 19 discussed. But I don't remember that, or plan letter
 20 in one month, what did that mean, another letter didn't 15:03
 21 go to March? I do know that.

22 407 Q. Yes. Could we just revise on something you said there.
 23 You said the red books have not been retrieved. They
 24 have, in fact, been retrieved?

25 A. Some of them. 15:03

26 408 Q. Well, quite a number of them, and they've been sent to
 27 you for review?

28 A. Yes.

29 409 Q. Isn't that right?

1 A. That's right.

2 410 Q. Do you think some of them are missing?

3 A. I think the earlier ones probably later ones were --

4 you know, with the later ones, 17, 18 especially were

5 the one's that I received but there was no record of 15:04

6 that particular one-to-one at the end of December,

7 unfortunately.

8 411 Q. Okay. You can't remember the meeting. You don't deny

9 that it took place?

10 A. Yes, that's right. 15:04

11 412 Q. You don't deny that these are the kind of issues that

12 were drawn to your attention?

13 A. Mm-hmm.

14 413 Q. What subsequently emerged following a January meeting

15 on the evidence that we've received so far between 15:04

16 Trouton, Mackle and Wright was the idea that

17 Mr. O'Brien would be met with and asked to produce

18 a plan, a remedial plan to address the shortcomings in

19 his practice.

20 15:05

21 Were you privy to that information --

22 A. No.

23 414 Q. -- in January of 2016?

24 A. No, I was not.

25 415 Q. The record here from your meeting in 2015 seems to 15:05

26 allude to a plan, a letter, with one month to improve?

27 A. Yes.

28 416 Q. Clearly if this note is a contemporaneous note made of

29 that meeting, that is something you were discussing.

1 Does it not ring any bells to you?

2 A. No. I'm really sorry but it doesn't. I am being
3 really honest, that really does not ring any bells to
4 me.

5 417 Q. Can we leave it at this. Would you have thought that 15:05
6 a plan from Mr. O'Brien with a period of time to
7 improve was a worthwhile pursuit?

8 A. Absolutely. I mean there's there no patient centre
9 letters on triage. Triage is one of the most important
10 part of the urologist's business. If the patients 15:06
11 weren't being triaged, what was happening then? That
12 would have rang, as far as I'm concerned, warning
13 bells. I really don't remember -- I'm really sorry but
14 I just don't remember it.

15 418 Q. We maybe can't take that much further then. 15:06
16 A. Yes.

17 419 Q. You didn't get any feedback from the meeting that they
18 had with Dr. Wright in January?

19 A. No. Do you mind if I comment on that?

20 420 Q. Please. 15:06
21 A. Because the reason is whenever the Oversight Meeting
22 was called in September I wondered why or how, because
23 I thought I was the only one that knew. Heather and
24 Eamon told me in March they were going to write
25 a letter to Mr. O'Brien. Then the next thing I knew or 15:07
26 remembered was the September meeting. I wondered how
27 the Oversight Group had gotten to know about it since
28 it was only Heather, Eamon and I that had known. Then
29 I realised that there had been a meeting in January.

1 Plus, also, there was an e-mail in February from
2 Richard Wright to me saying he thought --

3 421 Q. I think we're conflating too many things. Let's
4 structure this a little bit better?

5 A. Okay. 15:07

6 422 Q. Let's put January behind us. There had been a meeting
7 between Wright and the two others. You weren't aware
8 of that meeting?

9 A. No.

10 423 Q. You weren't aware, you're telling us, of the plan that 15:07
11 was hatched at that meeting to meet with Mr. O'Brien,
12 at least at that time?

13 A. No.

14 424 Q. Let me take you forward a step. On 8th February
15 Mrs. Trouton's records show there was a further meeting 15:08
16 with you. If we can have TRU-277937 on the screen,
17 please? Down to the highlighted section. Maybe just
18 at the top so you can show the date. This is
19 8th February. Just to the top, please. 8th February.

20 A. Mm-hmm. 15:08

21 425 Q. "Esther one-to-one". You did have regular one to one
22 meetings with Mrs Trouton?

23 A. Yes, I did.

24 426 Q. The note, it says, reading across, an abbreviation for
25 "urology" urol. It says: 15:08
26
27 "Apart from review backlog", and the next word might be
28 `working`, that is urology is working apart from the
29 review backlog.

1 A. Review backlog, yes.

2 427 Q. Is one way of interpreting that?

3 A. Yes.

4 428 Q. But AOB plan.

5 A. Yes. 15:09

6 429 Q. Again, it might make sense to suggest to you that
 7 following the meeting in January between Trouton and
 8 the Medical Directors and Mr. Mackle that this plan was
 9 being taken forward?

10 A. Mm-hmm. 15:09

11 430 Q. And that she was telling you about that?

12 A. Mm-hmm.

13 431 Q. Does that ring any bells?

14 A. It's funny because -- I'm just having to be honest with
 15 you here, I really remember the other things. 15:09
 16 [REDACTED] I remember that
 17 distinctly, having a long conversation. CD posts and
 18 the ins and days activity. She may have mentioned
 19 Mr. O'Brien, trauma, cancel elective activity. If
 20 it didn't jump out she may have mentioned it. 15:10
 21 I can't --

22 432 Q. Let me step forward again.

23 A. Yes.

24 433 Q. It's certainly the case that in your opinion at that
 25 time the main concern for Urology was the increasing 15:10
 26 waiting lists and the backlog of patients?

27 A. That's right.

28 434 Q. To the extent that refers to backlog being the main
 29 issue for Urology, that's correct, isn't it?

1 A. It is.

2 435 Q. 9th February Dr. Wright sends you an e-mail. It is
3 TRU-657616. Just scrolling down. Mr. O'Brien has
4 written an e-mail talking about his heavy work
5 commitments. Not to overly exaggerate, but he 15:11
6 suggesting he's working all day and all night, very
7 little time for rest.

8 A. Yes.

9 436 Q. Then that's copied through to Dr. Wright.

10 A. Yes. 15:11

11 437 Q. Then he copies it to you, as you can just see at the
12 top of the page.
13

14 "This almost sounds like a cry for help. We should
15 discuss"? 15:11

16 A. I remember that clearly.

17 438 Q. There's a picture emerging here --

18 A. Yes.

19 439 Q. -- and you don't remember the early parts of it, but
20 information being fed through to you about 15:11
21 Mr. O'Brien's performance, the need to address that,
22 and coming from a different angle, perhaps, Dr. Wright
23 telling you about this e-mail. Did you meet with
24 Richard Wright to discuss what was being interpreted as
25 a cry for help? 15:12

26 A. Yes. I think Richard and I -- I don't know that we met
27 about that but I do know that the next time we met or
28 thereabouts we did discuss it. I suppose by this stage
29 this slowness, you know -- if I can give you an

1 analogy. The way I looked at this was -- I called it
 2 the speed continuum in my mind. There were people who,
 3 when they got under pressure, went very slow and others
 4 went very, very fast. That brought its own problems
 5 too. I wondered, and I said that to Richard, 'where is 15:12
 6 he on this?' Because people were saying by now -- as
 7 I said to you I didn't know this man at all, but people
 8 were saying by now, 'he's just so slow. He goes into
 9 theatre all day. He knocks the theatre list off. He's
 10 not a team player'. Other people will have seen 14 15:13
 11 patients, he'll only have seen 10. But never at any
 12 point ever did I ever hear that there was an incident,
 13 an accident, an IR1, anything in relation to his
 14 practice. It was just the slowness.

15 440 Q. Let's just be careful here because, of course, you did 15:13
 16 hear about IR1s?

17 A. Later on, yes.

18 441 Q. Yes. The issue here built on top of what you may not
 19 remember hearing but certainly it, as it appears
 20 brought to your attention by Mrs. Trouton is, can 15:13
 21 I suggest, a need to assist this --

22 A. Man.

23 442 Q. -- doctor and provide some support?

24 A. Yes.

25 443 Q. You said you can remember speaking to Dr. Wright about 15:14
 26 it?

27 A. Yes.

28 444 Q. Did anything arrive in practical concrete terms in
 29 respect of that or how was it left?

1 A. I think it was left that Richard was going to meet
 2 Mr. O'Brien shortly after 9th February to discuss
 3 things through with him. If I can remember right, it
 4 was in relation to job planning and he was going to
 5 talk to him about job planning and what should be in 15:14
 6 a job planning plan and SPAs, and how many of those.
 7 I think he said would raise that at that particular
 8 event or arena. But I didn't have anything from any of
 9 my ADS, or come up through Martina or Ronan, or Heather
 10 at that point that there was any issues with 15:14
 11 Mr. O'Brien feeling that he was crying out for help,
 12 even though, apparently, he had sent e-mails way before
 13 me that he was finding it hard to deal with the
 14 workload. I wasn't aware of those.

15 445 Q. What you're saying is you did speak to Mr. Wright about 15:15
 16 this?

17 A. Yes. Yes.

18 446 Q. It was your understanding that he would take the issue
 19 away and deal with it with Mr. O'Brien in the context
 20 of job planning? 15:15

21 A. Job planning.

22 447 Q. Did you ever receive any feedback to say job planning
 23 has been discussed and we found a solution to this
 24 problem?

25 A. No. The next time I remember was the March meeting 15:15
 26 with Heather and Eamon. That was the next meeting.

27 448 Q. Let's move them to the March meeting. If we could have
 28 up on the screen an extract from your statement. It is
 29 WIT-23372, paragraph 7, please. It seems that what

1 you were one of his patients you would have been lucky
 2 because once you get in to see him he knew the name of
 3 your cat, he knew everything about you, but it was the
 4 ones who were waiting was the problem. what they were
 5 saying was he was a good enough clinician but he 15:18
 6 really, really had to speed up.

7 452 Q. Just if we look at TRU-277941. This is a meeting on
 8 21st March.

9 A. Mm-hmm.

10 453 Q. It's marked: "One-to-one Esther and Eamon" not, but 15:18
 11 I understand this is the handwriting of Mrs. Trouton --

12 A. It is.

13 454 Q. -- who was also at the meeting. If we can scroll it
 14 down, please. It says: "Need to get letter to
 15 AOB-this week". So do you think this is the meeting 15:19
 16 that you have referred to in your statement? It's
 17 a bit later than the start of March.

18 A. Yes. This is the meeting that I'm referring to that
 19 I was told that they were going to write to him.

20 455 Q. Yes. 15:19

21 A. Yes. That's it.

22 456 Q. And the letter, let's look at that, AOB-0979. No? Try
 23 00, please. Thank you. Now this is the letter. The
 24 note says: "Need to get the letter to AOB-this week".
 25 Do you think that was your instruction? 15:20

26 A. No. That was from Heather and Eamon to say: 'We're
 27 going to do this as soon as possible.'

28 457 Q. Yes. Were they taking ownership of this process?

29 A. Absolutely.

- 1 458 Q. Yes. To what extent did the process interest you?
- 2 A. Well, it interested me because going back to governance
3 and all the issues in and around governance, this
4 person was not completing his triages, which is a risk.
5 He wasn't doing his dictations -- which is a big risk. 15:21
6 He's the only person who can do dictations, and the
7 charts, et cetera. So I wanted this to be fixed very
8 quickly. And I did say -- I remember saying to them:
9 "But, you know, are you going to sit down with him and
10 discuss..." You know, it's one thing handing someone 15:21
11 a letter who is deep down into trouble but it's another
12 thing handing him the letter and sitting with the
13 person to see can you bring them up out of that
14 trouble. That was very important to me that that would
15 happen. 15:21
- 16 459 Q. Yes?
- 17 A. Yes.
- 18 460 Q. So you wanted an assistance or support-based approach?
- 19 A. Absolutely, I did.
- 20 461 Q. Did you discuss with them what they might look like? 15:22
- 21 A. They said that they absolutely would sit down with him.
22 They told me at the meeting that they were going to sit
23 down with him, that they were going to discuss how, you
24 know, how it was possible for this to happen, if he
25 needed any help, if there was anything that they could 15:22
26 do. And I said, you know, patient safety comes
27 absolutely first here and if this person needs help
28 then we need to give it, but we need to sort of the
29 problem, whatever the problem is.

- 1 462 Q. Yes. Well, we know what the problem was for the
 2 service, don't we?
- 3 A. Yes, of course.
- 4 463 Q. When did you first see the letter, do you think?
- 5 A. Even when it came to the September Oversight Group, the 15:22
 6 letter wasn't presented there. It was a report from
 7 Simon Gibson.
- 8 464 Q. Yes.
- 9 A. They called it a screening report, I think.
- 10 465 Q. Yes. 15:23
- 11 A. The letter itself wasn't presented there.
- 12 466 Q. I'm asking you when you first saw that letter?
- 13 A. I don't know. Probably, maybe when it came to December
 14 and when the SAIs all started to come through. To be
 15 honest with you, I don't know when I first saw that 15:23
 16 letter.
- 17 467 Q. Let's just look at it briefly. It tells that the
 18 reader there are currently 253 un-triaged letters
 19 dating back a year and a half to December '14.
- 20 A. Yes. 15:23
- 21 468 Q. Tell me this, were you aware of the data, even if
 22 you didn't see the letter at these meetings?
- 23 A. Yes. When it came to -- I wasn't aware of the
 24 particular data at the March meeting, no, not at all.
 25 It was just a letter that was going to this man for 15:24
 26 being slow.
- 27 469 Q. Can I ask the question another way?
- 28 A. Yes.
- 29 470 Q. To what extent were you aware of the gravity of the

1 A. He wasn't dictating.

2 478 Q. You regarded those at that time, at that meeting as
3 potentially Patient Safety issues?

4 A. Yes.

5 479 Q. Just scroll down. He's telling you about, he's giving 15:25
6 you statistics on triage. Then this letter, I am
7 conscious you didn't see it, the backlog figures are
8 there. It is recorded:
9

10 "We are aware that you have a separate oncology waiting 15:26
11 list of 286 patients, the longest of whom was to have
12 been seen in September 2013. Without a validation of
13 the backlog we have no assurance that there are not
14 clinically urgent patients on this list."
15 15:26

16 Were you aware of that particular nuance?

17 A. No, I wasn't, and that was the one bit. When I was
18 provided all those papers I was provided in the core
19 bundles, that was the part of the letter that I don't
20 -- (a) wasn't told about in their meeting, and (b) 15:26
21 wasn't told about in September 2016 when we had the
22 oversight, because the screening letter didn't have
23 that in it.

24 480 Q. If we scroll down. It's telling you about patient
25 centres and recorded outcomes. This is the dictation 15:26
26 issue.
27

28 "Colleagues are frustrated or often frustrated that
29 there's no record of your consultations or discharges

- 1 on the patient notes".
- 2
- 3 scrolling down. Then "patient notes at home".
- 4
- 5 Of those issues you were generally aware of the triage 15:27
- 6 issue?
- 7 A. Mm-hmm.
- 8 481 Q. Generally aware of the dictation issue.
- 9 A. Dictation issue.
- 10 482 Q. Generally aware of patient notes at home? 15:27
- 11 A. Yes, generally.
- 12 483 Q. You knew there was a backlog with review, but
- 13 you didn't appreciate --
- 14 A. No.
- 15 484 Q. -- you didn't appreciate that he had a separate 15:27
- 16 oncology waiting list?
- 17 A. It was almost as though -- the thing about urology was,
- 18 and I suppose in terms of context, there was backlog,
- 19 you know, in a lot of areas. A lot of the urologists
- 20 did have waiting lists, but his were way over and above 15:28
- 21 what everybody else's was. Urology in Northern Ireland
- 22 was a regional problem and needed a regional solution.
- 23 At no time was there going to be 0, 0, 0 in terms of
- 24 waiting the whole way down. That was a given. I'm
- 25 just saying as a background to this. Urology was a big 15:28
- 26 issue in Northern Ireland -- still is, I understand.
- 27 485 Q. why do you think these particular issues were being
- 28 drawn to your attention at this meeting?
- 29 A. Mr. Mackle left very soon after the letter was sent and

1 Heather moved also very soon after the letter was sent.
 2 I'm assuming I was being told at that point, you know,
 3 there's an issue about this man and here's what we're
 4 doing. Although I didn't know, by the way, at the
 5 meeting that Mr. Mackle was going to leave so soon as 15:29
 6 he did. I'm assuming this is a rounding up of
 7 business, as it were, in terms of Mr. Mackle.

8 486 Q. Yes. They went and they had their meeting.
 9 Mrs. Corrigan actually attended instead of Mrs. Trouton
 10 who was absent that day. 15:29

11 A. Okay.

12 487 Q. But Mrs. Trouton shortly left for a new role.
 13 A. That's right.

14 488 Q. And Mr. Mackle stepped down to be replaced by
 15 Dr. McAllister. 15:30

16 A. That's right.

17 489 Q. So you left that meeting with the sense that there were
 18 patient safety issues, even if you didn't know the
 19 granular detail of the letter. You must have been
 20 awaiting some outcome from that meeting? 15:30

21 A. I suppose going back to the very beginning and what
 22 we discussed and the burden of the job that I had to
 23 do, I absolutely had to delegate work because if
 24 I didn't, I couldn't do it all myself and, certainly --
 25 so I delegated as appropriately as I could. And they 15:30
 26 left my office, they were in my office that day, so
 27 when they left my office, I was sure that I had
 28 appropriately delegated the task of sitting down with
 29 Mr. O'Brien to organise, you know, a way forward.

- 1 Because again -- and I'll say it again -- Mr. O'Brien
 2 was -- I didn't know the man at all but everybody had
 3 told me he was an excellent clinician, he was very well
 4 respected, this man had no "black marks", for want of
 5 a better word, against his name. So I knew or 15:31
 6 I believed that it was possible to sort this, and
 7 I felt as though I had appropriately delegated it to
 8 them.
- 9 490 Q. Yes, but you delegated it, if that's the right word,
 10 because they were always taking the initiative and not 15:31
 11 you, the task that they were to perform was coming from
 12 them and they were telling you about it.
- 13 A. Yes.
- 14 491 Q. Not delegated in that sense.
- 15 A. Well, I didn't write -- I wasn't going to be writing 15:31
 16 the letter, it was them.
- 17 492 Q. Yes.
- 18 A. They came to me with the problem and the solution, if
 19 you like. And they agreed to write the letter.
- 20 493 Q. Yes. And then they exited stage left? 15:32
- 21 A. Yes.
- 22 494 Q. Shortly after the meeting, leaving you with the
 23 knowledge with the acute services directorate that you
 24 have a clinician who has got practise problems that are
 25 potentially harmful to patients. 15:32
- 26 A. Um-hmm.
- 27 495 Q. So did you receive any feedback from that meeting?
- 28 A. No, I didn't receive any --
- 29 496 Q. Did you seek any feedback from the meeting?

1 A. I didn't seek any feedback from the meeting but what
 2 I did do, because all of my ADs were moving around at
 3 that time, and everything was really fluid, but
 4 I remember saying to all of my ADs in -- you know, in
 5 meeting rooms: "Look, you must hand over whatever is 15:33
 6 on you're caseload to the AD coming in. You must. You
 7 have to. I can't do it and I can't run around finding
 8 out before things." So that was a given that everybody
 9 who was moving -- and it wasn't a difficult job to do
 10 because we were all on the same floor next door to each 15:33
 11 other, nobody moved rooms. So as far as I was
 12 concerned, and given, I suppose, the pressure that
 13 I was under, I didn't go seeking anything. No,
 14 I didn't.

15 497 Q. Okay. Mr. McAllister, when he took up his role, he 15:33
 16 wrote to you. If we could have up on the screen,
 17 please, WIT-14875, so you're copied into the e-mail,
 18 it's 9th May, and Dr. Wright, Ronan Carroll. Item 6,
 19 Urology. Obviously there's lots of other issues
 20 sketched out there. But the issues that he identifies 15:34
 21 within urology include the very issues that you are
 22 aware from your meeting in March relate to Mr. O'Brien.

23 A. Yes.

24 498 Q. And at the bottom of the page -- just scroll down to
 25 the end of this e-mail, please -- he said: 15:34

26
 27 "That's what has appeared so far. Basically, a very
 28 disturbing picture with significant governance risks.
 29 I'd be interested in your thoughts".

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And he receives replies from Mr. Carroll and Dr. Wright but we can't find any reply from you.

A. Well, respectfully, a lot of the things that are on that list were ongoing in the directorate. 15:35

499 Q. Yes.

A. I'm not sure that he discovered them all himself. Could we scroll back down?

500 Q. Of course, yes. Do you want to get to the top of the e-mail? 15:35

A. Yeah.

501 Q. Of course.

A. You know, the structure dealing with governance, what we knew and what we are doing and whatever -- mind you, what he's talking about there is the governance within medicine. 15:35

502 Q. Yes.

A. The monthly meetings with the Clinical Leads, the ADs and Heads of Service. The FY1 rotas were on the agenda all the time. Staff side were always meeting with us in relation to that. 15:35

503 Q. In a nutshell, a lot of these issues are already on your agenda and were being dealt with?

A. Yes, a lot of them. But I do remember saying to Charlie about urology and I remember him saying: "Yes, but Colin and I have got ideas about that." But, again, Charlie McAllister now was the AMD for all of these areas. He had identified the problems. 15:36

504 Q. Yes.

- 1 A. I knew, Ronan knew, Richard knew, and there was a lot
2 of overlap as well between Richard and I.
- 3 505 Q. Just on Mr. O'Brien's issue, Mr. McAllister is putting
4 it on to each of your agendas, perhaps. He obviously
5 has a responsibility as well as AMD and he has answered 15:36
6 for that. But in terms of your role, who is being --
7 you being with this issue from Christmas of the
8 previous year if Mrs. Trouton's account is to be
9 accepted, and you have met with Trouton and Mackle, you
10 know that the meeting has taken place and you know the 15:37
11 content, broadly, of the letter that Mr. O'Brien is to
12 receive and has received?
- 13 A. Yes.
- 14 506 Q. But you hadn't sought any feedback from the meeting and
15 you haven't discussed this with Mr. McAllister 15:37
16 directly, have you?
- 17 A. Yes, I did. I discussed it with Mr. -- because he came
18 for one-to-ones with me as well and I remember at his
19 first one-to-one, you know, just briefly going down all
20 of the issues here. I mean, the middle grade cover is 15:37
21 scant and is unable to provide -- you know, we've known
22 that for a very long time. I think he is writing the
23 obvious down there, to tell you the truth.
- 24 507 Q. But with Mr. O'Brien, you met with Mr. McAllister?
- 25 A. Yes, I did. 15:37
- 26 508 Q. Spoke about the O'Brien situation?
- 27 A. Yes. He said that he and Colin Weir had ideas about
28 how to fix it. And I said: "Well, will you go on
29 ahead and get it fixed really quickly, please, because

1 it is rumbling on", is the word I used. It wasn't
2 warning bells but it was just rumbling, it was just
3 mentioned here and there, you know.

4 509 Q. Uh-hmm. Now we get to August and September.

5 A. Yes. 15:38

6 510 Q. And you know the issue comes back on the agenda and
7 oversight and all of that, and we'll look at that just
8 now.

9 A. Okay.

10 511 Q. How come this issue has gone from March on to an 15:38
11 oversight Committee agenda without any action being
12 taken by you to make sure that it was brought to
13 a conclusion as quickly as you wanted it to be brought?

14 A. Yes, I think -- you see, are you asking me how it got
15 to the agenda in September? 15:39

16 512 Q. I'm asking, I suppose, given that the issue was first
17 brought to your attention in December?

18 A. Yes.

19 513 Q. You identified it in March as a patient safety issue,
20 at least potentially? 15:39

21 A. Mm-hmm.

22 514 Q. It comes on to the agenda in September in an unresolved
23 state. In other words, the better part of nine months
24 have passed and you have a clinician within your
25 Directorate who, apart from a short meeting in March, 15:39
26 hasn't been spoken to about this in circumstances where
27 he has been asked for a remedial plan and hasn't
28 produced it?

29 A. Again, I was under the impression that other people

1 were dealing with it. Heather and Eamon were going to
2 sit down with him and work a plan out. When I spoke to
3 Charlie, it wasn't in May I spoke to Charlie, it might
4 have been slightly later. I'm not going to say a date
5 because I can't remember a date. It was, in my mind, 15:40
6 that this particular issue was well within the bounds
7 of being sorted by his CD and AMD and his colleagues in
8 the urology team.

9 515 Q. At any point before you met Mr. McAllister and Mr. Weir
10 on 14th September 2016, did you receive or seek any 15:40
11 feedback from him or from them?

12 A. From?

13 516 Q. McAllister and Weir.

14 A. They sent out an appeal very shortly after. I spoke to
15 Charlie on the -- just after the -- sorry. Sorry. 15:41

16 517 Q. What I'm asking you is that you met them after the
17 Oversight Committee meeting on 14th September?

18 A. I think it was a few days after that.

19 518 Q. It was 14th September?

20 A. I brought them into my office. 15:41

21 519 Q. Yes. We'll come to that.

22 A. Yes.

23 520 Q. Before that, at some unspecified point shortly after
24 Mr. McAllister's appointment, you spoke to him?

25 A. Yes. 15:41

26 521 Q. He told you that himself and Mr. Weir had plans to sort
27 this out.

28 A. Mm-hmm. In fact there's e-mails to -- he said at one
29 point to Colin, 'I think we've missed the boat here'.

1 522 Q. Yes, that's in August?

2 A. Was that August?

3 523 Q. That wasn't to you?

4 A. No. No. That wasn't to me but --

5 524 Q. What I'm really asking you, Mrs. Gishkori, is you have 15:41
6 asked Mr. McAllister to sort this out and sort it out
7 quickly. You can't remember when you asked him to do
8 that, but the question is: did you pursue it with him?
9 Did you seek feedback from him? 'Charlie, what are you
10 doing to sort this out and have you reached 15:42
11 a solution?'

12 A. No, because he left very quickly after that as well,
13 after the September.

14 525 Q. No, you really are missing the point, Mrs. Gishkori.

15 A. Sorry, I beg your pardon. 15:42

16 526 Q. Let's think about the period before the Oversight
17 Committee meeting.

18 A. Okay.

19 527 Q. The several months between McAllister's appointment in
20 May and the Oversight Committee Meeting in September. 15:42
21 That period of three to four months?

22 A. Yes.

23 528 Q. He knows about the O'Brien issue, he knows about the
24 letter?

25 A. Yes. 15:42

26 529 Q. You know about the O'Brien issue and you know about the
27 letter.

28 A. Mm-hmm.

29 530 Q. You asked him to produce a solution quickly?

1 A. Mm-hmm.

2 531 Q. Did you ever go back to him?

3 A. No.

4 532 Q. why not?

5 A. Again, probably based on how busy I was. You know, the 15:43

6 urology issue wasn't the only issue going on at the

7 time, Mr. Wolfe. You have to understand that there was

8 fires all over the place to be put out. You know,

9 retrospect is a very good weapon to have when you are

10 looking back on things, but whenever at the time it was 15:43

11 just another one of an awful lot of issues. If I had

12 gone -- you have nine or three or how many issues

13 there, I couldn't have had the time to go back to him

14 and say, 'did you do that, that, that or that'. You

15 know. I had to trust my colleagues, that's what they 15:43

16 were there for. I had to trust my AMDs, my ADs, the

17 Clinical Directors below them. They had a job of work

18 to do. I was doing loads --

19 533 Q. You also have to manage them, Mrs. Gishkori.

20 A. Yes. Yes. 15:44

21 534 Q. You have to, because you're at the top of pyramid,

22 say to them --

23 A. Operationally, yes.

24 535 Q. -- you have to say to them, do you not: 'Listen, this 15:44

25 is a doctor who appears to be struggling. His

26 struggles are causing potential harm or patient risk.

27 I want this addressed, and I want it addressed quickly,

28 and I want you to report to me with how it has been

29 resolved'. At no point did you receive assurances of

1 to happen, perhaps, with those cases. So it is not the
 2 oversight itself I'm asking about.

3 A. No.

4 540 Q. But it is giving you information that Mr. O'Brien's
 5 case is potentially an MHPS case. Now presumably, 15:47
 6 having reminded yourself of this e-mail, can you help
 7 us, was that the first time you might have appreciated
 8 that your colleagues on Oversight were thinking of an
 9 MHPS process?

10 A. Yes, that would be right. 15:47

11 541 Q. Yes. You can't remember touching base?

12 A. It's very possible that we did because that's when
 13 sometimes most of the business was done, you know, like
 14 gathering people up after a meeting that was organised.
 15 You know, it was quick and it happened, everybody was 15:47
 16 there. So it's very possible that did -- I suppose
 17 I need to go back, you know, and.... Please go on.

18 542 Q. I'm sorry, are you okay?

19 A. Yeah.

20 543 Q. Are you sure? 15:48

21 A. Yes.

22 CHAIR: If you do need to take a break, we can.

23 A. No, it's okay.

24 CHAIR: In fact, it might be an appropriate time anyway,
 25 Mr. Wolfe. It is ten to four now. 15:48

26 MR. WOLFE KC: I'm in your hands.

27 CHAIR: we'll take a short break and we will come back
 28 again just after 4.00.

29

1 THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

2
3 CHAIR: Mr. wolfe, just during the break, just to be
4 clear, we're not going to sit beyond 5 o'clock today,
5 just so that Mrs. Gishkori knows that and she knows she 16:03
6 has to come back anyway. If it makes it any easier,
7 we'll reserve our questions until she returns.

8 544 Q. MR. WOLFE KC: I may not go up to five o'clock, I'll
9 park at a convenient point in the questions. Now I was
10 asking you just before the break, Mrs. Gishkori, about 16:03
11 the e-mail that Vivienne Toal sent on 6th September
12 suggesting that it would be good to touch base on
13 a range of issues, including potentially an MHPS
14 investigation concerning Mr. O'Brien. I think you
15 agreed with me that if you considered that e-mail at 16:04
16 the time, that might have been the first occasion in
17 which you would have been aware that an MHPS was in
18 consideration?

19 A. That is right, yes.

20 545 Q. What you might not have been aware, and let me ask you 16:04
21 about this, was that in advance of this, Mr. Simon
22 Gibson had been tasked with the role of carrying out
23 a screening report or a preliminary investigation into
24 certain issues. When did you first become aware of
25 that or was the need for that discussed with you? 16:04

26 A. No. No. The need for that was not discussed with me.
27 The first time I saw this screening report was just in
28 advance of the Oversight Committee and Simon had said
29 that he had been tasked with doing a screening report,

1 indeed he had given some recommendations in it as well.

2 546 Q. Yes.

3 A. So that's when I saw that.

4 547 Q. Now obviously we'll get to the Oversight Committee, et

5 cetera. 16:05

6 A. Yes.

7 548 Q. Now leaving aside the potential for having touched base

8 with Toal and Wright, and you can't remember whether

9 you did or you didn't, and that's your evidence.

10 A. Yes. 16:05

11 549 Q. Apart from that potential meeting to touch base, had

12 you ever discussed the circumstances of Mr. O'Brien

13 with, for example, the Medical Director in advance of

14 the oversight meeting?

15 A. No. 16:05

16 550 Q. Now 12th September. If we could bring up TRU-257627

17 and it's coming up to close of business, I suppose, and

18 Mr. Gibson is sending you the screening report for the

19 oversight committee meeting which is to take place in

20 the morning. 16:06

21 A. Yes.

22 551 Q. Let me just pull up what you've said about that in your

23 witness statement. If we go to WIT-23409. And at

24 paragraph 2 at the top of the page -- unfortunately,

25 the questions that you're asked are in a separate 16:06

26 place.

27 A. I know.

28 552 Q. But if I can tell you that you're being asked there

29 when did you first become aware that there would be an

1 investigation into the performance of Mr. Aidan O'Brien
 2 and you say: "I became aware when Dr. O'Brien was
 3 listed on the agenda for a meeting of the Oversight
 4 Committee. I was not aware prior to attending that
 5 meeting. The agenda for the meeting was circulated 16:07
 6 one day before, but due to a busy work schedule, I had
 7 not had sight of the agenda in advance of the meeting."
 8

9 A. Yes.

10 553 Q. Can you help us with that? 16:07

11 A. Yes, it honestly -- you know, Emma would have been
 12 saying to me: "Esther, there's your papers", you know,
 13 and I would have literally been running down the hill
 14 to go to the Oversight Committee, which I think was in
 15 Dr. Wright's office in Headquarters. I think Vivienne 16:08
 16 somewhere else had said she had read the papers the
 17 night before. I didn't. I did not read them the night
 18 before, I read them sort of on the way and then during
 19 the meeting, it all started to unfurl and became --you
 20 know, I read it as the meeting went along. 16:08

21 554 Q. I asked you maybe at some length about whether you
 22 touched base in the week before.

23 A. Yes. Yes.

24 555 Q. It was perhaps with this answer in mind, because this
 25 answer that you've given here rather suggests that 16:08
 26 upon -- perhaps even upon arrival at the meeting it was
 27 almost a surprise or, certainly, a discovery that
 28 Mr. O'Brien was on the agenda. Whereas, you certainly
 29 received an e-mail?

- 1 A. I did.
- 2 556 Q. Or it appears you received an e-mail suggesting that an
3 MHPS for Mr. O'Brien was at least a possibility.
- 4 A. A possibility, yes. And all I can say to you is
5 I don't really remember touching base after the 16:09
6 governance meeting. I can only tell the truth.
- 7 557 Q. Yes.
- 8 A. I can't remember -- I can remember when this whole
9 thing, as they talk about, the alarm bells started to
10 ring and they rang for me in this meeting. 16:09
- 11 558 Q. In what sense?
- 12 A. Because I read -- I started to read the screening
13 report and everything that was on it and thinking to
14 myself, gosh, you know, Heather and Eamon said they
15 were going to be dealing with this in March. There was 16:09
16 a lot of things went through my mind at that meeting,
17 Mr. Wolfe, so...
- 18 559 Q. What were those alarm bells saying to you? Was it: We
19 have failed to deal with this? Was it: This is more
20 serious than I anticipated or can I put a third option 16:10
21 to you: I don't like the way this meeting is going?
- 22 A. Well, I neither liked nor disliked it. It was
23 a meeting, there was an agenda, and that was that. For
24 me, it was really about the patients. For goodness
25 sake, we need to get these -- that was it, patients -- 16:10
26 you know, I didn't mind who wrote what and who -- you
27 know I went to the school of very hard knocks in
28 certain trusts, but it was the patients.
- 29 560 Q. Okay.

1 unsighted on the process here.

2 A. Okay.

3 567 Q. You say the concerns had gone to the CE, the Chief
4 Executive, before you knew the extent of the problem.
5 So if we can just maybe think about this in date terms. 16:12

6 A. Yes.

7 568 Q. 13th September is the oversight meeting.

8 A. Yes.

9 569 Q. Francis Rice was the Chief Executive?

10 A. Yes, he was. 16:12

11 570 Q. What is your source of knowledge for thinking that this
12 matter has reached the Chief Executive before it gets
13 to the Oversight Committee?

14 A. Well, at the Oversight Committee they were saying that
15 the Chief Executive already knew about this and that he 16:12
16 had -- I mean, I would need to see the minutes but that
17 he had sort of tasked Richard Wright with taking it
18 forward. That's why -- well, I'll tell you about that.
19 I phoned Francis and Richard the next day, so I knew
20 that Francis was aware of it. 16:13

21 571 Q. Yes, okay. We'll look at perhaps the Trust guidelines,
22 which has a provision for the Chief Executive becoming
23 involved. We'll look at that in a moment. But you're
24 saying that escalated to the CE before you knew the
25 extent of the problem. Is it not fair to say that you 16:13
26 knew the extent of the problem even before you got the
27 screening report?

28 A. I believe it's fair to say that I knew about the
29 problem but not the extent of it.

- 1 572 Q. So if I could just then, before we formally enter the
 2 meeting, I suppose, look at the Trust guidelines. If
 3 you can -- the first page for them -- I'll just go to
 4 the first page so you can orientate yourself.
 5 TRU-83685. I think you told us earlier that they were 16:14
 6 available to you on the Trust Internet?
- 7 A. Yes, they would have been.
- 8 573 Q. If we go to TRU-83688. If we just scroll down a
 9 little, please, and stop there. It says that:
 10 16:15
- 11 "Concerns that may require management under the MHPS
 12 Framework must be registered with the Chief Executive.
 13 The Clinical Manager will be responsible for informing
 14 the relevant Operational Director."
 15 16:15
- 16 There's two points there. This might have been in the
 17 mind of whoever informed the Chief Executive.
- 18 A. Yes.
- 19 574 Q. There had been an issue raised which may require
 20 management under MHPS. 16:15
- 21 A. Yes.
- 22 575 Q. "The Clinical Manager would be responsible for
 23 informing it the relevant Operational Director."
 24 You were the relevant Operational Director, nobody
 25 informed you? 16:16
- 26 A. No.
- 27 576 Q. In fact, as we read on: "The Clinical Manager", at
 28 2.4, "will immediately undertake a initial verification
 29 of the issues raised. The Clinical Manager must seek

1 advice within Employment Engagement and Relations
2 Department. "

3
4 You received a screening report, and we'll look at
5 that?

16:16

6 A. With the agenda. Yes.

7 577 Q. Yes. It was conducted by Mr. Gibson.

8 A. That's right.

9 578 Q. Plainly not a Clinical Manager.

10 A. No.

16:16

11 579 Q. Now you appreciated that he was the author of that
12 report, acting under the instructions of the Medical
13 Director?

14 A. Mm-hmm.

15 580 Q. Did anybody at any time point out to those gathered
16 around the table at the Oversight Committee that; we've
17 missed a stroke here. The rules of the game, if you
18 like, provide for clinical management input at this
19 stage rather than being led by a nonclinical manager?

16:16

20 A. The answer to that question is no, nobody did. Plus
21 also -- I mean, I've read this since, of course, in my
22 pack, but I wouldn't have read that in advance of the
23 meeting. But it's just to say to you that,
24 respectfully, Simon Gibson nearly ran the whole thing
25 from the point of view of the Chief Executive's office.
26 Whether he did it under his guidance or whether he just
27 took, respectfully, the ball and ran the whole way up
28 the pitch with it, it seems that that's what he did.
29 So nobody said round the table -- I always challenged

16:17

16:17

1 Simon, but then I got to the point where I didn't.

2 581 Q. Okay. In terms of the absence of clinical management
3 at this Oversight Committee meeting, looking back at
4 the issue do you think that was a problem?

5 A. Yes, I do. Very much so. It's why I contacted the AMD 16:18
6 as soon as I went up, because one of the things that
7 you'll find in Health and Social Care nowadays is that
8 there's an awful lot of bureaucracy in it. There's an
9 awful lot of people dish -- the way I looked at it, it
10 was like those blind trying to lead those with 20-20 16:18
11 vision. The people who really knew what should have
12 been happening were the people on the ground. It was
13 always the case with everything. They had the
14 solutions. They always did. But there was a tendency
15 for the bureaucracy in the organisation to just run 16:19
16 away with the thing and come up with -- I mean at that
17 meeting there was going to be another letter composed.

18 582 Q. Yes.

19 A. Here we go again now. Whereas, and I'm probably
20 jumping on, so I'll wait. 16:19

21 583 Q. Okay. The structure within the guidelines that
22 you have up in front of you --

23 A. Yes.

24 584 Q. -- provide for a Clinical Manager to carry out
25 a preliminary investigation if that's indicates that 16:19
26 MHPS --

27 A. Yes.

28 585 Q. -- might be an issue. The Chief Executive is informed,
29 and then the decision of the Clinical Manager is

1 notified to the Oversight Committee --

2 A. Yes.

3 586 Q. -- which has, as it describes in this document, as
4 a quality control function.

5 A. Yes. 16:20

6 587 Q. As opposed to a decision making function.

7 A. Yes.

8 588 Q. Did you appreciate that at the time? This Oversight
9 Committee made the decision, as we'll see, to have an
10 informal MHPS investigation as opposed to the Clinical 16:20
11 Manager.

12 A. Yes. But, again, that's why I tell you that I tried
13 very hard to bring it back to operational level to have
14 it sorted. Yes, I did appreciate it, is the answer to
15 your question. 16:20

16 589 Q. Okay. Let's look at the screening report then. You
17 said you read that at the meeting --

18 A. Yes. Well en route.

19 590 Q. As best you could?

20 A. Yes. 16:20

21 591 Q. It's to be found at TRU-257627. Sorry, it's not. It's
22 TRU-251423. It set out, under a series of issues,
23 Mrs. Gishkori, obviously we don't have the time to go
24 through it. Un-triaged patients, that problem is
25 described and the numbers given, 253 un-triaged 16:21
26 letters.

27 A. Yes.

28 592 Q. No plan received from Mr. O'Brien.

29 A. Mm-hmm.

1 593 Q. Some of those letters, 174, dating back 18 weeks.
 2 Alarm bells were starting to ring --
 3 A. Absolutely. Yes.
 4 594 Q. -- when you saw those figures?
 5 A. It did. 16:22
 6 595 Q. That was because of concerns about the impact on
 7 patients?
 8 A. Absolutely. And nothing else.
 9 596 Q. Outpatient review backlog.
 10 A. Yes. 16:22
 11 597 Q. Scrolling down. It's described -- you made the point
 12 earlier that the letter to Mr. O'Brien referred to
 13 a separate oncological review list that Mr. O'Brien
 14 seemed to retain.
 15 A. That`s right. 16:22
 16 598 Q. That wasn't mentioned here. Was that your point?
 17 A. That's the point I was trying to make. I didn't see
 18 it. I could be wrong.
 19 599 Q. Did you think that significant when you picked up on
 20 that point? 16:22
 21 A. Well --
 22 600 Q. I take it you only picked up upon it in preparation for
 23 this?
 24 A. Of course. In preparation for this and I found it very
 25 significant. If you talk about oncology at all, you're 16:22
 26 talking about patients who have either a very small
 27 window of opportunity to be treated and, do you know,
 28 even if it's oncology and the patient has secondaries
 29 or on a terminal pathway, what about keeping them

1 comfortable? what about giving them the best option
2 that there is? It just blows my mind to think that
3 patients wouldn't be cared for. That's when I really
4 do lose it, to tell you the truth. But I didn't see
5 this oncology -- even though at a point Mr. O'Brien 16:23
6 goes into some sort of big specific convoluted
7 explanation of it, but anyway, for me, to be very
8 simple, I just wanted this sorted as quick as possible.
9 Really.

10 601 Q. Then it refers to patient notes at home. We needn't 16:23
11 dwell on that. The fact that incident reporting had
12 been used as a method of logging this in the past, that
13 was no longer done. Do you have any view on whether
14 notes at home and the discovery that notes are at home
15 and can't be accessed within the hospital; is that 16:24
16 something that should have been recorded as an
17 incident?

18 A. Yes, of course, because, you know, it breaches the Data
19 Protection Act, whatever other -- and Richard was the
20 Responsible Officer for data protection. This is 16:24
21 a problem that has been ongoing for a very, very, very
22 many -- I would imagine it was custom and practice
23 years ago. I can remember doctors taking charts home
24 to write notes in and taking them back, long before the
25 legislation came in. When I saw that, even though 16:24
26 I was alarmed, I wasn't surprised. But on PAS -- it
27 was hard to know until you'd lost a chart whether it
28 was lost. Do you know what I mean? Until a chart came
29 up that you couldn't find it. I'm not sure if I'm

1 putting that right or not.

2 602 Q. The fourth issue that's raised is in respect of the
3 recording and the dictation of patient outcomes --

4 A. Yes.

5 603 Q. -- following clinical engagements. There had been no 16:25
6 formal audit by this stage?

7 A. No.

8 604 Q. Together, I think you're saying, these issues caused
9 you concern?

10 A. Yes. 16:25

11 605 Q. Just to scroll to the bottom of the page then. The
12 conclusion reached by, as it appears, Mr. Gibson, is
13 that there's a need for, or he recommends an NCAS
14 supported external assessment of Dr. O'Brien's
15 organisational practice, with Terms of Reference 16:25
16 centred on whether there's a risk of patients coming to
17 harm.

18

19 Did you pick up on that recommendation at any point in
20 your thinking at that meeting? 16:26

21 A. I knew that Richard did make referral to NCAS, as you
22 call it -- I just call it NCAS -- just previously or
23 just after it. As far as I was -- I knew the NCAS
24 flowchart fairly well. Normally what they say is try
25 to resolve this at the lowest possible level. Don't 16:26
26 start being convoluted about it if you can get it
27 sorted there and then very quickly with good governance
28 around it so that you can get it done. But Simon made
29 whatever recommendations he wanted, really.

- 1 606 Q. It doesn't appear that that recommendation was accepted
 2 at the subsequent Oversight Meeting.
- 3 A. Right.
- 4 607 Q. Let's look at that now. The Oversight Meeting, as
 5 we know, took place on the 13th. If we go to 16:27
 6 TRU-00026. This is the record of the Aidan O'Brien
 7 discussion. By this stage Mr. Gibson had spoken to
 8 NCAS and he had received oral advice which was to be
 9 committed to writing, was received -- it was dated that
 10 day and it wasn't received before the meeting. 16:28
- 11 A. Okay.
- 12 608 Q. But it was subsequently shared with you and others.
- 13 A. Yes.
- 14 609 Q. Do you have a recollection of the NCAS advice being
 15 related to the meeting by Mr. Gibson? 16:28
- 16 A. Yes, I think so. Did they talk about audit? To audit
 17 his practice? I think they said, basically that, you
 18 know, we should work together with the clinician to
 19 produce the most positive outcome and as soon as
 20 possible, I think. More or less they were in that -- 16:28
 21 and to keep them informed. Yes, I remember seeing the
 22 letter, but just now I can't --
- 23 610 Q. Maybe if we get the chance we'll go to the advice
 24 letter.
- 25 A. Yes. 16:28
- 26 611 Q. You do have a firm memory of advice being related to
 27 the meeting?
- 28 A. Yes.
- 29 612 Q. The outcome of this --

1 CHAIR: Just to be clear, Mrs. Gishkori, I think there
 2 may be some confusion here. Do you remember the
 3 advice -- the telephone call being spoken about at the
 4 meeting before you saw the letter?

5 A. No, I don't remember the telephone call being talked 16:29
 6 about, but I remember seeing the e-mail when NCAS
 7 produced the e-mail. Sorry, that was my fault. Sorry.

8 613 Q. MR. WOLFE KC: what I was specifically putting to you
 9 was this. The written advice from
 10 Dr. Fitzpatrick didn't arrive before the meeting? 16:29

11 A. Yes.

12 614 Q. It was circulated some two weeks later by Mr. Gibson,
 13 on the 28th, I think, or 27th September.

14 A. Okay.

15 615 Q. Mr. Gibson has told the Inquiry that at the meeting on 16:29
 16 13th September he was able to tell you --

17 A. Me?

18 616 Q. Not you, the whole meeting. He was able to tell the
 19 meeting this is what NCAS have advised, and he took the
 20 meeting through, he believes, three or four points that 16:30
 21 NCAS had mentioned, including, as you point out, the
 22 need for an audit of an aspect of Mr. O'Brien's work.

23 A. Was it in the minutes? I didn't --

24 617 Q. It's not in the minutes, that's why I'm asking you. Do
 25 you have a memory of the advice or any reference to 16:30
 26 contact with NCAS being discussed at this meeting?

27 A. I'm sorry, I don't.

28 618 Q. You can't.

29 A. No.

- 1 619 Q. The upshot of the meeting, as we can see in the bullet
 2 points, is that Mr. Gibson got the letter which weir
 3 and Carroll would present to Mr. O'Brien at a meeting
 4 which would take place within the week or within the
 5 fortnight. The letter should inform Mr. O'Brien of 16:30
 6 the Trust's intention to proceed with an informal
 7 investigation under MHPS and it also include action
 8 plan with a four-week time scale to address the four
 9 main areas of his practice that are causing concern.
 10 You, Esther Gishkori, are to go through the letter with 16:31
 11 Colin Weir, Ronan Carroll and Simon Gibson prior to the
 12 meeting, and Mr. O'Brien should be informed that a
 13 formal investigation may be commenced if sufficient
 14 progress has not been made within the four weeks.
 15
 16 Is that a fair record of what was agreed at that 16:31
 17 meeting?
 18 A. That's what they said, but I thought it was an
 19 informal. I think Richard -- maybe I could be wrong.
 20 The very last point I felt -- 16:31
 21 620 Q. If you go up to the third bullet point. This letter
 22 should inform AOB of the Trust's intention to proceed
 23 with an informal.
 24 A. Informal, yes. Of course, I understand.
 25 621 Q. If he doesn't meet the target, a formal investigation 16:32
 26 would be contemplated?
 27 A. Yes. Sorry about that, yes.
 28 622 Q. Does that square with your memory?
 29 A. It does.

1 623 Q. Were you part of the consensus at that meeting that
2 agreed that was the way to go forward?

3 A. Yes.

4 624 Q. You paused and thought long and hard about that?

5 A. Yes, it is a pause. Because I'm sitting there thinking 16:32
6 to myself: what happened after the March letter? Where
7 are we with that? Are these dictations still sitting
8 somewhere, you know, from a clinic? Nobody else can do
9 the dictation, only the person who saw the patient.

10 I'm thinking here we are now going to send another 16:32
11 letter. How are we going to do that? In my mind I'm
12 thinking, 'but Charlie McAllister told me that he and
13 Colin Weir, who was the CD, were considering ways to
14 deal with it'. That's what I was thinking. But

15 I wasn't brave enough at the meeting to say all of 16:33
16 that. Because, I suppose in some ways I wanted to go
17 up and check my e-mails to see had I had an e-mail
18 saying, you know, between March and now. I just still
19 felt that it should be informal as well. You can move
20 on because it's the next bit, I suppose I'm going to 16:33
21 say to you now.

22 625 Q. Just finish your answer as you wish to answer,
23 Mrs. Gishkori. There's no structure to this
24 particularly.

25 A. Okay. So I didn't really agree with this particular 16:34
26 course of action because I still felt at this point
27 there had been no indication that this man couldn't do
28 his work. No indication of -- as we knew at this point
29 of an incident, an accident, an SAI, any complaints

1 even. So I felt he should be made, just as his other
 2 colleagues do, I felt he should be made by the CD and
 3 the AMD to do it. And I felt it was their job to do.
 4 Yes, Martina could have helped, you know, but I wanted
 5 to get out of the room and go and find Charlie 16:34
 6 McAllister and find out what was going on. Honestly.
 7 626 Q. So what did you think was missing? I take your point
 8 that you didn't feel brave enough to articulate your
 9 real feelings about it. What did you think was missing
 10 from this plan of attack? 16:35
 11 A. So what was going to be in the letter that Simon was
 12 going to compose?
 13 627 Q. Sorry?
 14 A. So Mr. Gibson was going to write a letter. What was
 15 going to be in that letter? 16:35
 16 628 Q. Yes.
 17 A. Was it appropriate that he wrote the letter?
 18 629 Q. But he was going to be writing the letter and setting
 19 out detail on it and you were going to approve it?
 20 A. I just feel that informally -- 16:35
 21 630 Q. What was wrong with this approach?
 22 A. Well, there was still a big bit in relation to the
 23 informal process of MHPS. So the Clinical Manager, as
 24 you have already said, should be the one who
 25 establishes the facts. That didn't happen. Consider 16:36
 26 consultation with the Director HR NCAS, which they did.
 27 But then the next bit down is remedial action, i.e.
 28 local action plans, which I felt that a local action
 29 plan should be, and with the local team as opposed to

1 Mr. O'Brien getting another letter that now he knew
 2 everybody else knew and if he went off sick, what would
 3 we do? If he walked out the door, what would we do?
 4 How could we get all these dictated. So I wanted to
 5 sort it so that the solution involved him. 16:36

6 631 Q. The solution was going to involve him, was it not,
 7 under this approach?

8 A. Well....

9 632 Q. And we'll look at the letter in a moment.

10 A. Yeah, yeah. 16:36

11 633 Q. But was your problem with the decision that it was
 12 going to not only involve a time-tabled requirement for
 13 Mr. O'Brien to comply with the requisite standards and
 14 clear up the backlog, but was your concern that they
 15 were adding onto it an MHPS investigation? 16:37

16 A. I think my concern was that, clearly, it hadn't been
 17 dealt with by the CD and the AMD, and that's where
 18 I felt, before we start to send out an informal letter
 19 that says you may be excluded -- you know, what it said
 20 before, I just wanted it to be dealt with at the lowest 16:37
 21 possible --

22 634 Q. Let's pull up the letter that was sent to you.

23 A. Okay.

24 635 Q. TRU-251429. This is the e-mail that was sent to you,
 25 then we go to the letter. It's drafted very quickly 16:37
 26 after the meeting.

27 A. Yes, it is.

28 636 Q. You are specifically engaged by the content of this.

29 A. Yes.

1 637 Q. Mr. Gibson is saying that we've set a target of 70 per
 2 month. That is presumably 70 cases every month until
 3 the end of December with a view to dealing with the
 4 outpatient review backlog. He's saying to you,
 5 operationally this is your call. 16:38

6 A. Mm-hmm.

7 638 Q. First of all, let's go to the letter. Scroll down the
 8 page, please. Did you read the letter when it was sent
 9 to you?

10 A. This letter, yes. It was sent in a draft form. 16:38

11 639 Q. Yes.

12 A. Yes. Yes.

13 640 Q. Did you read it before you went out the next day to
 14 meet with Messrs McAllister and Weir?

15 A. Very possibly. 16:39

16 641 Q. Yes.

17 A. Although I don't know, but it came out very soon after
 18 the meeting.

19 642 Q. Yes. It's telling Mr. O'Brien, although, of course, it
 20 was never sent, that it's the Trust's intention to 16:39
 21 proceed with an investigation under MHPS. At this
 22 stage it will take an informal approach, as outlined
 23 within MHPS, but following the outcome of this they may
 24 proceed or we may proceed with a formal investigation.
 25 16:39

26 The informal approach -- skipping the next paragraph --
 27 will consider four areas of his practice and be time
 28 bound as indicated below. Each of the areas,
 29 un-triaged letters, outpatient review backlog, patient

1 notes at home, and recording of outcomes, which is to
 2 be the subject of 20 sets of notes per month audit.

3 A. Mm-hmm.

4 643 Q. He is then told in late October:

5
 6 "There would be an assessment of your progress against
 7 the targets and if there's insufficient progress, this
 8 may give rise to a formal investigation".
 9

10 The history of this, Mrs. Gishkori, was of informal
 11 efforts to address the problems with Mr. O'Brien. If
 12 you read the screening report, for example, you would
 13 have seen reference to those informal efforts which,
 14 over a period of several years, well before your time,
 15 had not worked. Here was a rigid time-tabled, targeted
 16 plan, but you did not want to use this? 16:40

17 A. Can I see the date of that letter, if you don't mind?

18 644 Q. It's dated 21st September but it was sent on the 13th
 19 with a view to it being sent in advance of the meeting
 20 with Mr. O'Brien, which was planned for week commencing
 21 19th September. 16:41

22 A. Okay. Yes. I still think that I'd said -- because
 23 we do know that Mr. O'Brien got wind of what Charlie
 24 and Colin were going to do and eventually started to
 25 go -- he went off sick in -- sorry, let me just go back
 26 to what you've asked me, then we'll move on. 16:41

27
 28 Again here we were with a letter that said, okay, this
 29 is informal. After a certain date we're going to make

1 it formal. You could be excluded. what I knew about
2 him up until --

3 645 Q. It doesn't mention that.

4 A. No, it doesn't mention excluded. It said it could be
5 formal. Sorry, can you put it back down? Sorry,
6 I can't. 16:42

7 646 Q. Do you want to go to the top of the letter?

8 A. Yes, please. Sorry. Sorry. Thank you.

9 647 Q. Okay. Is that good for you?

10 A. Yes. Thank you. Yes. It says: 16:42

11

12 "We will be taking an informal approach as outlined
13 within MHPS, but following the outcome of this we may
14 proceed with a formal investigation. The investigation
15 should be seen in the context of the letter written to 16:43
16 you on the 23rd where a number of concerns were raised,
17 no plan was provided at that time and concerns still
18 exist".

19

20 Yes, those four areas. Yes, okay. That's fine. 16:43

21 648 Q. Your concern about that letter was what?

22 A. My concern about the letter was really just that if
23 I now went by what everybody was saying about
24 Mr. O'Brien, he wouldn't respond very well to someone
25 saying, 'and if this doesn't go well, we're going to be 16:43
26 taking a formal approach'. In my mind I was really
27 very concerned about getting his dictations done,
28 number one.

29 649 Q. Yes.

1 A. And who was going to do these.

2 650 Q. Sorry to cut across you. If you start with the
3 problem.

4 A. Yes.

5 651 Q. The problem is these four areas of practice. 16:43

6 A. Yes.

7 652 Q. You have indicated to us that as long ago as March you
8 appreciated at least some of those problems as Patient
9 Safety concerns.

10 A. Yes. 16:44

11 653 Q. That really rang as an alarm bell when you saw the
12 granular detail --

13 A. Of it.

14 654 Q. -- in the screening report?

15 A. Yes. 16:44

16 655 Q. Those are the problems that you wish resolved?

17 A. Yes.

18 656 Q. Here is a letter which is going to be accompanied with
19 a meeting with Mr. O'Brien setting out a time-tabled
20 call to action. 16:44

21 A. Mm-hmm.

22 657 Q. You didn't like this. Why not?

23 A. It's not that I didn't like it at all, it's just that
24 I felt because I thought he would react better to his
25 own clinical colleagues working with him without 16:44
26 a letter going out to him. It just was the fact that
27 we were sending another letter, basically. I really
28 had hoped -- that's why I didn't say anything in the
29 meeting, because I really had hoped it would be dealt

1 with at operational level still. In my mind, may be
 2 naive that I was, but I still felt.

3 658 Q. Notwithstanding the history, you thought it would be
 4 better with a clinical level or operational level,
 5 Mr. Weir or Mr. McAllister going to him?

16:45

6 A. Yes.

7 659 Q. Is that why you approached those two gentlemen the next
 8 day?

9 A. Yes.

10 660 Q. The next day, 14th September, did you take the
 11 initiative of approaching them?

16:45

12 A. Yes, I did. There must have been a meeting on my
 13 floor. You know, my Secretary would have phoned
 14 Charlie's secretary and she set Louise up with
 15 a meeting or whatever. I think Ronan might have been
 16 there too. I remember speaking to Colin at one point
 17 but I definitely, definitely spoke to Charlie
 18 McAllister who was my direct line that day, and
 19 I called him into my office.

16:46

20 661 Q. Yes. Within the Section 21 statement we've asked you
 21 about how you were to relate to certain people in the
 22 MHPS process, including the Medical Director?

16:46

23 A. Yes.

24 662 Q. You said at WIT-23408 that, as far as the Medical
 25 Director -- just at V here. So far as the Medical
 26 Director was concerned, your role was to support and
 27 respect his decisions on the Oversight Committee.

16:46

28 A. Yes.

29 663 Q. You were going to Mr. McAllister and Mr. Weir with

1 a view to obtaining an alternative view on what had
 2 been decided?

3 A. Yes, I still --

4 664 Q. -- by the Oversight Committee?

5 A. Yes, I still respected him and I still -- I mean you 16:47
 6 can challenge someone still respectfully, which is what
 7 I feel I did, both him and Richard -- sorry, Francis
 8 Rice.

9 665 Q. But you weren't supporting the decision of the
 10 Oversight Committee as you suggest is your obligation? 16:47

11 A. Well, I wasn't -- I respected it but I challenged it,
 12 let's just say, as I suppose was my right to do in the
 13 meeting. I told you before that for various reasons,
 14 I just wasn't that brave to do that and I wanted to
 15 check all my facts when I got back up to the office. 16:47

16 But, you know, I phoned Richard and asked him
 17 respectfully, because Charlie and Colin felt it would
 18 take three calendar months to resolve the whole thing.
 19 That's what they felt. Although Simon felt it would
 20 take shorter times for some of the things, but that's, 16:48
 21 I suppose, neither here nor there.

22 666 Q. So your witness statement, let's go to WIT-23409 and
 23 just scroll down to (iii). Thank you. You say:

24
 25 "Following the Oversight Committee, I immediately spoke 16:48
 26 to Charlie McAllister and Colin Weir. Ronan Carroll
 27 was also present at the meeting. As both of these
 28 individuals were line managers to Aidan O'Brien,
 29 I wanted to confirm what information they held in

1 relation to the problems that I had just been informed
 2 of. Charlie informed me that he had received one
 3 e-mail from Simon."

4
 5 That was the request in August, wasn't it, as to 16:49
 6 whether Charlie had received any of the plans from
 7 O'Brien?

8 A. Any of the plans from Mr. O'Brien, yes.

9 667 Q. Charlie suggested a resolution to the problem, which
 10 you have outlined further at paragraph 8 above, and 16:49
 11 that solution was?

12 A. The solution was that Mr. O'Brien, who really loved
 13 theatre, his theatre sessions and liked being in
 14 theatre, Charlie said all that they would have to do to
 15 resolve it would be to remove him from his theatre 16:49
 16 sessions until such times as he had caught up with his
 17 admin duties. He said that he and Colin had already
 18 looked into it. I don't know if they had spoken to his
 19 colleagues, I'm not sure, but he said that it was
 20 perfectly doable and he felt that they could do it, it 16:50
 21 would be safe, effective, and they could do it within
 22 three calendar months, he told me.

23 668 Q. Did he see that as a sanction or did he see it as
 24 a form of assistance to Mr. O'Brien?

25 A. Gosh, I would have thought a form of assistance for me 16:50
 26 and Mr. O'Brien. Like, at the end of the day, it
 27 doesn't matter who it was, the patients were right in
 28 the middle of this.

29 669 Q. Yes.

1 A. You know. If Mr. O'Brien was assisted in the process,
 2 that's fine, but for me, the patients came first and
 3 I wanted this thing sorted just as soon as was possible
 4 for the patients' sake.

5 670 Q. Yes. If we go to WIT-23373, please. Just at the top 16:50
 6 of the page. Again, another perspective on why you
 7 approached Weir and McAllister.

8 A. Yes.

9 671 Q. You say:
 10
 11 "Sensing real and meaningful remedial action was
 12 necessary."
 13

14 A. Yes.

15 672 Q. You spoke with them and asked if they could suggest an 16:51
 16 official solution to address Mr. O'Brien's issues with
 17 administration and:
 18

19 "Being an anaesthetist and having worked in theatre for
 20 a long time with Mr. O'Brien, Dr. McAllister said he 16:51
 21 was almost certain that if Mr. O'Brien was relieved of
 22 his theatre lists, until his administration was up to
 23 date, he would soon catch up. Mr. O'Brien loved the
 24 operating theatre. I understand that he would be
 25 prepared to spend all day and into the evening there if 16:51
 26 he could. If someone else did his lists, he would
 27 consider this intolerable and both clinicians thought
 28 it would take three calendar months to rectify."
 29 A. Yes

- 1 673 Q. So it was viewed as a form of assistance, he loved
 2 theatre so much, he would be unhappy being away from it
 3 and he would catch up quickly. Was that the thinking?
 4 A. Yes. You know, I think everybody believed that
 5 Mr. O'Brien could do this. I think everybody believed 16:52
 6 that, you know, he just chose not to do some of his
 7 admin. So, I mean, it wasn't a sanction per se but it
 8 was a step that was needed in order to resolve
 9 a problem.
- 10 674 Q. Yes. Now at this meeting with Weir and McAllister, did 16:52
 11 you tell them about what had been decided at Oversight?
 12 A. Yes, I did.
- 13 675 Q. Did you tell them that an informal MHPS
 14 investigation --
 15 A. Was going to be underway, and I told him there was 16:52
 16 going to be a letter and that, you know, they were
 17 going to set out a template for him to follow,
 18 etcetera, yes. I told them about it. Yes, they knew.
- 19 676 Q. Did you tell them that Dr. Wright wished to have
 20 Mr. O'Brien excluded? 16:53
 21 A. No, I don't think so. Gosh, no.
- 22 677 Q. A moment ago you thought that the letter could --
 23 A. Yes.
- 24 678 Q. -- for exclusion?
 25 A. That was -- 16:53
- 26 679 Q. Mr. McAllister, I think, has told the Inquiry that you
 27 told him that Dr. Wright wished to have or was prepared
 28 to have Mr. O'Brien excluded.
 29 A. It was probably discussed at the meeting but, you know,

1 just in a general terms of discussion, I think,
2 although it's not in the minutes. But I don't know
3 where else I would have got that from. I certainly,
4 even though he was the excluded in the end, it must
5 have been discussed at a point somewhere. Sorry,
6 I don't know where. 16:54

7 680 Q. It wasn't any part of the Oversight Committee's
8 decision to exclude him?

9 A. No. No, it wasn't.

10 681 Q. Apart from this plan that was being talked through to 16:54
11 remove Mr. O'Brien from his theatre responsibilities,
12 was there any other detail discussed at that meeting
13 about how to carry this forward?

14 A. Yes. From what I remember, I think Mr. O'Brien's job
15 plan was due. Yes, job plan. He hadn't had his job 16:55
16 plan, and that this was a really good opportunity for
17 Mr. Weir to do his job plan and to discuss the things
18 that we had discussed. Because in a job plan it
19 probably would have been accepted it was going to be --
20 Colin said he would do it in a nonconfrontational, 16:55
21 supportive way, and that they would reach, you know,
22 a mutual decision. That was all part of the
23 conversation. It wasn't just, we're going to exclude
24 him from theatre, that's it, thanks, go. Colin said,
25 I think it was in an e-mail a few days later from Colin 16:55
26 that he was going to do it in a supportive way.

27 682 Q. Just finally with this meeting. Can you help us to
28 understand why, emerging from that meeting, you took
29 the view that you would be telling Dr. Wright, 'I don't

1 wish any longer to support the Oversight Group, the
 2 Oversight Committee decision'?

3 A. I don't think I said I don't wish to support it. What
 4 I did was I phoned Richard. I was to have a meeting
 5 with Richard and Francis Rice about something else very 16:56
 6 soon after that. I said to them, and then there was an
 7 e-mail I sent, I sent as well. I said respectfully,
 8 could we. I asked him if it would be possible for us
 9 in Acute to deal with this issue at an operational
 10 level. I've spoken to Charlie and Colin Weir, they 16:56
 11 feel they could resolve the problem in three calendar
 12 months and would you consider letting us have a go at
 13 this? Then the Chief Executive, Francis Rice was
 14 brought in as well. His opinion, he said, 'yes, I will
 15 let you do this, but no more than three months. At the 16:57
 16 end of three months, if no progress has been made, then
 17 I suppose it was going to go to formal. I don't know.
 18 He just said we in Acute would be given no more than
 19 three calendar months to sort it.

20 683 Q. Just to summarise, the Oversight Group plan wanted 16:57
 21 things resolved against a timetable?

22 A. Yes.

23 684 Q. He was going to be met with, there was going to be an
 24 informal MHPS?

25 A. Yes. 16:57

26 685 Q. But you left the meeting with McAllister and Weir with
 27 a plan to remove him from Theatre?

28 A. No, they weren't at the meeting, McAllister and Weir.

29 686 Q. No, the meeting you had with them?

- 1 A. Yes.
- 2 687 Q. You thought that was going to be a more efficacious and
3 more likely to be fruitful in delivering a solution?
- 4 A. I honestly did. I honestly believed in my heart, you
5 know, it made sense. 16:58
- 6 688 Q. Was any part of the thinking around this 'Mr. O'Brien
7 and his reputation, and we need to protect him from
8 adverse publicity, perhaps, associated with an MHPS
9 investigation'? Was that part of what was driving
10 this? 16:58
- 11 A. I wouldn't say protect him, no. I wouldn't have
12 protected anybody where there was Patient Safety
13 issues. I suppose it would have been a win -- the way
14 I was looking at it, and bearing in mind I didn't know
15 Mr. O'Brien from Adam. I didn't know the man at all, 16:59
16 but everybody else had told me, even in somebody Neta
17 Chada's report, the patients loved him, everybody
18 thought he was great. He set up the Service himself.
19 He was part of -- he set the Service up. So I'm
20 thinking, well -- and he also was a viable part of the 16:59
21 team, albeit in Theatre all day long. But, however, he
22 was still very much needed and, don't forget, Urology
23 was in an absolute dire straits in Northern Ireland.
24 Mark Haynes one of our consultants had to go to Belfast
25 on a Friday. Just so -- so all that was in my mind. 16:59
- 26 689 Q. Did you have a fear that if the informal MHPS group was
27 adopted that Mr. O'Brien would walk away?
- 28 A. I did. I did. I honestly did.
- 29 690 Q. And that would impact the Service.

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A. Yes.

MR. WOLFE KC: Okay, it's coming up to five o'clock.

CHAIR: I think that's where we'll call it quits for today.

MR. WOLFE KC: Yes.

17:00

CHAIR: I'm sure Mrs. Gishkori will be glad of a break. We will see her again but --.

MR. WOLFE KC: Can we leave it that the Inquiry will consider and liaise with Arthur Cox --

CHAIR: Okay. I'm sorry we can't give you a date today, Mrs. Gishkori.

17:00

A. That's okay. Thank you very much. I don't do very much these days.

CHAIR: We will get back to you before too long.

17:00

THE INQUIRY ADJOURNED TO TUESDAY, 28TH FEBRUARY 2023 AT 10:00