Urology Services Inquiry

Oral Hearing

Day 71 – Wednesday, 15th November 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

CHAIR: Good morning, everyone. Mr. Wolfe.

MR. WOLFE KC: Good morning, Panel. Your witness this morning is Dr. John Simpson. I quite forget whether he wishes to affirm or take the oath.

09:59

JOHN SIMPSON, HAVING BEEN AFFIRMED, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS:

1 Q. MR. WOLFE KC: Good morning, Dr. Simpson.

A. Good morning. 09:59

2 Q. My first task is to take you to the three statements that you prepared for the Inquiry to date and to have you adopt them, if you wish, as part of your evidence to the Inquiry. So, starting with your primary Section 21 response which we received last year. It's 09:59 WIT-25695, and you'll recognise that.

A. Yes.

3 Q. It is your primary response to the Inquiry. You put a little note on it to indicate that you've amended it and I'll bring you to those amendments shortly. 10:00

If we go to the last page of this. It is 25732, WIT-25732. That's your signature, is it, Dr. Simpson?

A. Yes, that is.

4 Q. The question, which I will repeat against all three of 10:00 your statements is do you wish to adopt this statement as part of your evidence to the Inquiry?

A. I do, yes. Thank you.

5 Q. Then the second -- or the addendum to this is

WIT-103283. I think it primarily deals with the monopolar and bipolar resection issue which emerged for the Inquiry after your primary statement?

A. Yes.

6 Q. Going to the last page of that, 103290, you see it is signed off on 27 October last, and that's your signature? 10:01

A. Yes.

7 Q. Again, do you wish to adopt that as part of your evidence to the Inquiry? 10:01

A. I do, yes.

8 Q. Thank you.

Then, finally, a very recent further addendum received on 9th November from you, WIT-105748. It deals with a number of typographical errors and focuses substantively on an issue to do with actioning results of investigations, an issue that arose in 2011. You had some input or knowledge on that and you wish to clarify points about that. We'll look at that in the course of your evidence this morning. 10:01 10:02

Just going to the last page of this, WIT-105751, as I say received from you 9th November. Again, do you wish to adopt that statement as part of your evidence? 10:02

A. I do, yes.

9 Q. Dr. Simpson, you were the Medical Director for the Southern Trust between August 2011 and July 2015; isn't that right?

A. Yes.

10 Q. That's primarily the reason why we have asked you along to give evidence. I will wish to explore with you the state of clinical and professional governance at the point at which you took up that post and how you developed it. The Panel may consider that this is a fairly significant period, having regards to the issues that it is examining. We'll want to explore with you this morning your ambition or goals for governance, what governance initiatives you oversaw, and with what success. Finally, we'll look at some of the specific issues that relate to urology and their association with Mr. O'Brien. 10:03 10:03

If we could have up on the screen, please, WIT-25704. This is the section of your statement where you set out your various roles, qualifications, and occupational history. You are a psychiatrist by profession? 10:03

A. Yes.

11 Q. You took up a consultancy in psychiatry in what was the -- I think it was -- was it the Newry and Mourne Trust in 1992? 10:04

A. It was actually the old area mental health unit which then the Trusts, the 17 Trusts were then shortly after that. My contract was transferred to the new Newry and Mourne Trust. 10:04

12 Q. So just scroll down. There's the answer. So you were a psychiatrist -- a consultant psychiatrist during that time.

You made an entry into what might be called medical management or professional management at, I think, a relative early point in your career. You became a clinical director of Mental Health. Just scrolling down, I think that was 1994?

A. Yes.

13 Q. From there -- scrolling down -- I think in 2007 Associate Medical Director. Then, as we know, 2011 into the Medical Director's role. 10:05

Help me with this: Your involvement in medical leadership posts from 1994, what was the interest in that; what drew you into that field? Obviously, it was supplementing or complementing your work as 10:06 a psychiatrist during many of those years?

A. Yes, that's it, really. I could go back to the '80s when there was a massive change in psychiatry. The Royal College of Psychiatrists had a very definite move into multi-disciplinary work and a multi-disciplinary 10:06 leadership. So, training as a senior registrar in psychiatry, there would have been management training, leadership. That was for all psychiatrists. So it wasn't a big jump really to move into medical leadership, but the opportunity arose. There were four 10:06 clinical directors in Newry and Mourne - medicine, surgery, obstetrics & gynaecology, and psychiatry. I went for that post, interviewed and got the post.

It didn't make my job any more difficult. I probably haven't known very much else apart from being a clinical director and a frontline psychiatrist through my entire career. They do complement each other. The delivery of psychiatric care is about 10:07
delivering in teams. The set-up in Newry and Mourne, I thought, was a very healthy teamwork-type atmosphere that I was very comfortable with, coming from psychiatry. And I found that the Newry and Mourne approach, being a hospital, was quite a comfortable one 10:07
and a very forward-looking leadership from Paddy Loughran Medical Director, and Eric Bowyer, Chief Executive. It was in addition to my full-time psychiatry post but the two things merged, really. I had a very good support from a senior manager at well 10:07
at that point.

14 Q. One of the things that we'll maybe touch upon as we go on this morning is that a number of witnesses who have held medical leadership roles in Surgery in the Southern Trust, and I can think off the top of my head 10:08
of Mr. Mackle, Mr. Brown gave evidence yesterday, Mr. Haynes, to name but a few who have given evidence to the Inquiry -- Mr. Weir as well -- they pointed to, if you like, a strain or a pressure felt by them in taking on a leadership or a management role alongside 10:08
a busy clinical practice in the sense that they weren't as well supported, or didn't perhaps have enough time on their hands to adequately manage those roles. That's not what you found in psychiatry?

A. No. In the Newry and Mourne Trust for more than ten years, there was a lot of support. It was a small hospital and a community as well, and a very good manager that I work with. It was different because at that stage I was also the budget holder as well as the Clinical Director for a team of about 60 people but it wasn't that difficult, I thought. However, when the new Trust formed in 2007, the original proposal was I should be a clinical director for Mental Health. I said no because I knew there was a massive job ahead in terms of integrating the various parts of Mental Health across the new Trust area. So I said, yes, I'll do it but I want to be the Associate Medical Director and I want two Clinical Directors and I want a Band 5 secretary to support me, and I want the kind of, if you like, partnership that I had had with the new Director of Mental Health that I had in Daisy Hill. Now, I wasn't the budget holder, which was the new Director of Mental Health, but we forged a partnership really. 10:09 10:09 10:09

So I'm not sure if the other guys realised what was ahead of them. I had a rough idea that it would be pretty busy, and I was experienced in those matters. The other thing that I got was backfill. I did get an extra payment, but the extra sessions were passed to a staff grade, a very experienced staff grade, who then freed me up. Well, I actually argued for two full days a week; I got one and a half. 10:10 10:10

15 Q. Yes.

A. So I was in a different -- coming from a different angle completely to the surgeons who were moving into this field de novo, really.

16 Q. Yes.

10:11

Then 2011, I suppose the big job, the Medical Director's role. How well did you feel in terms of experience and equipment to take on that role at that time? What were you bringing to the post and why did you want it?

10:11

A. Well, I had four years working under Paddy who, in fact, previously had been like a mentor to me -- paddy Loughran, that is -- and sitting around the table with the other Associate Medical Director every quarter. I had a good idea what was ahead of me. I was quite

10:11

interested because I thought there's a lot I could do to bring a multi-disciplinary approach to both the clinical world and the leadership world. Well, just looking for a new challenge really at the age of whatever I was; early 50s, whatever.

10:11

Interestingly, and I think it should be on the record here, I had come from a position, as we all had in the health service, where there had been expansion. We had been given development monies to restructure St Luke's,

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the old hospital, build a new one, investment in a community team. There was a dramatic change around 2011/'12 in terms of austerity, efficiency aims and so on. I didn't calculate on that having such a effect.

So, I was doing the job with optimism as a medical director.

17 Q. We'll, in a few moments, come to look at some of the initiatives that you undertook as Medical Director. You stayed in the post for four years. Why did you leave it in 2015? 10:12

A. At the time I was able to take early retirement. Looking back I would call it early burnout, because after about a year of, you know, going back to family and doing things, catching up, I noticed that I got my enthusiasm back, so I must have lost it. I think that's what the health service does to people. Particularly those were very, very good years but very busy years; everything was stretched. I was trying to push one way, the health service was being pulled, maybe, in a different direction. It wasn't all difficult but it was pretty exhausting. 10:13 10:13

18 Q. Yes. You say early retirement or early burnout. You had maintained employment within the Public Health Service in a number of governance roles. Just briefly to tidy that up and finish where you are, if you just scroll down we can see that I think you hold three roles. Let me see, are they there? If we go down. Yes. The first is from 2015 to present, you're employed at the Leadership Centre. You describe the kind of work you engage in there, including in association with Level 3 Serious Adverse Incidents. You have roles in MHPS investigations, and also you've had a role in the Hyponatraemia Inquiry or 10:13 10:14

post-Hyponatraemia Inquiry work stream. You then second had a role with the RQIA, including undertaking site inspections. You describe that there. Then, just over the page --

A. I would do less of those two jobs at the moment. I'm more of an adviser now in RQIA rather than inspections. I haven't done any consultancy work probably for about two years, well, two years really, since becoming more involved in the Southern Trust again. 10:15

19 Q. Yes. Your involvement in the Southern Trust, I think it is described at the end. Yes. From 2020 you have been chairing Serious Adverse Incidents reviews, primarily in the Mental Health Directorate. So that's your current lot. 10:15

10:15

Let me bring you back to Medical Director. We have the job description for that role at WIT-25757. If we scroll down, we can see that your key result areas are spread across a number of subdisciplines including governance, which is what we primarily want to focus on today. But just to show the breadth of the job, we'll come back to some of these governance features. Keep scrolling. Maybe just in the interests of time, I'll say them. You had responsibilities for service, medical education and training, research and development, quality, financial and resource management, corporate management, HR, and management responsibilities. So, it was a wide package of duties that you held. 10:16 10:16

A. Including infection control, which was again quite a big -- prevention of infection; IPC.

20 Q. You explain in your witness statement you had responsibility for 11 Associate Medical Directors and 20 Clinical Directors, give or take. 10:17

Where were you based? Were you based in Daisy Hill or based in Craigavon?

A. Both. Mainly in Craigavon in the headquarters. So, the main corridor, Chief Executive opposite, HR Director next door. 10:17

21 Q. You explain again in your statement -- this is WIT-25706 -- that you reported to Mrs. McAlinden, who was the Chief Executive at that time. If we go to WIT-25713, you explain that for the first two years, you were required to have regular 1-to-1 meetings with the Chief Executive as an informal performance review. These became less frequent thereafter. Why was that? Was that because they were unnecessary or was there a difficulty there in the relationship? 10:18 10:19

A. There were strains but whether they were any more severe than the strains between any Medical Director or Chief Executive, I'm not sure. Having said that, her office is directly opposite mine so there's plenty of communication. The strains would be the obvious ones. 10:19 The Chief Executive is obviously the chief accounting officer and has that responsibility to make sure we have break-even. My responsibility, I think, is more towards, if you like, patient safety, the doctors, the

GMC, and so there's that lively tension. So there were some lively debates at times, surely, yes. As the years, I think -- and I have to mention the austerity issue, it became more and more a preoccupation. The phrase that sticks in my mind most is "3% efficiency savings year on year". That obviously was mandated of the senior management team. I didn't agree with it.

22 Q. I'm going to take you to that just in a moment and see how that debate worked out. But in terms of the support that you felt from above and in terms of the support that you had to do the job, you mention that you were supported by one Band 8 manager, Mrs. Brennan. How well supported did you feel in the role?

A. It started off very well. Anne Brennan had worked there for all of those years with Paddy Loughran, so that was really important. Another person, Stephen Wallace, likewise. So that continuity was very useful. It was a very small department and it was very tight, but we were a good team and well organised.

What I didn't realise and what I look back on now and see is that from the professional point of view, I'm the only doctor at the senior management team and I'm the only doctor on the Trust Board. There were times I would have thought not so much supported, I would have liked actually more challenge, questions. Sometimes I would give an opinion to Trust Board and I would be hoping that someone would push me and ask me questions and get me to think, you know.

Another weakness, I think, looking back on the structure in terms of support was that from a professional point of view, the Director of Nursing, Francis Rice, was also the Director of Mental Health and learning Disability which in itself is a full-time job. The Director of Professional Social Work was also the Director of CYP, Children and Young Person's Directorate. At that senior management table, although they are the professional heads, their preoccupation is with the operational delivery and, increasingly, with efficiency savings and so on and so forth, and performance targets. That dominates the structure. Looking back, I think other Trusts were probably the same, but looking back I think that was a weakness. Where I'm making arguments, counter-arguments, as always, against the stringencies that we were under, those two people, who would be very sympathetic obviously, and very professional, but their main preoccupation is to go with the flow and maintain financial, if you like, balancing the books and also pushing through on performance targets.

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10:22

It became increasingly problematic, I think, as the years went by. I could see the point from the Chief Executive and so on, the Southern Trust was held up as an example of, you know, financial regularity and so on and so forth. But it became quite intense in 2014 because more was being asked of a Trust that was

10:23

already very lean. I could understand the pressure on the senior management team, the Chief Executive.

23 Q. You mentioned just a moment or two ago, I think it was in the context of a review of director responsibilities, that you thought it appropriate to suggest that your responsibility for infection prevention and control should sit elsewhere. You set this out in your statement at WIT-25726, paragraph 57.2. 10:23

A. That's a different one, I think. 10:24

24 Q. I should bring you to WIT-25701, sorry.

A. Yes.

25 Q. Your purpose in suggesting that was to free up more time for clinical governance, generally. That suggestion was received sympathetically but was refused. We can see Mrs. McAlinden dealing with that in response to you at TRU-250689. 10:24

Just while we're waiting on that, if we scroll down. Mrs. McAlinden really sets out her view that it's not a straightforward matter of shifting responsibilities. In raising this point in your statement, is the significance of it that you felt that the focus of your role should be on clinical governance, professional governance and Patient Safety in getting the structures and the systems around that right, and that this area of infection control, while important, was an unnecessary distraction for you? Is that the point you're making? 10:25 10:26

A. It was a big distraction. There was a Pseudomonas issue with neonatal deaths. There was a C-Diff problem. There was a problem with infections -- sorry, IV line sites. There was loads of activity. I also mentioned in the dispatches the issue with indwelling catheters and so on. It was a big area. I think the problem I had was that prior to my arrival, the responsibility for governance, I think, had been pushed down into the frontline, shall we say. I thought after a year or two it had become actually submerged, because it sounded like a good idea at the time. It became the responsibility of the Chief Executive working with an Assistant Director For Clinical Governance and I was side on to that, which was okay for a while. In fact, the AD for Clinical Governance was in the office next door to me. But I felt that as time went by, clinical governance was being submerged and not surprisingly because of the emphasis on productivity, performance, and so on and so forth. 10:26 10:26 10:27 10:27

What was also happening was I would be getting phone calls from the Board saying what about this SAI, John; what about that SAI, and I would say I haven't been consulted yet about those, because I would only be consulted about an SAI review when things weren't working very well. So, I didn't have that overview although what I did do was kind of insert myself into it. So there was a meeting every month of the Clinical Governance Coordinators from the four different parts 10:27

of the Trust and I would join that, with Debbie Burns who was the AD.

26 Q. Let's look at that issue you've raised and just try to understand it structurally within the Trust.

10:28

If I could bring up on the screen, please, from your statement, WIT-25730. At paragraph 71.1 you're saying you're concerned that as far as you were aware:

"I was the only Medical Director of a Trust in Northern Ireland who was not also the Director of Clinical Governance, therefore I did not have an overall view of Patient Safety and did not have the resource at my disposal to improve and develop clinical governance. Matters of concern would be escalated to me by the Assistant Director for Clinical Governance on an ad hoc basis." 10:28 10:28

Just help us better understand that. The responsibility for clinical governance, did it rest with the Chief Executive? 10:29

A. In name, but in practice it rested with me, you know, and that was how it worked out. It might have been a good idea at the start to sort of divulge and divest clinical governance down into the frontline but, from my perspective, I think I lost something from that and it took me a while to figure all of that out. In my job description it says I'm responsible for clinical governance as part of the senior management team, which 10:29

could have been fine, as I said, but there was weaknesses in the structure outside of clinical governance. I felt a little bit disenfranchised, if you like; responsibility without power.

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But also, from a positive point of view, I wanted to reform -- and we'll come to that -- mortality, morbidity meetings into a Patient Safety system. I also wanted the resource, which a big thing in Health Care Trusts, the budget. I didn't have the budget for 10:30 clinical governance. I couldn't say let's move here, let's move there, I want more to do this and so on. So I was always -- it was okay at first. I was always bargaining, if you like, chipping in saying could we do this, and relying very heavily on powers of persuasion, 10:30 and so on and so forth. No one really disagreed with me but anything I would say, the managers would say, well, yes, John, but what about these waiting list targets? The doctors would say yes but I've got to, you know, keep up the performance, there's so many 10:30 clinics to be done and so on and so forth.

So the ideas that I would have had weren't strange and weren't -- I didn't think so any way. I mean, I distributed a paper one time from the King's Fund 10:31 called Distributive Leadership to try to explain to people where I was coming from. I didn't think that I was really coming from left field but I think my perception was that they thought I was. I think the

structure that was there didn't stop me but it did slow me down, I think, and make things more difficult.

27 Q. Let's just pull this back to your job description again and maybe help to enhance our understanding of what you just said. WIT-25758. Scrolling back a little bit. 10:31
This is the governance heading in some of the things we'll look at this morning, Professional Leadership and Guidance to Support the AMDs, CDs, and the Clinicians. We'll look at how you tried to exercise that role in a moment. 10:32

Scrolling down to number 3, we'll just take a snapshot of some of these. I think this is the point you just made to the Panel, that you're a member of a senior management team and you have corporate responsibility 10:32
as opposed to specific or individual responsibility for ensuring a specific system of integrated governance within the Trust. It goes on, a further snapshot, picking up at number 4 your responsibilities as a responsible officer are set out. We'll look at how 10:33
you dealt with that.

But just going back to number 3 for a moment. In terms of the set-up around governance that you think -- judged by your answer -- was a regrettable or 10:33
retrograde set-up or framework, you talk about budget and having to try to persuade people that your course was a sensible one and it should be funded; were there communication issues as well? You know, were you

getting to hear about serious incidents that were perhaps happening around the hospital? How did you get to know about those? Was the system receptive to you being adequately informed?

A. I was dependent on being informed. I wouldn't have had the information to, if you like, know what questions to ask. As I mentioned earlier, I think a DRO person from the Board would say, you know, about a particular SAI, how's that going, what's the delays, and I wouldn't know about it. I was consulted where they -- that would have been the Assistant Director and the Clinical Governance Coordinators -- if they thought they had a difficulty with an SAI review, but I had no regular oversight of it. 10:34 10:34

You know, thinking back -- I don't want to blame austerity for everything but this system might have worked well had there been not such a pressure to deliver targets. I think I could have been -- I can't say more persuasive, but my persuasions might have been more successful in allowing me to develop what I wanted to develop had it not been for that. You know, even getting the budget and being the responsible officer and set up a new appraisal system, enhanced appraisal, you know, I had to argue for the money for that, something like £150,000 out of a budget of 500 million. That's how tight things were. That's the stress. It was achieved but everything was pressured and contingent upon financial break-even. 10:35 10:35

28 Q. Let me bring you to, I suppose, one vignette to illustrate the financial culture, what you refer to in your statement as the prevailing culture at that time.

In 2014 there was a particular pressure, I think it was to make £28 million worth of savings within the Trust. You explain that in your witness statement at WIT-25701. At paragraph 0 just there, I'll not read it all out but you say: 10:36

"To illustrate the prevailing culture at the time across the NHS and the emphasis in the Trust placed on financial break-even and year on year efficiency savings, I would draw your attention to the following." 10:36

This was a particular series of events in 2014 where you were asked, as with others, other directors, to make proposals that would contribute to the overall package of savings being required by the Commissioner and the Department. 10:37

If we go to TRU-25055 and just scrolling down a little. You're writing to Stephen McNally. Is he an accountant within the Trust?

A. Director of Finance. 10:37

29 Q. You're explaining to Mr. McNally what, in your view, is not possible in terms of delivering savings within your directorate. One suggestion appears to have been made around pausing medical revalidation for six months.

You set out, I suppose in no uncertain terms here, your view of that.

Could you just help us understand what was being suggested to you? Was it being made as, I suppose, a serious point to you that this is something that could be surrendered for six months? 10:38

A. Looking back, I can understand the Trust and the Trust Board's view, which was the previous number of years of which I had witnessed, the Trust had been very, you know, obedient, shall we say, very successful in financial management, improving performance, and so on and so forth. Anecdotally, probably the best in Northern Ireland. So I think the Trust leadership at that point thought asking us for 26 million in-year savings was just ridiculous. I think it was not well received. The contingency plan, dare I say it, was almost like a game of poker, who is going to blink first. So the suggestions were -- I couldn't have taken them very seriously, really. In fact, the budget in the medical directorate as such was tiny. When they're talking about those things, it's really scraping barrel bottom, etcetera, etcetera. So, they were unrealistic. 10:39 10:39 10:39

I suppose what the Director of Finance was trying to show to his -- you know, I answer to the GMC, he answers to the Directors of Finance in the Department, you know, that we are actually trying; you've pushed us 10:40

so far, this is how far, we can't go any further. I presume that was the thinking. I didn't appreciate it.

30 Q. Just to scroll down to show some. You say on revalidation, your advice is it would be unworkable and unsafe to pause this process. The Panel can look at the fine detail of that. 10:40

The second suggestion that you have to deal with is that litigation could be paused. Is that one that you were able to take seriously? 10:40

A. With all due respect to Stephen McNally, you know, he's an accountant, he's looking at balance sheets. I don't think he really understood. I tried my best to explain that these things were unrealistic. 10:41

31 Q. It's an indicator of --

A. Litigation didn't cost. I did the litigation. You know, I met with the Board, the DLS person, every month. Nowadays there's three deputy medical directors, one of which -- I did everything. So, how could there be savings? I didn't understand that. 10:41

32 Q. I think there's a third one on this sheet, something to do with water testing. There you go, perhaps illustrative.

A. We had just been through, as the whole of the North had been through, you know, baby deaths because of Pseudomonas, contamination of water supply in the neonatal units. Dr. Damani was the infection control lead and would have been scrupulous in his advice to 10:41

me. I took most of it. He did push the boat out certainly but with good reason. So the water testing might have been reduced slightly but really I don't think that would have looked very good.

33 Q. Just scrolling back up, we see Mrs. McAlinden's response to you. You can see that there. So, she is coming back on that and saying that really radical options have been put forward by others and you are being asked to step down; somebody has referred to Colm Robinson and his work. What was his work? 10:42

A. Colm managed, if you like, the routine audits. "Manage" is the best word because he relied very heavily on the nurses in the wards, the falls audits and wound audits and such like, which happened in every hospital. That was a very lean programme to start with. He was asking nurses to use their own spare time to work with him on these audits. So it was one post, a Band 3/4 post. I was concerned about the message that would send out. I knew probably we wouldn't have to implement these contingency plans but I was worried about the message that it would send out to frontline staff, that somehow or other Patient Safety measures could be paused. I didn't think that was a good idea.

34 Q. Yes. I think, just scrolling up further, you come back again and say you have:

"No option but to advise against any reduction or pause in our capability to measure and improve Patient Safety."

Is that a reference to Colm's role?

A. Yes, because I think they had accepted by that stage that the other possible financial reductions were not realistic. So that was probably the only thing that we disagreed on. 10:44

35 Q. Likewise, you would.

"... caution against any reduction in our capability to continue with Professional and Operational Governance." 10:44

Pointing to the serious financial difficulties, you go on to say:

"If the minister decides that there will be a reduction in the overall level of care provision, in that context it surely becomes more important that we continue to monitor quality and safety. In addition we must continue to improve the quality of whatever level of care we are permitted to deliver. Without continuous measurement, this becomes extremely difficult." 10:44 10:45

Is that a kind of description of your thinking, of your approach to governance in general?

A. Yes. My approach has always been Quality Improvement. You can never be perfect, you can't be safe, but you can safer. You can be criticised for not getting this right or getting that right by the public, the Coroner, whatever, but if you can show you are constantly trying 10:45

to improve, I think that goes down well with the public, the public understand that. Even where Quality Improvement doesn't necessarily improve quality, you were trying. That was my view.

10:45

I think by that stage I was getting pretty exhausted by the whole business. I think I handed my resignation in about five or six months later.

36 Q. Tell me, you've talked about the Trust's obedience, I think was the word, in terms of this break-even or 10:46
three percent strategy and how it was regarded, at least anecdotally, one of the Trusts that routinely came into line in that respect. Are you suggesting in your evidence that the culture of senior management or the attitude of senior management was more favourable 10:46
towards delivering the efficiencies, and less favourable or less interested in the Quality/Patient Safety agenda that you outline as being your interest?

A. Well, as I said earlier, no one really disagreed with me. They would agree. They're all good health service 10:47
people, I have to say. Agree in one moment but in the next moment "but we have to do this". So I don't doubt their commitment to Patient Safety and the lessons from the Francis Inquiry and to Mid Staffs. That was all very current. But it's hard to describe the 10:47
relentless -- it is probably still happening, I don't really know because I'm not up there any more -- but the relentless pressure to produce so-called, I think, efficiency savings. I had the understanding that --

well, if I got the sack as Medical Director, I'm still a doctor, I can still earn a living. These people, on pain of dismissal really, had to do what they had to do; I understood that. But it was very stressful, for them as well. I am particularly sympathetic to those people in middle management, the heads of service, the assistant directors, because they are the people that are asked to square the circle. I think a lot of the -- I appreciated the strain I was under but I think those people are under even greater strain. 10:48

37 Q. If we go to -- these emails were, if you like, in the build-up to a Board meeting that had to consider the contingency savings. If we turn to that briefly, WIT-25735. It is a meeting of 15th August. We can see your name as being present, and those in attendance are outlined. 10:49

If we move on to the next page, please, just scrolling down. The financial position is set out by Mrs. McAlinden. As said earlier, there is a need to produce 28 million to arrive at break-even, as it's described here. She goes on to outline a number of pieces of correspondence. There's a letter from the Chief Executive of the HSCB. In this letter, assurance is sought that none of the proposed contingencies will impact on Patient Safety and that all the proposed contingencies are supported by all Trust Directors, including professional leads. Mrs. McAlinden's response to that is that the commitment to safe care is 10:49 10:49

impossible to guarantee, as is the securement of clinical commitment due to the short term and counter-strategic nature of the necessary measures to achieve break-even. The Trust Board members agreed that the Chief Executive should include this point in her covering letter for the draft contingency plan.

Does that echo the point that you made a moment or two ago, that senior management, indeed middle management as well, was sympathetic to the notion that the continuing relentless drive for cost saving was going to impact on Patient Safety or potentially impact on Patient Safety? There could be no guarantee, as it suggests here?

A. That's a fair point. I think the potential risk was there; they recognised it. The letter from the Chief Executive at HSCB, it is a bit of a bind, really, isn't it, you know; we pushed you so far. The Southern Trust position was we have really done very well to work within your limits and so on, you shouldn't be asking us to do the same as every Other Trust since we've already performed better. That was the position.

38 Q. I think if we scroll down to WIT-25739, just a couple of pages down. We can see, I think after a discussion around the table -- I'll come back to your contribution to that discussion in a moment -- there were a number of key concerns agreed and they're set out there in the document in front of you. I think the last one is, perhaps, another echo of what you have just said:

"While the Trust Board is prepared to deliver on its responsibility" -- assumedly a legal responsibility -- "as set out in the Permanent Secretary's letter by enacting the approved elements of the draft plan, it would not be supportive of doing so given the detrimental impact of such actions on service users and staff".

A. That's a fair point. As I say, it was almost like a game of who is going to blink first between the Trust and the Board. At this point really I'm thinking, well, that's all very well, people, but my responsibility is to the GMC and therefore to the public and to the medical staff and professional staff; I can't go along with this. So I wanted that included in the minutes.

39 Q. If we just go back, I think you do make an intervention at this meeting. If we scroll back. Yes, it is just there, in fact. A number of the nonexecutive directors made contributions to the meeting. I think I'm right in saying that it was only yourself and Mrs. Burns among the staff as such who have made recorded interventions. You said or you raised your concerns about the potential adverse impact on quality by the proposals in the draft plan to temporarily redeploy resources to critical frontline services from areas such as Patient Safety, audit and evaluation. That's it, that's your concern in a nutshell?

A. Yes. And although it didn't happen, I was worried that

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the very notion of it would filter down to frontline staff. You know, that after a number of years of financial pressure and so on, that we just have to knuckle down and get on with the throughput. That was a worry. 10:54

40 Q. Yes.

In terms of your role, you wear several hats or you hold several responsibilities. One is to the GMC. You're an employee, you're also a Board member or 10:55 a director who attends the Board.

A. I would be an Executive director of the Board.

41 Q. Did you have a sense of any conflict of interest when it came to matters such as this?

A. Yes, I think so. As I say, the weight of the Trust and 10:55 the personnel at the top was towards fulfilling these targets. So the Medical Director -- it was me -- you're, shall I say, relatively isolated in these discussions, and it's important to make your presence felt. 10:55

With regard to the GMC, you see, it is not just a matter of me as a doctor, there's a responsibility of me as a Medical Director to ensure that the Trust -- the organisation within which doctors are employed -- 10:56 is a safe organisation. I think this is one of the issues that arose in maybe the Bristol Babies Inquiry and also the Mid Staffs Inquiry. If you like, I had to protect myself, if you like. I had to speak up.

As I say, I knew the likelihood of the contingency plan being put into place was unlikely but the thought of it was enough to worry me.

42 Q. Ultimately, as I understand it from your evidence, it wasn't implemented? 10:56

A. It wasn't.

43 Q. Yes.

A. And what happened about the 26 million, I can't remember precisely. 10:56

44 Q. In terms of you talk about the three percent and that still echoes in your ear today, had you a sense of what was going on on the frontline in terms of the delivery of the services and how it was impacting on clinicians in terms of their delivery, or what was expected of them in relation to delivery? 10:57

A. Yes. That would have dominated the discussion at my quarterly meeting with the Associate Medical Directors. It came up a lot in the discussions around job plans where, you know, job planning was a new thing, measuring what doctors do, a demand capacity assessment. So, it was a very live issue for all the clinical staff, not just the medics. My perception of it was -- again from a Quality Improvement point of view -- any systems engineer will tell you that a safe system needs to run at around 85 percent capacity. 100 percent capacity, it is going to fail at some point. 65 percent is not good either. You need that room to manoeuvre to run, running repairs, 10:57 10:58

developments, reflection, deal with peak demand. By that stage we were accepting as normal winter pressures as if that was acceptable; it's not. You know, the system should be built around capacity and demand to measure the two up.

So what was happening with the efficiency savings was, in fact, they weren't efficiency savings. They were making us less efficient in the long run.

45 Q. Obviously how the services are delivered are operational matters for each directorate and obviously cascading down into the services themselves. But were you receiving information/intelligence that the medical frontline staff were, if you like, because of these austerity measures, frequently having to, I suppose, resolve dilemmas in how they approached, for example the heavy waiting lists that they would have? Just to work this example through, the suggestion might be that if they're taking on an extra load to deliver on a waiting list initiative, that that's going to impact on their ability to be as efficient and productive in other areas of their work.

A. I think -- I don't think there was any evidence of people cutting corners in order to, you know, get the job done. Where that did arise would be -- I think it's in the evidence -- issues such as introducing new clinical guidelines. That takes time, it takes effort, it takes doctors out of their everyday work to do things differently. It requires training, changes of

organisation. There's always that tension between a clinical guideline and what a frontline practitioner says this works for me, and the old-fashioned idea of consultants saying to the health service, "This is my practice". That was disappearing but, still, they had their way of doing things. 11:00

Whenever you were trying to introduce changes like that, or the changes that I was suggesting about morbidity/mortality meetings, there was no suggestion that we can't do this, you know, it was just this is going to be difficult. You're asking us to do things which are difficult. Good ideas, John, but difficult to implement. I think I was worried but there was no direct evidence that things were falling apart, but I was concerned about how things might pan out in the years ahead. So my four years or so, I think the organisation survived quite well, frontline clinical staff, middle managers, senior managers, but it was at full stretch. 11:01 11:01

46 Q. If we, just to extend this debate a little, think about urology. Urology had skyrocketing waiting lists in virtually all domains, both outpatients, day cases, inpatients, and review. The Inquiry certainly hasn't received any particular evidence to suggest that the Trust was itself auditing morbidity of patients while they languished on waiting lists. The clinicians themselves would have had a good idea of what was needed for patients on the waiting lists. The argument 11:02

might be that they had an obligation, where they could, to try to mitigate risk for their patients to the extent that resource allowed them to do so. Would you view that as -- I use the word "obligation", you can choose another word if it is more comfortable -- would you see that as being an obligation on the clinician to mitigate where they can?

A. More than likely but I can't think of any simple examples to illustrate the point.

11:03

47 Q. I suppose one illustration might be Mr. O'Brien has given evidence to the Inquiry through a Section 21 that he took on an extra load of theatre work, more sessions than would have been part of his work plan, whether pursuant to working waiting list initiatives or what have you. In doing that, that obviously expands -- there's a need to expand his time in theatre to deal with that, but that might impact on other parts of his work?

11:03

A. Yes.

48 Q. That's the kind of dilemma that he certainly points out as being one that was impacting him.

11:04

A. That's not unreasonable. I didn't hear about that in particular but it was widespread, those kind of issues, for, if you like, the type of focus on waiting lists which was for, you know, procedures, that you can do more of these but this has a knock-on effect on other parts of the system. You know, opening the doors to do procedures, then other things happen. I think, possibly... My perception of healthcare, you see, is

11:04

that it is lifelong and it is mostly about managing chronic conditions. There's acute chronic episodes and there's acute care, but that's only a snapshot of what goes on in the bigger system. Possibly where to look on that would have been in the general practice because it is the GPS who are maintaining the patients as they wait for whatever pain relief operations or so on and so forth. It's difficult from the hospital Trust point of view -- well, the Trust point of view, to see what's going on out there. 11:05

We did have an Associate Medical Director for Primary Care, which was an excellent idea, Peter Beckett, to bring those to us. We organised meetings whereby clinicians from the various parts would go out to meet the three sectors of GPs to improve that communication. But all I can think back is the ethos of the time - we've got to keep active. Running to standstill, I think I saw in someone's deposition. That was not just urology. You know, my first year was heavily preoccupied by paediatrics, for example. I can mention three or four major problems that I had to work with. It probably should have been in my job description "firefighting" because that's where most of your time was spent. 11:06

49 Q. Yes.

Let me move then to some particular initiatives that you undertook. One of the issues that you took forward

was in respect of morbidity and mortality under that broad Patient Safety aspect of your description. Can you help us by summarising where you saw the state of Patient Safety in that domain when you entered your role, and what was your ambition or objective in terms of improvement?

A. Yes. I had come from a reform of the Mental Health Service and a new Psychiatric Inpatient in Craigavon. It wasn't that difficult to set up a multi disciplinary Patient Safety meeting. We didn't call it morbidity/mortality. In that area we had patient input from the patient advocate; we had input from the auditors of, you know, falls of various things. We reviewed serious incidents, we reviewed minor incidents. That was a monthly multidisciplinary look at quality that we established, and I thought it worked quite well.

When I looked at the M&M system in Craigavon and Daisy Hill, it hasn't changed since I was a houseman. You know, it was very much a lecture theatre-type approach. Very useful, educational, but no outputs as I could see. It was uni-disciplinary. Why should mortality be only for medics is the phrase I used. Because no matter how focused, say, a surgical team is on the lead surgeon, it is the whole team. So what I wanted was a multidisciplinary review, one that focused on learning and outputs as opposed to interesting cases or big scary cases, shall we say.

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The surgical one and the medical one were too big so I wanted them subdivided and then to come together. I wanted them all to be in the same afternoon so that radiology, paediatrics and so on could stagger their attendance at the various meetings. But it is a bit like rewiring an old house, it is much easier to build a new one. 11:08

The greatest success I had in that was in ED because we just created a new AMD post for ED. It had been under medicine, which was too big. So, a new AMD and a new CD in the Emergency Departments in both hospitals. So I set up a brand new M&M meeting there, which I checked, it's still going. It was easy because we started from scratch. There was a good team ethos in ED. So a team ethos into quality and safety was quite easy. I sat in a few of those meetings and I thought this is the model. They were multidisciplinary right from the start; there's a team ethos; there's an ethos of getting things done. There was no problem about bringing head of service and AD into the meeting, which would have been unknown in M&Ms. Where there were outputs, then the head of service would know exactly why the outputs were being demanded of the service and so on and so forth. It is very difficult to manage culture change, but you have to start. 11:09 11:09 11:09

50 Q. Let's just hold that thought and look at a couple of specifics around culture change and what you maybe saw

as being less than adequate. Let's start. You're only a few months into the role and you wrote on 25th November 2011 an e-mail about morality reports to Mrs. McAlinden. TRU-250591. You are talking about mortality reports, a work in progress. You're saying: 11:11

"These are one of but a number of windows on the quality of clinical activity. They seem to me to be useful but need to be more fully embedded into our governance systems. I don't think they should be seen as something that only belongs to the Medical Directorate, it is a much bigger and broader issue". 11:11

You say:

"The more I think about it, I see a need to integrate all of our reporting on clinical and social care governance both upwards to the Trust Board and downward to the clinical teams, not just the medics. I believe some Trusts in England produce an annual or biannual quality report which brings together all of intelligence on clinical and social" -- I think that should say "care governance. I think we should be aiming to do that in 2012." 11:11

So, a number of issues going on there. Maybe if you could just unpack it for us. You're suggesting, maybe as a statement of intent early in your posting, that the Trust needs to do better on these issues? 11:12

A. Yeah, modernise, I suppose, is a better word for it. We may have been the only Trust using those reports; I think maybe one other. I think it started under Paddy Loughran, the previous Medical Director. They're sort an eye in the sky look at the larger things about morality. They produce some interesting points. I mean, if there was a divergence between expected morality and real morality, we would look into it. A few times there was a divergence and we would have asked -- I remember asking Eamon Mackle to pull the charts in a few cases. In fact, they had already been looked at at the M&M meeting, which was fine. It was really just a taster: CHKS was the name of the firm that we'd employed. It wasn't the most decisive thing, it was a useful thing. I did look through the urology one because it is not a specialty where there's many deaths in theatre and so on and so forth. It is really more trauma, surgery, ED, medicine and so on and so forth. 11:12 11:12 11:13 11:13

It was really just the start; I wouldn't put too much weight on that. The point I was making really at the end was we needed to come up with a quality report. I mean, that was agreed. I think I was a bit ambitious thinking we could do it pronto, but that's the way I am. 11:14

51 Q. We'll go on just now to look at how you relaunched and rebadged M&M. There were two stages, really.

Does this e-mail suggest that in terms of the Trust at that time and its approach to looking at the quality of its activity, that really it did need to modernise? Was that primarily what you were saying?

A. Yes. Again, there was no disagreement on that but it's maybe not the number one priority, as we've said, with regard to activity and so on. I mean, yes, everyone agreed with it and we would present the result to the governance committee and so on, they were of interest. But it was only one of -- one of a number of windows that you could have to look at quality and performance in terms of safety, that is. 11:14 11:15

52 Q. Yes.

I suppose we've received evidence -- and this is 2011, so the Inquiry is looking at, obviously, a broader period than that -- but we received evidence that might suggest on one view that the measurement of quality, a sense of inquisitiveness around quality wasn't necessarily there; wasn't party of the operations and culture of the Trust maybe as the years go on. Did you get support for what you were trying to push? If you did get support, how was that manifested in activity terms? 11:15 11:15

A. Yes, I got support. I remember being with Gillian Rankin, talking about these things in the Acute Directorate. The response of the Associate Medical Directors was yes, but again, that's very interesting but do you realise what we're asked to do. 11:16

53 Q. Just to be specific, what were they being asked to do?
A. When I told them that I was going to change the M&M system into a Patient Safety system, and that there would be eventually patients working with me in the oversight of it, but in the first instance we would invite a nonexecutive director to, you know, gently introduce the idea that that should be the case, my argument was, well, it's better to have that debate in the Trust and being, if you like, questioned by Trust Board, rather than, if you like, a more embarrassing intervention by the Coroner much later or an. So that was the argument, really that we should really focus on these things. I'm not sure if it was much different than any other Trust. 11:16 11:17
54 Q. If we look just, there was this relaunch, as you call it, of M&M, 1st July 2013, so two years into your post, WIT-26041. Here, you're writing to the Associate Medical Directors. I suppose is this the first step of this relaunch? If I talk it in terms of steps, the second step in terms of creating subspecialty. Patient Safety meetings came two years later, is that right, with the creation of urology-specific -- 11:17 11:18
A. Probably before that. I can't remember the timing of it but we were making steady progress from 2012 right through to 2014/'15. 11:18
55 Q. Just help us with this relaunch then. Just maybe see the whole e-mail or the whole memo. Why was it a relaunch? Why was recalibration, if you like, necessary?

A. As I say, the M&M meetings to date were largely educational, based in lecture theatres, exclusively medical. I really wanted to not so much relaunch it as call it a new Patient Safety system, but we hasn't quite got agreement on that terminology. I think by that stage I'd won the support of the Associate Medical Director and others. I mean, they were clearly with me. What I wanted to get through with that memo was to the frontline, to every clinician. I may have said it somewhere but the point I was making was I'm the responsible officer, which was a new thing for a Medical Director to be, it is my responsibility to make sure when I revalidate you, that you're part of a governanced system, a Patient Safety system, that you engage in it. I wanted to make it clear, because I had this opportunity with enhanced appraisal, to say to the doctors I want you to actually engage and provide reflection and evidence of that in your appraisal statement. Appraisal was a very new thing. It is not really performance management but I wanted to introduce that requirement. 11:19 11:19 11:19 11:20

So that e-mail really was I was quite sure of my ground in that I had the support of the Trust and the senior medical leaders. I wanted to get it right down to the frontline medics and the other clinicians, obviously. 11:20

56 Q. The three bullet points in the middle of the page, could you help us with those? They seem significant.

A. Yes. Well, you see, previously there were -- there may

have been a culture of an M&M meeting beforehand on the initiative of a doctor or group of doctors, and that was great. I think I got asked about this in the Hyponatraemia Inquiry as well. Just because one group of doctors somewhere produces an improvement, it doesn't necessarily go anywhere. Even when there are outputs from an M&M meeting, they are not necessarily recorded, formalised or followed through. The learning point should be directly linked to our educational systems. In other words, if it was just learning, then we had educational systems where the learning would be, you know, the first priority on that agenda as opposed to I want to learn about this because I'm interested in it. 11:20 11:21

The second issue was that where things weren't clear, we should actually mandate the Trust audit programme, which was quite threadbare and, you know, not a priority, that has to be said. That should determine audit activity rather than again individual registrars or doctors saying I would like to audit this, that or the other. Then at action points, try system-wide improvements. That is where it goes in to management, to the heads of service and to the directors. So it is very -- I'm being very hopeful there, you know. It's a start. 11:21 11:21

57 Q. Yes. Just to make two points perhaps to you. In terms of, for example, audit, we've heard from Mr. Glackin, who was for a long time, I think six or seven years

maybe, clinical lead on the urology Patient Safety. That would have been perhaps after your tenure as Medical Director concluded. He was bemoaning the absence of both administrative support and the absence of support for targeted audit. 11:22

The second point you could maybe deal with at the same time is on the evidence before the Inquiry, there might be seen to be a disconnect between learning points; for example, learning points around the management of stent 11:22 replacement. How do they get into service-wide improvements? How do they become actioned? An ambitious programme, but have you any sense of your hopes for Patient Safety, how well were they implemented thereafter? 11:23

A. It's hard to say. I think I didn't stay long enough, really, to find that out. Again, it's just about changing culture because previous to that, not just in the Southern Trust, a lot would have depended on champions, a lead nurse, lead doctor, a lead manager 11:23 saying I want to push this through. What I was trying to say there was where we develop learning, important learning from episodes of -- it could be near-misses as well as untoward events, that should be the drive, not whether or not some individual should come up with 11:24 a good idea. That's a problem.

I think what Mr. Glackin's pointing to is correct. The previous idea was that a doctor, if you like, would bid

for a resource to get part of the audit department to work for them, and that depends on how important the doctor was, how good an argument they put forward. I was trying to make the point that case should come directly from the experience of the Trust as a whole as opposed to what one or the other person might argue for. Obviously the next point after that would be to expand the resource. What I was hoping for was if we had this real, if you like evidence-based, hard evidence-based opportunities for learning, then audit would have to be followed through on. But there wasn't the resource in the audit department to do that. That's how it was. 11:24 11:25

58 Q. Yes.

11:25

Then in 2015, in May 2015, I suppose a few months before you closed the door behind you and moved off to pastures new, there was a reform project presentation around M&M. If we just look at that briefly. WIT-26047. Is it right to look at these various steps as a project that you were working through the system over a period of years? If we look just at the next page, I think the goals are set out there. 11:25

A. Yes. I said earlier that it was very nice to be able to get straight into ED and start from scratch because ED, I attended the first two or three of them and was happy to leave them to it. So we got there straightaway. 11:26

The overarching goal, I think we were halfway there. I mean, I think we might have made that preparation to the other medical leaders. There was an informal Medical Directors' meeting of the five Medical Directors. At the same time, Julian Johnson was working within the Belfast Trust, coming from a different angle looking at how deaths are reported to the coroner and whether or not the department needed to have a second look at those as exist in Scotland. He was coming at it from a different angle, so we were both working together on this point. In other words, whenever the -- I forget the term -- the person who would be employed to take a second look at cases -- death certificates, not so much cases referred to the Coroner -- that they would be able to go into the M&M systems and look for evidence of what actually happened. 11:26 11:27 11:27

We have a thing called the IMEXHS system, which is an electronic recording system that we piloted in Daisy Hill. The case would be presented, projected onto the wall, the minute of the discussion would be minuted live, everyone would have an input into it. M&M medicine in Daisy Hill is quite a small operation, so it was very easy to get that started. That was the general gist of things. You could make a recording of what your thoughts were, what you were able to do, what you weren't able to do. As I say to provide assurance, really. It's to show that we're doing our very best to 11:27 11:27

learn from experiences but we're not perfect. But you need evidence of that, I think, on an ongoing basis.

59 Q. If we just go over the page, there's a list of proposed interventions. This is explaining to those coming to this meeting how, I think, at this meeting there was a proposal that we would now call it Patient Safety meeting, just to move on. But this was laying down the law in terms of how we, as a Trust moving forward, are going to bring greater professionalism, greater focus to our Patient Safety meetings; is that right? 11:28

A. Yes. We didn't hit all 15 targets at once but we were getting there at this stage. For example, in obs & gynae, they already had a specially-driven trigger list before my time. I wanted everyone to have that. Rather than just putting information in the IR1 system, you know, I'm worried about this or this happened, for the Trust and the frontline clinicians to say these are the areas that we want you to fill in IR1s about because we want intelligence back from them. It has to be said, though, the IR1 system, the paper-based system we inherited, it wasn't being used as intelligence gathering for Patient Safety, it was being used for all sorts of reasons. Doctors generally ignored it, it has to be said. 11:28 11:29 11:29

But there had been really good progress made in obs & gynae, away before my time, that they had already a trigger list -- probably driven by litigation, I have to say -- that they had to look at, you know; certain

things in obstetrics that regularly go wrong, and look at them. They also had the benefit of a risk midwife who, if you like, was to me the perfect example of where governance and clinical teams get together to make things happen. The risk midwife would be looking at that trigger list and deciding what actions to be taken. There was quite a good, I think, multidisciplinary approach between midwives and obstetricians in that. 11:30

60 Q. Can I just pick up on one intervention or one initiative set out here. If we move to WIT-26055, just five or six pages on down, there's a reference to a lessons learned letter. Is that new thinking or is that something that you were bringing in from elsewhere? 11:30

A. Well, there already was a lessons learned letter coming down to us from the Board, which they had extracted, if you like, from common SAIs across the five Trust. I thought we needed something local. I am not sure if we got that started, I think we did, but I can't remember a lot about it. 11:31

61 Q. So the idea was, for example, an SAI would produce some learning, it would be discussed at the Patient Safety meeting between the clinical lead of the Patient Safety meeting and interested others. A letter, if that's the right expression for it, would be developed for broader circulation? 11:31

A. It was to bring, if you like, the issues and the very good and healthy discussions that had previously

existed in M&M out into the wider clinical field for all professions.

One of the things we did achieve is to regularise the M&M Chair position into an appointed position, interviewed for competitively, appointed and given half a PA a week, a small amount of time but, nevertheless, previous to that the M&M Chair had been a volunteer. I also thought that was a very good idea as a way of introducing newer and younger consultants to medical leadership. Because my idea of that medical leadership, which I tried to explain many times, is not about being the most senior doctor, it's about making things happen, making good things happen. So we did that and I was very pleased with that. 11:32

MR. WOLFE KC: I wonder if now would be a useful time to take a short break.

CHAIR: Yes, 15 minutes. We'll come back at 11.50, ladies and gentlemen.

11:32

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: Thank you, everyone. Mr. Wolfe.

MR. WOLFE KC:

62 Q. Hello again, Dr. Simpson. 11:50

Could we bring you to the issue of your role as responsible officer in the context of appraisal and revalidation. You explain in your statement how your

role as responsible officer strengthened your position as Medical Director in the Trust, but you also highlight the general lack of resources for leadership and management at that time, as you explained this morning. Nevertheless, despite these resource issues, you say you oversaw the introduction of a revalidation programme for doctors and enhanced appraisal. Can I ask you about that? 11:50

If we turn to WIT-25871. It's useful. This is an email explaining that there is to be training for appraisees and an appraiser clinic. Just scroll down to the next page. It's perhaps a helpful illustration of the messages that were being sent out to those who were engaged in this programme. 11:51

Could you help me with this? I think you said earlier that appraisal wasn't intended or wasn't designed as a performance management initiative. But was it in any way shaped or directed towards, at least in part, helping to identify concerns in association with a doctor's practice, if they existed? 11:52

A. Yes. Some of the -- all of the appraisers were volunteers, if you like, other than the Clinical Directors, so we needed extra people; so that was the training, what if I'm not happy with this doctor's performance? The instruction was they should immediately stop the appraisal and alert the Clinical Director that they were not happy with the doctor's 11:52

presentation, if you like, and the evidence thereof. I don't think that happened -- it might have happened one or two occasions but not very often. What did happen was there were a number of doctors, a small number, who really struggled to engage in appraisal, 11:53
full stop. Because appraisal previously had been almost if you like this, you can do it, if not, we're not really going to get at you. There were three or four occasions it did highlight doctors' problems, more in terms of health, if I remember clearly. That was 11:53
useful.

But appraisal really was meant to be informative to help the doctors put their best foot forward. So there was a requirement to be involved -- my requirement, 11:53
I don't think anyone else did that -- that they should be involved actively in M&M and Patient Safety, wherever that might be in the Trust. And they should also discuss complaints. That was not nevertheless received very well at first because the idea would 11:54
be -- I think as the BMA and others had said, appraisal is about the doctors coming forward, but we made it clear, or I made it clear, that any complaints against the doctor would be given to the appraiser and the appraisee, not in any sort of punitive way. But the 11:54
idea really was, because quite a few people had mentioned it, they wanted something, they needed some meat and drink to discuss at an appraisal meeting, not just okay, that's very good, thank you. So when we did

an audit of the appraisals, we found that possibly only 60-odd percent where there had been a really good record of discussion feeding into the PDP plan. I was okay with that.

11:54

The most important point in the first instance was to get engagement. Because appraisal engagement prior to the Medical Act, prior to the introduction of revalidation, was around about 40-60 percent here and there. We got it up to near enough 100 percent. Not always of a great quality but at least that was the starting point. 11:54

There were other things which were good and bad about it. We allowed doctors to choose their own appraiser. That has since changed, they have a designated appraiser. The thrust was really to get engagement in the appraisal system as a necessary precursor to revalidation because the GMC requirement was at least one enhanced appraisal, which would include 360 feedback from patients, staff and colleagues, and reflection. We gave them a website. We created a website called Southern Docs where there was reflective templates to be used, and we expected doctors to present at least three or four. It wasn't hard and fast, but at least three or four of these reflective templates on their practice, say a major incident or a complaint or a learning point; we left it quite open. But the general idea was to get 11:55 11:55

a discussion going and to look at the doctor's practice with the support of an appraiser, and then for there to be a clear line from that to the PDP, the personal development plan. Of course that is what appraisal is about, it is about personal development for the doctor. 11:56

From the Trust point of view, it is important to know that we have evidence from the doctors that they are putting their best foot forward and showing what they can do and how they're going to improve. 11:56

The other thing that emerged over time was that where we did have criticisms of doctors, sort of at a low level or whatever, we could put that into their PDP and insist that it be there so that it is checked by the 11:56 appraiser at the next level. So there was an element of performance into it, but it was largely informative.

63 Q. Let me pick up on some of that. This was in part about changing culture, it was getting the system of appraisal in the mainstream. As you say, 40 to 11:57 60 percent, you got it up to close to 100 percent. At that level it was a success. I suppose if this Inquiry is looking at, I suppose, methodologies or instruments by which a Trust can pick up on doctors in difficulty, doctors not performing as they are expected to, if 11:57 that's one of the Inquiry's interests, the Inquiry, at least going back to the early days of appraisal, the Inquiry would be wrong to think that appraisal was focusing robustly or rigorously down on that kind of

issue. It wasn't about that, really?

A. No, and there's been criticism from the BMA and others since then where appraisals have been in some Trusts used more for performance. That, I think, isn't the right way forward. There has to be, if you like, a back-up to say, well, we're also going to look at your performance and adherence to guidelines and, you know, what we want you to do as an employee. This is about you telling us how you want to get better and can we help you. 11:58

64 Q. Right.

A. So it couldn't really -- I think there's a gap there in terms of performance management.

65 Q. Yes.

A. I tried to introduce it at the AMD level. What I said to all the AMDs was I want you guys to come up with your own performance targets for every year. 11:58

66 Q. We'll come to the AMD. Let's just step into this training document as a source to help us understand aspects of the appraisal process. If we go to WIT-25882. I think you've said in your evidence earlier the doctor's role includes identifying an appraiser for him or herself so they, in a sense, at that time got to select. It's for the doctor, at least in part, to identify factors that may inhibit performance. Of course, you say it was intended as informative as opposed to performance management. 11:59

We see in Mr. O'Brien's case that he was appraised by

his peer, Mr. Young, who was also clinical lead for five continuous years. Whether the purpose of the scheme is formative as opposed to management performance, that's not good governance, is it?

A. No, but it's a start because previously there would have been no requirement, really, to engage in appraisals. It was a start. There was a debate at the time as to whether or not a doctor should be appraised by someone from the same specialty. But what we tried to do as we moved on was to train professional, if you like, appraisers who could do that. I was in favour of that because my appraiser as an Associate Medical Director was Paddy Loughran, who was an anaesthetist, so I had to explain to him what I was doing in psychiatry, which is no bad thing. I believe the Trust now allocates appraisers, and I think it is changed every so often to keep things fresh. So, that wasn't ideal. 12:00 12:00 12:01

67 Q. As it says there, they have to identify factors that may inhibit performance. 12:01

We know, if we go to WIT-25905, that in terms of a review of practice during the appraisal process, there's an expectation that significant events will be examined. A report will be extracted from the Trust Datix. Is that the same thing as saying that an incident report should form part of the portfolio of evidence going into the appraisal process? 12:02

A. Yes, but it's still up to the judgment of the

individual doctor which significant event to focus on. Again, this is proceeding in baby steps; we want you to focus on something; we're leaving it up to you; it is better than focusing on nothing, which was the previous. The Trust Datix incident management system was no more than a prompt. I think it did frighten some people.

Datix, as it had been, was more like almost pejorative, "I've been IR1'ed. Somebody's reported me". It wasn't really being used properly as I thought it should be and I think it is now more likely to be an intelligence-gathering system for quality agreement. So, these were all very new. I'm not sure, in fact, that what I was doing was the same in other Trusts. I think doctors might have felt a bit uncomfortable. On the other hand, the website we put up, Southern Docs, was actually received very well in other Trusts who used it. But this was all very knew, I think.

12:02 12:03 12:03

68 Q. When you say "baby steps "and it gave some leeway, perhaps substantial leeway, to the doctor to select what examples to use, does that suggest -- and just help us understand the process -- that say there was a series of incident reports relating to a doctor, perhaps not portraying him or her in a good light, under the process at that time, or during your time, could that doctor have kept those to one side so that the appraiser didn't see them, or did the appraiser receive what was on the system?

12:03 12:04

A. I think significant events was a very broad brush. It was up to the doctor to choose which to bring to the appraiser, the appraisal discussion. So yes, as I said, it was a first cut in these things, it's not the finished article. But, on the other hand, it raises the question should there be a separate process of performance management to look at those things in detail, which I think we had the beginnings of with the medical leadership structure, but the medical leadership structure was very thin on the ground. 12:04 12:05

69 Q. In terms of -- I'm trying to think about this as well from the appraiser's perspective, the appraiser -- I think about Mr. Young as clinical lead -- he may have access to all sorts of, if you like, soft intelligence. You know, Mr. O'Brien's case, I'm not going to do DARO or I have disagreements with DARO; I'm not going to action results as soon as they're available; you know, I find triage impossible to do. Those kinds of things may not at any particular point in time find their way into an incident report but the clinical lead, just happens to be the clinical lead in this example, he is appraising the doctor and it is supposed to be informative. Is it your expectation and was it a well-communicated expectation that appraisers should be using that kind of material, that soft intelligence? 12:05 12:06 12:06

A. We wouldn't have communicated that down to them, no. I don't think we would have got any volunteers to do the appraisals if that was the case, if they were being asked. That was something that we heard from the

ground up, you know, what exactly do you want me to do? If it is to help a doctor get better and improve and so on, yes, we'll do that but we're not going to be, if you like, policing them. That current was also coming from the BMA, the doctor's union, and rightly so, 12:07
I suppose, that if you want to police a doctor's activity, for want of a better word, you need to use a different system.

With regard to all of those things you mentioned in 12:07
urology, it would strike me that -- as I think we did try to explain to doctors -- the appraisal system is a way of advocating that you need help, that you need help to develop. The personal development plan is -- what we've, I think, instructed the appraisers is to 12:07
bring those issues together into a plan that can be actually enacted, reasonably so. If not, then, you know, the appraiser should be approaching whoever the Clinical Director was, because the appraiser might not be the medical manager. But these were early days. 12:07
I don't know if... We were possibly pushing the boat out a bit with regard to the other Trusts. I can't be sure about that, it's my opinion that we were expecting quite a bit, I thought, of the doctors in the Southern Trust and it was how far can you bring them in 12:08
one or two years. I thought I had a certain amount of leverage because, you know, I think I might have said quite specifically if you don't engage with what I'm suggesting you should engage with, I'm not revalidating

you and you're not going to be a doctor. Whether that was the right approach or not, but carrot and stick sort of thing. But I was aware that we had a very large audience.

12:08

For example, if you had been in your first year as a consultant, you would have been doing this regularly through your training; ARCP, annual review, something, something. So the younger consultants who had recently been through, if you like, the senior registrar training, appraisal was just the next step, it was no problem whatsoever. Doctors of, you know, 30/40 years vintage in this system would look askance at this and say what's all this about?

12:09

70 Q. Let's just glance back at your job description again to remind us of your role vis-à-vis other medical leaders. It is WIT-5757. It was expected of you that you would provide professional leadership and guidance to support AMD, Clinical Directors and lead clinicians throughout the Trust in relation to governance of the medical workforce including clinical practice and service change. Could we focus on that?

12:09

12:10

You've said in your witness statement, this is paragraph 26.1, you initiated an informal performance review process with your AMDs, involving biannular more frequent meetings with each AMD to review their performance objectives, although these, in the nature of the informality of these meetings, weren't minuted.

12:10

You go on to explain that you approached this project in a testing of the water fashion to introduce the concept to medical leadership in the Trust. You saw your role in this process as one of leadership coaching. That's paragraph 26.1 of your statement. 12:11

Could you help to set that in context for us, those initiatives? Were you dissatisfied in any way with the quality of the AMD cadre or was it about helping them to get better? 12:11

A. What I had found and what I witnessed when Paddy Loughran was the Medical Director, so I'm sitting around the table with these ten -- actually we increased the post by two, so maybe 11 or 12 it was then -- to one degree or another, they would have seen 12:11 themselves as conduits, you know, relating to management the views of their colleagues almost as, you know, an equal among equals in reviewing their -- presenting their colleagues' views to management and then presenting management's views to their colleagues. 12:12 That was the ethos generally in the health service for a long time, and it was still there when I took over the Medical Director's post. Really it was an attempt to modernise and change that.

12:12

So I did a number of things. One of those things was to say to the medical leaders, look, medical leadership is about making things happen, more disciplinary wise with the managers with the different clinical groups;

making changes; making good things happen. It's not about maintaining the status quo, which was understandable, I thought. I wouldn't be overcritical that I thought they should be carrying out. What I said to them was, look, you identify for me what your objectives are and let's see how you get on with them and I'll hold you to account for that, in a friendly and informal manner just to kick things off. And also for them to take that view down through their system to the CDs and also to their consultants. I had experienced that as the AMD for Mental Health, if you like. So the Director of Mental Health would be saying to me, John, what are we doing here? What are you supposed to be doing, what's your plan? We would agree on something, I would go and do my bit, he would go and do his bit. More of an equals thing but still the whole business of making things happen. So yes, the culture that I arrived to find was one of let's keep the ship afloat, let's keep moving, let's maintain the status quo. 12:12 12:13 12:13 12:13

71 Q. It was about changing or adjusting their outlook?

A. Yes.

72 Q. In terms of --

A. These were, I think -- not every one of them, but to be fair to them, these were very senior practitioners, excellent in their fields. We mentioned Eamon Mackle, an extremely skillful surgeon; maybe medical management not his strongest point, but he is there, like the others, because of his seniority. I got as far as 12:14

I could with that. By the by, what I was able to do was increase the complement by, I think, two new MDs; one for infection control, that became Dr. Damani, one for ED, that was Seamus O'Reilly. Two new CD posts. I made a rule those should be competitive interviews and they should be interviewed on the basis of a leadership, which is a competency-based interview process, in other words can you give me examples of things you have done in this modality or that modality of leadership. So, it was that. 12:14 12:15

Then the other change -- it's related to this -- that I made was instead of sitting in on interminable consultant interviews, many of whom we appointed then didn't turn up, took jobs elsewhere, that I interviewed or inducted every new appointee, should it be a consultant or staff grade, and explained the same process to them, that they were now leaders; whether they liked it or not, that's how the system viewed them; that there was a medical leadership structure; that you didn't have to be in it to contribute to it; that I expected all consultants and staff grades to contribute to medical leadership. The final thing I said to them was if you find that the current medical leadership structure isn't working for you, come straight to me. 12:15 12:15 12:15

73 Q. Thank you.

A. And I think the other arm to this process was I created an educational programme for that level of Clinical

Directors, lead clinicians, and consultants who wanted to come on board into medical leadership.

74 Q. Could I draw your attention to something Mr. Mackle said in his evidence in terms of, I suppose, the support he had from you. If we go to TRA-02098, just go to line 9. I'm asking him about his AMD role and whether he felt, at least on a personal level, generally supported by each of the medical directors he worked under. He goes through each of them. Just scrolling down. Most of the time then in terms of time spent with a Medical Director would have been with you. He says "I was moderately supported". I said that suggests a lot more could have been done to help you. I'm not sure the stenography picks this up precisely or whether he did express himself in these terms: 12:16 12:16 12:17

"Well, shall we say, I expected more of an interpersonal relationship. I thought I was alone but then I recognised other AMDs had the same".

12:17

"I felt there was an interpersonal relationship"; I wonder whether that should say "poor personal relationship". That was certainly the memory I had in my head. Then in preparation I saw that the word "interpersonal relationship" had been recorded. No matter, it appears to suggest some kind of negativity in terms of his perception of his relationship with you in the context of whether he was well supported. He expands that into other AMDs and said he understood 12:17

that they felt the same.

Can you comment on that for us, if you can?

A. Well, I was there to do a job, I wasn't there to make friends. You know, I did try very hard to help Eamon. I did put pressure on him. He was particularly behind with the job plans compared to the other AMDs, and that was something I would have pushed him on. I had no choice to do that. So, it was a working relationship. As you can see, I probably met him, I think, more than any other AMD to provide that support and encouragement. But I wasn't supportive of the status quo and that's the truth. I thought that, say, in contrast to where I had been, because my job plans had all been completed before 2011 -- I don't know what year that was -- so he was a couple of years behind. I did understand the difficulty. In contradistinction to, say, anaesthetics, where it's easier to come up with a team job plan and a demand capacity match, and then fit each doctor, each anaesthetist, into the job plan team and therefore individual job plan. Understandably much more difficult to create that kind of approach or result, actually, that existed in anaesthetics compared to surgery. But again, with all due respect, I think Eamon had that view that he was there to represent his colleagues' view. My view was I expect things to happen. 12:18 12:18 12:19 12:19 12:19

75 Q. You touched upon what you said to him about job plans. Let's just bring that up for completeness. TRU-250634.

This is 2012. Just at the bottom of the page, you are writing to Eamon with a number of points. You say, as regards job plans:

"All of the other AMDs have made significant progress in this regard. Your performance in this area is a matter of concern." 12:20

He writes back to say he is on sick leave. Let me see. Yes, sorry, I just spoiled the redaction. Not a significant matter, I think. 12:21

That's an example of you having, I suppose, to chase his performance.

12:21

In terms of the evidence, as I say, I brought you to the transcript and it uses the word "interpersonal", whatever that might mean. If I can interpret that as him saying that there were poor personal relationships between you and the other AMDs, is that fair, in your view? 12:21

A. No.

76 Q. How did you routinely meet with them to support them or guide them?

A. So, every year I would do each one of their appraisals. That would have been a bit of concentrated activity around, say, March/April to the summer. Then I had possibly bimonthly performance meetings. Then there were the team -- sorry, what I tried to do is create an 12:22

AMD team, so there was that quarterly team meeting. Possibly the two AMDs I would have been most critical of were medicine and surgery, but I was fully appreciative of the difficulties they had. I think they were overstretched. I could see the massive 12:22
responsibility in general medicine in terms of numbers of doctors, and the more specific problems with surgeons are probably more difficult to manage than others. There is that self-selecting personality type that you get among surgeons, and I think Eamon had 12:23
difficulty in bringing his group into being a team, and therefore no progress on a team job plan and really hard-nosed, if you like, discussions with each one of them about job plans.

12:23

What I tried to explain was my view, which was that the initial job plan is not the be-all-and-end-all of things. It is an initial job plan, it is a yearly negotiation. That's how I managed things in Mental Health, maybe erring on the side of being easy on the 12:23
doctor first off but then year on year, you are looking at metrics to see exactly what's happening, is there fair distribution of work between the team members. That would be how I would have used it, you know, I can't tell you all and give orders, but really 12:24
consultant A is doing a lot more than consultant B, can we even this out a bit. That would be an annual discussion. That's what I thought should have happened, and did happen in other specialties. But you

obviously have to take account of the fact that Eamon did have some health problems which were quite serious. This is where he asks Robin Brown to come up and help him with urology.

77 Q. We'll come to that in a moment but just finally on AMDs and indeed Clinical Directors as well, what was your expectation of them? I'm thinking in particular, obviously they have a range of activities that they might be expected to engage in, but where they have an awareness that clinicians for whom they are responsible in managerial terms are in difficulty, maybe providing less than optimal service, maybe placing aspects of the service at some risk, was there a clear understanding that at some point along the line, you would need to hear about it? 12:24 12:25 12:25

A. Certainly. An example, I mentioned earlier about paediatrics. Within a few weeks of starting, Gillian Rankin had brought me up to her office because there needed to be a bringing together of minds with regards to children in casualty with potential surgical problems, appendicectomies, and also trauma. The ED consultants were basically being left holding the baby, who do we get to come and see this child? The surgeon saying I'm not a paediatric surgeon, the paediatrician saying I'm not a surgeon; then the Central Surgical Unit for children wanting a referral from ED that would have, if you like, the imprimatur of possibly both surgery and paediatrics. Long negotiations went on with that, which we made a lot of progress with. After 12:25 12:26

a period of time, I just decided that the AMD for Paediatrics was not performing and I asked him to stand down. That would have been well known to everyone. Coincidentally, the Clinical Director for Paediatrics resigned for personal reasons, so I had to step into that role. This is all 2011/2012, to, if you like, encourage a new leadership to come forward, which we did do. But everyone would have been aware. The basic issue that I had with the AMD for CYP, children and paediatrics, was that very issue that you mentioned, taking responsibility for clinical governance in a very real way to solve the problem, and the problem wasn't being solved and I wasn't happy about that. 12:26 12:27

12:27

So I can imagine that the other AMDs would have thought this is quite serious. What I was trying to explain to them was, well, look, it's better that we take this seriously now rather than be criticised later for not taking action. 12:27

78 Q. Yes.

A. What happened, as I say, that first year, by December/January 2012, the Pseudomonas problem had arisen with the neonatal deaths. We had a non-accidental -- a potential, suspected non-accidental injury in paediatrics which resulted in a baby death. I had to refer three of the consultant paediatricians to the GMC. There was a whole host of issues in that area. So this is business, this is what happens. 12:27

When you ask that question, I mean at our quarterly AMD meetings, I would be bringing these discussions, these points, to the other AMDs that this is where you guys are sitting on, you're sitting on an responsibility. 12:28

79 Q. You can see that. You explain in your witness statement paragraph 65.1 that the opportunity to formally raise concerns to you -- and here you cite Mr. O'Brien or urology -- were at the clinical governance sections of the quarterly AMD meetings, or 12:28 for professional governance at the HR and Medical Directorate meeting. Let's just briefly look at perhaps the structure of the quarterly AMD meetings. If we go to a sample of minutes for June 2014, WIT-25821. If we just scroll through, you can see 12:29 towards the end of the meeting, Section 5 of the meeting, it's called Governance Reports. It records that you asked your AMDs to report governance issues by exception. Is that a standing item on the agenda?

A. Yes, and it had been before my time under Paddy 12:30 Loughran. What I wanted to do with that was really to bring it into like a team arena where all of the AMDs could learn from each other about governance issues. I would have expected their governance escalation to be happening anyway, but that was an opportunity for, if 12:30 you like, me to do a bit of team building, to get the discussion going, and to ask -- although they were very reticent to do this -- but to try to ask maybe Dr. McAllister to challenge Dr. Chada, what is that

about, to get that kind of discussion going. Because I remember when Paddy Loughran was doing it, he would often use me to ask questions and get a discussion and a debate going about governance.

12:30

It was about raising the awareness of the responsibility of these people of what they had. What they brought to me was up to themselves, I couldn't determine that. It wasn't necessarily that this was the main thrust; they would be expected to bring that 12:31 to their operational director or directly to me as Medical Director and to the HR Medical Director meeting.

80 Q. Obviously within your job description, you are the designated officer for fitness to practise issues, for 12:31 referrals to the GMC. So while you say it's up to them what they brought to these meetings, was there also an expectation and understanding that where issues were crossing a particular line, that you would need to know, that there was a duty to inform you? 12:31

A. Yes, but more so directly to the medical HR meeting through their meetings with me or through their Clinical Director -- sorry, Director of Service, or through HR. Each directorate would have an HR person embedded in it as well as what I had at the Medical 12:32 Director HR meeting. That's where the main -- they would know that's where doctors should be sent to, whether it's performance, MHD, maintaining high potential standards, potential referral to GMC, that's

where that would go for individual doctors. This was more about system problems, if you like.

81 Q. Let me move to urology specifically. There's a range of somewhat disparate issues I want to raise with you. Can I raise a staffing issue with you? If we go to TRU-25059. Sorry, let me go back to your statement, WIT-25696. At paragraph (d), you're explaining that you're involved in a series of emails on 17 February 2012 regarding negotiations with Mr. Patrick Keane, the Specialty Adviser For Urology, on the job plans for the upcoming new consultancy post, the consultant urology posts, specifically the proportion of SPAs, Supporting Professional Activities, which were to be allowed. It seems that the Trust wanted to advertise the post with 1.5 SPAs rather than 2.5 and Mr. Keane indicated that would not attract colleague support. Do you remember this issue? 12:32 12:33 12:34

A. Yes.

82 Q. The internal emails, if we go to TRU-250955. I think there was a suggestion that the post could be advertised as 2.5 for a fixed period and that the job plan could be adjusted down afterwards to 1.5? 12:34

A. Yes, I agreed to that.

83 Q. That's the wrong reference. 250595. 12:35

What was happening here, it would appear, is that on one view publicly the Trust was putting out an advertisement suggesting 2.5 SPAs for the job but there was a recognition internally that this couldn't be

maintained for the longer term?

A. My view, and I think what we agreed, and I think it was agreed regionally if not nationally, is there's a split in that 2.5. So it is a standard consultant contract, 2.5 Supporting Professional Activities. But I think what we were insisting on, and why we agreed 2.5 to be reduced -- not to be reduced but that 1.5 was for doctor's own professional development and the other one is for what we, the Trust, ask the doctors to do in terms of being involved in, you know, improvement activities, service development, so on and so forth. In other words, you were guaranteed your 1.5 Supporting Professional Activities, but the other one was contingent upon doing things which were of benefit to both doctor And Trust. It probably wasn't -- I don't know where that came from initially but I don't think there would have been any point advertising a point with 1.5 SPA's. Nowhere else was doing that. I think we did want to get the point across that it was 1.5, if you like, for yourself and one for us, as in the employer. 12:36 12:36 12:36 12:37

84 Q. So in the approach, taken there was no misrepresentation of the remuneration that a doctor would enjoy?

A. I don't think so, no. I think we'd already established that, you know. I can't remember the detail but I know we'd already established that split in the 2.5. I think that was agreed nationally as well, I'm pretty sure. Yes, because I think we also agreed that, say 12:37

you had four consultants in a team, so they had these four sessions that belonged to The Trust, if you like, that three of the doctors could give their Trust PA, SPA if you like, to a doctor to do a specific piece of work. It was really about fair play and taking account and making note of what was happening. 12:38

Prior to that there was a bit of unfairness amongst doctors, you know, that a certain doctor might go off and do all sorts of esoteric things and visits all over the place and other doctors would have to cover for it. I didn't like that idea. 12:38

85 Q. So it was giving an element of control to the Trust?

A. Fair play as well, yes.

86 Q. Let me then turn to an initial view you appear to form in relation to the approach to clinical governance within urology. It concerned a trainee doctor called Dr. Aminu. 12:38

A. Aminu, yes.

87 Q. And you were copied into an email on 2 March 2012. If we can bring that up on the screen, please. It is TRU-250598. This is being written to Dr. Weir, who was -- was he a director for -- 12:39

A. Medical education.

88 Q. So, Mrs. Roberts is writing to him to inform Dr. Weir about a doctor. 12:39

"... who is currently under investigation by the GMC. She understands that the Training Programme Director

For Urology has spoken with Michael Young and Aidan O'Brien and there have been no complaints about Patient Safety or probity. We will be responding accordingly".

If we can pick up the issue with reference to your statement. It is at WIT-25697. Yes, just to take up at the Director of Acute had -- sorry, maybe we'll start at the top. You explained the inquiry that had come in and the Director of Acute, Dr. Gillian Rankin, had received a similar inquiry from the GMC on 29 February, which she brought to your attention. The issue, as you explained, just to cut to the chase, was that an inquiry was raised in terms of whether concerns had been raised about the competency of this doctor. Scrolling down. You say that Mr. Brown, in his role as Clinical Director at that time, discovered that a senior nurse, Shirley Tedford, had already raised concerns about the competency of this doctor to the Lead Clinician For Urology, Mr. Young, "but that this had not been escalated to either of us", that's to you or Dr. Tedford. 12:40 12:41 12:41 12:42

A. No, Robin Brown.

89 Q. Robin Brown.

You're explaining -- just so that we fully understand the picture -- Mr. Young was aware of the concern, having heard about it from the nurse, but hadn't drawn it to your attention and hadn't drawn it to Mr. Brown's attention; is that it? 12:42

A. Yes, nor Mr. Weir as the Assistant Director of Medical Education.

90 Q. You go on to say:

"Although this was a matter of concern, the swift and appropriate response by Mr. O'Brien did compensate," 12:42

because, as I'll demonstrate now, after you raised a concern about how the matter had been dealt with, Mr. O'Brien went and spoke to the doctor and then forwarded a report to you. 12:43

If we go to TRU-250599.

A. Yes, I think Mr. O'Brien must have been the educational supervisor for that doctor. In other words, he was in Mr. O'Brien's team. I think that's why he replied. 12:43

91 Q. TRU-250599. You are speaking to the Director of Nursing, presumably because it was a nurse who had raised the concern about this doctor, Dr. Aminu, with Mr. Young. What you're saying to Francis Rice, you're explaining the background. 12:44

"This kicked off by a letter that you had received from the GMC. Our urology consultants thought he was just about okay. It seems the nurses have a totally different view. My guess is that there is something amiss in urology regarding multidisciplinary working, never mind professional governance". 12:44

Then, just before I ask you some questions about that, if we go to AOB-819723. On the same day, 13th March, you write to Robin Brown and Aidan O'Brien asking for something in writing regarding the concerns about performance of this doctor. Then you go on at the end to say to both Gillian Rankin and Francis Rice: 12:45

"It is a matter for concern that a senior nurse would have significant concerns about the performance of a doctor that don't seem to have been followed through. I think that there must be some learning here regarding clinical governance." 12:45

This is, I suppose, just under two years into your role as Medical Director. Your concern, it appears to be, is that... 12:45

A. One year.

92 Q. One year, sorry, yes. Just coming up on just under one year.

12:46

Your concern is that there's a live concern on the ground about the competence of a doctor or the actions of a doctor. The nurses had this concern, rightly or wrongly; the doctors don't seem to have that concern, rightly or wrongly, but the problem is the person who knows about it and who has responsibility to do something about it, that is Mr. Young, hasn't raised it. Is that the point? 12:46

A. Yes. I mean, as I said in the email, it's my guess

there's something amiss. I wouldn't have thought very much different of any area in the Acute Directorate -- and that's why I brought Francis into it -- whereby I thought nurses were very reticent to criticise doctors in any shape or form. So, there was that lack of action in terms of Michael Young but there was also this block that Gillian certainly -- sorry, Shirley Tedford did report it to Robin Brown. Robin is only coming up once a week from Daisy Hill to look at things and doesn't see everything, so fair enough. But Shirley then also has her professional lines to say this doctor may be putting the whole system at risk. It wasn't that bad as it turns out. I'm quite removed from the frontline, so to speak, and I can only guess what's going on there, and I'm expecting people to raise issues up through the system, first to Robin, then to Eamon and then to me. It indicated to me that there was a general cultural problem, I didn't think necessarily particularly in urology, but generally. I was pretty aware of it throughout the Trust and it was a real contrast to my experience of mental health. Mental health nurses, mental health social workers would have no computation whatsoever about putting a doctor in his place and, if that didn't work, coming to me as the Clinical Director or Associate Medical Director. I was a bit concerned about that.

12:47 12:47 12:48 12:48 12:48

I discussed it with Francis and Gillian, what we did, and Francis as I described to you has a full-time job

in Mental Health never mind being Director of Nursing. What we did was a series of walk rounds. There was a whiteboard initiative being brought into all the wards with the new technology and we used that as an opportunity to go and visit all the wards. But the subliminal message, which is a very gentle message, is look, any concerns at all, it is not just a matter of going to the doctor, you can go to your lead nurse, the lead nurse can go to Francis, Francis can speak to me. It was trying to open that up. It was very limited, it was a limited intervention. How far we got with that, I don't know. 12:49 12:49

93 Q. The Panel may consider it prescient that early in your role in the Medical Director's office, you are pointing to -- and saying that it was your sense that it was more widespread than urology -- but you're pointing to a sense that professional governance, clinical governance, are potentially weak. Ultimately, I suppose, it comes down to ensuring that those who have a responsibility, whether that's the clinical lead, the clinical director or the Associate Medical Director, that they are doing their jobs to escalate matters or to challenge matters at source. 12:49 12:50

A. Yes.

94 Q. Did you, appreciating that was the culture that you were working within, take any particular initiatives in that respect, or was it part and parcel of building the change that we've looked at already through M&M and that kind of thing? 12:50

A. I'm pretty clear on the memory at the time that what concerned me was the deference to seniority, to hierarchy. That, to me, was the problem. It spills over into clinical governance and so on and so forth, but the block is because of undue deference to hierarchy. That was my view. I had seen evidence of that right across the Acute Directorate; more so in Craigavon than in Daisy Hill. Daisy Hill is a smaller hospital and less in the way of those blockages, shall we say. I saw it more as a cultural problem throughout that had to be tackled. I thought my best way was to tackle that systematically as opposed to individually. I'm pretty sure similar problems existed elsewhere. 12:51

95 Q. Yes. Clearly there can be no quick fix to those kinds of things. We'll probably go on this afternoon to look at some of the specific issues that didn't come up to you and were left improperly addressed, some might argue, in association to Mr. O'Brien's practice. But when you look back from that position at the things that didn't arrive on your desk, nobody told you about them, I think, will be your evidence, if I can anticipate. What does that say to you, given that you had a sense of that at the very beginning through this incident. 12:51 12:52

A. I had a sense of it everywhere; that was my problem. As I say, there were firefighting issues arising all over the place. One of the positives in that was I knew Robin Brown quite well from working together in Craigavon -- sorry, in Daisy Hill. We were both 12:52

Clinical Directors. I'm pretty sure he would have made it clear to Shirley Tedford that it's very easy to approach me if you have any concerns about anything clinical governance wise. But then Robin is at a disadvantage because he is coming up from Daisy Hill maybe half day a week and so on and isn't fully cognisant of all these things. But I was confident leaving things with him, he's a very approachable, sensible manager.

12:53

96 Q. Can I just finish and we'll take an hour this afternoon just to go through some of the other issues.

12:53

A particular issue around Mr. Mackle. He was the AMD for Surgery; one of his areas of responsibility was urology; one of the clinicians who he had to deal with across a number of issues, including job plan, chasing triage as an issue, an issue around benign cystectomies, an issue around intravenous fluid in antibiotic management, a number of incidents leading in late 2011 to a facilitation in relation to a job plan dispute. He has recalled in his evidence that at some point in 2012, he can't recall a specific date, that he was advised that there was a concern abroad that he was bullying or harassing Mr. O'Brien. The upshot of that, just to put it in simplistic terms, was that he was invited to stand back from having a director input in the management of Mr. O'Brien, and Mr. Brown, as the CD, was to become more prominently involved if issues were to arise.

12:54

12:54

12:55

He said, just to be clear -- if we can just bring this up on the screen, please. WIT-11679 at paragraph 92. Just scrolling down.

"At my next meeting with John Simpson, I advised him of the issue and the change in governance structure in Urology. There was no formal investigation of the complaint and I've checked with Zoë Parks, etcetera, and she says there's no record on my file of the accusation of bullying." 12:56

So he is saying there, without going into specifics, that he told you about the issue and the change in the structure. Is that something you remember?

A. Not in the same way, no. He may have said something to me about that. My perception was that he was struggling with job plans, one of them was urology, and that he proposed he needed help from Robin Brown to come up from Daisy Hill to help him manage. That was the general agreement. 12:57

If he had been accused of bullying, I would have taken that very seriously because in another case, another doctor accused another AMD of bullying and to me that calls into question the whole validity of medical management, including pipeline. So, that would have been investigated had it been raised. I would have said, I imagine, to Eamon, look, write that down, bring it up to HR, put something on record, we will have to

look at that, because that's what I did in other cases.

But I did read his transcript and I think he makes the point that he was a bit -- quite upset by the whole thing and maybe not thinking very clearly. He may have thought that he said that to me but I don't remember any comment about bullying. 12:58

97 Q. It wasn't discussed with you by any other person in senior management?

A. No. I probably would have informed the Chief Executive that there was a change -- maybe she already knew -- that Robin Brown was come up to help Eamon. That was the general view which seemed a reasonable thing to do. As I said earlier on, it was putting Robin in a difficult position but he was up for it, so I agreed to it. 12:58

MR. WOLFE KC: It is one o'clock. Back at 2.00?

CHAIR: Yes. Two o'clock, everyone.

THE INQUIRY THEN ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS: 12:58

CHAIR: Thank you, everyone.

MR. WOLFE KC: Good afternoon, Dr. Simpson.

98 Q. Could I have up on the screen, please, WIT-16551. 13:57

Drawing your attention, Dr. Simpson, to a record of this meeting, it obviously predated your time in the Medical Director's hot seat. 1st December 2009,

attended by Mrs. McAlinden, then Acting Chief Executive, and Dr. Loughran, Mr. Mackle, Mrs. Burns notably, Mrs. Trouton notably; Mrs. Rankin. I didn't read out Mrs. Clarke deliberately. I've named the people you would have had some interactions with in terms of -- primary interactions with that might have related to urology when you took up post. 13:57

The reason for bringing you to this document is that all of those significant, important people are in attendance. If we scroll down, please, to the next page. It is a meeting concerning urology. Just scroll back up, sorry. A number of quality and safety issues are addressed at the meeting. One of them is an issue in relation to the use of IV antibiotics, which was then the subject of a review or informal consideration or investigation as to the appropriateness of the practice. Just scrolling down, the action is set out there. It was a practice which certainly concerned Mr. O'Brien and perhaps Mr. Young, although Mr. Young's evidence in relation to that is yet to be given to the Inquiry and he takes some issues. 13:58 13:58 13:59

Then there's a second issue in relation to quality discussed, the triage of referrals. One consultant's triage is three weeks and he appears to refuse to change to meet the standard of 72 hours. When Mr. Mackle gave evidence, he believed that that was a reference to Mr. O'Brien. Red flag requirements for 13:59

cancer patients:

"One consultant refuses to adopt the regional standards that all potential cancers require a red flag and are tracked separately". 14:00

Then, fourthly, the chronological management of lists for theatre. Those are issues on the agenda concerning urology and clinicians within urology at that time before you take up post; a year and a half before you take up post. 14:00

By the time that you do take up post, Dr. Simpson, the behaviours of Mr. O'Brien around triage are said to be continuing, according to the evidence. There had been an issue which was investigated around benign cystectomy. In the middle of 2011, just before you took up post, there was an investigation conducted by Mr. Brown in relation to the disposal by Mr. O'Brien of some patient notes in a bin, fluid management or fluid balance notes. There had been a lively dispute between Mr. O'Brien and managers in relation to his job plan that went to facilitation. 14:00 14:01

Were any of those issues drawn to your attention by way of hand-over? 14:01

A. No. Only the letter that Eamon Mackle sent to I think Gillian, copied to me, about the benign cystectomies, the conclusion of that report which seemed to me to

close the matter. This minute is completely new to me. I've never seen anything or heard anything about it.

99 Q. Yes. If we go back to what you've just said, you refer to being told about the benign cystectomy issue. TRU-281958. It's 28th July and Patrick Loughran, Medical Director at that time. This must have been just a week or two before you took up the position and he was to vacate the position. You're copied into this under the heading "Urology Review", along with Mr. Mackle and Ms. Brennan. Were you doing some kind of hand-over or dummy run before taking up the position? 14:02 14:03

A. Yes. We had a couple of weeks in July where I shadowed Paddy, and I was confident enough that most things could be handed over in terms of continuity with regards to the same managers being in place, particularly Anne Brennan. I did suggest to The Trust that Paddy should be kept on for a session or two per week for a few -- maybe six months, but that wasn't agreed to. I thought that would have been helpful. 14:03 14:04

100 Q. I mean there are other emails that the Panel are aware of and you have referred us to around this issue. But in short, they seem to be saying to you the review has been conducted -- to use the language of this -- the final report produced by Marcus Drake, who was a urologist who came over to do a desktop review of the patient charts, seems to be the words here supportive or indeterminant. They're not his words but that's the description given to you. 14:04

As you explain in your Section 21, this was really a matter for Mr. Mackle to follow up and put to bed, and if there were any issues requiring your involvement, they would be drawn to your attention. That was your expectation? 14:05

A. Certainly, yes.

101 Q. Is it fair to say then that when you started the Medical Director's role, you didn't understand there to be any issues or concerns regarding Mr. O'Brien or the practices within urology service in general? 14:05

A. Definitely not. No, there wasn't. I have a vague memory, it wasn't straightaway but it was maybe at some stage, but it's a vague memory of me in a meeting or an informal meeting with Debbie Burns as Director of Acute, so it must have been actually 2013, perhaps. Possibly Eamon Mackle was in the room and I must have asked a question because the answer was "That's just Eamon, he's very slow". I can't remember what the discussion was about. It might have been about a number of things. 14:05 14:06

102 Q. Sorry, did you say that's just Eamon or is that's just Aidan?

A. Sorry, Aidan. Yes.

103 Q. Is that what you meant to say, Aidan? 14:06

A. Yes. That's just Aidan, that's just him, he 's very slow.

That's the only memory I have of any concerns being raised. I can't remember the discussion, in particular what was the subject matter, but there was nothing to alert me. That puzzles me, but there was nothing to alert me of any concerns.

104 Q. I'll raise some issues with you this afternoon in relation to triage and in relation to patient charts, dictation and what have you, and take your views on each one briefly.

Can I start with the issue of actioning results. The scenario is the clinician has referred a patient to diagnostics, whether that's histopathology or whether it is radiology, to get a scan done. The report comes back. The question, I suppose, is who's going to read it, when's it going to be read and when is action going to be taken. It's that context we're looking at.

Can I ask you to look at an email, 2nd September 2011. It's TRU-250590. It's, as I say, 2nd September. You're just not three or four weeks, perhaps, and it is from Gillian Rankin to a number of people. The issue is meeting regarding a consultant urologist. It says:

"I think there would be merit discussing current issues around one of our senior staff. Is there any chance we could meet 2.00 to 3.00 p.m. Monday next."

Then there's a specific message for Eamon.

Do you know what, at first blush on reading that, what that was about or who it concerned?

A. No. I mean, I've looked at that last year. I've no memory of it, to be quite frank. Why it wasn't followed up... I was up in Gillian's office for other reasons, as I mentioned earlier, with the paediatric interface with ED. I have just drawn a blank on that. I have no idea what that is about. 14:08

105 Q. I'm going to seek your views on whether my efforts to fill in the blanks could be right, and you can comment accordingly. 14:09

If I can draw your attention to an email chain about a week prior to this email. It starts at TRU-276808. Just scroll down. This is Heather Trouton, and she's writing to a number of people, including Eamon Mackle. It's, as I say, 25th July 2011, a week before the email calling a meeting about a particular urologist. What she's saying here is: 14:09

"I was going to address this verbally with you a few months ago but just to be sure, can you please check with your consultants that investigations which are requested, that the results are reviewed as soon as the result is available and that one does not wait until the review appointment to look at them." 14:10

Going on up then, and we can see Martina Corrigan

copies that email in to a range of people, including Mr. O'Brien and other of the consultants in urology. The date on that is 27th July. Then Mr. O'Brien responds to that. In essence, there's a lot of questions set out but he's saying that he is writing in response to the email "informing us that there's an expectation that investigative results and reports should be reviewed as soon as they become available", and he's concerned about that for several reasons. 14:10

Just going on up the page, there is then an email on 25th August suggesting that Martina will need some assistance in replying to that. 14:11

On up the page I think there might be further... 14:11

"I have been forwarded this email by Martina and I think it raises a governance issue as to what happens to the results of tests performed on Aidan's patients. It appears that at present he does not review the results until the patient appears back in Outpatients Department." 14:12

Clearly, management are concerned that results could go unread while a patient waits for a review appointment, which at that time and subsequently was not necessarily easy to get, that is a review appointment, because of waiting list background. 14:12

I wonder can you help us. When you look at that, do you think the meeting called for 2nd September could have been to address that issue, or do you simply not know?

A. I don't know but it sounds like a possibility, certainly. But then I had no sight of any of these emails or no discussion about them. 14:13

106 Q. Nobody came separately to you --

A. No.

107 Q. -- to say this is the issue we need to discuss? 14:13

A. No.

108 Q. The original email that I brought to your attention mentioned "issues", plural. Just to go back to it, TRU-250590. So it's issues, plural. "Current issues around one of our senior staff". 14:14

What happens next around this issue is drawn to your attention, at least the broader issue of actioning results. Diane Corrigan from the Commissioner's Office wrote to the Trust on 14th November. If we could have 14:14 up on the screen, please, WIT-105752.

Just to fill you in with a bit more background, the issue around actioning results was a development or a spin-off of a root cause analysis case where the 14:14 patient concerned ran into difficulty because a swab was retained in her cavity during surgery. A scan after four months picked up an abnormality, but Mr. O'Brien didn't read the scan report so that the

patient came in as an emergency patient at about 12 months post theatre, post surgery, and it was then detected that there was a foreign body in her cavity.

That issue about reading the report or the investigation report as soon as it might be available had not been picked up on within the SAI review, and this is Mrs. Corrigan's reason for writing. 14:15

If we go down to the last page, the second page of this letter in the final paragraph, where she picks up on the point: 14:15

"It is the practice of the patient's consultant urologist not to review lab or radiology reports until patients attended their outpatient appointment. There was no further comment on this practice nor any recommendation relating to this in the SAI. I believe that this highlights an area where the Trust would have considered action to be appropriate". 14:16 14:16

From that letter coming in, it's drawn to your attention; isn't that right?

A. Yes.

109 Q. Gillian Rankin copies you into an email in relation to this. If we can go to WIT-10574. Sorry, wrong one. If we go to WIT-105754. Just scrolling down. The letter from Diane Corrigan is being copied around this level of management. Then moving up, there's 14:16

discussion about who should draft a response. Then in the next email at the top from Gillian Rankin, there's an agreement that Deborah Burns would take care of the drafting and Gillian Rankin explains that would be great. 14:18

"This was discussed with all AMDs on two occasions in the past year and I think our only specific issue is with one urologist and Heather" -- that is heather Trouton, I think -- "has been working on this in detail". 14:18

I think this is identifying the fact that it is one urologist and we believe that to be Mr. O'Brien. Did you ask any questions around this to see whether the actions or conduct of this clinician were being effectively addressed? 14:19

A. Yes. I believe I sent an email to Debbie and Gillian on 9th December. Scroll up slightly. It was something along the lines of, "Dear Debbie, what's the progress on this". 14:19

110 Q. Yes.

A. And she replied, that afternoon in fact, that a letter had been drafted and an action plan was in train.

111 Q. Certainly the follow-up from Mrs. Corrigan was to write a letter, I think. The letter is below that, I think. 14:19

A. This would have been -- every Friday I would sit down with Anne Brennan and try to tidy up loose ends.

112 Q. The letter is at 56 is it? 58. There we are. The

upshot was that this was a letter going back to Mrs. Corrigan. You can see what was being proposed in the last paragraph. The Trust was going to consider whether it would be appropriate to devise a protocol around this. But I'm just wondering -- well, that's a general response to a problem. It was being flagged to you that there was a problem with a particular urologist. We obviously had the proposed September meeting which, according to Mr. Mackle, the meeting didn't take place for whatever reason. He thought it was an issue to do with this. He thought it was going to be a discussion in relation to actioning results. Then the matters develop and it is now in the eye view of the Commissioner, and the word back to the Commissioner is we're going to look at this and develop a protocol, perhaps. But I wonder, wearing your hat with the responsibility for the practice of doctors, whether there was enough information there for you to get to grips with the particular doctor concerned, or what was your way of dealing with that?

14:21
14:21
14:22
14:22

A. Well, with that issue or any other issue, my view would have been there's all sorts of changes of practice that doctors have to cope with and whatever. Where a doctor should be escalated to me, I don't think it's my business to escalate it to myself. A doctor should be escalated to me whenever there is a lack of engagement, for whatever reason, or concerns because then that indicates there's a broader problem, possibly each a fitness to practise issue, whatever. What I remember

14:22

from that is there seems to have been a plan to fix the problem. If it hadn't been fixed, I would have assumed that would have been escalated to me. But it wasn't; I don't know why exactly. But it seemed to me that was a problem being fixed. Appropriately so, because that was the responsibility of, if you like, the three people involved, the Assistant Director For Clinical Governance, Debbie Burns; the Lead Clinician Associate Medical Director who is responsible for the performance of his doctors, and the Operational Director, all of whom I would have trusted to escalate to me whenever necessary. 14:23 14:23

113 Q. Does it appear to you somewhat odd that you're being called in to a meeting in September, the meeting doesn't happen but it's a meeting to urologist unnamed, and then that disappears. The meeting doesn't happen, no discussion, you're not reporting any discussion around a particular urologist, and nothing else emerges from that. 14:24

A. All I can assume is I assumed they were fixing the problem. If they hadn't fixed it, they should escalate to me. Why they didn't, I'm not sure. I was available. Other doctors were escalated to me. So, I have to pass on that. I don't really understand. 14:24

114 Q. Just to focus on, perhaps, what you might have expected on this singular issue, a doctor declaring that he has great problems or concerns with the notion he should action results promptly or read results and action them promptly. We know that this wasn't the only case of 14:25

a patient getting into difficulty or potential difficulty because Mr. O'Brien didn't read the results promptly. There was one case in 2020, which is part of the nine SAIs that have led to all of this. There was another case, Patient 92 in 2018. It may be that Mr. O'Brien continued to take the view that he wasn't resourced for adequate time to read these reports promptly, and it may be that he continued to practise in the way that I described. 14:25

From a governance perspective, there really was a need for somebody to sit down with him at this moment in 2011 and say, right, this is the rule, this is what we expect, and you're going to be monitored for compliance. Does that seem reasonable? 14:26

A. I would expect that. Where I would expect I would be brought into it is if there was non-compliance over a period of time. That to me then calls into question, you know -- maybe not so much fitness to practise but is there wider issues here that need to be investigated. It wouldn't have been the slightest problem to me to look at this, really. 14:27

115 Q. Could I ask you --

A. I think the only possible explanation is that, you know, with low-level concerns that, if you like, the guys in the front are meant to fix and if they are not fixing them, maybe, I don't know, maybe they feel they are failing if they have to refer up to me. 14:27

I know from reading other transcripts that there seems to be this idea that referral to a Medical Director, the medical HR meeting and potentially Maintaining High Professional Standards is some kind of never event. But it wasn't like that, in my view. It would be better to refer up earlier. In some cases that happened, and in fact we exonerated some doctors where there had been concerns which were unfounded. Others, we went further. That kind of -- those series of issues, I think, should have been what you would call the preliminary or informal stage to take a broader look at that. I'm not sure why that didn't happen. That would have made everything a lot easier. 14:27 14:28

116 Q. Just to pull up on that point about something of a squeamishness or a never event 14:28

to use that term, about bringing things to you because they may be regarded as too low-level, there's perhaps an example of that kind of thinking in discussions that were taking place around triage and in relation to Mr. O'Brien's tendency to retain patient charts at home. 14:28

Let me ask for your comments on this sequence. If we go to TRU-278249. I suppose really the top email there encapsulates what Mrs. Burns is saying. For a period of perhaps a couple or several years, it had been noticed that Mr. O'Brien had been retaining charts at home, and that was causing difficulties when 14:29

patients were coming in. Sometimes he could be contacted and he would bring the charts back promptly but sometimes patients might come in as an emergency and there was no chart there. Mrs. Burns is saying, in the context of one particular incident, asking did the patient get seen: 14:30

"I think if we can't agree with him, John Simpson needs involved."

14:30

So that goes to Anita Carroll, Heather Trouton and Martina Corrigan. Mrs. Trouton decided that the appropriate course would be to speak to Michael Young and Robin Brown in relation to this. We can see TRU-278249. Sorry, wrong reference. If we go to WIT-98423 at the bottom of the page. If we work from the bottom up, she's writing to Messrs Brown and Young, and the issues are triage and having charts at home. She is saying: 14:30

14:31

"I really need a response in one week on how this is being addressed for now and the future or I will be forced to escalate to Debbie."

Debbie Burns already knew about the issues. 14:32

"It is already being suggested that Dr. Simpson be involved" -- that was the previous email from Debbie Burns which I showed you -- "which I have not

progressed to date but it may have to come to that unless a sustainable solution can be found."

Then if you just go up the page towards Mr. Brown's input, to take his input. Michael Young says I will speak, and Mr. Brown says "Well, Aidan is an excellent surgeon and I would be more than happy to be his patient. That could be sooner than I hope", he jests, "so I would prefer the approach to be "how can we help"." 14:32

I assume, judging by what you said earlier, that you are thinking that these issues, if they are protracted, if they are not getting fixed despite repeated engagement with Mr. O'Brien, they should come to you? 14:33

A. Definitely. I know from reading other transcripts this view that Maintaining High Professional Standards is some kind of disciplinary process; it is not. It was more or less designed by the BMA to deal with the process of people being put on gardening leave where senior doctors couldn't be dealt with, knowing what to do, and so on and so forth. When I came into post, as HR described it to me, this is a comfort zone for doctors compared to the disciplinary processes for other staff. That wouldn't have been a bother to me to have add it under Maintaining High Professional Standards. After a year, I did agree with Kieran Donaghy that we should be looking for doctors to be escalated to us sooner rather than later, particularly 14:33 14:33

where there's a train of lower level concerns that may or may not indicate a major problem, before a major problem happens.

117 Q. You talked earlier -- sorry to cut across you -- about the efforts you put in to try and change the outlook of your AMDs and to some extent your CDs as well; you were meeting with them and telling them how you wanted to do business. Given that those were the messages you were putting out, can you try to explain, or at least comment on, the thinking that is revealed in these emails. Mrs. Trouton was obviously operational staff so you had no, I suppose, direct input into her way of working. But we have Mr. Brown here clearly aware of the difficulties being caused, and he's not drawing them to your attention. 14:34 14:34 14:35

A. Yes, and I know Robin's approach. Robin Brown is a very benevolent type leader who likes to see the best in people, and I can understand that approach. It took me a year to get through to everyone that Maintaining High Professional Standards can sometimes exonerate the doctor. It is not a disciplinary process, it's a discovery process. The fact that NCAS, National Clinical Advisory Service, is involved from the start makes it very clear, it is about remediation, the outcome is to be remediation, it's to fix the problem. So, when you have ongoing problems like that and they are not being solved, use the Medical Director's Office, the HR advice, the expertise there was between the four of us, Kieran Donaghy, Ian Parks, myself and 14:35 14:35

Anne Brennan, to come up with a resolution.

The other thing -- and reading through the other transcripts, this seems to be mixing -- is the cases did fix, if you like come up with solutions, it was 14:36
normally or usually when the doctor was represented by either the BMA or the Hospital Consultant Specialist Association because those guys are negotiators, they understand the Health Service, what we can do, what we can't do, they advise the doctor appropriately that 14:36
this is all about getting things fixed. It's never comfortable to be the subject of an HR procedure but it's also an opportunity for a doctor to clear his name, to say, look, I have my side of the story, and lift it out of the frontline to another view. 14:36

What we found was that operating MHPS, quite often we needed to get a Clinical Director to be the case investigator from a different part of the hospital because Clinical Directors didn't really like to be 14:37
that person. So we came up with that kind of arrangement. Normally it would be Dr. Chada, who volunteered to be the case investigator, and normally Stephen Hall, sadly deceased, as the case manager. It takes it out of the frontline, so to speak, and brings 14:37
a bit of a spotlight onto it. We can look at where the risks are, the concerns are; the doctor has an opportunity to put his best foot forwards with regards to his representation, and NCAS advice on remediation.

The outcomes are is there a health problem, is there a disciplinary problem, is there a practice problem? But also the outcome is then reviewed by ourselves at that Medical Director's HR meeting. What I'm looking for there is there engagement with the remediation plan because that's the key to me whether or not this doctor needs to be considered for referral to the GMC. That would have happened.

14:37

What would have happened in those cases is that we would have discussed something like this amongst ourselves. The Employment Liaison Adviser from the GMC would come in afterwards and we would discuss cases like that with her, either potential referrals or referrals. Even then, you know, the doctor is then -- there's another investigation separately by the GMC. The doctor again has an opportunity to seek remediation, sort the problem out. I don't know why that wasn't escalated. I just don't know.

14:38

118 Q. Dealing specifically with the issue of triage, you'll know that Dr. Chada, in her report, referred to 783 untriaged referrals dating back to your time as Medical Director. The Inquiry has received some evidence that the issue of triage was drawn to your attention. Just I'll go through the three items and then you can comment.

14:38

14:39

Mr. Mackle, at WIT-11784. Just scrolling down, he says as regards the issue of triage being an ongoing

problem, he was first aware of it in 1996. This is the last four lines of the paragraph.

"I did inform Paddy Loughran and John Simpson of the issue but I admit I didn't raise it as a serious governance concern and neither did they question it as being one. On reflection due to the repeated failure to perform timely triage, a thorough investigation should have been undertaken." 14:39 14:40

Mrs. Corrigan, at AOB-60406, she says that you were aware of the difficulties. This is paragraph 6, four or five lines down:

"I am aware that in the past Dr. Gillian Rankin would have addressed the problem with Dr. Simpson in his role as Medical Director." 14:40

She goes on to say on the next page, I think it is paragraph 6 -- No. She says at one point... Sorry, if we go to the next page, sorry, at paragraph 12. She says: 14:40

"I know the issue would have been addressed with Mr. O'Brien verbally but I suspect it was never in writing to him. I know it was verbally addressed by Eamon Mackle, Paddy Loughran, John Simpson and more recently Dr. Wright." 14:41

There's two witnesses to the Inquiry suggesting the triage issue was raised with you. Just in fairness, Mr. O'Brien makes it clear that you didn't speak to him verbally, didn't speak to him about the issue, but Mrs. Corrigan evidently thinks you did and Mr. Mackle thinks he raised it with you, albeit not as a serious governance concern. 14:42

A. I have no memory of that, none at all. So...

It is a serious matter of concern. 14:42

119 Q. Yes. At one point, as you know, Mrs. Burns, it's alleged, although she has a different view of it -- maybe I'll just rephrase that to be absolutely clear, keep it neutral -- at one point a so-called default arrangement was put in place so if that triage wasn't performed, the patient was placed on the waiting list in accordance with the classification of the referral. So a routine case, if it needed upgraded, wouldn't be upgraded because it wouldn't be triaged but it at least found its way on to the waiting list. Was that issue discussed with you? 14:42 14:43

A. No. The evidence by Eamon and Martina and Debbie -- the Inquiry is the first time I've heard of any of this.

120 Q. Yes. 14:43

Mrs. Burns, to be clear -- bring this up on the screen please, WIT-98934. Just in the middle of the page. The question is "What is the evidence that the problem

was referred to higher authority"? I think the proper way to understand that is if you look to five lines down, DB, that's Deborah Burns, "cannot remember if she made John Simpson aware of the problem".

14:44

Within that note, as you can see a bit of a shorthand note, she went on to give evidence in relation to this, suggesting that you didn't have a good relationship with Acute sector consultants. I think that's --

A. 200 of them? I mean, that's nonsense. I have no idea -- 14:45

121 Q. I suppose it is difficult for you to deal with the perception, but plainly issues were not raised with you, on your account. We've seen how Mr. Brown hesitated and then didn't ultimately bring the charts or triage issue to you. You've been at pains to explain that you took a very balanced view of MHPS; it wasn't a disciplinary weapon, as such. 14:45

A. Yes.

122 Q. But do you think you could have sent out the message that, you know, difficult doctors or doctors with shortcomings would have something to fear if the issues were brought to your attention? 14:45

A. I sent out those messages numerous times. For example, there was another consultant where there was low-level concerns, bullying. I had to put the message out, really, people, you need to give me evidence of it. Even though the HR Director was telling me, well, that bit of evidence isn't much. What I decided to do was 14:46

to launch MHPS because it needed to be dealt with. Although there was very little beyond the informal phase, it actually produced a result and the bullying stopped. So, I can't understand this.

14:46

Possibly, maybe, I'm the first Medical Director whose also Responsible Officer and a direct line to the GMC. As I've described to you, and perhaps it didn't get through everywhere, it's not just -- it's that old-fashioned idea, you know, that these doctors are wonderful, until something terrible happens and then you have to escalate to the GMC. It wasn't like that. I mean, there were plenty of cases that were escalated and dealt with fairly firmly, and compassionately at times. Probably when there has been a bigger issue. You know, there has been some criminal cases, for example, that were straight up to me. But lower-level concerns, that seems to have been missed somewhere.

14:47

14:47

I never took the view that doctors were special people; they're people who do a special job. Had that -- well, who knows. If that was escalated to me, my approach would be let's fix this for the benefit of the Trust and for the benefit of the doctor and for the benefits of the patients. What would guide me in that would be not so much did he comply with this or did he comply with that, it would be really I would be looking at the doctor's insight and serious engagement with remediation and getting the problem fixed.

14:47

So, even after MHPS is finished, there will be, say in cases where there's remediation, we don't walk away from it, we review it every month and get reports as to how well that's going. The big issue for me as a Medical Director is if I think that there isn't proper engagement or there's evasiveness or there's something else going on, to me that indicates a problem with fitness to practise, the more global fitness to practise. But as I said earlier on, that would be then discussed with the Employment Liaison Adviser. If it was that I did refer someone to the General Medical Council, they would do their own investigation, make their own judgment. 14:48 14:48

This is unknown. I don't know why. It is not just me, this is unknown to everyone, really, I thought.

123 Q. You did some work around the administration of the transition from being a private patient into the NHS. You did some work in 2014, including what was described as a paying patient's roadshow. I don't need to bring this up onto the screen but the work was described as introducing a formalised process necessary for the Trust to meet with the Department 's audit requirement. Is it fair to say you were trying to tighten up the procedures around that? 14:49 14:49

A. Yes. I think it actually kicked off under Paddy Loughran's time and we finished it, myself and Anne Brennan, just to bring clarity to, you know, we're

not a private hospital but private patients can be treated if they're transferred appropriately to an NHS system.

124 Q. In that context, I want to ask you about this. Bring up on the screen TRU-27504. Sorry, try 27508. Scroll down four pages, please. 14:50

Note: The correct bates reference for the document being referred to below is TRU-274504. Annotated by the Urology Services Inquiry.

There's a message sent by Mr. Haynes, if we scroll down the page, to Mr. Young and Mrs. Corrigan, in May 2015. He is saying: 14:51

"I feel increasingly uncomfortable discussing the urgent waiting list problem while we turn a blind eye to a colleague listing patients for surgery out of date order, usually having been reviewed in a Saturday non-NHS clinic." 14:51

He sets out further detail around that. That's the issue. He's asking Mr. Young -- if we just scroll down the page -- "This needs to be challenged to put a stop to it". 14:51

Up the page then, we see Mr. Young's response. "Point taken. Agreed. Play a straight honest game." The suggestion might be that he's going to address it. 14:52

I think the evidence around whether it was addressed is still to be fully revealed to the Inquiry, but this is a year after you've re-emphasised, perhaps, the need for probity around the transfer of private patients

into the NHS.

Would you have expected an issue like this to be addressed locally by the clinical lead or the clinical director, or would you have expected to have heard about it yourself? 14:52

A. If it wasn't fixed, I should have heard about it. It was, you know, it was my policy, if you like. If the medical leadership structure couldn't handle it, then they should have said to me, look, this isn't working; we understand what the policy is. In general, I think the vast majority of doctors thought it was a very sensible policy; this is clarity. At the same time we were doing job plans and if doctors wanted to do private lists, they could go to the Ulster Independent Clinic or whatever. All of this was in the job plans. All of this was above board Board and very clear. 14:53 14:53

If that hadn't have been sorted out, I would have expected to hear about it because, as you say, a question mark over probity. 14:53

125 Q. And nobody drew it to your attention?

A. No.

126 Q. A couple of final issues, Dr. Simpson. You were aware of an issue, or an issue was drawn to your attention, concerning antibiotics for patients who had indwelling catheters. If we go to TRU-250625, I think we can see Dr. Damani. He was a microbiologist; is that right? 14:54

A. Yes. He was the lead clinician, and we made him, in

fact, Associate Medical Director at some point then for infection control. He might have been that at that stage. So I would have been in touch with -- and I was the director responsible for infection prevention and control, so I would have been in regular contacted with Nizam.

127 Q. Yes. He is attaching a letter about antibiotic prescribing in urology. This, just for the avoidance of doubt, is distinct from the issue in 2009/2010 about intravenous fluid management and antibiotic. This is a separate issue. He's saying: 14:54 14:55

"I attach a letter which was sent to urology. Discussed this with urologists and received no reply."

14:55

The letter is a letter from 2010. Just scrolling down. It was addressed to Mr. Young. You can see at the bottom of the page, copied to Mr. Akhtar and Mr. O'Brien. Really it was addressing a concern about empty microbial negativity and the overuse or inappropriate use of antibiotics. 14:55

If we go to your witness statement in this respect, WIT-25726. At 57.1, you say:

14:56

"The only concern raised regarding Mr. O'Brien which had the potential to impact on Patient Safety was this", the antimicrobial prescribing for indwelling catheters by urologists.

You go on to explain why that might be a problem.

Could I ask you this, doctor, the letter or the email from the microbiologist, Dr. Damani, it was a general letter. It doesn't appear to have been making any allegation about any specific consultant, let alone Mr. O'Brien. Where you've said the only concern raised concerning Mr. O'Brien which had the potential to impact on Patient Safety, had you some information that Mr. O'Brien had a shortcoming in his practice in this respect, or why did you phrase it that way? 14:56 14:57

A. No. I think I was trying to answer the question. It says "Please explain why and identify the person", and I knew that the Inquiry was interested in Mr. O'Brien. But the letter from Nizam Damani was about both consultants and junior staff. He had picked it up from Raj, Dr. Raj who was doing the antimicrobial ward rounds, and also the GPs that there was a problem. I think the specific problem in urology was there was always a debate about guidelines, particularly with microbiologists and frontline clinicians. I think what Nizam was complaining about was there was no discussions. He wanted a debate. That's okay, that's what we hoped for. As I think I mentioned, an antimicrobial ward round was quite a new thing, introduced by Dr. Damani. So it is a staff grade, quite brave, going into, if you like, second-guess prescribing habits of doctors, not just in urology but 14:57 14:58 14:58

right across the Trust, to challenge. Our view was, well, that's okay, we don't have to get absolute adherence to guidelines but we want a discussion at least. So, I think the letter from Nizam came because Raj had felt he wasn't getting feedback or a potential for discussion.

I presumed at the end of that that there was then an opening up of discussions because if there hadn't have been, Nizam would have told me because I was meeting him every week.

128 Q. Yes.

A. But in a broader sense of guidelines, you know, we were having big problems with venous thromboembolism, VTE, guidelines being different in different parts of the Trust and trying to get everyone to agree on a Trust approach. This was to try to get everyone to agree on a Trust approach for prescriptions for antibiotics. We had similar problems with the respiratory physicians in their antibiotic treatment in community acquired pneumonia. So, it was a general problem.

129 Q. Can I just go back to your answer. Could I ask whether it would be fair to correct what you said at 57.1. If there was no particular -- no evidence at all in relation to Mr. O'Brien's practice, as appears from the email it is a general concern that urologists haven't responded to correspondence and hadn't engaged in the discussion that Mr. Damani wanted. But it wasn't, as you suggest here, it wasn't a concern regarding Patient

Safety and Mr. O'Brien?

A. Strictly speaking, that's true. That should be adjusted regarding -- I suppose any concern regarding urology consultants and -- you know, urology consultants, because their practice was obviously determining what the juniors were doing on the ward and what was in the letters going out to the GPs. So, yes. 15:00

130 Q. One final issue of perhaps low-level concern that crossed your desk in relation to Mr. O'Brien concerned his responsiveness to litigation requests. If I could refer you to TRU-250703. Obviously litigation is one of the concerns that comes under your job description. Karen Wasson is the staff member with specific interest in that area. She is chasing this with Eamon Mackle. 15:01

15:01

"A number of medical negligence cases where we have requested information involvement reports from Mr. O'Brien and have yet to receive a response."

Then I think up the page, you're copied in. 15:02

If we go to 250705, just two pages down. Just scroll down, please. We can see that one of the points she's making is that Mr. O'Brien had been asked for a report on 30th August 2012 and the report wasn't received until 20th January 2014. In isolation, that looks like a long time; maybe there were complexities around it. You wrote to Mr. O'Brien, and he wrote back saying that he was unaware of repeated reminders. This is 15:02

TRU-250706. Did that tardiness in relation to responding to litigation requests cause you concern, or was that not untypical of practitioners?

A. It wasn't. I'm not sure that even Mr. O'Brien would have been an outlier. That was a common enough chase-up that we would have had to do to get responses from consultants with regard to litigation. I think, I suppose, it was an understanding on that; there's a lot of other things going on clinically. It's quite a big job probably to respond to that, to go back and look at notes and make that response. So I'm not sure if he was that much of an outlier compared to others. 15:03 15:04

131 Q. In that respect.

As we observed this morning, Dr. Simpson, towards the start of your tenure as Medical Director, you were, I suppose in the context of Dr. Aminu's case that we looked at, you're furrowing your brow and saying, looks like there's a professional clinical governance issuing within urology, and, as you explained this morning, you were seeing that in other places as well. That was an issue in 2011. Fast forward to 2015 and issues that you think you should have known about, should have been brought to your attention because they were unresolved, weren't making it to you. Does that suggest perhaps that, at least within urology, the culture of not disseminating, not communicating, not escalating hadn't really changed that much? 15:04 15:04 15:05

A. That's quite possible. It's difficult to change

culture. I would have seen that, I think, in the context of Craigavon Hospital generally going right back to 1992, when Craigavon was its own Trust of the 17 Trusts, which was never a good idea, separate from the community, separate from Daisy Hill. My instinct, both as a consultant starting in 1992 and then Medical Director 2011, was there was that sense of elitism that really might have been partially justified but is not best -- it's not well disposed to, you know, proper clinical governance. 15:06

For by MHPS, GMC and so forth, the way to deal with these things at the coal face. Healthy teams keep each other right and they set the right culture. It's not reasonable, you know, to expect any clinician of any stripe to be at their best for 30 years. You know, performance will wax and wane, the team should compensate for that. Where they can't compensate, that's the time to escalate. Teams can't compensate whenever the clinician is not working with them. If that keeps going up the chain, then it is clear that by the time it reaches any medical director, then you know there's a much larger problem. 15:06 15:07

132 Q. I think you maybe say it best -- not to criticises how you are saying it now -- but within your statement in terms of the learning, if we just pull up WIT-25731. You're saying the specific difficulty was and still is to embed clinical governance into everyday clinical practice. This is at 72.5. The objective being is to 15:07

get a multidisciplinary rather than uni-disciplinary working fashion. By creating that, it's more likely that issues of concern can be addressed at the earliest possibly opportunity?

A. Yes, I think I said it better there, certainly. I've experienced that. An outlier in a healthy team can be brought back into line, and that's what you'd expect. If that can't happen, then the team has to say, well, we have to do something about this because that poor performance reflects on all of us. That's where the problem should be, you know, solved or not solved. If it's not solved, then it should be escalated. 15:08 15:08

133 Q. If I take you to just an earlier part in your statement. WIT-25729, 67.2. You're saying that:

15:08

"Medical oversight and clinical governance has improved over recent decades. There's now a greater understanding of its importance by doctors, managers and healthcare leaders. There has been investment in medical leadership." 15:09

Where do you observe that best? Where have you seen that? You're out of Craigavon, you're out of the Trust as a Medical Director for eight years. Where's this expression of, I suppose optimism or confidence, come from? 15:09

A. Well, I did some site visits with RQIA. Not just mental health, we visited, inspected, the private hospitals, the hospices, the Children's Hospital, and

others. You could see that there was a change.

I think the big change probably, as I mentioned earlier on, the younger consultants back then coming through to new appointments, late 2000-2010, had been trained in this, that they're part of a team, that they're going to be assessed every year to see can they be a consultant and finish the training. Then that carries on. So, that culture has changed. I think it has been slower in some specialities than others. 15:10

In terms of understanding and improvement, you know, the current Medical Director has three Deputy Medical Directors in his own Trust. There have been extra posts created. I think there's a view now about what is the optimum management span of control for a Clinical Director, should it be 20 consultants rather than 100. So there's a much more clear view. I think there's a clearer view that, you know, doctors are responsible for Quality Improvement and not just the patient in front of them. 15:11

There will always be this tension between the needs of the Trust which is we have to serve the population, and the doctor who just sees the patient in front of him. That tension will always be there. 15:11

134 Q. You make a point in this paragraph about there will always be a difficulty, particularly at an early stage, to identify and manage concerns about a senior doctor

who is deliberately evasive. Is that intended as a general remark or are you suggesting that Mr. O'Brien was deliberately evasive?

A. It's difficult for me to say because I've only been reading the transcript since; I haven't had any experience of any of the problems that were raised at the time. But I've had other experience with doctors who have been deliberately evasive. Again, certainly within psychiatry, but it's much easier. You know, a consultant is part of a team, a part of a consulting team, part of a multidisciplinary team. There's no hiding place, really. Using the calling card of seniority or the hierarchical thing, it's just not there. But, you know, it has to be tackled. 15:12

I think what I'm trying to say there really is what I said earlier on, doctors are not special people, they are people who do a special job. They have all the problems that ordinary and everyday people have, white coat or not. 15:13

135 Q. Yes. We know that, I suppose, within four or five months of you vacating the Medical Director's post that Mr. Mackle and Mrs. Trouton approached the new Medical Director, Dr. Wright, and told him about their concerns about Mr. O'Brien's practice. The trigger for that, at least from Mrs. Trouton, would appear to be, well, a further concern has come to light about Mr. O'Brien's failure to dictate clinical encounters. But they, for whatever reason, felt it was an appropriate time to 15:13

approach the Medical Director but ironically you had never been approached in that way, and one could probably draw a line between that approach and eventually the MHPS process commencing in the early months of 2017. 15:14

When you think, knowing all that you know about this now, do you reproach yourself in any way for the fact that these issues didn't come your way to be dealt with, or do you think that in terms of trying to build culture and build support for the medical leadership that you did all you could to expose these issues? 15:14

A. I can't think of anything else I could have done except being available, which was -- I was available and approachable. I was approached and I was available for other issues that were escalated. Now I think it's more of a judgment call of what the threshold is and I think it was too high, whereas in other cases I made it very clear it should be lower. I find it hard to understand what happened. I just... 15:15

136 Q. Okay. Thank you very much for your evidence. The Panel may have some questions for you.

CHAIR: Thank you, Dr. Simpson. I'm going to hand you over, first of all, to Mr. Hanbury, who will have some questions. 15:15

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

MR. HANBURY: Thank you for your evidence, Dr. Simpson, very clear. I just have a few random, diverse questions for you in no particular order.

137 Q. Job planning. You mentioned surgeons may be more something than physicians; maybe I am misquoting you. Do you have a theory for that? We usually quite like a regular job plan. 15:16

A. Well, I made a contrast really with -- we had issues with physicians as well -- no, I made a contrast with the anaesthetists because I thought the best way to approach this is let's get fair play in the team; this isn't just the Trust wanting to keep tabs on you. The anaesthetists were able to create a team job plan first. It's easier because they are bite-sized chunks. They knew what their demand was, they knew what their capacity was and they could then redivide the team plan job plan into individual job plans. 15:16

What could I say about surgeons. You're a surgeon, I presume? 15:16

138 Q. Okay, I'll let that go. But just to go on from your comments about team job plans, that's not something, I think, the urologists ever who were asked to deal with did. Do you think that was a missed opportunity?

A. Yes. I think, you know, the surgeons work alongside the anaesthetists, they would have been well aware of the progress that that particular MD, Charlie McAllister, had made. I think, like any change, if you are working with a team of people, it is easier than if 15:17

you are working with each individual as you go along. I think maybe that's where things fell down. Trying to deal with a one-to-one job plan with 25, 30 people, that's going to take time.

139 Q. Okay. 15:17

A. You can get into the trenches -- I mean, one of the things, and we discussed this quite regularly with the Chief Executive, we had a round table meeting quite regularly -- the general view was don't be getting into the trenches with a doctor. If they say 13 PAs and you 15:18 say 12.5, you know, go with that but it's going to be reviewed next year. So I think that would have been my advice. And my approach is get the baseline done even if you don't completely agree with it, and review year on year on, year on, year on. What I would have done, 15:18 certainly in psychiatry, is that I would have made it clear that everyone knew what everyone else's PAs were. Whether that was legal or not, I don't know. My idea was, look, we all have to work together on this and I want to ensure fair play to all of you. There were 15:18 individual job plans created in psychiatry but there was that team approach. If you've got a healthy team to work with to start with, you know, you're going to make progress. If the surgeons don't see themselves as a team, which I don't think they did, fair enough, then 15:18 you're going to make slow progress dealing with them individually.

140 Q. Thank you.

Moving on, I wanted to ask you about your observation about waiting list initiative activity being done during the working week. What was your implication there because most of the surgeons were on 12 or so PAs at least, presumably they were being paid for every session anyway? What was the implication to your observation? 15:19

A. If they justified they were doing something at weekends or whatever, but the problem is I didn't know, we didn't have a record. The auditors were quite within their rights to say if you don't know exactly where these sessions are, day, evenings, weekends, how can you know when the waiting list initiatives are done out of hours or not. 15:19

141 Q. Another question going on from that. If you have a clinician who is struggling with admin in other parts of their activities but also doing a lot of waiting list initiatives, should that raise a red flag? 15:19

A. It would certainly raise a question as to why.

142 Q. Yes, okay. 15:20

A. The basics have to be done first.

143 Q. Okay.

A. At the same time, I witnessed a lot of pressure from senior management to get these extra sessions done and get the waiting list down. That was a big priority. 15:20

144 Q. So there may have been pressure for performance?

A. Oh, undoubtably. Undoubtably, yes.

145 Q. You're relaunch of the old-fashioned morbidity/mortality to a patient's safety was

interesting. Was there really a half-day type idea where clinicians are freed up? We're very familiar in England. Here, was there a big pushback for loss of activity from either the Board or --

A. Not really. The pushback was getting everyone's diaries to coincide. I think there was a rolling audit day, I think, in surgery already. We just thought we'd use that. So there was some huffing and puffing in certain areas but everyone came along to it eventually. 15:21

146 Q. So it wasn't a big problem? 15:21

A. We got over it.

147 Q. The standards and guidelines are interesting. There are so many, aren't there, and I think every hospital struggles with that. But if something important comes along, for example prostate state cancer management for urologists, was there a mechanism that the AMDs or someone you appointed would chase up, do a sort of gap analysis or some other mechanism to see how a department was doing compared to a standard? 15:21

A. When we got standards in, we would appoint a change lead, but that was very much a volunteer and we needed someone with that particular expertise who would be the champion for the change and lead it through. So there was a process to implement standards and guidelines. I don't think we were sophisticated enough to follow up the adherence, that I can remember. I know that process of tracking standards and guidelines was new in my time. I can't claim total credit for it. There was Margaret Marshall and Anne Brennan, they were a lot of 15:21 15:22

people involved in that, but we didn't have any tracking mechanism in 2011. That was my main concern first of all. Standards and guidelines were coming in from the CMO's Office, from NICE, from all sorts of different directions and not through one single point. 15:22
All the Trusts then agreed it should come through the Chief Executive's office and disseminate down and then track. I don't think we were sophisticated enough to audit the adherence.

148 Q. Thank you for your honesty there. 15:23

Recruitment, we heard from a lot of witnesses, has been a big problem; certainly urologists. Are there any magic fixes there? What are your comments in general terms? 15:23

A. The smaller specialties in Northern Ireland are always difficult because there's a smaller pool. Literally you could probably be a direct correlation to difficulties in recruitment to distance from Belfast, as simple as that. So we had problems but the 15:23
Western Trust had bigger problems. The Southeastern Trust, being part of Belfast almost, you know, Dundonald, easily commuting distance, would have less problems. We had difficulties but we knew we weren't in as much difficulty as the Western Trust. 15:24

149 Q. Thank you. Two more short ones.

One about the saline TURP and, in general terms, the equipment of new equipment when new, safer techniques

come along. In general it seems to have taken some Trusts a long time to adopt something that the rest of departments across Northern Ireland adopted fairly soon. There may be a few reasons for that. Purchase of the equipment seemed to be a big problem. Do you have any comments there? 15:24

A. I think that was after my time. I'm not really sure what happened about that. But as I said in my witness statement, you know, we were early adopters for other guidelines. The Belfast Trust, I saw that witnessed. But where the other three Trusts -- if we're going to be compared to anyone we should be compared to Southeastern, Western Or Northern, with a smaller complement of staff. When you look at that case, and it was a big case that the Coroner drew attention to, largely I think because if the Coroner hadn't dealt with it, we may never have heard about it if it hadn't been a death. So he made a big splash with it, as he should have done. 15:24 15:25

The issue, on my reading of it, was more about adherence to WHO guidelines with regards to Patient Safety huddle, and WHO checklist, team working, and measurement of fluid in/fluid out, and intraoperative sodium measurement. Charlie McAllister, Lead for Anaesthetics, was very sharply on to that and was able to given assurance of safety until the switch was made from glycine to saline. 15:25 15:26

150 Q. Just one more, if I may. The Urology Department had

a lot of problems with quoracy of their multidisciplinary meetings, particularly with radiology and oncology. Did they ever come to you for help to try to negotiate?

A. No. I only heard about that through reading the transcripts. 15:26

151 Q. So that never filtered up to you, that particular problem?

A. No.

CHAIR: Thank you. 15:26

Dr. Swart.

DR. SWART: Thank you for your evidence. I recognise many of your struggles as a previous Medical Director myself, so my comments are in that light, really. 15:26

152 Q. I'm interested in where the directives from on high, so from the DH, came in terms of quality. Most specifically, in 2011 there was a document called Quality 2020 produced by the Public Health Authority and it has lots of objectives in it. One of the 15:27 objectives was that every service should have, essentially, a quality score card and that quality and safety should be the top of every Board and management meeting's agenda. Was that brought to your attention frequently? Did you succeed in any of that? Because 15:27 I can't see quality score card certainly, and I can't see quality and safety at the top of the Board either. I might be wrong. What was your perspective?

A. Yes, I remember that initiative from the Public Health

Agency. That would have been -- I've forgotten the doctor's name. All the Medical Directors would have been brought to that. What they tried to do, not unreasonably, was to get Quality Improvement projects together and sort of change leaders, whatever. 15:28
I criticised it at the time. A very good initiative but my view was it was very much a top-down approach rather than getting out amongst the frontline teams.

At the same time, the Board did have a Patient Safety 15:28
agency -- I forgot the actual title -- who did do that and tried to build from the ground up. But the sort of global let's have Quality as our priority, it never really --

153 Q. In England, for example every Board meeting generally 15:28
would start, for example, with a report from the Medical Director with a quality score card. Did you ever talk about that at Board level?

A. No.

154 Q. No. 15:28

A. I mean, I did suggest early on, 2011, that we should have, as Trusts in England had, an overarching quality report taking into account all of that. I know again people agreed with me, and there was an attempt to get that off the ground from Paula Clark, Director of 15:29
Planning, but it didn't really happen.

155 Q. It's not that easy to do, of course, for a variety of reasons. But in your role on the Board as Medical Director, were you given the job of educating the Board

in terms of how to look at data with respect to Quality, or ensuring that the Finance Director understood the Quality agenda? Did you have that remit or did you feel you were fighting with the other directors about that? 15:29

A. The problem I had with the Board was just the amount of information that was delivered to the Board. I think they struggled to interrogate all of the information. What I tried to do -- I mean, you know, Board papers before IT were at least a foot high. You have 15:30 non-executives, myself and others. Most of those papers were about activity levels and financial, you know, management as such. There was no coherent approach to that.

15:30

As I said earlier on, I think I would really have liked a medic to be one of the nonexecutive directors, to, if you like -- not just me, put the Trust on the spot and say what are you did about Quality; where is this report; I want to see that. But I think the 15:30 non-executives were overwhelmed with the detail of process.

156 Q. One example I would say would be with respect to cancer, where there's a lot of information about ministerial targets, even in the latterly constructed 15:30 performance meetings, but no information on precise compliance with peer-reviewed standards, which is quite a simple thing. Do you think the Board had any awareness of that or were they just overwhelmed because

of the breadth and depth of the --

A. The Trust Board?

157 Q. Yes.

A. No. I think -- yes, I mean, I think they went with the flow, understandably, which was about activity and financial management. There were maybe discussions but, you know, a typical Board meeting, at least a half day, if not a whole day, and the professional directors brought in at the end, any comments. 15:31

158 Q. Did you ever have the really barn door discussion of are we going to be shot for the money or shot for Patient Safety; what matters more to the Board? 15:31

A. Well, that Board meeting --

159 Q. Was that the closest you got to it, that one?

A. Yes. Well, there was another big argument over closing an infection control overspill ward. That was hot and heavy. It actually came to a vote at the Trust Board because I completely disagreed with its closure. Again, it was closed because they wanted to open extra beds for winter pressures. I was saying yes, but if we have to close a ward because of C Diff or more likely Norovirus, you're losing capacity anyway. That was a hot and heavy debate. 15:31 15:32

160 Q. But Mid Staffs, for example, those lessons are well-publicised and the key thing was money over quality. How aware was the Board of that? 15:32

A. I'm not sure.

161 Q. Okay. I'll move on from that.

A. Probably the best place for those discussions were the

Board development days and so on, where we would have had more of a discussion. I think it would have been better if we had had three executive professional directors, social work, medicine, nursing, as opposed to just me because everyone else is focused on activity.

162 Q. It is a big remit for one person.

A. I think the balance of power, shall we say, might have been tipped differently. I think the Trust, if I'm right, because I didn't know but I was looking through the evidence, after I left, at some point or other they did create an Executive Director of Nursing, which I think is a big step forward. 15:33

163 Q. On a slightly different tack, there's quite a lot about job planning in our various bits of evidence; it's a big issue for most Trusts. My experience of job planning is that there is an opportunity to put objectives into job plans and team job plans in terms of standards to be achieved, but I can't see that featuring in the job plans we've seen here. Why is that? Why was there no inclusion, or was it simply thought that it would be added later? Do you have any perspective? 15:33

A. Yes, I think it was that that would be a name. Just getting the basics done in terms of the baseline job planning was a massive effort and very, very slow. Using job planning in a more proactive sense like that, perhaps it did come to that after I left but we hadn't got that far in 2014/'15. 15:34

164 Q. We also heard evidence from people in various roles, I'm thinking particularly of the clinical lead role now where there was a statement there was no job description, no formal development for clinician leads; there seemed to be a rather confused understanding of the role of clinical governance of any such role. Does that surprise you? 15:34

A. No, I think I would be very sympathetic to lead clinician. In a medical management structure, medical leadership structure, that's quite thin on the ground; well meant when it was first developed. But when that's thin on the ground, I think there's an awful lot expected of the lead clinician when they are trying to help. My view of the lead clinicians was that they're trying to help us. I wouldn't have been expecting too much of them. I also thought that we should be going easy on the lead clinicians because I wanted them to apply for clinical director posts; I wanted them as a sort of introduction to medical leadership. 15:35 15:35

Again with the whole pressure of activity and so forth, I had great sympathy for anyone who was a lead clinician.

165 Q. How should that be fixed because they need time, they need development, they need guidance? It's a hard job. 15:35

A. I wonder should we have them really, because I think you are better off as a clinical director. When I was doing the psychiatry job MD, I had two clinical directors. They had sessions to work with me, they

knew what they were doing, they had the responsibility, they had paid responsibility.

I suppose you're thinking about urology. Perhaps in a subspecialty where the Clinical Director has a number of subspecialities, they may want a lead clinician in that subspeciality, but I would have thought of that more in terms of advice about specifics of that specialist as opposed to taking a lot of responsibility. I don't think there was a job description. 15:36

166 Q. Would you accept that maybe there was a little lack of clarity as to whose job it was to raise issues, clinical issues on the ground in that scenario where we all have a responsibility as doctors to raise issues anyway? There does appear to have been a lack of clarity. 15:36

A. I think that's fair enough.

167 Q. Is any of that responsible for the fact that things weren't escalated? We've heard things about hierarchy, deference, blinded by people's seniority. We've heard the operational management saying that's a medical manager's job and the medical manager saying that's an operational manager's job. How much of that confusion was evident to you at the time you were in post? 15:36 15:37

A. Not within urology, I didn't pick up on that.

168 Q. Just generally, I mean.

A. Generally, as I say there were a significant number -- a significant stream of doctors were escalated to me.

169 Q. So you wouldn't have described that as an issue?
A. Yes. I remember one particular issue, without going into too much detail, of a consultant who was -- I think I mentioned it earlier, actually -- there was concerns about him bullying, or her, let's say, juniors. There was a reluctance to bring that forward; does this meet the threshold. I was being told that informally, and I remember it. In fact it was one of the things that Paddy Loughran passed on to me, that you need to deal with this, John. It did need a bit of encouragement into the system to say, look, you need to bring this forward. All I can think of is that everyone seems to think it is the nuclear option; from in my perspective, I was thinking can I fix this. 15:37 15:38
170 Q. You seem to be a fan of MHPS; would that be correct? Most people seem to complain about it. 15:38
A. Well, I had heard about it. As it was described to me by Kieran Donaghy, HR Director, and Zoë Parks, Malcolm Clegg, very experienced people, were saying no other profession has this luxury, was their view. It was written by the BMA, and it was to solve that problem of doctors being put on gardening leave. We had to work out how to use it, which we did. I think we had a good team, was the point really, to know how to use it. 15:38
171 Q. If you had to change it, what would you change in MHPS? 15:39
A. It only occurred to me recently, just looking through all the -- what's the word? -- the transcripts, that where it worked well, and I think where it didn't work well reading through the one led by Dr. Chada, was it

became very confrontational very early on. What doctors need to know is that that's the wrong approach. What I experienced with the BMA and with the Hospital Consultants Association was a negotiating type approach. You can't really tell a doctor, by the way, the person you bring into an MHPS has to be an experienced negotiator from the union, but it should be someone who has those skills. I think we should be saying that to them; not just anyone. To get the pest out of the system, you need someone who is prepared to negotiate on your behalf, who can liaise with the Trust, who can liaise with NCAS and come to a negotiated solution. Because we did do that. 15:39 15:39

172 Q. Going back to the directors that you got as medical director about Quality, where did that come from? As Medical Director, you are the guardian of quality safety generally on the Board. Who in the Department of Health contacted you with key matters that you needed to bring to the Board's attention, or key matters that needed to be brought into commissioning frameworks or anything of that nature? 15:40 15:40

A. Well, a letter from the CMO is the one that you look at very --

173 Q. Did you get many of those?

A. Not many but there were -- there could have been five or 10 a year. So, I mean one of the big ones was December, Christmas Eve 2011, that there had been baby deaths unaccounted for, potentially contamination of water supplies. I couldn't remember the actual letter 15:40

but that was the CMO. When the CMO sends you a letter, you pay attention.

174 Q. Was it your experience that a letter like that goes to you for action as Medical Director, and that it is also brought into the commissioning discussions? 15:41

A. Yes. A letter such as that goes to the PHA, goes to the Board, goes to all the chief executives as well as the medical directors, yes.

175 Q. And to the Health and Social Care Board, or now the SPPG. 15:41

A. Yes. That would be Karen Harper would have been the --

176 Q. So they would have all been aware of that?

A. Oh, yes.

DR. SWART: That's all from me.

CHAIR: Just a couple of things from me. 15:41

177 Q. We've heard from, I can't remember now which witness, but basically with the drive to meet targets, that was where the focus was, and you've sort of confirmed that today. Is it fair to say that Quality got lost and the Quality metrics and the need for Quality got lost in 15:41 the need to meet targets?

A. In general, I would say to me it felt it was submerged. It was meant to be there, everyone agreed it was the right thing to do but it was always 'but we've got this other thing to do first'. I mean, the reform of M&M 15:42 into a Patient Safety system, I would consider that a big achievement. That was exhausting. No one told me to do it, no one particularly helped me with it except, you know, Anne Brennan, Stephen Wallace and

a few others.

178 Q. I'm thinking more now at Board level. Because the focus was so constantly on performance, do you think that the whole issue of quality of service was lost? The consideration of it was lost at Board level? 15:42

A. It was put on the long finger, I suppose, is the better term. That's good when we get round to it. I mean the simple things were infection control, because that was the one area where I had a lot of control over. So, you know, introducing bare below the elbows, the proper 15:43 isolation of patients, changing behaviours, doctors not have dangly things hanging over patients and so on, proper insertion and checking of IV lines, we did get good engagement with that. We had a team of infection control nurses, they had the imprimatur of the Medical 15:43 Director behind them
and we also had the ability to audit compliance. In small ways in very obvious things like that, because if you don't do that, you're going to get a C. diff outbreak or a Norovirus outbreak, or you're going to 15:43 get wound infections -- sorry, not wound infections but IV line infections. So, there were certain wins.

We were, and I say we, we had infection control nurses doing audits. At one stage we actually brought in PPI, 15:44 Personal and Public Involvement. I don't know if we got round to it but we had two people from the community offering to help us with the audits. To me, that was a good success, where you can actually make

changes but it takes quite a bit of an effort.

179 Q. It took effort but perhaps not money?

A. You do need resource. As I said earlier on, there was an awful lot of arguments about money. You can get into the trenches over this. The arguments should be about capacity and demand. As I say, capacity should be never running at 100 percent and then you can do things. So, the argument augers back from central government is we're putting money in, but you have to measure demand which was increasing. Our capacity was being squeezed in terms of efficiency saving, so the mismatch. You had great sympathy for frontline staff on a ward, a ward sister, and the pressures they were under. 15:44 15:45 15:45

Even small things like, you know, cutting back on the hours of a ward clerk who should be taking, you know, administrative tasks off the ward sister was a false economy. There were pressures coming from everywhere. I was very aware of that more in infection control than anywhere, more than any other things, because it is a very direct, obvious thing that you can measure and look at. People did work with us. In fact, at one point we were the highest performing Trust in the UK both with regards to C. diff infections regarding peripheral lines. So, I can't be too hard about them, they did work with us when they could. 15:45 15:45

180 Q. You talked about trying to change the culture and how that is slow to happen. I just wondered whether there

was any correlation between attempting to change the culture and the budget constraints?

A. Yes. I mean, looking back, the progress that we did make, the things that needed to be done with investing in management, clinical management being multidisciplinary, all the papers that I had disseminated from the King's Fund, if austerity had not hit us in 2012/'13, I think we would have solved those problems because we were starting to solve them. As I said earlier on, no one really disagreed with me. 15:46

181 Q. But they just didn't have the budget to meet it?

A. The budget and the stress. I mean, people were stressed to keep up with the demand at all levels. As I said earlier on, particular sympathy for middle managers because they were asked to do the impossible. 15:47

182 Q. Just one final point. Mr. Wolfe drew your attention to some emails about the Urology Department and the problems that there were. There was a urology meeting and a minute of a meeting about the Urology Department. 15:47

Your predecessor, he was at that meeting, he appeared to know about those issues; yet you followed him around but you didn't, might I suggest, get a full hand-over from him. Would that be fair?

A. No. He didn't mention urology but there were plenty of other things he mentioned to me. It would have been good if he had been able to -- had been allowed to stay on. My suggestion was about six months, maybe a half day a week. 15:47

183 Q. I suppose the corollary of that is when you left and Mr. Wright came in, I think, as your replacement, what kind of hand-over did you give to him about the issues?

A. We met quite a few times. I think he was quite happy with what -- I can't remember any specifics but there was a few meetings possibly could have been done better but, as I alluded to earlier on, I was burnt out at that stage, I needed to get away. I stepped out of the Health Service and the Southern Trust totally. 15:48

CHAIR: Thank you very much, Dr. Simpson. That concludes your evidence. 15:48

I think we're going to take a short break, Mr. Wolfe. I know you wanted to try and start the next witness this afternoon. Is that still in hand? 15:48

MR. WOLFE KC: I wonder could we just step through the preliminaries with him, get him sworn, prove a few things, check the tech is working okay.

CHAIR: That's fair enough. We'll take a break now until 4.05 and then have a short session after that. 15:49

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: Thank you, everyone.

MR. WOLFE KC: Good afternoon, Panel. Your witness this afternoon, at least for a short period of time, Chair, is Prof. Roger Kirby. I understand he proposes to be affirmed. 16:02

ROGER KIRBY, HAVING BEEN AFFIRMED, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS:

184 Q. MR. WOLFE KC: Good afternoon, Prof. Kirby. Martin Wolfe speaking. We consulted last Friday, if you recall. 16:03

A. I do. Thank you.

185 Q. Apologies for keeping you waiting. It has been a long day already for you, no doubt. I understand you have an important engagement tonight so we don't propose to sit for much longer than 15 or 20 minutes, and hopefully shorter than that, so that you can be on your way. Just simply to introduce ourselves and maybe deal with some preliminaries. 16:03

16:04

You can hear me okay?

A. Loud and clear, yes. Thank you.

186 Q. Let me just check that you have in front of you a hard copy, a paper copy, of the witness disclosure bundle.

A. I do, yes. Right in front of me here, yes. 16:04

187 Q. When I refer to bundle number page 457, let's see if I can bring you to that.

A. I have to get it on my other computer here so give me a little minute.

188 Q. We'll have that up on the screen here. It's AOB-42537. 16:04

A. I need a little minute to get back to that.

189 Q. An easier way of saying that is it's your medical report concerning Patient Or Service User A?

A. Yes, I've got that. I've got a paper copy of it and

I'll get it on my screen as well. I have that.

190 Q. When we get going tomorrow, we'll try and move through this kind of transaction as efficiently as possible. Maybe what I will do is call out what we call the Bates reference number for the purposes of getting the document up on the screen in the chamber here, and I will also give you the standard page number. 16:05

A. Right.

191 Q. You may be able to follow that.

16:05

You, Prof. Kirby, have produced nine medical reports --

A. Yes.

192 Q. -- in respect of the nine series Serious Adverse Incident review reports which were produced for or on behalf of the Southern Trust in respect of cases in which Mr. Aidan O'Brien had some involvement. Isn't that correct? 16:06

A. That is correct.

193 Q. What I'm going to ask you to do is -- this is obviously the first of those reports. As I've said, there are nine. Do you wish to adopt those reports as part of your evidence to the Inquiry? 16:06

A. Yes, I do.

194 Q. We've received no indication that you wish to amend any of them so are you content that they stand as an accurate account of the opinions that you hold in respect of those cases? 16:06

A. Yes.

195 Q. I won't, as I say, bring you through all nine of them

but the answers you supply applies to all nine of them; is that correct?

A. That is correct.

196 Q. We can see, just by way of illustration on the first page of this report, a list of the documents provided to you and which you have relied upon in formulating this report. Obviously there's sometimes a different and overlapping set of reports attached to each of the reports? 16:07

A. Yes. 16:07

197 Q. Is it fair to say this is a comprehensive statement of the material that you took into account?

A. Yes, it is. Although I have had some additional material since, I don't think it materially changes my view on any of these nine cases. 16:08

198 Q. Yes.

Just to explain how you came into the position of drafting these reports and becoming involved in this exercise, you received instructions from Tughans Solicitors of Belfast; is that right? 16:08

A. That is right, yes. About a year ago; something like that.

199 Q. Do you consider that you are offering expert opinion in respect of those matters having regard to your experience and qualifications? 16:08

A. Yes, I do.

200 Q. Just something about your expertise. Kindly, I think yesterday, you provided us with a curriculum vitae. We

can bring that up on the screen. It's AOB-42642. I am not sure if you have a paper copy alongside you. I have never before read a CV amounting to 39 pages; I'm sure it reflects a very busy life.

A. I apologise for that. 16:09

201 Q. No apology required.

I suppose just to pick up on some of the highlights, you are currently President of the Royal Society of Medicine; is that correct? 16:10

A. That is correct.

202 Q. Your professional life. If we could scroll up, please. The format of this is personal details and education. You won't see this unless you have a paper copy, professor. We can see your professional qualifications 16:10 and then your appointments. It is the case, is it not, that your first consultant urologist post was at St Bartholomew`s Hospital in April '97?

A. Correct.

203 Q. Then you moved from there to St George's from 16:10 April 1995 to April 2004?

A. Correct.

204 Q. With that post, you were also Director of Postgraduate Medical Education?

A. Correct. 16:11

205 Q. Then Professor of Urology at St George's from November 2001?

A. Correct.

206 Q. Moving then to establish the Prostate Centre --

A. Correct.
207 Q. -- in London in July 2005?
A. Yes.
208 Q. Is that a private facility or an independent sector facility focusing on prostate disease? 16:11
A. It was.
209 Q. Is that a concern that you established?
A. Yes.
210 Q. And you were Medical Director?
A. Correct. 16:12
211 Q. You stayed in that role until November 2019. Was it at that point that you retired from medical practice?
A. Yes.
212 Q. We can see from your CV that you have deployed your energies in a range of writing initiatives, both books 16:12 and peer-reviewed articles. I think I counted more than 300 peer-reviewed articles or books; is that right?
A. Yes.
213 Q. Your primary interest is in prostatic disease; is that 16:12 correct?
A. Yes.
214 Q. In terms of the instructions that you received in order to prepare medical reports, are you familiar with the standard expert's declaration which is typically signed 16:13 off when an expert provides a report into our domestic courts?
A. Yes, I'm aware of that.
215 Q. Are you broadly familiar with the Ikarian Reefer Rules?

These are rules that emerged from an English High Court decision or judgment which form the bedrock for experts' declarations.

A. Yes, I'm aware of that. I have a copy in front of me here.

16:14

216 Q. Good.

Having regard to those rules and the standard expert declaration, and in the absence of a declaration from your report, can you confirm the following for me: That the evidence that you have provided, both in the form of a report and the evidence that you will provide to the Inquiry over the next day or so, is that and will that be the independent product of you as an expert uninfluenced by the issues or the exigencies of these proceedings and those who have instructed you?

16:14

16:14

A. Yes, I can confirm that. That is the case.

217 Q. Do you, in turn, recognise that your obligations in giving evidence are primarily to assist the court, and that this duty overrides any obligation to the party or parties who have retained you?

16:15

A. I understand that, yes.

218 Q. Thank you.

The opinions you've expressed in the nine cases you have considered, I think it's fair to say, is it not, that the conclusions that you have reached within those reports do not raise any significant criticism, and perhaps no criticism at all, of Mr. O'Brien's

16:15

clinical practice?

A. I understand where he's coming from, yes. It wasn't my intention to criticise but to understand why he`d done the things he did in regard to those nine patients, yes. 16:16

219 Q. Just to be clear, the reports that you provided are for the purposes, primarily, of these proceedings, the proceedings of this Inquiry. They have not been provided for the purposes, for example, of a General Medical Council proceedings or, indeed, for any civil proceedings? 16:17

A. No, they have not. I'm aware that we may need to prepare those reports later but at the moment those are not -- these reports that you have are not geared towards the GMC. 16:17

220 Q. In terms of your foreknowledge of Mr. O'Brien, before being instructed to provide expert medical opinion in respect of these nine matters, did you know Mr. O'Brien?

A. No, I didn't, no. I've never met him personally. 16:17
I have liaised with him on one Zoom meeting organised through Tughans. That's all.

221 Q. Was that for the purposes of finalising your opinions?

A. Yes.

MR. WOLFE KC: Okay. I think for the purposes of this 16:18
afternoon, we can park the bus there and let you board a bus.

A. Thank you.

222 Q. We'll tune in again at 10 o'clock in the morning and

hopefully get your evidence completed tomorrow.

A. Thank you very much.

CHAIR: Thank you, Professor. We'll see you again tomorrow. Thank you.

16:18

10 o'clock, ladies and gentlemen.

THE INQUIRY ADJOURNED TO 10:00 A.M. ON THURSDAY 16TH NOVEMBER 2023