Urology Services Inquiry

Oral Hearing

Day 21 – Tuesday, 31st January 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

THE INQUIRY RESUMED ON TUESDAY, 31ST DAY OF JANUARY, 2023 AS FOLLOWS:

CHAIR: Good morning, everyone. Mr. Mackle.

10:00

MR. EAMON MACKLE CONTINUED TO BE EXAMINED BY MR. WOLFE KC AS FOLLOWS:

MR. WOLFE KC: When we were last with you, Mr. Mackle, last Thursday, one of the last points you were making 10:00
to us was that, as Associate Medical Director you had to raise certain issues with Mr. O'Brien, and that while he was gentlemanly and outwardly pleasant, you sensed that he, I suppose, resented the fact that you were challenging him on a range of issues. I just want 10:00
to pick up on that theme to start with this morning. If we could turn to your Section 21 at WIT-11769. At paragraph 92 you say that in 2012, you were unsure of the exact date but you were informed that the Chair of the Trust, that's Mrs. Roberta Brownlee, had reported 10:01
to senior management that Aidan O'Brien had made a complaint to her that that you had been bullying and harassing him, and I want to ask you some further detail about that. You say that this matter was drawn to your attention when you were called in to an office 10:01
on the administration floor of the hospital to inform you of the allegation or the accusation. Just to be clear, doing your best with your memory, is that the issue that you were summonsed to the office to discuss?

A. When I say I was summonsed, I wasn't asked to come up to the admin floor. I had arrived up at the admin floor to go and see -- normally I would have called up at different times during the day to go and see Heather Trouton and/or the Heads of Service. There, from the staircase that comes up, you turn right, there's a door there into the admin part, you turn left, that corner office is the Acute Director`s office or secretaries, or PAs office, and then as you walk along that corridor down to the far end just round the corner is where Heather Trouton's office and the Head of Service's office was. So I was on that corridor when I was asked to come into an office. 10:02 10:02

1 Q. Yes. Doing your best on the issue, is that the issue, the matter of this allegation, is that what was addressed? 10:02

A. That was the sole thing that was discussed.

2 Q. Okay. In terms of how it was put to you, is that as much detail as you are capable of giving?

A. Basically, yes. I mean I was completely shocked, horrified, flabbergasted, gutted, whatever term you'd like to use, which, as a result, I found it difficult to -- I found it difficult to explain why I couldn't remember with guarantee who spoke to me. I believe it was Helen Walker, as I said immediately after I went down to looking for either Heather or Heads of Service it was Martina Corrigan who I met, but the only thing that was said to me at the time was to warn me that the Chair of the Trust had reported to management that it 10:03 10:03

had been reported to her that I had been bullying and harassing Aidan.

3 Q. Before we get to the Martina Corrigan bit of the transaction, can you recall whether this was a lengthy conversation with whoever it was. You say it may have been Mrs. Walker, and we will come to that, but was it a short conversation? 10:04

A. It was a short conversation and I was advised to be very careful.

4 Q. Did you sit down for the conversation? 10:04

A. No, it was just standing inside the doorway.

5 Q. Was there only one person present or more than one person?

A. Well myself and the other person, yes, just the two of us. 10:04

6 Q. Do you recall inquiring as to whether there was further detail on this or what was to be done about it?

A. I was just so shocked, I didn't, I was completely shocked to have been accused of it, you know. That was it, really, I suppose. At the end of the conversation I was advised to be very careful, and then I left and went down the corridor. 10:04

7 Q. Did you challenge the allegation when it was made, to the best of your knowledge?

A. I can't remember. I mean, whether I said something, in fact, I don't believe, it's untrue or something like that. I don't remember exactly what I said. Anything I say in that respect I would be making up, I couldn't tell you exactly. 10:05

8 Q. You say you left, went down the corridor to Martina Corrigan's office. Was she on that corridor?
A. Yes. Yes, at the far end of the corridor, just at the corner.
9 Q. What was your purpose in going to her? 10:05
A. Well, I had been en route to there -- I can't remember if it was a specific route to Heather or the Heads of Service, I often would have popped up to see if there were any issues, I think it was a pop up for any issues the time I called up. Then I wanted to talk to 10:05 somebody.
10 Q. Sorry?
A. Sorry. Then I wanted to talk to somebody. I suppose at that stage I started talking rather than a few minutes earlier, or a few seconds earlier. 10:06
11 Q. Yes. Again, when you spoke to Mrs. Corrigan, is that the only person you spoke to at that time?
A. She was the only person in the room, yes.
12 Q. You go on in this section of the statement to say: 10:06

"In approximately 2020 I truthfully had difficulty recalling who informed me, Martina Corrigan said I told her at the time that it was Helen Walker -- that's Assistant Director of Human Resources -- I now have a memory of seeing but can't be 100% sure that it's 10:06 correct.

I recall having a conversation with Dr. Rankin who advised that for my sake I should step back from

overseeing Urology and I was advised that Robin Brown should assume direct responsibility. I was also advised to avoid any further meetings with Aidan O'Brien unless I was accompanied by the Head of Service or the Assistant Director. As a result I instructed Robin Brown to act on all governance issues regarding Urology and in particular any issue concerning Aidan O'Brien. At my next meeting with John Simpson" -- who was Medical Director at that time? 10:07

A. Correct, yes. 10:07

13 Q. "I advised him of the issue and the change in governance structure in Urology. There was no formal investigation of the complaint and I checked with Zoe Parks and she said there is no record on my file of the accusation." 10:07

Just a few points arising out of that. You say you discussed it with Mrs. Corrigan in 2020. Why were you discussing it at that time with her?

A. Or approximately 2020. When the Inquiry was being set up I expected to be called. And that's why I couldn't remember at that stage who. 10:07

14 Q. Why did you think it might be an issue in advance of the Inquiry or when the Inquiry was announced?

A. Well, for me it was a pretty significant event, whereas I believe that Aidan O'Brien had made a complaint against me, directly about bullying and harassment. I thought that was a significant event and that's why -- but I couldn't remember exactly myself and I thought 10:08

if I am asked, I couldn't be sure who it was, and that is why.

15 Q. Have you ever spoken to Helen Walker about the issue since?

A. No. 10:08

16 Q. In terms of anyone else in HR, have you spoken to anybody else in HR about this?

A. The only person I spoke to in HR was Zoe Parks, and that was in connection when I was preparing my statement. 10:08

17 Q. Yes. Did she recall the issue?

A. No, she said she had no record, there's nothing on my HR file in that connection.

18 Q. You say you recall having a conversation with Dr. Rankin? 10:09

A. Yes.

19 Q. Who at that time was Director of --

A. Acute Director, yes.

20 Q. Just following this along the sequence. Who you spoke to in HR telling about the issue, then Corrigan, in 10:09 what context were you speaking to Dr. Rankin about this?

A. I can't recall exactly what way -- whether it came up -- I think it came up at an informal meeting, it wasn't a formal meeting we had in connection with it at all. 10:09 I remember it was discussed with her and, at that stage, she advised me to be very careful not to meet him on my own again, that I should always have Head of Service or Assistant Director with me to avoid any

suggestion that I could have been bullying or harassing him.

21 Q. Did you bring the issue to her attention or did she know about it?

A. I don't recall. 10:10

22 Q. You then spoke to Mr. Brown, who at that time was Clinical Director of Surgery?

A. Yes.

23 Q. You asked him, instructed him I think you said, to deal with Mr. O'Brien if issues arose? 10:10

A. Yes.

24 Q. Essentially, was the thinking that he would stand in your shoes in terms of his interactions with Mr. O'Brien?

A. At that stage -- prior to that, with Robin being based 10:10 in Daisy Hill and myself being based in Craigavon I tend to get more of the issues brought directly to me and the point was then I wanted to deal -- I'd already asked Heather and Martina knew to deal more with Robin, and vice versa to Robin, I said to him, 'look, I need 10:11 you to take a closer eye on governance for Urology'.

25 Q. Did you tell him the reason for this?

A. I don't know that I did, but I can't be sure one way or the other.

26 Q. But to be clear, Dr. Rankin was aware of the reasons 10:11 for the change?

A. Yes, Dr. Rankin, Mrs. Trouton, and Martina Corrigan.

27 Q. And John Simpson?

A. Yes.

28 Q. And John Simpson; you made him aware that Mr. Brown would be more to the forefront in dealing with any issue that might arise concerning Mr. O'Brien?

A. Yes.

29 Q. Was that change in approach, to your mind, approved as such, because it appears somewhat unusual that you would be handing over essentially an aspect of your powers or your duties as AMD to somebody else? 10:12

A. Well, a lot of what I really did was CD role because I was based in the Craigavon site. Things were fed directly to me rather than to Robin, so a lot of that was just being passed back to Robin. 10:12

30 Q. In terms then of your view of this, if we could go to an earlier part of your statement, WIT-11745. At the bottom of the page, and we are going to go over to the other page as well, you recite what we know or what you have said, and you say: 10:13

"I consider this to have been a false accusation and on reflection I believe it may have been malicious. Prior to 2012 I had acted as a major challenge to Aidan O'Brien's opinions and views regarding development and modernisation of the Urology Service and I think he resented my input". 10:13

In paragraph 29 you deal with the kinds of issues that you were addressing with Mr. O'Brien, including the modernisation of the service, the job plan, and how you had been involved in a process which ultimately reduced

Mr. O'Brien's pay by 3 PAs. You say:

Furthermore you helped organise the nine cystectomy review and challenged him regarding breaches to the protocol for managing the IV fluids and antibiotic patients. You also challenged him over failure to triage and being involved in discussion to refer him to Human Resources regarding the disposal of patient records in a bin, and also actively supported Gillian Rankin regarding the necessity for Aidan O'Brien to review the results of patients' investigations once they are available.

10:14

10:14

As we saw on Thursday, many of those issues had occurred in 2011 and you say that this issue was brought to your attention in 2012.

10:14

Of the issues you were addressing with Mr. O'Brien, did any of them become fractious? I know we reflected, to some extent, on this on Thursday, and you said he was, I suppose, gentlemanly or polite in his approach to you?

10:15

A. It was frustrating, but no, they were not fractious. There were no outbursts, shouting, things like that. I mean, Aidan O'Brien, whatever else one may say about him, he is a gentleman.

10:15

31 Q. You were assured, just scrolling down the page, that management did not believe the false allegation. Who gave you that assurance?

A. I believe Dr. Rankin.

32 Q. Does that suggest that it was, to your mind or to your impression, discussed amongst management?

A. I don't know. I can't say. I admit I was very relieved to have support and believed but I can't say what discussion went on other than that, you know, what discussion was held with other people I don't know. Dr. Rankin did not make me party to any conversations specifically that she had had with other people about it. 10:16

33 Q. You go on to say that the failure to investigate and exonerate you meant you had to be careful about acting in any sort of challenge role, and your oversight of Mr. O'Brien's practice was reduced for fear that it could be misconstrued as evidence of harassment. 10:17

"On reflection I now feel he achieved his intended objective."

Were you content at the time that the matter wasn't to be formally investigated? 10:17

A. I don't deny that, yes. But as time went on I realised I wished it had been.

34 Q. Why do you say that?

A. Well, at the time I felt -- I was relieved that I was believed. I suppose one does not like to be subject to a formal investigation and in that respect I was very relieved from that point of view that I wasn't going to be, but it did restrict my interactions with him and it 10:17

would have restricted even if it hadn't been a form of bullying, I mean, even if I had been exonerated it probably would have affected my interactions with him from then on anyway even if I had been exonerated because I still would have felt I had to be very careful. 10:18

35 Q. In terms of the practical effect of you handing some of the reins, if you like, or some of the issues to Mr. Brown, what was the practical impact of that, in your view? 10:18

A. I suppose it reduced the number of times I was getting e-mails or comments or things like that directly about Aidan O'Brien. It had that effect. It still meant -- I had a significant workload still as it was, both clinical, but with the other specialties as well and there are a lot of issues still ongoing within general surgery, to a certain extent ENT and orthopaedics, so I still had more than enough work in that aspect, if you know what I mean. 10:19

36 Q. Yes. We know, as we will see as we go on this morning, that issues such as triage, patient records being retained and other issues that developed, they were still happening. There were still issues so far as management were concerned with Mr. O'Brien's practice. You were still being told about those? 10:19 10:20

A. Some, maybe not to the extent, you know. To a certain extent I was to some things, but I can't say how much I was being told about. I suppose it reduced my direct -- I would not have actively instigated something at

that stage as regards Aidan O'Brien's practice because I did not want to be seen to the one to be driving it, but, for example, the 2016 letter, once issues were raised at the end of 2015 and said look, we need to do something about, that was different. I was now not the main initial driver, so to speak.

37 Q. Just to be clear. You obviously held the role of Associate Medical Director?

A. Yes.

10:21

38 Q. Issues, let's pick one, triage, were coming through the system as regards Mr. O'Brien, this was a problem for operational management. It was still the case that these issues were being drawn to your attention, but in terms of interacting with Mr. O'Brien to try to resolve those issues, that was being done face-to-face or by e-mail, telephone, by Mr. Brown and Mr. Young?

10:21

10:22

A. Yes.

39 Q. Whereas previously perhaps it would be face-to-face --

A. I probably -- I was more hands on in a lot of those things whereas afterwards I wasn't. But then again, I would have thought, in most set-ups, the Clinical Director would be the person would be more hands on anyway rather than we only had one to two Clinical Directors, now there are three. I didn't always have two, that's why I was more directly involved. Plus, when you add one of the Clinical Directors was not on the same site, also meant that my role quite often overlapped with what would have been the Clinical Director's role.

10:22

10:22

40 Q. If I can ask you directly? Do you think the effect of you stepping back, if I can use that term, had any impact, adversely or otherwise, in terms of the management response to Mr. O'Brien?

A. I can't give you a straight answer because I can't -- the reason I can't give you a straight answer is I can't say what the others felt they could do or not do from an operational point of view or without me directly being involved. It was known that, if necessary, I would meet with him with Martina or Heather with me. It wasn't that I was never to meet him again, it's just I would be meeting him with one of them if I had to. So, I think -- I can't say if they felt it restricted the practice. I felt that there was enough there still to have continued an oversight with them plus Robin. 10:23 10:23 10:23

41 Q. As we'll see this morning, some issues were drawn directly to your attention --

A. Yes.

42 Q. -- and you had an opportunity to contribute. Is there any sense that this development left you in some sense glad that the responsibility for managing Mr. O'Brien at the top of the hierarchy, if you like, within that division, was taken out of your hands? 10:24

A. You know, no, I wasn't that. I was I was glad, as I said, that I had been supported by management. It wasn't considered that I had been bullying him, I felt glad about that, and that I wasn't, as a result, going to be subject to a formal Inquiry into it. But with 10:24

time, I then realised that, you know, that was restricting me to a certain extent and that I felt, by that stage -- I can't say how long afterwards, it was maybe six months, it might have been a year, I don't know, I felt I wish I had been exonerated. 10:25

43 Q. In terms of the starting point for this, the communication that you received in that office in 2012 was that Mrs. Brownlee had spoken to senior management and she had been told that you were harassing and bullying Mr. O'Brien and her informant was Mr. O'Brien. 10:25 Let's just look at that again. Your belief that it may have been Mrs. Walker who shared that with you, and I know that comes through Mrs. Corrigan --

A. Yes.

44 Q. -- and in assessing what you have said about that, you 10:26 tend to the view that it was Mrs. Walker but you can't say for sure?

A. I personally can't say for sure, because I just cannot visualise the situation at the time, if you know what I mean. That's why I wrote it accordingly because 10:26 I realised if I put down anything else I couldn't stand over it myself.

45 Q. Yes. Mrs. Walker has been asked about this. If you just put up on the screen her response, WIT-91872. Just in the middle of the page there, she's asked to 10:26 respond to what you'd said at paragraph 92 of your witness statement, which we have just looked at. She says, a few lines in:

"I have no recollection of ever hearing this and nor have I had any discussion or correspondence with Mrs. Brownlee about any matter concerning Mr. O'Brien or Mr. Mackle. I have no recollection of having any discussion in the context described by Mr. Mackle. In light of this Section 21 I have double-checked with Mrs. Zoe Parks and she confirmed there is no such complaint on record."

So, she appears to be ruling herself out as the person who had the conversation with you. 10:27

A. Mm-hmm.

46 Q. Mrs. Brownlee, for her part, says that she never made a complaint about Mr. Mackle bullying or otherwise, and Mr. O'Brien says that he did raise a complaint, a grievance, about you in 2012, and he points to that. It doesn't appear to have used the language of bullying or harassment, it was, strictly speaking, a financial complaint. Let's just look at that complaint. 10:28

If we go to WIT-90376. Sorry, that's the wrong page? WIT-90380, please. Yes. We can see 30th January 2012. It's the same year that you referred to when talking about the bullying and harassment complaint. If we go to the third paragraph, perhaps. He is saying that back in 2010, he had agreed with the Head of the ENT and Urology that he would be remunerated for some additional work to be conducted in Thorndale on Fridays, and he goes on to say when he received payment 10:29

in April 2011, he didn't recognise the amount. The payment appeared to have been halved, and some sessions he wasn't paid at all. When he inquired about this, payroll personnel informed him that they were unable to decipher the signature and he was then provided with a copy of the claim form and he was able to ascertain from that that you had made the deductions. That's the complaint that he said he made in respect of you in 2012. That complaint was drawn to your attention, was it? 10:30

A. Yes, by Dr. Rankin.

47 Q. If we go to WIT-90379, this is Mrs. Parks, who we have heard something about. She records that she has spoken to you about the issue: 10:31

"These claims were change by the AMD Mr. Mackle but I have spoken to Mr. Mackle and Heather Trouton and it seems there was some misunderstanding about what had agreed against his job plan, however they agreed to concede as changes shouldn't have taken place without prior discussion with Mr. O'Brien." 10:31

There was, plainly, a complaint, a financial complaint. You were spoken to about it by Zoe Parks, you also think by Dr. Rankin? 10:31

A. Yes.

48 Q. Did you speak to Mrs. Trouton about it as well?

A. Yes. I can't recall exactly but I know we did talk about it, because I had sat in her office originally

when it was being done.

49 Q. Yes. I don't think we need to get into the minutiae of the financial issue but it appears that you were prepared to give ground on the issue and the issue was resolved? 10:32

A. I was wrong not to have referred it back to him rather than sent the form on through to Finance. I should have sent it back to him for further clarification, and I accept totally I was wrong in that.

50 Q. Is it possible, Mr. Mackle, that your perception of what was being complained about did become, in its telling, somewhat confused when this issue, the financial issue, was raised with you in 2012? 10:32

A. I don't think so, no. I mean, I can't remember the timing. You know, that was not a good time for me from a family point of view as regards my wife's health, and so I cannot recall when in 2012. Was it before March or was it after March the complaint was made to me? In that respect I don't recall which, but what I was told at the time was, it was Roberta Brownlee and that was where the complaint had come from. That part I do remember. That stuck out that the Chair of the Trust would have been saying, you know, speaking negatively about me, and that's the part of the conversation I vividly remember. 10:33 10:33

51 Q. Are you now remembering two distinct issues raised, it appears, that year, a bullying and harassment issue and a financial issue; are they distinct events in your mind?

A. I think they are but I can't say for definite. As I say that occurred January/February time that the complaint was made. March was a significant date for me. I think it was later in the year but I don't know.

52 Q. Yes. I am conscious of what you say stands out in your mind, the fact that Mrs. Brownlee was attached -- 10:34

A. Yes.

53 Q. -- to the narrative? Let me just press this one point finally. Is it possible that in the telling to you of the financial issue raised by Mr. O'Brien, that somebody could have said you need to be careful, your behaviour in this could be construed as bullying and harassment? 10:34

A. I don't recall it being said that way when I was informed. No, I don't recall it being said that way. I do recall Dr. Rankin advised me to be very careful to make sure nothing else -- nothing I would do in the future could be construed as bullying and harassment, that part I do recall but not the initial telling. 10:35

54 Q. After this issue was put to bed, the financial issue, and what you appeared to be saying the separate issue of bullying and harassment, were those issues ever the subject of conversation again after that period of time elapsed? 10:35

A. Not that I recall, no. 10:35

55 Q. I want to spend the rest of the morning looking at the developments that occurred after that, taking us up to 2016, when you met with Mr. O'Brien. In the period after 2012, and before you met with Mr. O'Brien in

March 2016, did you have any face-to-face engagements with him to challenge him about any aspect of his practice?

A. I would have had face-to-face engagements with him over clinical things I think but not that I can recall over any challenge.

56 Q. Yes. We looked last week at the issues around triage, for example, amongst other issues. In the period after 2012, it's fair to say that the issue of triage was never resolved? 10:37

A. Correct.

57 Q. It was still an issue in March 2016, just as it had been an issue at the start of your role as AMD. The Inquiry will have an opportunity to look at the correspondence in respect of that. It appears from that correspondence, and the Core Participants can comment on this as they wish, but Mr. Brown was more often the recipient of correspondence from operational side dealing with shortcomings in triage than were you, but let me just look at aspects of that so that we can work out what you were aware of. If we look at TRU-276904. This is November 2013. Heather Trouton, the Assistant Director, is writing to Mr. Young and Mr. Brown, and the subject is "missing triage, needing a response". If we can scroll down, please. Within this she is also dealing with the issue of having charts at home. She says that she had personally spoken to Mr. O'Brien about this practice on various occasions, Martina Corrigan also much more often?

"While we very much appreciate Aidan's response I suspect that without further intervention by senior colleagues it will not happen".

A. Sorry, could you scroll down, please?

58 Q. Yes, of course. She says, and this is referring to correspondence that's come in from Mr. O'Brien:

"Mr. O'Brien recognises that they have been very patient and that they have offered help in the past but the delays continue."

The upshot of it is, that is the operational side: "We really need you to speak with Mr. O'Brien in the capacity of a colleague but also as your capacity as Clinical Lead and Clinical Director in Urology as well as of course as patient advocate."

I am bringing that to your attention. It appears it's a cry for help from the operational side to get this sorted out and it's going to the Clinical Director and the Clinical Lead. The issue of triage clearly still being spoken about. Is it coming to your attention as well throughout all of this?

A. I can't say that there was -- that I thought there was no issue with triage, but I can't recall -- I mean I could not recall specifics of being raised as a major issue until the end of 2015. I mean the triage was an ongoing issue all the way through, and I admitted last

Thursday we collectively did not see an issue -- a Patient Safety issue with that. Debbie Burns had introduced in 2014, the system whereby they were automatically put on the waiting list and then the triage may be upgraded, or triage may upgrade them. But as I say, there was a collective failure to see that there could be a serious risk from it.

59 Q. Yes. I mean, we needn't go directly to the e-mails just in the interests of time, perhaps, but what we see over the period of the next two or three years, perhaps, leading up to 2016, is a series of what might be described as workarounds, some polite pressure being put on colleagues to help Mr. O'Brien help the service out of this fix, another solution was well, he will only deal with the named referrals? 10:42 10:42 10:43

A. Yes.

60 Q. Then, even that appears not to have corrected the problem, and Mrs. Burns or the service -- maybe not particular to her we will keep it general for the moment -- comes up with the idea of using the general practitioners' classification of the referral for putting on to waiting lists while we await the triage. Were you aware of these various fixes that were attempted? 10:43

A. I was aware of the ones where Michael Young took on red flags, where Mahmood Akhtar had a team of red flags of the support he has given at times. When I was initially preparing my report I had completely forgotten about the workaround, no -- of having initial 10:43

knowledge of that of the GP using it, and when I saw the evidence I realised I had known about that but I had forgotten about that part.

61 Q. Mm-hmm. Mm-hmm. We have these workarounds, and as I say, I think you acknowledge that they didn't succeed. Could I have your reflections on why, rather than attempt to broker these alternatives to Mr. O'Brien doing the triage, why was his role not more aggressively or robustly pushed? 10:44

A. When you see all the evidence, the documentation, the e-mails, et cetera, all tabulated and all together, it's obvious that something more should have been done, you know, and I admit that. As I said on Thursday, a lot of how we judged him was on, you know, he was not somebody who kind of buzzed in for an hour during the day, disappeared off to do his private all afternoon, never seen after that that. He was there late in the evenings. He had always that reputation of being there. He was held in high regard by everybody, by the anaesthetists, other doctors, the nurses in the wards, and that's why he'd get judged accordingly. I think it's easier if you have somebody who you get the impression is an absolute slacker to start to take them on managerial-wise and performance-wise, but he was seen as performing and performing hard -- working hard and that's why. 10:45 10:45 10:45 10:46

62 Q. Could I ask you for your impressions of the default arrangement that was used, that's the idea we spoke about earlier.

A. Mmm.

63 Q. If we go to TRU-277196. The timeline has moved into 2014. Look at the bottom of the page first. And it's:

"Can you arrange for the following Urology referrals to be returned from triage as soon as possible?" 10:46

Then Catherine Robinson, in the booking office, is saying, as you can see --

CHAIR: Sorry, Mr. Wolfe, could we move on to that, please? 10:47

MR. WOLFE KC: Of course.

64 Q. That's the bottom of the page e-mail. Then brings Mrs. Robinson's intervention. She is saying:

"These have all been chased several times." 10:47

It's all being dealt with on the operational side. I am not suggesting that you have seen this, Mr. Mackle. The discussion is around booking these patients into the waiting list. At the top of the page, Anita Carroll says to Mrs. Trouton: 10:47

"Don't panic, as you know we are going to the GP triage anyway." 10:48

Your impressions of that. Does that suggest that this default arrangement was in some sense a good solution and that there was nothing to be concerned about?

A. It was a solution which I suppose was a fail-safe solution, that something happened. As I said, I -- we did -- in fact I think it was 2017 I published, with Robert Spence a review of one year's red flag referrals -- referrals to upper and lower GI in Craigavon we found a very small percentage got upgraded. We didn't have the numbers for those that produced cancers but that was even lower again. So GPs largely get it right, but we, from a colorectal point of view, used the triage system not so much for the cancers but we did look at it from that point of view, but things like inflammatory bowel disease, et cetera, which were not technically covered by the red flag process and couldn't wait for an urgent appointment. 10:48 10:49

65 Q. But I think, as you acknowledged last week, triage was something that was valued within the system? 10:49

A. Yes.

66 Q. If it isn't being triaged, if referrals are not being triaged there is this risk, it may be low percentages but there is this risk that patients who have come in with an urgent referral or routine referral are not being appropriately -- 10:49

A. I don't disagree with that, yes.

67 Q. Yes. Certainly, as the timeline moves on, 30th November 2015, Mrs. Corrigan is writing to Mr. Young. If we can turn to TRU-258498. She says: 10:50

"I will really need help at getting this resolved as there are currently 277 not triaged letters from

Mr. O'Brien who has been on-call dating back to October 2014."

As we go on this morning we will look at how this issue became one of the issues that was looked at in March 2016 meeting. But within the Service and within the Directorate, surely it was appreciated by this stage, Mr. Mackle, that Mr. O'Brien, for whatever reason, and he says he just didn't have the time to do referrals other than red flag referrals, surely it was appreciated that these non-red flag referrals just weren't being done or were being done in fewer numbers than ought to have been the case? 10:50 10:51

A. Sorry, I'm not sure all of those were red flag referrals but I can't be 100% certain on that one. 10:52

68 Q. No, what I'm saying is, his position, that he could not find the time to do anything other than red flag referrals, was that position known to you?

A. I don't recall ever being told that Aidan had stopped doing all referrals other than red flags. At that stage they were working the Urologist of the Week process, whereby they had traditionally what had happened, in general we did that a bit early in 2000, 2002 I introduced it, where the surgeon was on-call for emergencies but would still have clinics to do, maybe was in theatre to do the next morning, would have clinical issues and was trying to manage those patients around that, that was not a particularly safe system, so we introduced it in general surgery around, I think 10:52 10:52

it was 2014 but I can't remember exactly it was introduced for Urology as well, where they had half a day, where they could concentrate on emergencies, they had no clinical issues and that was each morning -- each morning during the week they had first access to the theatre. We in general surgery said they could always have the first slot in the theatre in the morning, unless we had a really dire emergency, to get their significant cases done, and as part of that, during that time, they would do their triaging. That was agreed by all, that they would take on to do that. At no point in time did I know that Aidan O'Brien was not doing it. 10:53 10:53

69 Q. What you do know and what the system knows is that, taking these figures on this e-mail as they are, there is a substantial backlog. It's going back 18 months. What is the diagnosis? 10:53

A. That there's a failure -- there is a definite failure for him from a performance point of view. This is one of the issues that triggered the following month the discussion about what to do with the Medical Director. 10:54

70 Q. Yes.

A. During December.

71 Q. Of course. But I say what is the diagnosis, was there an attempt to diagnose what the problem was before we got to that point in March? 10:54

A. No.

72 Q. It was, as you have described it and others have described it, periods of compliance followed by lengthy

periods of non-compliance and chasing and chasing and then, as it seems, a build-up that was never tackled. Was there no attempt to grapple with a cause? What is the cause of this so that solutions could be arrived at? Or, was it considered insufficiently important or too bothersome to actually effectively address it? 10:55

A. I can't give you a straight answer on that. As I say when one looks back now, one thinks why on earth did we let it go on? I can't give you a straight answer why it -- I can't think -- I don't think there's one simple thing that we said, you know, oh don't worry about it, everything will be fine. It was not that. There may have been an element of fatigue, I suppose, the number of times he was challenged, he'd do it, challenged, he'd do it, eventually people stopped challenging to the same extent. I think there was probably reliance on the fact that the fallback system introduced by Debbie Burns at least would prevent the risk. There was an element that Aidan would never say himself I am not able to do them, I can't do -- he never would turn around and say, I have all this backlog because I can't get anything done. He never came forward and said -- well I tell a lie, sorry, because there was back in 2007 when he did ask for time for admin, but he wasn't coming along and saying, 'I cannot do this, I'm failing'. So I can't give you one simple reason why, I'm sorry. 10:55 10:56 10:56 10:56

73 Q. Yes. You say fatigue, amongst several reasons, perhaps, but whatever those reasons are, it is in the

face of what I think you now accept was risk of harm to patients?

A. Yes.

74 Q. Maybe small numbers --

A. But.

75 Q. -- still relatively speaking, but we know that there were six Serious Adverse Incidents generated in the time that followed, starting in 2015/'16, and then with one patient -- sorry, I don't have the cipher list in front of -- and then a further five on top of that. You say in your witness statement, if I can just bring up WIT-14780, and if we go to item C at the bottom of the page, you say that you accepted in the context of the persistent and recurring issues regarding triage, you don't recall ever considering the MHPS Framework "as far as I can tell, none of the Acute Directors, Medical Directors considered the MHPS Framework either. I now believe on reflection that the repeated failure by Aidan O'Brien to complete timely triage should have triggered an investigation under the MHPS Framework."

A. Yes.

76 Q. That's obviously with the benefit of thinking about matters now. What, in particular, would have justified an MHPS investigation, do you think? Or why would that have been an appropriate step?

A. I think the continued failure to triage, but when I think back having to change the rules of how you book patients on the clinics because one Consultant's failure to triage when other consultants in the

speciality were, I think that should have been more formally investigated.

77 Q. Yes.

A. As to whether he needed support or whatever or NCAS involvement but to formally investigate it. 10:59

78 Q. Yes. It's the absence, as you now realise, of any formal attempts to get to grips with this issue, instead the repeated informal approach that you think was problematic?

A. Yes. 11:00

79 Q. You said in your witness statement that, as regards the retention of patient notes or charts at home, that was a problem that was known to affect some clinicians, perhaps many clinicians and not just Mr. O'Brien. The issue you say was first flagged with you, as far as you 11:00 can recall, in 2013. If we just bring up Martina Corrigan's input on that. WIT-11966. I will just check the reference on that. Yes, sorry, I was confused by the redaction. Ms. Corrigan is saying to -- this is the bottom of the page, sorry, 21st 11:02 September 2013, to Mr. Brown, which he copied in, and she says:

"Below is another Datix received in respect of charts being at Aidan's home. This is the second one last 11:02 week and I am receiving at least one of these each week as health work records are continuing to spend time for charts that they discover are in Aidan's house."

Scrolling up the page, Mr. Brown said that you dealt with this matter -- sorry, this matter was raised a couple of weeks previously. He texted, that is Mr. Brown texted Mr. O'Brien but he didn't reply.

"Last time there was a problem like this I drove over".

He says: "... did look like a bit of an ambush and might have been a bit counterproductive. I think it might be better if I could catch him at the beginning or the end of an MDM". 11:02 11:03

And he proposes that. So Mr. Brown is going to address the issue. But the issue wasn't resolved, was it, Mr. Mackle? 11:03

A. No, it wasn't.

80 Q. It's still an issue in March 2016?

A. Yes.

81 Q. If we go to, for example, TRU-278656, and just start at the bottom of the page, please. Pamela Lawson is e-mailing Anita Carroll, and she is highlighting that these are the details of the IR1 forms regarding charts Mr. O'Brien has had to bring in from his home for clinics and admissions. So detailing charts for which incident reports have been raised from 2013 into February 2014, and if we look at the top of the page, we can see that you are copied into this. Again, more than 50 incident reports raised in relation to charts that cannot be found and assumed to be in Mr. O'Brien's 11:04 11:04

home. Mr. Mackle, in terms of an issue like that, we can see that it raises data protection-type issues, so clinical notes, property of the hospital and property of the patient, they shouldn't be in a Consultant's home, I suspect, except perhaps overnight, if he's coming from a clinic, say, in Enniskillen and has yet to reach hospital premises to return the chart. But again, when you see and when you saw those kinds of odd numbers, was there any consideration between you and your colleagues as to what this was a symptom of? 11:05 11:06

A. No. I forwarded that e-mail, I see, to Deborah Burns to make her aware as well.

82 Q. Yes.

A. But no, we didn't.

83 Q. It wasn't, as you now know, simply a data protection issue. Assumedly if you had thought about it, one of the issues that might have occurred to you was that this was a retention of notes so that further work could be done on the record and, as we now know, a problem emerged from 2015, I think you say, where it was recognised that Mr. O'Brien wasn't dictating the outcome of clinics? 11:06 11:07

A. Yeah.

84 Q. But that wasn't recognised?

A. No, that wasn't thought of or considered at that time, no. 11:07

85 Q. Was there any consideration of a diagnosis of the problem? What lies behind the fact that so many charts are not with us and not in the right place?

A. Aidan O'Brien, when I first went to -- when I went to Craigavon and ultimately he was appointed a year or so later, his office was next door to mine and he always had charts in his office on the floors, loads of them. His system from the very start always had that and I think there was an element that it was kind of that's the way Aidan does it and people tolerated it. If you were looking for a chart you went into his office and there were row upon row upon row on the floor of charts so they would be easily looked at and identified, and I think there was an element of, it was accepted, not accepted that the charts weren't available but not actively considered why. 11:08 11:08

86 Q. If we look, and I would be anxious to have your observations on this, at an e-mail that was sent to Mrs. Trouton in 2015. TRU-277895. Just if we start at the bottom of the page. Anita Carroll writing to Heather Trouton and Martina Corrigan. 11:08

I'm not sure what the first question means, but clearly the subject matter is "charts at home and Aidan O'Brien -- should have something on Risk Register in relation to this. Suggests Anita Carroll. Mrs. Trouton says that she spoke to Mr. Young about this last week and he is going to speak to Aidan again. I will consider the Risk Register below with that, you are supposed to address the risk and eliminate it. This is down to a personal way of working which seems impossible to stop." 11:09 11:09

It appears to be an element of weariness in what's said there and we will ask Mrs. Trouton about that.

A. Mmm.

87 Q. In terms of it being impossible to stop, what does that say about the management of this clinician in respect of a problem that has been prevalent for some several years? 11:10

A. That the softly softly approach doesn't work or isn't working. Most consultants, once you spoke to them, would have acted, changed their practice and settled, you know, without you having to continue to go back. I think it just shows that that approach did not work, or was not working. 11:10

88 Q. Yes. I know that you have reflected in your witness statement that some issues were well dealt with. You reflect the fact that the IV antibiotic issue, the cystectomy issue, to take but two, were, in your view, appropriately handled. We do have these other issues which is, as I think you accept or acknowledge, were not well-handled. Another example I want to ask you about, and have your view on, is the issue of private patients. 11:11 11:11

If we just bring up your witness statement, WIT-14787. At paragraph 41 you say you cannot recall being presented with any evidence that Aidan O'Brien was prioritising patients for scheduling on the basis of them having seen him privately. 11:11

"I believe the issue was raised as a possibility with Heather Trouton on a few occasions but then when challenged by Heather Trouton and Martina Corrigan Aidan O'Brien had sound clinical reasons for his prioritisation. I cannot recall when I was informed of this, for the avoidance of doubt, I had no direct or first-hand involvement in the matter."

Does that suggest that you were informed about the issue by Martina or Heather at one point or another 11:12

A. An occasional time I had heard there had been a question whether somebody had been admitted had been private and Martina would check, and I believe it was Martina checked, he would have a clinical reason why they needed to come in, and so I was never raised with me that patients without clinical reasons who had been seen privately were queue-jumping. 11:13

89 Q. Can you see, Mr. Mackle, an anomaly in an operational manager challenging a senior Consultant about an issue such as this? 11:13

A. I take your point. It should probably therefore have been Michael Young challenging him.

90 Q. Mr. Haynes took this issue up with Mr. Young on two occasions. I just want to look at that with you. If we go to WIT-54107. He is writing to Michael Young and Martina Corrigan in May 2015. He is a recent appointment. He has been in the Urology service just about a year at this point? 11:14

A. Just about a year, yes.

91 Q. There has been discussion about the waiting list issue and he is concerned about how Mr. O'Brien addresses private patients in this context, and he says that:

11:15

"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 on a Saturday non-NHS clinic. On the attached total urgent waiting list there are 89 patient listed for urgent TURP, the majority of whom will have catheters in situ, they have been waiting up to 92 weeks."

11:15

He cites the example of a patient, and we will redact that patient's name in due course, and he says that:

11:15

"This patient was seen in a private clinic on 18th April and admission arranged for 25th May 2015 against a background of retention two months earlier."

11:16

He goes on in the remainder of the letter to say:

"This behaviour needs to be challenged and a stop put to it."

11:16

He's happy to discuss and plan a strategy for taking this forward. So, he is putting the ball into Mr. Young's court to address.

If we can go to the earlier page, WIT-54106, and he is writing again, it's now November and he recalls the earlier correspondence and he says that, in his view, particular private patients are being brought on to NHS lists having significantly jumped the waiting list.

"I have expressed my view on many occasions, this is immoral and unacceptable. Aside from the immorality of patients who have the means to seek private consultations having their operations on the NHS list to the detriment of patients without the means who sit on the waiting list for significant lengths of time, the behaviour is apparent to outsiders looking in."

He asks: "Can you advise me what action has been taken since I raised this?"

We will deal with Mr. Young in due course in relation to this, but as the Associate Medical Director for this Department, was Mr. Young coming to you and saying these issues are now being addressed with me on two occasions, and Mr. Haynes says he has expressed his view on many occasions, I am not sure what forum that was in?

A. No.

92 Q. No. What should have been done, in your view, Mr. Young being familiar with the concern now on at least two occasions?

A. I think once Michael was having it raised by a Consultant colleague he should have escalated it.

93 Q. By escalating it, drawing it to your attention or Mr. Brown's attention or dealing with it himself?

A. If he dealt with it in June and it was still happening, then it hadn't been resolved, therefore he needed to escalate even further and I would have said that was something I would have taken on myself. 11:18

94 Q. Was it a known problem in the Southern Trust that consultants were promoting their private patients unfairly on to NHS lists? 11:19

A. No. As I think I said the other day, I have had -- I did private practice myself and occasionally they would have been brought in, but there were clinical reasons for bringing them, there were genuine clinical reasons, not routinely, they were not routinely bumped up the list, and I was not aware that other clinicians routinely moved patients up the list. In fact, I was not aware that anybody was routinely moving people up the list because they had been seen privately. 11:19 11:19

95 Q. Was this an issue that was well-policed by the Trust, in your view?

A. I don't think the Trust had a system for -- actually, when you ask was it policed, the Trust, as far as I know, did not have a formal system for assessing it and for looking into that and for auditing it, no. I don't know if other Trusts do but I know our Trust didn't. 11:20

96 Q. Going back to your earlier answer that Mrs. Corrigan

and Mrs. Trouton would have received, to the best of your understanding, acceptable clinical justifications from Mr. O'Brien if challenged. That does suggest that there was a level of conversation around this issue, but it didn't particularly reach your ears? 11:20

A. Not particularly. I mean I think an individual case or two was mentioned, something like that, but not a routine thing. At least I was not aware that every week, oh this patient has jumped the list or that, no, I was not. 11:21

97 Q. You know that by the time of the MHPS investigation, that I think the figure was nine cases were investigated, nine private patients who had been treated in an advantageous way, was the allegation. Again, the fact that this issue appears not to have been addressed, certainly not addressed to the satisfaction of Mr. Haynes so that when it came to the end of 2016, he was suggesting to the Medical Director that it needed to be investigated formally through the MHPS process, or added to the list of things that would 11:21 be formally investigated. Do you accept that, before that, this issue was given a blind eye, it wasn't properly challenged or explored?

A. I think -- it's difficult for me to answer for others in that respect because what I knew there was not 11:22 a major issue, and there appeared to be clinical grounds. I was not aware of Mark Haynes' e-mails. He hadn't spoken to me about it, so I can't answer for others on what happened after Mark sent the e-mail or

the second e-mail, I don't know.

98 Q. But what you can say is that Mr. Young didn't draw it to your attention?

A. No.

99 Q. And what he ought to have done, in your view, was to have escalated it if the issue couldn't be resolved at his level? 11:22

A. Yes.

100 Q. Can I ask you about the particular issue of pre-operative assessment? 11:23

CHAIR: Mr Wolfe, might this be an opportunity to take a short break?

MR. WOLFE KC: Yes, I think so, Chair.

CHAIR: So 15 minutes, if we say about 25 to.

11:23

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

MR. WOLFE KC: Mr. Mackle. Just coming back to an issue the pre-operative assessment I would like to ask you to comment on. If we could have up on the screen TRU-277928. At the bottom of the screen. 11:40

Mrs. McKeown, did you know her?

A. Yes.

101 Q. And her role was Head of Theatres?

A. Yes. 11:41

102 Q. She is saying to Martina Corrigan and others, copying in Mrs. Trouton and Mr. Carroll, that:

"As you will see, three out of the five patients have

not been to pre-op. Can you please investigate why and advise why these patients were never sent to pre-op, as to get this level of notification of their surgery is, as I'm sure you will agree, unacceptable. We are now in a position where we are unable to get these three patients pre-assessed due to the extremely tight timeframe before their surgery. I have also attached a second e-mail from Rachel -- that's Rachel Donnelly -- regarding Mr. O'Brien's inpatient list on 4th November". 11:41 11:42

There are again a couple of patients on the list who have not been to pre-op.

That issue is ultimately forwarded to you. If we just scroll up, please. Do you recall that issue being raised with you? 11:42

A. Not specifically. I've read the e-mail, obviously, with the witness bundle but I don't recall. I can't specifically remember it at the time. 11:42

103 Q. Yes. Was a failure to provide for the pre-op of patients or for the timely pre-op of patients, an issue that was raised with you beyond this?

A. Prior to that, that I can think of, no, although pre-op assessment came under Ronan Carroll's and Dr. Stephen Hall who is over all responsible for that Directorate or that -- Directorate, yes. The provision of theatres -- theatre management was not under my remit at all. 11:42

104 Q. Okay. You tell us in your witness statement that in or

about late 2015, you became -- or the management became increasingly aware of a concern regarding the patient centre letter and outcomes. Let me just look at that with you. If we can have up on the screen your statement, please. WIT-11819. At paragraph 226, you say that: 11:43

"In this context, some of the urologists were undertaking waiting list work validation and found that many of Mr. Aidan O'Brien's patients that clinical outcomes and letters were not recorded and there was no record in the chart. It is also noted that many of the hospital charts were not available for clinics." 11:44

This takes me back to something we discussed earlier, that the absence of the patient chart or the patient file was undoubtedly symptomatic of Mr. O'Brien's need to clear up dictation, that seems clear at this remove, but it wasn't something that occurred to you at the time? 11:44

A. Sorry, I didn't quite --

105 Q. The fact of him retaining patient notes at home being symptomatic of this other issue --

A. No.

106 Q. -- wasn't something had occurred to you? 11:45

A. I assumed they were related to private patients rather than related to NHS patient. I know they were NHS charts but I didn't think of them as being charts of clinics. I assumed charts were taken up because he had

seen a private patient or was seeing one.

107 Q. Yes. This issue was drawn to your attention by whom?

A. I'm assuming Heather Trouton.

108 Q. Could I just look perhaps at what might be an example of what we are talking about. If we go to TRU-258492, please. Sorry, if we go to 258494. If we start at the bottom of the page, I am going to work up. If we keep in mind the name of the patient without actually using his name. We can see that this is from Alana Coleman to Leanne Brown on 14th July: 11:45 11:46

"Please see attached referral, please forward to Mr. O'Brien and advise of the outcome."

The next step, just scrolling up, please: 11:46

"Please advise of triage. Does this patient require a review or is this just information?"

So that's August. Next e-mail, please? This is to Mr. O'Brien's secretary: 11:46

"This patient was seen in June at the South-Western Area Hospital. Patient has not been discharged or reinstated for a review following last attendance. 11:47 Please advise of Mr. O'Brien's decision on the attached referral. Is there the referral for info or urgent routine review?"

Scrolling on up. It's now November and there has been no response to the queries on this patient. It's still November, Mr. O'Brien's secretary has been contacted again and Leanne says:

11:47

"No follow-up has been arranged. Can you check the outcomes sheet to see if he needs reviewed or discharged, please?"

Andrea says to Martina Corrigan: 11:48

"See below. This Consultant does not use clinic outcome sheets. The clinical decision is outstanding."

What's a clinic outcome sheet? 11:48

A. Basically, if you see a patient in the clinic you dictate what you are going to do with him and it's recorded whether the patient is for further investigation, for discharge, for review, for admission, and if they are for review how urgent the review is. 11:48

109 Q. If you see a patient in clinic, is that something you should do? You should complete this so that people in the system have an idea of what has happened and what's coming next, or is it something that's not in any sense obligatory? 11:48

A. I can't remember exactly this one. There was a while where actually the sheet appeared for us to fill in, but largely the sheet was completed from the dictation

on the clinic and you said in your clinic letter what all needed done. I think my secretary largely filled it in at that stage. There was a spell where it did appear in the clinic to fill in, but largely I think it was filled in by the secretary, based on what you dictated, and it was obvious from what you dictated what you wanted done. 11:49

110 Q. If we could scroll up the page, please. Martina Corrigan is writing to Michael Young in relation to this: 11:49

"Can we discuss, please?"

Then at the top of the page, Michael Young has apprised himself of the issue and he says: 11:49

"Appears to have been seen."

There's no letter. What does US mean?

A. Ultrasound. 11:50

111 Q. Ultrasound?

A. It's the ultrasound request. The form that would go in with it? Not form, but electronically.

112 Q. Michael Young says: 11:50

"I would suggest this is not serious but the patient and GP are not in the loop."

I think he is suggesting not that the issue is not

serious but that the patient isn't in a serious predicament, but that the patient nor the GP are in the loop, assumedly because -- they are not in the loop, I should say, assumedly because there's been no outcome from the clinic? 11:50

A. And ultimately no letter, either.

113 Q. Yes. So the options are put on to the AOB review clinic, so this is probably what AOB is thinking or send an e-mail to AOB asking for his outcome of the consultation and if no response gained then patient 11:51 will be added to one of his clinics.

When you say in your witness statement that it was starting to emerge in 2015 that Mr. O'Brien wasn't dealing with patient-centre letters and outcomes, have 11:51 I interpreted that e-mail chain as being akin to what you are referring to?

A. Yes.

114 Q. Is that an example?

A. Yes. 11:51

115 Q. I ask that, because upon perusal of the documents, that issue is difficult to spot in a documentary form. We don't see other examples. We could be wrong and obviously if there are other examples in e-mail chains or whatever, others might draw them to our attention. 11:52 You put your knowledge of this issue in the context of other consultants reviewing what were Mr. O'Brien's files for a validation exercise and this information, this concern emerging through Mrs. Trouton and then on

to you, perhaps?

A. That was my recollection of how it came about. You know, I don't recall seeing that e-mail until ultimately with the witness bundle, but it was around about that time that it was -- in fact, it was in December, mid-December probably or mid to late December that I was made aware of several issues that it was now felt that, look, we have to tackle this, we can't be softly softly. 11:52

116 Q. By this stage in 2000, the late end of 2015, there was a new Medical Director in post? 11:53

A. Yes, he had come into post that summer.

117 Q. Dr. Richard Wright?

A. Correct.

118 Q. And he had replaced? 11:53

A. John Simpson.

119 Q. Yes. In terms of -- you and Mrs. Trouton decide that you would meet with Mr. Wright or Dr. Wright?

A. I can't recall exactly the steps of what way that happened. I know that, having discussed with Heather we felt this needs escalated, this needs dealt with. In one sense, I wonder -- I felt that we had cut to Esther Gishkori before I approached Richard Wright and yet, at the same time, I can't be sure that we did. Essentially Heather and I discussed it and we felt it had to go further and we decided to take advice from Dr. Wright. 11:53 11:54

120 Q. What was the driver for going to Dr. Wright? I think you're right, there was a meeting with Esther Gishkori

but what in substance was the reason for, after so much time having passed without a formal initiative, what was the driver --

A. There were now -- the patient letter centre -- patient centre letters, the letter dictated at clinics and outcomes, that was a new thing. The triage was up around a couple of hundred while it was done, so it was a combination of it. I don't know that we said this is the one reason why; it was when you looked at -- there's several major issues now here that we need to deal with, and I think that was why. 11:54 11:55

121 Q. Mm-hmm. Was the patient centre dictation issue, was that qualitatively more significant than any of the other issues?

A. I would think so, yes. Personally, I would put that in the higher one, yes. 11:55

122 Q. And why, could you explain that for us?

A. Well, if a patient was seen at a clinic and you don't know what's happening to them, then what's the point in being seen at the clinic in the first place? There's no idea of what the Consultant's view of the patient was, what their plan was, what the management plan was, none of that existed, and that, I think, then, left a complete -- people in complete limbo as regards what was going on. By this stage we were using electronic care record so letters like that would have appeared on the Northern Ireland Electronic Care Record which means if you don't have a patient's paper records as not unusually happens nowadays, we have the letters online 11:55 11:55

and we can see what's happening and what's been done in the past.

123 Q. Did you discuss that particular issue with any of the consultants who were discovering the problem?

A. That had been reported through to me by Heather so I did not directly talk to them about it. 11:56

124 Q. Your meeting with Dr. Wright, people have said, I have seen in a couple of statements, the thinking is that that occurred in January?

A. I believe I talked to him in December and he said he'd meet us in January. 11:57

125 Q. Yes. Who went to that meeting?

A. Heather Trouton, myself, and I can't remember who else was there, if anybody else was there. And Richard Wright obviously, yes. 11:57

126 Q. Yes. That was something of a milestone meeting, in the sense that you were going to the Medical Director for the specific purpose of drawing his attention to a range of concerns in the practice of Mr. O'Brien?

A. Yes. 11:57

127 Q. This was a new departure, you hadn't taken this initiative for the previous Medical Director?

A. No, no, not in the formal sense. Triaging had been mentioned in the past with him but not, as I said before, not that I raised it as a particular concern. 11:57 I just mentioned some of the issues we were having in Urology, other issues we had -- and there were just kind of a synopsis of what was going on. That was a formal, when I say formal, that was we raised as

a specific problem or set of problems that we wanted to discuss that we felt needed escalated.

128 Q. Yes. I have called it a milestone meeting, I think you would tend to agree with me. No record of that meeting made by anyone? 11:58

A. No. Not that I know of.

129 Q. Not by you, anyway?

A. No.

130 Q. Any reason for that? Should it have been recorded?

A. I can't give you a straight answer. It would be nice to have had it recorded. On reflection it would have. A lot of our meetings were not recorded. The assistance was not provided for recorded meetings, a lot of meetings that were held, technically I suppose this was informal although he did come up to the 11:58 11:59 hospital, but it's not a formal meeting that there was an agenda went out, which those meetings tended to be minuted. And that's something, you know, as -- the AMDs did not have that sort of support for their role to have people take minutes at meetings that they were at and to follow up on actions. 11:59

131 Q. In terms of bringing these issues to this Medical Director, the fact that there was a new issue, so far as you were concerned, the patient centred dictation issue, if that issue, coupled with the others, had arisen, say, during the time of Mr. Simpson's reign as Medical Director, do you think you would have been making the same approach? 11:59

A. I think we would have.

132 Q. In other words, would you have felt encouraged to make that approach to previous Medical Directors?
A. I would -- I think there was enough at that stage that we -- you know, I suppose we didn't have a choice but do you know what I mean, it is obvious by then we needed to progress it. If it had been with Dr. Simpson I think with that amount of information, we would have gone ahead as well. 12:00
133 Q. Yes. In other words, there would have been no inhibition to you bringing that kind of information to any of the previous Medical Directors? 12:00
A. No.
134 Q. What was your objective in going to see Dr. Wright? What was the purpose?
A. Get his advice on what to do and how to manage it, and I suppose at the same time it also meant then that I was covered from the point of view of the previous issue which I had mentioned about the bullying and harassment so that I had cover from that point of view, that I was being given advice on what to do and not just starting something myself. 12:00 12:01
135 Q. Was that a conscious thought?
A. It would have been, yes. I can't specifically remember now, but that would have featured definitely in my thinking. 12:01
136 Q. In terms of the items of concern in relation to Mr. O'Brien that you drew to Dr. Wright's attention, was it simply the new issue or did you outline some background to him?

A. The background to how Aidan O'Brien had practised and worked over the time was mentioned and discussed but the issues that were raised were the triaging, patient centred letters and that there were the notes at home, there appeared to be an increased problem with that. 12:01
As I mentioned in my statement, I can't recall that we specifically raised with him the issue about validating of review backlog. I think that was added in about March time, by the time of the letter.

137 Q. Yes. Would you have mentioned to Dr. Wright your 12:02
concern about the bullying and harassment allegation?

A. I don't recall if I did or not.

138 Q. Yes.

A. I don't know that I did, but I can't recall if I did or not. I think I didn't, but I don't know. 12:02

139 Q. Would Dr. Wright have been apprised of the, if you like, historic attempts to get to grips with some of these issues on an informal basis?

A. My recollection is we had been dealing with triage for years, the patient centred letters and outcomes, they 12:02
weren't a long-standing issue but I can't remember what was mentioned there. Then the notes at home was an increasing problem.

140 Q. Dr. Wright says -- just pull up his witness statement briefly, WIT-17863. At paragraph 37.1, I'm conscious 12:03
that there's a mistake in the date, he says:

"Once Mr. Haynes was appointed as Associate Medical Director in the autumn of 2016" -- that should be

2017 -- "... I have confidence that professional issues were being appropriately escalated to me. Prior to that it now seems clear that such issues were not being properly highlighted with a turnover the Associate Medical Directors and Assistant Directors in the month preceding this was not helpful for continuity of approach."

If I could just bring up one other reference in this kind of context? WIT-17876. He says: 12:04

"I was not aware of significant problems within team Urology until early September 2016, when Mr. Haynes highlighted the issues around the patient administration performance of Mr. O'Brien. These had come to the fore because Mr. O'Brien was on sick leave and the Directors had appropriately arranged for his patients to be reviewed by other consultants." 12:04

Obviously I asked Dr. Wright about that. Having met him in December or spoke to him in December '15 and met him in January '16, what's your perspective on the degree of detail and coverage of the issues concerning Mr. O'Brien? 12:04

A. I believe I forwarded him a copy of the letter. 12:05

141 Q. That was in March, that's right?

A. Yes. So I mean, he was informed -- he was forwarded a copy of the letter which we had sent which he had instructed us to do. He advised us to go back to get

the facts rechecked, to tabulate it, to put them in a letter to Mr. O'Brien and start the process with Mr. O'Brien to see what plan he would have to resolve it.

142 Q. Yes. 12:05

A. And we followed his instructions.

143 Q. Yes. As you have said in your witness statement, he provided you with directions or advice as to what would come next. What was that direction and advice?

A. The advice was to produce -- to recheck the facts, 12:06 produce a letter, give it to Mr. O'Brien and ask him to respond to it.

144 Q. You have said in your witness statement that, just the reference is WIT-14764, paragraph 30, we don't need to put it up, but you do not consider that the process 12:06 which you were now engaged in, moving to a meeting with Mr. O'Brien in March 2016 with the letter, you don't consider that that was an outworking of the MHPS process?

A. It may have been Dr. Wright's thinking of that but he 12:06 did not say to us that this was the first stage or working towards MHPS, so it was not part of MHPS.

145 Q. It's fair to say that it was, in your mind, a process or it had a formality in terms of attempting to tackle these issues that hadn't been in place before? 12:07

A. Yes, and to do it on a more formal basis than conversations in corridors, et cetera.

146 Q. Mm-hmm. We can see TRU-277940, that on 18th January, presumably some time after your meeting with

Dr. Wright, that Martina Corrigan is writing to you and Mrs. Trouton --

A. Yes.

147 Q. -- with a draft of a letter. She apologises for not getting it to you sooner. She wanted to rerun and update the information before including this in the correspondence. She wasn't sure if it was to be a joint letter, and she's putting it over to yourself and Mrs. Trouton to approve. 12:08

12:08

Scrolling up the page. It's 16th March before you have gone through this letter, it seems:

"Eamon went through this today. Would it be possible to just refresh the latest figures so that we can send?" 12:08

Why the lack or apparent lack of urgency, Mr. Mackle? Two months have passed. It was December when you first sought a meeting with Dr. Wright, and even at this stage you are looking to update figures rather than just get on with sending the letter. Can you recall the lack of urgency? 12:09

A. I can't give you a straight answer on that one, I cannot recall, no. 12:09

148 Q. You meet with Mrs. Gishkori on 21st March. If we look at TRU-277941, we can see at the top of the page the date, I understand this to be her note:

"One-to-one, Esther and Eamon"

Scrolling down the page, it says: "Need to get letter to AOB this week."

Was she impatient for the issue to be addressed? Or should I say was she anxious for the issue to be addressed as quickly as possible?

A. I can only say from reading her note of what she was asking about, yes. I can't specifically recall the meeting, but, yes. 12:10

149 Q. If we look at the letter that emerged then finally. It's at TRU-282023. Is it your understanding that Martina Corrigan drafted the letter?

A. I think she did, yes. I think I may have said in my statement at one stage Heather drafted it, but I think it was Martina. Basically Martina and Heather did the principal between the drafting of it, yes. 12:11

150 Q. In terms of input, this letter didn't go back through the Medical Director's office, it was essentially with the Directorate -- 12:11

A. Yes.

151 Q. -- to progress it, having received Dr. Wright's advice?

A. Yes. It went to the Medical Director's office on 30th March. 12:11

152 Q. No consideration given to taking Human Resources' advice?

A. Medical Director didn't advise me to.

153 Q. In terms of this letter you intended would be handed,

and was handed, to Mr. O'Brien at the meeting which took place I think on 30th March. What was your objective with that meeting and with the letter?

A. It was to spell out in writing to Mr. O'Brien, as you know, what the issues were, what needed done, and that we required a plan for how it would be tackled, or they would be tackled. 12:12

154 Q. Yes. You were prepared to attend the meeting, notwithstanding the concerns of bullying and harassment that we have discussed? 12:12

A. I was being accompanied. I wouldn't had held that meeting on my own.

155 Q. Yes. You were accompanied by Martina Corrigan?

A. Yes.

156 Q. Do you know why the -- 12:13

A. I can't recall.

157 Q. -- the Assistant Director didn't attend?

A. I expected you were going to ask me that. I don't recall why.

158 Q. In terms of the, I suppose, hierarchy or the power dynamics, were you comfortable that it was the Head of Service and not somebody at Director level or Assistant Director level who accompanied you? 12:13

A. I was happy having somebody there who could vouch for my behaviour during the meeting. 12:13

159 Q. In terms of the conduct of the meeting was it you who did the speaking as opposed to Mrs. Corrigan?

A. Yes.

160 Q. So you led on the issues from a management perspective?

A. Yes, yes.
161 Q. Where did the meeting take place?
A. I believe it was the -- there's -- opposite corner from the Acute Director's office is an AMD -- in those days it was an AMD office. 12:14
162 Q. Was it formal in the sense that you came in and sat down and conducted the meeting with those kind of niceties?
A. I can't recall exactly how we did, exactly that but yes, I had planned this as a formal meeting and I had 12:14
thought about it, you know, beforehand.
163 Q. Yes.
A. About how I'd do it, and present it to him.
164 Q. Yes. I'm not sure I have seen the invitation that must have communicated to Mr. O'Brien the need for 12:14
a meeting. I am not sure if we have that.
A. I have not seen it in my bundles so I can't recall.
165 Q. Yes. Do you know whether he was informed in advance as to the purpose of the meeting?
A. I don't recall, no. 12:14
166 Q. You've said in your witness statement, and if we pull up WIT-14785, at paragraph 33. You thanked him for coming and explained that you had a letter to discuss with him.
12:15
Upon informing him of the issues I asked him to respond a commitment to address the issues and to produce a plan to address all of the issues. Aidan took the letter and my recollection is that all he then said was

he would have to consider the points in the letter. I believe I also asked him to let us know if he needed any help."

A. I can't -- I will be honest now, I have reflected on this at different times. That last sentence I can't recall if I actually did ask him or not. If he had asked or had spoken to me I had planned to say something like that, let us know, if he had said how am I going to cope with this, I would have been saying that in my planning for the meeting, but, to be honest, I know I put that down there but I can't say categorically that I actually did ask him. 12:15 12:16

167 Q. Yes. That's helpful. Just set against that what you said in your account to Dr. Chada back in 2017 as part of her MHPS investigation. If we go to TRU-00770, paragraph 21. You say as it's phrased here: 12:16

"On 24th March 2016 a letter was sent to Mr. O'Brien regarding concerns about triage backlog letters not being done and notes at home. As AMD I took the letter and went to speak with Mr. O'Brien. I didn't go through the letter but it set out to him the actions he needed to take and I asked him to address the issues. We did not discuss any supports to address the issues. My role as AMD ceased around this time and so I was not involved in the follow-up after the letter went." 12:17 12:17

Just a couple of points about that. It says on 24th March a letter was sent to Mr. O'Brien?

A. No.
168 Q. Do you think that's right?
A. No, it wasn't. There was a formal meeting.
169 Q. Yes. Your recollection is bringing the letter to the meeting and handing it to him? 12:18
A. Yes.
170 Q. That would have been his first sight of the letter?
A. My recollection is I said there are issues, just the bullet points that are there 1 to 4, not -- I don't recall reading the letter out to him. 12:18
171 Q. Yes.
A. But said there are issues regarding the -- in fact I think -- I probably but I can't confirm whether I did or not, but I think I probably read out the first paragraph effectively of what was said there, but said 12:18 there were several issues that we have concerns about and these are what they are.
172 Q. Yes.
A. I handed him the letter and he, if I recall rightly he just folded it and put it in his pocket. 12:18
173 Q. Yes. Just on that point, the letter, it wasn't sent to him in advance?
A. No.
174 Q. It was given to him at the meeting?
A. Yes. 12:18
175 Q. You, in essence, outlined the points in the letter, the four bullet points, if you like, or the four issues?
A. Yes.
176 Q. As you said here, "we did not discuss any supports to

address the issues". Just by contrast with what you have said in your statement?

A. I know.

177 Q. "I believe I asked him if he needed any help." It appears, on the basis of a more contemporaneous statement to MHPS, that supports weren't discussed? 12:19

A. No, I don't believe -- I don't recall them being discussed. Equally, I don't recall being asked.

178 Q. Yes. We will come to Mr. O'Brien's response in a moment. But in terms of the letter itself, if we go back to TRU-282023. We can just scroll down. The issues are un-triaged Outpatient referral letters, you put the statistic of 253 backdated to December are outstanding, December 2014. Nothing specific there about what needs to be done to get this on a proper footing, it's a description of factually, of where you are at? 12:19 12:20

A. Yes.

179 Q. Then if you go down to the current review backlog. Just on that issue, Mr. O'Brien, in common with other consultants, had a backlog in his review list? 12:20

A. Mmm.

180 Q. That's not an issue that was ever taken forward as part of MHPS?

A. No. 12:20

181 Q. The issue, as I understand it, and help me with this if you can, was that there was a need to validate that backlog list to ascertain whether those on the list were properly on the list and the degree of urgency

with which they needed to be seen?
A. Yes.
182 Q. What was the concern around that?
A. As I said, I don't recall discussing that, you know, with Dr. Wright. That was something that Martina and Heather I think felt was an issue as well that should be put down, so it went into the letter. I didn't object to it being in the letter, I don't disagree with it being in the letter, but it was not something which had originally been discussed with Dr. Wright as an issue. 12:21
183 Q. Are you saying that although it went into the letter it wasn't an issue that had been flagged as a significant concern with you in advance?
A. I don't think -- well, not that I can recall. 12:22
184 Q. But it ends with the requirement for him to put a plan on how these patients will be validated and proposals to address the backlog?
A. Yes.
185 Q. That's what you were asking him? 12:22
A. Yes.
186 Q. Scrolling down, there's a reference then to the patient-centred letters and a description of the issue there, and it ends with:

12:22

"This lack of documentation combined with no record of clinic outcome means further investigations or follow-up may not be organised by admin staff."

Again, no specific detail there about what is expected of him?

A. No.

187 Q. Then: "Patient notes at home, needs addressed urgently and brought back to the hospital without further delay." 12:23

Then the letter ends with: "You will appreciate that we must address this governance issues and therefore we would request that you respond with a commitment and immediate plan to address the above as soon as possible." 12:23

I suppose in terms of a target or a specific requirement, it was an immediate plan. Was that further fleshed out at the meeting, to the best of your recollection? 12:23

A. No.

188 Q. Was he given a date or a timetable within which to produce this? 12:23

A. No.

189 Q. In light of the history of informality and commitment to change and changes made and then falling off on certain issues such as triage and what have you, do you now recognise that, in the absence of a fixed timetable, compliance with what you were asking was going to be difficult? 12:24

A. Yes.

190 Q. Why was there not a specific timetable?

A. I can't give you a straight answer. I can't recall why we didn't put a timetable down. I just don't remember or recall why.

191 Q. Was this simply a box-ticking exercise?

A. No, it was, in a sense for us, as had been advised by Richard Wright, putting a line in the sand of where we were so therefore from now on we will have a written set-up of where we where were, for future follow-up what's happened to that, and for that reason. 12:24

192 Q. If it wasn't a box-ticking exercise, was there discussion amongst you, that is with Mrs. Trouton, Mrs. Gishkori, Mrs. Corrigan, about what would necessarily have to happen next if Mr. O'Brien didn't produce an immediate plan? 12:25

A. I expected that we would be back to Richard Wright for further advice. 12:25

193 Q. Who did you expect would go to Richard Wright for further advice?

A. The AMD, me.

194 Q. You obviously didn't do that? 12:25

A. No.

195 Q. You sent him a copy of the letter, isn't that right?

A. Yes.

196 Q. You told him that you had met with Mr. O'Brien?

A. Yes. 12:26

197 Q. Did he seek any further feedback from you beyond that?

A. No. There was, I think Simon Gibson on his behalf some months later did, but not at that time.

198 Q. Did Simon Gibson speak to you some months later in

relation to it?

A. There was an e-mail from Simon Gibson I know, but I can't remember if Simon Gibson spoke to me at that stage about maybe about six months later.

199 Q. Mr. O'Brien recalls that at the meeting he asked you what should be done to address the situation which you were particularising for him, and his recollection is that you shrugged your shoulders and didn't provide any indication that support would be available to help him navigate these issues? 12:26 12:27

A. I would have been very careful of my body language for that meeting. I would not have just been shrugging my shoulders if I had been asked.

200 Q. Mm-hmm. Have you a recollection of how long the meeting lasted? 12:27

A. It was a short meeting if I remember right, but I can't tell you exactly how short.

201 Q. Did he engage on the issues?

A. There was no discussion from him to explain why any one issue was an issue. As I recall, he took the letter, I read the bullet points, he took the letter and then basically folded it up and put it in his pocket. I think, I think he may have said something like he'd consider it, but I can't recall exactly what he said at the end. But he did not go through the letter in any detail or offer any explanation. 12:27 12:28

202 Q. Yes. So apart from you saying that he would consider it, is there anything else you can offer the Inquiry in terms of his response to it? We know what you have

said in broad terms?

A. Yes.

203 Q. But in terms of his response to it, 'I will consider it'?

A. I think that was all he said, something like that. 12:28

204 Q. You had spoken earlier in your evidence about leaving the post, Dr. McAllister taking over. Dr. McAllister and you worked closely together. You would have had an informal verbal handover to him?

A. Yes. 12:29

205 Q. I forget whether I asked you this last week, but would he have been advised that Mr. O'Brien's practice was causing concern and that you were fresh from a meeting with Mr. O'Brien at which a letter calling for a plan had been handed over? 12:29

A. I think actually it was even before that. I think he knew we were going to, you know. Charlie McAllister and myself operated on a Tuesday while he was my anaesthetist, and as the AMD for Anaesthetics we had conversations as friends, colleagues and that, and we 12:29 had conversations about issues within the Directorate, yes, over not just at the end of -- I mean, over a long period of time we had, so he was aware.

206 Q. Yes. Did you build on that with him, and, for example, say this needs followed up. We have left him with the 12:30 letter. We are expecting a plan. If he doesn't produce a plan, it needs action?

A. I can't remember what way. It was a verbal handover but I cannot remember exactly what happened at that

handover, I don't know if he can, but I can't, I'm sorry.

207 Q. We know, as you suggested, six months later Simon Gibson is, at Dr. Wright's direction, carrying out further work around Mr. O'Brien's practice. Just to be clear, you had no further engagement with Dr. Wright after the meeting, apart from sending a copy of the letter to him? 12:30

A. No.

208 Q. Zoe Parks was the HR officer with responsibility for clinicians and medical practices, that was her area? 12:31

A. Yes.

209 Q. Could I ask you for your reflections on what she has said. WIT-90076. At paragraph 38.3 she is saying that -- she is acknowledging that the letter was issued to Mr. O'Brien in March 2016. She says that she understands that HR were not informed of these concerns giving rise to the letter at the time. She was on maternity leave at that juncture. At 38.3 she says: 12:32

"I believe that this initial concern should have prompted immediate preliminary inquiries by the clinical manager to take a deeper dive and scope to establish the full nature of the concern. The fundamental consideration within the MHPS Framework is the continued safety of patients and the public. Action when a concern first arises requires the Clinical Manager to consider if urgent action needs to be taken to protect the patients and if a precautionary 12:32

restriction or exclusion on practice is required until they can clarify the nature of the concern. The key governance question I am asking is that no-one seemed to understand to take accountability for determining the full extent of the problem to ensure any necessary protective measures for patients could be put in place immediately and properly monitored." 12:33

The thrust of her concerns appears to be that you were going to Mr. O'Brien on the basis of what you knew to be wrong. 12:33

A. Yes.

210 Q. You identified four issues and set those out, but here was a fork in the road or a milestone opportunity to look deeper and fully identify, or more fully identify issues of concern. She has a point, doesn't she? 12:34

A. Oh, yes, she does. As I said earlier, I mean, I did not recall MHPS. I didn't recall it at the time. Heather Trouton and I approached the Medical Director for his advice and we followed his advice, and he did not suggest that we approach HR or utilise the MHPS process, MHPS process. 12:34

211 Q. Mm-hmm. Part of this, Mr. Mackle, I wonder would you agree, part of this is a lack of appreciation, or perhaps suspicion on the part of management, that there could be other issues here, allied to perhaps an assumption that there are no patients coming to any particular harm here. Is that an explanation as to why this was kept so narrow in terms of what was presented 12:35

to Mr. O'Brien?

A. Well, no. I mean, I think those were the main issues that we had raised with Dr. Wright as ongoing things. We took the patient outcomes, we saw that as -- and patient dictation as a significant issue. The number of charts that were not, you know, that he had at home, were then proceeded to be significantly higher than perhaps what people had originally considered. I think it was in those grounds it was being dealt with, those were the issues -- the issues there were then and the triaging, they were the issues that were seen to be the pertinent issues. As I said we approached Dr. Wright. He gave us advice on what to do. But even if I had recalled MHPS, with the previous allegation of bullying and harassment I personally would not have instigated, and even if there had been no issue of bullying and harassment I don't think there's any other AMD or CD in the hospital would directly start an MHPS process without having discussed with the Medical Director beforehand what they are going to do. 12:35 12:36 12:36 12:36

212 Q. But leaving the niceties of MHPS to one side, I mean, if you go back over the history of this, and we have explored it over the last day-and-a-half, if you join the dots between IV antibiotics and Mr. O'Brien's response to that and not complying with the rules, at least initially, according to your evidence? 12:37

A. Yes.

213 Q. Patient Safety issue, triage, as you now recognise, a Patient Safety issue, keeping records at home, which

is symptomatic of limited dictation from clinics, and so we go on, the failure to action results from investigations, told that he should do it and responding to it in a way which you've indicated was obstructive, if you join all of that together and then read what Zoe Parks has said, it's quite clear whether this is Dr. Wright's blind spot as well, but there was a managerial blind spot in failing to recognise the need for a deeper approach? 12:38

A. As you say, yes. I mean, the -- what's it -- the IV antibiotics, IV fluids antibiotics, Medical Director`s instructions on what to do, the cystectomies, the Medical Director's instructions what to do, notes we did follow up with HR at that stage, the review of results of investigations, there was, you know, Dr. Rankin did produce and everybody had to review them and secretaries weren't allowed to file them until they had been initialled or signed, and then this, we were advised by Dr. Wright on what to do. 12:38

214 Q. Mmm. 12:39

A. What I'm saying is, yes, there was a collective issue here, I don't deny that, I think collectively we failed. I think we should have picked up on more, more should have been actioned.

215 Q. But it's in the response from Mr. O'Brien that perhaps your suspicions ought to have been raised. As your evidence suggests, IV antibiotics raised with him, and it takes a considerable period of time to achieve compliance? 12:39

A. Yeah.

216 Q. Actioning results, issues drawn to his attention and he pushes back on it. Triage, notes and records, all these issues received an element of non-compliance or pushback, and then this new issue arises, at least new to you, at the end of 2015 when you see that there's no dictation or limited dictation from clinics. Is it not in that context when you see non-compliance or limited compliance that suspicions should have arisen about other aspects of his practice? 12:40

A. Knowing what we know now, yes. My understanding is the MHPS process didn't throw up some of it either, that it didn't work in that respect either. It's easy, with hindsight, to say that, and I don't disagree with you. But at the time, kind of, you deal with one issue as it comes along, and we didn't join up all the dots as you were suggesting. 12:41

217 Q. Dr. Wright's perspective is set out at WIT-17866. At paragraph 42.2 he says in his opinion it seems that there was significant data available regarding many of the key issues and, as he sees the issue, the main factor was a reluctance to formally address the issues identified rather than a lack of data. Do you agree with that? 12:41

A. Reluctance, you know, as it's written it says there's a reluctance to formally address the issues. The issues were identified to him as well. You know. And the past issues were identified to him, and in that respect, once he was not saying to do anything more 12:42

formal with regards to the issues, I admit I was not going to raise that and say no, I want it to go formal.

218 Q. I suppose from his perspective is when it is brought to his attention the advice from him is to bring this element of formality into it? 12:42

A. There's that formality, yes.

219 Q. But he is standing back looking at it from the perspective of the period before he came into post and before these issues were drawn to his attention, so within the Directorate, of which you were AMD, he is 12:43 seeing lots of informality and non-compliance and a reluctance, as he puts it, to address it formally, for whatever reason?

A. But the issues that had been addressed in the past were given to him as background, so when we met with him in 12:43 January he was informed of the issues in the background.

220 Q. Yes.

A. Sorry, in the past.

221 Q. Yes. And his point is, you went at those issues 12:43 informally and ineffectually because there was a reluctance and this is the question I'm directing to you. Was there a reluctance before he came into post and you approached him, was there a reluctance on your part and on your management team's part to address this 12:43 formally?

A. Well, not -- well, the reluctance -- you know, the first ones I mentioned earlier, the notes was formally addressed. Cystectomies, IV fluids, they were all

Medical Director involvement and managing it, and perhaps that set the tone for how things should be managed after that. So it wasn't that we -- I did say earlier though where Aidan was concerned he was considered a good clinician and hard-working, that coloured how we looked at him rather than saying we were reluctant to do anything formally it did colour how we looked at him and how we assessed the issues as they arose, because he was considered to be an excellent clinician. 12:44

222 Q. It wasn't so much a reluctance, in fact it was an interpretation of how he practised that while there are some problems here, they are not terribly serious, he has other attributes and, therefore, that becomes the reason for not challenging him? 12:45

A. I think that would probably be more than reluctance.

223 Q. MHPS as a process. Just finally. You didn't have MHPS in mind in any of your dealings with --

A. No.

224 Q. -- Mr. O'Brien? If you were suggesting to this Inquiry what might be improved around the use or the awareness of this process, as a means with other managerial tools to address difficulties with clinicians, what would you say? 12:45

A. As I say, I accept I had been on a form of training for MHPS back in, as I said, 2008, for the Western Trust but that was never utilised, that was never put into practice. I think updates in that respect, I think whether somebody from HR attends the governance 12:45

meetings when they are being held, the Directorate governance just to hear the issues that are there, I think that input from HR would be, and also in highlighting when we should be using other processes. By utilising only the Medical Director we took the Medical Director's advice as being the ultimate way in how to handle things, but I think that's something we should have been -- not something that should have been -- I think that's something that could be improved. I think support for the Associate Medical Director, I had a lot of support from Heather Trouton and the Heads of Service, I'm not saying in that respect but from a managerial support point of view, as AMD issues perhaps there should be somebody there to support them the way the Medical Director had at that stage, for example, Anne Brennan to support him, and later on Simon Gibson, someone who would support the AMD, not just one AMD but several AMDs in their role so if issues did arise they would be the ones to see things were followed up and actioned, et cetera, from a clinical point of view that weren't necessarily operational. 12:46 12:46 12:47 12:47

225 Q. When you reflect in terms of your own personal exercise of managerial responsibility around Mr. O'Brien, and particularly in light of the issues that are now reported by the Trust as being issues of concern, have you any other reflections about the lessons that you have learned as an AMD in relation to how these issues should be handled? 12:47

A. I think the role as it existed then was significant and large. I had a full clinician's role as well as covering the general surgery in emergencies, I had sub-specialties in oesophagogastric surgery and colorectal, that was my prime reason for doing medicine, for doing surgery, was that aspect of it. The AMD role was on top of that but I think the amount of time I had available probably -- not probably, didn't allow me to fulfil it to the best of my abilities or maybe to the best the post expected. I think there is a potential issue in having AMDs who are full clinicians whose post dictates that they need to have a full clinical role, a full-time clinical role. If I had been, for example, just a subspeciality and not an emergency role, et cetera, that might have allowed me a lot more time to devote to it, but I think that's one of the issues of having AMDs who are full-time clinicians. There are advantages, but I think there are also significant disadvantages as happened in my case, with time. 12:48 12:48 12:49 12:49

226 Q. Okay. Very well, thank you, Mr. Mackle, for your answers. I understand that the Panel will have some questions for you.

MR. EAMON MACKLE WAS QUESTION BY THE PANEL AS FOLLOWS: 12:49

CHAIR: Yes, thank you, Mr. Mackle, for your evidence. We will all have separate questions to ask you. I am going to go back to things you said, but if you can

just deal first of all with the lack of knowledge that you are expressing about the MHPS procedure and even it being on your radar as a tool in your toolkit to deal as a manager with clinicians. Frankly, I have to express the view that I find that surprising. If I consider other professions, other professions would know what might happen to them if they were not compliant with rules and regulations of their profession, for example. I just wonder do doctors generally not know about MHPS and the fact that it could be used, not just as a disciplinary tool but also as a tool for their benefit? 12:50 12:50

A. I can't give you a straight answer of what people thought of it. I think they probably have been perceived by many as being disciplinary rather than supportive. I think that aspect I don't think has been fully emphasised to medical managers about their roles in that aspect. I think information if -- knowledge, if it's not used or updated, it tends to get forgotten, and I think that is also an issue with it. I think perhaps in approximately 2008 when I had that training it was mentioned in that aspect, but when none of that was being used or utilised it did forgotten. I can't speak for all the other AMDs on their knowledge or issues with, or perhaps they had issues that had already been enacted under their flag and therefore -- 12:50 12:51 12:51

227 Q. More familiar with it?

A. Yes. So I'm sorry, I can't answer you more clearly than that.

228 Q. Thank you. Just going back you said yesterday that you were asked to apply for the AMD role. Can you recall who that was that approached you and said you should apply for this?

A. It was either Debbie Burns or Mairéad McAlinden or it may have been Debbie saying that Mairéad it suggested, I think it might be that way around. Although Mairéad McAlinden was not the Chief Executive at the time, it was Colm Donaghy, but I think it was between the two of them but I can't remember which one specifically said it. 12:51 12:52

229 Q. When you did apply were you aware of who else had applied?

A. Yes.

230 Q. Was there was a process then that was gone through with everybody yesterday and all of that? 12:52

A. Yes.

231 Q. I am sort of jumping between topics here, but looking at the quality of service, you say that essentially in terms took a back seat to output in terms of performance numbers, target dates and that kind of thing, and I just wondered where did that pressure to meet the targets come from? Was it external, was it internal, and why then did it have such an effect on an assessment of the quality? 12:52 12:53

A. As I said, I think there was a major focus on performance. That was fed to us through, we refer to it as down the hill, which is Trust headquarters, it came from Trust headquarters but the whole issue of

performance, how much pressure they were under from service delivery unit, I can't tell you. I don't know. I wouldn't be able to answer that.

232 Q. In terms of the focus then being on meeting target dates, for example, did that take precedence over all other aspects of it? 12:53

A. No, it wasn't that it took precedence -- well it took up a significant amount of time, I suppose, rather than precedence, if you know what I mean. It reduced the amount of time available. 12:53

233 Q. Okay. Sort of connected to that there's the issue of audits and what you have described were ad hoc audits --

A. Mm-hmm.

234 Q. -- that were carried out by junior doctors? 12:53

A. Clinical audits.

235 Q. Am I right then there was nothing targeted from above from managerial strata above you or indeed by yourself to the clinicians, to the departments, to the services, to say we need an audit on this? 12:54

A. Not that I know of. There were -- what was it? There was a workload audits -- sorry, the Trust -- I can't remember the name of the exact thing it was, but you got feedback on how much workload you were doing compared to other Trusts, your length of stay, your number of day cases, things like that. CHPS is what it was. That was a standard thing that came out but there weren't -- I don't recall a lot of other audits being commissioned by the Trust to look at patient pathways, 12:54

things -- except when they are setting up a new service or developing a service, there was work put into patient pathway at that time but not after it was set up.

236 Q. You yourself, as Assistant Medical Director, you didn't direct anybody to say I need some information about this particular aspect of the service? 12:55

A. We didn't have anyone to direct.

237 Q. The Head of Operations, for example?

A. From an audit point of view, I don't think -- well, I never would have thought of that because there was no -- we weren't told you have people here who will carry out specific audits if you want to carry out into your speciality or Directorate or whatever else, we weren't told we had that available. 12:55

238 Q. You wouldn't have thought to say to say I want to know how well the service is operating, how well the clinicians within the service are operating, and therefore the type of audit you describe being carried out on your behalf in terms of the triaging of your clinical specialty you didn't think to maybe roll that out across the other specialities to see whether there was a general issue? 12:55

A. Sorry, I have lost you. Apologies.

239 Q. Sorry. I think you talked about when there was work done that showed only a certain percentage of referrals were -- 12:56

A. Yes.

240 Q. You didn't think it was, for example, a useful exercise

to roll out in the other specialties of surgery?

A. We actually -- well that was basically the summary that we put in the article in the Ulster Medical Journal. It was an ad hoc article that I had suggested with Rob Spence, the Registrar we had at the time, who was working with me at the time, about doing it and he did it, and in it we did put at the end we felt there should be a review to see the benefit of triage et cetera. But it wasn't -- 12:56

241 Q. Was that something you could have directed as Associate Medical Director for the Craigavon Area Hospital, for example? 12:56

A. I don't think I would have been able to get that done. This work was done by Rob.

242 Q. I don't mean you yourself doing it -- 12:57

A. The statement was done by the Registrar. There was nobody -- there was nobody in admin there to help do all the work for him, so he did that himself.

243 Q. Okay. You talked about the Wednesday meetings. To what extent at those Wednesday meetings was there any discussion about issues with clinicians? 12:57

A. There would have been, as issues arose -- I can't remember all the specifics of it. Maybe Heather Trouton or that could explain better than I can or remember better than I can but if there were issues with specific consultants or that they were raised. 12:57

244 Q. But it wasn't a regular agenda meeting item, for example?

A. No, but each speciality was discussed and issues that

we would have had within the speciality rather than what the patients problem were there in the speciality.

245 Q. I suppose then that -- I will come back maybe to that question. Do you think that everyone knowing everyone else, as you say, and needing everyone else to rely on to help their own patients if that were needed, do you think that is a feature of Northern Irish hospitals compared to other hospitals, say? 12:58

A. I can't say about other hospitals but I think it is a feature of Northern Irish ones. 12:58

246 Q. Yes. I know we have heard statistics that 80 something percent of all doctors in Northern Ireland have gone throughout the same medical school and know each other?

A. I was about to say that because during the Troubles we didn't get inward investment from doctors elsewhere, it was not a feature. Now, yes, the medical school has lots of students from the UK who apply to Queens, but when I went through Queens, two Malaysians and four or six Norwegians, nobody from the South, one American but his dad had been at Queen's and that was it. There wasn't a collection of English. 12:58 12:59

247 Q. I think that might have been common across other faculties at that time. Has that led to a specific Northern Ireland medical culture that means that people are reluctant to criticise their colleagues or to challenge them? 12:59

A. I don't know. One of my roles was to challenge. I did that on the Monday evening meetings was challenge, and that was what -- you know, Gillian Rankin and I had

discussed, I think Heather as well, but Gillian discussed I would do the challenge, and that was not something I felt I couldn't do. Outside the formality, perhaps, but I couldn't -- I can't tell you what other people thought of it, you know, sorry. 13:00

248 Q. Mr. Wolfe was talking to you there at the end about Mr. O'Brien's response when issues were brought to his attention and how effective issues were dealt with. It seemed to me from your evidence that where there was eyewitness evidence, for example, he seemed to be 13:00 throwing the notes in the bin; where there's clear information about the IV fluids and that, is coming from objective evidence about that, that Mr. O'Brien seemed to accept that there was an issue, and his acceptance of it being perhaps inappropriate and 13:01 dealing with it was effective, yet whenever there is anecdotal evidence or he is not presented with objective evidence on a more formal basis, if you like, nothing happens. I just wondered if there is an importance or is there a lesson to be learned there 13:01 about the importance of having objective evidence about practices, not for Mr. O'Brien particularly but for all doctors?

A. I think, yes. I mean when you have objective evidence it is a fait accompli, it is there. People have to, 13:01 they can't ignore it. Well they can but it's not easy for them to ignore it.

249 Q. The second part of that question is in the role of Associate Medical Director, AMD, is it not necessary

for you to be able to carry out your role appropriately to have such objective evidence?

A. And to have -- yes, and to have objective evidence, I think that's where the MD role needs support, you know. I'm not saying each MD needs somebody to support them but somebody to support -- 13:02

250 Q. Someone to --

A. -- collective MDs.

251 Q. To pull all that information together and to present it to you so that you have that -- 13:02

A. Yes.

252 Q. -- as a basis?

A. As a formality of it rather than just, you know -- a lot of meetings that were had were corridor. I am not talking about with clinicians but even amongst the senior management, a lot of it was done in corridors. 13:02

253 Q. I suppose that brings me back to your point about time and whether you think it's appropriate for an Associate Medical Director to maybe have a part-time clinical role; I mean, you talk about the advantages of being a clinician in that role but would you see it as a semi-sabbatical, if you like, would be the appropriate way to deal with it in terms of a 50/50 split? 13:02

A. Well, if you are going to have -- I think if a clinician is going to do it they have to be in a role where they can reduce their clinical activity without reducing their clinical effectiveness and knowledge and skills. Anaesthetics is a prime example where I think 13:03

they can easily do it. They can go to half time and they still have half their sessions and are still doing anaesthetics. Surgery is not one of those one, unfortunately. It is very much a craft as well and you need to maintain those skills by practising it. Other specialties I think do lend themselves to it. I think it's very difficult for a surgeon to do the role and be effective as a manager and be a good clinician at the same time and a good surgeon. 13:03

254 Q. Can I just ask generally if, why do you think that -- I think you say that it was Mr. O'Brien supported by his colleagues. Why do you think that they did not see the advantage of moving to Team South, the reconstruction of the Urology Services? Surely if there was a risk if that was not implemented that Craigavon and Daisy Hill would lose its Urology service altogether? 13:04

A. I think -- oh they wanted the idea of Team South, I think they wanted an expansion, but it was the other issues that came with it were not appreciated, you know, actual, you know, admitting on the day of surgery, the use of pre-op, things like that. 13:04

255 Q. It was the practicalities of it, that was the issue rather than the actual --

A. They did want. 13:04

256 Q. -- advantage of it?

A. That was in the end why they approved the five job plan, they agreed their job plans at that stage because they realised they weren't going to get the extra

consultants if they weren't prepared to agree on the job plans.

257 Q. Okay. I just wondered, the impression is that having this allegation made against -- well it's not an impression, you say effectively you took a back seat in terms of dealing with Mr. O'Brien because of that allegation and you were advised to do so. I just wonder did you ever have to do that in respect of any other clinician for whom you had responsibility? 13:05

A. No, no. 13:05

258 Q. Another issue you talk a lot about Mr. O'Brien's reputation as extremely hard-working, a gentleman, who had time for everyone and was very highly thought of. I just wonder given that reputation, which presumably Mr. O'Brien himself must have been aware of, do you feel that that then made it difficult for him to show any weakness or vulnerabilities in terms of his practice? 13:06

A. I can't say what his reason was. I just don't know. It is a possibility, I accept what you are saying, it's a possibility, but I don't -- 13:06

259 Q. I know you can't speak for Mr. O'Brien and I'm not asking you to, but I am asking you, I suppose, as a medical manager with responsibility for clinicians and perhaps, you know, more generally if someone is highly thought of and is lauded by their colleagues and by their peers and by their superiors, does that then make it more difficult for that person in a general sense then to say, 'look, I am struggling here, I need 13:06

help, I can't manage to do what needs to be done in terms of my surgical responsibilities and my admin responsibilities'?

A. I think perhaps, and I am being broad in this, I think the nature of people who do surgery is you have to have a certain ego to do surgery and a self-confidence that you make decisions how to manage a patient and you follow it through, but you can't do this and spend ages dithering on it. I think maybe they attract that type of personality. 13:07

260 Q. So it's the nature of the beast really?

A. Yes. Which came first though, that's the question.

261 Q. As a surgeon yourself you perhaps would not have been best placed to see that somebody might have been struggling; would that be fair? 13:07

A. That might be, yeah, could easily be, and not just myself, the other surgeons as well.

262 Q. Okay. Just generally. Thank you Mr. Mackle. I have no further questions for you but I am sure Dr. Swart has, or Mr. Hanbury are you going to go first? 13:08

MR. HANBURY: I would also like to take you back to the regional review in 2009 and the Monday evening meetings. There are some couple of clinical things. Firstly the review backlog. Many Urology Departments have problems with Outpatients. What were your proposals, do you remember any details or recommendations? 13:08

A. One of the major problems we had with the backlog was the view ratio we had in the Trust, we were the worst

in the province, and one clinician was the worst of all of them.

263 Q. So what were your proposals?

A. We needed to improve the new to review ratio. One of the things that was introduced and certainly the unit pushed for this as well, the Belfast based, the commissioners effectively, that you would have so many reviews per new patient, but clinics were to be set up with a certain need to view ratio, that in itself hides the problem. Your backlog builds up but it hides you still have a need to review problem. Add in the fact that when they the unit waiting list wanted work done, and this is not just in Urology, this is in general surgery as well, they funded new patients but no reviews, so that created a review backlog as well. A general view of Urology was the number of consultants and the staff support they had, that was also another issue. That in itself was not a review backlog unless you said emergencies get dealt with, to the detriment of other patients. Part of it was the need to review ratio and how that was looked at. 13:08 13:09 13:09 13:09

264 Q. Moving on to admissions on the day, well for general surgery, what was the concern of the Urologists about why that might not be a good idea? Do you remember their objection? 13:10

A. The same problem I had with my colleagues, they have always brought them in the day before. It's convenient to bring patients in the day before. It gives you time to see them, make sure the consent is done. It was no

different, I think, between the Urologists and my own colleagues, they weren't keen to go down that route, they did -- and with encouragement, but they didn't automatically see it as an advantage to them in that there was no direct benefit to the clinician by 13:10
bringing the patients in on the morning of surgery as opposed to the day before. Yes, there is a benefit for the patient will sleep in their own bed the night before, and the bed throughput and everything else, but from a clinician's point of view it was less 13:10
convenient.

265 Q. Okay. Thank you. Also about the nine cystectomies, I mean one of the drivers in improving outcomes guidance was not do things you do less often, and Mr. Drake's analysis showed approximately 12 cases over 13:11
approximately a six-year period so the numbers are easy to calculate. Was there resistance, did you see resistance to stopping doing a benign cystectomy and --

A. Yes, the cystectomies -- sorry, my apologies.

266 Q. What was the resistance? 13:11

A. The resistance was that the review had detailed malignant, radical cystectomies was what was mentioned, not for benign disease. Okay, we can't do that but they haven't said we can't do that and not for the benign, that was the resistance, and they wanted to 13:11
continue to do it, that was checked with the commissioners and THEY came back and said no, you can't do them.

267 Q. And once that was established --

A. No, there was one patient, if I remember right, I don't want to mention her name, who did get operated on after that which I picked up, and then there's another edict came out saying they had to stop.

268 Q. Thank you. The next thing about review of results, both Radiology and Pathology we saw Patient 5 and 8 problems with missed results. I mean, you are a busy colorectal general surgeon, what would happen in your office when an unexpected malignant result would come through, would you pick that up or MDT? 13:12

A. Now if there is unexpected results coming from Radiology that is meant to be flagged as well by Radiology and that's --

269 Q. Back in the time?

A. No, Radiology didn't routinely contact people to say there's an issue. The results would have come back to my secretary. My secretary, who had been with me for years, would have looked at them and if she saw something obvious she would have flagged it up, but at the same time they sat on her desk until I went through them and initialled them to make sure there's nothing on them, and if there was anything on them then that was actioned accordingly and there would be further investigation, MDT or whatever. 13:12 13:13

270 Q. So it was up to you personally to pick that up? 13:13

A. Yes.

271 Q. Thank you. So pre-op assessment, obviously this worked for you on bringing patients in on the day, the Inquiry has been aware of two patients, 90 and 91, where the

lack of pre-op assessment had probably led to a poor surgical outcome. What would your comments be on the ease of referring patients through for pre-op assessment, was it automatic, did it work well, was the quality of the pre-op assessment when it was asked for? 13:13

A. Yes, I never had any problems with it. It was straightforward. You'd put them on a list to say they are for surgery and they get sent off to pre-op. My recollection is, my recollection is it went off to the clinic for pre-op assessment and then depending on when 13:14 theatre was going to happen, et cetera, maybe they had further tests or a further check at that stage. If we had somebody that I was concerned about, I would have either said they need seen urgently, or if I was worried in this respect would have been the oesophageal 13:14 patients since you are opening their chest, I would contact Dr. McAllister and let him know there was one there so he would organise this. The pre-op assessment for them was more involved. We, in the early stages, used to walk them up and down the stairs. In later 13:14 stages they were on a bicycle and had the function tests, et cetera, physiological tests carried out that way, so he would have been aware himself of those ones.

272 Q. But that may have taken a little time but that was easy to organise from your point of view? 13:15

A. It was easy. It didn't take much time at all.

273 Q. Thank you. You mentioned Mr. O'Brien, his requirement for a large amount of administration time. Could you just repeat those 3.87 PAs. Could you just remind us

how much time per week that equates to?

A. Well four PAs is 16 hours.

274 Q. Per week?

A. Yes.

275 Q. Of administration? 13:15

A. Yes.

276 Q. You also comment in your statement that he would spend some time organising admissions and waiting lists, things like that. Would you make a comment on whether that sort of work might well be devolved to a waiting 13:15 list office or some other --

A. I devolved it.

277 Q. -- arrangement?

A. It was not -- it's -- I do not consider that a useful part of my time, to spend a lot of time on it, not to 13:16 say it wasn't worth doing but the waiting list management was not -- I can't really -- it's one of those things, you knew what was on the waiting list, you just picked them off the top of the list unless they are particular urgent things needed done or be it 13:16 cancers or a patient in significant pain and discomfort.

278 Q. I suppose slightly refining the question. Did the other Urologists have to do it themselves in the way, that is themselves and their secretaries? 13:16

A. I can't answer straight you on that. I think Martina Corrigan might be able to answer that because I know they talked about a scheduling meeting they held on a Thursday afternoon but I was never involved in, but

they had some sort of a scheduling meeting on a Thursday afternoon and Martina Corrigan is probably the best one to ask on that one.

279 Q. Thank you. Last question. Triage. Was this ever a problem amongst the -- apart from Mr. O'Brien, didn't seem to have a particular problem with it, was this a problem among other surgical specialties? 13:17

A. Not that I ever had to talk to them about it. The odd time somebody built up to maybe -- you do it within 24, 48 hours, I don't think we generally did that, if you were operating all day Tuesday and you'd something else on a Wednesday you wouldn't get it done. Generally it was done on a weekly basis. The current system at the start of the week, at the start of the week triage in general surgery during their week they do the triage. The colorectal is now split among the colorectal surgeons and the general surgeons take the non-colorectal elective stuff, but it is not -- there's not a big backlog that I know of or have seen -- 13:17

280 Q. It's works well? 13:17

A. Reasonably well. It's maybe not exactly the way they say you have to have it done within 24, 48 hours, I would be lying if I said that, but reasonably well, yes. No significant backlog.

MR. HANBURY: I have got no further questions, thank you very much. 13:18

DR. SWART: Thank you for giving your evidence. I won't be too long. Back for a minute to your role as Associate Medical Director. Undoubtedly this is a big

job, it has huge responsibility attached to it. Some of that has been referred to today, and you yourself have said you didn't really have enough time to do it justice. One of the key responsibilities is that of clinical governance and Patient Safety. Did you, when you were doing the job, ever think to yourself I don't really think I can do this justice? Did you question how you were going to manage it at that time? 13:18

A. Well, Patient Safety and governance was, in many ways, I suppose we devolved it out in the Trust and the Lead Clinicians looked after the Clinical Directors and ultimately the Associate Medical Directors. We had our MDM and ultimately the Patient Safety meeting which we were involved in introducing -- did I ever think to myself, I did think at different times this job is very busy, I did have difficult doing it. Did I verbalise that to others? No, to be honest, I didn't. 13:19

281 Q. Did you verbalise it to yourself, that's what I'm asking?

A. I did think it was a busy job and I had difficulty, at times, doing it. When you get de-fibbed or dc-converted you start to think why, but more than that, I did not go along to people and say I can't do this job. Back to question which was a question about the surgical ego. 13:19

282 Q. Just phrasing it a different way as well. You have a Medical Director, Medical Director really sets the ethos of medical management and leadership, I think. Did the Medical Director ever ask you, for example, at

the beginning, you know, how is it going, are you coping with the responsibility? Is there anything that you perhaps need help with? Did you have any of those conversations?

A. Not that I can recall. 13:20

283 Q. Was there an open door to the Medical Director's office so you could pop along and say can I have a word about this or that?

A. Although they were on the same site they were not in the same building. We talk about up the hill and down 13:20 the hill. Up the hill was the hospital, down the hill was Trust HQ. I would have gone down the hill a lot and just chat -- but not always necessarily with the Medical Director, with some of the other -- Debbie Burns at one stage was in performance and reform when 13:20 she was there I would have gone and chatted to her, and you'd be down at times for meetings and various things. I didn't feel that I was restricted from talking to the Medical Director if that's what you are asking, no.

284 Q. Not so much restricting it's just the openness. You 13:21 did have meetings with the Medical Director with other Associate Medical Directors I understand?

A. Yeah, we had our own one-on-ones and I think it was a monthly, a Friday afternoon once a month.

285 Q. Those specific Medical Director meetings, did you have 13:21 the opportunity then to talk about difficulties in managing doctors or about doctors who were in difficulty and was there a general discussion opportunity to share experiences?

A. I don't recall individual doctors ever being discussed at that, I could be wrong but I don't recall. I think those would have been carried out more than the one-on-one meetings. As I mentioned in my evidence, the one time that the doctors in difficulty proposal came up I was on leave, is all I remember. It's 2011, I was on leave and it never got re-presented. But I know, because the official document went out less than a week later, and it was meant to be drafted.

13:21

286 Q. There wasn't a culture of understanding the need to remediate problems with doctors and actually think a bit further as to what kinds of issues are causing problems, particularly of behaviour, for example?

13:22

A. Not that I can recall offhand. I don't recall the set-up -- the interactions what you do -- how you manage meetings, how you do bullying -- I don't recall those.

13:22

287 Q. What about the direction, the strategic direction for audit and particularly clinical audit, did you get a sense of direction from the Medical Director or the senior management of the Trust in that regard?

13:22

A. No.

288 Q. No. Okay. Similar though but not the same. We have heard a lot about serious incidents in this Inquiry and I am quite interested in your experience of identifying serious incidents in your Directorate. Who did you see as responsible for leading that process in terms of deciding it was a serious incident in the first place, if we just start with that?

13:22

A. There was a review I believe of Datixes carried out with one of the ENT surgeons did that with -- he was involved in that. Then when it went beyond that some of them would go to Heather, and Heather would flag them up to myself on a Wednesday afternoon and we'd discuss them. 13:23

289 Q. Were you actively involved in deciding it is a serious incident or it isn't?

A. At that point, yes. Not the initial filtration.

290 Q. Okay. Once the investigation has been completed, most Trusts have extensive numbers of investigations with action plans attached to them. Where did the action plans go and did they get properly monitored, or was it a difficult thing to control for you? What was your view of that? 13:23 13:24

A. Any learning from SAIs was then presented at the Patient Safety meeting and I would have presented them in general at that stage, I would have been presenting them.

291 Q. How did you make sure it all got finished off, because when there's learning there's nearly always things to do? 13:24

A. There are, and I can't say that was always followed through.

292 Q. What about informing the rest of the Consultant body and other relevant people about the serious incidents, was that well shared or was that problematic? 13:24

A. It was shared amongst the Surgical Anaesthetic Directorates, specific things for -- well, the

medicines issues were shared at all Directorates. The pharmacist would come to each one at the start of the meeting and present them. The issues that we had that we felt were relevant to another Directorate, usually at the Patient Safety meeting would have been discussed and then flagged for them -- or this SAI, you need to -- you are involved and there are issues for your Directorate as well. 13:25

293 Q. Thank you. We have heard about a few information governance issues last week and this week. I will just start with one that a patient's family flagged up, which was a patient which went to a private hospital for an operation, the notes did not go with the patient, there was quite a bad incident and part of the issue was this issue of information travelling between Trusts and who is responsible, and so on, which I don't think was ever fully explained. We have got the issue of lots of charts at home, which clearly is a risk to Patient Safety for a variety of reasons. We also had some problems around people appearing on operating lists on the day of surgery not being registered at the Trust having come from somewhere else, so quite a lot of different things. In your view, how strong is the focus on the information governance risks and the links to Patient Safety, and how would that have been dealt with in your Surgical Directorate? Because it's quite a big issue, as we see it; was there a good awareness of this, do you think? 13:25 13:25 13:26

A. I don't think there was, not an awareness of the

numbers of charts, that was very definitely not known, that I think would have been --

294 Q. Is that not a serious incident in its own, really? I mean, what would your attitude to that have been at the time? 13:26

A. The number of the charts, those number of charts, that is a serious incident, but I suppose by that stage it was beyond that, it was into raised it with Richard Wright for advice on how to manage it, et cetera. I suppose some things may not have made it directly to 13:26 have been an SAI when they are being actioned and followed up by the team, by the management team. If that's what you are asking me, sorry, I am not sure --

295 Q. I am trying to get sort of what was the culture in terms of understanding the risk to Patient Safety from 13:27 these issues which start off as maybe it's a small issue, and actually, when you think about it, it's quite a big issue?

A. I don't think that was understood. As I said, I think it was he was judged on the basis of what people 13:27 thought of him rather than just on the facts alone. When you see it tabulated it's very difficult to ignore it now. In fact, it's impossible to ignore now.

296 Q. It's obviously easier for us with hindsight but I'm just trying to get an idea of what the culture was 13:27 like. Another cultural issue that comes out is this issue of job planning where job planning is meant to be a tool for managing doctors to some extent, but with job planning best practice would be that you sit the

team down and you work out what work needs to be done and you come to an agreement. You can also set objectives for the team and so on. What was the general direction given to you as Associate Medical Director for what you needed to do with job planning, and how did that feel as Associate Medical Director and were you able to do what you needed to do? 13:28

A. There was great difficulty doing it. As you can see, there was over a prolonged time trying to get agreement. They would not agree. In fact, Mr. O'Brien was not prepared to agree to a job plan with any reduction in PAs, and ultimately his salary. 13:28

297 Q. Did you sit down with the team of urologists and do this in an open way?

A. A lot of the job planning earlier on was done through the Monday evenings trying to agree objectives and how it would be done and how we'd work them, et cetera. It wasn't -- it may have been set out but it wasn't -- you know, there was a lot of pushback. 13:28

298 Q. Yes. Okay. You didn't use job planning individually with objectives for each Consultant in that way? I can't see that in the paperwork. 13:29

A. No, job planning didn't entail that and still, to my knowledge, does not entail that for any of the --

299 Q. No. The private patient issue has come up, mainly from some of the witnesses so far, as a significant issue. Just in simple terms, the Trust has a private patient policy, I understand, which says that if you see someone privately and you bring them into hospital you 13:29

need to transfer them to be an NHS patient?
A. Yes.
300 Q. This clearly was not particularly being adhered to in the way it was meant to. Do you think that was a general problem in the Southern Trust or do you think 13:29
it was specific to some areas, or do you have any feel for that at all?
A. I can't say specifically. I think it probably existed in other areas, not, shall we say, not that people were key jumping but utilising the process of how patients 13:30
when they transferred and the form filling, et cetera, for that, that may not always have been done.
301 Q. You talk about softly softly. But somewhere when you are managing a problem like this the buck has to stop with somebody in the chain in terms of you have 13:30
a doctor in difficulty and there are patients who are therefore either coming to harm or at risk from harm. Where does the buck stop? Where does the final buck stop for managing a difficult doctor, do you think? Who has got that job card? 13:30
A. I actually think the Medical Director, which is why we went to him for advice each time, because we felt the buck stopped with him.
302 Q. Mm-hmm. Do you think that all the people involved in that chain have been given the right tools and the 13:31
right support to execute their duties in this regard?
A. When you say the chain?
303 Q. Did you have the right tools in your box to --
A. I have to admit no, because I didn't think of utilising

-- I didn't so I can't claim I had the tools. The tools were there but I didn't recognise them.

304 Q. Okay. Thank you.

CHAIR: Thank you very much, Mr. Mackle. We are going to rise now. It's just half past one, so half past two for our next witness. 13:31

MR. WOLFE KC: During one question of Mr. Mackle I drew attention to a document at TRU-277941. You will remember it was a handwritten note of a meeting of the 21st March 2016 at which Mr. Mackle attended with Mrs. Gishkori. It was not Mrs. Trouton -- sorry, it was Mrs. Trouton's note. It was Mrs. Trouton's note of the meeting and not Mrs. Gishkori, and I am sure I will be asking Mrs. Trouton about that this afternoon. 13:32

CHAIR: Thank you very much. 13:32

THE INQUIRY ADJOURNED FOR LUNCH

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIR: Good afternoon, everyone. Sorry for the slight delay. Mr Wolfe, I understand there's to be an amendment to the statement and I think that was the hold-up. I think they were going to get it amended on the screen but I don't think we should wait any longer. 14:37

MR. WOLFE KC: I think that relates to a witness tomorrow, perhaps.

CHAIR: I was told it was this witness but we can check it out anyway. 14:37

MR. WOLFE KC: This witness this afternoon then is Heather Trouton and I think she intends to take the oath.

MRS. HEATHER TROUTON, HAVING BEEN SWORN, WAS EXAMINED BY MR WOLFE KC AS FOLLOWS:

305 Q. MR. WOLFE KC: The first thing we are going to do is bring up on the screen the Section 21 responses, which you have placed before the Inquiry. The first one is number 2 of 2022. It's dated 3rd March of last year. The first page, WIT-11988, you will recognise that, I think. If we take you to the last page and your signature, it's a lengthy response, I think it's 174 pages. WIT-12161, and that's your signature? 14:37 14:38

A. Yes, it is.

306 Q. Can I assume that you would wish to adopt that statement, subject to one correction, as part of your evidence? 14:38

A. Yes.

307 Q. In fact, the correction I think you need to make is in the second of the statements. The second statement is number 37 of 2022. The first page is WIT-14808, and you are familiar with that? 14:39

A. Yes.

308 Q. The last page, bearing your signature and the date WIT-14837, and it was signed on 8th June by yourself?

A. That's right.

309 Q. Again, would you wish to adopt that as part of your evidence, subject to the correction I am going to -- 14:39

A. Yes.

310 Q. The correction or the revision you would wish to address is at paragraph 48, WIT-14826. It concerns an

issue I think we touched on this morning. So paragraph 48, to paraphrase you are saying that you don't that a copy of the letter sent to Mr. O'Brien on 30th March was given or shared with the Service Director or the Medical Director that's what you are saying in that paragraph, and you wish to correct that. What do you wish to say about it? 14:40

A. When I read my witness bundle I saw that Mr. Mackle had sent a copy of the letter to the Medical Director at that point, so I was unaware of that but I now know it to be the case. 14:40

311 Q. He also provided a statement to the MHPS investigation which you will recall was led by Dr. Chada. I want to bring you to that statement and just take a moment to explain to the Inquiry a little wrinkle around that. I am told that CaseView is currently down. 14:41

CHAIR: Okay. I think that will need sorted out. Perhaps Mr. MacInnes could check that for us, please. Can I just ask if everyone is happy to continue without case use and just make use of the transcript when it's available, or would you rather take a break until it is up and running? 14:41

SPEAKER: Chair, it may be an Internet issue rather than CaseView. The internet is sporadic.

CHAIR: Can we take a straw poll of how many people -- is it just the Inquiry laptops that it's not working? 14:41

MR. WOLFE KC: Maybe just take five minutes.

CHAIR: We will take a short break until we see if we can get it resolved quickly or not.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: I understand that the technical issues have been resolved. It seems to be Tuesdays that we encounter these technical difficulties, but hopefully not too often. I understand also, Mr. Wolfe, that it was Mrs. Trouton's statement that was being updated and it has been, just the amendment that you are referring to. 14:53

MR. WOLFE KC: Okay. Thank you.

312 Q. Before the break, Mrs. Trouton, you were indicating that you had provided a statement to Dr. Chada's investigation and there's a little wrinkle around that that we need to clarify, so if we go to TRU-00795. We can see the first page of a four-page statement. We can see that your name is at the top. The statement is given on 5th June 2017. As you can see, it runs through to TRU-00798. We can see then, if we move on to the next page TRU-00799, and just slowly scroll through that, please. This is again I think a four-page statement but it's got tracked changes. So, for example, at the top of the second page, we can see that some changes have been tracked into it. We can then see, if we go to TRU-00803 -- just I will pause here to say that the live note is down again? 14:54 14:54 14:55

CHAIR: Can I just say the issue is not at our end and we will get it fixed.

CHAIR: Sorry, I think it might be resolved,

Mr. MacInnes. Is it working? Can I just check everybody has it working again? No, not everybody. I understand the broadband is external to this building so we have little control over it, where the issue is, but it sounds to me as though there is an intermittent problem with the broadband then at their end. I am not quite sure how we resolve this. Can I just check is everyone -- is there at least one person on each Core Participant team who has it? Mr. Millar, Mr. Reid, yes, and the Inquiry? One of us has it. I think we will continue rather than take another break. We need to get through some of Mrs. Trouton's evidence without disturbing her any further. 14:56 14:56

MR. WOLFE KC: Okay.

313 Q. Is it correct to say, Mrs. Trouton, that after you saw how your statement had been typed up by the MHPS investigation you noticed some difficulties with it that you would have liked to change and you did make those changes by way of a tracked note? 14:56

A. Yes. 14:57

314 Q. What appears to have happened, and we will maybe need to check this with Dr. Chada, is that your unchanged, in other words your original version, complete with the bits that you were unhappy with, was taken by the MHPS investigation to be your final view, and they didn't appear to have used your tracked change version, is that your understanding? 14:57

A. That's my understanding, yes.

315 Q. Just to be clear, the tracked changes that we can see,

for example, at TRU-00800, were made by you back in 2017?

A. Yes, that's right.

316 Q. Yes. You will have to help me with the e-mail that you have sent to Siobhán Hynes in February 2022 which we find at TRU-00803. So you were sending this to her in 2021, for what reason? 14:58

A. I was looking at my original statement, obviously in preparation for the Inquiry, and I didn't recognise it as a true version, so I went back to check what amendments I had made, because I was sure I had made amendments. Then I found the e-mail where I did make the amendments and then I went back to Siobhán and said I had sent amendments, you don't seem to have noted them. I think that's what I was doing at that point. 14:58

317 Q. Without overcomplicating it, this e-mail explains your thinking behind the amendments?

A. Yes.

318 Q. Okay. I hope that doesn't overcomplicate things, Madam Chair, but I thought we should deal with that in a little bit of detail. 14:59

Members of the Panel, Mrs. Trouton, obviously we know from Mr. Mackle's evidence that you were a co-signatory of a letter that was handed to Mr. O'Brien on 30th March, that letter bearing the date 23rd March 2016. It obviously contained reference to a number of concerns about Mr. O'Brien's practice that had been, some of them at least, part of your managerial concerns 14:59

with others for a period of some time before the March meeting. You didn't attend that meeting, and we will look at that, but your evidence gives us the opportunity, the Inquiry the opportunity to look at those concerns, how they were dealt with, managerial response to them and we will look at that in the context of the MHPS Framework as well. But just starting with your career and your role, you are currently the Executive Director of Nursing, Midwifery and Allied Health Professionals in the Southern Trust? 14:59 15:00

A. That's correct.

319 Q. You have been in that position since January 2018?

A. That's right.

320 Q. If we go to your witness statement, WIT-12012, in ease of the Panel's note, at answer 86A, you take us through your career. You are a nurse by profession, isn't that correct? 15:00

A. That's correct.

321 Q. You have occupied a number of nursing roles in your early career. In October 2009 you took up the role with which we are most interested and that's Assistant Director for Surgery and Elective Care, isn't that right? 15:01

A. That's correct.

322 Q. You were stationed within the Surgery and Elective Care Directorate? 15:01

A. Yes.

323 Q. Is it fair to say that was your first engagement with Urology Services upon taking up that role?

A. Yes, and no, because my other previous posts, for example, patient flow coordinator, et cetera, would have managed the flow of Urology patients in the Trusts, so it wasn't that I wasn't familiar with Urology, but it was the first post where I had direct managerial responsibility for the Urology Service.

324 Q. You remained in that Assistant Director role right through until March 2016, isn't that right?

A. That's correct.

325 Q. You took up a new role in April 2016 as Assistant Director for Integrated Maternity and Women's Health and Cancer and Clinical Services? 15:02

A. That's correct.

326 Q. So you had, in essence, seven years in the Assistant Director role in SEC, Surgery and Elective Care. Your movement to a new role in April 2016, you have described it I think as due to a general reshuffle of Assistant Directors, and you were replaced by Mr. Carroll, Mr. Ronan Carroll? 15:02

A. That's correct. 15:03

327 Q. When you think about it now, of course the timing of that in some respects was unfortunate, given the issues that the Inquiry is grappling with; you, as I have just outlined briefly, were the co-signatory of this letter to Mr. O'Brien? 15:03

A. Yes.

328 Q. We will look at the fine detail of that, but Mr. Mackle agreed with my characterisation of that as being a formal attempt, certainly compared to the informality

of previous initiatives, to try to get to grips with some of these difficulties?

A. Certainly more formal than previous.

329 Q. Yes. You were in a new post within a week or so after the delivery of that letter? 15:04

A. Yes, 1st April. It was delivered on 30th March and I started my new role on 1st April.

330 Q. Yes. That's not to say Mr. Carroll was a stranger to these issues. He had some working knowledge of Mr. O'Brien and some of the difficulties, if I can put 15:04 it in those neutral terms, that occasioned his practice and managerial response to it?

A. Yes. Ronan was the Assistant Director of Theatres and Cancer and other areas that obviously had a close affinity with Surgery. 15:04

331 Q. In terms of the role that you perform as Assistant Director, I want to spend some moments looking at that. You would have reported to a Director of Acute Services, isn't that right?

A. That's correct. 15:05

332 Q. During the currency of your role, you reported to four Directors in total, Joy Youart?

A. Yes.

333 Q. I will get these in right order, Gillian Rankin?

A. That's right. 15:05

334 Q. Then Debbie Burns and then, lastly, and for a relatively short period of time, Esther Gishkori?

A. That's correct.

335 Q. Right. Just in terms of the things that we are looking

at, and you have sat and observed and heard the evidence over the last day or so with Mr. Mackle, is that changing of the guard in the top job within the Directorate, was that unhelpful in terms of grappling with these issues, or neutral? 15:06

A. I would say neutral. Joy Youart was very, very short with me because she left literally a few months after I started. I started in the beginning of October 2009 and I believe Dr. Rankin took over in December 2009, so it was very short for Mrs. Youart. Dr. Rankin was 15:06 quite a period of time, so there was a good bit of stability with Dr. Rankin. Similar with, two years with Deborah Burns, and then Esther Gishkori was towards the end of my time in SEC. So you are right there was a change of personnel. I would say that 15:06 there was a very similar approach by Dr. Rankin and Mrs. Burns, very strong, in control type Directors. That's not to say Joy Youart and Esther Gishkori wasn't, but Mrs. Gishkori maybe had a wee bit more, maybe it was because she was new into post, but a wee 15:07 bit more devolved, maybe, style, whereas Dr. Rankin and Debbie Burns had a very much more involved style.

336 Q. Mm-hmm. Sometimes when I ask witnesses questions about issues concerning Mr. O'Brien and the management of him, I am in danger of giving the impression I didn't 15:07 think there was anything else in your in-tray to be focused on, but with that apology, or expression of understanding, your role was obviously more than just the management of one clinician. But thinking about

those issues and just trying to paint in some of the detail at this point, were you well supported in general terms by your Directors if you wanted to bring concerns, escalate concerns about a clinician, or indeed any issue to them? 15:08

A. Yes, I had a good working relationship with all four Directors.

337 Q. Yes. Were they, I suppose the question is receptive to you bringing problems, difficulties, to their door?

A. Yes, yes. 15:08

338 Q. That was one tier of management upwards?

A. Yes.

339 Q. We will come on to talk in a moment about, sort of, operational management side of it which you belonged to and the medical or professional management, and I am 15:08 sure not sure if you find that dichotomy helpful, and we will look at that. But the tier below you in your work within Surgery and Elective Care there were a number of specialties, isn't that right? There was general surgery, breast surgery, ENT, Endoscopy, 15:09 Urology was one of several others, and each of those services or sub-specialties had a Head of Service, or at least there was, just help me with this, three Heads of Service; is that right?

A. Three Heads of Service. Martina Corrigan was 15:09 responsible for Urology and ENT and Outpatients, five Outpatients Departments. Head of Service changed a wee bit, but Trudy Reid was General Surgery and Louise Devlin, I think at that point, was Trauma and

Orthopaedics, would have been the three Heads of Service.

340 Q. If we could maybe just focus on Mrs. Corrigan, helpfully I suppose from our perspective, she is in that role as Head of Service with responsibility for Urology for as long as you were in post as Assistant Director? 15:10

A. Yes, correct.

341 Q. Indeed when we look at the medical management side, Mr. Mackle was Associate Medical Director for that expanse of time as well. In terms of how you worked with Mrs. Corrigan, what was your expectations of her, if there were difficulties, and her expectations of you? 15:10

A. For the most part because my remit was so large across a lot of areas, the Heads of Service would have much more close working relationship with each of their, because it was devolved down a bit smaller, so I'd have expected Martina to manage the day-to-day business of the services, manage -- I mean a Head of Service is quite a senior post in itself so she would have been able to manage a number of problems and issues and be able to sort, and then escalate to me whenever she had done really what she could and then escalate to her manager, as I did to the Director of Acute Services. 15:10 15:11

342 Q. We will see, when we look at some of the specific examples, how she would have copied you in, that is Mrs. Corrigan copied you into correspondence raising issues with you, not always but perhaps she had to take 15:11

them so far, run into an obstacle and then escalate to you, is that?

A. That's usually normal. You manage within your sphere, or as much as you can do using all the people around you, and then whenever you need a feel you need a bit of help and support, then you escalate. 15:11

343 Q. Take a brief look at your job description, WIT-12164. "You will be responsible to the Director of Acute Services for the delivery of high quality care to the patients in the Trust Surgery and Elective Care Division. You will be responsible for the operational management of all specialties in the division". 15:12

Those are set out. It's across two sites, is it?

A. Yes, mm-hmm. 15:12

344 Q. Craigavon and Daisy Hill?

A. Yes.

345 Q. Your responsibility is to collaborate closely with senior clinicians and other disciplines to implement the objectives of the Trust's delivery plan and ensure effective multidisciplinary working. You are to provide clear leadership to staff, all staff in the division and be responsible for effective financial management. 15:12

"The job holder will also support the Director of Acute with long term planning of service reform initiatives." 15:13

In a nutshell, a very worthy document and it's broken

down. In a nutshell was your job to oversee everything that supported the delivery of care?

A. In a nutshell, yes. Probably more around the operational management of everything that goes into support care, so the function of the wards, the function of the Outpatient Departments, the function of the nursing staff, whoever goes around it, and then, as you will be aware, there was the medical line which you will see in the job description I work closely with and collaborate closely with senior clinicians, but I didn't manage clinicians, I worked closely with them, but I felt that my role was to provide everything that was needed to allow those senior clinicians to be able to provide care, and all clinicians, for that matter, whether you are nurses or allied health professionals, et cetera. 15:13 15:14 15:14

346 Q. Okay. You didn't manage clinicians, you make that distinction but we see, I suppose, plenty of attempts on your part to manage their output?

A. Yes. 15:14

347 Q. Or what they are failing to do. Is it fair for me to suggest that you were in a managerial role in respect of them?

A. I certainly was responsible for the overall patient care, and where there were any element that impinged on good patient care, it would have been remiss of me not to try and do something about that, and that included obviously looking at the work of the medical staff as well as every other, if that makes sense? 15:14

348 Q. Yes. To what extent, I suppose, did you have the power to instruct a clinician in his or her behaviour or conduct in respect of a duty? If a duty wasn't being performed, did the power lie with you to say please do that? 15:15

A. Power to instruct didn't lie with me. The power to encourage, support, enable, provide the circumstances by which they could do, I certainly was involved in that, whether it was coming up with a new process. But the power to instruct them to do something, I didn't 15:16 feel lay with me.

349 Q. Do you think that power, if I can use it in those sort of hierarchical terms, did that rest on the medical management side of the line?

A. If you look at the job description of medics there, the 15:16 line management is either through their Associate Medical Director up to Medical Director and through the Director of Acute Services, so probably both those two lines would have had more power. It seemed to bypass the Assistant Director and go directly to the Director 15:16 of the Acute Services on the operational side, but obviously, obviously I was needed to ensure that the Director of Acute Services had the information to be able to make decisions.

350 Q. When we see you writing to Mr. O'Brien saying, 'please 15:17 get this done', or being copied into an e-mail from Martina Corrigan inviting Mr. O'Brien to get this done, that is encouragement, facilitation, but it's not, in essence, an exercise of the power that could go

anywhere except to escalate it across to the medical management to action it if it wasn't responded to?

A. That's certainly how it was back then. It was quite hierarchical in its set-up in that there were lines of engagement, for want of a better word, and that's the way it was. 15:17

351 Q. Yes. There is reference in your job description to the issue of disciplinary management, just look at that briefly, WIT-12168, and at number 42 under "human resource responsibilities", it says that you have to "take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust." 15:18

Where did your disciplinary jurisdiction extend to or who were you responsible for in disciplinary terms? 15:18

A. I think it was everyone except medics.

352 Q. Another feature of your job description is to -- just briefly look at it WIT-13165, just three pages back. At paragraph 6 you are: "To ensure high standards of governance in the division, include compliance with controls, assurance standards, the assessment and management of risk, and the implementation of the old Department safety first framework." 15:18

15:19

It's showing its age, that document?

A. It is.

353 Q. In governance terms, what did you understand your role to be? What were the parameters of that?

A. Governance, from my perspective, was very wide, really, because I had financial governance, I had Human Resources and all the governance that goes around that, we have heard about information governance, Clinical Governance, governance of good standards at ward level, Outpatient, Admin, so it was very, very wide. I know I have been looking at it very much in Medical Governance or Clinical Governance which, of course, it included, but it was just using everything that was available to me with regards to complaints, adverse incidents, SAIs, standards and guidelines, to ensure that we were adhering to good practice, and obviously then good patient care. 15:19 15:19

354 Q. Just to take any one of those examples, what would have been your role if an Incident Report or a Datix had been raised and there was to be consideration as to whether that should go down an SAI route. Do you have a role in that? 15:20

A. Yes, I did. Once a week myself and one of the Clinical Leads I think for a period of time it was Mr. Reddy but it could have been others, and we would have gone through the moderate to major incidents, not every incident but the moderate to major and we would have looked at, I suppose, trends, but then obviously those particular incidents that stood out. Then if we felt that some needed screened for an SAI, and sometimes it was the Governance Coordinator brought it to my attention that a particular incident had happened and it may need screening, myself and Mr. Mackle would have 15:20 15:20

sat and went through the screening criteria that was set out by the Department to see if it met the criteria. If it did, then we said yes that needs to be an SAI. Or back then -- way, way back then it could have been an RCA or serious event, and then the Governance Coordinator set up a panel then to go through the SAI. So it was more in the screening part of it, safe medical criteria.

355 Q. As that process unfolded through its stages of review or investigation and then conclusions, recommendations and action planning, did you have any input in those various stages? 15:21

A. Rarely. I think in my career in that period I was asked to sit as a member of one SAI, not in the Surgical Directorate, I think it was medicine, but rarely was I involved in an actual SAI. 15:21

356 Q. Yes. But say there was a recommendation in an action plan affecting Surgery and Elective Care at the end of an SAI process, would that have come to your desk to assist with implementation, or did that sit on the Clinical and Medical side of the house? 15:22

A. It didn't come directly to my desk. What tended to happen was there was a Friday morning meeting from 8:00 to 9:00, as I recall, chaired by the Director of Acute Services, and at that meeting all the Assistant Directors and Associate Medical Directors would have gone to that meeting collectively, the SAIs would have been tabled and the recommendations looked at, and then the recommendations were taken collectively because 15:22

usually an SAI recommendation rarely just transposes to one part of the system, it's usually system wide learning, so usually it was the Friday morning meeting that those recommendations would have been discussed and then action taken collectively.

357 Q. In terms of how you interacted with those on the operational management side, both below in terms of Heads of Service and then your fellow Assistant Directors and then Directors, you met on a weekly basis with Heads of Service, is that right? 15:23

A. That's correct.

358 Q. What was the focus of those kinds of meetings?

A. Usually, and probably foremostly, performance, because that was the big drive during those years. Probably performance. It definitely would have been finance, 15:23 because I was responsible for a 50 million pound budget to stay within a financial envelope, governance issues obviously, maybe nursing issues, ward issues, anything pertinent that came up, and it was a two-way process because they brought issues to me but I also brought 15:24 issues from the Acute Senior Management team to them, if that makes sense, so it was a two-way information sort of sharing session as well as looking at issues.

359 Q. Your engagement with your Directors, there were four of them obviously, and perhaps that varied over time, but 15:24 what was their means of engaging with you and what was challenging for you in how you do your job?

A. I mean, we all worked on the same floor and quite close to each other so there was a lot of informal

engagement. Formally, we met as a Directorate group of ADs with the Director one afternoon a week and those meetings would have been themed week on week. One week we may have focused on performance and the performance team would have come and gave us all the data. The next week governance. The next week would have been HR and Finance, so it was themed in that way and most Directors followed that pattern. So we met once a week for a whole afternoon to go through all those things, informal meetings, Friday morning governance meeting, that I have already alluded to, would have been the main ways of engaging but it was quite informal as well as formal. 15:25 15:25

360 Q. Would those kinds of meetings, both with the Director and below that your meetings with the Heads of Service was that an opportunity to discuss, amongst the wide variety of other things that you no doubt discussed, but would you have opportunity to examine doctors in difficulty, or difficulties being caused by doctors in your services? 15:25 15:26

A. Probably more on a one-to-one, though. And I would have had a one-to-one obviously with each of my Heads of Service. So the meetings that were collective were more the general issues and the general, whereas the one-to-ones would have been more likely to be where Martina and I would have discussed particular consultants. It could have happened in Trauma and Orthopaedics, it could have happened in General Surgery but in the one-to-ones. 15:26

361 Q. Yes. Sometimes because we have this great public inquiry looking at aspects of Mr. O'Brien's practice, we could run away with the idea that Mr. O'Brien and his perceived shortcomings in practice was a constant item on the agenda, or a constant source of conversation with your management, whether above or below you. Was that the case? 15:26

A. No, it wasn't. I had, as you have said all the various services, but as well as all my various services I was a member of Acute Services Senior Management team so I had other responsibilities. So Unscheduled Care, for example, we had a system of Assistant Director of the Week, for example, so I would have spent one week in six responsible for the patient flow through the hospital. As the overseer of a number of surgical wards I am responsible for flow through ED for all the emergency admissions. I spent a lot of time with planning and the Planning Department around creating investment proposal templates for new services and expanded services. Then, of course, it was general nursing issues and as a nurse, I found myself often leading nursing issues for the Directorate. In fact between '14 and `15 I was the nurse who took responsible for leading Nursing Development in the whole of the Directorate, so the time spent specifically with Mr. O'Brien was probably a very small proportion of what I did on a daily basis, and a lot of regional meetings as well. So you will have heard about during those years the huge drive from the 15:27 15:27 15:27 15:28

Department to the Board around productivity, efficiency, outcome, so I spent probably a lot of time at Linenhall Street going over performance, so that was the level that I was, sort of, working at, and then obviously dealing with the other issues as they arose. 15:28

362 Q. I might get different answers to this question when I ask different managers, but can you help us with a characterisation of the extent to which Mr. O'Brien was a feature of the work that you had to do? Obviously, and I think you will accept this yourself, 15:29 but there were issues that you didn't know about, and you might accept when I ask you to perhaps ought to have known about or Inquiry might have be made into, but in terms of what did come across your desk over that period of seven or eight years or so, how would 15:29 you characterise his imprint on your responsibilities and time?

A. There's no doubt, certainly, at the start of my time in post, which would have been the end of 2009, beginning of 2010 and probably through 2012, you will have heard 15:29 about the Team South model and the working with the Department and the Board around getting investment into Team South and building up the service, and you will have heard of the Monday night meetings that I went to, which was every Monday night from five o'clock to half 15:30 six. So therefore Urology, certainly in those earlier years, it was a significant part of my job because we were trying to get and secure Team South, so from an operational perspective I absolutely was involved in

that, and Mr O'Brien was a part of that, although that was a collective. So I suppose once Team South was up and running, probably from 2012 to 2016, not as much of my time, because the service was sort of established, there was, as I have said in my statement, a huge issue with securing consultants to get it up to the five-person model, so I was involved obviously in that and the middle grades, getting all the investment in and all the things that go with creating a service, so yes, I was involved certainly at that investment level, if that makes sense? 15:30 15:31

363 Q. In terms of the difficulties that your statement suggests he caused within this Service, Triage and et cetera, et cetera, in terms of them coming on to your agenda, was that but a small feature of your work? 15:31

A. It was definitely a feature of my work, yes, there was lots of other work but it was a feature. I mean right from the word go, and I think there's notes of a meeting on 1st December 2009 with the Chief Executive then Mairead McAlinden, Medical Director, whatever, so there was notes of that meeting which categorised the triage issue right upfront, and other issues so I was only two months in post at that stage, so right from the get-go these issues were there and widely known about so it was a challenge. I mean urologists in total were a challenge. I think this morning, I hope you don't mind me referring to the fact you asked about were they reluctant to take on the service, they weren't reluctant to take on the service but they 15:31 15:32

didn't readily want to modernise their service, if that makes sense. They wanted the bigger service but they didn't want to change their practice, and Mr. O'Brien most definitely would have been one of those consultants who would have pushed back quite a bit with the BAUS guidelines and the requirements from the HSCB et cetera, et cetera, so there would have been a lot of clinical push back and I would have been very aware of that. 15:32

364 Q. Just before we come to look at this in a little bit more detail, let me ask you about the medical management side of the house then. I think you have said in your statement that you worked closely with the Associate Medical Director? 15:32

A. That's correct. 15:33

365 Q. Again, helpfully throughout that period was Mr. Mackle, but you say your roles were distinct. There was some overlap in, for example, reviewing adverse incidents, as you have just outlined, and working to address operational issues as they arose. Where was the, if you like, the cut-off, if that's not an unhelpful term, between your role in the management of personnel-type issues, performance by the clinician of their role and what was expected of that clinician? Is there a way of easily or readily explaining that or was there so much overlap that the roles were almost as a partnership? 15:33

A. I think it was probably more of a partnership. I think when I relied on any of my medical colleagues was around their expertise of medical things. You know,

I would have sought their guidance as to is this acceptable, is this normal practice, is this not normal practice? What's a risk et cetera, et cetera? So I would have -- I am a nurse by background, I have a certain level of clinical insight, obviously you don't go through being a nurse without having a certain amount, but when it comes to challenge, and certainly Consultant challenge, I definitely would have relied on my consultants and my medical management line to do that clinical challenge, because it's difficult enough I think to do that as a medic, I think it's even more difficult to do that as a nurse. So I did rely on that heavily. 15:34 15:34

366 Q. I think you have reflected in your witness statement in several places that the challenge that you sometimes brought to Mr. O'Brien, this isn't your word, it's mine, wasn't particularly well-respected, it was difficult, he was polite, but you were a nurse and as a clinician your perception was he knew better and he didn't take that challenge well? 15:35 15:35

A. I think that's a fair reflection. He was very polite and he was a gentleman, but the word dismissive might be too strong, but it certainly was, I hear what you say, and he was polite and on many occasions he did do what I asked him to do, but I don't think it would have been strong enough to change his practice, at a core level. 15:35

367 Q. Can you think of any -- what are you reflecting there by way of a concrete issue?

A. If you think of triage, for example, and you will have seen the number of times he was asked to do his triaging, and many occasions he did, and I looked back and there was intermittent parts where he seemed to do it okay, but, as he has reflected and I have seen in the various statements, he really strongly felt he wanted to do advanced triage, which was not what we required of him, and I would have said to him we don't require you to do advanced triage we just need you to check if the GP referral category is the right one. So I can ask him to do that, I can suggest that's all we require of you, I can say that's all I need of you. Was I going to change his mind so he went okay, Heather, I hear what you are saying, I will not do advanced triage. I think that's an example of where he felt he would know better than I did. 15:36 15:36 15:36

368 Q. That's where you rely on the medical management side of the line?

A. Yes.

369 Q. You have said at WIT-12049 -- we don't need to bring it up -- it's on the screen, at paragraph 171: 15:37

"The key responsibility of the Associate Medical Director role was regarding the Clinical Governance of the consultants and clinicians." 15:37

Do you mean that in the wider sense of ensuring that where issues arose, that the clinician concerned was properly managed from a Patient Safety and a clinical

correctness perspective?

A. I think it probably meant from a good medical management perspective, so the standards required of a medical practitioner, that those were adhered to by each clinician. 15:38

370 Q. Yes. The medical management line involved hierarchically the Associate Medical Director Mr. Mackle, the longest period of time, I think?

A. Yes.

371 Q. Mr. Brown in a Clinical Director's role, and Mr. Young in a Clinical Lead role. 15:38

A. Yes.

372 Q. Just thinking about the latter two, what was your connection with those managers in terms of your role and in terms of theirs? 15:38

A. I didn't have a huge amount of interaction with Mr. Young. He would have had a lot of interaction with Martina Corrigan. I would have had more interaction with Robin Brown who was Clinical Director. He'd probably have been really my first go-to person, and 15:39 certainly after 2012 he was my go-to person for Urology and then obviously Mr. Mackle. Mr. Mackle and I would have met every Wednesday, just for a short period of time, and talked about various issues. So probably not so much Mr. Young, yes, Mr. Brown and yes, Mr. Mackle. 15:39

373 Q. Given your responsibilities to deliver on the operational side, and given the issues that were posed by Mr. O'Brien in terms of those operations, are you in a position to comment on the effectiveness of the

medical management line in terms of their ability to provide a sufficient or adequate challenge function to Mr. O'Brien?

A. To my experience, it was two things: One, Mr. Young and Mr. O'Brien had worked very closely together, and certainly in early days you will reflect there was only the three consultants; Mr. Akhtar, Mr. Young and Mr. Mr. O'Brien. They obviously worked very, very closely together and therefore it may have been difficult to challenge each other when you are in a group. Mr. Brown did some Urology, some low level Urology, so again he would have worked probably relatively closely with the group of urologists. So again, probably difficult to challenge but should have been a wee bit more removed because he was based in Daisy Hill, he was a general surgeon, he did different things. Then Mr. Mackle, you have heard, he worked in Craigavon and did try that challenge. I think, rightly or wrongly, but after the 2012 issue of bullying and harassment perception, whatever that was, that certainly cast a shadow over the medical management and I was therefore heavily reliant on Mr. Brown, and there seemed to be a style of support and encouragement and speaking to, and I will talk to him and leave that with him, I will talk to him. I have talked to him, and that seemed to be, I couldn't seem to get much more purchase than that through the medical management lines during those years. 15:40 15:40 15:40 15:41 15:41

374 Q. Yes.

A. My honest reflection.

375 Q. Just dealing with what I think you are doing, which is setting up something of a contrast, were you better satisfied with the effectiveness of the medical management when Mr. Mackle had his full powers pre-2012 as compared with, if you like, his substitute in that role after 2012, Mr. Brown? 15:42

A. I think so. I think Mr. Mackle was probably more willing to challenge, and I think we lost a lot when that disappeared. 15:42

376 Q. I just want to ask you your recollections in relation to this bullying and harassment issue. Were you in this room this morning when Mr. Mackle was asked about that?

A. Yes. 15:43

377 Q. You don't deal with this issue in your Section 21 statements, but I note from what you said to Dr. Chada that you had some awareness of this. If I can just bring up your statement TRU-00797. And just scroll down so we can see paragraph 14. Thank you. Maybe we will work with the amended version, I'm not sure if there's much of a difference in the text. Paragraph 14, you address the issue and you say: 15:43

"Some time ago Eamon Mackle tried to address the issues but Dr. Rankin had said not to do anything further because a complaint had been received accusing Eamon Mackle of bullying and he was told he should not address further issues with Mr. O'Brien. Eamon Mackle 15:44

appointed Robin Brown to be a go-between with Urology. Mr. Brown made attempts to improvements for short term, then the went back to his behaviours again. There was a general eventual that Eamon Mackle was unable to deal with the issues because he was told not to. In my opinion Mr. Young and Mr. Brown felt uncomfortable holding Mr. O'Brien to account." 15:45

Do you stand over that --

A. Yes. 15:45

378 Q. -- impression of events?

A. Yes.

379 Q. In what you have said about Mr. Mackle being told about a bullying complaint, and that he should not address further issues with Mr. O'Brien, how did that come to your knowledge? 15:45

A. Probably told about it by Mr. Mackle himself and Mrs. Corrigan. I wasn't there on the day, but I was told about it thereafter, and obviously the outworkings of that was me being directed to deal with Mr. O'Brien thereafter. 15:46

380 Q. Obviously, you are recalling that in the statement here in 2017. You don't put a date on it. Could it have been 2012 or do you not know?

A. It could have been. It did feel like about halfway through, you know, so there was a significant amount of time afterwards where I dealt with Mr. Brown so it feels about right, but I don't know exactly. 15:46

381 Q. Yes. I just want to focus a little bit on what

Mr. Mackle said to you, if I can push your memory a little bit. What did he tell you about this complaint of bullying? Did he give you any detail?

A. Not really. He just said he had been, I think the words he used to me was warned off dealing directly with Mr. O'Brien due to concerns about bullying and harassment. I mean it was just as general as that. There was no detail. 15:47

382 Q. Did you, in turn, speak to anybody about it, because the fact that Mr. Brown was now in the role of challenging Mr. O'Brien and you were more often going to Mr. Brown, that had an impact on you, so did you speak to anybody about that? 15:47

A. I have no doubt, I mean it was discussed with my director because my director wouldn't have known anything about it, then they would have expected me to be dealing with Mr. Mackle, so the fact that I openly discussed how I dealt with Mr. Brown, therefore it was known. 15:47

383 Q. Yes. 15:48

A. As I went through my witness bundle, I noticed that the Directors often dealt directly with Mr. Brown as well.

384 Q. Mr. Mackle -- your director was Dr. Rankin at that time?

A. Dr. Rankin at that particular time, yes. 15:48

385 Q. Yes. Did she, in any of your discussions with her, let it be known to you that she was aware of this issue?

A. I genuinely can't recall a conversation specifically about that. I really can't remember whether it was

spoken about or just an understanding.

386 Q. Did you ever discuss it with Mrs. Corrigan?

A. Oh, I am sure I did.

387 Q. Any specific memories of addressing it with her?

A. No, just, again, her coming in to tell me because I believe that Mr. Mackle appeared in her office on the day in a badly shaken state, and I think Martina told me that that had happened and that was the reason why. 15:48

388 Q. Just so that I'm clear, are you saying that your first awareness of this general issue that Mr. Mackle had been confronted with this allegation, I suppose, was through Mrs. Corrigan? 15:49

A. I believe so. Whoever spoke to me first I can't say 100%, but it would have been either Martina or Mr. Mackle himself. More likely Martina. 15:49

389 Q. But your belief is that at some time or other you spoke to both of them about aspects of the issue?

A. I must have, otherwise I wouldn't have known to deal with Mr. Brown.

390 Q. Yes. You may recall that in 2012 Mr. O'Brien submitted a complaint, it was a financial complaint. I will just bring it up on the screen. WIT-90380. He is writing to Dr. Rankin. It concerns what he regarded as a shortfall in a payment due to him pursuant to what he says was an agreement to carry out additional work in Outpatients. Can you recall that issue being drawn to your attention? 15:49 15:50

A. I don't recall this letter being drawn to my attention at the time, no.

391 Q. Do you recall the issue generally being brought to your attention, even if you didn't see the letter?
A. To be honest, not really, I don't. I'm not saying I didn't because obviously I signed the sheet along with Mr. Mackle with the amendments on it so I'm not saying I didn't, but I'm not -- I don't recall being involved in the aftermath. 15:51
392 Q. Yes. Just one other piece of correspondence I will put to you. WIT-90379. This is the remarks in medical HR writing to, I think, HR colleagues regarding these waiting list initiative claims. Zoe Parks says: 15:51

"These claims were changed by the AMD Mr. Mackle." Zoe Parks "had spoken to Mr. Mackle and Heather Trouton, and it seems there was some misunderstanding about what had been agreed against his job plan. However they had agreed to concede that changes shouldn't have taken place without prior discussion with Mr. O'Brien." 15:51 15:52

Does that help you at all?
A. Well it must -- she obviously did speak to him, I have no reason to believe she didn't.
393 Q. Yes.
A. But it obviously didn't resonate, stay in my mind. She obviously did. 15:52
394 Q. Obviously, if you don't remember that conversation, you have no recollection of any suggestion being made to you that this type of conduct changing the payment to

Mr. O'Brien could give rise to bullying and harassment allegations?

A. No, that wasn't something I was aware of at the time.

395 Q. I'm not suggesting it was, I am just pondering with you whether that is a possibility that could have occurred. 15:53

A. I suppose it's possible.

396 Q. It's not something you remember?

A. It's not something I remember being a specific issue that would have eventually caused the other.

397 Q. In general terms then, the suggestion, if it was made, 15:53 and this is obviously the subject of some debate, that Mr. Mackle's behaviour towards Mr. O'Brien went beyond the proper line and could have amounted to bullying and harassment, in terms of your exposure to the relationship in the period up to 2012, how would you 15:53 characterise Mr. Mackle's management style?

A. I suppose it would have been -- I was mostly party to it in meetings, probably the Monday night meetings, probably, most frequently. There's no doubt Mr. Mackle was frustrated by the lack of progress, so my 15:54 recollection was that you have discussed a specific issue and you would have thought that you had made progress with the specific issue, and then the following Monday night you would have come back and there would have been -- Mr. O'Brien would have said 15:54 no, I didn't agree to that, that's not what I said, that's not what I recall, and you had to start the whole process over again. I think there was a level of frustration there, both Dr. Rankin and Mr. Mackle, but

I didn't see any bullying behaviour, it was more just a sense of frustration more than anything else, was my recollection of it.

398 Q. Would you have been conscious, and I have no doubt there are other personnel involved, but that Mr. Mackle was involved, I don't say to the fore, but involved in issues which Mr. O'Brien may not have taken kindly to, and the job plan was an issue? 15:55

A. The job plan, the IV antibiotics.

399 Q. Yes. The triage, and things like that. Would you have appreciated that Mr. Mackle was engaged on those issues with Mr. O'Brien? 15:55

A. Yes, well certainly on the IV antibiotics and seeing through the process and to hold to account to the process, absolutely. I wasn't involved in the cystectomy piece because I have only seen that lately, but again, that sort of review of work, and then, of course, the challenge around the NICE guidelines no the need to review ratios, how many patients in a clinic and bringing in the morning of surgery, so those sort of developmental pieces Mr. Mackle would have challenged. 15:55 15:56

400 Q. In terms of Mr. Mackle then taking a back seat, if that's an appropriate expression, just so that I am clear about this, it's not that Mr. Mackle was removed from the managerial tier vis-à-vis Urology or even vis-à-vis Mr. O'Brien still was periodically kept informed of issues concerning Mr. O'Brien as they arose? 15:56

A. Yes, absolutely.
401 Q. And his input was sought and discussions had with him?
A. Yes.
402 Q. Where do you then see the deficit or the dilution of the challenge if Mr. Mackle was otherwise kept abreast of these issues but stopping short of dealing with Mr. O'Brien directly? 15:57
A. I suppose an example, if I can give an example, was in my e-mail to Mr. Young and Mr. Brown, I think it was November '11, November '11 -- November '13, where I am obviously frustrated about the lack of response to triage and notes at home, and I really seek the support of Mr. Young and Mr. Brown from a clinical, I think I used the word peer challenge and patient advocate and whatever, and the response was from Mr. Brown was, well, I hear what you are saying but I have spoken to him and I will speak to him again but he is a wonderful doctor and he is a fantastic clinician and if I had a Urology problem I would want him to deal with it, so therefore, I would want our approach to be how can we help, how can we support? I suppose at the end of '13, four years later -- 15:57 15:58
403 Q. Maybe just while we are talking about that, if I could put a document on the screen. It is one I had intended to return it to later but you have introduced it -- 15:58
A. Sorry.
404 Q. It's convenient, we can look at it now, it's an example or an illustration of the point you are making. TRU-77039. I am not sure if that's the one you are

referring to. I think it's a longer e-mail, isn't it?
A. If you go down.
405 Q. Go down, please.
A. Go down to ... that's my e-mail.
406 Q. Okay. This is you writing at the end of 2013. 15:59
A. Mm-hmm.
407 Q. You have been in post for four years?
A. Mm-hmm.
408 Q. You are writing on triage, an issue that's preoccupied at least part of your time in this role. You were 16:00 explaining you had written to the two of them. If you scroll on down, I think you say at the end, you are writing both about patient notes and triage, but you say:

16:00

"We really need you to speak with Mr. O'Brien both in the capacity of a colleague but also in your capacity as Clinical Lead and Clinical Director for Urology as well as of course patient advocates and need a response within one week." 16:00

What was your impression of what you got back?
A. I think if you scroll on up --
409 Q. We will see that e-mail as well, yes.
A. Mr. Young says "I understand I will speak". 16:00
410 Q. Yes. Mr. Brown does speak, I think?
A. Yes.
411 Q. If we go on up.
A. Refers to a lengthy one-to-one meeting he had in July

on the subject.

412 Q. Yes.

A. And a phone call the week before last, and agreed that we're making a lot of headway, but at the same time recognise he devoted every waking hour to his work. Perhaps Michael and Aidan and Robin could meet and agree a way forward and then "excellent surgeon; more than happy to be his patient, prefer the approach to be how can we help?" 16:01

413 Q. Yes. 16:01

A. That's very, very appropriate to help, absolutely, very appropriate, but four years in, I think I was looking for something a wee bit more.

414 Q. Yes. What you are getting back, if I can elaborate on this, is the emphasis on his attributes rather than, I hope this is fair to Mr. Brown, rather than the kind of challenge and solution that the service was obviously requiring for the benefit of the patients, is that fair? 16:01

A. That's fair. 16:02

415 Q. In terms of your abilities or powers when met with this kind of response from the medical management side of the line, were you powerless or could you have taken that response elsewhere?

A. Well, I obviously did take it to my Director, which was Debbie Burns at that point, because Debbie meets with Mr. O'Brien I think in February, which is what, two months later. 16:02

416 Q. Yes.

A. So I obviously do go on ahead and take it further and I'm sure Mr. Mackle knew at the same time. But within the hierarchy, and certainly at that time, I didn't feel I could go outside of those two lines, so in the course of asking myself, should I have gone directly to the Medical Director myself, should I have gone to the Chief Executive myself, but that's good in hindsight but then you stayed within the relation lines. 16:03

417 Q. Yes. It's perhaps a convenient example upon which to ask you about your reflections or your impressions of the effectiveness of the medical/operational management split and whether it had the potential to have, I suppose, gaps within it when the focus of both sides of management should be on Patient Safety, mitigating risk and delivering an effective service. Does that illustrate perhaps a gap you can't -- well, you can take it further, but if medical management are not going to push it, you have got to spend time taking it further, and then I think it was February before Mrs. Burns is able to come up with a solution with Mr. O'Brien which involved him only taking named referrals? 16:03 16:04 16:04

A. I know we are looking at an issue that didn't work out and there were many issues where operational and professional management worked very well together to come to very good solutions, but I think in this particular issue that was maybe much more difficult and more challenging. It didn't work as effectively obviously as it could have or should have done. 16:04

418 Q. Apart from people being more energetic or more robust, or whatever the appropriate adjective is, is there structurally or systemically that you have reflected upon might serve to avoid such difficulties or ensure that the challenge is more effectively directed? 16:05

A. I have worked with consultants quite a long time, not so much in my latter years because I am more focused on nursing, but certainly in those years and my reflection particularly is that they are largely seen as independent practitioners, and they have a lot of 16:05 autonomy. I think that's even recognised amongst their peers that they have a lot of autonomy, and I think, therefore, there's a recognition that each will act as to how they see fit as in managing their patients, with the understanding, of course, which really is a given, 16:06 that their practice is safe and they look after their patients well, but there is a level of autonomy in all Consultant practice that is difficult to challenge both from a management line, probably difficult to challenge professional to professional when you get to 16:06 a Consultant level, and that's what I have experienced and witnessed over the years. That autonomy probably still exists, largely.

419 Q. You had certain information or certain data about particular issues, we have talked about triage in 16:06 passing already, it's an obvious issue, it was in your face?

A. Yes.

420 Q. Taking notes home after clinics and retaining them,

that was an issue in your face.

A. Yes.

421 Q. What wasn't quite in your face on that was what that issue was symptomatic of. It was symptomatic, I would suggest, and we can test this with other witnesses, 16:07
that dictation post clinic wasn't being done and the notes were being retained to afford Mr. O'Brien a more convenient time to process that element of his administration, I may be right, I might be wrong about that, but the issue of dictation was hidden from you 16:07
until, as I understand it, Mr. Haynes, and other new consultants were validating aspects of the review list. More generally, do you think at that time the Trust emphasised sufficiently the importance of data and audit in order to gather relevant data about patient 16:08
experience, patient care pathway, and aspects of clinical performance?

A. I don't think it was as well developed, 2009, 2016, as it is now. There was clinical audit. The audit was largely done by the junior doctors as part of their 16:08
training and development. There was a very small Trust central audit team but there was not an audit facility function in surgical management at all. There was a lot of audit done into nursing practice. We had a suite of nursing quality indicators that were audited 16:09
regularly, but there wasn't the same level of audit into medical practice, so therefore those things were hidden, to me, until such times as Mr. Haynes and the new people coming into the Service, through their

opportunity to review some of Mr. O'Brien's patients, started to speak out and say, and sort of escalate those concerns so that would have been hidden from me up until...

422 Q. Mm-hmm. We will maybe look first thing tomorrow when we get going with the evidence, that I think you have reflected in your witness statement the kinds of performance issue pressures? 16:09

A. Oh, yes.

423 Q. And the demands that that placed on you and on surgery as a Directorate, but was the -- is there any sense that that emphasis on output and performance took the place or was regarded as more of a priority than Patient Safety indicators and Quality of Care indicators? 16:09 16:10

A. I don't think it was overtly placed as more important. I think the amount of energy and time and effort that went into performance left less time and capacity for a deeper focus on patient quality outcomes. There was a huge drive from the Department and the HSCB, as it was then, on waiting times, and there's nothing wrong with that because people need to be seen and they need to be seen timely, but huge energy on meeting your nine-week and, you know, time to be seen, et cetera, et cetera, for theatre, huge focus on theatre utilisation, Outpatient clinics, and at that time as well there was a huge focus on efficiency, so finance was a big driver as well, so it didn't negate the need for good quality care, of course it didn't, but 16:10 16:11

probably 80% of your energy went into doing performance.

424 Q. You probably think back now and recognise some of the gaps in terms of the information that was available to you and your managerial team around important issues - for example, and we will come to it tomorrow again, how quickly are consultants accessing results of investigations and moving into action? How quickly are they reading them? Is there any shortfall? Is there any exceptions? Is that impacting on patients? The multidisciplinary team in cancer, the whole area has been sort of identified as being without audit of the cancer-care pathway, save for the, if you like, the statutory or the ministerial directions on 4182 day access times. So what does the absence of audit around those kind of, and they are just two examples, tell us? Does that tell us that we are now a more mature service and we can do that kind of thing better now and audit was in its infancy, or was it that you didn't have the capacity, whether resources or personnel, to get that kind of work done because of other pressures? 16:11 16:12 16:12 16:12

A. I think it was both. I think the concept of audit, et cetera, probably wasn't as well-developed and capacity was most definitely an issue, and when services were commissioned by the Board, they were commissioned solely for the people to see patients or the theatre staff or the ward staff. There was nothing in the funding or the commissioning around a quality post or an audit post or -- it was purely focused on 16:13

service delivery. Now, I am sure, implicitly, quality is there, of course it is, and they would expect it to be, and rightly so, and I think the quality was expected implicitly by any qualified clinicians, that they would do the right thing, that they would have the best outcomes for their patients. Looking back, of course, that wasn't to be possible, but that was the thought process. 16:14

425 Q. Yes. As we can see with the Mr. O'Brien issues, there was kind of an ad hoc gathering of information. When the letter went in March, Mrs. Corrigan had to, to some extent, scramble around and count up the number of outstanding triages, the number of clinics that weren't dictated, there was uncertainty around the number of files, patient charts, so, in the absence of hard data evidence, it's -- and that data obviously became available, but more broadly across a clinician's practice, the absence of that kind of hard evidence causes difficulties in terms of visibility and then challenge? 16:14 16:15

A. And it wasn't being collected of any Consultants to that level.

426 Q. Yes. In terms of the management of doctors with difficulties, or difficult doctors, what was in your toolkit, if you like, as a manager, to do anything about that? Was it, as you have outlined already, try to address it yourself or through your management team and, if it's not working, push it across to the medical side? 16:15

A. It was a combination of medical side but also the Director of Acute Services. As I said in my second statement, I was completely unaware of the MHPS process until the public inquiry. It would have been extremely useful, I think, if I would have known about it. I wouldn't have been able to enact it because all the roles in it are obviously medical, but I certainly would have been able to digest it.

427 Q. I am conscious that you have said that you weren't aware of it until the public inquiry. Were you conscious, in 2017, when you gave your statement, that you were contributing to an MHPS investigation? 16:16

A. Well, that might sound naive, but, no, I wasn't. I went in and gave my statement and didn't appreciate the totality of the process that they were -- 16:16

428 Q. I am glad I asked you that question because I'd rather assumed that that was maybe an error of expression on your part?

A. No, no, I --

429 Q. So you didn't know that while you sat down with Dr. Chada, that you were contributing to a formal MHPS investigation? 16:17

A. I knew it was an investigation, but I didn't know it was a maintaining professional standards investigation.

430 Q. Yes. And your lack of awareness, of course, indicates that you'd no training in either the MHPS framework or indeed the Trust guidelines that sit beside MHPS. Has that position changed now, 2023? You are Executive Director of Nursing and I suppose your engagement with 16:17

medical clinicians is less direct, in a managerial sense, than your Assistant Director role, but are you now aware of training provided to your former colleagues on the operational management side in MHPS?

A. I believe there is going to be training. So, yeah, I'm certainly aware of the process now, of course, and there's now a report brought to Governance Committee with more detail on the MHPS process and how many doctors are going through it, et cetera, et cetera, so I am very familiar with it now in this role, but I wasn't previously... 16:18

431 Q. Given that it's really a tool of medical management and their HR supports and you were on the other side of the line, now that you know of the process, can you articulate to what extent it might have been helpful for you to have known about it in -- throughout that period when you were Assistant Director, but particularly perhaps in 2015 when you were finally going to see the Medical Director? 16:19

A. I think it would have been. I have read it, obviously, now in detail. The service that NCAS provide I think is very valuable. I think what really appealed to me about it was, it was patient-centred, so it was really focused on Patient Safety, but it also focused on the doctor themselves and the support mechanisms, whatever. It really looked at peer challenge, which I think was something that we really could have been doing with as an independent peer challenge, though if you think about the patient-centeredness and the support and the 16:19

challenge and the, sort of, the standards, the objectiveness of what the NCAS could have offered, from an independence perspective, I think that might have been very helpful, both to the Trust and to Mr. O'Brien himself, if it had been done and done well. 16:20

432 Q. Mm-hmm. So are you suggesting that if you had had awareness of this, you could have, in the midst of your frustrations around triage and the other issues that we will look at, you could have started a conversation about the need to consider the MHPS process, NCAS 16:20 input, and that kind of thing, to at least get a debate going about the need for a more structured solution?

A. Well, I think I would have found it helpful. In saying that, those who would have known about the MHPS process were aware of the issues, but yet it wasn't, certainly 16:21 in those first six years, picked up on, so whether I would have got any traction with it, I will never know, but at least I would have had it to open that discussion.

MR. WOLFE KC: Okay. It's twenty past four. I think 16:21 it's a suitable place to leave it for today.

CHAIR: It's been a long enough day for everyone.

MR. WOLFE KC: I know we have Dr. Wright coming along tomorrow as well. I have indicated to Mr. Lunny that it's unlikely he would be called before 2 o'clock, 16:21 possibly even a bit later, so he will make his own arrangements. I think he might come, anyway, earlier.

CHAIR: He is certainly welcome, we are not trying to keep him away, Mr. Lunny, but, equally, if he has

something to do in the morning, we are not expecting him here in the morning.

MR. WOLFE KC: Yes.

CHAIR: Thank you, everyone. Then, 10 o'clock tomorrow morning. 16:22

THE INQUIRY WAS THEN ADJOURNED TO WEDNESDAY, 1ST FEBRUARY 2023, AT 10 A.M.