Urology Services Inquiry

Oral Hearing

Day 16 – Wednesday, 7th December 2022

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

Held at: **Bradford Court, Belfast**

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

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Gwen Malone Stenography Services

THE INQUIRY RESUMED ON WEDNESDAY, 7TH DECEMBER 2022 AS FOLLOWS:

CHAIR: Good morning, everyone.
Mr. Devlin. Mr. Wolfe.
MR. WOLFE KC: Good morning. Your witness this morning is Mr. Shane Devlin. I think he proposes to take the Oath.

MR. SHANE DEVLIN, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS:

1 Q. Good morning, Mr. Devlin.
A. Good morning.
2 Q. Thank you for coming to the Inquiry.

Can I just start by asking you to confirm your witness statements for us? You've, so far, provided the Inquiry with responses to two Section 21 notices, which we call witness statements for ease of reference. The first one, if we can have it up on the screen, is WIT-00520. That's the first page. I don't think you have any changes to make to that, Mr. Devlin?
A. I do not. No.
3 Q. If we go to the last page, WIT-00103, please. That's your signature, Mr. Devlin?
A. That's correct, yes.
4 Q. It is dated 11th February 2022. Would you like to adopt that statement as part of your evidence to the

Inquiry?

A. Yes, please.

5 Q. As I've said, you provide a second response to the Inquiry. It can be found at WIT-21153. The Inquiry will note that statement is particularly focused on the MHPS part of your terms of reference. I can see Mr. Devlin nodding his agreement to that. So it is a short statement. The signature page is at WIT-21166, dated 24th June 2022. Same again, Mr. Devlin, do you wish to adopt that statement as part of your evidence to the Inquiry?

A. Yes, please.

6 Q. I'm obliged. Thank you.

Just a short housekeeping matter. I'm not sure that it will be necessary for you to mention the names of any patients in your answers. I don't anticipate that.

A. I don't believe so.

7 Q. But if that was to arise in your thought processes, whether to explain any particular matter, please refrain from naming the patient.

A. Certainly.

8 Q. We'll supply you with a cipher list. There's not one in front of you at the moment but that can be easily arranged.

Inquiry, by way of introduction to this witness, as you know, Mr. Devlin was the Chief Executive of the Southern Trust between March 2018 and February of this

year. Accordingly, he is particularly well placed to set the scene for the future work of the Inquiry by providing evidence in respect of the Trust's Corporate and Clinical Governance procedures and arrangements in relation to the circumstances which led to the early alert and the commencement of the Lookback Review, including by providing his views on whether there were shortcomings in those arrangements and their operation in connection which the Inquiry must consider under its Terms of Reference. That's the framework, or the parameters, I suppose, under which you are going to give your evidence over the next day and a half, Mr. Devlin.

We will look at the Governance structures, but it is not intended this will be a deeper detailed dive into those Governance structures at this stage.

A. Okay.

9 Q. A little bit about your background. If we could have on the screen you're curriculum vitae, WIT-00104. While that's coming up, what's your current occupation or role, Mr. Devlin?

A. I'm currently the Chief Executive of Integrated Care System in Bristol, North Somerset and South Gloucester. An Integrated Care System is the process where we are collaborating health and social care across England into 42 systems, and I'm the Chief Executive of Bristol, North Somerset and South Gloucester.

10 Q. You have been in that role since February of this year?

A. February of this year. February 14th.
11 Q. This is your CV, as we can see from the top. If we scroll down again, just for convenience for the Panel's note, to 106 in that sequence, WIT-000106. If you just scroll down you'll get there. Thank you. In the middle of the page those are your qualifications?
A. That is correct. Yes.
12 Q. We needn't bring it up on the screen, but within your witness statement, WIT-00042, you set out some of your in-job or on-job continuing training. That's one thing, as appears from your statement you appear to take seriously, the need for continuous development through training courses and that kind of thing?
A. Absolutely. I think one of the key elements, I hope you can see from the CV and from the rest of the days, that for me training isn't going on a training course, it is about experiencing and learning and improving.
13 Q. On the job?
A. On the job, absolutely.
14 Q. Scrolling down again to WIT-00108. Just highlight the bottom of that for me. I think I'm right in saying, Mr. Devlin, that you have 20 plus years experience of working in the public health sector commencing with your first HSC post, I think I'm correct in saying?
A. That's correct.
15 Q. In Lisburn, as it then was?
A. It was. I had graduated in Economics. I had worked for a small startup organisation looking at economic development competitiveness and then I moved into the

Health and Social Care arena in 1998 as a Quality Manager in what was then Down and Lisburn Trust, which then became the Southeast Trust in the re-organisation of the health service in 2007.

16 Q. If we go back to WIT-000104 in this sequence, we can see that immediately before you took up your post in the Southern Trust, you had been Chief Executive of the Northern Ireland Ambulance Trust?

A. That's correct, yes.

17 Q. Before that you had a role in the Belfast Trust?

A. I was Director of Performance, Improvement and Informatics in the Belfast Trust. Before that I was a Director in the business services organisation looking at the transformation of back office functions for Health and Social Care. I was Performance Director for Northern Ireland for the back office functions of Health and Social Care.

18 Q. One of the things I picked up from what you said of your various posts, certainly the Belfast Trust post and the Ambulance Trust post, improving performance seems to be a key task in each of those posts?

A. Absolutely. In terms of organisational performance, I'm looking at how we can continuously improve, both Quality Improvement as well as a wider range of what you might call business improvement functions, so both the corporate and also working in the clinical and social care governance, and quality improvement arena as well.

19 Q. The Southern Trust posts to which you were appointed in

March, I think you took it up on 19th March 2018?

A. Correct.

20 Q. That was your first Chief Executive post within a Health and Social Care Trust as distinct from the Ambulance Trust.

A. The Ambulance Trust itself is a Trust, and delivery of Health and Social Care Trust is a very small Trust, and quite a different trust because it is providing emergency medicine and emergency care prehospital. It is a Trust in the sense that it has a Trust Board, it has all of the appropriate governance. It has many, many clinical and social care governance and corporate challenges, so it is a Trust. It is Northern Ireland's sixth trust. What it isn't is an integrated health and social care delivery trust, which you are correct, therefore, this was my first Chief Executive job in an integrated care delivery trust, although obviously I had worked in that for most of my previous 20-something years in health and social care.

21 Q. In that sense was this a step up for you?

A. Yes.

22 Q. Career progression?

A. It certainly was. I mean I enjoyed greatly my time in the Ambulance Service. I think the Ambulance Service is much underplayed and it is a hugely important part of the system, but it was a step up to come into a Health and Social Care Integrated Trust which was, at that time, about 13,500 employees employing all services from the cradle to the grave as it would have

been described on many indications. So it absolutely was a step up.

23 Q. I'm going to come on to look, shortly, at some of the challenges that you faced. Just looking at the job description, first of all, for the Southern Trust position of Chief Executive. We can go to TRU-02126. Here we have, I suppose, a summary description of your role. You were the Accountable Officer for The Trust?

A. Yes.

24 Q. That means accountable to various, I suppose, internal entities and also externally to the HSCB and the Department. Does the external element of that involve much in the way of contact with the Department, for example? Meetings? What was the form of communication?

A. Yes, certainly. First of all, as officially the Accounting Officer for the organisation, clearly whenever I was appointed the Permanent Secretary writes to me as Accounting Officer, and, therefore, there is a delegated responsibility as Accounting Officer from the Permanent Secretary, as a result there is considerable engagement with the Permanent Secretary. I explain the various elements of the Department. Over time, and over my four-year tenure, that relationship changed quite a lot because of COVID, obviously, in the second half of my tenure. The structures changed quite dramatically. In terms of the relationship, absolutely, I would have met with the Permanent Secretary, and all the other Chief Executives

collectively, at least monthly, maybe even towards -- certainly in the COVID period, weekly, but certainly pre-COVID at least monthly. We would have looked at how we can improve the whole system, it was called the Transformation and Implementation Group, TIG. There was a lot of engagement on a monthly basis with the Permanent Secretary, and TIG involved both the Permanent Secretary, Chief Medical Officer, Chief Nursing Officer, etcetera. So there was a huge amount of engagement as Chief Executive of the Trust with the Department in looking at systems working.

In terms of looking at the Trust working, as opposed to the systems working, there would have been formally, at least twice a year, there would have been a formal engagement with myself as Chief Executive, the Chair and also the Permanent Secretary. Then there would have been regular engagement with Deputy Secretaries around issues that may have come up. I mean I was engaged a lot with the Department. I previously had worked in the Department as a secondee, and I knew a lot of the people in the Department as well. There was both the formal, but I also would have engaged informally with the Chief Nursing Officer, the Chief Social Worker, etcetera, so there was lots of engagement with the Department both formally through TIG, as well as informally, and then on at least a six-monthly basis.

With regard to the Health and Social Care Board --

25 Q. Stop for a moment.

A. Yes, certainly.

26 Q. As you will appreciate from the Inquiry's Terms of Reference one of its interests is communication between the Trust and the Department, HSCB and HSA. It is right to say, isn't it, that the Department would have known nothing about the issues within Urology in terms of those issues that give rise to the Inquiry until it received an early alert in late July, 31st July 2020?

A. Certainly, from my understanding, I would not have discussed it with the Department at that point of time. There may have been clinicians who worked in the Department who may have been aware of, as many clinicians are in the Department, about what is going on in the Trust on an informal basis. I couldn't say there was or there wasn't. But in terms of me personally, I had not been engaged with the Department. I had not formally notified the Department of anything with regards to Urology. Therefore, in terms of Urology, it is not a topic that I had had any conversation with anyone in the Department with before the issue of the early alert in 2019.

27 Q. Presumably there --

A. 2020.

28 Q. -- would have been conversations with the Department about the pressures being felt within various Directorates of The Trust, and Urology, as you probably realise from the reports that were going to Trust Board

and from your senior management team directly to you, Urology was a division that was particularly under pressure?

A. No, from a Chief Executive perspective there wouldn't have been those conversations with the Department. The conversation on pressures would have been with the Health and Social Care Board, the nature of the Health and Social Care Board being the performance element of the Health and Social Care system. So, the conversations I would have had, for example, in the six monthly reviews with the Permanent Secretary would have come after what was called ground clearing. Ground clearing was a process whereby the Department would meet with the Trust, not at Chief Executive level, it would have been at Director level, and Director level with Director level in the Department, they would have looked at a range of issues and only following ground clearing meeting -- during my time that would have been led by a Department Secretary level in the Department, and then from the Trust it would have been the Director of -- probably Director of Performance would have been at the ground clearing meeting. I would have to double-check, but it certainly was Director of Performance. The ground clearing meeting was the place where the Trust could talk to the Department about what was happening in the Trust. I would then meet with the Permanent Secretary after ground clearing and issues that were highlighted from the ground clearing meeting may have been discussed -- could be discussed, sorry --

at the meeting with the Permanent Secretary. As far as I recall, and certainly when I look at the notes, we did not discuss Urology with the Permanent Secretary at those meetings. The pressures that may have been felt in the organisation may have been discussed in ground clearing meetings. I was not party to those ground clearing meetings because they were at the Director and Deputy Secretary level.

29 Q. Yes. By the sounds of that, Mr. Devlin, pressures within Urology wasn't something you were pushing on to the agenda then with the Department?

A. No. I mean issues -- and I'm sure we'll come on to it -- but issues of pressure in general and, clearly, pressures with regard to both staffing, so pressure is both a demand issue and a supply issue, staffing being a supply issue, and demand being a pressure issue, they in general were talked about and how we would manage to address those issues. I was not pressing on any Speciality in those meetings with regards to the Permanent Secretary at Departmental level.

30 Q. Thank you for that. Let's move to the HSCB.

A. Certainly.

31 Q. In terms of communication with that organisation, obviously they're the commissioning organisation within Northern Ireland?

A. Yes.

32 Q. On that level there's obvious engagement Between Trust and HSCB.

A. Yes.

33 Q. Tell me about that.
A. So the role of the HSCB, as was, and I'm very aware now that is a different position, but if I'm describing the position when I was in role. If I could describe the process by which the HSCB and commissioning worked, and then I can talk about how we then communicated. The process was very clear. On an annual basis there would be a commissioning direction created, usually at a policy level in the Department. A commissioning direction would indicate what the big areas of development for the Health and Social Care sector would be in the year. That commissioning direction would become a commissioning plan. That commissioning plan was something the Health and Social Care Board would produce. That commissioning plan would identify, usually through programmes of care, so Acute, Children's, Mental Health, their programmes of care, usually through programmes of care would identify: here are the things we, as a system, believe need to be done in Northern Ireland this year. The commissioning plan was always an annual process. That commissioning plan would then be issued to Trusts to say, as a Commissioner, we would like to do these things this year. It was a detailed document, it was in many cases, two to three hundred pages of a commissioning plan. What would happen is every Trust, in this case the Southern Trust, would then digest that commissioning plan and would respond in what was called a Trust delivery plan; would respond and say, well,

actually, you want us to do this in the Family and Childcare world, or you want to purchase a thousand tonsillectomies, whatever the case may be, and we would respond through the Trust delivery plan. That Trust delivery plan would be approved through Trust Board. Alongside that, in that Trust delivery plan there would be issues around the sourcing of the plan or issues around, in terms of human resource and financial resource. That Trust delivery plan would indicate how much of the commissioning plan we could meet. It was very rare that we could ever meet everything the Commissioner wanted, as is evidenced in the delivery plans. You would show that we can do this but for various reasons we can't do this. That Trust delivery plan would be approved by our Trust Board and submitted to the Health and Social Care Board.

What would then happen is that Trust delivery plan and that commissioning plan would come together and the Board would then issue to us what is called a Service and Budget Agreement. That is, basically, the signed-off agreement that says, we have given you our commissioning plan, we have returned the Trust delivery plan, and here is what the contract will be for the year between the Commissioner and the provider. Then there would be regular communication with the Health and Social Care Board. That could take the form the Directors of Performance and Performance Managers meeting regularly with the Board. When I say

"regularly" certainly in my early days in Health and Social Care that would be weekly. What I would say over the last three to four years it hasn't been weekly, it has tended to be more monthly, to look at that Service and Budget Agreement and see are we delivering on what that agreement said that the organisation should deliver on. What would happen at Chief Executive level then is that once a month the Chief Executives would meet with the Chief Executive of the Health and Social Care Board, and that's the opportunity for the Chief Executive at the time to discuss with us how the system was performing, other things we needed to do differently, etcetera. So, that's the formal mechanism. Therefore, there was always formal performance relationships between the Health and Social Care Board and with the Trust. That would have allowed for conversations around particular specialties or particular challenges, and those performance meetings. In my previous life when I was a Director of Performance in the Belfast Trust, I would have been meeting with the Director of Performance in the Board and, I mean, at that point it would have been weekly, actually. We would be looking specifically at performance challenges and what can be achieved.

34 Q. One performance challenge, I suppose -- if it is correct to frame it in that way -- which we have come across already in the Inquiry, is the need to deliver the service safely all along the care pathway. The example of that that stands out, and I propose to look

at this in more detail with you in the course of your evidence, an example that stands out is that there's guidelines for the delivery of prostate cancer care. One, of course, hopes that all clinicians are going to deliver the care with the guidelines, but that shouldn't be on trust, that should be something that should be monitored or tracked, and, perhaps, audited. Do you recognise within that that there's obviously a resources issue? In order to deliver care safely in the way I've described it has to be resourced?

A. Absolutely.

35 Q. In short terms -- I want to go on to this in more detail -- is that something that is the subject of specific discussion, with, for example, the HSCB, or do you get a lump of money and you are expected within any particular Directorate to simply deliver safely as best as the money will allow?

A. I think your latter description is closer to the process. I don't think it is as simple as it is one or the other. I think, clearly, there is an amount of money in the commissioning plan to deliver certain services, and it is expected that it would be delivered within that cost frame. What I would stress is that at performance level, and those conversations with the Health and Social Care Board, those conversations were being had around the outputs. In other words, did we deliver 100 of this, did we deliver 200 of this? I do not recall getting into very many conversations with the Health and Social Care Board about how we

would deliver that, because that was not the relationship. The performance relationship was, did you deliver 100, as opposed to, tell me how you delivered 100? I think that's the important reflection.

36 Q. Yes. We didn't get very far into your job description before paused for those --

A. You also asked about the conversations with the Health and Social Care Board.

37 Q. Yes.

A. There were also informal conversations. I think that is important to stress. What I have described is the formal conversations with the Health and Social Care Board. The conversation was not simply between Chief Executive and Chief Executive. There is a network of conversation between employees of the Trust and employees of the Board, because the Health and Social Care Board, in line with the Public Health Agency, who were partners at that time, have clinical specialists. It's not just this formal, there is quite a considerable network of conversation that goes on between the Health and Social Care Board and people at all levels in the Trust. It is not just a simple performance related conversation.

38 Q. A particular issue that has achieved prominence already is conversations around Serious Adverse Incidents.

A. Correct.

39 Q. There's a particular pathway between the organisations to work that out.

A. That's correct.

40 Q. I think the Inquiry sees that's quite a broad relationship at a number of levels.

A. It is.

41 Q. Just let's scroll down, please. Within your job description a number of -- just scroll down, please, to the next page -- results areas are identified: Delivery. Patient/client care. Strategic Leadership. Corporate Management. Governance. Just pause there. That's obviously a key interest from the perspective of the Inquiry. You are required to ensure robust arrangement are in place to meet the statutory clinical integrated governance requirements. Number 25 there, and we'll look at that in a moment.

Just scrolling down. External Relationships. Finance. BAF Resources. I think I said ten. Development of Self. Human Resource Management Responsibilities. Then I think an eleventh is these general requirements. It is a broad portfolio and no doubt a difficult job, particularly in the climate which you were to occupy the role with COVID affecting costs and its ability to deliver in anything approaching a normal way from the spring, early in 2022; isn't that right?

A. Yes. March. Late February when we knew.

42 Q. If you just go back to WIT-00104. Under Key Achievements you say that you're very proud of all your achievements, but the key achievements within the Southern Trust were set out in those five bullet

points. Leading the Organisation through the pandemic, designing and delivering a Trust Board development programme which focused on improving accountability and developing a new culture and strategy. That doesn't tell us an awful lot, but is part of this, what I'm going to come on to talk about shortly, your proposals to redesign the corporate structures to integrated a new Directorate Learning from Improvement?

A. It is actually more than that.

43 Q. It is broader than that.

A. Would you like me to explain how it is broader than that?

44 Q. We'll come to that. Designing and leading on a process of agreeing the key purpose and objectives for each Directorate and turning those into Directorate dashboards and safety thermometers. Can you explain that for us?

A. Yes. What I would stress is this got tied up in the COVID agenda, but what we were trying to do was -- for each of the Directorates have key objectives. One of the challenges I felt the Directorates had many, many, many things to do but actually focusing on what the key outcomes were. So we created score cards for each of the Directorates that looked at key outcomes for each of the Directorates. That allowed me to then meet with each Directorate on a fairly regular basis, but formally at least every quarter to understand where we were against those key Directorates. One of the Directorates then, actually through Maria O'Kane as

Medical Director, we began to explore safety thermometers like in Mental Health. That was the idea of having indicators that would highlight where potentially things were starting to go slightly in the wrong direction, and that would allow the Directorate to manage and looking at those safety indicators. Mental health was the place that was also tried as well. Fundamentally what the scorecard was trying to do was get key indicators around, for example, the Acute Directorate around elective care, around unscheduled care, around monthly training, finance, those kinds of things, and making sure we were managing those on a very regular basis. I would stress that when COVID happened we changed a lot of our management processes and it became much more command and control, but up until that point we were regularly holding those meetings with Directorates and looking at the wider scale of performance.

45 Q. Was this use of scorecards within Directorates to --

A. It was.

46 Q. Was this something that surprised you in the sense that it wasn't there before?

A. Yeah. I mean having come from organisations where they were and had implemented them, I was a little surprised at the lack of structure to the management of the Directorates. What I was trying to do was bring some structure that brought together finance indicators, performance indicators, HR indicators, and allowed me, as Chief Executive, to know that the Directorates were

functioning in line with their objectives. That didn't exist when I came in.

47 Q. Just touching on the two other matters you mentioned. You led a codesign programme of improvement for the Daisy Hill Hospital. You set that out there, and you were part of the HSE Regional Management Board. That was of particular significance in the context of COVID and the need to reimagine the delivery of health service in the region?

A. Correct. The Regional Management Board was set up, actually, as part of the COVID legislation. It was part of how we would manage the system as one whole system of command and control, because we were in a global pandemic, a major incident.

48 Q. Yes. Obviously you set out with pride your achievements but, obviously, with every job there are things you reflect upon that could have been done better, perhaps. Were there disappointments or regrets from your time in the Southern Trust?

A. Not that I could control pandemic, but I think we would have delivered an awful lot more as an organisation, organisation development. We were building a very strong team. I came in and actually I had four vacancies in the team. I brought them together. We created a new team. We were starting to put controls in such as scorecards, such as weekly governance meetings through the Medical Director, etcetera. We were starting to do stuff. We were unable to finish out a lot of that because we spent two

years in pandemic mode. My disappointment is not, it's not a disappointment in any one, but my disappointment was there were things that I would liked to have delivered out on that did not come to its full account because we completely changed the organisation overnight.

I would love to have seen us be able to move much more care, and we did a lot of care in the community, I would love to have seen us move a lot more care into the community. That's a disappointment because I think the Southern Trust is exceptional at Care in the Community, and has been evidenced as being exceptional at care in the community through many, many programmes. I would liked to have been able to do more that and really take emergency medicine into the community a lot more, to avoid our hospitals becoming jammed. I also then reflect on our elective position. Because of what happened during COVID, but not just COVID, our inability to balance the Unscheduled Care challenges with Elective Care challenges. I am disappointed that we were unable to do more Elective Care. That's something that, I think, if we hadn't have had the pandemic situation we had, and been able to get more care into the community, then we could have returned more elective care, and I am disappointed that I was unable to do that. I think if you can return more elective care you can keep people safer. That's just the way that it works.

49 Q. Yes. In terms of the circumstances that give rise to this Inquiry, have you had moments to reflect on that?
A. Absolutely.
50 Q. Obviously we'll go into some of the detail of it. But at a high level, perhaps, have you reflected on that and whether you have any cause for disappointment in perhaps your own involvement or lack of involvement?
A. Yes. I have reflected a lot. I don't think you can be a Chief Executive of an organisation heading into a public inquiry without reflecting deeply. I think there were clearly opportunities that my involvement, my deeper involvement may have addressed some of the issues earlier.

For example, at the end of the MHPS process, accepting that we had an action plan, accepting that the action plan was very focused on what were considered administrative challenges, that's a massive reflection to me. In the cold light of day when I reflect on that, I don't believe there are administrative challenges because they are all connected to Health and Social Care. Therefore, I have reflected a lot on that, and my relationship with Ahmed Khan at the time and whether I could or should have done more at that moment in time, and focused on it at that moment in time as opposed to the other major challenges I was trying to deal with. I have reflected a lot on that. I think that, for me, is the biggest opportunity where, as Chief Executive, I could have been more involved in

the process, was at end of the process MHPS process when Ahmed presented to me, here's the outcome. I said, thank you very much. Is it being managed? Yes, it's being managed. I went, thank you very much. And I moved on to the other big challenges, of which there were many. That's the key point I have reflected on.

51 Q. We'll certainly poke at that a little bit further as we go on.

A. Yeah.

52 Q. When you were about to take up this post, had you a sense that it was going to be a particularly challenging post, or what did you have in mind in terms of what was going on in the Southern Trust, which had gone through a number of chief executives in the years prior to your appointment?

A. That's correct.

53 Q. Some temporary post holders. Did you have a sense of what the challenge was ahead of you?

A. Absolutely. I mean, Northern Ireland and Health and Social Care in Northern Ireland is a very small place. Therefore, I had lots of conversations with people working in the Southern Trust. I lived in the Southern Trust and that's part of the reason I was attracted to it, because I wanted to do something back in my own community. I had lots of conversations and lots of people had said it's a great place to work. Others had said, don't go there because there are real challenges. I was very well aware that, having --

I mean, if I were to be successful, which I was, I would be the fifth Chief Executive in three years. I was very aware that the Southern Trust was undoubtedly held up as the performance -- the key Trust of successful performance during the Elective Care reform years. It was the end of the 00s, into the early teens. I'm very well aware that its unscheduled Care performance was the highest in Northern Ireland, and I was also very well aware that the years before me taking up the post that it had fallen from those positions. I was very aware that I was coming into an organisation that was challenged. I was aware of the elective pressures that were on. I was also aware that it was starting to see 12-hour breaches in the Emergency Department, which it had never seen before. Therefore, I was very well aware of the challenge I had. But, part of the desire to take on a job as a Chief Executive is to take on the challenges that are there in front of you. You don't take on a job to come to work at 9 o'clock, go home at 5 o'clock, and send a few emails. That's not what a Chief Executive job is. Therefore, I was well aware of the challenge and I wanted to be able to make a difference. Particularly, as I say, I live in the area. Most of the people who work in the Southern Trust also live in the area, and it's about doing the right thing for the people that you live and work with.

54 Q. Yes. I want to take a short walk through some of the Governance structures.

A. Certainly.

55 Q. You can help me with what was important from your perspective in your role, given that the requirement to provide assurance to the Board and, obviously, that assurance is required for elsewhere. You have told us in your witness statement that the role to ensure that the Trust had robust and effective arrangements in place for Clinical and Social Care governance. You go on to reflect within your statement about the important role of all of the Board's committees and the subcommittees, but drawing particular attention to the Trust`s Governance committee, which is required to provide the Board with assurance on all aspects of the Governance agenda, except Finance, using Clinical Governance metrics and other evidence. The Governance committee is at the heart of the, by definition the Governance exercise, the Governance function.

A. Correct. It is the one committee that looks in detail at the key elements of both Clinical and Social Care Governance and also elements of Corporate Governance. Even though when I'm saying that, they totally intertwine and they look at integrated governance. It is absolutely the committee where those issues are looked at in detail for the organisation as a whole. In terms of its agenda, I'm very well aware that the Inquiry will know what is on its agenda, but in terms of its agenda at the core of that is the Governance report, that Governance report looks at Clinical indicators as well as issues of other areas, such as

litigation, etcetera, but, primarily, it focuses on clinical indicators, both Health and Social Care indicators.

56 Q. This is the Clinical and Social Care indicators that comes to this committee?

A. That's a fundamental report that it looks at SAIs, it looks at incidents, it looks at clinical indicators, the outcome indicators, etcetera. That is really the channel by which Clinical and Social Care Governance is visualised at a Board level. I'm more than happy to go into, I think there are challenges in that process, but that's the vehicle by which that report presents to the --

57 Q. As I work through this, and I'm conscious I'm going to ask you questions about -- if I can call it your reform agenda, your change agenda. I want to ask you questions in that context in a moment or two. But another aspect of the Governance committee that I wish to address just now is: is the use of Clinical Governance metrics? Is the use of metrics something that you were familiar with in your role?

A. Absolutely, yes. The idea that Clinical and Social Care Governance and performance is both data driven, which clearly is metric and, therefore, intelligence, as well as looking at processing systems. So absolutely. That's fundamental to that particular report. It has been reviewed on numerous occasions to try to home in on those metrics. But, absolutely, at the heart of that report is a range of statistical

process control charts. It looks at the indicators and how we are safe or how we can become more safe.

58 Q. Was that process of gathering data and then using it intelligently, was that in good health when you came?

A. Given the fact it's an area that I think I engaged quite early on with the both Medical Director and Chair of the Committee, there was improvements to be made in that area. I think the challenge in the Health and Social Care system, and in this case the Health and Social Care Trust, is that the range of indicators could run to thousands. It really could. The challenge was to try to narrow it down into what are the key safety, quality and social care governance indicators. It was a constant challenge to try to get the right indicators. But, fundamentally, it is an area that I was involved in heavily to see how we could improve the measurement that we brought to those committees.

59 Q. You also refer in your statement to the importance of the patient/client experience committee. Its purpose was to provide the Board with assurance that the Trust's services, systems and processes provided effective measures of patient, client and care experience.

A. Yes.

60 Q. That was an opportunity, through that committee, to take a deeper dive into certain areas of clinical practice and patient experience.

A. Yes. It was a deeper dive often to patient experience.

I wouldn't suggest it was a deeper dive into clinical practice, although the experience, obviously, is as a reflection of the practice that somebody received.

61 Q. Yes.

A. Yes. The committee was there. I think anyone who works in the world of patient and public involvement understand that no one patient or no one small group of patients could ever reflect the complexity of what it is like to be a patient of the Health and Social Care Trust. However, those individuals provided very good feedback through to the Chair of the committee, who was John Wilkinson, very good feedback on their experiences as patients/clients, of our service. It allowed that voice to be heard around the Board table via the Chair and, also, a layout of some of those patient stories to be heard directly by non-execs and execs. It provided a real opportunity for that voice. I don't believe you could ever have a holistic committee that could ever represent all voices of patients and clients, but it was a good way of allowing that voice to be heard by execs and non-execs.

62 Q. We know, for example, on 24th October 2019, one of the Specialist Nurses from Urology came to speak to that committee to reflect the patient experience reflecting the waiting list pressures, its impact on patients, spoke of the difficulties, sometimes, in meeting cancer targets and the impact on patients.

For the Inquiry's note, the reference to that it

TRU-128158.

I don't need to bring you to that, but I want to ask a general question. When you have a practitioner coming to that committee, reflecting the difficulties faced during the patient experience as a result of the patient experience, where does that go to? If there's real difficulties facing the staff and their ability to deliver for patients in a way that conforms with the guidelines or expected norms? Where does the information from that go to in order to, perhaps, drive change or lead to proposals for change?

A. All committees have a space on the Trust Board to raise issues that have been raised at a committee at a Trust Board level which would allow -- you'll see from the minutes every single committee, the committee notes and committee Chair reports to the Trust Board. In practice, any committee Chair could raise to the Trust Board as a whole. In that particular case I do not recall, off the top of my head, that was raised to the next Trust Board meeting, because you raised it with me and I genuinely don't know.

63 Q. I believe the report from the committee is part of the Trust Board pack for the next meeting, perhaps. I can't say off the top of my head?

A. Yes.

64 Q. Our impression, perhaps, and you could maybe assist us with it, our impression, perhaps, is reports coming from the committees aren't generally the subject of

great debate or input at Board level. Clearly Board members form parts of these committees and maybe that is the Board having the debate at the committee level, but when it gets to full Board, little apparent appetite -- and this is a general observation, of course -- little real engagement on some of the meatier issues that emerge from the committees?

A. I think that's a very fair reflection. The job of the committee is to try to deal with those issues at committee. However, there was always the vehicle that if the Chair of the committee felt it should be discussed at Board, then it should be discussed at Board. But I'm reflecting on the minutes and reflecting having been at four years worth Of Trust Board minutes. I think it is a fair reflection you make. It was not a regular occurrence for information that was discussed at committees to have any detailed conversation at the Trust Board. We did, in probably October, November 2021, then begin to have a conversation about risk appetite and about what the process should be for escalating from committees to Board. We brought in the Good Governance Institute, I believe it was, to help us understand how best to escalate from committee to the Board. That was, actually, the last Workshop I was part of before I tendered my resignation because I remember it was the day I actually tendered my resignation. That Workshop was to help the Board to understand how we could improve that process and having some kind of tiered

level of risk being carried at committees, and then being moved into the Board environment. I do not know whether that was delivered on post my exit.

65 Q. Thinking about it, and we can obviously tease this out with those who are there still and now, you would have been hopeful that some form of mechanism or test or trigger would have been identified for that purpose?

A. Correct. Yes. One thing that did happen is that the committee Chair would meet with myself and the Trust Chair not long after the committees, a very short meeting, where they could, if they felt it important to raise any major issues to us. But, again, it was not a thing. There would not regularly have been any issues raised with us from the committee because the assumption was the committee was doing its job, and if it needed to, it would raise. I think there's quite a considerable point of learning in that in terms of making sure that committees regularly raise issues to the Board rather than by default don't. I think there's a big point of learning.

66 Q. You refer in your witness statement, WIT-00026 -- we have it up on the screen. It is not entirely necessary -- to your initiative to create a performance committee?

A. Yes, that's correct.

67 Q. You introduced a performance committee, the purpose of which is:

"Assists the Trust Board ... overseeing the delivery of planned results by monitoring performance against

objectives".

The idea of this committee was to allow the space and the time, which wasn't otherwise available at Board level, to consider a detailed analysis of key performance indicators?

A. That's correct. It was clear, having worked in other organisations, other organisations had performance committees. It was also clear to me when I arrived that the length of time that people are able to spend going into detail at a Trust Board meeting around performance was limited, because Trust Board meetings themselves are limited by time. I had suggested to the Chair that it would be wise and the right thing to do to provide a space for non-execs and execs -- not just non-execs, the whole Board, to explore performance at a greater detail, and also then to take deep dives into different areas of performance at every meeting. One might have been about cancer, one might have been about mental health and learning disability, and allowing the Directorates to present to that committee how they were performing, often against that which was articulated in the Trust delivery plan, which I had mentioned earlier, how they were performing against that. It wasn't just that. It could have been wider clinical guidelines, it could have been wider issues of the wider performance. That meeting became, I think, an important opportunity and, in some cases, got behind some performance issues. But, again, I would stress that it was deep dive into

certain areas. I think across the complete Health and Social Care Trust it is difficult to get behind every element of performance, hence the importance of Directorate Performance and Directorate Governance.

68 Q. One of the things we may reflect upon later, perhaps, was when you look at some of the shortcomings that were identified through the Serious Adverse Incident reviews conducted by Dr. Hughes and Mr. Gilbert and others in 2020 and into 2021, there was an absence of data to highlight departures from expected norms. What was available, perhaps, and maybe, it is a matter for the Inquiry, maybe insufficiently used was knowledge, informal anecdotal knowledge about shortcomings that wasn't reflected back to the leadership. In a performance committee context, would it be possible to get that kind of thing on to the agenda, and how would that be done?

A. Yes. If you think about the performance reports and, again, the Inquiry, I'm sure, will have a couple of those performance reports, it was very broad and tried to look at the complete range, and then it would go into deep dive and, therefore, in those deep dives it would certainly have been the case to look at how things were measured and monitored; were we measuring the right thing, who was learning from that? But by the nature of the deep dives you only go into a particular area. I can't recall when we started it, but I'm certain there would only have been six or seven performance committees in my tenure, maybe slightly

more than that, in no way would it go into every specialist area. It could not have done that. But that was the purpose of the deep dive, to try to go underneath and understand how performance was being monitored, being measured, and whether it was working or not, and whether it was improving performance and keeping people safe. That was the reason for the committees.

69 Q. Moving away from the committees, and there are other committees but they appear to be the ones most relevant to the Inquiry's interest. You also talk about the Risk Management Strategy within the Trusts --

A. Correct.

70 Q. -- and the fact those arrangements are audited?

A. Yes.

71 Q. You refer us to the use of local directorate risk registers with issues of significant importance to wider Patient Safety being escalated to the senior management team and, presumably, inappropriate cases on to the Corporate Risk Register?

A. That's correct. Each team, each Service Area but primarily Directorate will have a risk register. They will review that risk register at their governance meeting. In many cases that will be, I think, at least on a monthly basis. There is an opportunity, and it does happen, whereby risks can be escalated. A risk obviously can be managed at a local level. It may be the case where a risk needs to become a corporate risk because it is much bigger than the local level. All

risk registers are managed in a fairly standard way. It would have been the previous Australian/New Zealand approach, which would have looked at risk, probability and impact. That changed a couple of years ago, but very similar. Risks are assessed based on that standardised approach and should, therefore, scores from that standardised approach become both high and also the Directorate feels it cannot manage that risk at a local level, then it can be put forward to become part of a Corporate Risk Register. The senior management team would then meet, as it did every week, but it would meet in Governance form to look at those risks and they may become part of a Corporate Risk Register. It is important to note that simply putting it in the Corporate Risk Register doesn't remove the importance of the Directorate to deal with it, but it allows us to look at key risks to the organisation. Certainly before I had left, maybe a year before I left, we began to explore: is there a better way to improve the way we manage risk? We did a lot of work on the Corporate Risk Register to look at major themes of risk rather than the risk register being built up from within the organisation but looking at what the objectives of the organisation are, and trying to look at risks around the workforce, the risk around safety, etcetera. A lot of work went on to try to evolve the Corporate Risk Register into a genuine management tool as opposed to a place to record a risk. I think there's always a danger of risk registers that people

assume, well I've recorded the risk, therefore. That isn't why we have a risk management strategy, that isn't why we had risk registers. Risk registers are a tool to help us improve, to become safer. So we spent a lot of time looking at the review of that. At a local level each Directorate has a Directorate risk register and Services will also have a Service Risk Register. That's what internal audit will have look at in terms of the connection between local risk and corporate risk.

72 Q. I am interested in the concept of the risk register as a management tool.

A. Yes.

73 Q. We will come on, in the course of your evidence, to look at, for example, standard guidelines, and I can tell you 2014 it comes on to the risk register for the first time and remains on the register for relevant purposes, and still on the register today, but I take it up to July 2020. During that period the level of risk goes from -- it's the bottom of the line -- low to moderate.

A. Low to moderate. Yes.

74 Q. I'll look at that with you later. In terms of the use of the risk register as a management tool, is that a way of saying management should see the risk and work out ways of dealing with it using the resources at their disposal?

A. I mean the key element of a risk register is both probing an impact to understanding the risk and

mitigation. That's fundamentally what a risk register is about. A mitigation is itself an action plan. In some cases the risk cannot be mitigated and there is an acceptance of risk. You sit it there and say, we are going to have to live with this risk. But in most cases in Health and Social Care that isn't the case. In most cases it requires mitigation, and in most cases, therefore, it is a tool for management because it is a tool for action. It is not a tool for observation. It is a tool for action which is, if we are going to mitigate this risk, what are the things we're going to do? That's where we would talk at both the Governance Committee and the senior management team, about what action are we taking as a result of what we are learning through our risk management process. Clearly, in a high-performing system, that is the kind of thing that happens throughout the whole of the hierarchy of the organisation. I think there is learning and challenge in that because I don't believe that in every part of the organisation that is the way risk management and risk registers are used. I think it is clear now, having reflected on the evidence, both read and my understanding, I think in many cases risk registers are used as a place to hang stuff on as opposed to being a tool for management.

75 Q. These various components, the risk register, risk management, the committee structure, they're all components of what you have described as the Integrated Governance Framework?

A. Correct.
76 Q. Those tools within that framework are, in theory, used to provide assurance to the Board?
A. That's correct.
77 Q. The Board, in turn, is working in the context of a Board assurance framework. If you can, the relationship between those two concepts, those two entities?
A. Certainly. The Board assurance framework, the BAF as it is referred to. The BAF is produced on an annual basis, if you start at the top and I'll explain how it connects. The Board Assurance Framework is produced on an annual basis. That looks at what the main objectives of the organisation are and, in many cases, that is about provision of safe services, meeting performance, etcetera. What the assurance framework looks at is, if we are to be successful in meeting those objectives, what are the key actions we need to take, and what are the controls that we will put in place to make sure we meet those requirements? The risk register is reflecting on, well, actually, what is the risk to us not being able to meet those objectives? In many cases that risk will be quantified, or at least qualified, in both the probability of it happening and what's the impact if the risk occurs. They are absolutely connected. You start with the Board Assurance Framework saying, here with the big objectives we want to achieve and if we are to be successful, here's the things we will have to have

delivered. The risk register looks at what is the risk to us achieving those things. It is both at a Board level but also at a local level, therefore risks will come up and you will be saying, if that risk becomes reality, we have a real difficulty in achieving that objective of safety or performance, or whatever the case may be. They are absolutely interconnected. The Board Assurance Framework is an annual document or statement of where we are going. The risk register is a regular, live issue that needs to be looked at on a regular basis. The Board Assurance Framework is reviewed on an annual basis to say, did we achieve what we were meant to achieve on, and did the things that we thought were going to help or stop us, did they actually materialise.

78 Q. Another different but important part, I suppose, of delivering health services safely is the ability for members of the team, your workforce, to be able to communicate to those who they feel can make a difference. You have reflected in your statement staff do engage with you on Clinical Governance issues, and you refer to staff going through their own Directorate lines, staff coming directly to you, whistle blowing, and you, yourself, had an open door policy?

A. That's correct.

79 Q. You met with your senior management team once formally and once informally every week, in addition to, I suppose, incidental discussions and meetings.

A. If I start with the latter. In terms of the meetings with the senior management team, very clearly the door is open and physically is open, continuously. We all share the one corridor and therefore there is the opportunity for people to be able to always interact. There's a general informal nature about that. There was a formal nature for the senior executive team which was, as I say, every week on a Tuesday. Every week on a Thursday there is the opportunity to come together. The Tuesday meeting is really the business meeting. The Thursday is an opportunity for people during the week to reflect and share on anything that is considered a challenge. Obviously we added to that during COVID where, actually, it was every single day we were meeting as what is called bronze command, every single day on top of that.

In terms of ways in which people could raise Clinical and Social Care challenges, there's the initial formal route through the datix system, through incident reporting, and many people do that. Ultimately, the collection of those incident reports come through to me as Chief Executive through the Clinical and Social Care Governance report. Clearly that's a route, not a direct route to the Chief Executive, that's a route in which most people would raise absolutely see something, say something, which is our approach to while blowing. We reintroduced and re-energised about four years ago. That gives the people, we trained

people and give them an opportunity to say if you want to raise something here are the routes that can be done. Not quite like the freedom to speak up guardians of the NHS, not quite that level, but a similar approach to the freedom to speak up guardians. Then on top of that clearly clinicians and anyone knew my door was open. There were occasions on which clinicians did walk in and say, can I talk to you about something? Or in many cases would have rung the office and say, I would like to come to talk to Shane about X, Y, Z. These were clinical issues. They would, and then I would have discussed it with the appropriate Director or, in some cases, with the Medical Director, the Nursing Director, etcetera. That was a vehicle that people could use. I think in a large organisation, the most obvious route people will not be with the Chief Executive. The most obvious route will be through their own line and through incidents, but the door was open and, on a number of occasions, people choose to use that as a vehicle.

80 Q. Yes. I want to come on, obviously, in due course to look at how that cultural aspect, if I can call it that, worked between you and members of your senior management team, in particular, the Director of Acute and the Medical Director in the context of the issues that we are concerned about.

Is it of concern to you that no one at staff level, on the ground level, if I can put it in those terms, below

the hierarchical positions of Director, approached you with any concerns in relation to Mr. O'Brien's practices or other issues that were going on within Urology?

A. I can certainly say that no one from that level did approach me. Is it a concern? I think if individuals in any team feel that they are not being listened to and they feel that, actually, I want to have this raised, it is disappointing that people couldn't come to my door as Chief Executive. You always want that. I'm not too sure that would have been the case in Urology, or any other service, because I think people would have seen the Director of Acute Services as more accessible than the Chief Executive by the nature of the Director of Acute Services being there, head of their hospitals, as opposed to the Chief Executive who was physically not in the hospital. You know, I think that in a large Health and Social Care organisation, I think people would be more likely to raise it to the management team of the hospitals than directly to the Chief Executive. But it didn't happen with Urology.

81 Q. If the findings, as we know it to be from the Serious Adverse Incident reviews, was, to take one example, it was widely known within the MDT that Cancer Nurse Specialists were not deployed, for whatever reason, by Mr. O'Brien, and that represents a departure from a standard, a well-known standard. If that information is not leaving that MDT and going up even a level to the Head of Service, let alone to the Directorate,

whether Medical Directorate or Acute, what does that say about the health of the organisation?

A. I think what it might say about the health of that particular part of the organisation, and I think we have to be careful that there are teams where other information may flow differently, but in terms of your point, I think what it says is individuals didn't want to, or feel comfortable to, or didn't recognise that. They could have raised it in the organisation whether through an IR1 form, whether through see something, say something, or whether by knocking on my door. What it tells me is that particular team didn't. It may be you could infer that they didn't know that they could, know that they should, or felt comfortable and confident that if they said it, it would be listened to. I think you would have to explore that with those individuals. What I can state by fact is they didn't.

82 Q. Are you confident that kind of keep it in-house scenario that I've depicted wasn't part of the broader culture at Southern Trust?

A. I think what I began to understand as I came into the role -- and we may get on to this with regards to the Governance review, etcetera -- is that Governance was managed, without fail, within the Directorates, not as a corporate. It is one of the things I discovered quite early. I've used this statement before with other people, it felt like the organisation was a confederacy rather than a corporate. What I mean by that is it became very strong business unit, Acute,

Mental Health, Disability, etcetera, therefore that's why I reflect on I think it stayed within the Directorate rather than the Corporate, and that's what we were trying to change. I know you will have heard from Dr. O'Kane yesterday and you briefly talked about the weekly governance report, that is such an important part of trying to take it out of the confederacy and the siloed approach into a corporate approach. What I can say categorically is when I came into post there was not a corporate approach to Clinical and Social Care Governance, there was Directorate approaches. That may be an indicator as to why people wouldn't have raised it to the Corporate because they saw their employer as being that Directorate.

83 Q. I want to explain that in greater detail through you in a moment. Another feature that you've alluded to, more positively perhaps, the flow of information to the Board. You set out three examples within your witness statement. I think if we maybe have it up on the screen to illustrate it. WIT-00047. You spend 20 or so pages explaining how --

A. Correct.

84 Q. It is not a criticism, but I'm not going to go through the detail of that. What you say, it illustrates through those three examples, one example being poor quality of care, or the alleged poor quality of care in obs and gynae in the delivery suites. Another issue was the concerns triggered by an alleged assault in a mental health ward, and that review expanded out into

looking at the whole Bluestone Unit. A third concern is by Dr. A concerning what he regarded as the mis-categorisation of incident reviews. Those specific clinical matters, perhaps, in some respects, wider Patient Safety issues, all make it up on to the Board through Committee reports and are there to be discussed by the Board if they have the appetite or the interest to do so beyond what the Committee have said about them. Is that fair?

A. Yes, absolutely. I mean, the reason why I included this in the evidence was to demonstrate how the Trust Board can work to deliver both safety and improvement. These three individual activities. Dr. A just predated me, although the activity of the identification of the problem predated me, but the actual delivery was during my time. The obs and gynae and mental health one were absolutely within my timeframe. They identified key safety challenges, particularly the mental health and the obs and gynae one, and the way in Which Trust Board dealt with those through myself, my Directors and the Trust Board indicate how Trust Board can work to ensure both safety and improvement. As you say, there's 20 pages there and I'm not going to go through it in detail, you will have seen it. It was clearly identification of a problem. If you take the Bluestone one, identification of a problem, a very strong director at the time, a gentleman called Barney McNeany. Working in partnership with the Medical Director, Dr. O'Kane, and really driving how can we

understand how we stay safe, how we become safe, bringing in a third party in the Royal College of Psychiatrists who provide independent review as well, and then driving an action plan and improving, and keeping the Trust Board continually engaged in that process. It indicates that the Trust Board system can work -- did work in those particular cases -- and kept patients safe and addressed clinical challenges.

85 Q. Yes. The Inquiry will no doubt observe from its reading that these issues individually were on the agenda month after month for quite a period of time --

A. Correct.

86 Q. -- allowing the Trust Board to take cognizance of the various developments and, as I say, challenge, if they saw fit. You described these three examples as revealing clear engagement, challenge, planning and ultimately improvement. Another example that comes to mind is the circumstances that give rise to this Inquiry in August 2020. We'll look at it in some detail later?

A. Correct.

87 Q. The Board is told about a series of Serious Adverse Incidents, as it was described at that time, which were to be investigated concerning a retired Consultant Urologist. Issues concerning Mr. O'Brien had not been on the agenda until then in the period January 2017 when the Board was told, albeit the clinician isn't named in the minutes, that he had been excluded and there was to be an MHPS investigation. Can I have your

position on this, and we'll look at it in some greater detail later. Should concerns in relation to Mr. O'Brien have featured on the Board's agenda prior to July/August 2020, or, at the very least, should developments in the MHPS process have been reported to the Trust Board prior to the developments in the summer of 2020?

A. In terms of the MHPS process, and reflecting, looking back on that, I would agree with you there should be a position where we can regularly present back on MHPS processes, and that wasn't the case. Therefore, with regard to MHPS, absolutely there should be a process. I'm pretty sure the learning has already been implemented in the Trust around that area. So absolutely on that case.

With regards to specific details in terms of Mr. O'Brien and those things, I can understand why it wasn't regularly on. I'm sure we'll come on to that later in terms of the level of alarm that was being driven at a senior level. I'm more than happy -- I'm sure we'll explore this in detail. On reflection, having read what I have read in terms of the many thousand pages of witness statement, and on reflection knowing where we, I think it would have been advantageous for it to have been on the Board, but I understand why it wasn't, and I'm more than happy to explore that later.

88 Q. We'll explore that shortly.

I interpret your statement as telling the Inquiry that in terms of Corporate and Clinical and Social Care Governance, upon your arrival in the post of Chief Executive there were reasonable foundations in place but you faced a number of challenges which caused you some concern, particularly around Clinical and Social Care Governance. Is that fair?

A. I think it's fair to say having worked in more Trusts at that point, therefore I had experience of Clinical and Social Care functioning in a Trust, I came into the Southern Trust and it was not as invested in as I have seen in other organisations. That was my initial perception. I was also very well aware that at a Directorate level, the Directorate Governance meetings seemed to be quite immature in their development. I'm aware that certainly up until maybe 2016, 2017, there wasn't a large investment in local governance. I was also very well aware, having worked in other organisations, where clinical audit was really to the forefront of the organisation. Clinical audit wasn't to the forefront of the organisation in the southern area. There were things that didn't quite feel as well invested in as I would have expected from other organisations.

89 Q. Just while you're saying that, let's bring up on to the screen how you articulated within your witness statement. WIT-00037, please, at the bottom of the page. The preamble to that was talking about what the system was on arrival. You say one of the steps that

you took was to commission the Health and Social Care Leadership Centre to review the governance system. This is how you articulate your concerns:

"1. The level of expenditure in the governance functions felt light. I was used to appropriately funded teams for areas such as SAI management, complaints, standards and guidelines".

Let's work through these, not at any great length, but expand on that for me, if you would. Is that telling us that in order to do governance robustly and effectively you need people in places, in offices doing the hard graft of gathering and interpreting the material?

A. Yeah. I'm sure we'll come on to the governance review later, but one of the key things in the governance review were those three channels of SAIs, complaints, standards and guidelines. Whenever the governance review was completed -- I won't go through the detail of it now, I'll happily go through it when you ask me to do so -- the three areas I felt we needed to do more work on was not just the process of running these things, but the process of learning these things. Therefore, it is not just having the people to collect and enter the data, but it is the time that is required to take learning from SAIs, complaints, and also to ensure the standard and guidelines, of which there are many that come into organisations, are implemented fully. I suppose what I reflected when I arrived is

that the organisations I had worked in previously would have had more resource in both the collection of SAI information, complaints and standards, but actually would have had more resource in deployment and learning from those statements. That was my feeling. Clearly, what the Governance review managed to draw out was that comparison with another Trust, which I think in the report was the Northern Trust, it wasn't just a feeling, it was a fact. It was a fact that, in fact, the Southern Trust hasn't the level of resources in those areas that other organisations may have had. For me, that was my initial view which was then proven through the Governance review that we did need to put in resources in those places.

90 Q. The second concern that you had was a concern that there was some squeeze on or some restriction on the flow of information up from the Directorates to the SMT. In other words, you didn't have a clear view of what was actually going on on the ground?

A. With regards to Clinical and Social Care Governance, as I reflected earlier this idea of confederacy rather than a corporate, what was happening was governance was being managed at a Directorate level but we were not regularly at a senior management team looking at what was happening governance on a dynamic basis, on a weekly basis. What would happen, absolutely, the governance report would come to the senior management team before it went to the Trust Board, and we could discuss that. That's not dynamic clinical and social

care governance. Dynamic clinical and social care governance is constantly looking across the organisation, hence the agreement at the time to create that weekly governance meeting where issues of SAIs, complaints, incidents could be discussed across the organisation and then every executive manager then on the Tuesday, following the Thursday meeting, would then discuss what was happening in the whole of the organisation. Therefore, the win came when the Governance report came in preparation for the Governance Committee dynamic. That's a point in time and it's quite a length of time rather than a dynamic, our governance system.

91 Q. The third point, which may be a consequence of the level of expenditure, I don't know. You can maybe reflect back to me on that. You're saying that the level of data and statistical evidence being brought to the senior management team in respect of quality and safety was lower than what you were used to in other organisations. Can you put that into a concrete example for us?

A. If I can give you an example of an organisation that I previously worked in where there was high-level data analytics whereby issues would be identified. For example, under mortality there would be a regular mortality meeting, regular mortality reports, and they would be brought to the senior management team where we could look at the issue of mortality. If I give you an example of my previous organisation, that led us to

say, why does mortality, particularly in respiratory in one our hospital sites look very different from mortality in respiratory in a different hospital site, and we were able to go and explore why that was the case as a senior management team. That kind of detailed analysis and looking at, in this particular case mortality, was not regularly coming to the executive team. In fact, one of the things that, certainly again we introduced was to make sure that mortality was coming at least to the Trust Board on a regular basis, and then we were looking at mortality as part of a much more dynamic system.

92 Q. I know within your statement -- we needn't go into the fine detail of it -- but you've explained that you were coming into an organisation that had, I suppose, a high level of instability in the Chief Executive function, in the Medical Director's role perhaps to some lesser extent, but we know the history of people in posts for short periods of time in Dr. Wright's case, in an acting-up capacity in Dr. Khan's case. You talk about your immediate challenge being to recruit a substantive senior management team and to begin a process of creating a strong governance environment in order to, I suppose, provide the circumstances in which you can more readily provide robust assurance to the Trust Board. You set about doing this by instigating an independent review under the authorship of Mrs. Champion.

A. Yes.

93 Q. That review reported at the end of 2019. I want to come to that in a moment. At what point did you feel that some of these issues that you've highlighted, in particular around the creation of an environment by which information about Clinical and Social Care governance could more readily come to the senior management team as opposed to being siloed within directorates? By what point did you begin to feel you were making progress with that?

A. If I take you back a slight point, which I can then build on. My first challenge was to build a new team. I had an interim Director of Finance, an interim Director of Nursing, interim Director of Medicine, and interim Director of Mental Health and interim Director of Community Services. My first job, before I could get on to building new systems of governance, was actually to build a new team. That did take me until, I think the last two posts were Barney McNeany and Dr. O'Kane. That was probably in January 2019. The first job wasn't to try to create new systems, the first job was to be able to get a team that actually was the team that we could call the senior management team. That took me six, seven, eight months to do. Before I could really start looking at improvement, I had to get a substantive team in senior management. It goes back to your point about turnover. That was the situation that I was in. Once I had that, then we could start to look at what potential opportunities there were. Certainly working with the Governance

committee and working with Dr. O'Kane when she came in was to look and see what is the information we could be providing to the Governance Committee, and what information we can start to bring to the senior management team. It took me until January 2019 to get a team around. I came in in March 2018. That was the initialling timeframe. We quickly got on to then at that point we need to look at governance in its holistic approach, and that's when myself and Maria agreed to bring June Champion in, and agreed to look at the review. Before that was finished we were beginning to say the main areas are complaints, SAIs, and very much looking at standards and guidelines. We didn't wait for the overall report to come in. We were already starting to work on some of that. Then we were regularly looking at reviewing the governance reports and the performance reports, hence the creation of the performance committee, to understand are we getting the right information. Of course, I would like that to have been quicker, but the reality is I didn't have a team in place to begin with to begin to move that stuff forward.

94 Q. I think what you said in your witness statement is that a major catalyst for instigating this independent review was the revelations from the Cawdery Serious Adverse Incidents.

A. Yes.

95 Q. I don't think we need the to open this in any detail, but at WIT-00070 you reflect there that the approach to

that SAI in terms of its terms of reference or its focus just wasn't specific enough on some of the issues. It tended to focus on the client as opposed to the implications for the victims of that incident. You would have discussed your concerns about governance with Dr. O'Kane as well.

A. Mm-hmm.

96 Q. She seems, in her witness statement, or one of her witness statements at WIT-45185, she reflects concerns about what she describes as the paucity of the functions usually associated with providing a robust system of governance. She says she brought those to your attention and you supported the commissioning of June Champion to investigate and report. Let's just look at her report. I suppose, the executive summary -- it is a lengthy report and obviously time doesn't allow us to look through it in detail. Let's look at the executive summary at WIT-00509. If you can help us. What was, in broad terms, your interest in securing a report from Mrs. Champion?

A. Certainly. If I can go back to the point that you made about the Cawdery situation. If I can explain why that triggered for me the alarm bells that I felt it was important I dug deeper into this. Going back to this issue of Directorates looking at governance rather than the organisation looking at governance, the first time I was involved in the SAI process for Cawdery, and I must stress, it started before I joined so therefore I couldn't have been involved very early. The first

point I was involved and, therefore, I would argue Corporate Governance was involved was when the report was finalised and presented to me as Chief Executive. That triggered an alert to me, which is this is not an SAI where learning and improvement only lies in the Mental Health Directorate, it is, in fact, learning and improvement that is for the whole of the organisation. That triggered my concerns because, actually, if we were looking at the Clinical and Social Care Governance as an organisation, then those kind of conversations would be having had at an organisational level, not at directorate level. There were secondary issues with regards to the Cawdery report, which I'm not going into detail, you have that. Clearly I, along with the Public Health Agency, instigated a second report on that. Putting that to the side, that was the trigger when then got me to think, why don't we have a corporate -- I'm going to call it a corporate approach to Clinical Governance. I know that confuses the terms of Corporate governance and Clinical Governance, but a corporate overview of Clinical and Social Care Governance. That's when I spoke to Maria, who had been in post a matter of a few months, and we agreed that it was important to really open up governance. Are we managing governance, both Clinical Governance and Corporate Governance, in the best way for the whole of the organisation? Because what was clear to me was that it was being managed within the units not as a whole organisation, and if we were to

drive -- going back to the Board Assurance Framework conversation we had earlier, if you were to drive to the overall outcomes of the system with regard to safety and quality, that was not being connected, it was being stuck in that process. That was the conversation I had with Maria O'Kane and we had agreed we wanted to look at both the wider aspect of Clinical and Social Care Governance and how that fit, and how that was fitting into the overall organisational governance environment, the integrated governance environment, hence why we wanted independent review and we had spoken and secured June Champion through the Leadership Centre to do that. June had been heavily involved in the implementation of a number of the improvements of the hyponatraemia outcome, and we were both, myself and Dr. O'Kane were very aware of June, having worked with June in perviously in previous organisations.

97 Q. The executive summary helps to orient us. The first paragraphs deal with the background. The third paragraph reflects the input from what she refers to as senior stakeholders within the organisation, giving some of the background. Down to the fourth paragraph, please. It describes senior stakeholders identifying a lack of connectivity across the existing governance structure and a lack of a robust assurance and accountability framework, which added to the perception that the core elements of the integrated governance were being delivered in silos with various reporting

lines. What she's talking about now is a proposed -- my screen keeps lapsing on me. Is it the same?

CHAIR: I think our screens are fine. It may be an issue with --

A. It is the same for me, Chair.

CHAIR: I am just wondering, it might be an appropriate time to take a break and we can get the technicians to look at it. It is now almost a quarter to one. If we break for lunch and come back at a quarter to two, if that's suitable to everyone.

MR. WOLFE KC: Just to be clear, it blinks off every few seconds.

CHAIR: Yes. If we leave the AV operators here, you can try it out over the lunch break and see what happens.

MR. WOLFE KC: Very well. Thank you.

THE INQUIRY ADJOURNED FOR LUNCH AND THEN RESUMED AS FOLLOWS:

CHAIR: Good afternoon, everyone. Hopefully the technological issues have been resolved and we can continue on. If anybody does have any difficulties with any of the technology, please let us know, because it doesn't seem to apply across the board to everyone.

MR. WOLFE KC: Yes.

98 Q. Could we have up on the screen, please, WIT-00509, please. You'll recall, Mr. Devlin, we were looking at the Executive Summary of Mrs. Champion's report. I was

looking at a section -- just scroll on, please. I was reading from that part of the paragraph which commenced:

"Senior stakeholders identified a lack of connectivity across the existing Governance Structure and a lack of a robust assurance and accountability framework which added to the perception that the core elements of integrated governance were being delivered in silos at various reporting lines."

She then turns to a proposed revision of a good governance structure, and that will provide the Trust with an assurance and accountability framework which will address the concerns expressed. Is that what you had in mind, Mr. Devlin, when you were explaining the confederate --

A. Correct.

99 Q. -- centralised dichotomy?

A. It was. It was.

100 Q. You want to move to a more centralised or corporate views of Clinical Governance?

A. I think it was important not to take away the responsibility at the local level for Clinical and Social Care Governance. It was not an attempt to centralise everything, but it was an attempt to get line of sight into the centre and to have some control in the centre. You can't run an organisation's Clinical and Social Care Governance from an office

somewhere in the centre. It has to be local. But it didn't have both of those and, therefore, what I was hoping to get from the review is an appreciation that we need something in the centre as well as having tentacles out into the organisation.

101 Q. If we go down the page to 510 in the series. I think I'm right in saying -- yes, Mrs. Champion is pointing out there are some good aspects already in place. You weren't, I suppose, to use the old phrase, wanting to throw the good out with the bad.

A. No. No.

102 Q. Here she says:

> The core elements that underpin a good governance framework, strategic and operational systems of internal control and processes were evaluated against best practice guidance.
>
> She goes on to say: The analyses demonstrating good building blocks are in place.

That's what you wanted to keep --

A. Absolutely.

103 Q. -- but changing the structure. As I say, it is a bit of the race through this so the Inquiry is orientated to the significance of the report as a starting point for the reform I'm going to ask you to explain in a moment.

Just before we do so, just down the page to 511, she sets out the categories of the 48 recommendations that are set out then commencing at WIT-00560. That's where she sets out the recommendations in an appendix in some detail.

I just want to draw some attention to this first section of Board governance, because that was to become a controversy with Mrs. Brownlee and I want to bring that out in a moment. You can correct me if I'm wrong, I think if we go to recommendations 45 and 46 at WIT-00564. Am I right in saying that those two recommendations in particular, and perhaps there are others, gave the momentum to what the Trust was to do next, which was to scope out a new model?

A. That's correct.

104 Q. Particularly 46, I think. The Trust should ensure the Directorate reporting arrangements are included in a review of Trust Board subcommittee structure and the review of SMT Terms of Reference.

That was to give birth, ultimately, to the Learning For Improvement Directorate?

A. And the Performance Committee.

105 Q. And the Performance Committee?

A. Also, then, the weekly approach to the dynamic governance that I described earlier.

106 Q. Yes. Just before we get to -- the Trust scoped that out, and there's another document I'm going to refer

you to. There was some dissent in respect of these recommendations, and I want to take your view on it. If we turn to WIT-00583. Take me to 582 first so I can show the Inquiry the opening page. It's maybe down a page again, 581. Yes. Thank you.

These are the notes of a Director's workshop. You brought everybody together at Board headquarters to discuss the Champion recommendations and how they might be taken further; is that fair?

A. That's correct. Yes.

107 Q. Then if we go to 583, down a couple of pages, please. 00583, please. The Chair, who was at that time Roberta Brownlee --

A. That's correct. Yes.

108 Q. -- she makes remarks towards the start of the meeting. Stated that: Mindful of Board behaviours that all members subscribe to and the spirit and honesty as Chair of the Trust Board she felt very offended by the report in how it was written in relation to Trust Board. For example, she was named as a contributor when, in fact, she had not been involved and only met the author at the final draft stage. Whilst she agreed with the Chief Executive that he can undertake a review at any time, she understood that it was a review specific to Clinic and Social Care Governance, yet it went wider -- as we've seen from the recommendations, albeit briefly -- it went wider than in its Terms of Reference and strayed into Corporate Governance which

she felt should have involved herself and the non-Executive directors. She made the point that the Trust Board has responsibility to ensure the Trust has effective systems in place for governance, therefore it was important for the Trust Board to have discussion on the report and an agreed way forward.

Did she have a point that the report of Mrs. Champion had strayed into an area of Board competence when, as she seemed to reflect, the Board and its nonexecutive directors weren't adequately consulted about it?

A. I think there is a point, but let me explain -- if I can explain around that point. I felt very strongly that we needed to understand what was working with regard to governance. I said earlier in my evidence, Clinical and Social Care Governance cannot be looked at in isolation of overall organisational governance. It is a physically impossibility to do so. I had raised with the Chair that we were carrying out this report and that I was keen we moved forward on that. I had offered the Chair the opportunity to be interviewed by June Champion, which happened. Clearly, in hindsight, I could have done a lot more with the Chair and the non-execs in advance to warm them up to the report. So I totally appreciate the point she was making. The point I was making was as Chief Executive, and you saw my job description earlier, with ultimate responsibility for systems and processes within the organisation, I felt it was important to do an

independent review and to take those independent view takings back to myself and the Trust Board, etcetera. I felt I had engaged with the Chair by letting her know we were doing the report and also with the author of the report, June Champion, being able to interview her, and other non-execs. But I think very strongly you cannot have a review of Clinical and Social Care Governance without having a review of overall governance of the organisation. I cannot suggest what would have happened if there had been different outcomes, but if it had been a report that said the outcomes were glowing and everything was fine, I suspect this would not have been the reaction. The reaction was that it highlighted a number of challenges that I, as Chief Executive, needed to take on Board, my colleagues, my exec team colleagues and my non-exec colleagues needed to take on Board. There is a point, I could have done more at the beginning of the process, but it doesn't take away my responsibility to make sure the processes are sound within the organisation. I felt I gave non-execs the opportunity to be involved in the process by being interviewed as part of the process, and I feel, as you can see from the minutes, I think the recommendations were fair because we did not have a perfect system of governance. The fact we're sitting here today, we did not have a perfect system of governance.

109 Q. You were able to move forward from this dispute, if I can put it in those terms, by agreeing only to

progress some of the recommendations but leaving --

A. That's correct.

110 Q. -- in abeyance those affecting the Board level.

A. 1 to 13, if I remember correctly, and I would have to go back to the report, are areas we didn't agree to take forward. For me, there was enough in the report that I needed to get on with with my new team, with Dr. O'Kane and the Director of Nursing that I needed to get on with, that I wanted to take forward. I came to the conclusion that I would get to the others.
I couldn't predict we were going to have a global pandemic and all kind of things, I believed I could get to the others pretty quickly, that clearly couldn't be the case because other things happened. But I did, to try to move the process forward, agree that we would not address items 1 through 13, I think.

111 Q. You reflect in your witness statement a degree of, I suppose, coldness or --

A. Yeah.

112 Q. -- less than good working relationships between you and Mrs. Brownlee on occasion?

A. Yes.

113 Q. Is this the primary example?

A. That is one occasion. I think it is fair to say that on this particular occasion there was a coldness, and I'm sure if you speak to other members of that Board meeting they might reflect that as well. That is not a complete reflection of my relationship with the Chair for the full time I was there. We had many

a productive Board meeting, as you can see from some of the other evidence I have provided. But there were periods of coldness, to use the term that's been used, and this would be one of those. Because I did feel very strongly that if we were to be a learning organisation, and to really drive improvement, then we had to learn how to take criticism. This was not a cold critical report but there were criticisms in that report and I felt we needed to take that on the chin and be a learning organisation. I felt the reaction in that meeting --

114 Q. Sorry to cut across you. Reservations were shared by other nonexecutive directors. I think they are reflected in the minute to some extent.

A. Yes.

115 Q. In general did this dissent hamstring your ability to take the organisation in the governance direction that you wished, or setting the first 13 recommendations to one side to go back to, was, nevertheless, a natural way of going about things, in any event?

A. I think, on reflection, I would like to have got more of those first 13 approved at that point in time, because I think, to go back to my original point, Clinical and Social Care Governance and Corporate Governance is not a separate entity. Therefore, to move forward with those considered Clinical and Social Care Governance without really challenging the architecture of governance, I think was not a successful as I wanted it to be, but sometimes you

have to go with something that gets movement as opposed to dig your heels in and actually get no movement. I felt it was the right way to go. I genuinely believed we would get to the others if I had time to work on convincing people. As I say, unfortunately, then the world changed slightly not long after that.

116 Q. Yes. Let's just go briefly to the scoping out of the recommendations which were the subject of a document later in the year. If we go to just the cover page of the document to orientate ourselves. WIT-00589, please. This is a document produced by your Governance team, presumably?

A. Primarily by the governance team supported by Dr. O'Kane. It was a document we discussed in detail.

117 Q. Yes. For present purposes, I know there's a lot in it, but one of the key changes or one of the key debates was between retaining what was then the current model, which it's described within the document as a distributed Clinical and Social Care Governance model.

A. That's correct.

118 Q. And the alternative, which I assume you were putting your weight behind, which was a corporate business partner model?

A. That's correct.

119 Q. We'll just look briefly at that, and the Inquiry can review the detail of that in its own time. Just looking at the extant model, as it was at that time, the distributed model, WIT-00596. The model was each

Directorate had a Director who was responsible for the Governance portfolio and reported to the Medical Directors; is that right?

A. No. Each Director had responsibility for the complete functioning of the Directorate. Within that area there was a Governance Coordinator, who was a senior manager, who would have had a professional governance line to the Medical Director. But the Director was responsible for everything within the Directorate, whether that be performance, staffing, delivery -- everything. They had a team and on top of that team was a governance coordinator, who was a senior manager.

120 Q. Yes. The features of that system or that arrangement are set out there. Going over the page to 597, some of the -- I suppose the disadvantages that you were seeing in that model were the -- I suppose across the Directorate there's different ways of doing things?

A. That's correct.

121 Q. Whether it was the screening process for an SAI identification. You might have an HSCB handing down a guidance document but, on the ground, in practice, within directorates you were seeing some disparity?

A. I think what it drove was variation because the directorates had been allowed to grow up over time -- that happens in organisations -- grow up in time and therefore there was not a corporate standardised approach that was managed and monitored. There was local flavour which could drive variation. I suppose one of the obvious indicators of that variation was the

length of time that some of the things took in different directorates. You could have had in Community Services a Serious Adverse Incident taking a very short length of time. You could have SAIs in Mental Health taking a very long time. The reason was the amount of resource each directorate would give that that process was different. Therefore, having local ownership drove variation, and we all know variation can be the cause of harm. That was a big thing for me was to try to drive out variation.

122 Q. Yes. One of the big drivers of the proposed change was visibility, visibility of issues to the senior management team.

A. Correct.

123 Q. If we just scroll down to look at some of the features. I suppose that's a summary paragraph at 20:

> The lack of standardisation of systems and processes across directorate teams inhibits the ability for clear corporate quality assurance and oversight.

Then the benefits of a corporate business partner model are set out. Before we go to those, perhaps it would be helpful to look at the organigram that you set out in your statement. It is quite a complicated one set out. Perhaps we'll go to the one in your statement first at WIT-00033. I think, in the context --

A. Sorry, that's the proposed structure at that point in time as opposed to the as-is structure.

124 Q. Yes. As I understand it, this is coming in this year. I'm not sure if Mrs. O'Kane was asked about this yesterday, but this is the plan.

A. It is. What I would say is that some parts moved ahead. The likes of the Learning For Improvement within the Executive Medical Directorate, in the middle, a lot of the issues around SAIs, complaints, etcetera, moved ahead in advance of the formal structure being put in place because there were things we wanted to put in place. This certainly was the plan to appoint those individuals.

125 Q. Yes. Just talk us through this structure. I think, as you've described it, all of the governance-related issues ultimately, using this structure, flow to the Medical Director?

A. All of the governance-related issues as per the local Directorate Governance absolutely flow through the Medical Director. What I would say is that the responsibility for service delivery in the Directorate still lies with the Director who is delivering. It is important that -- it is not that the Medical Director would take on all responsibility for all services, that couldn't be the case, but certainly for Clinical and Social Care Governance of those services.

126 Q. From her we see all these various boxes?

A. Correct.

127 Q. -- items of governance, including SAIs, including audit, including complaints and compliments; all these things go into this new Directorate?

A. That's correct.

128 Q. Headed by the Medical Director who then has a direct line into the senior management team and your office?

A. And my office.

129 Q. Yes. If we just go back to the scoping document that we were looking at at WIT-00597. The bottom of the page, please. We see the potential benefits of this include:

Corporate overall oversight of all clinical and social care governance processes including -- those listed there -- allowing depth of governance function to ensure that staffing levels remain consummate with task requirements, a standardised focus on the elements of clinical social care governance and on those elements making up Learning and Improvement and Standardisation of Processes across service areas in those fields.

Just scroll down, please.

Benefits for monitoring of learning and assurance of implementation, with the triangulation of data to inform improvement plans and learning. Benefits for recording and development of action plans in response to those various bodies including RQIA. Processes governing the identification and implementation of standard and guideline processes. Benefits for Trust-wide standardised staff training and management of managing and responding to complaints.

It is your understanding that that has been has approved and is to be implemented in the course of this year?

A. It was approved before I left, so it was one of the very last things I took through Trust Board and, therefore, it is now my understanding, being implemented. As I say, there are elements of it that was being implemented along the new approach to complaints, the new approach to SAIs, the new approach to standards and guidelines, etcetera, irrespective of the new structures were being implemented because they were identified in the governance review and agreed at the meeting, that special governance meeting as really important things to move forward with now, particularly learning from the SAI processes, not necessarily within Urology but across the whole Trust.

130 Q. Have you thought about how would a structure such as this, this change of structure, improving consistency and standardisation, giving greater visibility to the senior management team of emerging governance issues; have you reflected on how, if at all, that would have impacted on any of the matters that this Inquiry is concerned about?

A. Certainly. I think one of the important elements of this structure is that single point of coming together of all of the information and, therefore, anything to do with Managing High Professional Standards or complaints or incidents, etcetera, would be discussed at that -- the screen would need to be moved up

slightly -- but at that level just below this box. So what you would then have is you would have an Assistant Director of Clinical and Social Care Governance for the whole organisation who would be managing the local governance coordinators and, therefore, at the governance meetings, where you would be looking at indicators, you would be looking at who has been excluded, all those kind of things, there is a single eyes-on, which is the Assistant Director of Clinical and Social Care Governance, who is looking into those meetings. Therefore I'm not saying it would be failsafe, because obviously this is future proofing, what I am saying there would be a much greater chance of understanding the signals because there was a central approach to coordinating governance across the whole of the organisation. Therefore, I think we would have had line of sight but also a vehicle to check and challenge, which is really what this is also about. It is having a vehicle for the Medical Director to check and challenge through the organisation.

131 Q. I suppose it is right to reflect that even an improved structure such as this isn't a panacea?

A. No, not at all.

132 Q. If the information isn't coming out of the area on the ground where the problem is, whether because the culture isn't right, people aren't speaking or not being encouraged to speak, or because the data isn't there because it is not being tracked or there's insufficient audit arrangements, then that doesn't

percolate up to a Head of Service and it doesn't reach the Medical Director?

A. I absolutely agree with that point. I think what this would have allowed us to do is where you would then start to see silence, you can then begin to ask questions. For a structure to work you need to have the architect for the structure, you need systems, you need data and you need culture, and those three come together. If, in this situation, one of those four acute governance areas were not regularly producing data, or were not regularly questioning, or were not regularly showing improvement, having that eyes-on you would then be able to say, why am I not getting it? I expect every Thursday when you come to the Trust-wide governance meeting you are coming with details of SAIs from last week, complaints from last week, incidents from last week, challenges from last week. If they weren't coming, I think you would start to say, what is happening. I agree with you, it is not the panacea, structures are the processes, data and culture, but actually this would have given eyes-on to be able to ask the question, well, why am I not seeing the data that I thought I should be seeing?

133 Q. You said quite properly, you reminded me several times, I think, quite properly, that it is not just about this change of structure under your watch. You were able to get on with other things, such as how SAIs should be dealt with, and that kind of thing. We discussed earlier, briefly, the CSCG report, the Clinical and

Social Care Governance report goes to the Governance Committee. We've all looked at the reports. Lots of data. Lots of reports on trends, statistics of that nature. What, if anything, is happening differently, for example, around SAIs and how they are looked at within the Governance Committee that wasn't the case before these changes were made?

A. Okay. The approach to SAIs, the approach that we took was to, first of all, try to standardise our approach. So there's a separate document, and I hope it is in the evidence bundle, which was the approach to SAIs. If it isn't I can certainly make sure that it is. It was approaching saying this is how we should do SAIs. I appreciate there's standard guidance but this is how we should do it. That was the first improvement with standardisation, with a big focus on user patient client care engagement, because that was a big bit that really wasn't as strong in the original guidance. In terms of them coming to the Governance Committee, as it's called, what that allowed us to do was to bring to the Governance Committee a section in that report that talks about SAIs, it allows us to say how many more have come on, how many have gone off, also then to summarise the immediate learning from the SAI, and also to be able to reflect on potential further learning. I think that was a process that was just really starting to be embedded. It did allow the non-exec members to challenge and question. I think if you were to look through the minutes there were some challenges

and questions. I think there is a further -- when I left there was a further journey on that to get a greater line of sight into the learning from the SAIs. I don't mean surfacing the knowledge but actually implementing change. That probably wasn't as fully embedded in the governance group or the steering group, as could be. I think that's still an opportunity for improvement, really embedding the learning into the Governance Committee.

134 Q. Certainly it was my impression of reading the CSCG reports, they come to the Governance Committee, as you've said -- this isn't meant to sound as pejoratively as it might, quite turgid in terms of the statistical detail, that kind of information. But you would struggle to see how the problem, such as a failure to Triage which might be at the core of an SAI report, or the failure to comply with whatever guidance, for prescribing or allocating a nurse to a cancer patient, you struggle to see how that learning emerges and is then shared. Is there more focus on these quality and improvement type issues at governance than there was before?

A. I think there's more focus, but I agree with your point in terms of it doesn't draw out the learning in the way it could draw out that learning. That's what I'm saying. I think there's further improvement in that. There's probably opportunity to reflect on not just the SAI. The way it is reported is an SAI, probably to look at thematically what happened in the last year,

etcetera, we were not at that point doing those kind of things.

135 Q. That's the ambition?

A. It was certainly my ambition. But I imagine it probably remains Maria's ambition.

136 Q. I hope I have dealt fairly and sufficiently with some of the changes, and the Inquiry will, no doubt, reflect whether it needs to hear more on that and will decide whether further evidence is needed in due course.
I want to move on and look at, specifically, what was going on in Urology, try to get to grips with what you knew and when and how you responded to it.

How would you characterise your role in connection with the shortcomings associated with the Trust's Urology Services?

A. In terms of my connection with the shortcomings, over the period of 2018 and 2019 my connection was very loose. I explained how and why, but I think it's fair to say that when I came into post there were clear things that I needed to get on with, articulated by my predecessor, etcetera, articulated by the Board, and that didn't include the challenge in Urology.
Therefore, my connection with Urology primarily began when the then Medical Director, Dr. Khan raised to me -- I think possibly August, it could have been September but I think it was August -- the coming to the conclusion of the MHPS process, and then certainly in September raised to me the outcome of that process.

I had not been involved up until that point at all, not been raised to me at all at that point. My focus was very much on those areas building the team but also addressing the issues identified to me when I came into the organisation.

137 Q. Mr. McNally was your predecessor?

A. Stephen McNally was my predecessor.

138 Q. I think you shared with us recently a note, it is described as "continuing issues." Just open that for a moment. WIT-90985, please. Could you help us identify that document?

A. Yes, certainly. That was the document that Stephen gave me and we met, and he talked me through it for about an hour.

139 Q. Was that the hand-over document?

A. Yes.

140 Q. At a hand-over meeting with Mr McNally?

A. With Stephen, yes, before he was leaving, yes.

141 Q. If we just scan through it, please. Paediatrics, hyponatraemia fall out, the report had just been issued in January?

A. It had in January. The specific issue that Stephen was raising to me is obviously one of the young children who was part of that Inquiry was a patient of the Southern Trust, and Stephen was making me aware of that, and also the mother of that patient wanted to meet with me and the clinician.

142 Q. Some of these things are public knowledge. Obviously the Cawdery killings was raised with you.

A. That's Dr. A referred to in the Trust Board meeting.
143 Q. Yes. A whole area of elective cancellations, and various other specific incidents, 6 and 7, medical revalidation, and issues to do with --
A. Private GP practice.
144 Q. Thank you. I don't think there's another page.
A. No, that's it.
145 Q. Yes. They were being introduced to you as key issues that you need to get to grips with quite quickly.
A. That's correct.
146 Q. These were the priority areas?
A. Absolutely.
147 Q. Not the only priority areas, no doubt, but the ones that Mr. McNally was apparently dealing with and you needed to hit the ground running with them?
A. That's correct. Some of them became very large issues. The Cawdery murders and the SAI's, etcetera, particularly elective care became an enormous issue, elective cancellations, but all nine of those were issues that needed to be addressed.
148 Q. Nothing, as we see in this document, about Urology Services, nothing about the commencement of an MHPS investigation in respect of Mr. O'Brien?
A. No, nothing..
149 Q. As you tell us in your witness statement, certainly within a few months Mrs. Toal was speaking to you about Mr. O'Brien's practice. We'll come to that in a moment.

Given you were, I suppose, at that point a stranger with anything to do with the issues in Urology in the broadest sense, including any concerns about Mr. O'Brien's practice, what would you regard as the, if you like, the test or the trigger which your staff ought to have been aware of for bringing issues or matters of concern to your attention?

A. Most directors would have brought to me -- because I would have met directors on a one-to-one basis every month, so most directors would bring to me those issues that they felt were new and were causing a potential Patient Safety harm, a finance deficit, the various things that you would expect. So I would expect a director to bring to me new things that were coming up but, also, if there were things they were actively working on that they were challenged by or were concerned they couldn't deliver, I would also have expected them to bring to me that. And they did. They did on a regular basis. Particularly around operational issues of winter, for example, Unscheduled Care, etcetera. They did and we had lots of conversations, as I say, on a monthly basis about issues that they needed to raise to me.

150 Q. They should unload their in-tray on to your desk, albeit at different levels of detail, depending on the issue, or do you expect them, I suppose, to be more selective? Directors are paid to manage.

A. They have to be selective. Ultimately, if I were to do

everyone's -- to do all the in-trays, as you describe, that's a dysfunctional operation. These are directors, they have job descriptions, they have roles, etcetera. What I was asking of them is if there are things they are concerned they cannot deliver, or they are concerned that raise a risk, financially, Patient Safety, etcetera, then we have that opportunity. Directors did. If we take the Director of Children's Services, it was a regular basis that the Director would talk to me about looked-after children that they were concerned about, or whatever the case may be. But it is not their job to offload their in-tray to me. Far from it. It is their job to do their job. Many raised to me when they felt they needed to raise to me.

151 Q. Let me take a moment to recap on what had gone before your appointment and what was to continue in relation to Urology after your appointment up to June/July 2020, so we have that contextual framework.

You've told us that Mrs. Toal came to you. You are not able to put a date on it, and you don't have a record of it, so far as I can establish?

A. No.

152 Q. She came to you and expressed concerns in relation to Mr. O'Brien's practice?

A. She raised to me, as part of my regular meetings with Vivienne and all Directors, she wanted to raise to my attention there was an MHPS case ongoing, and that was Mr. O'Brien, and raised to me that it was Ahmed who was

the case manager, and I should expect to see an outturn of that case within a matter of months.

153 Q. She gave you detail about the scale of the issues in relation to triage, dictation --

A. Correct.

154 Q. -- private patients, retention of notes, etcetera?

A. Yes.

155 Q. In speaking to you, that suggests, I suppose, what I called the trigger. There is a trigger of concern and that's a Patient Safety concern associated with practice that you needed to be aware of?

A. That's certainly what I would interpret Vivienne speaking to me about.

156 Q. When you come into post the MHPS investigation was about a year old. You may not have known that immediately.

A. No.

157 Q. It reports in June '18 in terms of the investigation, and then a determination is made in late September by Dr. Khan?

A. Yes.

158 Q. You come into it. Mrs. Toal has spoken to you in advance of that, but you come into it with Dr. Khan at that point. We'll look at that.

A. Yes.

159 Q. The determination isn't progressed because, at least in part, I understand the grievance of Mr. O'Brien issued in November 2018 stymied that. Also going around at that time Dr. O'Kane is appointed Medical Director in

December '18, and in March '19 Mr. O'Brien is reported to the General Medical Council by Dr. O'Kane. During 2018 and throughout 2019 there are episodic concerns expressed between the Head of Service in Urology and the Associate Medical Director and encompassing Dr. Khan, that there has been departures from the monitoring plan which had been put in place in respect of Mr. O'Brien. We'll look at aspects of that.

I suppose what the Inquiry is aware of, certainly, from some of the evidence it has received, and there's more evidence to be received, that there isn't an appearance of actively challenging Mr. O'Brien in relation to these matters. All of the evidence is yet to unfold and the Inquiry will look at that. Come January 2020, concerns are being expressed in relation to the reliability of the data available to the monitors of Mr. O'Brien and questions are being asked about whether, given the weaknesses identified in that data, whether challenges can be made to Mr. O'Brien; all the while there are these difficulties in achieving compliance. Set beside that are a number of new adverse incidents arising out, at least in part of Mr. O'Brien's care of patients. I'll come back to this just in a moment. There was an active Serious Adverse Incident investigation taking place arising out of events in 2016, and I know your attention was drawn to that. That's by way of context.

Let me take you to the conversations that you were having. As you have said, Mrs. Toal, as presumably part of her normal stock-taking type meeting with you, explains to you her concerns about Mr. O'Brien. Are those meetings typically unrecorded?

A. Yes. They would be one-to-one catch-ups, which would be supervision style, but it would be an informal conversation. I would record if there was any major decisions were made, but that wasn't the purpose of the meetings. It was an opportunity for directors to meet with me to share thoughts, comments, and then if there were things to be formally noted, then I would do so. I did not formerly note something from that meeting I had with Vivienne Toal.

160 Q. Would it be fair to say you had made no record at all of your engagement with Mrs. Toal in respect of Mr. O'Brien, Dr. Khan in respect of Mr. O'Brien, and Mrs. O'Kane in respect of Mr. O'Brien?

A. I would say no, I haven't. It was a series of conversations that then Maria, Vivienne and Ahmed would have taken action to take action. They would have left the room to take action.

161 Q. In terms of your dealing with Mrs. Toal, that was at a point when MHPS had yet to report, what was the upshot of that meeting?

A. It was part of a monthly meeting where I was starting to learn the organisation, learn what was happening, and I was asking directors what were important in their portfolio. It would have been part of that

conversation. Again, as part of me learning what was happening in the organisation. I was three months into the organisation at the time.

162 Q. Yes. Dr. Khan spoke to you at one point about his ability to continue as --

A. That's correct.

163 Q. -- both case manager and medical director. Do you remember that?

A. There was a series of emails, actually. I don't think it would have been a formal conversation but there was a series of emails where Ahmed did note the fact that from a capacity perspective, primarily, he didn't feel he could do both. But then my understanding, when he came back following conversations he had with Vivienne, I think, Vivienne Toal, he came to the conclusion it was too late in the process to be withdrawing from being the case manager, was my understanding.

164 Q. If we just put up on the screen WIT-00084. This documents your meeting with Dr. Khan. He recalls that -- you had regular meetings with him?

A. At least monthly. Often it would be slightly more because Ahmed was new and I was new.

165 Q. Yes. He recalls that he kept you advised of MHPS progress.

A. He did. He kept me advised in the short period of time, and he would make me aware it was happening and he would make me aware that he was coming to a conclusion.

166 Q. Just in general, the MHPS process in this case

commencing with investigation March 2017, it had a lengthy enough lead-in prior to that, Terms of Reference to be agreed, change in the identity of the case manager, etcetera. In your experience have you seen an investigation take as long as this one, through to late June the following year?

A. I would not have experience of an MHPS process taking that long.

167 Q. Although you were aware of it at some point, you didn't see the need to become involved --

A. No.

168 Q. -- to try to turbo boost the process?

A. No. I took assurance from Vivienne Toal, from Ahmed that it was being managed, being processed, and I didn't. It did not become a major area of focus for me. I said that in the beginning and it is with regret, with hindsight. But I did not see it in that way. I saw it was a process about a doctor who was in an MHPS process and I took assurance that both Ahmed and Vivienne were managing that process. That's a massive learning point for me.

169 Q. In one sense the Inquiry is generally, of course, interested in MHPS as a stand-alone issue, and would be happy to receive your observations on what you should have done, or others should have done, to improve this process?

A. In this particular case there is no doubt in my mind to improve it I should have prioritised MHPS as a major thing for the Chief Executive to become involved in.

What I was looking at were the nine or ten issues that I had taken over three months previous. What I was looking at was we were facing into a very difficult winter. I had challenges in the Unscheduled Care environment. I was also looking at real changes at Daisy Hill Hospital with regards to medical workforce. They were the things I was prioritising. Learning from that as a Chief Executive, MHPS is the thing that should be prioritised. I have to be 100% honest in that. Learning there if -- and it is unlikely in my future career where I am now, but if an MHPS case were to come across my desk it would be a priority. It wasn't because I was looking at other organisational priorities, including building a new team, which I didn't have any directors. So I was looking and I was not seeing it as the priority that now, on reflection, it was.

170 Q. Just specifically, and leaving any sense of culpability or blame out of it, what point do you see opportunities for Chief Executives, such as in your position, should get involved if we were writing the MHPS framework again?

A. I think they should absolutely get involved in the action planning stage. When an action plan has been agreed, it becomes one that the Chief Executive takes personal responsibility for making sure that action plan is implemented. As you're very well aware, we are not talking about hundreds of MHPS cases a year. We're talking, certainly in the Southern Trust, less than

a dozen at any one period of time. Therefore, if rewriting that policy, given the importance, it should be a standing agenda item for the Chief Executive with his or her senior management team. It wasn't. I hope it is now. I hope within the Southern Trust it is now, but it wasn't under my watch.

171 Q. Do you agree with Mr. Khan that he came to you at the stage where he had, I suppose, a draft determination and he was looking at -- sorry. He came to you at the point when the investigation had reported and he was looking for advice on how to write his part of it and he sought advice from you?

A. He sought advice, and the only advice I gave him, which was, this has to be seen as an independent process and you have to write this in the way that you see it. I think his concern, because it is a challenging thing, I think, for clinicians to criticise other clinicians at times. The advice I gave, and I don't think he needed the advice, was that you have to write it 100% as you see it. That is the only way I can describe it. You have to write it as you see it.

172 Q. Do you recall specifically that he was told that he should base his recommendations on the evidence and follow the image based framework?

A. Absolutely. Play it as you see it. There's nothing else you can do in that situation.

173 Q. You say you sought assurances from Mrs. Gishkori and Dr. Khan that the issues which had been identified two years earlier that gave rise to the MHPS had been

addressed. I think it is just in the -- go down a little, please. It's the third paragraph. You say:

"I was advised that an SAI was being carried out to fully understand the learning, however in the interim control measures had been put in place. This involved monitoring by the service lead. Martina Corrigan, and the Assistant Director for Surgery, Ronan Carroll. This involved weekly monitoring of agreed actions. Following these conversations, I was assured that the existing issues were being dealt with."

Just to be clear, are you sure you sought that assurance from Mrs. Gishkori?

A. No. I certainly sought that assurance from Dr. Khan, and Dr. Khan had subsequently spoken to Esther Gishkori about that. Apologies, when I read the way that was written. I sought assurance from Ahmed, and I think Ahmed put it in an email back, he had spoken to Esther. But I can go back and look at that to be certain, but certainly from Dr. Khan.

174 Q. Yes. In terms of the assurance, again, I can find no documentary record of either any request for assurance or the nature of the assurance provided. Is there any documentary record?

A. No. It is my recollection of a meeting with Ahmed, where I asked him were the issues being addressed. He said they were. He also then raised to me more information in an email at a slightly later date which

indicated he felt that maybe the -- the indicators were not quite Mr. O'Brien had stepped out of slight control, but he was assured that the activities were back in control.

175 Q. We'll come to that email presently. Would you agree with me that when you're seeking assurance in respect of the -- I suppose the safety of the practice of a clinician in the context of whether things had arisen in the previous two years, whether they were under control or resolved or whatever the phraseology is, that is something that should be committed to writing?

A. I do accept that. But I also reflect on the meeting which was: if things were out of control I would have expected to be told. But I agree with you, in hindsight I should have documented those conversations with Ahmed.

176 Q. The nature of the assurance that you sought was in respect of what had given rise to the MHPS you wanted to establish whether they were now under control.

A. That's correct.

177 Q. Did you interrogate the assurance you were given?

A. No. Again, I would go back to the point I made earlier, this was not considered as a major issue for me on my radar. And I was not interrogating. The Medical Director said to me it is being managed, we have a report, we have an action plan. I was not seeing any indication coming through to me, either numerically or from other people. If the Medical directors said to me, yes, we have a plan, a plan will

be developed; I was accepting of that. I have learned, and I am learning that I should have probably have dug deeper. But given what was on my in-tray, to use your term earlier, given what was in the in-tray, given where we were, there were many other things that as Chief Executive I was focusing on in a large integrated trust. If one of my senior staff says, Shane, this is under control, we have an action plan. Then I said, thank you, and I move forward. There is learning in that, there really is.

178 Q. I suppose the learning might be several-fold. You had an Acting Medical Director who wasn't experienced in the role, so I suppose the question arises there's a need to be effectively superintending him to make sure his sense of it is just about right. He's not failing to see things that he should be seeing or not failing to ask questions he should be asking, and that wasn't done?

A. That's correct. It wasn't.

179 Q. I suppose, when you think about the assurance that was in place, it was monitoring of the work that Mr. O'Brien was expected to do, but it was monitoring a limited basket of clinical or -- I think you agreed with me clinical and administrative in this context -- just say clinical -- the clinical activities that were in the basket for monitoring were limited in nature?

A. They were limited in terms of they only refer to those things that were being deemed as administrative in nature, which we both now agree were not administrative

in nature. But they were the areas of focus, yes.

180 Q. They were, I suppose, the obvious issues that were in plain sight which you wouldn't have known necessarily that the Trust were aware of, at least in part for several years?

A. No.

181 Q. I suppose the point being that it took until 2020 for issues that weren't in plain sight, at least some of those issues, to become visible.

A. Absolutely. I mean it became visible at the point when Mr. Haynes and Maria, and other things which I'm sure we'll come on to. But at that time I took assurance, I learned and I'm reflecting that that assurance should have been poked and prodded and tested, but I go back to the point it was not on my list of major issues. I reflect and I apologise for that, because actually in that period between that point and when it was actually identified, there was at least nine people, which we now know through the SAI process, who could have come to harm. I have reflected on that, but I was focusing on the areas that I saw important in building the organisation, and I did not see a clinician, who we now know is Mr. O'Brien, a clinician and the challenges that clinician had did not land on to my desk as: this is the most important thing you need to deal with. On reflection we can all see the evidence, but I have to say what happened at that moment in time.

182 Q. If we turn to Dr. Khan's determination or decisions arising out of MHPS. If we could have on the screen,

please, TRU-464548. Did you read it at the time?

A. I did read it at the time because Ahmed had discussed it with me. I did read it at the time.

183 Q. If we go through to 26453, please. Go to 264553, please. Go down the page to number 5. Thank you. You will recollect, perhaps, some aspects of this. No evidence of concern about his clinical ability, but clear issues of concern about his way of working, administrative processes, and management of workload. It sets out some of the impact statistics. The third bullet point picks up on an issue of insight, which was commented on by Dr. Chada in the final paragraphs of her investigation report. Presumably some level of concern if the clinician isn't reflecting well on what has emerged?

A. Yes.

184 Q. There's an issue of communication.

A clear obligation to ensure managers within the Trust were fully and explicitly aware that he was not undertaking routine and urgent triage.

scrolling down, please.

Remarks upon the impact on the Trust's ability to properly manage patients.

scrolling down, please. Some other incidental findings in relation to the GMC's Good Medical Practice, comments in relation to his advantaging of private

patients, and it says the issues of concern were known to some extent for some time by a range of managers and no proper action was taken to address and manage the concerns. It's not just a concern within this report about the actions -- the reported actions of an aberrant practitioner, but questions to be directed to managers within the service as well.

Just scrolling down to the next page, down to 55, please. Dr. Khan's adopts three determinations for action. First of all, he identifies the need for a conduct panel. I think just before that there's reference to the need for an action plan. Just scroll up to that. Yes. Scroll up a little higher.

It is in order for The Trust, in order to continue to have assurance, that Mr. O'Brien's administrative practices and management of his workload be the subject of an action plan which should be put in place with the input of PPA, NCAS, the Trust and Mr. O'Brien. He provides for the review and monitoring of that action plan and how that should be done.

The action plan must address any issues with regards to patient-related administrative duties and there must be an accompanied, agreed, balanced job plan.

Did you appreciate by this stage -- I think you did -- that because of the assurance you got that there was

already an action plan in place but this was --

A. Over and above.

185 Q. -- a new one, a revised one, which was to be scoped out with the input of all of these people? The need for a a conduct hearing. Then if we can go down to 26 -- let me just see the digits on the page number again, please? Scroll down to 557 in that series. Down two pages, please. Scroll down towards the bottom.

In his final conclusion section, Dr. Khan has remarked that the investigations has highlighted issues regarding what he has described as systemic failures by managers at all levels, both clinical and operational within the Acute Services Directorate. The report identifies there are missed opportunities by managers to fully assess and address the deficiencies in practice. No one formally to assess the extent of the issues, or properly identified the potential risk to patients.

He says in order for the Trust to understand fully the failings in the case he recommends that the Trust conduct an independent review of relevant administrative processes.

It is the case, Mr. Devlin, that two of these items weren't progressed at all. One was only progressed in the summer of 2020. Have you any observations to make in relation to, first of all, the failure to progress

the independent review of administrative actions prior to the summer of 2020?

A. In terms of the actions, I had assumed those actions would take place through the directorate. But my overarching view is that once the grievance came in, we stopped the progress of these activities. Again, I think there's learning and reflection on that. I'm not saying it is the right thing, I'm just saying given that level of pushback from Mr. O'Brien through the grievance and that the actions themselves were driven from the MHPS process, which is the issue that he was questioning, we did not progress those actions because we stopped because of the grievance. We wanted the grievance to happen, and then the actions, clearly. But I agree, in the cold light of day, it could have been possible to progress those other two. But the decision we took -- I mean, certainly I was advised by HHR and Medical Director that once the grievance had come in, that stops what we need to do. Clearly it would have stopped one of those but we managed to make it stop all three. On reflection, I think there's two ways to look at it. One, they were all connected to MHPS which he was taking the grievance against the way we ran MHPS, but there was probably the opportunity to have continue with at least one, if not two.

186 Q. The review of administrative actions was commenced, albeit some time after this report issued, but was commenced before the grievance had ever completed.

A. That's -- I believe it had but I would have to go back

to see. I had assumed that the actions would be taken forward by the Director of Acute Services in partnership with the Medical Director. And that was my assumption on these actions.

187 Q. It is quite clear, is it not, even if you have to use hindsight, that failures of management in implementing aspects of their own administrative process described the systemic are not only worrying for an organisation but require urgent action?

A. Reflecting using hindsight, you are correct. I did not drive urgent action when I read that report. I asked the organisation through the directors to take it forward. I'm not saying that's correct, I'm just reflecting on what happened. On reflection, if I had paid more attention to this particular issue as opposed to the other issues that were on my desk, I may have taken a different approach. But what I would say is that once that grievance came in, the advice clearly to me was: Right, the grievance is in. Right, we now need to deal with the grievance and we won't be dealing with the other action.

188 Q. Of course you readily appreciate the dynamic that says: Got to do something about this. Because the same managers could be making the same mistakes and the same practitioner is in place working in accordance with management direction, or should be. So there is a recipe for repeating the mistakes of the past if they are not specifically identified and addressed.

A. I agree. I am not defending that position. I agree

with you.

189 Q. Nor are you saying, as I understand it, that there was any particular mitigation or so they shouldn't put in place to try to address what are identified here as shortcomings by management?

A. Not at my request there wasn't. As I say, the assumption that I made was that these actions would be taken forward in the way that many reports, many actions are taken forward by the appropriate director. Reflecting on that assumption, it was the incorrect assumption.

190 Q. These issues were, as I understand it, discussed with you in the next year, in 2019. I just want to see if you can -- it is Dr. O'Kane's note which she supplied us with this week, I think. I just want to see if you can help us with this. Obviously we will have to direct questions to Dr. O'Kane.

WIT-90981. There's a meeting regarding AOB. You will see at the top of the page some discussion about AMC. And some discussion, I think, about Mr. O'Brien's concern that some of his colleagues were not practising safely. Then it goes on to organisational part discussed. Meeting with Shane, that says after the report Vivienne/Shane. A systemic dip. It appears to be the kind of language of the determination. Can you recall ever having a discussion -- and this may not necessarily be a record of the meeting with you, it could be between Mr. Haynes and Dr. O'Kane, but can you

recall discussing with Dr. O'Kane whether you should get on with the investigation into the organisation's managerial failures?

A. I don't recall that. What date, may I ask, was that?

191 Q. I can't tell, unfortunately. There is -- if we go on to WIT-90983. Scroll down, please. Stop there. Can we have the whole page up, please. So there is an entry on this page which says, two-thirds of the way down, I will talk to Shane re organisational part. I can't help you with dates. My question is can you recall discussing if this is what this document means, proceeding or not proceeding with the organisational part of Dr. Khan's determination?

A. I can't recall discussing that with Dr. O'Kane.

192 Q. Just so that we can nail it down. The advice that you received that we shouldn't process with this was received from who?

A. I'm going to say that it would have been through Vivienne and HR. But I can't explicitly recall a time when someone said "We are stopping everything because of the grievance". So I'm very well aware we received the grievance. I personally received it. And I am aware, then, as a result of that, Vivienne would have told me we cannot progress. But I could not recall a date when that would have been the case.

193 Q. Yes. One can readily understand the inability to proceed with the conduct hearing and the obstacle placed in the path of that by the grievance. Did Mr. O'Brien meet with you, I think it was 27th --

A. He met with me to give me the box of grievance; yes.
194 Q. And he sought specific assurance that you wouldn't move ahead with that pending completion of the grievance.
A. Right.
195 Q. But in terms of the action plan that Dr. Khan imagined, the new action plan with buy-in from NCAS and Mr. O'Brien, did you receive similar advice that that one could not be taken forward either?
A. No. No, I didn't receive that advice. The assumption was that we were not moving forward because we stopped because of the grievance. I didn't receive any advice or guidance as to why we were not progressing with that action plan. Nor did I challenge or ask. The assumption was, the grievance came in, this process will stop until the grievance is heard and outcomes are made. In my mind the logic was because they were all connected and, therefore, I didn't question it stopping. They were all connected. All of the outcomes, all of the actions were driven by an MHPS process that was being questioned. Therefore, in my mind, I didn't question it. But I assumed that was the reason we were stopping, because it was all connected to the one overarching review and report.
196 Q. And those decisions were made or resided in Human Resources?
A. Well, I certainly didn't make those decisions -- okay? So the running of the MHPS process, and certainly running of grievance would have been in HR. When other things were not progressing I was not challenging them

because I presumed that everything was stopped because of the grievance.

197 Q. You didn't question or challenge them?

A. No. I didn't. I didn't. Again, I go back to the point that I still -- I did not at that point in time -- I saw this as an issue with "a" clinician that needed to be addressed. An issue that clearly articulated in the document there were no clinical concerns over Mr. O'Brien. And we can go back to the beginning of the day, we all now agree that clinical and social care governance and governance is connected. But at that moment of time the document said that there were no clinical concerns with Mr. O'Brien as a clinician and the issues were administrative in nature. I did not put my personal attention into this process. I was looking at the other major organisational processes. I can't say any more than that. That was really the position i was in.

198 Q. But you would agree with me that the conclusion that may be reached here, legitimately reached, was that this was the height of complacency, to let MHPS reproach and determine and, notwithstanding the grievance, to fail to have done anything?

A. I believed that action was in place from the existing action plan and therefore I believed that we were safe from that existing action plan. I have never in my career become directly involved in an MHPS process, whether as a chief executive or as a director. Because those processes were being managed through a medical

directorate route, through an HR route, and in many cases I would not have been involved. Therefore, I read the review, I acknowledged that in my reading of the review as very early in the review it talks about no direct clinical concerns as regards Mr. O'Brien's practice. I was made aware there was an existing management plan to try to govern the things that were identified in '16, '17 and, therefore, I said I was satisfied by that and I moved on to other areas that I was being challenged with as a new chief executive in an organisation. I can reflect, have reflected, but that's the fact of what happened at that moment in time.

199 Q. Can we take a short break now?

CHAIR: It is 3.10 now, so 25 past.

THE INQUIRY ADJOURNED FOR A BREAK AND THEN RESUMED AS FOLLOWS:

200 Q. MR. WOLFE KC: I just want to finish with this whole area of whether it was, essentially, safe or otherwise to fail to interrogate the assurances that you were given and to accept that MHPS determinations couldn't be taken forward or shouldn't be taken forward. Would you agree with me that as chief executive, with patient safety issues on the line, it's entirely within your remit to countermand or at least, take a step back from that, energetically discuss the prudence of, on the one part the action plan to a small range of clinical matters and, on the other hand, the wisdom of not

pursuing any of Dr. Khan's recommendations?
A. I agree it would have been prudent to have done so. I would still go back to the point of what I was dealing with at that time and, therefore, the choices I made were based on what I saw was important in front of me to try to manage the overall safety of the organisation. I didn't view this -- and, in hindsight, we can clearly have all the evidence -- I did not view this as a major, major safety issue because I viewed it in terms of being, as the first line of the report says, there are no obvious clinical issues and, also, I viewed it as something that was being managed under an existing process around administration. I do not question the point you are making. It would have been prudent for me. I'm not questioning that. But I'm trying to help the Inquiry understand the reasons why I did what I did, which was I focused on other parts of the organisation because I saw them as more important at that time based on the challenges we were facing.
201 Q. I have to press you on this, Mr. Devlin, again. It takes one hour to bring a few people around the table to say, "Listen, I'm worried about this. We need to think more". Sometimes you have to go from the macro down to the micro when there is, on the face of Dr. Khan's determination, a concern for patients.
A. I know. I'm not denying that. I'm trying to help the Inquiry understand why I did what I did.
202 Q. One of just -- if we could open, again, WIT-00084. It's the paragraph beginning "When the matter was

raised with me". You asked for the assurance. We have gone over that.

You were advised that an SAI was being carried out to fully understand the learning. Then you go on to speak about the interim control measures. Is it fair to say, Mr. Devlin, that you didn't revisit the issue of the SAI and ask what the full learning was that had emerged?

A. I did at a later date, absolutely. And I sought that from Ronan Carroll, I think I remember at the time. Absolutely. And that was an issue that I wanted to explore and did explore with Maria and other people. But absolutely I wanted to understand what the outcome of that final SAI was.

203 Q. We know that that SAI concerned the failure to triage five patients, one in 2015 and four in 2016. And we know that that SAI was instigated in 2017. I think, ultimately, it was the autumn of 2017. It reported in May 2020. Are you aware of that?

A. Yes, that's correct. Yes, I am aware.

204 Q. Do you know what happened to delay the SAI to such an extent?

A. No. Sorry, I don't.

205 Q. It wasn't something you were keeping an eye on?

A. No. In terms of SAIs, I mean, again, overarching approach would be to be taken at directorate level, and I was not taking an overarching view of this SAI.

206 Q. So just looking at how you phrased it in your

statement, the SAI was there to give us better or fuller learning in respect of this practitioner. You didn't ask any further questions about it at the time. It emerges as a report six weeks before he retires in May 2020 against a backdrop where we have a monitoring plan that isn't looking at the issue of clinical practice and where we've stopped any further action on the determinations and where you have an SAI not producing the learning, I suspect, in the kind of time frame that the Trust would like to expect. This was a situation, was it not, where, despite the MHPS, nothing new was happening to manage and control the actions of this clinician?

A. Nothing from me, that is correct. I was not -- and, in fact, when I got the SAI report I don't believe it would have been six weeks before Mr. O'Brien retired, I think I probably got it at a slightly later date than that. But you are correct, I was not monitoring the Mr. O'Brien case. That's exactly what it is. I would expect directors to have raised it to me if there were issues that they wished me to -- they were concerned about, but I was not monitoring the Mr. O'Brien case.

207 Q. You weren't receiving periodic updates on --

A. Not at all.

208 Q. -- deviations from the --

A. Not at all. No. No.

209 Q. When you say "not at all", I want to take you just to something that Dr. O'Kane says in a moment.

But just looking at the format of your statement here, you talk about obtaining the assurance in 2018 and explaining that, and then you jump ahead to the middle of 2020. And, indeed, if we go to your second statement, please. Just allow me a moment. If you go to WIT-21154 WIT-21154. Scroll down the page, please. You say at paragraph 6 that: "My next and last involvement with the case was on 27th November 2018." That's before we get to the summer of 2020, when you spoke to Mr. O'Brien about his grievance.

I want to ask you about Dr. O'Kane's recollections. If I could have on the screen, please, WIT-45159.

She's asked: Did you raise any concerns about the conduct or performance of Mr. O'Brien? And, if yes, a series of questions follows. So scrolling down to the table, please. So the nature of the concern on the left-hand box, Mr. O'Brien deviated from the 2017 action plan formulated following MHPS. And this was raised with that list. And "Actions Taken" is the third column. So he recalls discussing -- Dr. Khan, case manager, discussing with those involved, including Mr. O'Brien, Dr. Lynn, etcetera. This was discussed in oversight group on 3 October and updated by Mr. Haynes by email on 7 October. This, in turn, was discussed with the Chief Executive at one-to-one meetings and at Trust Board confidential sections.

She recalls that deviations from the 2017 plan were discussed with you at one-to-one meetings and at Trust Board confidential sections. Now I see no record of such discussions being raised with the Trust Board in the confidential section and I know, just to fully orientate you, that Mrs. Brownlee has recalled that no issue in respect of Mr. O'Brien's practice was raised with the Board after January '17. One-to-one meetings with Dr. O'Kane, she was bringing to your attention deviations from the monitoring plan?

A. I would not recall that, to be perfectly honest. What I certainly did discuss with Maria later on in the process was, once the 2020 period arrived, we would have regularly discussed it at our one-to-one but not the deviations from the plan and certainly not in confidential sections of the Board meeting.

210 Q. So what you are saying is, as you said in your statement, that after saying good-bye to Mr. O'Brien in late November 2018 in respect of his grievance, you weren't reconnected into this issue --

A. No.

211 Q. -- or issues concerning Mr. O'Brien until the summer of 2020.

A. And I've clearly documented my evidence when Maria then approached me to say, in 2020, what had happened with regard to Mark Haynes, etcetera.

212 Q. Knowing what you know now, and I've explained to you that during 2019 the email materials available to the

Inquiry show concerns about deviation both in triage and in dictation post clinics continued to be an issue. Mr. Haynes was raising issues about the robustness of the data, particularly the robustness and reliability of the backlog reports that come from medical secretaries into the admin system and then to head of service and beyond. And there were also concerns then raised about SAI reports. One further SAI initiated Patient 90 or 92. Certainly one further SAI initiated in 2019, and a further concern being reported emerging from the Belfast Trust's MDM. Are you telling the Inquiry that none of that was drawn to your attention?

A. No. None of it was drawn to my attention. And people would have had the opportunity to do so through formal and informal mechanisms and, therefore, I do not recall it being drawn to my attention.

213 Q. Do any of those matters cross the threshold for raising with the chief executive by medical director, by director of acute, whoever it might be?

A. I would have expected issues of patient safety, in the way you've described them, would have been raised to me in detail. And they weren't. Nor did I ask, as I explained to you before. Nor, as I openly said to the Inquiry, was I curious about that because my attention was drawn elsewhere.

214 Q. The director of acute services up until the middle of 2019 was Esther Gishkori?

A. That's correct.

215 Q. You said in your statement that -- if I could just have

up WIT-00030, please. At the bottom of the page, please.

In terms of the issues we were discussing, she was in a somewhat pivotal position as director of acute urology services. This came under her directorate and if there were concerns about the practice of a clinician within that directorate, she should have been over the detail; is that a fair synopsis?

A. That is, yes.

216 Q. She resigned in April 2020, and that was pursuant to a negotiated settlement --

A. Yes.

217 Q. -- between herself and the Trust?

A. That's correct.

218 Q. We don't need to explore the fine detail of that.

Just go over the page, next page. Thank you.

The issues from the Trust perspective were performance and capacity issues, capability issues?

A. That's correct.

219 Q. She disputed the position.

A. Yes.

220 Q. You had a couple of meetings with her in 2019.

A. Yes.

221 Q. I just want to ask you about some aspects of those. If we go to TRU-299682. This is a meeting between yourself, Esther Gishkori, and Vivienne Toal?

A. That's correct, yes.

222 Q. 3 June 2019.
Could you help the Inquiry, what was the purpose of this meeting and series of meetings with her?

A. Yes. Certainly.

I had become more concerned about the performance of the acute directorate and, as you can see from the summary at the top of that document, performance was dropping. Financially the directorate was overspending in excess of £10 million a year. We had major issues in Daisy Hill Hospital, which is one of our hospitals with regard to consultants -- letter of concern from consultants. I'd had an anonymous letter of concern as well from other doctors and I had been visited by a number of doctors as well who were concerned about the management of the directorate.

I had attempted to discuss with Esther the concerns and try to find a way to find a new role for Esther in a way that, I think, many chief executives try to do. That new role would have been in a nursing capacity, in a patient/client user capacity, which would have allowed me to look at the management attempt within Acute and to try to support that management team and bring in fresh blood. And there is no doubt that the Acute directorate was enormous -- is enormous. It is as big as many Trusts in England and it is just a directorate. And the management was struggling. And

that was the purpose of the initial meeting.

I would like to have been able to do this in a much more humanly way and I would like to have not got to the point of having an agreed resignation. I would like to have got to a different place but, unfortunately, it became clear that Esther did not agree -- and still does not agree, I assume -- in the position that I was making. And we went through a negotiated process through the labour relations agency, and we came to the conclusion that Esther would leave the organisation. So, for me, it was very much focused on a range of issues that were coming up to me from the Acute directorate.

223 Q. Towards the bottom of this page she makes a point, not to put too fine a point on it "you want me out, plain as the nose on your face", which probably reflects an element of distrust had crept into the relationship.

Over the page you raise an issue about the management of associate medical directors and clinical directors. Let me just put you in touch with that bit of the note. About halfway down, please. Yes. This isn't a verbatim record and the Inquiry will recognise that, but what was the issue and is it at all germane to the Inquiry's interests that you're putting to her managing -- that is associate medical directors, is it? --

A. And clinical directors.

224 Q. And clinical directors -- presumably within acute services?
A. Correct.
225 Q. -- is part of her role as director.
A. Correct.
226 Q. What was the problem there?
A. The point that was being made to me and had been made to me in previous times from Esther, which is the responsibility for managing AMDs and CDs lie with the Medical Director. And I didn't agree with that. Irrespective of the fact that there is reference in both job descriptions to AMDs, ultimately you can't run a management team and part of that management team see themselves being managed by the clinical line. There's a role of the operational director. In the same way as if you had a nurse in there or you had a pharmacist, etcetera, you would expect that overall director to be -- well, sorry -- "I" expected that overall director to be managing the team. And Esther's view, as I recall it, was, well, they are managed by the Medical Director, performance is managed by the performance director, HR is managed by the HR director. I don't agree with that and that's really where that comment came from.
227 Q. What was the shortfall, then, for the service if she wasn't performing her management functions as you envisaged?
A. I think the shortfall lies -- is a grip of the directorate understanding what is happening and being

able to take corrective action. If you don't see yourself as having a management responsibility for the members of the team, then it could be argued that when something has to be done with that team, you may feel that somebody else is responsible for that action.

228 Q. Is it also part of her role to provide support to associate medical directors?

A. I think it is part of the director's response to provide support to all of the team members within that senior team. So if we are talking about team management, then we are talking about the director being the leader of that team and therefore it is important to provide support and advice and to be there, but also to be challenging as well.

229 Q. In what ways, if at all, did you see the shortcomings in her performance as impacting on the urology service or was it more general than that?

A. I didn't see it directly on urology services. What I saw it was that I had heard a number of doctors concerned that they felt the directorate wasn't being managed well. Performance was dropping. As I say, there were challenges of money, challenges of locum doctors -- there were challenges all over the place. Therefore, for me, it was a matter of could I help her get a grip on that and, if she can't get a grip on that, could I find somewhere else for her to deliver value for patients and clients and allow me to get on with looking at a new director and maybe a new team.

230 Q. You make a remark at the next meeting, and forgive me

if it seems I'm just picking up on phrases. Some stand out. And if you wish to say anything to more properly contextualise these records, feel free to do so.

A. I will do.

231 Q. You say, at TRU-299686 -- and if you bring us towards the bottom of the page, maybe two-thirds of the way down. Yes, just stop there.

She's reflecting upon the senior management team. She doesn't need to be part of the senior management team in any role that you might envisage for her, is my reading of that. You make the point to her: "I need to be sure you will drive radical change." Now, this meeting is June 2019. It may even -- forgive me, it may have been July. She went on sick leave and you had a follow-up meeting with her. It doesn't matter about the date. It was the middle of 2019. Have you any sense of what you meant by that, the need to drive radical change?

A. Yes, I do. And we were looking at the situation whereby locum expenditure was going out of control, agency expenditure was going out of control, our front door, as in emergency department, was clogging like never before, we had shortages of nurses, and the system just -- so irrespective of human beings, I think everyone in the system was working unbelievably hard, the system wasn't working -- isn't working or wasn't working. And, really, what I was looking for was radical thinking about the system. It goes back to the

point I made earlier about trying to drive care out of hospital into the community in terms of really getting to grips with the role and function of Daisy Hill Hospital, which is a really important part of our system. So it wasn't about the day-to-day management of a directorate. I don't pay a director to manage day to day. And I was looking for genuine innovation and change. Because it felt like it was mechanically running a system and the system wasn't getting better. Because the system won't get better if you are mechanically running every day. You need to radically think about the system. That's what I was asking for. That's what I was looking for.

I suppose my comment in that meeting was, I need to know you are up for that. Because if Esther was up for that then I was up to how can we try to manage to make this work. Because this wasn't an attempt to say no matter what those meetings showed I wanted Mrs. Gishkori to leave. I didn't. I wanted the system to work. That's why I specifically asked the question: Will you be able to drive radical change? Because this was not a matter of tweaking, this was about radical change. There were fires everywhere going on.

232 Q. Yes.

I think you made the point to me earlier that at no juncture did Mrs. Gishkori draw your attention to any particular concerns within urology?

A. No. Not at all.
233 Q. None related to Mr. O'Brien. She was replaced by Mrs McClements.
A. Melanie McClements. That's correct.
234 Q. That was at the point she went off on sick leave initially, in the summer of 2019.
A. Initially when Esther went off sick there was a different manager that came in. Anita Carroll came in for a short while, who was an deputy director or assistant director, then Melanie came in after that.
235 Q. Did either of those women draw your attention to any concerns within urology?
A. Not at that point, no. I mean, clearly they were -- Melanie was heavily involved in the 2020 work, but not at that point.
236 Q. Let me, having taken that sojourn, go back to the grievance and the MHPS issue. MHPS isn't the determination -- or the outcome of MHPS isn't moving forward, it is stuck behind the grievance. The grievance is lodged in October/November 2019?
A. October 27th, I think. I would have to check.
237 Q. It doesn't attract a hearing until the summer of 2020. Now, the grievance in pieces of paper terms looked significant. There were requests on the part of Mr. O'Brien for disclosure of relevant documents which were processed on several occasions. But the grievance, as I say, doesn't receive a hearing for some -- I'm trying to calculate in my head -- 18 months? 20 months?

A. Yes.
238 Q. Have you ever heard the like of it?
A. Not in a grievance, no.
239 Q. Was the hope that this might wither off on the vine and you wouldn't have to deal with it?
A. In terms of the organisation, I hope not. I don't believe so. But, clearly, it was not being enacted as quickly as it should have been enacted. I don't think anybody would have thought it would wither on the vine.
240 Q. What we do know, of course, is this has to be viewed through of patient safety lens. You can't get to deal with the issues set out in the determination -- rightly or wrongly. You have made your pitch on that and given your explanation for what you think HR or whoever else it was owned that decision. But 20 months, 18 months, is far too long even in a COVID context to be addressing this?
A. And I believed that the action plan was in place. I believed that my directors would raise to me if they felt that the action plan was required to raise to me as a patient safety issue. Wrongly now, of course. And I'm not saying it was right. But I believed that's what would happen, the directors would raise to me, if they had concerns over that period, because it was out of control. It was not raised to me in those ways.
241 Q. The Board was unaware --
A. That's correct.
242 Q. -- of any of these developments.
A. Unaware of the -- they were aware, obviously, at the

very beginning, MHPS. Nothing came to Board, but I'm not sure it would have done. Nothing came to me to come to Board. Nothing came to Board during that period of time.

243 Q. Yes. What did come to you was MHPS investigations, the determination as issued, roadblock (called grievance) decision not to move forward, but were content to rely on our monitoring arrangements.

A. That's correct.

244 Q. Now, that particular set of issues, content to rely on existing monitoring arrangements, notwithstanding the views expressed by Dr. Khan about the need for a new action plan, not withstanding the views expressed about the need for an investigation into management arrangements, those kinds of issues are the issues that you might expect a Trust Board to have some interest in from a scrutiny and challenge perspective?

A. Reflecting on this, yes, you would. But, unfortunately, that was not the line of sight that I was looking at it from. As I said before, I was looking at it: well, it was in control, there is an action plan, there are many things going to Board that I saw were immediate issues of both safety, money, HR, and those are the things I was bringing to Board. I did not bring an update on the MHPS process of an individual clinician where I believed there was an action plan in place and I believed the action plan was governing the issues of administrative nature. I can keep going through that point because that's the

position I was at.

Reflecting on it, absolutely. You would imagine that if, God forbid, there was ever to run it again. Absolutely. Because one of the issues was clear was the action plan was not being monitored and managed in the way that I believed it was. I wasn't hearing from my team on a regular basis that there was deviation. So I had nothing to bring to the Board because it was not coming to me in that way.

245 Q. Yes.

A. But with hindsight, absolutely. I couldn't agree more with you.

246 Q. There were three people with a seat at the Board table who had knowledge of MHPS having reported and the rest of package that I just outlined: yourself, Mr. Wilkinson who was the non-executive director attached to the MHPS process and, interchangeably, Dr. Khan, moving on to the new medical director Dr. O'Kane, for the longest part of this timeline.

A. Also the director of HR who always was in attendance at the Board meeting. The Board -- there were only five executive staffing members of the Board but all of my senior team attend the Board and are treated as members of the Board.

247 Q. Yes. And no discussion between yourselves about the need to bring this to the Board?

A. No.

248 Q. Was there any sense then or now that matters of,

I suppose, an employment nature shouldn't go to the Board until they are fully worked through or would it be wrong to think that that's any kind of explanation or excuse?

A. My recollection, employment matters are brought when they have been concluded. I would be very surprised if there's a trail of bringing employment matters.

249 Q. Yes.

A. Because those individuals involved in the employment matters wouldn't be in a public or confidential Trust Board environment. I would suspect you are correct. I suspect employment matters would come as part of the HR director's report or, otherwise, once something has been concluded as opposed to in process.

250 Q. Yes, but this wasn't, of course, purely an employment matter.

A. No.

251 Q. In the sense that the Board had the right to know about the exclusion and the commencement of the MHPS, it surely had a need to know -- I think you agree with me in hindsight -- about the outcome of that and, in particular, the fact that we couldn't move forward with it or the view had been taken that we couldn't move forward.

A. And I think, you know, clearly, and as I've explained to the Panel, a part of that, it could be argued, was the responsibility of the Chief Executive, the responsible Medical Director. Nor was the Board asking information of me on this particular case either.

Therefore, whereas the Board was asking of me information on many other things that were happening, as you can see from the agenda. So I just think there was a range of issues that it didn't come to Board. I can't say anything other than that.

252 Q. Just finally for this afternoon, just going back to the issue of SAIs, Serious Adverse Incidents generally. At that time was delay in the production of reports a feature of life in the Southern Trust more generally?

A. It was a feature more generally because the number of SAIs verses the resources that were available to deliver SAIs meant that there were quite a few that had long progression. That was part of the idea of introducing the weekly monitoring, to see where we are, what we are closing, etcetera. But it was not unusual and, again, I think in the governor's report I shared in my papers, you will be able to see the length of time that SAIs were taking given the resource challenge. I think there are other ways in which we can do SAIs from a learning perspective and possibly having, you know, employed panels and all kinds of things. But the way we were trying to do it was by asking clinicians both within the organisation, outside of the organisation, to spend time doing these. And I think there is potential opportunity for improvement by thinking of a different way and to resource SAI.

253 Q. I think you'll agree with me, if the principle at stake here is learning, learning in the context of patient safety, then producing a report three years after the

incident has taken place, and the SAI we're thinking about four years after the incidents had taken place, that's getting to the stage of being almost worse than useless?

A. Yes. The opportunity for learning has disappeared.

254 Q. More generally, the Inquiry will no doubt be interested in what can be done to address that. One of the reflections the Inquiry so far heard is the fact that the panels that populate these reviews, these SAI reviews, tend to be, quite often, made up of busy clinicians, and trying to bring them together at the same time to discuss issues and reach consensus on what have you is a systemic difficulty that's difficult to overcome?

A. That's correct. And I think there are other options such as having employed panels of maybe retired clinicians, maybe asking third parties: Come in and do SAIs. I think there are opportunities. And also probably looking at the thresholds on what could be a structured clinical judgment review verses an SAI. I think there's lots of opportunity to see how it can be better. But my understanding -- and apologies, I have not been in Northern Ireland for nine months -- but my understanding is the Public Health Agency and/or the RQIA were looking at the review of the SAI process. I could be wrong on that but I think either of them were.

MR. WOLFE KC: If it is convenient, we could break now and hopefully get through most of it in the morning,

maybe early afternoon finish?

CHAIR: A 10 a.m. start then?

MR. WOLFE KC: I'm content with that; yes.

CHAIR: See you all then.

THE INQUIRY WAS THEN ADJOURNED TO THURSDAY, 8 DECEMBER 2023 AT 10.00