PAT-000200

Personal information redacted by USI

19th September 2016

Corporate Complaints Officer
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Dear Sir/Madam,

Patient 84
DOB: Personal information redacted by USI
H&C No.: Personal information redacted by USI

I am writing to make an official complaint about the neglect towards myself resulting in my total dissatisfaction on how I have been treated over the past few months.

To give you the background into my situation, I was phoned by a consultant (Mr Puyson I believe) on Friday 25th March 2016 (Good Friday) to say that I had a blockage in my ureter, noticed on a recent CT scan, and that it would be best that I come into hospital as soon as possible to get surgery. I was informed that the Easter weekend would be a good time as there was some capacity to do the surgery as I was on an emergency list. I was obviously a bit alarmed and was in the middle of packing for the Easter weekend away. Of course, I realised the seriousness of my condition so I cancelled my plans and the consultant and I agreed that I would receive a telephone call on the Saturday morning to confirm bed availability. I didn't receive this call and then had to do some chasing myself. The staff currently on weren't aware of the plans for surgery. I eventually got confirmation on Easter Sunday morning to come to hospital for the surgery planned on Monday but when I arrived the staff were surprised as I shouldn't have needed to stay pre-operatively and therefore could have just came to hospital on Monday morning. This is just to highlight the severe lack of communication from the start and the fact that my weekend plans were cancelled unnecessarily. However, in saying all that, what followed is the real reason for this letter.

After the surgery by Mr O'Brien, I was told that the blockage had been removed (although the stone escaped back up to the kidney) and that I did have a lot of stones in both kidneys and a stent was placed in the right ureter. I understood the logic for a stent and I was informed that it will be uncomfortable at first and that I may feel the urgency to pass urine a bit more frequently as the stent protrudes inside the bladder slightly. I was informed that the stent should be removed in 6 weeks' time. I felt that this was fine and that this would be good timing for my pre-booked holiday at the end of May.

Unfortunately, from the beginning I had persistent pain with the stent at the tip of my penis particularly when passing urine, and I was passing fresh red blood post exercise and had severe urgency and severe frequency. This clearly had a major impact on my life both at home and in work. I was on regular Ibuprofen and Paracetamol to alleviate the pain but the pain was not being controlled. I was worried about my severe signs and symptoms so I contacted Mr O'Brien's secretary and asked could I speak to him or a member of his team for some medical advice and to discuss the symptoms I was

that this is one example of too much wrong communication from those who may not be there the following morning.

Patient 84 had right ureteric stenting performed on 28 March 2016 following ureteroscopy and migration of the obstructing stone into the hydronephrotic right kidney. Another example of wrong communication is the advice, information or assurance that Patient 84 claims to have been given that the stent would or should be removed during or after six weeks. In almost 25 years as a consultant urologist, I have never, ever committed myself to perform a procedure within any particular time unless I have actually fixed a date. However, during those 25 years, such commitments have been given to patients on numerous occasions by junior staff who have never once seen a waiting list.

In my view, it would have been ideal or optimal for Patient 84 to have had his stent removed and to have had ureteroscopic lithotripsy two to four weeks later as stent-induced, ureteric relaxation by then would have been adequate to permit ureteroscopy. If it had been possible for Patient 84 to be readmitted after such an interval, then all of his subsequent morbidity would have been avoided. It is in that regard that I have complete empathy for him. Unfortunately, that was not possible as he was then competing for readmission with scores of other patients waiting for longer periods with similar priorities.

In my defence, I have been entirely aware of the morbidity, sometimes serious, associated with ureteric stents since the 1980s. Most substantively, I have used every available, additional operating session during those months in an attempt to reduce the waiting times for patients in similar situations, and have done so without remuneration. As a consequence, the total number of patients on my inpatient waiting list has been reduced from 275 on 28 April 2016 to 232 on 13 October 2016. Unlike Patient 84, or my colleagues whose sessions I used, I did not have any family holiday during that time. To some degree as a consequence, I have not had the time to read every email sent to me each day, never mind resolve the issues raised.

An email was sent to me advising me that Patient 84 had a holiday in Personal information redacted by USI and that he was wondering whether he could have his surgery performed before then. I was unable to facilitate that request. I did not read the email of the 05 May 2016 requesting that I contact Patient 84 to give him advice concerning his stent while on holiday. I did read the

email of 17 June advising that Patient 84 had had urinary infection and requesting his admission as soon as possible. Once again, other patients in an identical situation were waiting longer to have the same procedure. I was unaware that I had ignored numerous calls made by Patient 84.

I have tried my very best to contact and communicate with as many patients as possible but have found it physically impossible to contact all of them. It is necessary to contact patients during their waking hours. Contacting and communicating with patients during their waking hours has resulted in administrative work being displaced to their sleeping hours, and rendering it all the more difficult to complete that work, even with the use of most of my supposedly free time.

More importantly, with a total of 232 patients awaiting inpatient admission, 136 of them categorised as urgent, it has been impossible to facilitate all patients, enquiring about and seeking admission, irrespective of the gravity of the indication. However, recently circulated data has revealed that four of my consultant colleagues have had totals of 29, 77, 59 and 41 patients awaiting inpatient admission. Indeed, the total number of patients of those four colleagues awaiting urgent admission was 131 on 13 October 2016, less than the number of patients awaiting urgent admission on my waiting list. It is my view that these figures portray such a disparity in the fortunes of patients on different waiting lists as to render that disparity indefensible.

Patient 84 suggested that a ‘window’ be established each day to phone patients with urgent concerns. This could well be considered an attractive and practical proposal for those who have such relatively small cohorts of patients from whom concerns may be received. I believe that it would be more profitable to pool operative resources to ensure that such patients are admitted after the shortest period possible, thereby minimising the need for any such window of communication,

Aidan O’Brien.

16 October 2016

SECTION D - Details of concerns held but NOT raised/reported

1. Please provide full details of any concerns you held at the relevant time specifying the nature of those concerns in as much detail as possible.

My father had Personal information redacted by USI which resulted in years of involvement with various departments across most of the hospitals in Northern Ireland. He advised us, his family, that the lack of consistent care provided by Mr O'Brien in the Urology Department in Craigavon Area Hospital was the worst he had ever encountered. He described one particular incident on 31.03.15 when he was advised to attend for admission for insertion of a stent. Upon arrival at the designated time he was advised that he was not on the list for the procedure and following on was only admitted after a number of hours waiting for the issue to be resolved.

2. Please explain why you did not raise your concern(s) at the time and state if there was something that prevented you from raising your concern(s).

We were grateful for the care my father received over the years and did not want to formalise our concerns at an earlier stage of our involvement with Mr O'Brien and the Urology Department in case it had an impact on the patient/consultant relationship. My father found Mr O'Brien to be arrogant and dismissive in his dealings with him

5.0 DESCRIPTION OF INCIDENT/CASE

a significant factor in the decision.

03 August 2014 - attended DHH ED with severe abdominal pain. Admitted to DHH and had resection of a recurrence of a small bowel tumour; discharged 2 September 2014.

September 2014 - referred back to the Oncology service. After further discussion, it was agreed that, rather than proceeding with palliative chemotherapy, he would be kept under surgical review, and treatment considered in the event of progressive disease.

15 December 2014 - attended Colorectal Consultant Surgeon 9 (ConsSurg9) who planned to review Patient 16 in 4 months.

02 March 2015 Patient 16's review appointment brought forward at the request of his daughter. Patient 16 was reviewed at surgical outpatient clinic. He reported abdominal pain and his carcinoembryonic antigen (CEA) test (blood test used to help diagnose and manage certain types of cancer) was increasing.

11 March 2015 - CT scan detected a left sided pelvic mass, causing hydronephrosis (a swelling of a kidney due to a build-up of urine). It happens when urine cannot drain out from the kidney to the bladder from a blockage or obstruction), and a new lung nodule.

12 March 2015 – Discussed at Cancer Multidisciplinary Team (MDT) meeting. ConsSurg9 wrote to Consultant Urologist 11 (ConsUrol11) referring for consideration of a ureteric stent to relieve the blockage. ***Red Flag*** label. Patient 16 was also referred back to Oncology (ConsOnc10).

12 March 2015 – letter from ConsSurg9 to patient and copied to GP, " ...... *I have referred you to kidney specialist to see about placing a little tube to relieve that blockage.*"

26 March 2015 - reviewed at Consultant Urology 15's (ConsUrol15) clinic. The clinic letter notes, '*He was seen by the Oncologists today and is planned for chemotherapy. As such we have arranged for him to be admitted electively on 31st March for insertion of a left ureteric stent. Pre-op assessment has been completed at the clinic today*'

26 March 2015 - at the Oncology clinic, decided to proceed with palliative Oxaliplatin and Capecitabine chemotherapy, (treatment began on 23 April 2015).

31 March 2015 - admitted to CAH presumed to be under care of ConsUrol13 and had cystoscopy + optical urethrotomy + ureteroscopy + insertion of ureteric stent. Performed by ST4Urol12 with assistance by ConsUrol13. Operation note, "*Oncologists to contact when chemotherapy complete for stent removal / replacement*".
01 April 2015 – Theatre / Recovery Care Pathway. "*Pt transferred from Recovery Day 1......... A/W ConsUrol13 to R/V .... ".*

2.	Please specify the date when any concern or complaint was raised and if you cannot recall date(s) please try to indicate an approximate timescale.

Concerns were raised regarding my father's care by Dr O'Brien on a number of occasions. These took the form of phone calls to the department (Mr O'Brien's secretary), some of which are documented in the SAI report and discussions with Mr Hart (oncology) and Mr McKay (surgeon). These concerns and complaints culminated in a formal complaint being made on 21.12.16.

3.	Please note the name and/or position held of the person you raised any concern with or reported any complaint to at the time.

MR Hart (oncology) at review appointments
Mr McKay (surgeon) at review appointments
Mr O'Brien's Secretary (30/11/15, 30/12/15, 10/05/16)
Mr O'Brien (01.12.16)
oncology staff during dads hospitalisation in June 2016.

4.	Please advise for each occasion a concern or complaint was raised whether this was done verbally or in writing (e.g. via letter/email etc).

all concerns / complaints prior to that in writing on 21.12.16 were verbal.