Southern Health
and Social Care Trust
Quality Care - for you, with you

11 July 2020

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien
Personal Information redacted by USI

Via E-Mail only

Personal Information redacted by USI

Dear Mr O'Brien

I am writing to advise you of a number of concerns that have arisen in respect of your practice as a Consultant Urologist.

On 7th June 2020 at 22.25, you sent an email which was copied to me, in which you explained that you had added 10 patients to the Trust's list for urgent admission. On my initial review of the list of patients in my capacity as AMD, I noted that 2 of the patients were stated to have been listed on 11th September 2019 and 11th February 2020, both requiring *"Removal/Replacement of Stent and Right Flexible Ureteroscopic Laser Lithotripsy".*

It appeared to me that these patients had been assessed on the dates given by you, but the outcomes of these assessments did not appear to have been actioned by you as required with the patients being added to the inpatient waiting list on the Trust's Patient Administration System. These patients therefore appeared on the face of it to fall outside the Trust's systems with all the potentially very serious clinical risks attendant on that.

Since this has come to light, the Trust has been seeking as a matter of urgency to establish the position in relation to these 2 specific patients and also to clarify whether any other patients are similarly affected. A review of records back to January 2019 has been undertaken.

At this stage, I enclose a summary of the concerns following initial review of patient records dating back to January 2019.

Southern Health & Social Care Trust
Craigavon Area Hospital
68 Lurgan Road, PORTADOWN BT63 5QQ
Personal Information redacted by USI

The concerns identified will be managed in line with the '*Maintaining High Professional Standards in the Modern HPSS*' Framework (MHPS). I have enclosed a copy of this document for your information.

We are at the initial enquiry stage of the process and I would like to offer you the opportunity at this point to make any initial representations on the concerns outlined in the attached document.

Once we have concluded our initial enquiries, a determination will be made about the next steps in the process. The possible actions following initial enquiries are set out in detail within the MHPS Framework at Section I Paragraph 15.

The Medical Director has been in contact with NHS Resolution (formerly National Clinical Assessment service (NCAS)) regarding this matter to seek advice on the management of your case. This is a normal part of any MHPS process. I enclose a copy of the letter received from NHS Resolution, for your information, and would draw to your attention, that you can contact them directly to discuss your case confidentially with an advisor.

In line with MHPS Section I paragraph 18, and following advice from NHS Resolution, the Medical Director and I have considered any necessary restrictions. We believe, that given our level of concern at this stage of preliminary enquiries, that it is necessary to put in place the following restrictions with immediate effect:

1. **That you are no longer to undertake clinical work.**

2. **That you do not access or process patient information either in person or through others either in hard copy or electronically.**

I would invite you to consider the underlying principle in Section II paragraph 22, and request that you voluntarily undertake to refrain from seeing any private patients at your home or any other setting. I would request confirmation of this undertaking, by return, via email.

I would also request that you notify me via email of any patient / clinical related information, reports and files which you have in your possession at home so that we can make the necessary arrangements to have them returned to assist us with our preliminary enquiries, and ensure any appropriate patient follow up.

I must also advise you that given the existing referral to the GMC in respect of the outstanding MHPS case, the Medical Director has informed the GMC's Employment Liaison Officer regarding these most recent concerns.

Southern Health and Social Care Trust

Quality Care - for you, with you

Chair
Eileen Mullan

Chief Executive
Shane Devlin

4 January 2022 Healthcare Ref: [redacted]

Private & Confidential

[redacted]

Dear [redacted]

RE: Urology Record Review

RE: [redacted]

On the 31st August 2021 the Minister for Health announced in the Assembly that he was commissioning a Public Inquiry under the Inquires Act 2005 into the circumstances surrounding Urology Services in the Southern Health and Social Care Trust (Southern Trust).

As the Chief Executive of the Southern Trust I instructed that a lookback exercise of all patients under the care of Mr Aidan O'Brien for the period January 2019 to June 2020, when Mr O Brien retired be undertaken. All the patients who were under Mr O'Brien's care during this 18 month period have been shared with the Urology Services Inquiry (USI). I advise you of this as you may receive communication from the USI.

In order to provide the necessary assurance for this lookback exercise we commissioned Consultant Urologists who were external and independent to the Trust to undertake a review of your Fathers medical records. I can now advise following this review of your Fathers care, aspects have been identified that require a further review. This means an independent Consultant will complete a Structured Clinical Record

Review (SCRR) of your Fathers care. We have included a leaflet to explain this process in further detail.

The external independent Consultant has determined that the treatment plan [redacted] was given in 2010 was potentially not appropriate. This treatment plan will be reviewed in the SCRR. Once this is complete we will write to you to inform you of the outcome.

Firstly can I pass on my condolences on the passing of [redacted] in [redacted].

I note [redacted] was initially diagnosed with prostate cancer in 2010 under the care of Mr O'Brien. Mr Haynes, Consultant Urologist reviewed him in November 2020 and he advised that at the time of diagnosis he did not recall being advised of the treatment options of radiotherapy or a surveillance pathway involving monitoring of his PSA (prostate specific antigen blood test which indicates possible prostate cancer or progression of cancer). Mr Haynes advised that you were commenced on a medication only (Bicalutimide) which was at a potentially lower dose than should have been for the management of the prostate cancer. Mr Haynes discussed the options going forward and agreed with you that the medication should stop and a surveillance pathway be commenced. I note [redacted] PSA was being monitored 3 monthly and the results indicated this was stable within normal range.

We appreciate that up until you have received this letter this may have been a worrying time. The Liaison Team attempted to contact you on the 8th, 9th and 15th December to discuss this letter prior to sending. The leaflet included with this letter outlines the support services available to you. Dedicated Trust Liaison Officers who are trained professional staff are available for any queries, concerns or questions you may have. This is a strictly confidential service for the purpose of this review process.

I apologise it has taken some time to complete. This was due to the volume of patients involved and wanting to assure ourselves that every patient record was reviewed fully.

Southern Health and Social Care Trust

Quality Care - for you, with you

20 June 2022

Private & Confidential

Healthcare Ref: [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Dear [redacted]

RE: [redacted]

I refer to correspondence dated 4 January 2022 from my predecessor Mr Shane Devlin, Chief Executive, advising that the Trust was undertaking a Lookback Review exercise of all patients who were under the care of Mr Aidan O'Brien, Consultant Urologist.

Mr Devlin's letter further advised that as the Trust's Lookback Review identified concerns with your father, [redacted] care, we were having a Structured Clinical Record Review (SCRR) undertaken to establish if there were themes and learning from his care.

An experienced NHS Consultant Urologist from outside Northern Ireland, who is a member of the British Association of Urological Surgeons (BAUS), has completed the SCRR and has now returned his report. I would now like to share the detail of this with you.

Before I progress on to describe the findings of the SCRR, I would like to to express my sincere condolences on the death of your beloved father in [redacted]. Losing a loved one is never easy; I recognise that receiving this letter regarding his past medical care may cause further distress. I apologise unreservedly if that is the case.

When your father was initially diagnosed with prostate cancer in 2010 Mr O'Brien commenced him on a drug called Bicalutamide, which is a type of hormone drug, at a dose of 50mg. [redacted] remained on this until it was correctly discontinued by Mr Haynes in November 2020. The SCRR report has highlighted that Bicalutamide 50mg was inappropriate treatment for a number of reasons; it is not registered as a treatment for localised prostate cancer and any form of hormone treatment represented an additional risk for your father due to his history of significant cardiovascular disease. The treatment your father received was not in keeping with standard clinical practice.

The SCRR also found that no evidence that your father's case was discussed with the Urology Cancer Multidisciplinary Team in 2010 or any time since. This is expected for all newly diagnosed cancer patients as it is in this forum where the wider clinical team discusses the case and collectively decide on what the best treatment options could be.

In your father's case the SCRR found there was no evidence of any patient discussion regarding treatment options, risks and benefits. Again, this was not the standard of care expected for patients.

The Consultant who undertook the SCRR has described Patient 82 treatment and care as "poor care". I apologise unreservedly for this poor care.

I recognise this might be a lot of information for you to understand and that you may have further questions at this time. If you would like to meet with Mr Haynes (in his capacity as a Senior Urology Consultant and Divisional Medical Director) and a senior manager, to discuss the situation further this can be arranged by contacting Sarah Ward, Head of Service for the Lookback Review on Personal Information redacted by USI.

As previously advised, the Trust has set up a Urology Helpline to inform and support patients and families during the Trust's Lookback Review process.

This Helpline remains available should you have any queries about the Lookback Review in general or your father's case specifically. The contact details are: freephone 08004148520 weekdays 10am – 3pm and / or email urologylookback@southerntrust.hscni.net.

I would also like to use this correspondence to update you on an inaccuracy contained in Mr Devlin's of 4 January 2022.

Mr Devlin's letter informed you that there was to be an Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust. This was correct however, the information pertaining to the Inquiry in Mr Devlin's letter was incorrect and because of this, you have been misinformed.

I very sorry that this was the case. I would like at this time to correct the error and clarify the situation.

Mr Devlin advised that the Minister of Health, Mr Swann, announced his intention to have a public inquiry into Urology Services on 31 August 2021. This was incorrect. The actual date that Minister Swann announced to the Assembly his intent to set up a statutory public inquiry into the Urology Service in the Southern Health and Social Care Trust under the Inquiries Act 2005, was in fact 24 November 2020.

I can confirm the Urology Services Inquiry commenced on 6 September 2021. The Chair of the Inquiry is Christine Smith QC.

As your father was patient within the timeframe of the Trust's Lookback Review we have shared his details with the Urology Services Inquiry team. Ms Smith may have already written to you directly as your father's next of kin as I understand she was doing so with all deceased patient's next of kin.

If you would like further information about the Urology Services Inquiry, more detail is available on the Inquiry's website at www.urologyservicesinquiry.org.uk.

Finally, I would like to thank you for your patience as we have progressed with the Urology Lookback Review.

Yours Sincerely

Dr Maria O'Kane
Chief Executive

Patient 5's Daughter advised her daddy was doing well, he has had a CT scan and is waiting on the results, which is causing him anxiety.

Patient 5's Daughter said it can be emotionally traumatic if you have cancer and is supported, doing well and develops a second cancer having a missed scan during lockdown and the cancer spreads. She suggested if the scan was read in January this may have prevented the spread of the cancer.

Dr Hughes suggested he would get Oncology and Mr Gilbert to advise. He said the scans were reviewed and there were no lesions there before.

Patient 5's Daughter asked if the scans were read and treatment started would this have prevented the cancer spreading.

Dr Hughes believes nothing will change how their father feels dealing with 2 cancers. He asked if the family had any other questions.

Patient 5's Daughter said she felt they covered all questions.

Dr Hughes advised there was good audits done in bowel cancer and would be putting in recommendations to discuss.

Patient 5's Daughter felt if Governance was in place this would not have happened to her daddy. She asked how the quality assurance cascaded down and up.

Dr Hughes agreed and said the Trust should be proactive and not reactive. He said processes should be put in place. He advised he had been discussing with CCS MD Dr D McCall and AMD Dr Shahid.

Patient 5's Daughter asked if the issues are in the overall report.

Dr Hughes advised at MDM 8 or 9 recommendations were appropriate. The failure was onward referral and the failure to re-refer to MDM. He advised the report will be based in facts and guidelines. He advised in the report Mr Gilbert will say what patients should have received and this will be written in plain English. This report will be used as evidence in the independent Enquiry. He said it was good to get an insight into the families expectations.

Patient 5's Daughter feels it is important to record in her daddy's report timeline, Patient 5 felt he got good care from MrO'B. Patient 5 felt MrO'B "saved my life".

Dr Hughes explained Mr Gilbert thought the care given to Patient 5 around his renal cancer was exemplary. He said to Hugh he couldn't use words missed cancer after using exemplary. But the failings were around support and clinical Nurse Specialists with safety checks taken away and very poor MDM input with the lack of Oncology in attendance. He advised the findings are based on systems not on one professional.

Patient 5's Daughter felt MrO'B was very personable and cared for his patients. The family were encouraging their daddy to get better unknown to them he had another cancer. She suggested the whole Governance process was systemic.

Dr Hughes advised the other 8 families has the same opinion of MrO'B and were shocked when they realised the care wasn't as it should have been.

Southern Health and Social Care Trust

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: 121877

Date of Incident/Event: 28 July 2020

HSCB Unique Case Identifier: S18334

Service User Details: (*complete where relevant*)
D.O.B: [redacted] Gender: M Age: [redacted]

Responsible Lead Officer: Dr Dermot Hughes

Designation: Former Medical Director Western Health and Social Care Trust. Former Medical Director of the Northern Ireland Cancer Network (NICAN)

Report Author: The Review Team

Date report signed off: 26 February 2021

Date submitted to HSCB: 1 March 2021

6.0 FINDINGS

- XX case was appropriately discussed at the multidisciplinary meetings pre- and post-surgery.

- A urology review was planned for July 2019 following the CT scan report in June, but this did not happen. The review team note that XX appeared to be lost to follow up.

- In a letter to XX dated 30 November 2019, Dr.1 advised that he was arranging a further CT scan to be performed in December and to reviewing him at the urology clinic in January 2020.

- The review team note that the scan was performed on 17 December 2019 and reported by the radiology team on 4 January 2020, but no follow up occurred.

- The review team have identified that the MDM was not quorate as no oncologist present for the meetings.

- XX was not referred to a Cancer Nurse Specialist or Keyworker to support him with his diagnosis. Nor was any contact details given to him. The Northern Ireland Cancer Services recommendations for Peer Review include that "all newly diagnosed patients have a Key Worker appointed, a Holistic Needs Assessment conducted, adequate communication and information, advice and support given, and all recorded in a Permanent Record of Patient Management which will be shared and filed in a timely manner"(1). This did not happen and was detrimental to the patient's experience.

- The review team are of the opinion that a specialist nurse would also have been a failsafe for identifying the delayed scan report and bringing it back to the MDM sooner.

  The review team are mindful that the family have concerns that when XX presented in ED with urinary symptoms a PSA was not undertaken. It would appear from the electronic records that a PSA test was never undertaken until August 2020.

- The CT scan, performed in January 2020, was not actioned until July 2020. Fortunately, no significant metastasis related event occurred in this 6 month period so will probably have no long-term effect on the disease's progress.

Southern Health and Social Care Trust

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

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Patient 5

5.0 DESCRIPTION OF INCIDENT/CASE

Dr.4 noted in his clinic letter that the scan performed in December 2019 had not been followed up and that there had been no communication with Patient 5 about the results.

A review was planned for November 2020.

6.0 FINDINGS

- Patient 5's case was appropriately discussed at the multidisciplinary meetings pre- and post-surgery.
- A urology review was planned for July 2019 following the CT scan report in June, but this did not happen. The review team note that Patient 5 appeared to be lost to follow up.
- In a letter to Patient 5 dated 30 November 2019, Dr.1 advised that he was arranging a further CT scan to be performed in December and to reviewing him at the urology clinic in January 2020.
- The review team note that the scan was performed on 17 December 2019 and reported by the radiology team on 4 January 2020, but no follow up occurred.
- The review team have identified that the MDM was not quorate as no oncologist was present for the meetings.
- The MDM was quorate 11% 2017, 22% 2018 and 0% 2019 and 5% in 2020.
- Patient 5 was not referred to a Cancer Nurse Specialist or Keyworker to support him with his diagnosis. Nor was any contact details given to him. The Northern Ireland Cancer Services recommendations for Peer Review include that "all newly diagnosed patients have a Key Worker appointed, a Holistic Needs Assessment conducted, adequate communication and information, advice and support given, and all recorded in a Permanent Record of Patient Management which will be shared and filed in a timely manner" (1). This did not happen and was detrimental to Patient 5's experience.
- The review team are of the opinion that a specialist nurse would also have been a failsafe for identifying the delayed scan report and bringing it back to the MDM sooner.
- The review team are mindful that the family have concerns that when Patient 5 presented in ED with urinary symptoms a PSA was not undertaken. It would appear from the electronic records that a PSA test was not undertaken until August 2020.
- The CT scan, performed in January 2020, was not actioned until July 2020. Fortunately, no significant metastasis related event occurred in this 6 month period so will probably have no long-term effect on the disease's progress.