UROLOGY SERVICES INQUIRY

USI Ref: Notice 22 of 2022
Date of Notice: 29th April 2022

Witness Statement of: Colin Weir

I, Colin Weir, will say as follows:-

[1] Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

1. I was appointed Consultant in General Surgery to Craigavon Area Hospital Group Trust (later Southern Health and Social Care Trust) in August 1996.

2. I have held several senior roles including Associate Medical Director for Education and Training until 31/7/2018, and Foundation Programme Director until 31/7/2017.

3. I was appointed Clinical Director ('CD') in surgery after competitive interview starting 1/6/2016 and ending 31/1/2022. For clarity, my area of responsibility initially (until December 2018) was urology, ENT, and general surgery in Daisy Hill Hospital. After December 2018, when I returned from a period of sick leave my area of responsibility was switched to General Surgery on the Craigavon

167. No.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: _____  _____

Date: _____21/6/2022_____

Site and then to both Craigavon and Daisy Hill sites in January 2021, after the retirement of the CD on the Daisy Hill site. Therefore there was overlapping of roles from 1 June 2016 until July 2017 when I was Clinical Director, Foundation Programme Director, and Associate Medical Director for Education and Training; from July 2017 to July 2018 when I was Associate Medical Director for Education and Training and Clinical Director; and from July 2018 to January 2022 when I was Clinical Director only.

4. My direct line manager was Dr C McAllister as Associate Medical Director, who was appointed to the post on a temporary basis in addition to his role as AMD for Anaesthetics. I was directly answerable to him and had weekly meetings with him along with the other Clinical Director (Mr. Haynes). Dr. McAllister's tenure ended in October 2016 and his acting replacement was Mr. Haynes, whom I believe commenced in January 2017. *This date should read "**on 1st October 2017**" as per amendment to statement received on 20/02/2023 (TRU-320007 refers). Annotated by the Urology Services Inquiry.*

5. During my tenure as urology CD, I had sick leave in November 2016 for about 4 weeks [redacted], in late August 2017 for 6 weeks [redacted], and again from late November to February 2018 [redacted]. I had further sick leave from late November 2018 through to February 2019 with some working from home [redacted]

6. Soon after commencing my post as Clinical Director for Surgery and Elective Care with responsibility for urology I was made aware there were outstanding issues in relation to Mr. O'Brien. I was sent a copy of correspondence to him written on 23 March 2016, *[20160615 - E Confidential letter to AOB located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]* sent to me on 15 June 2016. This correspondence highlighted outstanding issues namely:

   (i) Untriaged outpatient referral letters;
   (ii) a review backlog of 679 patient;
   (iii) lack of documentation;
   (iv) patients notes kept at Mr. O'Brien's home.

103. Governance concerns could be raised through Head of Service, Assistant Director, AMD and the Director of Acute Services or myself. An Acute Governance Committee would oversee the process, chaired by the Director of Acute Services, and met on a monthly basis. Those processes were outside my remit and can be addressed and explained by others. During my tenure, and in relation to urology, there were no governance concerns I can recall other than one (of a series) of concerns which relates to this Inquiry. In this case, Mr. O'Brien was the subject of ongoing concerns as described in answer to Question 39 above. In this first instance the process was entirely informal with an action plan drawn up me [*20160921- E meeting re Mr O'Brien located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*] . However, this was overtaken by the intervention the Medical Director (Dr Wright) and a more formal process followed with investigation under the MHPS framework and in line with the Trust's implementation of that. Subsequently, there was monitoring of Mr. O'Brien's performance against set targets on triage, undictated letters, booking of patients in date order and priority, and ensuring no patient notes were at Mr. O'Brien's home. The process involved other members of the management team having the same information shared including the Head of Service and Assistant Director. It is important for me to record that I was not primarily responsible for this process and had very limited experience of the process other than in the case of Mr. O'Brien.

[46] Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

104. I had some support from the medical hierarchy, with weekly meetings with the acting AMD for Surgery (Dr McAllister) at least approximately to December 2016, when he was removed from the post. At times, it was

*This date should read "**to October 2016**" as per amendment to statement received on 20/02/2023 (TRU-320007 refers). Annotated by the Urology Services Inquiry.*

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 33 of 2022
Date of Notice: 29th April 2022

Witness Statement of: Colin Weir

I, Colin Weir, will say as follows:-

General

[1] Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order using the form provided.

1. There is a significant overlap between this question and some of my answer to Question 1 of my first Section 21 Notice (No.22 of 2022). However, there are also a number of discrete additional points of relevance (e.g., regarding my training). I therefore consider it necessary to repeat in large part the account given previously, albeit with these additional points included in it.

accordingly.

63. During my time as Case Investigator, I achieved the goal of preliminary investigation and report to the Oversight Committee within a four-week timeframe (see para 32 above). However, the removal of myself and appointment of Dr Chada created a new set of investigations and interviews to be undertaken. The appointment of Dr Chada or another investigator on or around 6th January 2017 would on balance have avoided the need for extension to complete MHPS process.

64. However, I should not have been asked to undertake this role. With greater experience, I would have rejected the approach to do this.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: _____  _____

Date: _____21/6/2022_____

From: Wright, Richard
To: Scullion, Damian; Tariq, S; Weir, Colin; Haynes, Mark
Subject: Temporary management arrangements
Date: 11 November 2016 09:57:50

You will be aware that Dr McAllister has stepped temporarily stepped aside as AMD for surgery and anaesthetics to facilitate an ongoing internal Trust process. During this period I would expect management issues to be dealt with by the Clinical Directors in liaison with Mrs Gishkori and myself in relation to professional issues. I will update you if the situation changes.
Regards
Richard Wright

Sent from my iPad

challenging because, not long after my appointment, I was made aware of the issues in urology pertaining to one consultant, Mr. O'Brien. Initially, I was asked to manage the situation on an informal basis. However, in retrospect I had not realised the enormity of the problem nor the previous attempts to resolve it. None of this was communicated to me. Other than the meeting above, and until a formal investigation commenced in January 2017, I did not feel there were enough more formal meetings, or minuted meetings, or opportunity to gain advice, or communicate a complex and challenging case with the management team (that is, the Director Acute Services, Esther Gishkori, Medical Director, Dr Richard Wright, Assistant Director Surgery, Ronan Carroll, and Associate Medical Director, Dr McAllister, in post for a short time). There were no meetings until the MHPS investigation with more senior hierarchy that I can recall. There were some emails around this [*20160921- E meeting re Mr O'Brien located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*]. I must state, however, that the Head of Service Martina Corrigan was invaluable, with clear communication and she helped me to manage some of the complexities of the issues with Mr. O'Brien.

<u>Concerns regarding the urology unit</u>

[47] The Inquiry is keen to understand how, if at all, you, as Clinical Director, liaised with, involved and had meetings with the following staff (please name the individual/s who held each role during your tenure):

i. **The Chief Executive(s);**

ii. **the Medical Director(s);**

iii. **the Director(s) of Acute Services;**

iv. **the Assistant Director(s);**

v. **the Associate Medical Director;**

vi. **the Clinical Lead;**

Southern Health and Social Care Trust

Quality Care - for you, with you

Ref No: 73816020

THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST ONLY

JOB DESCRIPTION

JOB TITLE: Clinical Director – Surgery & Elective care (2 posts)

BASE: Craigavon Area Hospital / Daisy Hill Hospital

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Services

OPERATIONALLY RESPONSIBLE TO: Associate Medical Director – Surgery and Elective care

ACCOUNTABLE TO: Chief Executive

HOURS: Salaried Part-time position

JOB SUMMARY

The appointee will provide clinical leadership and contribute to the strategic development of Surgical Services in the Southern Health and Social Care Trust.

There are 2 posts available;
He/She will:

- Participate as a member of the Surgery and Elective Care Divisional Team;
- Be responsible for medical operational issues within Surgery across the Trust.
- Provide professional advice to the Associate Medical Director and Divisional team on professional medical issues of the Division.
- Support the Associate Medical Director in the performance management, job planning and appraisal of designated clinicians.

The appointee will be professionally accountable to the Medical Director for medical professional regulation within the service.

KEY RESPONSIBILITIES

Setting Direction:

- To support the Trust in the development of a high quality, responsive scheduled and unscheduled care services, ensuring that regional and local targets are achieved.
- To advise the Management Team of Divisional priorities and pressures across the Division.

job description which highlighted key responsibilities, professional leadership role, leading the medical team and general responsibilities.

Engagement with unit staff

[28] Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

82. I had meetings with the Lead Consultant, Mr. Young, on an ad hoc basis and meetings with the whole team if significant developments or concerns arose. I met Mr Young to discuss issues in relation to Mr. O'Brien and regarding payments for urology on call work *[20161005 E Urology oncall located in 20161005 E Urology oncall].* This only happened on one or two occasions. I had regular meetings (at least 3 times a month) with the Head of Service to appraise me of any issues relevant to my Clinical Director role. For example, we discussed waiting times for patients, staffing issues and locum appointments. I also met all the Consultants to discuss job plans. I estimate that, on average, urology unit work would occupy an hour a week.

[29] Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

83. I was not involved in scheduled meetings or minuted scheduled meetings working on an ad hoc basis but had regular contact with the Head of Service. For example, there would have been email correspondence, almost entirely

Urology Services Inquiry

15. In terms of relevant training:

a. I note that I received emails on 3 February 2017 inviting me and others to NCAS (National Clinical Assessment Service) Investigator training but I could not attend as I was surgeon of the week.

b. I also recall a half day of one-to-one training or update session from NCAS officer, Grainne Lynn, in early 2017. I am currently trying to find a record of this.

c. I note that I had NCAS training previously, recorded in my personal 'e diary' as, 'Managing Concerns. NCAS. Office Suite 3, Lisburn Square House, Haslem's Lane, Lisburn. 14th October 2014, 10-4:30pm'.

d. I attended a full day or half day course on MHPS provided by NCAS in Craigavon Area Hospital 24 September 2010. *[1. annexe e NCAS located in S21 33 of 2022 Attachments]*

[2] Provide any and all documents within your custody or under your control relating to paragraph (e) of the Terms of Reference except where those documents have been previously provided to the Inquiry by the SHSCT. Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. If you are in any doubt about the documents previously provided by the SHSCT you may wish to contact the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

[3] Unless you have specifically addressed the issues in your reply to Question 1 above, answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the

Corrigan, Martina

From: Corrigan, Martina
Sent: 15 June 2016 14:48
To: Weir, Colin
Subject: FW: Confidential letter to AOB - updated March 2016
Attachments: Confidential letter to AOB - updated March 2016.docx

Hi Colin

As discussed!

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by USI
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

7. I believe this was sent to me because Dr McAllister (acting AMD), in around June or July 2016 (from personal undated handwritten note) had asked me to try and resolve this outstanding issue. More specifically he asked me to try and resolve this with negotiation with Mr. O'Brien and have him agree to an action plan without recourse to formal investigation or procedures

8. I was not aware of these issues in any way prior to being informed by the acting AMD.

9. I was also informed that the Lead Consultant, Mr. Young, was aware of the issues and that he would be approaching Mr. O'Brien in the first instance.

10. I recorded in my handwritten notebook a meeting with My Young on 9.8.2016. I noted “AIDAN-MY will D/W with him”, meaning that, as Lead Consultant, Mr. Young would discuss with Mr. O’Brien issues in relation to some or all the four concerns raised above *[1. personal handwritten notebook, located in S21 22 of 2022 Attachments].*

11. On 22.8.2016 Simon Gibson, the Assistant Director, emailed more senior managers to enquire if any plans or proposals were received in relation to Mr. O'Brien and the concerns above. [20160823 - E Confidential AOB located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]

12. Dr McAllister suggested by email on 23.8.2016 that we hold off any further actions until the “dust settles on the process.”[20160823 - E Confidential AOB located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]

13. On 31st August Mr. Haynes noted a patient of Mr. O'Brien’s was not triaged. [20160902 - E Urgent for investigation please located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD] The patient was seen by me for leg pain possibly due to a circulation issue, but metastatic disease was noted in keeping with metastatic prostatic

6. Dr McAlister first mentioned to me that there were concerns about Mr O'Brien's triage, keeping notes at home and undictated clinics in or around August 2016. He put it in terms of there being a bit of an issue with charts, triage and clinics but it wasn't put to me as a really serious problem.

7. I met with the Head of Service, Martina Corrigan around the end of September 2016 and I got further information about charts that were tracked to Mr O'Brien but were not in the Trust, that Mr O'Brien was way behind with triage of GP referrals and a backlog needing to be addressed. AT this point the intention was very much to deal with the issues informally. There was no formality about the matter. The approach to managing the issues was all informal and it was about how we could help Mr O'Brien to get him back on track. No-one knew the enormity of the problem.

8. I was appointed as Clinical Director around April 2016 and the issues of concern were not immediately brought to my attention. I recall discussions between Mark Haynes and Dr McAlister at the weekly Thursday meetings about the concerns but it was not addressed directly with Mr O'Brien because he may not have been at the meetings. I think I first became aware there were issues around the summer of last year. I discussed the concerns with Michael Young who is the clinical lead in Urology and he was aware of the concerns.

9. I remember that the intention was for Martina and Ronan to discuss with Mr O'Brien but I do recall it was always meant to be on an informal basis. This meeting didn't happen as far as I understand. I had discussed the matter with Martina and Michael Young and then I was made aware that it had gone to the Medical Director's office and that Dr Wright was looking at it.

10. I don't think people knew the enormity of the problem or how far back it was going on. I know I was told at a point not to meet with Mr O'Brien about this issue. I can't recall who said this to me, it may have been Ronan.

11. In terms of TOR 1, I know now that there is a problem with Mr O'Brien not triaging patients but I didn't know the extent of the problem at the time.

12. In respect of the issue to do with notes, again I was aware there was an issue with Mr O'Brien having notes at home but not the extent of the problem.

13. In relation to the undictated clinics I was broadly made aware of an issue by Dr McAlister but I did not know the detail or extent of the problem.

14. In relation to TOR 4, I was not aware of any issue related to private patients.

15. I know managers within the Trust were aware of the problems with Mr O'Brien and I was shown a letter dated March 2016 addressed to Mr O'Brien. Dr McAlister felt the correspondence in March 2016 had not addressed the problem and he wanted to manage it in a different way. I recall Dr McAlister saying that Mr O'Brien was a good surgeon and he felt could help him get back on track. This was all without the knowledge of the enormity of the problems.

96. I have explained (e.g., at Questions 5 to 8 above) that my role in clinical governance was limited other than a main issue with Mr. O'Brien.

97. Within approximately 2 weeks of commencing appointment as Clinical Director I was made aware of an ongoing unresolved governance issue with one of the consultants in the unit (Mr. O'Brien). This was during regular weekly meetings with the Associate Medical Director (Dr McAllister). The issues raised were of Mr. O'Brien's failure to triage patients in a timely manner, that there was a review backlog of oupatients, and that because there was a backlog of dictated letters there were no outcomes recorded in many cases. Also, there were a significant number of NHS/HSC notes belonging to the Trust that Mr. O'Brien kept at home. At this stage I was not informed of precise numbers, how long this had been occurring, what previous action plans and meetings had occurred to address this, or any other significant briefing. I consider it a failure of good governance to ask a newly appointed Clinical Director with no previous experience to resolve, informally, a longstanding and complex problem with only a weekly meeting with my line manager.

[40] How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

98. I was not aware of concerns in governance meeting minutes and I have no record of such documents or any other type of governance documentation. I had no involvement or written communication regarding the Risk Register.

Urology Services Inquiry

topic.
Charlie
Sent from my BlackBerry 10 smartphone.

And Simon Gibson replied (S21 No 32 of 2022 Attachments, 4. 20160822 E Confidential AOB SG);

From:

Gibson, Simon	Personal Information redacted by the USI
22 August 2016 18:02	
McAllister, Charlie	
RE: Confidential - AOB	

Ta
Thought not, just covering off all the angles! Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office Southern Health & Social Care Trust
Personal Information redacted by the USI Mobile: Personal Information redacted by the USI
DHH: Personal Information redacted by the USI Ext Personal Information redacted

11.6 Prior to the email from Simon Gibson above and my reply I had learned during the week beginning the 15th August 2016 that it had been appreciated, by I believe Martina Corrigan, that there was an ongoing issue with triage of referrals by Mr O'Brien and rather than improving the situation had actually got worse. I am fairly certain that it was the HoS Martina Corrigan who told me this and that this information had been escalated to Esther Gishkori and the Medical Director however it might have been Esther who told me, I do not recall. Armed with this information ~~and the subsequent rumor that Formal procedures under MHPS were being considered/discussed (again I cannot recall who informed me of this)~~ I discussed the situation with Mr. Colin Weir, CD for Urology, at our regular Thursday meeting on the 18th August 2016. We discussed what steps could be taken to sort this chronic problem out once and for all. Among the things we discussed I suggested that removal from theatre until the backlog was cleared would be the most effective incentive for Mr. O'Brien to address the triage backlog and any other issues. Mr. Weir appeared concerned at this suggestion and said that Mr.

The highlighted text above should be deleted as per email received 20/02/2023 (TRU-320005 to TRU-320006 refers) as Mr Weir was not aware of the rumour until approximately September 2016. Annotated by the Urology Services Inquiry.

O'Brien would 'go mad'. I asked him to think about it over the weekend and come up with a solid plan that would sort this problem out once and for all and consider speaking with Mr. O'Brien the following week.

11.7 However following Simon Gibson's email of the 22nd August 2016 I emailed Mr. Weir 23rd August 2016 at 11.11) (S21 No 32 of 2022 Attachments, 20160830 E confidential AOB CW):

From: McAllister, Charlie
Sent: Tuesday, 23 August 2016 11:11 **To:** Weir, Colin
Subject: FW: Confidential - AOB

Strictly in confidence.

Hi Mr Weir

Please see below. This has come to light subsequent to our discussions on this subject last Thursday. It appears that the boat is missed. I know that you are on leave this week and I'm off for the following two so wont get a chance to meet/discuss.

Please hold off on attempting to address this issue until the dust settles on the process below.
Thanks
Charlie

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie **Cc:** Carroll, Ronan; Trouton, Heather **Subject:** Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

I would be grateful if you could respond to this e-mail, even if you have not received any plans or proposals. Given the sensitivity of this subject, I would be grateful if you would respect the confidentiality of this e-mail. Kind regards

Simon

Corrigan, Martina

From: McAllister, Charlie <[redacted]>
Sent: 23 August 2016 11:11
To: Weir, Colin
Subject: FW: Confidential - AOB
Attachments: Confidential letter to AOB - updated March 2016 final.docx

Strictly in confidence.

Hi Mr Weir

Please see below. This has come to light subsequent to our discussions on this subject last Thursday. It appears that the boat is missed. I know that you are on leave this week and I'm off for the following two so wont get a chance to meet/discuss.

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Thanks

Charlie

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB

Dear all

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I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

I would be grateful if you could respond to this e-mail, even if you have not received any plans or proposals.

Given the sensitivity of this subject, I would be grateful if you would respect the confidentiality of this e-mail.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
[redacted]
Mobile: [redacted]

AOB:

The oversight group was informed that a formal letter had been sent to AOB on 23/3/16 outlining a number of concerns about his practice. He was asked to develop a plan detailing how he was intending to address these concerns, however no plan had been provided to date and the same concerns continue to exist almost 6 months later. A preliminary investigation has already taken place on paper and in view of this, the following steps were agreed;

- Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB
- The meeting with AOB should take place next week (w/c 19/9/16)
- This letter should inform AOB of the Trust's intention to proceed with an informal investigation under MHPS at this time. It should also include action plans with a 4 week timescale to address the 4 main areas of his practice that are causing concern i.e. untriaged letters, outpatient review backlog, taking patient notes home and recording outcomes of consultations and discharges
- Esther Gishkori to go through the letter with Colin, Ronan and Simon prior to the meeting with AOB next week
- AOB should be informed that a formal investigation may be commenced if sufficient progress has not been made within the 4 week period

ACTIONS:

1. **Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB next week**
2. **Esther Gishkori to meet with Colin Weir, Ronan Carroll and Simon Gibson to go through the letter and confirm actions required**

Irrelevant information redacted by USI

[redacted]

Irrelevant information redacted by USI

[redacted]

Stinson, Emma M

From: Gishkori, Esther <Personal Information redacted by USI>
Sent: 14 September 2016 13:17
To: McAllister, Charlie
Subject: FW: Confidential - AOB
Attachments: Confidential letter to AOB - updated March 2016 final.docx

Thanks Charlie.
At least you have a starting point.
I am clear that I wish you and Colin to take this forward and explore the options and potential solutions before anyone else gets involved.
We owe this to a well respected and competent colleague.
I can confirm that you will have communication in relation to this before the end of the week.
Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted by USI **Mobile** Personal Information redacted by USI
Personal Information redacted by USI

From: McAllister, Charlie
Sent: 14 September 2016 12:25
To: Gishkori, Esther
Subject: FW: Confidential - AOB

Hi Esther

Further to our meeting today here is the only communication that I have received on this subject.

Regards

Charlie

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

Sensing real and meaningful remedial action was necessary, I spoke with both Mr O'Brien's CD, Mr Colin Weir and AMD (now Dr Charlie McAllister) and asked if they could suggest an efficient solution to address Mr O'Brien's issues with administration in particular. Being an Anaesthetist and having worked in theatre for a long time with Mr O'Brien, Dr McAllister said he was almost certain that if Mr O'Brien was "relieved of his theatre lists" until his administration was up to date, he would soon catch up. Mr O'Brien loved the operating theatre. I understand that he would be prepared to spend all day and into the evening there if he could. If someone else did his lists, he would consider this intolerable. Both clinicians thought that it would take 3 calendar months to rectify.

Mr Weir was to meet Mr O'Brien and discuss the plan. It was to be supportive, constructive, and low key but very clear with no room for deviation. This plan was set out in an e mail from Colin Weir to Charlie McAllister on 16th September 2016. I was hopeful about it, but when I told him, the Medical Director was reticent. The Medical Director and Vivienne Toal (Director of HR) preferred to continue with the oversight Committee deciding on what action was to be taken next. I was invited to this committee and was a member, completing actions and reporting back to the committee as appropriate.

Mr O'Brien went off for Personal Information redacted by USI in November 2016. He was due to return to work in January 2017. However,it had latterly come to light that there had been further issues of concern with a possibility of actual patient harm, again in relation to the referral process. It was therefore decided at an oversight committee meeting in December (at which I was represented by one of my assistant directors, Ronan Carroll) that Mr O'Brien be excluded from work for the duration of what was now a formal investigation.

Paragraph 8.

On 13th January 2017, in my capacity as the Director of Acute Services, I wrote to Mr O'Brien, giving him the opportunity to review and return comments on the SAI review into patient Patient 10 He replied on 25th January with 11 pages of comments.

Mr O'Brien's 11 pages of comments and questions sent people in all directions answering and gathering comments. For me, he simply didn't follow a system which had been religiously and ably followed by ALL the other team members.

Paragraph 9.

Some time between August 15 and September 16, I read a letter of complaint. Not about Mr O'Brien but about the fact that the ward staff were not expecting the complainant to appear for surgery and therefore there was no bed for the patient. It transpired that Mr O'Brien himself had phoned the patient the night before and told him to come in the following day. Unfortunately, the ward staff nor consequently theatre staff had been informed.

Personal Information redacted by the USI

Personal Information redacted by the USI I was off work for circa 2 months. The case of Mr O'Brien was managed by the oversight group during that time and thereafter. I know that Ms Corrigan, the HOS for Urology, monitored Mr

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training | Clinical Director SEC
Southern Health and Social Care Trust

Secretary Jennifer Personal Information redacted by USI

From: Gishkori, Esther
Sent: 15 September 2016 14:59
To: Weir, Colin; McAllister, Charlie; Carroll, Ronan
Subject: FW: meeting re Mr O'Brien.

FYI below.
.....and my response will be?

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted by USI Mobile Personal Information redacted by USI
Personal Information redacted by USI

From: Wright, Richard
Sent: 15 September 2016 14:52
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Re: meeting re Mr O'Brien.

Hi Esther. As director of the service naturally we have to listen to your opinion. Before I would consider conceding to any delay in moving forward with what was our agreed position after the oversight meeting I would need to see what plans are in place to deal with the issues and understand how progress would be monitored over the three month period.
Perhaps when we have seen these we could meet again to consider. regards Richard

Sent from my iPad

On 15 Sep 2016, at 14:40, Gishkori, Esther Personal Information redacted by USI wrote:

> Dear Richard and Vivienne,
> Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
> I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.
>
> Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
> Now that they both work locally with him, they have plenty of ideas to try out and since they are both relatively new into post, I would like try their strategy first.

Since I can't improve on this I am forwarding in toto.

Thanks

Charlie
From: Weir, Colin
Sent: 16 September 2016 14:41
To: McAllister, Charlie
Subject: Action Plan

Charlie
These are my initial thoughts. Anything to add? Change?

Dear Dr McCallister

Further to discussions I propose that I as CD and you as AMD implement the following action plan in relation to outstanding issues in respect of Mr O'Brien

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien
2. To implement a clear plan to clear triage backlog.
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation
5. All patient notes to be return from home without exception
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training |Clinical Director SEC
Southern Health and Social Care Trust

Secretary Jennifer Personal Information redacted by USI

From: Gishkori, Esther
Sent: 15 September 2016 14:59
To: Weir, Colin; McAllister, Charlie; Carroll, Ronan
Subject: FW: meeting re Mr O'Brien.

FYI below.
……and my response will be?

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted by USI **Mobile** Personal Information redacted by USI

carcinoma. The triage delay was 3.5 months and apparently this would not have changed the outcome but there was a concern regarding delayed triages in general. This was raised with the AMD (Dr C McAllister) on 31st August 2016 and he suggested it be referred to the lead Consultant first (Mr. M Young) and myself second as per email31 August 2016.*[20160916 - E Missing triage located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]*

14. I don't know what further action flowed from that exchange of emails, but an email on 15.9.2016 noted a meeting between the Director of Acute Services, Assistant Director and AMD (and sent to the Medical Director), suggesting that myself and the AMD be allowed 3 months to deal with Mr. O'Brien and the outstanding issues.[*20160915 - E Meeting re Mr. O'Brien located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]* There was an oversight committee whose function or membership I had no knowledge of, I was not part of that committee, and any communication or decisions came to me via the acting AMD.

15. I was sent an email on 15.9.2016 from the Head of Service noting over 50 patients with outstanding triage, with the longest wait being 52 days.[*20160916 - E Missing triage located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*]

16. On 16.9.2016 I emailed an action plan to Dr McAllister in which I noted the need: [*20160921- E meeting re Mr O'Brien located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]*

    (i) for a series of face to face meetings with Mr. O'Brien,

    (ii) to ask Mr. O'Brien to implement a plan to clear triage backlog,

    (iii) to have the review backlog validated and change the new to review ratio to reduce that backlog,

    (iv) to ask that all dictation be done at time of clinic or consultation,

Corrigan, Martina

From: Corrigan, Martina
Sent: 16 September 2016 18:08
To: Weir, Colin
Subject: FW: Urgent for investigation please

Hi Colin

I am not sure if I had forwarded this to you already?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Young, Michael
Sent: 08 September 2016 17:32
To: Corrigan, Martina
Subject: RE: Urgent for investigation please

Few points
1/ GP probably should have referred as RF in first place. A PSA of 34 is well above normal
2/ if booking centre has not received a triage back then I agree that they follow the GP advice
3/ if recent scan had shown secondaries then they were present at referral. As such then this was at an advanced non curable stage even then.
4/ I think the point here is that although non-curable I would have thought that treatment would still have been offered in the form of anti-androgen therapy at some stage over the subsequent few months.
5/ So to follow this to the next step means that if still following our current Routine waiting time would have resulted in the patient not being seen for a year. Some clinicians would have regarded this as resulting in a delay in therapy.
6/ It is not clear if arrangements were made, but the triage letter was not returned ?
7/ The patient was in fact seen within a few months.
8/ The apparent delay of just a few months has however not impinged on prognosis.

My view

MY

From: Corrigan, Martina
Sent: 07 September 2016 12:14
To: Young, Michael
Subject: FW: Urgent for investigation please
Importance: High

As discussed this afternoon

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Corrigan, Martina
Sent: 02 September 2016 14:51
To: Young, Michael
Cc: Weir, Colin
Subject: Urgent for investigation please
Importance: High

Michael,

Please see email trail and Charlie's comments below.

Can you please discuss with Colin when you are back from Annual Leave and advise course of action ?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Carroll, Ronan
Sent: 01 September 2016 13:09
To: Corrigan, Martina
Cc: McAllister, Charlie
Subject: FW: Personal Information redacted by the USI HCN Personal Information redacted by the USI
Importance: High

Martina
Please see Charlie's comments and direction of travel for this issue – can I leave with you to progress and feedback to Charlie and myself when action/decisions have been reached/need to be taken – can we address this asap
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

From: McAllister, Charlie
Sent: 31 August 2016 18:37
To: Carroll, Ronan
Subject: Re: Personal Information redacted by the USI HCN Personal Information redacted by the USI

My thoughts are that this should go through Mr Young (as Urology lead) first and Mr Weir second (as the CD).

Then happy to become involved.

C
Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Wednesday, 31 August 2016 17:40
To: McAllister, Charlie
Subject: FW: Personal Information redacted by the USI HCN Personal Information redacted by the USI

Charlie
Please can you read the series of emails. Suffice to say that although the outcome for the pt would not be any different, this as you know is not the issue that needs to be dealt with.
Await your thoughts
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

From: Corrigan, Martina
Sent: 31 August 2016 13:17
To: Carroll, Ronan
Subject: FW: Personal Information redacted by the USI HCN Personal Information redacted by the USI
Importance: High

Can we discuss please?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Haynes, Mark
Sent: 31 August 2016 09:34
To: Corrigan, Martina
Subject: Fw: Personal Information redacted by the USI HCN Personal Information redacted by the USI
Importance: High

Ignore the hcn but the story here is raised PSA referred by GP on 4th may. GP referral as routine. Not returned from triage so on wl as routine. If had been triaged would have been RF upgrade (PSA 34 and 30 on repeat). Saw Mr Weir for leg pain and CT showed metastatic disease from prostate primary. Referred to us and seen yesterday. As a result of no triage delay in treatment of 3.5 months. Wouldn't change outcome.
SAI?

Sent from my BlackBerry 10 smartphone.

From: Coleman, Alana Personal Information redacted by USI
Sent: Wednesday, 31 August 2016 08:34

Southern Health & Social Care Trust

Oversight Committee
22nd December 2016

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Ronan Carroll, on behalf of Esther Gishkori, Director of Acute Services

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager
Tracey Boyce, Director of Pharmacy, Acute Services Directorate

Dr A O'Brien

Context
On 13th September 2016, a range of concerns had been identified and considered by the Oversight Committee in relation to Dr O'Brien. A formal investigation was recommended, and advice sought and received from NCAS. It was subsequently identified that a different approach was to be taken, as reported to the Oversight Committee on 12th October.

Dr O'Brien was scheduled to return to work on 2nd January following a period of sick leave, but an ongoing SAI has identified further issues of concern.

Issue one
Dr Boyce summarised an ongoing SAI relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Dr O'Brien to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. It was noted as part of this investigation that Dr O'Brien had been undertaking dictation whilst he was on sick leave.

Ronan Carroll reported to the Oversight Committee that, between July 2015 and Oct 2016, there were 318 letters not triaged, of which 68 were classified as urgent. The range of the delay is from 4 weeks to 72 weeks.

Action
A written action plan to address this issue, with a clear timeline, will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

(v) to encourage Mr. O'Brien in full engagement of this process and that if he complied with these no further action would be needed other than ongoing monitoring to ensure the same concerns did not recur.

17. There was an email exchange with Mr. O'Brien between 5th and 18th October 2016 to try and meet him to undertake a job plan review. [*20161018 E job plan located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*]

18. This did not happen and then I was on sick leave [redacted] from approximately 11.11.2016. I also note that Mr. O'Brien was on sick leave from around 17.11.2016.

19. Because of this, there was no activity involving me until I was made aware, via email forwarded to me on 30.11.2016 from the Medical Director, that following SAI investigation in respect of Mr. O'Brien that there remained outstanding issues. [*20161209 - E Confidential located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]*

20. I was forwarded an email written by Simon Gibson, Assistant Director to the Medical Director's Office, on 30.12.2016 that, [*20161230 - E Confidential AOB located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*] after a meeting, Mr. O'Brien was informed he was being "immediately excluded" to "allow the Trust time to scope the scale of the issues which have been identified". It listed those concerns and included: notes at home, untriaged referrals, undictated clinics, and conclusion of an SAI.

21. I was not party to or involved with these meetings or discussions or involved in or aware of the SAI process.

22. Martina Corrigan (Head of Service) and I met the remainder of the urology consultants on 3.1.2017 to explain Mr. O'Brien's exclusion. [*20170103 - E Confidential AOB located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]* It was recorded that Mr. O'Brien had at that stage returned notes that he had retained at home.

Southern Health & Social Care Trust

Case Conference
26th January 2017

Present:
Vivienne Toal, Director of HROD, (Chair)
Dr Richard Wright, Medical Director
Anne McVey, Assistant Director of Acute Services (on behalf of Esther Gishkori)

Apologies
Esther Gishkori, Director of Acute Services

In attendance:
Dr Ahmed Khan, Case Manager
Simon Gibson, Assistant Director, Medical Director's Office
Colin Weir, Case Investigator
Siobhan Hynds, Head of Employee Relations

Dr A O'Brien

Context
Vivienne Toal outlined the purpose of the meeting, which was to consider the preliminary investigation into issues identified with Mr O'Brien and obtain agreement on next steps following his period of immediate exclusion, which concludes on 27th January.

Preliminary investigation
As Case Investigator, Colin Weir summarised the investigation to date, including updating the Case Manager and Oversight Committee on the meeting held with Mr O'Brien on 24th January, and comments made by Mr O'Brien in relation to issues raised.

Firstly, it was noted that 783 GP referrals had not been triaged by Mr O'Brien in line with the agreed / known process for such referrals. This backlog was currently being triaged by the Urology team, and was anticipated to be completed by the end of January. There would appear to be a number of patients who have had their referral upgraded. Mr Weir reported that at the meeting on 24th January, Mr O'Brien stated that as Urologist of the Week he didn't have the time to undertake triage as the workload was too heavy to undertake this duty in combination with other duties.

Secondly, it was noted that there were 668 patients who have no outcomes formally dictated from Mr O'Brien's outpatient clinics over a period of at least 18 months. A review

of this backlog is still on-going. Mr Weir reported that Mr O'Brien indicated that he often waited until the full outcome of the patient's whole outpatient journey to communicate to GPs. Mr Weir noted this was not a satisfactory explanation. Members of the Case Conference agreed, that this would not be in line with GMCs guidance on Good Medical Practice, which highlighted the need for timely communication and contemporaneous note keeping.

Thirdly, there were 307 sets of patients notes returned from Mr O'Briens home, and 13 sets of notes tracked out to Mr O'Brien were still missing. Mr Weir reported that the 13 sets of notes have been documented to Mr O'Brien for comment on the whereabouts of the notes. Mr Weir reported that Mr O'Brien was sure that he no longer had these notes; all patients had been discharged from his care, therefore he felt he had no reason to keep these notes. Mr Weir felt that there was a potential of failure to record when notes were being tracked back into health records, although it was noted that an extensive search of the health records library had failed to locate these 13 charts. Members of the Case Conference agreed further searches were required taking into consideration Mr O'Brien's comments.

Historical attempts to address issues of concern.
It was noted that Mr O'Brien had been written to on 23rd March 2016 in relation to these issues, but that no written response had been received. There had been a subsequent meeting with the AMD for Surgery and Head of Service for Urology to address this issue. Mr Weir noted that Mr O'Brien had advised that at this meeting, Mr O'Brien asked Mr Mackle what actions he wanted him to undertake. Mr O'Brien stated Mr Mackle made no comment and rolled his eyes, and no action was proposed.

It was noted that Mr O'Brien had successfully revalidated in May 2014, and that he had also completed satisfactory annual appraisals. Dr Khan reflected a concern that the appraisal process did not address concerns which were clearly known to the organisation. It was agreed that there may be merit in considering his last appraisal.

Discussion
In terms of advocacy, in his role as Clinical Director, Mr Weir reflected that he felt that Mr O'Brien was a good, precise and caring surgeon.

At the meeting on 24th January, Mr O'Brien expressed a strong desire to return to work. Mr O'Brien accepted that he had let a number of his administrative processes drift, but gave an assurance that this would not happen again if he returned to work. Mr O'Brien gave an assurance to the Investigating Team that he would be open to monitoring of his activities, he would not impede or hinder any investigation and he would willingly work within any framework established by the Trust.

IV. The scheduling of private patients by Mr. Aidan O'Brien

12.1 In the 26 January 2017 Oversight Committee meeting, there was a discussion in relation to whether formal exclusion was appropriate during the formal investigation, in the context of:

a. Protecting patients;
b. Protecting the integrity of the investigation;
c. Protecting Mr O'Brien.

12.2 Mr Weir (CD & [then] Case Manager) reflected that there had been no concerns identified in relation to the clinical practice of Mr O'Brien.

12.3 The members discussed whether Mr O'Brien could be brought back with either restrictive duties or robust monitoring arrangements which could provide satisfactory safeguards. Mr Weir outlined that he was of the view that Mr O'Brien could come back and be closely monitored, with supporting mechanisms, doing the full range of duties. The members considered what this monitoring would look like, to ensure the protection of the patient.

12.4 A Return to Work Action Plan and monitoring arrangement was then drafted by the Acute Directorate management team & agreed by the Oversight Committee on 3rd February 2017.

12.5 This Return to Work Action Plan was shared with Mr O'Brien. He agreed to adhere to this plan during MHPS investigations.

12.6 As per the Return to Work Plan monitoring arrangements, I as Case Manager was to be informed of any deviation or departure from compliance with the Plan by Mr O'Brien. I received regular assurance reports. During the investigation period, I also requested assurance reports from Acute Directorate if needed to assure myself of compliance.

12.7 Although it wasn't written in the Return to Work Plan, the understanding among the oversight committee was that this Plan remained in-force during the period of MHPS formal investigations.

in the subsequent response to him in March 2017. An email documenting the change of Case Investigator decision was sent from me to Dr Khan on 21st February 2017.

57. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

(i) what risk assessment did you undertake, and

(ii) what steps did you take to mitigate against this? If none, please explain.

If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.

57.1. Yes; the issue was considered.

57.2. I was reassured by Mr Weir's assessment that the issues raised were largely administrative and that no patient safety issues had arisen. The Acute Services Directorate had put a number of measures in place to triage patients appropriately and address the other administrative concerns raised. We believed in 2017 that the support measures put in place around Mr O'Brien were sufficient to ensure safe working practices as the investigation continued. This recovery plan was instituted by the Acute Services Directorate team as they were responsible for delivering the clinical urology service and had the relevant expertise at hand. They monitored these support measures weekly and reported monthly to the Case Manager. Upon Mr O'Brien's immediate return to work, initial updates were provided to the Oversight team. The primary responsibility for establishing and maintaining mitigating and support measures in place lay with the Acute Services team under the leadership of Mrs Gishkori (Acute Services Director) and assisted by Mr Carroll (Surgical Assistant Director) and Mrs Corrigan (Head of Service).

57.3. As a consequence of an investigation carried out by an incident raised by one of the urology team it became clear there were some further patients that may have had a delay in treatment which could potentially have affected their

(i) From June 2015, 318 GP referrals not triaged in line with agreed process for such referrals;
(ii) A backlog of over 60 clinics with undictated letters, extending over 18 months and therefore no outcome or action plan;
(iii) That some patient notes were at Mr. O'Brien's home.

125. During the period of exclusion from 30th December 2016 to 24th January 2017, there were:
(i) 783 GP referrals not triaged;
(ii) 668 patients with no outcome dictated;
(iii) 307 notes returned from Mr. O'Brien's home, with 13 notes being missing;
(iv) (a new fourth concern that) 9 private patients had NHS treatment in a shorter timeframe than other patients.

126. There was a Case conference on 26th January 2017 which I attended. It was chaired by Vivienne Toal (Head of HR); also present was Dr Richard Wright (Medical Director), Anne McVey (Assistant Director of Acute Services), Dr Khan (MHPS Case Manager), Simon Gibson (Assistant Director), Siobhan Hynds, and myself.

127. The meeting had my investigation presented and the group confirmed that there was unacceptable practice in relation to delayed outcomes being dictated. The meeting agreed there was a "case to answer" and a formal investigation was required. I noted at the meeting I had no concerns identified in relation to Mr. O'Brien's clinical practice (meaning aspects of his practice, e.g., operating skills, decision making, and so on). I was of the view that Mr. O'Brien should be allowed to return to work during this investigation with close monitoring of his activity. The committee agreed and they also agreed that the operational team would decide what this monitoring would be.

Hynds, Siobhan

From: Carroll, Ronan <Personal Information redacted by USI>
Sent: 11 July 2017 17:55
To: Hynds, Siobhan
Subject: FW: Charts in Office
Attachments: charts in office (11.7 KB)

FYI

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

From: Corrigan, Martina
Sent: 11 July 2017 17:40
To: O'Brien, Aidan
Cc: Carroll, Ronan; Weir, Colin
Subject: Charts in Office

Aidan

As per your return to work action plan:

Notes should never be stored off site and should only be tracked out and in your office for the shortest time possible - having checked on PAS today there are 90 charts stored in your office dating back to January 2017. I had emailed you 21 June 2017 (attached) and these charts are still tracked out to you.

Therefore, Colin has asked that I arrange for you to meet with him, Ronan and myself on your return from Annual Leave next week and we can discuss when this best suits on Monday.

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EXT Personal Information ***if dialling from Avaya phone. If dialling from old phone please dial*** Personal Information redacted by USI
EXTERNAL Personal Information redacted by USI
Mobile: Personal Information redacted by USI

Personal Information redacted by USI

Secretary Collette Mc Caul
Personal Information redacted by USI

From: Johnston, Pamela
Sent: 18 July 2017 16:41
To: Weir, Colin
Cc: Carroll, Ronan; Corrigan, Martina
Subject: RE: Emergency urology case with planned elective admission

Colin,

This is only case I have had raised by my theatre team as ? inappropriate booking for emergency list.

I have had a quick look at Urology bookings: Mr O'Brien UOW for weekend.

Sat 15/7/17: x 5 urology cases

Sun 16/7/17: x 6 urology cases

Mon17/7/17: 4 roll over urology from Sunday due to other clinical priority and + 2 new urology bookings

I can provide TMS details for in depth review, some patients noted as septic.

Regards
Pamela

From: Weir, Colin
Sent: 18 July 2017 14:59
To: Carroll, Ronan; Corrigan, Martina; Johnston, Pamela
Subject: RE: Emergency urology case with planned elective admission

Pamela

Are you aware if any other patients were similarly "booked" over the weekend?. The carry over affects capacity for urgent cases and emergency theatre utilisation

I hope it isn't true as it would be a gross misuse of theatre emergency time

I suggest we investigate all urological case done over weekend

From: Carroll, Ronan
Sent: 18 July 2017 14:28
To: Corrigan, Martina
Cc: Weir, Colin
Subject: FW: Emergency urology case with planned elective admission
Importance: High

Martina
Please see Pamela's email & query. Can you investigate pls
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by USI

From: Johnston, Pamela
Sent: 18 July 2017 14:01
To: Carroll, Ronan
Cc: Kearney, Emmajane; Murray, Helena; McArdle, SiobhanM
Subject: Emergency urology case with planned elective admission

Ronan,

I have been informed that surgery took place for patient Personal Information redacted by USI; DOB Personal Information for Urology procedure on 15/7/17 with Mr O'Brien.

The patient brought a letter to hospital for elective admission. Procedure completed in emergency theatre was Ureteroscopy and Lasertripsy in theatre @ 20:39-22:09.

I know there is a possibility that patient was on elective WL and then proceeded to have complications leading to emergency surgery however I would appreciate if this could be looked into.

Can you advise how might one proceed with this query?

Many thanks
Pamela

Pamela Johnston

Theatre Manager
Main Theatres
Anaesthetics, **Theatres** & Intensive Care
Southern Health & Social Care Trust
Craigavon Area Hospital

Direct Dial Personal Information redacted by USI

Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training |Clinical Director SEC
Southern Health and Social Care Trust

Personal Information redacted by USI Personal Information redacted by USI

Secretary Collette Mc Caul
int Personal Information direct Personal Information redacted by USI

From: Carroll, Ronan
Sent: 28 July 2017 09:21
To: Weir, Colin
Subject: RE: Emergency urology case with planned elective admission

Why?

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by USI

From: Weir, Colin
Sent: 28 July 2017 09:20
To: Corrigan, Martina; Carroll, Ronan; Johnston, Pamela
Cc: Murray, Helena
Subject: RE: Emergency urology case with planned elective admission

I wouldn't take this further

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training |Clinical Director SEC
Southern Health and Social Care Trust

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Secretary Collette Mc Caul
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From: Corrigan, Martina
Sent: 27 July 2017 17:35
To: Carroll, Ronan; Johnston, Pamela
Cc: Weir, Colin; Murray, Helena
Subject: RE: Emergency urology case with planned elective admission

Ronan

Please see attached as requested

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EX Personal Information ***if dialling from Avaya phone. If dialling from old phone please dial*** Personal Information redacted by USI
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Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by USI
Personal Information redacted by USI
Personal Information redacted by USI (DHH)

From: Weir, Colin
Sent: 18 October 2018 11:33
To: Khan, Ahmed; Gibson, Simon; Carroll, Ronan; Clayton, Wendy; Haynes, Mark
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Ahmed/Simon

Please for your urgent consideration and action

See email correspondence below. Please see attached excel spreadsheet and go to Oct TAB or see below in email trail

Mr O'Brien has accumulated a large backlog of dictated letters and large numbers of charts in his office.

I am his Clinical Director

I have NOT seen the review and results and recommendations into his practice, but I am assuming he is in breach of this given these findings

Can you instruct me on how you would like to proceed.

I can certainly meet his with Ronan to discuss and record outcome from any meeting with him but I need to know if any sanctions need to be put in place if he has breached any of the review requirements or if your office wish to take this over?

Colin

From: Clayton, Wendy
Sent: 18 October 2018 11:07
To: Weir, Colin
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

From: Carroll, Ronan
Sent: 17 October 2018 15:52
To: Young, Michael; Haynes, Mark
Cc: Clayton, Wendy
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Michael/Mark
Please see update from Wendy

1. Dictation to be completed
2. Notes in office

Aidan needs spoken with and asked to address dictation asap & to return notes (possible notes are for dictation)
I am in CAH tomorrow pm

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

From: Clayton, Wendy
Sent: 17 October 2018 15:11
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Return to Work Action Plan February 2017 FINAL.

See below dictation report. There are approx 82 charts in the office on level 2. Do you need me to try and find out how long they have been there?

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to dictated
Mr Jakob					18	25.09.18	30
Mr Glackin	5	6	7	06/06/2018 (1 letter)	11	26.09.18	29
Mr Haynes	0	0	19	26.09.18	0		55
Mr O'Brien	17	0	91	15.06.18	0		
Mr O'Donoghue					15	26.09.18	12

Gibson, Simon

From: Haynes, Mark <[redacted]>
Sent: 16 November 2018 13:56
To: Khan, Ahmed; Gibson, Simon
Subject: FW: AOB

Hi Ahmed / Simon

Are you aware of this? Surely this behaviour (phone calls from wife and his son / legal advisor to Mr Young, below with Mr Weir) shouldn't happen?

How can we (his colleagues) be protected?

Mark

From: Weir, Colin
Sent: 15 November 2018 11:34
To: Carroll, Ronan; Hynds, Siobhan
Cc: Young, Michael; Gishkori, Esther; Haynes, Mark
Subject: RE: AOB

Can I put on record that last Thurs 8th Nov Mr O'Brien met me in my office from 08:50 to 09:15hrs. He requested the meeting

The conversation centred around his investigation. I was supportive to him as a colleague, and Clinical Director and I thought that was to be the focus of the conversation

He did ask me about evidence I had given to the investigation relating to meeting with Dr McAllister when he was AMD and prior to the investigation. I wasn't expecting this and tried to answer briefly my recollection.

I now feel that

1. he should not have made this approach
2. his questioning and my responses could undermine the investigation and action plan
3. he put me in a difficult and awkward position
4. having met Mr Young and knowing his experiences: I cannot meet or discuss anything with Mr O'Brien anything other than day to day activities in his work as a Urologist.

Can we please be protected from this as I suspect evidence is being gathered from us and make the Medical Director aware?

Colin

From: Carroll, Ronan
Sent: 15 November 2018 10:04
To: Hynds, Siobhan
Cc: Young, Michael; Weir, Colin; Gishkori, Esther
Subject: AOB
Importance: High

Siobhan,
Mr Young has advised me this morning that he received phone calls from Mrs O'Brien (Saturday evening) and Michael O'Brien (Monday Evening). Both these phone calls centred on the Mr Aidan O'Brien's investigation.
Give me a ring if you require anything further

understaffed and wait times were long and the team was working at full capacity it would have been inappropriate to demand changes in performance.

[44] How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

102. My role included job planning for all the urology consultants. My role was not to undertake appraisal as this was a separate process. In theory, a consultant who did not engage or submit an annual appraisal could be referred to me for follow up, but this was never required during my tenure. Job planning review was a two-way process with meetings with each consultant. We would agree rotas, annualised activities and other roles. Then either I, in some cases, or the consultant, in others, would use a commercial system (Zircadian) that the Trust purchased to support the process. This allowed each party to agree or disagree the job plan. In one case (Mr. O'Brien) this was complex and repetitive and required many hours work by me to achieve an agreed job plan. However, the system and process is robust, fair, and open to regular review. My only criticism as a user is that the Zircadian system is at times very complex and more time consuming than it needs to be to use.

[45] The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

113. There was a further review of job planning in April 2018 but the start date retrospectively was to be February 2017.

114. There was a lengthy email from Mr. O'Brien in September 2018 regarding changes he wished to make in his job plan

115. There was further email correspondence in October and December 2018 Personal Information redacted by the USI regarding job planning, but I was unable to respond and then my responsibility for urology stopped.

116. By the commencement of my sick leave in Mid-October 2018 through to December 2018, the job plan was not finalised, resolved or signed off on the Zircadian system. During Personal Information redacted by the USI sick leave, I did respond to an email from Mr. O'Brien [ref 20181205] in relation to job planning but, by then, I was becoming quite unable to work in any capacity. I ceased my urology CD role before I returned to work in March 2019, with an approximate end date of 30 December 2018.

[54] When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention? Please provide full details in your answer.

117. I was appointed to Clinical Director on 1 June 2016 and occupied that role until 31 January 2022. However, my urology responsibilities stopped in December 2018.

118. Around June 2016, the Acting AMD for surgery (Dr McAllister) made me aware, during our weekly Clinical Directors meeting, of issues with Mr. O'Brien,

He concluded by stating he was happy to work with a defined framework set by the Trust, to comply with hospital policies/procedures, to work to pre-determined defined timescales and he gave an assurance that no patient files would be removed from the Trust. He reiterated he had no desire to impede or interfere in the investigation in anyway. Mr O'Brien stated that the concerns centred around his administrative practices and he believes the concerns can be managed with a framework in place.

Mr O'Brien further stated that when the issues were raised with him in March 2016, there was no plan as to how he was to address the matters. He stated he began to deal with some of the outstanding cases whenever he had time to do so during his working week.

5.0 Summary

There are 4 main issues of concern to be considered as outlined above. The initial 4 week preliminary investigation has scoped the likely scale of the concerns and the numbers of patients involved.

The investigation is at a very early stage. While initial indications suggest some patients have potentially been adversely affected/harmed as a result of failings in the practice of Mr O'Brien, the Case Investigator is reliant on completion of the review by 4 Consultants to determine the full implications.

Given the numbers involved, it is not possible to give any definite date for the conclusion of the investigation. It is envisaged that the investigation will take as a minimum, 12 weeks to complete.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 32 of 2022

Date of Notice: 29th April 2022

Witness Statement of: Charles McAllister

I, Charles McAllister, will say as follows:-

1. **Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order using the form provided.**

1.1 I was appointed as a Consultant Anaesthetist and Intensivist to the Legacy Craigavon Area Hospital Trust (which became part of the Southern Health & Social Care Trust) in August 1994. I retired from the SH&SCT in April 2018. I was asked by the SH&SCT and volunteered to return to work in Intensive Care in Craigavon Hospital at the outbreak of the COVID pandemic in N. Ireland (2020) but retired again in May 2020 when no longer needed. Following retirement and ceasing all clinical work in 2018 I destroyed all paperwork, diaries and records that I could find from my working life hence I am relying on memory and documents provided to me by the Trust (and hence forwarded to the Inquiry) for this Inquiry.

Urology Services Inquiry

13.2 However, in my response to question 12 I have offered a view on what the situation was in 2016 and the application of MHPS and the systems in the Trust at that time.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: _____Charles McAllister [redacted]

Date: _____9th June 2022_____

Mackle), that before I started the surgical management role, this had also been escalated to the Service Director and a management plan had been put in place that this Surgeon would be shadowed by another Consultant Urologist and a second Consultant Urologist would be on call when this Surgeon was on call. I do not know if this had been shared with the Medical Director but I assumed so. That Consultant left the Trust later that year.

The highlighted text below should read "at the end of April/beginning of May" as per email received 20/02/2023 (TRU-320005 to TRU-320006 refers). Annotated by the Urology Services Inquiry.

4.4 I set about trying to get my head around as many of the issues in Surgery as quickly as I could by talking with many relevant parties ~~over the month of April~~ 2016 on both the Craigavon Area Hospital and Daisy Hill Hospital sites. This included several surgeons, the Heads of Service for General Surgery (Amie Nelson), Head of Service for Urology and ENT Surgery (Martina Corrigan), Heather Trouton (the preceding Assistant Director for Surgery) Ronan Carroll (Assistant Director for Surgery) and Esther Gishkori (Director of Acute Services).

4.5 Since Dr. Richard Wright had been appointed to the role of Medical Director SH&SCT from the Belfast Trust in July 2015, Esther Gishkori had been appointed Director of Acute Services to the SH&SCT from the Prison Service in October 2015 and Ronan Carroll had been appointed as Assistant Director Acute Services on the 1st April 2016, I thought it wise to ensure that Esther Gishkori, (as per Trust Guidelines, 2010, paragraph 2.3), her AD Ronan Carroll and the Medical Director were aware of the issues that I had become aware of at that point. Hence, I sent the following email (9th May 2016 15:41) (S21 No 32 of 2022 Attachments, 1. 20160509 email re problems from RC):

From: McAllister, Charlie [redacted]
Sent: 09 May 2016 15:41
To: Carroll, Ronan [redacted] Gishkori, Esther [redacted] Wright, Richard [redacted]
Subject: Problems

Dear All

Since being asked to take over responsibility for Surgery as AMD I have been trying to get my head around as many of the issues as possible. To date:

1.2 Pertaining to this Inquiry I was appointed as Associate Medical Director (AMD) for Surgery in April 2016 in addition to being AMD for ATICS (Anaesthetics, Theatre, Intensive Care and Chronic Pain, some 38 Consultants and Staff-grades). I ceased being AMD for Surgery by October 2016.

1.3 As Surgical AMD my role was to be the interface between the Director of Acute Services, their assistant (Assistant Director), the Medical Director, his assistant (Assistant Director) and the two Clinical Directors in Surgery, Lead Clinicians for the various sub-specialties, the Consultants and Staff-grades, of which there were approximately 39. This was in addition to a full clinical commitment to anaesthesia, Intensive care (ICU) and a one in five night and weekend ICU on-call including evening ward rounds at 21.00.

1.4 Aside from my clinical duties as Surgical AMD I had to attend regular meetings; monthly Morbidity and Mortality Meeting (4 hours), monthly Clinical Governance Meeting (1 Hour), monthly AMD/CD Meeting with the Medical Director (3+ hours), monthly Theatre Users Group (Chairman) Meeting (3 hours), quarterly Drugs and Therapeutics Committee Meeting (3 hours each), weekly one to one meeting with the Surgical Clinical Directors, monthly meeting with the Director of Acute Services/Assistant Director, Monthly meeting with the Medical Director (frequently cancelled) and sundry other meetings the details of which I cannot recall.

1.5 Issues that were raised with me were shared/escalated to the AD Surgery who then escalated to the Director of Acute Services, or shared/escalated directly by me to the Director of Acute Services or the Medical Director or both as seemed appropriate from who I took advice and instruction.

1.6 I have listed below the issues that were presented to me in the email sent to Ronan Carroll (AD), Esther Gishkori (Director) and the Medical Director (Dr. Richard Wright) on the 9th May 2016 at 15.41 (S21 No 32 of 2022 Attachments, 20160509 email re problems from RC). I have no memory of any meetings or discussions related to issues listed in that email other than those pertaining to Urology/Mr. O'Brien. I have

Stinson, Emma M

From: Carroll, Ronan [redacted]
Sent: 09 May 2016 22:37
To: McAllister, Charlie
Subject: RE: Problems

Importance: High

I think it is safe to say you have a good handle on things
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: McAllister, Charlie
Sent: 09 May 2016 15:41
To: Carroll, Ronan; Gishkori, Esther; Wright, Richard
Subject: Problems

Dear All

Since being asked to take over responsibility for Surgery as AMD I have been trying to get my head around as many of the issues as possible. To date:

1. There is no real functioning structure for dealing with governance. Mr Reddy is the Gov laed for surgery so is supposed to attend weekly meetings with AD and HOS to review IR1s that have come in, however the AD routinely missed the meeting (Before RC) so no actions tended to come from them.
2. There were supposed to be monthly meetings with the clinical leads, AD, HoS and AMD to discuss issues but attendees poor at keeping the date so frequently cancelled.
3. FY1 rota issues. Not enough so non-compliant.
4. Paeds interface very poor and not resolved.
5. Largely each specialty left to manage themselves, reliance on HoS to escalate issues.
6. Urology. Issues of competencies, backlog, triaging referral letters, not writing outcomes in notes, taking notes home and questions being asked re inappropriate prioritisation onto NHS of patients seen privately.
7. Not enough CAH lists so very inefficient extended days (not enough beds to service these) and spare theatre capacity in DHH with underutilised nursing and anaesthetic capacity.
8. Middle grade cover is scant so unable to provide a urology rota at night thus gen surgery regs cover this. G Surg regs occasionally have to help with urology elective lists.
9. ENT – not enough theatre time so extended lists – with problems as per urology. Problem with junior doc rotas.
10. Ortho. Job plans still not agreed.
11. SOW handover – variable – some consultants don't attend – but is in job plan as far as I know.
12. NIMDAT middle grade allocation – never get our full allocation on either site. Becoming increasingly difficult to find suitable locums to fill gaps. Likely to hit the point in the next year to 18 months where running two acute middle grade rotas isn't feasible. DHH rota particularly shaky.
13. If junior doc numbers particularly low then build up a backlog in dictation and results – governance risk.
14. I am not aware that sign-off of results is secure. Governance risk.
15. Colorectal issue – dysfunctional relationship between CAH and DHH. Possibly agenda to collapse DHH in order to have two Surgical rotas on the CAH site – one colorectal and one for everything else.
16. Interface between gastroenterology and GI surgeons.
17. Breast service teetering. Radiology support precarious.
18. Significant backlog of IR1s/SAIs. Governance risk.

Urology Services Inquiry

I'd be interested in your thoughts.

Charlie

4.6 I received the following reply (9th May 2016, 15:47) from Dr Richard Wright, Medical Director (*S21 No 32 of 2022 Attachments, 20160509 email re problems from RW*);

From: Wright, Richard [redacted]
Sent: 09 May 2016 15:47
To: McAllister, Charlie [redacted]
Subject: Re: Problems

That seems a fairly accurate summing up. can't all be fixed in a day. Should we have a get together to work up an action plan? regards Richard

Sent from my iPad

4.7 And the following reply (9th May 2016 at 22:37) (S21 No 32 of 2022 Attachments, 2. 20160509 email re problems from RC) from Ronan Carroll Assistant Director Acute Services:

From: Carroll, Ronan [redacted]
Sent: 09 May 2016 22:37
To: McAllister, Charlie [redacted]
Subject: RE: Problems
Importance: High

I think it is safe to say you have a good handle on things

Ronan

Ronan Carroll

Assistant Director Acute Services

ATICs/Surgery & Elective Care

4.8 I have been unable to find a reply from Esther Gishkori, Director of Acute Services, which would have been unusual but I recall we discussed it.

4.9 So, from this email and the replies from Dr Richard Wright, Ronan Carroll and subsequent discussion with Esther Gishkori I was clear that not only were the issues generally surrounding Urology and specifically regarding Mr O'Brien known about before my appointment, but the other twenty issues I listed were also known about by the relevant people in senior management. I recall being surprised and concerned by the apparently relaxed attitude to the large number of concerns that I recounted, which I had described in correspondence as a 'very disturbing picture. Significant governance risks'.

5. **If you were not aware of the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance'* what was your understanding of the reporting of concerns relating to other doctors practices? How, if at all, did this understanding inform your response to concerns you were aware of regarding urology services?**

5.1 I was aware of the Trust Guidelines for Handling Concerns about Doctors' and Dentists Performance 2010. However, when it came to medical professional issues I felt it appropriate to also inform the Medical Director, given that a medical professional was involved, in addition to the Director of Acute Services.

6. In your roles as Clinical Manager what, if any, training or guidance did you receive with regard to:

i. The MHPS framework;
ii. The Trust Guidelines; and
iii. The handling of performance concerns generally.

6.I None that I can recall.
6.ii None that I can recall
6.iii None that I can recall

Urology Services Inquiry

4. Were you aware of the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance'* published 23 September 2010? If so, when you were aware of concerns, did you implement those Guidelines? If so, set out in full how you did so on every occasion and with whom you engaged. If not, why not?

4.1 Bearing in mind that this was quite some time ago – yes, I was aware of these guidelines and the MHPS guidelines, published in 2005. These were two of a tsunami-like wave of guidelines, policies and protocols produced by the Trust, the Department of Health and various other relevant regional and national bodies disseminated to staff via the intranet with increasing frequency between 2005 and 2016.

4.2 Shortly after assuming the role of AMD for surgery in April 2016 I was specifically made aware of issues in Urology. The issues pertaining to Mr. O'Brien predated my involvement and had been most recently addressed via a letter to him (dated the 23rd March 2016) by the previous AMD for Surgery (Mr. Mackle) and the previous Assistant Director for Surgery (Heather Trouton) with the full knowledge and support of the Director of Acute Services, Esther Gishkori, as per the Trust Guidelines 23rd September 2010, and the Medical Director (Dr Richard Wright). This was shared with me shortly after my becoming AMD for Surgery by Mr. Mackle, Heather Troughton and Head of Service for Urology (Martina Corrigan). I do not recall being told that HR were involved at this stage but would have assumed so especially as so many senior managers were involved and issues had been on-going for so long. Consequently, I did not, that I can recall, assure myself that HR were involved. On reflection this was out-with the Guidelines and a mistake on my part. Please see 11.3 below on the monitoring process and feedback I requested at the time. Please see 8.1 for another case where I was involved in implementing the Guidelines.

4.3 There was also an issue with another recently appointed Urology Consultant at that time who was reputedly uncomfortable with open urological surgery (as opposed to endoscopic surgery) and whose judgement in management plans for the more complex urological cases was a point of concern. I was informed (I believe by Martina Corrigan, HoS for Urology, Heather Trouton, outgoing AD for Surgery but it may have been by Mr

Urology Services Inquiry

7. Specifically, what if any training or guidance did you receive with regard preliminary enquiries under Section I paragraph 15 of MHPS or the undertaking of an initial verification of the issues raised under paragraph 2.4 of the Trust Guidelines and the conduct of investigations under Section I paragraph 31 of MHPS and the Trust Guidelines.

7.1 None that I can recall.

8. The Inquiry is interested in your experience of handling of concerns regarding any staff member. Prior to your involvement in respect of the case of Mr O'Brien, specify whether you ever have had occasion to implement or apply MHPS and/or the Trust Guidelines in order to address performance concerns and outline the steps taken.

8.1 I cannot recall having to implement MHPS prior to the case of Mr. O'Brien but I was parachuted into a MHPS Formal Process in progress on one occasion. Shortly after taking over the role of AMD for Surgery I was asked to take over the role of Case Manager in a case of a Consultant in Obstetrics and Gynaecology. This case had been running for some time before my involvement. The preceding Case Manager was Dr Stephen Hall, a locum Consultant Radiologist who suddenly, unexpectedly and tragically died on the 12th April 2016. Shortly after Dr Hall's death Dr Richard Wright (MD) asked me to take over as Case Manager for this case which I agreed to do. I was invited to an Oversight meeting in early May 2016 Chaired by Kieran Donaghy (Acting Chief Executive) and attended by Vivienne Toal (Acting Director of HR), Esther Gishkori, Dr Phillip Murphy (AMD for Medicine) and a couple of others that I cannot recall. We were brought up to speed with the case by Kieran Donaghy supported by Vivienne Toal and informed that the PSNI were now involved and that any Trust based investigation was consequently suspended.

8.2 As I stated above this case had been on-going for some time and the subject of the MHPS process was in receipt of a rolling 4-week exclusion order. My role, as I recall, was limited to signing letters provided to me by HR (Vivienne Toal) which were sent to the Consultant every four weeks informing of the ongoing sanction of exclusion from work whilst the police investigation was taking place (as per paragraph 16, Restriction of Practice and Exclusion from Work). It was my understanding at the time

to the Head of Service, Martina Corrigan, the Assistant Director with responsibility for Surgery Heather Trouton (subsequently Ronan Carol from April 2016) and the serial Directors of Acute Services – Joy Youart, Dr Gillian Rankin, Debbie Burns and Esther Ghiskori. This of course was part of the problem – the roster of Directors of Acute Services over a short period of time who were in crisis management mode for much of that time.

12.10 Perhaps, in the interest of providing as full a response to the Section 21 Schedule as possible I could outline why in my email of the 30th August 2016 to Mr Weir I though it - “V disappointing. This is not the direction of travel I wanted for many reasons” when a different direction was taken than the approach proposed by Esther, Mr. Weir and myself.

12.11 I had no knowledge of the medical management issues that led subsequently to Mr. O’Brien being referred to the GMC. I understand that this followed on from a look-back exercise conducted in 2020 some 4 years after my involvement. In 2016 Mr. O’Brien was generally considered to be extremely hard working, if not the hardest working Surgeon in the Trust, was regarded as technically excellent in Theatre with the most demanding of major urological surgery, and just as importantly excellent in direct pre-op and post-op care.

12.12 Personally, although I have anaesthetised for Mr. O’Brien I more frequently have looked after his patients in the Intensive Care Unit. What I saw was as good as any surgeon and better than most. He saw his patients in ICU twice a day during the week and at least once a day at the weekend whenever he had a patient there. He was always available for consultation/advice/action on any patient who was admitted to ICU with or who developed urological issues whether they were his patient or not. I never heard any colleague criticise or complain about his clinical work and anaesthetists seem to enjoy working with him. He was one of the very few Consultants I would regularly see in the hospital at night (ICU consultants do an evening ward round between 21.00 and 22.00) and he was frequently in at weekends. Whenever a patient of his did not have what he thought was an optimal outcome he would present this himself (and not a trainee as most Consultants did) at the monthly Morbidity and Mortality meeting in painstaking or even excruciating detail.

AOB-50009

11/12/2020

Re Aidan O' Brien

Dear Mr Anthony

My name is Charles McAllister. I qualified in Dublin in 1982, became a member of the Royal College of Physicians in Ireland in 1987 and a Fellow of the Faculty of Anaesthetists of The Royal College of Surgeons in Ireland (Now the College of Anaesthetists in Ireland) in 1990. I was appointed as a Consultant Anaesthetist and Intensivist in Craigavon Area Hospital [CAH] (subsequently to become part of the Southern Health and Social care Trust) in 1994, where I remained until my retirement on reaching 60 in 2018. During the majority of those 24 years I was responsible for the Intensive Care Unit (ICU) in that Hospital/Trust.

Mr O'Brien had been appointed as the first Urologist in CAH a short time before my appointment but had already established a urology service single handedly from scratch. I occasionally did lists in Theatre for Mr O'Brien but came into contact with him far more often through patients that he had in ICU. I was struck at the time at the range and depth of urological surgery being undertaken. I was also struck by the commitment and dedication that Mr O'Brien demonstrated to his patients. He would see his patients in ICU twice a day during the week and at least daily at the weekend whether he was rostered on duty or not. He would always make time to meet with and discuss patients' conditions with relatives. He was also readily available for telephone advice/discussion regarding the best plan for his patients and for any patients in the unit who presented with or developed urological issues.

In 24 years there was never a cross word between Mr O'Brien and myself. I never witnessed him being other than courteous, honest, caring, dedicated or kind to any patient, relative or member of staff. The ICU Consultants do a 9 pm supervised ICU handover. Mr O'Brien was one of the very few Consultants I would see in the hospital at this time other than the Emergency Department Consultants.

I would have been happy for Mr O'Brien to look after me or any member of my family. He will be missed.

If I can furnish any further information that would be of assistance please get back to me.

Very best regards

Charles McAllister MB, MRCPI, FCAI

Personal Information redacted by the USI

[11] On your retirement from your role of Associate Medical Director for Surgery in April 2016, who replaced you in that role? What handover did your provide that individual generally and specifically with regard to issues of concern raised with Mr Aiden O'Brien in March 2016? Disclose copies of any documentation which may have formed part of a handover generally or specifically with regard to Mr Aiden O'Brien, or confirm that no such documentation exists.

42. I was replaced by Dr Charles McAllister. I have, when gathering information to aid with this response, sought information from Charles McAllister. He was able to confirm he had a copy of the 23 March 2016 letter but I can't recall if I gave it to him nor can he recall if it was given to him by me or by someone else. I recall that I carried out a verbal handover of any pressing issues in the Department and included the issues regarding Aidan O'Brien. I informed Dr McAllister that we had become aware of several issues namely: (a) failure to triage and that there was to the best of our knowledge 253 referral letters untriaged; (b) that there appeared to be a problem with recording of consultations/discharges; and (c) that there appeared to be a significant number of charts that were in his possession. I don't recall if I informed Dr McAllister about the issue of validation of the review backlog. I believe that I informed Dr McAllister when I had been made aware by Heather Trouton, and that I had had discussions with the Medical Director, Dr Richard Wright, and appraised him of our concerns. I advised him how, on the advice of Dr Wright and following confirmation by Martina Corrigan as to the extent of the problem, Heather Trouton drafted the 23 March 2016 letter which I co-signed and had given to Aidan O'Brien. I informed him that Aidan O'Brien was to address the issues and to revert with a plan of action. I also informed him that the Director of Acute Services, Esther Gishkori, was aware of the problem and was in agreement with the advice from Richard Wright and with the letter.

<u>Implementation and Effectiveness of MHPS</u>

[12] Having regard to your experience as a clinical manager in relation to the investigation into the performance of Mr Aidan O'Brien, what impression

Southern Health and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you.

1. Untriaged outpatient referral letters

There are currently 253 untriaged letters dating back to December 2014. Lack of triage means we do not know whether the patients are red-flag, urgent or routine. Failure to return the referrals to the Booking Centre means that the patients are only allocated on a chronological basis with no regard to urgency.

2. Current Review Backlog up to 29 February 2016

Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

3. Patient Centre letters and recorded outcomes from Clinics

Consultant colleagues from not only Urology but also other specialties are frustrated that there is often no record of your consultations/discharges on Patient Centre or in the patients' notes. Validation of waiting lists has also highlighted this issue. If your

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Irrelevant information redacted by USI

patient is reviewed at another Urology Clinic a new appointment slot is required due to the lack of documentation.
This lack of documentation combined with no record of clinic outcomes means further investigations/follow-up may not be organised by admin staff.

4. **Patient Notes at home**

This has been an ongoing issue for years and needs addressed urgently. We request that all SHSCT charts that are in your home or in your car be brought to the hospital without further delay.

You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

Yours sincerely,

Eamon Mackle
Associate Medical Director

Heather Trouton
Assistant Director

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Irrelevant information redacted by USI

Urology Services Inquiry

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie **Cc:** Carroll, Ronan; Trouton, Heather **Subject:** Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

I would be grateful if you could respond to this e-mail, even if you have not received any plans or proposals. Given the sensitivity of this subject, I would be grateful if you would respect the confidentiality of this e-mail. Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office Southern Health & Social Care Trust
Personal Information redacted by the USI Mobile: Personal Information redacted by the USI
DHH: Personal Information redacted by the USI Ext Personal Information redacted

11.12 I subsequently learned that Mr. Gibson had had a telephone conversation with NCAS (the National Clinical Assessment Service, which was subsequently rebranded as Practitioner Performance Advice, PPA) on the 7th September 2016 essentially listing the issues raised in Mr Mackle and Heather Trouton's letter to Mr O'Brien of the 23rd March 2016. NCAS in the form of Dr Colin Fitzpatrick replied by letter dated the 13th September 2016. Interestingly despite not having sight or knowledge of this NCAS letter or contents our plan closely mirrored the advice given by NCAS, including considering the removal from theatre. I also note that Formal procedure was not recommended. I don't know what happened after the 22nd September 2016 or the success or otherwise of any action because by October 2016 I was no longer AMD for Surgery.

11.13 By the time I came on the scene, in April 2016, informal steps had already been taken a week or two previously by Mr. Mackle and Heather Trouton as evidenced in their letter of the 23rd March 2016. I do not know what advice they had received or what discussions they had had other than I was made aware that there had been discussions

Corrigan, Martina

From: Corrigan, Martina
Sent: 17 August 2016 17:08
To: McAllister, Charlie
Subject: FW: confidential
Attachments: Confidential letter to AOB - updated March 2016 final.docx

Hi Charlie

As discussed this morning attached and below:

See updated position below:

1. Untriaged outpatient referral letters

There are currently 174 untriaged letters dating back to May 2016

2. Current Review Backlog up to 31 July 2016

Total in Review backlog = 679

2014	243
2015	244
2016	180

Regards

regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Corrigan, Martina
Sent: 16 August 2016 16:41
To: Wright, Richard
Subject: RE: confidential

Hi Richard,

As discussed, please find letter. I will update the figures and send these through shortly.

Regards

Martina

Martina Corrigan

Stinson, Emma M

From: Gibson, Simon [redacted]
Sent: 22 August 2016 18:02
To: McAllister, Charlie
Subject: RE: Confidential - AOB

Ta

Thought not, just covering off all the angles!

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
[redacted]
Mobile: [redacted]
DHH: [redacted] Ext [redacted]

From: McAllister, Charlie
Sent: 22 August 2016 17:57
To: Gibson, Simon; Mackle, Eamon
Cc: Carroll, Ronan; Trouton, Heather
Subject: Re: Confidential - AOB

Dear Simon

As you know I came into this mid stream. I have received no communication from Mr O'Brien on this topic.

Charlie

Sent from my BlackBerry 10 smartphone.

From: Gibson, Simon
Sent: Monday, 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

I would be grateful if you could respond to this e-mail, even if you have not received any plans or proposals.

Given the sensitivity of this subject, I would be grateful if you would respect the confidentiality of this e-mail.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI
Mobile: Personal Information redacted by USI
DHH: 02830835000 Ext Personal Information redacted

Stinson, Emma M

From: McAllister, Charlie [redacted]
Sent: 30 August 2016 09:02
To: Weir, Colin
Subject: Re: Confidential - AOB

Thanks. V disappointing. This is not the direction of travel I wanted for many reasons.

C

Sent from my BlackBerry 10 smartphone.

From: Weir, Colin
Sent: Tuesday, 30 August 2016 09:13
To: McAllister, Charlie
Subject: Re: Confidential - AOB

OK got it

Colin Weir
From Blackberry

From: McAllister, Charlie
Sent: Tuesday, 23 August 2016 11:11
To: Weir, Colin
Subject: FW: Confidential - AOB

Strictly in confidence.

Hi Mr Weir

Please see below. This has come to light subsequent to our discussions on this subject last Thursday. It appears that the boat is missed. I know that you are on leave this week and I'm off for the following two so wont get a chance to meet/discuss.

Please hold off on attempting to address this issue until the dust settles on the process below.

Thanks

Charlie

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Wednesday, 31 August 2016 17:40
To: McAllister, Charlie
Subject: FW: Personal Information redacted by the USI HCN Personal Information redacted by the USI

Charlie
Please can you read the series of emails. Suffice to say that although the outcome for the pt would not be any different, this as you know is not the issue that needs to be dealt with.
Await your thoughts
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

From: Corrigan, Martina
Sent: 31 August 2016 13:17
To: Carroll, Ronan
Subject: FW: Personal Information redacted by the USI HCN Personal Information redacted by the USI
Importance: High

Can we discuss please?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Haynes, Mark
Sent: 31 August 2016 09:34
To: Corrigan, Martina
Subject: Fw: Personal Information redacted by the USI HCN Personal Information redacted by the USI
Importance: High

Ignore the hcn but the story here is raised PSA referred by GP on 4th may. GP referral as routine. Not returned from triage so on wl as routine. If had been triaged would have been RF upgrade (PSA 34 and 30 on repeat). Saw Mr Weir for leg pain and CT showed metastatic disease from prostate primary. Referred to us and seen yesterday. As a result of no triage delay in treatment of 3.5 months. Wouldn't change outcome.
SAI?

Sent from my BlackBerry 10 smartphone.

From: Coleman, Alana <Personal Information redacted by USI>
Sent: Wednesday, 31 August 2016 08:34
To: Haynes, Mark
Subject: FW: Personal Information redacted by the USI HCN Personal Information redacted by the USI

Unfortunately, due to a backlog in the processing of Serious Adverse Incidents (SAI)s, this meeting was largely taken up with those but the eventual aim was to cover a wide range of governance topics.

Dr Gillian Rankin was the Acute Services Director before Debbie Burns. She told me she had set up the Friday governance meeting as governance did not feature anywhere when she joined. The meeting was virtually non-existent when I joined but it was not difficult to revive as the Terms of reference and list of attendees were already there. I included the Clinical Directors in the list of attendees as they often brought a different perspective to the topics discussed.

Paragraph 7.

Mr O'Brien

An e mail to me from the Medical Director, Dr Richard Wright on 9th February 2016, suggested that in replying late to an e mail from a member of the legal team, Mr O'Brien (who from the time line of his e mails suggested that he was working almost 24/7) was crying out for help. This was the first time Mr O'Brien had been mentioned to me as possibly having an issue.

At their AMD meeting around the end of February / beginning of March, Heather Trouton (Assistant Director for surgery) and Eamonn Mackle (AMD for surgery) told me that they were going to write to Mr O'Brien telling him he needed to complete his triage referrals quicker, complete timely dictations and that he needed to be quicker in general. I did not see all of the contents of the letter. I asked what prompted them to initiate this letter and they told me this was an ongoing problem that had dated back to Dr Rankin's time. It was just that it was getting harder and harder to manage his "slow style of working" and that others were now complaining as they were having to help with his unfinished work.

I did not know Mr O'Brien at all nor did I know his history in the ST. However, Mr Mackle and Heather Trouton did know him well. In fact, Mr Mackle stated he had been having issues with Mr O'Brien "dating back a number of years". I understand that Mr O'Brien accused Mr Mackle of bullying (p32 para 4 and 5 Investigation report; Dr Neta Chada) Mr Mackle left his post soon after the sending of said letter.

Mr O'Brien was always described to me as an excellent clinician who was trusted with patient safety issues by his colleagues. They never doubted his clinical ability. This was a surgeon who had been instrumental in setting the service up. He agreed as to how referrals would be triaged and never, to the best of my knowledge, said he was not going to do these referrals.

Paragraph 8.

After there was no response to the AMD and AD's letter of March 2016 and after Mr O'Brien protested profusely to a member of the legal team, blaming unnecessary administration on his late response, Mr O'Brien became an item on an already existing Oversight committee. I was first aware of this when I looked at the agenda on my way to the meeting and his name was included on that.

12.13 This work ethic and his characteristics of being tenacious, painstaking and narrowly focused is what enabled him to single handedly set up the Urology Service in the Legacy Craigavon Hospital (now part of the SH&SCT) in 1992, despite opposition from the Regional Centre in Belfast, and work as a solo practitioner until 1998

12.14 It was also these characteristics that had me convinced that an aggressive, formal approach with MHPS would lead to heels being dug in on both sides and a prolonged and tortuous process.

12.15 In 2016 I felt there was an opportunity to help Mr. O'Brien address his undoubted short-comings which had been ongoing for years, as evidenced in the letter of the 23rd March 2016. There was a new Clinical Director (Mr. Weir who he got on well with and as far as I know liked and respected) and a new AMD (me). There was an opportunity to focus on helping him address his issues in a 'positive/constructive/supportive role' by individuals where there was a mutual respect, but with the sword of Damocles hanging over his head of being barred from Theatre if he did not comply. I did not see how suspension from all clinical duties or a dogfight was going to help the triage, outpatient, cancer care and Theatre waiting lists and that was our most pressing concern. It would also have a very negative effect on his Surgical and Nursing Colleagues who respected him. Certainly Mr. Weir, Ronan Carroll and Esther Gishkori were up for it. Please see series of emails in PDF 20160922 E Meeting re Mr O'Brien 15th September – 22nd September 2016 *(S21 No 32 of 2022 Attachments, 6. 20160921 E Meeting re Mr O'Brien)*. I do not know what happened after the 22nd September as I ceased to be AMD soon after.

13. Consider and outline the extent to which you feel you can effectively discharge your role as Clinical Manager under MHPS and the Trust Guidelines in the extant systems within the Trust and what, if anything, could be done to strengthen or enhance that role.

13.1 I ceased to be a Clinical Manager in October 2016 and retired from the SH&SCT in April 2018. Hence, I am not aware of the extant systems in the Trust and do not have a role to utilise them. I would hazard that those systems have changed significantly since 2016, more especially since November 2020.

Stinson, Emma M

From: Carroll, Ronan <[redacted]>
Sent: 22 September 2016 15:41
To: McAllister, Charlie; Gishkori, Esther; Weir, Colin
Subject: RE: meeting re Mr O'Brien.

Importance: High

Charlie/Colin
So can I ask and offer some suggestions/solutions as to how we may monitor progress against the action listed below. The clock is ticking now toward December
Come back to me if you wish me to action anything/all

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien – At the first meeting obviously after the context of the meeting being explained the proposed plan/actions need to be shared with AOB and agreed
2. To implement a clear plan to clear triage backlog. – is this the outpatient referral letters, including RF's? How are you planning to monitor that this is cleared? I would propose with regard to the RF's that I would ask the cancer team to monitor the triage turnaround, with regard to outpatients I would ask Anita to put a process in place to monitor
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this – RBL validation – are we offering additional Pas for this to be done? If not, then something in his job plan will have to stop for this clinical validation to happen. Then when this task has been completed the remaining on the RBL can only be dealt by as your suggestion the template being adjusted, this has a lead in time of 6 weeks due to partial booking process. When this is implemented we will monitor the progress of AOBs RBL (I can have this run at anytime)
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation – I will speak to Anita to ensure AOBs secretary receives digital dictation following any consultation
5. All patient notes to be return from home without exception NA
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed absolutely
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: McAllister, Charlie
Sent: 21 September 2016 11:55
To: Gishkori, Esther; Weir, Colin; Carroll, Ronan
Subject: RE: meeting re Mr O'Brien.

Hi Colin

Thank you very much for this. Apart from the fact that you spelt my name wrong (!) this is absolutely excellent and I agree completely. It would be important to do this in a positive/constructive/supportive role and that Mr O'Brien would be aware of this. I think that this approach will give the best chance to achieve this. And for improving the current situation.