Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 17 of 2022
Date of Notice: 29th April 2022

Witness Statement of: Simon Gibson

I, Simon Gibson, 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.**

1.1 I was involved in matters within the scope of the Public Inquiry covering two time periods, from April 2007 – September 2009 as Assistant Director for Surgery & Elective Care and from April 2016 to now, in my role as Assistant Director to the Medical Director.

1.2 In my role as Assistant Director for Surgery & Elective Care, my responsibility was to lead on all aspects of the service provision under my responsibility, including General Surgery, Urology, ENT, Trauma & Orthopaedics, Oral Surgery and outpatients. I attended Senior Management Team meetings with other Assistant Directors across Acute Services, where a wide range of topics relating to performance, finance, HR and governance were considered. To avoid repetition and ensure all questions are answered as completely as possible, my narrative of detail of issues raised, meetings

for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

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

Signed: __Simon Gibson_____

Date: __27th June 2022_____

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 46 of 2021

Date of Notice: 29th April 2022

Witness Statement of: Mr Simon Gibson

I, Simon Gibson, 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.**

   1.1 I was involved in matters within the scope of the Public Inquiry covering two time periods, from April 2007 – September 2009 as Assistant Director for Surgery & Elective Care and from April 2016 to now, in my role as Assistant Director to the Medical Director.

   1.2 In my role as Assistant Director for Surgery & Elective Care, my responsibility was to lead on all aspects of the service provision under my responsibility, including General Surgery, Urology, ENT, Trauma & Orthopaedics, Oral Surgery and outpatients. I attended Senior Management Team meetings with other Assistant Directors across Acute Services, where a wide range of topics relating to performance, finance, HR and governance were considered. I have answered a wide range of questions in relation to this tenure in Section 21 No 17 of 2022, submitted on 27th June 2022.

Oversight Committee, but in attendance only in my role as Assistant Director, along with Malcom Clegg, the Medical Staffing Manager (Appendix 5 20160913 Oversight Committee Action notes. This document is attached as an Appendix to this statement). *Relevant document can be located at S21 No 46 of 2022 Attachments, 10. 20160913 Action Note Oversight Committee*

c. Who communicated these matters to you and in what terms?

12.3 Dr Richard Wright communicated these matters to me, in terms of their being in relation to four areas of Mr O'Brien's practice, namely:

a) Untriaged outpatient referral letters
b) Outpatient review backlog
c) Patients notes at home
d) Recording outcomes of consultations and inpatient discharges

d. Upon receiving this information what action did you take?

12.4 Upon receiving the information that there were concerns in relation to four areas of Mr O'Brien's practice, I wrote to Martina Corrigan on 18th August 2016. I wrote seeking information as, at the same time I became aware there were concerns, Dr Wright requested that I complete a screening report of the range of concerns identified. I completed this screening report on ~~7th~~ September 2016. *Relevant document can be located at, Relevant to HR/Evidence after 4 November HR/Reference 77/ Toal no 77/20160906 Attachment_AOB Screening Report*

Note: *As per addendum to this witness statement at TRU-320001 to TRU-320004 the highlighted date should read the 5th and not the 7th. Annotated by the Urology Services Inquiry.*

12.5 The purpose of this Screening report was to provide detail on the areas of concern identified and allow Dr Wright to convene an Oversight Committee to consider the content of the Screening report.

given that they were administrative in nature, but again recognise that this was not following the correct process and should not have been undertaken.

30. Having had the opportunity to reflect, outline whether in your view the MHPS process could have been better used in order to address the problems which were found to have existed in connection with the practice of Mr O'Brien.

30.1 In completing both Section 21's for the Urology Service Inquiry, my main reflection is that the formal MHPS would have been better used if deployed much earlier than September 2016. As I referenced in Section Number 17, I personally should have sought a formal response to Mr O'Brien, rather than persisting with an informal approach.

30.2 With the value that hindsight brings, my reflection is that, had previous Acute Directors used this formal mechanism rather than pursuing informal discussions and requests, Mr O'Brien's practice may have been better managed. I do believe that Mrs Gishkori's decision do not follow the decision of the Oversight Committee in September 2016 was a missed opportunity to manage Mr O'Brien at that time.

Statement of Truth

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

Signed: __Simon Gibson_____

Date: ____13/7/22_____

UROLOGY SERVICES INQUIRY

USI Ref: Notice 46 of 2021
Date of Notice: 29th April 2022

Addendum Witness Statement of: Mr Simon Gibson

I, Simon Gibson, wish to make amendments to my response to Section 21 Notice Number 46 of 2022. The amendments are as follows:-

1. At paragraph 12.4 (WIT – 33921), the date the screening report was completed was 5th September 2016 and not 7th September 2016 as indicated in my response. I attach my calendar entry for 5th September 2016 indicating a meeting with Ms Pamela Lawson at 9.30am, as evidence of meeting the Health Records Manager, as indicated in "Issue 3" of the Screening report of 5th September. The screening report was completed after the meeting. Please see 'calendar entry' attached.

2. Paragraph 13.1 (WIT- 33922) should be amended to state that the screening report was completed on 5th September 2016 (and not the 7th September). I wish to amend the second sentence as follows "I completed the screening report on 5th September 2016, and I discussed this report informally with Dr Wright as Medical Director on 7th September 2016, who wished to convene an Oversight Committee to formally consider this screening report and determine the next steps."

3. At paragraph 17.1 (WIT – 33928), I accept that Dr O'Brien was not on sick leave and the paragraph should be amended to "There was an Oversight meeting on 12th October 2016 to consider and review a number of ongoing investigations, of which Mr O'Brien's was one. It was agreed to keep the case of Mr O'Brien under review."

4. At paragraph 20.1 (WIT – 33930), I have now considered the email from Mr Carroll dated 28th December 2016 (AOB – 01300), and my email dated 28th December 2016 **(TRU – 251445)**, and acknowledge that I was first aware of the concerns in relation to private patients in December 2016. The paragraph should now state "I first became

aware of these concerns when assisting the Medical Director draft the Terms of Reference in December 2016, and having received an email from Ronan Carroll on 28th December 2016 at 1115."

5. At paragraph 21.1 (WIT – 33930), the sentence "Once a decision had been taken to conduct an investigation in December 2016, I was not involved in the subsequent steps of this process" should be amended to "Once a decision had been taken to conduct an investigation in December 2016, I was involved in some subsequent steps of this process, as I assisted in drafting the Terms of Reference and subsequently in suggesting amendments on 19th January 2017".

6. At paragraph 28.1 (WIT – 33937), the sentence "Once the investigation was commenced under these guidelines in January, I had no involvement in the case, therefore my impression is restricted to viewing this case from a distance" should be amended to "Once the investigation was formally launched in late January, I had no further formal involvement in the case, therefore my impression is restricted to viewing this case from a distance".

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

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

Signed: __ Simon Gibson (signed electronically_____

Date: ____20/2/23_____

Urology Services Inquiry

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

5.1

From	Until	Job Title
April 2007	September 2009	Assistant Director, Surgery and Elective Care

Duties and responsibilities:

To operationally manage the surgical services and specialties within the Southern Trust. These specialties were:

- General Surgery
- Urology
- ENT
- Trauma & Orthopaedics
- Oral Surgery
- Outpatients

To ensure that all elective targets were achieved and governance issues were managed.

The elective targets were:

- Maximum 9 week waiting time for new outpatient appointments

- Maximum 13 week waiting time for day case surgery
- Maximum 13 week waiting time for inpatient surgery

The governance issues would have included responding to complaints, IR1's and issues identified on the Risk Register.

Appendix 1 - SEC Job description located in Section 21 17 of 2022 Attachment
The job description is an accurate reflection of my duties and responsibilities in this post.

5.2

From	Until	Job Title
September 2009	November 2013	Assistant Director, Best Care, Best Value and Income Generation

Duties and responsibilities:

The duties and responsibilities were to find new ways to address the financial gap within Acute Services and to explore new ways of delivering Acute Services in accordance with best practice, whilst achieving financial balance in the future.

Appendix 2 - JD Best Care Best Value located in S21 17 of 2022 Attachments.
The job description is an accurate reflection of my duties and responsibilities in this post.

Urology Services Inquiry

5.3

From	Until	Job Title
November 2013	April 2016	Assistant Director, Medicine and Unscheduled Care

Duties and responsibilities:

To operationally manage the medical services and specialties which were under my remit within the Southern Trust. The specialties were:

- Neurology
- Dermatology
- Respiratory
- Nephrology
- Stroke
- Acute Geriatric medicine
- Cardiology
- Gastroenterology
- Endocrine/Diabetology
- Rheumatology

To ensure that all elective targets were achieved and governance issues were managed.

The elective targets were:

- Maximum 9 week waiting time for new outpatient appointments

33.1 I would have overseen the quality of services in Urology by considering documentation such as complaints, SAI's and DATIX reports and acted on these as appropriate. In addition, it is my recollection that at the inception of the Southern Trust, the quality of services in all specialties was defined by the 9 week and 13-week access targets. In essence, performance was a sub-set of quality. I oversaw the delivery of the access targets through the performance metrics as outlined below at Question 34. Adherence to the 72-hour target for triage was another aspect by which quality of services could be assured.

34. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this overseeing performance metrics?

34.1 I was responsible for the performance metrics in Urology. There were regular meetings of the Acute Services Senior Management Team (from my recollection called ASSET) regarding performance for all specialties in the Acute Directorate, including Urology Services. There was a particular focus on the elective care targets of 9 weeks for outpatients and 13 weeks for inpatients and day cases. The Acute Services Directorate would be provided with data from Lesley Leeman, Head of Performance within the Performance & Reform Directorate and her team. For example, the Trust would receive correspondence from the Service Delivery Unit at the DHSSPS **Appendix 25 - Letter to Trusts re PTL Plans - December 2008 located in S21 17 of 2022 Attachments** highlighting:

"……. the expectation, that in the majority of specialties, Trusts will achieve the 2008/09 maximum waiting time targets for elective services (including AHP services) by 31 January 2009 and sustain these through February and March"

34.2 Monthly meetings would be held, to consider current performance. I would have attended these meetings. I cannot recall which of my team attended with me at these meetings. (**Appendix 26 - sdp meeting 131108 located in S21 17 of 2022 Attachments.)** If performance was not as expected, remedial plans – known as "cutting plans" – would be agreed to ensure the targets were delivered by 31st March every year. These cutting plans were weekly calculations designed to work out the supply of appointments required to meet the demand from patients whilst ensuring that, by 31st

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.

54.1 As mentioned earlier, my Microsoft Calendar has not retained details from the 2007-2009 period to allow me to identify meetings held. In addition, the Southern Trust email archiving system did not commence until 2009 **(Appendix 30 - 20220505 - Email re Email archive located in S21 17 of 2022 Attachments).** Therefore, in responding to Questions 54-65, I feel obliged to preface these responses with my observation that I have had to rely on retained documents from the 2007-2009 period which I have been able to locate, but which may not be the full set of documents from that time. In addition, I am relying on a small number of emails from this period **(Appendix 31 - 20081003 - Email - Preparing Urology referrals for triage and Appendix 32 - 20081201 - Email Urgent - Urology-ICATS referrals located in S21 17 of 2022 Attachments)**. It appears some emails from my old cahgt (Craigavon Area Hospital Group Trust) email address were migrated to the inbox of my new email account. I have very little personal recollections from this period that have stayed with me.

54.2 The earliest evidence I have available to me that I first became aware of issues of concern relating to Mr O'Brien was in April 2008, at the workshop where the issue of triage was discussed. In October 2008, it was reported to me by my Operational Support Lead, Sharon Glenny, that there were delays in obtaining the outcome for Mr O'Brien's triage of referral letters. This may have been reported to me verbally or by e-mail, I cannot recall. I believe that the reason this issue came to light was due to the implementation of the Integrated Elective Access Protocol during the latter half of 2008. This set quantifiable timescales for the processing of documentation to ensure that a "Partial Booking" system could be implemented and that outpatients would get their new appointment within 9 weeks. This was a new process which centrally recorded outpatient referrals and if there were delays in the triage element of this new process, which should have taken 3 working days.

54.3 In October 2008, there was correspondence with Sharon Glenny, Operational Support Lead and Aidan O'Brien **(Appendix 31 - 20081003 - Email - Preparing Urology referrals for triage located in S21 17 of 2022 Attachments)** to discuss:

60.1 I assured myself by considering our performance against the Trusts adherence to the 9-week target for outpatients appointments. Other than delays in triage of outpatients by a small number of days, I was not aware of any other concerns. If required I assured myself of the triage delays by discussing this issue with my operational team. Reflecting back, this arrangement was not sufficiently robust, as the delays continued to be experienced periodically. The response was not comprehensive but was rather more reactive, with staff cajoling and encouraging Mr O'Brien to triage in a timely manner.

61. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

61.1 It is my recollection that the chasing up of delayed triage letters did not remedy the concerns, as they continued periodically up until I handed responsibility for Urology services over to Mrs Trouton. In terms of what could have been done differently, a more formal approach to Mr O'Brien could have been considered rather than the passive, informal method being used. However, the wider context is that the Southern Trust was still a new organisation and as a new management team attempting to manage the introduction of the complex new procedures within IEAP, it is my view that had I sought a more formal approach, it may not have been accepted by Directors of Acute Services as the best course of action. There were a small number of consultants who were struggling with various elements of the IEAP, and we were trying to bring staff along with us constructively, rather than to be confrontational in our approach. I would reiterate that – at that time – this was the only issue of concern I recall in in relation to Mr O'Brien, and that we were working with him to comply with the IEAP targets. However, in hindsight, I feel that this issue should have been escalated to achieve a more formal approach.

62. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those

held and actions or decisions taken by myself and others to address any concerns are covered within questions 4-72.

1.3 In my role as Assistant Director to the Medical Director, my responsibility was to support the Medical Director by leading on a number of key functions:

- Undergraduate medical education
- Postgraduate medical education
- Medical Revalidation & Appraisal
- Research & Development
- Emergency Planning & Business Continuity
- Supporting doctors in difficulty

1.4 My duties included meeting with the teams within each of these areas to take forward issues and opportunities to improve the services provided. I do not in this role have direct responsibility for managing Urology.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also 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.

2.1 This witness statement includes 34 appendices, which include new appendices provided to the USI as the original document request did not cover the period from 2007-2009.

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

National Clinical Assessment Service

CERTIFICATE OF ATTENDANCE

It is hereby certified that

Mr Simon Gibson

attended

Case manager training workshop

delivered by NCAS

on Tuesday 30 August 2016

This workshop has been approved for 6 CPD credits.

Workshop objectives

- *Explain why the decision to investigate is made*
- *Suggest other options to resolve performance concerns*
- *Describe roles and responsibilities of those involved in investigations*
- *Plan for an investigation which meets national requirements*
- *Describe the principles of robust and meaningful terms of reference and write effective Terms of reference*
- *Recognise the key skills and attributes of a case investigator and case manager*
- *Describe the components of a robust investigation report*
- *Weight an investigation report against other known information*
- *Explain the characteristics of a management case*
- *Explain the role of the panel hearing and the importance of decision making based on fact*
- *Describe what happens after an investigation, including opportunities for remediation and options for interventions*
- *Describe the potential legal challenges to an investigation.*

representations from the practitioner about his or her exclusion or any representations about the investigation;

- Case Manager – this is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority;
- Case Investigator – this is the individual who will carry out the formal investigation and who is responsible for leading the investigation into any allegations or concerns, establishing the facts, and reporting the findings to the Case Manager. He / she is normally appointed by the CE after discussion with the Medical Director and Director of HR and should, where possible, be medically qualified;
- the Director of HR 's role will be to support the Chief Executive and the Medical Director.

INVOLVEMENT OF NCAS

9. At any stage in the handling of a case, consideration should be given to the involvement of the NCAS. The NCAS has developed a staged approach to the services it provides HSS Trusts and practitioners. This includes:
   - immediate telephone advice, available 24 hours;
   - advice, then detailed supported local case management;
   - advice, then detailed NCAS performance assessment;
   - support with implementation of recommendations arising from assessment.

10. Employers or practitioners are at liberty to make use of the services of NCAS at any point they see fit. However, where an employing body is considering exclusion or restriction from practice the NCAS must be notified, so that alternatives to exclusion can be considered. Procedures for immediate and formal exclusion are covered respectively in Sections I and II of this framework.

11. The first stage of the NCAS's involvement in a case is exploratory – an opportunity for local managers or practitioners to discuss the problem with an impartial outsider, to look afresh at a problem, and possibly recognize the problem as being more to do with work systems than a doctor's performance, or see a wider problem needing the involvement of an outside body other than the NCAS.

12. The focus of the NCAS's work on assessment is likely to involve performance difficulties which are serious and/or repetitive. That means:

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

Corrigan, Martina

From: Corrigan, Martina
Sent: 17 August 2016 17:07
To: Wright, Richard
Subject: RE: confidential

Hi Richard,

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

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: Wright, Richard
Sent: 09 August 2016 09:21
To: Corrigan, Martina
Subject: confidential

Hi Martina. Did we ever make progress with regard to the issues raised re Urology which Eamon had been dealing with? Regards Richard

Corrigan, Martina

From: Corrigan, Martina
Sent: 18 August 2016 13:57
To: Gibson, Simon
Subject: RE: CONFIDENTIAL - Dr A O'Brien
Attachments: RE: confidential; RE: confidential

Hi Simon,

As discussed, please see attached information that I had forwarded to Richard and we can catch up on Monday PM to discuss in detail

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: Gibson, Simon
Sent: 18 August 2016 09:50
To: Corrigan, Martina
Cc: Wright, Richard
Subject: CONFIDENTIAL - Dr A O'Brien

Dear Martina

Richard has briefed me on the above, and asked that I commence a discreet piece of work on issues of concern and actions taken to date.

Could you forward any relevant information you have on file, and we can meet for an initial discussion next week.

Kind regards

Simon

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

- clinical performance falling well short of recognized standards and clinical practice which, if repeated, would put patients seriously at risk;
- alternatively, or additionally, issues which are ongoing or recurrent.

13. A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the HPSS or private sector other than their main place of HPSS employment until the NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals. This can be found at www.ncaa.nhs.uk. See also circular HSS(TC8) 5/04.

14. Failure on the part of either the clinician or the employer to co-operate with a referral to the NCAS may be seen as evidence of a lack of willingness to resolve performance difficulties. If the practitioner chooses not to co-operate with such a referral, and an underlying health problem is not the reason, disciplinary action may be needed.

INFORMAL APPROACH

15. The first task of the clinical manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. As a first step, preliminary enquiries are essential to verify or refute the substance and accuracy of any concerns or complaints. In addition, it is necessary to decide whether an informal approach can address the problem, or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary.

16. The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone. Root cause analyses of individual adverse events frequently show that these are more broadly based and can be attributed to systems or organizational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions.

17. In cases relating primarily to the performance of a practitioner, consideration should be given to whether a local action plan to resolve the problem can be agreed with the practitioner. The NCAS can advise on the practicality of this approach. This may involve a performance assessment by the NCAS if considered appropriate – (Section IV paragraph 7 refers). If a workable remedy cannot be determined in this way, the Medical Director, in consultation with the clinical manager, should seek the agreement of the practitioner to refer the case to the NCAS for consideration of a detailed performance assessment.

Appendix 1

Step 1 Screening Process

Issue of concern i.e. conduct, health and/or clinical performance concern, raised with relevant Clinical Manager**

→ Clinical Manager/Operational Director informs:

- Chief Executive
- Medical Director
- Human Resources Department
- Practitioner

↓

Chief Executive appoints an Oversight Group – usually comprising of:

- Medical Director / Responsible Officer
- Director of Human Resources and Organisational Development
- Appropriate Operational Director

↓

Clinical Manager and HR Case Manager undertake preliminary enquires to identify the nature of the concerns and assesses the seriousness of the issue on the available information.

↓

Clinical Manager and HR Case Manager, consults with NCAS and / or Occupational Health Service for advice when appropriate.

↓

Clinical Manager and HR Case Manager notify the Oversight Group of their assessment and decision. The decision may be:

- No Action Necessary
- Informal remedial action with assistance and input from NCAS
- Formal Investigation
- Exclusion / Restriction

** If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

28.2 The impression I have formed of the implementation of MHPS and Trust guidelines in relation to the Mr O'Brien case was primarily one of surprise that Mrs Gishkori decided to move away from the decision of the Oversight Committee to commence an investigation in September 2016.

28.3 I was also surprised that the formal investigation took from January 2017 to September 2018 to complete. I note from the timeline in the Case Investigators report that there were a number of lengthy delays which accounted for the length of this investigation.

28.4 A final impression I have is one of concern that the Case Managers recommendations were not implemented in a timely manner; I am aware that the Case Manager submitted his recommendation in September 2018.

29. Consider and outline the extent to which you feel you can effectively discharge your role 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.

29.1 I had no formal role within MHPS; my role was administrative in nature in supporting the Medical Director and worked to his or her direction. Therefore, I feel I am able to effectively discharge my role within the existing systems of the Trust.

29.2 On reflection, I do recognise that the screening of concern stage of the MHPS process should have been the undertaken by the clinical manager rather than myself, and that my actions at that stage were outside the agreed guidelines. I undertook the screening of concern as the Medical Director directly asked me to, and the concerns under consideration with administrative and statistical in nature, rather than any concerns requiring clinical consideration. I felt confident in being able to summarise the issues

at home and recording the outcomes of consultations and inpatient discharges **(Appendix 29 - Screening report 20160907 located in S21 17 of 2022 Attachments)**

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

48.2 A screening report was completed to risk assess through quantification of the impact of the concerns.

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.

48.3 I provided the screening report to allow Dr Wright as Medical Director to consider whether the concerns may have impacted on patient care and safety. I did not consider this myself, as this was not my role; my role was to provide the information to the Medical Director.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

48.4 It was my understanding that monitoring arrangements were put in place to address these concerns. Esther Gishkori as Acute Services Director was responsible for implementing these monitoring systems, which were monitored and implemented by Martina Corrigan as Head of Service and Ronan Carroll as Assistant Director.

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

48.5 I did not assure myself that these systems were working, as this was the responsibility of Esther Gishkori as Acute Services Director.

(f) If you were given assurances by others, how did you test those assurances?

48.6 I was not given assurances by others.

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.

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

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

Southern Health & Social Care Trust

Medical Directors Office

Screening report on Dr Aidan O'Brien

Context

The Medical Director sought detailed information on a range of issues relating to the conduct and performance of Dr O'Brien. This report provides background detail and current status of these issues, and provides a recommendation for consideration of the Oversight Committee.

Issue one – Un-triaged outpatient referral letters

When a GP refers a patient into secondary care, the referral is triaged to consider the urgency of the referral. If triage does not take place within an agreed timescale as per the Integrated Elective Access Protocol (IEAP), then health records staff schedule the referral according to the priority given by the GP. This carries with it the risk that a patient may not have their referral "upgraded" by the consultant to urgent or red flag if needed, if triage is not completed. This may impact upon the outcome for a patient.

In March 2016, Dr O'Brien had 253 untriaged letters, which was raised in writing with him and a plan to address this was requested. No plan was received and at August 2016, there were 174 untriaged letters, dating back 18 weeks; the rest of the urology team triage delay is 3-5 working days.

Issue two – Outpatient review backlog

Concerns have been raised that there may be patients scheduled to be seen who are considerably overdue their review appointment and could have an adverse clinical outcome due to this delay.

In March 2016, Mr O'Brien had 679 patients in his outpatient review backlog, which was raised in writing with him and a plan to address this was requested. No plan was received and at August 2016, there were 667 patients in his outpatient review backlog, dating back to 2014: whilst outpatient review backlogs exist with his urological colleagues, the extent and depth of these is not as concerning.

Issue three – Patients notes at home

Mr O'Brien has had a working practice of taking charts home with him following outpatient clinics. These charts may stay at his home for some time, and may not be available for the patient attending an appointment with a different specialty, making the subsequent consultation difficult in the absence of the patients full medical history.

For a period in 2013/14, instances when charts were not available were recorded on the Southern Trusts Adverse Incident Reporting (IR) system: there were 61 consultations where charts were not available. In speaking to the Health Records Manager, Mr O'Brien is currently continuing this practice although this is not now recorded on the IR system.

Mr O'Brien was spoken to about this issue in 2012 by Dr Rankin, and twice in 2014 by Mrs Burns, the Directors of Acute Services at the time, seeking a change in behaviour, although none of these meetings were formally recorded.

Issue four – Recording outcomes of consultations and inpatient discharges

Whilst there has been no formal audit of this issue, concern has been raised by his urological colleagues that Mr O'Brien may not always record his actions or decisions regarding a patient following a period of inpatient care or outpatient consultation. This may cause subsequent investigations or follow up not to take place or be delayed.

Summary of concerns

This screening report has identified a range of concerns which may be counter to the ***General Medical Councils Good Medical Practice*** guidance of 2013, specifically paragraphs 15 (b), 19 and 20:

15. ***You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:***

- *a. Adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
- *b.* ***Promptly provide or arrange suitable advice, investigations or treatment where necessary***
- *c. Refer a patient to another practitioner when this serves the patient's needs.*

19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. ***You should make records at the same time as the events you are recording or as soon as possible afterwards.***

20. ***You must keep records*** *that contain personal information about patients, colleagues or others securely, and* ***in line with any data protection requirements.***

Conclusion

This report recognises that previous informal attempts to alter Dr O'Brien's behaviour have been unsuccessful. Therefore, this report recommends consideration of an NCAS supported external assessment of Dr O'Brien's organisational practice, with terms of reference centred on whether his current organisational practice may lead to patients coming to harm.

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Date of report 7/9/2016

Appendix A – Extract from NCAS Assessment Services www.ncas.nhs.uk

1. **Record-based assessment**

This assessment, currently focused on primary medical and dental care, enables the referring body to decide whether there is a problem that needs further investigation or assessment. An in depth, structured review of clinical records is useful for identifying concerns at an early stage but does not, on its own, give enough information to support a decision on a practitioner's fitness for purpose. The process may include an interview with the practitioner to explore issues arising from the review.

2. **Assessment of health**

Sometimes concerns about a practitioner focus on health and how this may be influencing performance. In these cases we can offer an occupational health assessment or provide advice to organisations who may wish to commission their own health assessment. We have significant experience in occupational health services specifically tailored for clinicians in performance difficulties. We are also able to offer timely access to specialist health services where onward referral is necessary. For example, health or behavioural assessment might suggest that a problem has its origins in cognitive impairment, requiring advice from a neuropsychiatrist or neuropsychologist.

3. **Assessment of behavioural concerns**

Where the concerns about an individual practitioner have their primary focus on the practitioner's behaviour and relationships with colleagues, and where there is not misconduct requiring use of disciplinary or fitness to practise procedures, we may suggest an assessment of behavioural concerns. This assessment involves completion of psychometric questionnaires followed by a full-day structured interview with an NCAS behavioural assessor, drawn together with an occupational health assessment and multi-source feedback. The aim is to:

- provide an independent view on any behavioural factors about the practitioner which are causing concern
- identify other factors that may be contributing to these concerns
- make recommendations for addressing any difficulties identified.

4. **Full performance assessment**

This is our most detailed intervention, taking a broad view of performance and making detailed practical recommendations. It is particularly valuable where there are complex, longstanding and/or multiple concerns. It includes an assessment of the practitioner's health, a behavioural assessment and assessment of clinical practice based on workplace observation. The process looks not just at the practitioner but at the practitioner's working environment - referred to as 'the context of practice'. The result is a comprehensive report with clear findings and conclusions in. respect of the individual's practice, which provides

Urology Services Inquiry

13. Outline the circumstances which prompted you to seek advice from NCAS on 7th September 2016, including when, by what means and in what terms did you become aware of the concerns raised? What, if any, discussions did you have with any individual, including the Medical Director, Service Director, Associate Medical Director's and other Assistant Service Director's, before contacting NCAS and what was the nature of these discussions?

13.1 As detailed in my response to Question 12a. I became aware of concerns raised shortly before 18th August 2016, when Dr Wright briefed me on a range of concerns. When I completed the screening report on ~~7th~~ September 2016, I discussed this report informally with Dr Wright as Medical Director, who wished to convene an Oversight Committee to formally consider this screening report and determine the next steps. The date for this Oversight Committee was set for 12th September 2016. To assist the consideration of the Oversight Committee, Dr Wright requested that I seek the advice of NCAS, which I did by telephone on the same day.

Note: As per addendum to this witness statement at TRU-320001 to TRU-320003 the highlighted date should read the 5th and not the 7th. Annotated by the Urology Services Inquiry.

13.2 I had no discussions with the Service Director, Associate Medical Director's and other Assistant Service Director's.

14. Does the letter from NCAS dated 13 September 2016 accurately reflect the nature of the discussions you had and advice you received from NCAS at that time? Was an audit of note-taking commenced by the Trust at that time? If so please provide the outworkings from the same.

14.1 From my recollection, the letter accurately reflected the nature of the discussions held with Dr Colin Fitzpatrick at NCAS at that time. Dr Fitzpatrick wrote the letter which confirmed our discussions. In relation to the note-taking audit, this was in reference to one of the four concerns identified, namely:

Chloe Williams

From: CST-C
Sent: 07 September 2016 10:57
To: Colin Fitzpatrick
Cc: CST-C
Subject: 18665 - new SHSCT case: Call-back details as discussed

Importance: High
Sensitivity: Confidential

Follow Up Flag: Follow up
Flag Status: Flagged

Categories: Jill, NEW CASES/CALL BACKS

Dear Colin

Please see below the advice brief for the above mentioned case. Please can you place a call as per the details below:

Referrer name	Dr Simon Gibson, Southern Health and Social Care Trust
Referrer contact number	Personal Information redacted by the USI
Referrer e-mail address	Personal Information redacted by the USI
Call arranged by	Jill Devenney
Call back date requested	Wednesday 7 September 2016
Call back time requested	Available anytime today
Summary of concerns	Concerns about a Consultant in Urology. There are concerns surrounding clinical practice and administration thereof. The RB is considering whether an external evaluation of the doctor's practice may be beneficial. There is reportedly a massive urology backlog; practitioner allegedly not triaging letters and potential late referrals to other departments.
Other notes or comments	Only skeleton details have been provided thus far. It would be helpful during the call-back if you could confirm the Practitioner's name and GMC number. I can then liaise with Dr Gibson to secure other key data in due course (if deemed appropriate following call).

I have assigned you to the case so you should be able to see everything on EKS.

Many thanks for picking up this call-back for me today.

BW

Jill

Jill Devenney | Case Officer, Unit C
National Clinical Assessment Service (NCAS)

Tel: Personal Information redacted by USI

NHS
National Clinical Assessment Service

NCAS
N I office
HSC Leadership Centre
The Beeches
12 Hampton Manor Drive
Belfast
Co Antrim
BT7 3EN

Tel: Personal information redacted by USI

www.ncas.nhs.uk
Personal information redacted by the USI

13 September 2016

PRIVATE AND CONFIDENTIAL
Sent by email only

Mr Simon Gibson
Assistant Director
Southern Health and Social Care Trust
Craigavon Area Hospital
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ

NCAS ref: 18665 (Please quote in all correspondence)

Dear Mr Gibson

I am writing following our telephone discussion on 7 September. Please let me know if I have misunderstood anything as it may affect my advice.

You called to discuss a consultant urologist who has been in post for a number of years. You described a number of problems. He has a backlog of about 700 review patients. This is different to his consultant colleagues who have largely managed to clear their backlog.

You said that he is very slow to triage referrals. It can take him up to 18 weeks to triage a referral, whereas the standard required is less than two days.

You told me that he often takes patient charts home and does not return them promptly. This often leads to patients arriving for outpatient appointments with no records available.

You told me that his note-taking has been reported as very poor, and on occasions there are no records of consultations.

To date you are not aware of any actual patient harm from this behaviour, but there are anecdotal reports of delayed referral to oncology.

The doctor has been spoken to on a number of occasions about this behaviour, but unfortunately no records were kept of these discussions. He was written to in March of this year seeking an action plan to remedy these deficiencies, but to date there has been no obvious improvement.

We discussed possible options open to you. The Trust has a policy on removing charts from the premises and it would appear that this doctor is in breach of this policy. This could lead to disciplinary action. He was warned about this behaviour in the letter sent to him in March so it would be open to you to take immediate disciplinary action; however, I would suggest that he is asked to comply immediately with the policy.

With regard to the poor note-taking it would be useful to conduct an audit. If there is evidence of a substantial number of consultations for either inpatients or outpatients with no record in the notes, this is a serious matter which may merit disciplinary action and possible referral to the GMC. If, after the audit, it appears that the concern is more about the quality of the notes rather than whether there are any notes at all, a notes review by NCAS may be appropriate. If you wish us to consider that, please get back to me.

The problems with the review patients and the triage could best be addressed by meeting with the doctor and agreeing a way forward. We discussed the possibility of relieving him of theatre duties in order to allow him the time to clear this backlog. Such a significant backlog will be difficult to clear, and he will require significant support. I would be happy to attend such a meeting, if this was considered helpful.

Relevant regulations/guidance:

- Local procedures;
- General Medical Council Guide to Good Medical Practice;
- Maintaining High Professional Standards in the Modern HPSS (MHPS).

Review date:

7 October 2016.

As it seems likely that further NCAS input will be required, we will keep this case file open and review the situation in about one month. If you require further advice in the meantime, please do not hesitate to contact me.

If you have any further issues to discuss, or any difficulties with these arrangements, please contact the Northern Ireland office on the direct line above.

I hope the process has been helpful to you.

Yours sincerely

Dr Colin Fitzpatrick
NCAS Senior Adviser

cc: Jill Devenney, Case Officer (N I)

Please ensure that any information provided to NCAS which contains personal data of any type is sent to us through appropriately secure means.

Gibson, Simon

From: Gibson, Simon <[redacted]>
Sent: 28 September 2016 16:03
To: Wright, Richard
Cc: Gishkori, Esther; Stinson, Emma M; McAllister, Charlie
Subject: Dr A O'Brien
Attachments: leto_160913_to+rb_advice+letter_18665.pdf

Dear Richard/Esther

You will recall that as part of the collation of evidence in relation to the above, I sought advice from NCAS which was discussed when the Oversight Committee met.

The written advice from NCAS has now come in and is attached. Whilst the informal work is underway with Dr O'Brien, this NCAS advice will be placed on file for reference should we need it at the end of the informal piece of work.

I hope this is useful

Kind regards

Simon

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

From: Gibson, Simon
Sent: 28 September 2016 15:53
To: Gibson, Simon
Subject:

commenced on 1 April 2017 (with a term of 36 months) and is produced at **[CF7].** The current SLA with Northern Ireland commenced on 1 April 2022 (again for a term of 36 months) and is produced at **[CF8].**

6. The SLA enabled to the Southern Health and Social Care Trust to contact NHSLA/ NHS Resolution in the same way that any English Trust could. Advice cases such as this were within the scope of the SLA and there were provisions that if other interventions were requested these could be paid for separately.

Involvement of NCAS/the Advice Service

7. I have taken the opportunity to review further my involvement with this case and comment on some distinct features with regards to both the Investigation by the Trust and the advice provided by PPA.

Prior concerns

8. It occurs to me that there were a number of missed opportunities by the Trust with Dr O' Brien's case. Initially when Simon Gibson telephoned me on 7 September 2016, I recall asking if there were wider concerns with regards to Dr O'Brien's capability and I was told that there were not. My observation is that Simon Gibson cannot have been fully informed at the time he contacted me because find it difficult to believe that there were not prior concerns about capability before this call took place. Anecdotally I understand there are individuals who worked with Dr O'Brien who had concerns about his capability for a long time. I do not have any documentary evidence that these concerns were ever raised formally.

9. I suspect that there had been issues prior to the Trust's contact with NCAS/the Advice Service. I do not know what the Trust was aware of prior to contacting NCAS/the Advice Service but it is possible that within the organisation there may have been concerns relating to Dr O'Brien's capability which ought to have been considered as part of a review. If there were no capability concerns, the matter might have been (and for a period was) viewed as potential disciplinary conduct matter. The process for progressing the case on this basis should have involved a focused and swift investigation. This did not happen. For example issues with regards to taking patients notes home should have been explored immediately upon senior personnel at the Trust becoming aware, strict instructions could have been given to remedy the issues and this did not happen.

10. Whilst I was given an indication of the seemingly disciplinary issues on the initial call in September 2016, I can see that there was then a substantial shift between the initial call and 28 December 2016 by which stage there was a more sizeable problem as by

that point a Serious Adverse Incident had been identified and there was concern about patient harm.

11. Once capability concerns were identified there needed to be a clear diagnosis of the issues and the scope of an investigation defined. That is a stage when the Trust might have taken some wider soundings to be clear it investigated the right issues.

12. Upon being informed of a Serious Adverse Incident and patient harm, I would expect a Medical Director, to carry out a soft investigation in relation to wider concerns around clinical capability, which would then inform the Terms of Reference of any subsequent investigation. This might be considered as another missed opportunity.

13. The categorisation of the initial concern can make a significant difference to how a case progresses, with the distinction between capacity (with options for assessment and remediation) and conduct (which can lead to a disciplinary). If Simon Gibson did not know about any clinical capability concerns in September 2016, that avenue under the MHPS Framework (detailed further below) effectively disappeared.

Failure to progress an effective investigation

14. Even when the case was thought to involve clinical issues and apparent patient harm, there was a failure to progress a timely effective investigation within the Trust. We sent three separate emails chasing progress to the Trust on 1 January, 1 March and 1 May 2017 which were not responded to and as a result the PPA case file was closed in August 2017.

15. The file closure following no response to chasing emails is standard practice. I recognise that this makes the assumption that the Trust is capable of managing the process, however it seems that very little was done in the gap between the call between Richard Wright and my (then) colleague, Grainne Lynn on 28 December 2016 (where patient harm was highlighted) and a call was received from Dr Khan on 17 September 2018.

16. Under the MHPS Framework the investigation should be undertaken within four weeks. The problem with this is that it is almost always unachievable, which results in people having lower expectations about a timely investigation. A much more realistic timetable would be 12 weeks, in order to undertake a proper exploration of all potential concerns.

17. I am familiar with the issue of an investigation getting underway and new concerns coming to light. We now train investigators to think carefully about how to deal with this and whether to modify their Terms of Reference or to start a separate investigation that need not delay or derail the first.

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]

Gibson, Simon

From: Gibson, Simon
Sent: 13 September 2016 14:12
To: Gishkori, Esther; Toal, Vivienne; Clegg, Malcolm; Wright, Richard
Cc: Stinson, Emma M; White, Laura; Mallagh-Cassells, Heather
Subject: CONFIDENTIAL - Letter to AO'B - first draft
Attachments: Letter to AOB - 1st draft 13-9-16.docx

Dear all

Draft of letter for comments back please.

Esther – I phoned Martina with regard to what is a realistic yet challenging target with regard to the outpatient review backlog. Her view was 229 in the month of October (19 additional clinics) would not be achievable, and we don't want to set him a target we know he can't reach, and then penalise him. So, we have gone with 70 per month, every month, until end of December. Operationally, this is your call, but just wanted you to be aware of the thought processes behind the target chosen

Kind regards

Simon

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

Southern Health and Social Care Trust

Draft letter

21st September 2016

Dear Mr O'Brien

Formal notification of investigation under Maintaining High Professional Standards (MHPS)

I am writing to inform you of the Southern Trusts intention to proceed with an investigation under MHPS with regard to a range of issues in relation to your practice. At this stage, we will be taking an informal approach as outlined within MHPS, but following the outcome of this we may proceed with a formal investigation.

This investigation should be seen in the context of the letter written to you on 23rd March (copy attached), in which a number of concerns were raised and a plan was sought from you to address these concerns. No plan was provided and the same concerns still exist.

This informal approach will consider four areas of your practice, and be time bound as indicated below.

Area 1 – Untriaged letters

In August 2016, you had 174 untriaged outpatient referral letters, dating back 18 weeks. It is the expectation of the Trust that by the time you commence your next Urologist of the Week session, on 21st October, this backlog is eliminated. Furthermore, it is the expectation of the Trust that at the end of your week as Urologist of the Week, you are completing the triage of outpatient referral letters within the Trust standard of 72 hours.

Area 2 - Outpatient review backlog

As at 31st August 2016, you had 658 patients on your outpatient review backlog, including 229 going back to 2014. It is the expectation of the Trust that this 2014 backlog is reduced to zero by the end of the calendar year, with a reduction of a minimum of 70 patients per month.

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by USI / Email: Personal Information redacted by USI

Area 3 – Patients notes at home

I am aware that you have had a practice of taking notes home with you, and this has been discussed with you previously, yet this practice has continued. It is the expectation of the Trust that all hospital notes at your house are returned to Martina Corrigan, Head of Service for Urology, within 24 hours of the date on this letter.

There are to be no exceptions to this.

Once these charts are returned, they will be recorded and their location tracked on PAS either back to filing, your office or your secretarys office, in line with Trust procedures.

Area 4 - Recording outcomes of consultations and inpatient discharges

It has been brought to my attention that on occasion you might not make contemporaneous notes following an outpatient consultation or inpatient discharge. It is the Southern Trusts expectation that, from the date on this letter, you make contemporaneous notes to ensure that your colleagues are aware of the clinical management plans for any patient.

A clinical note review will be undertaken of 20 sets of notes seen by yourself in the four weeks following the date on this letter, to assess your compliance with this expectation.

In late October, an assessment will be made on your progress towards the targets in these four areas of practice, as outlined above. Should the Southern Trust conclude that sufficient progress has not been made, or other issues are identified during the four week period of assessment, then a formal investigation will be commenced under the terms of MHPS.

I very much appreciate that investigations can be particularly stressful and I therefore wish to advise you that the services of Carecall (0808 800 0002) are open to you throughout the course of the investigation to provide help and support.

Under MHPS, it is intended that the Investigation Team will conclude their investigation by 31st October; however, you will be kept informed if this is not achievable.

Yours sincerely

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by USI / Email: Personal Information redacted by USI

at home and recording the outcomes of consultations and inpatient discharges **(Appendix 29 - Screening report 20160907 located in S21 17 of 2022 Attachments)**

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

48.2 A screening report was completed to risk assess through quantification of the impact of the concerns.

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.

48.3 I provided the screening report to allow Dr Wright as Medical Director to consider whether the concerns may have impacted on patient care and safety. I did not consider this myself, as this was not my role; my role was to provide the information to the Medical Director.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

48.4 It was my understanding that monitoring arrangements were put in place to address these concerns. Esther Gishkori as Acute Services Director was responsible for implementing these monitoring systems, which were monitored and implemented by Martina Corrigan as Head of Service and Ronan Carroll as Assistant Director.

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

48.5 I did not assure myself that these systems were working, as this was the responsibility of Esther Gishkori as Acute Services Director.

(f) If you were given assurances by others, how did you test those assurances?

48.6 I was not given assurances by others.

the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expediously as possible and the Oversight Group will monitor progress.

2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following

Click on the link to access the Acute Services Page

<image003.png><image004.png><image005.png>

From: Gibson, Simon
Sent: 15 September 2016 15:25
To: Stinson, Emma M
Subject: FW: *HOLD* Meeting with Simon, Colin Weir and Ronan re Investigation
Importance: High

Dear Emma

Please see below – is this meeting not proceeding?

Kind regards

Simon

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

From: Carroll, Ronan
Sent: 15 September 2016 13:31
To: Gibson, Simon; Weir, Colin
Subject: FW: *HOLD* Meeting with Simon, Colin Weir and Ronan re Investigation
Importance: High

I received an email from Esther to say this meeting was cancelled

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

Gibson, Simon

From: Wright, Richard <Personal Information redacted by USI>
Sent: 15 September 2016 18:05
To: Gibson, Simon
Subject: Re: *HOLD* Meeting with Simon, Colin Weir and Ronan re Investigation

Classic Esther. About turn after the meeting. I've asked her to outline her plans in detail for us to consider. We haven't agreed to any change yet. R

Sent from my iPad

On 15 Sep 2016, at 15:33, Gibson, Simon <Personal Information redacted by USI> wrote:

> Dear Richard
>
> Please see below – has there been an update in relation to the meeting regarding Dr O'Brien?
>
> Kind regards
>
> Simon
>
> Simon Gibson
> Assistant Director – Medical Directors Office
> Southern Health & Social Care Trust
> Personal Information redacted by USI
> Mobile: Personal Information redacted by USI
> DHH: Personal Information redacted by USI Ext Personal Information redacted

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From: Stinson, Emma M
Sent: 15 September 2016 15:30
To: Gibson, Simon
Subject: RE: *HOLD* Meeting with Simon, Colin Weir and Ronan re Investigation

Dear Simon

Yes – I understand that Esther spoke to Dr Wright

Many Thanks
Emma

Emma Stinson

PA to Mrs Esther Gishkori
Director of Acute Services
SHSCT, Admin Floor, Craigavon Area Hospital

<image001.png> **Direct Line:** Personal Information redacted by USI **Direct Fax:** Personal Information redacted by USI
<image002.png Personal Information redacted by USI

Please consider the environment before printing this email

Gibson, Simon

From: Gibson, Simon
Sent: 16 September 2016 16:31
To: Wright, Richard
Subject: AOBrien
Attachments: Letter to AOB - 1st draft 13-9-16.docx

Dear Richard

For Charlie.

Charlie/Colin must understand the importance of:

- Formally recording the meeting
- Providing quantifiable actions required
- Agreeing realistic dates Eg: Doesn't need 3 months to return charts – 5 days is generous.

Kind regards

Simon

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

Toal, Vivienne

From: Wright, Richard [redacted]
Sent: 16 September 2016 13:44
To: Toal, Vivienne
Subject: RE: meeting re Mr O'Brien.

Hi Vivienne. I had a meeting scheduled with Francis and Esther this am and this topic came up. Esther agreed in principle to provide the info requested and to ensure that there was a documented meeting with Me OB outlining the implications of not getting this sorted within 3 months. Francis was keen to pursue this a under those circumstances but not to let it run further than the three months if still non compliant. Happy to discuss further. Richard

---

From: Toal, Vivienne
Sent: 16 September 2016 08:57
To: Wright, Richard; Gishkori, Esther
Subject: RE: meeting re Mr O'Brien.

Esther – I am conscious you go off on leave today; how do you wish to handle Richard's request below?

Vivienne

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 [redacted] 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.
>
> I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.

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

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.

16.4 However, I was aware that RCA's were ongoing, as these were reported by the Medical Director to the Employment Liaison Advisor (ELA) of the GMC, at meetings generally held quarterly with them between 2017 and 2020. I attended these meetings, along with the GMC ELA, the Medical Director and sometimes staff from the Medical HR Department.

17. Outline the circumstances and the process by which you understand concerns in relation to Mr O'Brien came to be discussed by the Oversight Group on 22 December 2016 and address the following:
a. What information was before the Oversight Group on that date, and from what source did the information discussed at that meeting emanate?

17.1 There was an Oversight meeting on 12th October 2016 to consider and review a number of ongoing investigations, of which Mr O'Brien's was one. It was agreed to keep the case of Mr O'Brien. ~~under review as he was on sick leave at that time.~~

Note: As per addendum to this witness statement at TRU-320001 to TRU-320003 the words highlighted should be deleted as Mr Gibson accepts that Mr O'Brien was not on sick leave. Annotated by the Urology Services Inquiry.

17.2 As a result of this decision to keep the case under review, there was a subsequent Oversight Group meeting on 22nd December specifically to consider the case of Mr O'Brien. The information before the Oversight Committee is as detailed in Appendix 10 (20161222 Action note 22nd December AOB. This document was provided by Dr Tracey Boyce and Mr Ronan Carroll. *Relevant document can be located at Relevant to Acute/Evidence after 10 December Acute/Document No 77 Esther Gishkori/20170124 Action Note 20161222*

b. What do you understand to have been decided at that meeting, and what action was to take place following that meeting?

17.3 The decision at that meeting was for Dr Wright to make contact with Mr O'Brien and inform him of the decision to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS

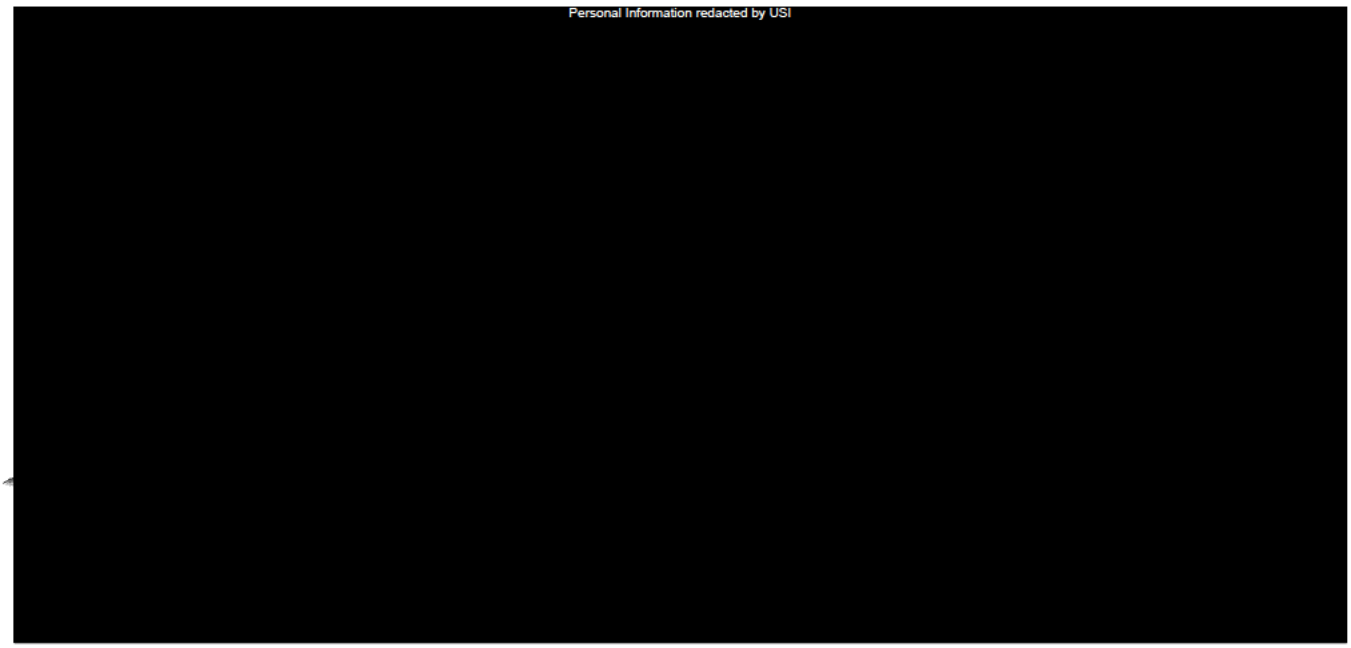
Southern Health & Social Care Trust

Oversight Committee
12th October 2016

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Esther Gishkori, DAS

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager

Discussion:



Mr A O'Brien
Mrs Gishkori reported that Mr O'Brien was going for planned surgery in November and was likely to be off for a considerable period. It was noted that Mr O'Brien had not been told of the concerns following the previous Oversight Committee. It was also noted that a plan was in place to deal with the range of backlogs within Mr O'Briens practice during his absence.

Mrs Gishkori gave an assurance that, when Mr O'Brien returned from his period of sick leave, that the administrative practices identified by the Oversight Committee would be formally discussed with him, to ensure there was an appropriate change in behaviour. It was agreed that this would be kept under review by the Oversight Committee.

28.2 The impression I have formed of the implementation of MHPS and Trust guidelines in relation to the Mr O'Brien case was primarily one of surprise that Mrs Gishkori decided to move away from the decision of the Oversight Committee to commence an investigation in September 2016.

28.3 I was also surprised that the formal investigation took from January 2017 to September 2018 to complete. I note from the timeline in the Case Investigators report that there were a number of lengthy delays which accounted for the length of this investigation.

28.4 A final impression I have is one of concern that the Case Managers recommendations were not implemented in a timely manner; I am aware that the Case Manager submitted his recommendation in September 2018.

29. Consider and outline the extent to which you feel you can effectively discharge your role 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.

29.1 I had no formal role within MHPS; my role was administrative in nature in supporting the Medical Director and worked to his or her direction. Therefore, I feel I am able to effectively discharge my role within the existing systems of the Trust.

29.2 On reflection, I do recognise that the screening of concern stage of the MHPS process should have been the undertaken by the clinical manager rather than myself, and that my actions at that stage were outside the agreed guidelines. I undertook the screening of concern as the Medical Director directly asked me to, and the concerns under consideration with administrative and statistical in nature, rather than any concerns requiring clinical consideration. I felt confident in being able to summarise the issues

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

Issue two

An issue has been identified that there are notes directly tracked to Dr O'Brien on PAS, and a proportion of these notes may be at his home address. There is a concern that some of the patients seen in SWAH by Dr O'Brien may have had their notes taken by Dr O'Brien back to his home. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Action

Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10th January 2017
Lead: Ronan Carroll

Issue three

Ronan Carroll reported that there was a backlog of over 60 undictated clinics going back over 18 months. Approximately 600 patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

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

It was agreed to consider any previous IR1's and complaints to identify whether there were any historical concerns raised.
Action: Tracey Boyce

Consideration of the Oversight Committee

In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach.

It was agreed for Dr Wright to make contact with NCAS to seek confirmation of this approach and aim to meet Dr O'Brien on Friday 30th December to inform him of this decision, and follow this decision up in writing.
Action: Dr Wright/Simon Gibson

The following was agreed:
Case Investigator – Colin Weir
Case Manager – Ahmed Khan

One immediate action that I confirmed at our meeting is the expectation of the Trust that all hospital notes at your house are returned to Martina Corrigan, Head of Service for Urology, within 72 hours of the date on this letter.

There are to be no exceptions to this.

Once these charts are returned, they will be recorded and their location tracked on PAS either back to filing, your office or your secretary's office, in line with Trust procedures.

Issue three – Unreported outcomes from clinics

It has been reported that, as at 15th December, you had a backlog of 61 undictated clinics going back to November 2014 (Appendix 3). This means that a significant number of patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

Issue four – Non-compliance of Trust policy in relation to management of private patients being seen within NHS services

A case has been raised which may indicate that you may have offered an advantage to an NHS patient awaiting an inpatient procedure who had previously attended you in a private outpatient capacity, to the disadvantage of other patients awaiting an inpatient procedure, by not listing patients in chronological order.

These issues were considered by the Southern Trusts Oversight Committee on 22nd December. Given the seriousness of these issues, the Oversight Group further considered if exclusion or any restrictions of practice should be placed upon you during the course of the investigation.

It was agreed by the Oversight Committee that there was the potential that your administrative practices may have led to patients coming to harm. If this was the case, should you return to work, the potential that your administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude you for the duration of a formal investigation under the MHPS guidelines. In line with NCAS and DHSSPS guidelines, this decision was discussed and endorsed by NCAS on 23rd December.

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by USI / Email: Personal Information redacted by USI

sessions. Mrs O'Brien stated that she and her children have sacrificed their family life for her husband's job and stated that she found it most hurtful that it should be reduced to this moment, and that it was grossly unfair.

It was again reiterated that there is an obligation to address concerns when these are raised, and that Dr Wright had been made aware of serious concerns about Mr O'Brien's administrative practices which may have / has the potential to lead to harm for patients.

Mr O'Brien was made aware of the paragraphs in the MHPS documentation relating to exclusion. He queried if he can continue to work with private patients. Dr Wright suggested that he take advice from his union, but said that as RMO, he would discourage this. Dr Wright suggested that Mr O'Brien ask his colleagues to review any private patients that he has.

Mr O'Brien was made aware of support services available through Care-call and OH. He was advised that an OH appointment would be made for him and would be communicated to him. Prior to meeting concluding, Mr O'Brien apologised to Dr Wright.

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From: Gishkori, Esther
Sent: 03 January 2017 15:17
To: Carroll, Ronan; Gibson, Simon; Corrigan, Martina
Cc: Hainey, Lynne; Wright, Richard; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB

Ronan,
I'm sure Simon will be able to answer the queries below but I just wanted to comment on point 4. Mr O'Brien is at liberty to do what he wants off ST premises but he cannot use the services of the Trust in the carrying out of his own private work. Not unless
the secretarial staff do the work outside core hours and don't use any facilities of the Trust.
Thanks
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: Carroll, Ronan
Sent: 03 January 2017 14:49
To: Gibson, Simon; Corrigan, Martina
Cc: Gishkori, Esther; Hainey, Lynne; Wright, Richard; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB
Importance: High

Richard/Simon/Esther
Colin & Martina & I met with the urology consultants this am, at which we shared with them all the events that had been taking place and the decisions that had been taken.
From this meeting we need to answer a few questions

1- What are the ToR for the investigation/review
2- How long would you expect the review to last?
3- What was Mr O Brien advised re the undictated outpatient clinics i.e. can he dictate or has he to cease having anything to do with the outstanding backlog
4- What is the Trust's position on Mr O Brien undertaking private work and in particular using Trust secretarial staff to type private patient work whilst off?
5- What is the Trust position in regard to notes being transported in staff's private car to and from SWAH? Clinics run twice mthly (2nd & 4th wks)

Mr O Brien contacted Martina and advised that the notes which were not on Trust's premises have been left in his office. Martina has checked and this is confirmed, these notes will be transferred to the med exe office asap to be tracked to Martina on PAS and then a refreshed report will be ran to see if there are any more outstanding.

The Team are going to think/discuss and come back to Colin & I on thurs with how they proposed to complete the actions required associated with review.

Hainey, Lynne

From: Gibson, Simon
Sent: 04 January 2017 12:09
To: Gibson, Simon
Cc: Hainey, Lynne; Wright, Richard; Corrigan, Martina; Carroll, Ronan; Gishkori, Esther; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB

Dear Ronan and Esther

Following discussion with Richard, responses to your queries are below, coloured for ease of reference:

1- What are the ToR for the investigation/review
In line with the MHPS Framework, the TOR will be determined following the 4 week scoping exercise during which the scale of the potential problems are being considered by the Investigating Team

2- How long would you expect the review to last?
As indicated below, the scoping exercise is expected to be completed by 27th January. Once the formal investigation is commenced, it also expected to complete within 4 weeks, but this is dependent upon the complexity of the investigation and could well be extended

3- What was Mr O Brien advised re the undictated outpatient clinics i.e. can he dictate or has he to cease having anything to do with the outstanding backlog
As Mr O'Brien is excluded from work, he is unable to participate in the backlog. As indicated in the action notes from the Oversight Committee on 22nd December, it is expected that a plan for how this backlog will be managed will be presented to the Oversight Committee on 10th January.

4- What is the Trust's position on Mr O Brien undertaking private work and in particular using Trust secretarial staff to type private patient work whilst off?
In line with the MHPS Framework, Mr O'Brien is not completely at liberty to undertake private practice outside the Southern Trust. As his Responsible Officer, Dr Wright advised Mr O'Brien not to undertake private work during the period of this investigation, and to inform any private providers that he was currently excluded from his main employment. The exception to this would be if Mr O'Brien felt there were any patient safety issues; if this was the case, Mr O'Brien was advised that he should arrange transfer of care to a colleague.
However, I would agree with Esthers comments below in relation to secretarial issues.

5- What is the Trust position in regard to notes being transported in staff's private car to and from SWAH? Clinics run twice mthly (2nd & 4th wks)
This should be undertaken in line with Trust procedures; possibly these may need to be reviewed in light of the issues identified

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office

CURWDO	AO Brien Urology cl		0
CURWOB	AOB urology CAH		0
EURAOB	Enniskillen AOB urology	June 2014	147
Totals			**365 charts**

From: Clayton, Wendy
Sent: 23 December 2016 13:02
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Audit of charts re AOB

Ronan / Martina

I have ran a PAS query to see how many charts are tracked out to Mr O'Brien. I believe this will be useful for your meeting next Friday:

Tracking code	Description	No. of charts tracked to AOB
CU2	Mr AOB O'Brien	8
COABO	AOB office	210
CURWDO	AO Brien Urology cl	0
CURWOB	AOB urology CAH	0
EURAOB	Enniskillen AOB urology	147
Totals		**365 charts**

Happy to talk through.

Wendy

Wendy Clayton
Operational Support Lead
ATICS/SEC
Tel: Personal Information redacted by USI
Mob: Personal Information redacted by USI

From: Clayton, Wendy
Sent: 23 December 2016 11:59
To: Carroll, Ronan; Corrigan, Martina
Subject: Audit of charts re AOB

Ronan

I have undertaken an audit of 11 SWAH clinics

There were 183 patients attended, I did a random audit on 98 charts and 55 were tracked to AOB = 56%

Do you want me to do anymore?

Regards

Wendy Clayton
Operational Support Lead

From: Carroll, Ronan
Sent: 28 December 2016 11:05
To: Boyce, Tracey; Wright, Richard; Gibson, Simon
Subject: FW: Audit of charts re AOB

Please see outcome of charts tracking exercise

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

From: Clayton, Wendy
Sent: 23 December 2016 13:10
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Audit of charts re AOB

I have included longest date as requested that the chart has been tracked to the borrower:

Tracking code	Description	Longest date tracked to borrower	No. of charts tracked to AOB
CU2	Mr AOB O'Brien	August 2006	8
CAOBO	AOB office	June 2003	210
CURWDO	AO Brien Urology cl		0
CURWOB	AOB urology CAH		0
EURAOB	Enniskillen AOB urology	June 2014	147
Totals			**365 charts**

From: Clayton, Wendy
Sent: 23 December 2016 13:02
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Audit of charts re AOB

Ronan / Martina

I have ran a PAS query to see how many charts are tracked out to Mr O'Brien. I believe this will be useful for your meeting next Friday:

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CURWDO	AO Brien Urology cl	0
CURWOB	AOB urology CAH	0
EURAOB	Enniskillen AOB urology	147
Totals		**365 charts**

Happy to talk through.

Ramone Building
Craigavon Area Hospital

t: Personal Information redacted by USI
e: Personal Information redacted by USI

From: Cunningham, Andrea
Sent: 19 December 2016 13:09
To: Robinson, Katherine
Subject: FW: Backlog report - no clinic outcomes
Importance: High

Update as discussed.

Regards
Andrea

Andrea Cunningham
Service Administrator
Ground Floor
Ramone Building
CAH

E: Personal Information redacted by USI
T: Personal Information redacted by USI

From: Elliott, Noleen
Sent: 15 December 2016 14:04
To: Cunningham, Andrea
Subject: Backlog report - no clinic outcomes

Andrea,

Please find attached list of clinics with no outcomes completed as per 15th December 2016.

Noleen

Mrs Noleen Elliott
Mr O'Brien's Secretary
Level 2
CRAIGAVON AREA HOSPITAL
Tel No: [redacted]

Gibson, Simon

From: Gibson, Simon
Sent: 20 January 2017 15:09
To: Wright, Richard
Subject: FW: Terms of Reference for Investigation

Dear Richard

Are you OK if I adopt the "less said, the better" on this matter?

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

From: Gishkori, Esther
Sent: 20 January 2017 11:46
To: Carroll, Ronan; Gibson, Simon; Hynds, Siobhan; Toal, Vivienne; Wright, Richard
Subject: Re: Terms of Reference for Investigation

Simon,
I have some concerns in relation to you speaking to Mr Young about anything in relation to this case. However, given the serious misinterpretations between Ronan, you and I, I think another meeting of the oversight committee may be the best next step. Not least to discuss the latest findings of the case. Mr Young would not be aware of any of this.
Just so as I'm clear, did the oversight committee meet since the letter from Mr O'Brien's barrister came in?
I will be in DHH this afternoon so may see you there.
Esther.

Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Friday, 20 January 2017 09:58
To: Gibson, Simon; Gishkori, Esther; Hynds, Siobhan; Toal, Vivienne; Wright, Richard
Subject: RE: Terms of Reference for Investigation

Thank you Simon

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

From: Gibson, Simon
Sent: 19 January 2017 21:49
To: Carroll, Ronan; Gishkori, Esther; Hynds, Siobhan; Toal, Vivienne; Wright, Richard
Subject: Re: Terms of Reference for Investigation

Dear Ronan

Given the below, I can understand your perspective.

Please accept my genuine apologies if the situation was not as interpreted.

Kind regards

Simon

Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Thursday, 19 January 2017 17:25
To: Gibson, Simon; Gishkori, Esther; Hynds, Siobhan; Toal, Vivienne; Wright, Richard
Subject: RE: Terms of Reference for Investigation

Simon
So just that I am able to provide an account of my conversation with Esther following my conversation with you Simon and to make it absolutely clear that have not managed to misinterpret anything. I take exception to this.
I did not tell Esther that the decision had been taken to allow AOB to return to work. What I did say was that I just had had a conversation with you (Simon) the content of which was the possibility of AOB being permitted to return to work following the exclusion period.
Ronan

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

From: Gibson, Simon
Sent: 19 January 2017 15:51
To: Gishkori, Esther; Hynds, Siobhan; Toal, Vivienne; Wright, Richard
Cc: Carroll, Ronan
Subject: RE: Terms of Reference for Investigation

Dear Esther

Somehow, Ronan has managed to completely misinterpret the discussion we had, so I will repeat it here so everyone is clear.

Under MHPS, the period of immediate exclusion can only last for 4 weeks, at which point a decision needs to be made whether to formally exclude an individual, or allow them to return, either with or without restrictions to their duties. This will be a decision vested in nominated managers in the Trust.

With regard to the AOB case, this decision needs to be taken by 27th January. To prepare for this decision, Dr Wright asked that I speak to Michael Young to ask his views as to whether there were duties AOB could undertake, either

independently or with supervision or administrative support, which would be reasonable to allow him to return to work. I have not yet had this discussion with Ronan.

This is as far as we have got.

No decision has been made; we are doing the preparatory work to allow an informed discussion to lead to a decision.

Ronan – I am sorry if this was somehow unclear, but this is the current position.

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

From: Gishkori, Esther
Sent: 19 January 2017 15:31
To: Gibson, Simon; Hynds, Siobhan; Toal, Vivienne; Wright, Richard
Cc: Carroll, Ronan
Subject: RE: Terms of Reference for Investigation

Dear Simon,
Ronan was telling me just now that you have been in touch to say that Mr O'Brien will be returning to work.
He said that the investigating panel has made this decision after a barrister's letter came into the Trust.

Can you update me please?

I need to know how the issue of potential harm to patients will be managed should Mr O'Brien return.
We have not yet had time to scope the potential impact on our patients or organisation yet. This notwithstanding, we know of two red flags that have waited since 20015. They have been asked to come in and we will soon know the outcome of these consultations and investigations.

Best
Esther.

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

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.

Dr Khan asked whether there was any historical health issues in relation to Mr O'Brien, or any significant changes in his job role that made him unable to perform the full duties of Urologist of the Week. There was none identified, but it was felt that it would be useful to consider this.

Decision
As Case Manager, Dr Khan considered whether there was a case to answer following the preliminary investigation. It was felt that based upon the evidence presented, there was a case to answer, as there was significant deviation from GMC Good Medical Practice, the agreed processes within the Trust and the working practices of his peers.

This decision was agreed by the members of the Case Conference, and therefore a formal investigation would now commence, with formal Terms of Reference now required.
Action: Mr Weir

Formal investigation
There was a discussion in relation to whether formal exclusion was appropriate during the formal investigation, in the context of:

- Protecting patients
- Protecting the integrity of the investigation
- Protecting Mr O'Brien

Mr Weir reflected that there had been no concerns identified in relation to the clinical practice of Mr O'Brien.

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 would this monitoring would look like, to ensure the protection of the patient.

The case conference members noted the detail of what this monitoring would look like was not available for the meeting, but this would be needed. It was agreed that the operational team would provide this detail to the case investigator, case manager and members of the Oversight Committee.
Action: Esther Gishkori / Ronan Carroll

It was agreed that, should the monitoring processes identify any further concerns, then an Oversight Committee would be convened to consider formal exclusion.

It was noted that Mr O'Brien had identified workload pressures as one of the reasons he had not completed all administrative duties - there was consideration about whether there was a process for him highlighting unsustainable workload. It was agreed that an urgent review of Mr O'Brien's job plan was required.
Action: Mr Weir

It was agreed by the case conference members that any review would need to ensure that there was comparable workload activity within job plan sessions between Mr O'Brien and his peers.
Action: Esther Gishkori/Ronan Carroll

Following consideration of the discussions summarised above, as Case Manager Dr Khan decided that Mr O'Brien should be allowed to return to work.

This decision was agreed by the Medical Director, Director of HR and deputy for Director of Acute Services.

It was agreed that Dr Khan would inform Mr O'Brien of this decision by telephone, and follow this up with a meeting next week to discuss the conditions of his return to work, which would be:

- Strict compliance with Trust procedures and policies in relation to:
    - Triaging of referrals
    - Contemporaneous note keeping
    - Storage of medical records
    - Private practice
- Agreement to read and comply with GMCs "Good Medical Practice" (April 2013)
- Agreement to an urgent job plan review
- Agreement to comply with any monitoring mechanisms put in place to assess his administrative processes

Action: Dr Khan

It was noted that Mr O'Brien was still off sick, and that an Occupational Health appointment was scheduled for 9th February, following which an occupational health report would be provided. This may affect the timetable of Dr O'Brien's return to work.

It was agreed to update NCAS in relation to this case.
Action: Dr Wright

Gibson, Simon

From: Gibson, Simon
Sent: 19 January 2017 10:46
To: Hynds, Siobhan; Toal, Vivienne; Wright, Richard; Gishkori, Esther
Subject: RE: Terms of Reference for Investigation
Attachments: Terms of Reference for Investigation January 2017 DRAFT FINAL (2).docx

Dear all

I have considered this draft in the context of NCAS advice, and amended to try and make TOR as specific, focussed and quantitative as possible, by adding in the information presented by Ronan at the 10th January meeting.

In particular, the learning from another case in relation to non-chronological scheduling of patients is that this element in particular is better if very specific

Would welcome comments.

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

From: Hynds, Siobhan
Sent: 18 January 2017 13:53
To: Toal, Vivienne; Wright, Richard; Gishkori, Esther
Cc: Gibson, Simon
Subject: Terms of Reference for Investigation
Importance: High

Dear All

Please find attached draft terms of reference for Mr A O'Brien investigation for your comment / approval.

Many thanks

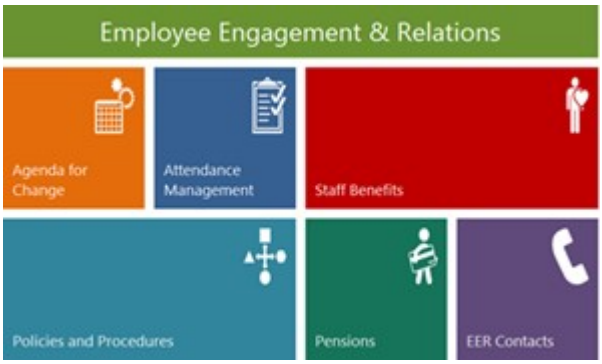
Siobhan

Vivienne

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources Department

Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ

Tel: Personal Information redacted by the USI Direct Line:
Mobile: Personal Information redacted by the USI Fax: Personal Information redacted by the USI



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TERMS OF REFERENCE FOR INVESTIGATION

December 2016

A formal investigation has been initiated into concerns relating to Dr Aidan O'Brien, Consultant Urologist. These concerns arose following the conclusion of a Serious Adverse Incident Investigation, are concerns which are repetitive in nature and highlight Dr O'Brien's failure to comply with remedial action requirements, previously agreed.

The concerns relate to Dr O'Brien's administrative practices, and the potential for patients to have come to harm as a result of those administrative practices. The under noted terms of reference set out the scope of the investigation.

Grade:	Consultant, Urology
Base Hospital:	Southern Health & Social Care Trust Craigavon Area Hospital
The matters to be investigated:	***The below outlines the issues of concern to be investigated, this does not preclude investigation of any further issue of concern which may arise during the course of the investigation.*** **1. To determine whether there have been unacceptable and/or unreasonable delays in the care relating to 783 referral letters untriaged by Mr O'Brien during the period June 2015 to October 2016 and whether patients have come to harm, or had unnecessary delays in treatment, as a result.** **2. To determine whether the length of time the 307 sets of patient notes were stored at home by Dr O'Brien has affected the clinical management plans for these patients either within Urology or within other clinical specialties.** **3. To determine whether there has been an unreasonable delay by Dr O'Brien in dictating clinic outcomes from 668 outpatient consultations, and whether there may have been delays in clinical management plans for these patients as a result.** **4. With an initial focus on patients undergoing an endoscopic resection of their prostate in 2016, to determine whether Dr O'Brien has seen private patients as outpatients and then scheduled the private patients for their procedure on the NHS in non-chronological order, contrary to Trust policies and procedures**

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TRU-267983

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TERMS OF REFERENCE FOR INVESTIGATION

A formal investigation has been initiated into concerns relating to Mr Aidan O'Brien, Consultant Urologist. The concerns relate to Mr O'Brien's administrative practices, and the potential for patients to have come to harm as a result of those administrative practices. The under noted terms of reference set out the scope of the investigation.

Grade:	Consultant, Urology
Base Hospital:	Southern Health & Social Care Trust Craigavon Area Hospital
The matters to be investigated:	***The below outlines the issues of concern to be investigated, this does not preclude investigation of any further issue of concern which may arise during the course of the investigation.*** ***Matters to be investigated:*** **1. (a) To determine if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process.** **(b) To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay in treatment as a result.** **(c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.** **(d) To determine if any un-triaged patient referrals or delayed triages in 2015 or 2016 resulted in patients being harmed as a result.** **2. (a) To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust.** **(b) To determine if any patient notes have been stored at home by Mr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.** **(c) To determine if any patient notes tracked to Mr O'Brien are missing.** **3. (a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'Brien in 2015 or 2016.** **(b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'Brien in dictating outpatient**

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TERMS OF REFERENCE FOR INVESTIGATION

	clinics. **(c) To determine if there have been delays in clinical management plans for these patients as a result.** **4. To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.** **5. To determine if any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.**
Case Investigator:	**Dr Neta Chada, Associate Medical Director** supported Mrs Siobhan Hynds, Head of Employee Relations [redacted]
Case Manager: Designated	**Dr Ahmed Khan, Associate Medical Director (Paediatrics), Daisy Hill Hospital** [redacted]
Board Member	Mr John Wilkinson, Non-Executive Director (contactable via the Chair's Office)

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

Corrigan, Martina

From: Carroll, Ronan <[redacted]>
Sent: 19 November 2018 17:48
To: Gibson, Simon; Haynes, Mark
Subject: RE: MHPS investigation

Simon]
Tks – I am unaware of contact being made
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob [redacted]
Ext [redacted]

From: Gibson, Simon
Sent: 19 November 2018 13:19
To: Haynes, Mark; Carroll, Ronan
Subject: FW: MHPS investigation

Dear Mark and Ronan

Just for information, the below e-mail was sent to Aidan over the weekend.

Did anyone get approached?

Can you inform colleagues not to engage if telephoned in such a way.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
[redacted] (DHH)

From: Khan, Ahmed
Sent: 19 November 2018 13:15
To: Gibson, Simon
Subject: FW: MHPS investigation

Fyi.

AK

From: Khan, Ahmed
Sent: 17 November 2018 14:32
To: Aidan O'Brien; O'Brien, Aidan

Cc: Hynds, Siobhan
Subject: Re: MHPS investigation

Dear Mr O'Brien

It has been brought to my attention that members of your family have been in contact with Trust employees to discuss the ongoing case you are involved in.

This is entirely inappropriate and must cease immediately.

I have informed staff not to engage with your family members if approached in such a way.

I would be grateful for your acknowledgement of this e-mail.

Yours sincerely,

Dr Ahmed Khan

Case Manager- MHPS
Medical Director (Interim)

Sent from my Samsung Galaxy smartphone.

Southern Health and Social Care Trust

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MR A O'BRIEN, CONSULTANT UROLOGIST
RETURN TO WORK PLAN / MONITORING ARRANGEMENTS
MEETING 9 FEBRUARY 2017

Following a decision by case conference on 26 January 2017 to lift an immediate exclusion which was in place from 30 December 2017, this action plan for Mr O'Brien's return to work will be in place pending conclusion of the formal investigation process under Maintaining High Professional Standards Framework.

The decision of the members of the case conference is for Mr O'Brien to return as a Consultant Urologist to his full job role as per his job plan and to include safeguards and monitoring around the 4 main issues of concerns under investigation. An urgent job plan review will be undertaken to consider any workload pressures to ensure appropriate supports can be put in place.

Mr O'Brien's return to work is based on his:

- strict compliance with Trust Policies and Procedures in relation to:
    - Triaging of referrals
    - Contemporaneous note keeping
    - Storage of medical records
    - Private practice
- agreement to comply with the monitoring mechanisms put in place to assess his administrative processes.

Currently, the Urology Team have scheduled and signed off clinical activity until the end of March 2017, patients are called and confirmed for the theatre lists up to week of 13 March. Therefore on immediate return, Mr O'Brien will be primarily undertaking clinics and clinical validation of his reviews, his inpatient and day case lists. This work will be monitored by the Head of Service and reported to the Assistant Director.

CONCERN 1

- That, from June 2015, 783 GP referrals had not been triaged in line with the agreed / known process for such referrals.

Mr O'Brien, when Urologist of the week (once every 6 weeks), must action and triage all referrals for which he is responsible, this will include letters received via the booking

From: Carroll, Ronan
Sent: 18 October 2018 12:39
To: Gibson, Simon; Weir, Colin; Khan, Ahmed; Haynes, Mark
Subject: RE: Return to Work Action Plan February 2017 FINAL.
Importance: High

Simon
I think you are stating the obvious.
With Martina having been off since June the overseeing function has not taken place and in the day to day activities was overlooked
But We need to understand why this the dictation has gone out, this could explain the volume of notes or there may be some other reason
Ronan

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

From: Gibson, Simon
Sent: 18 October 2018 12:31
To: Weir, Colin; Khan, Ahmed; Carroll, Ronan; Haynes, Mark
Subject: RE: Return to Work Action Plan February 2017 FINAL.

Dear Ronan

What is most concerning here is that there were monitoring and supervision arrangements put in place, which we confirmed to a range of interested parties.

If he has a backlog of clinic letters and discharges going back to June, have these arrangements fallen down?

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the 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 the 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 c
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated

Corrigan, Martina

From: Gibson, Simon <[redacted]>
Sent: 24 January 2020 12:57
To: OKane, Maria; Weir, Lauren
Cc: Carroll, Ronan; Haynes, Mark; Corrigan, Martina; Hynds, Siobhan; McNaboe, Ted; Khan, Ahmed; Carroll, Anita; McClements, Melanie; Toal, Vivienne
Subject: FW: For Response - Meeting Request - AOB

Dear Maria

As requested below, I co-ordinated and chaired this meeting. The purpose of the meeting was agreed as consideration of the below points laid out in your e-mail of 17th November, specifically:

1. describe in detail the management plan around the backlog report ,
2. the expectation re compliance
3. and the escalation

to assist a meeting with Mr O'Brien to discuss his deviation from the action plan

Present at the meeting were:

- Simon Gibson
- Ronan Carroll
- Martina Corrigan
- Mark Haynes
- Ahmed Khan

The Backlog Report

The Backlog Report was commenced in approximately 2016, (it existed before though detail and format may have been different) to quantify workload between secretarial and audio-typist staff and allow movement of work where necessary. Information was gathered by completion of a template by secretaries themselves on a monthly basis, when they were asked to quantify the level of work awaiting to be done either by their consultant or themselves.

This information was compiled into a report and circulated to consultant staff, and copied to relevant Heads of Service and Assistant Directors. It was not forwarded to medical staff acting in their capacity as CD or AMD. There appears to be variable consideration of this report by specialties within either patient safety meetings or specialty meetings. It should be noted that one of the reasons this report did not receive regular consideration was that there was some scepticism of the accuracy of this data, as it did not reconcile with individuals own recollection of behaviour or workload of colleagues. In essence, it was felt that there may have been inaccuracies in the data provided by staff. This data was never independently verified, and there was no electronic method of collecting this data. It was never raised in the Patient Safety meetings in Urology, and was not regularly discussed at the Urology specialty meeting.

Expectation re compliance

None of those present at the meeting were aware of any written standards in relation to what was considered reasonable for dictation of results or letters after clinics. The Trust has never stated a standard, and those present were not aware of any standard set externally by Royal Colleges or other organisations. Therefore, on the occasions when this data was considered, there was no agreed standard to use as a gauge against reported performance.

Escalation

As there was some cynicism in relation to the validity of the data, combined with a lack of standards to assess compliance, there was no agreed process for escalating any concerns regarding non-compliance in relation to the monthly backlog report.

It should be noted that those present agreed that the weaknesses identified in the current process described above may cause challenges in taking forward this issue with Mr O'Brien

In concluding the discussion, those present felt that the best way to move this topic forward was for a group of interested staff to:

1. *Agree and describe why this information is being collated: for example, is it largely for resource / secretarial workload*
2. *Disaggregate into two areas those indicators for which clinicians are responsible and those indicators for which administrative staff are available*
3. *Agree and describe a consistent process for how this information is collated, and the method by which the information can be independently verified*
4. *Provide a Trust wide standard of performance in relation to these performance indicators which all clinical staff should be expected to adhere to*
5. *Agree the process for escalation for when monthly information indicates a deviation from this Trust wide standard of performance*

Considering the processes outlined above in the wider sense of supporting medical staff who have had issues identified, I feel there would be benefits in an urgent discussion regarding the day-to-day management of Mr O'Brien by his operational line management team to ensure that supervision of his administrative duties are being carried out as expected. This would allow an opportunity to identify if there are any concerns starting to emerge, so that appropriate supports can be offered to Mr O'Brien, to ensure that concerns do not continue.

Happy to discuss.

Kind regards

Simon

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

From: OKane, Maria
Sent: 17 November 2019 12:11
To: Hynds, Siobhan; Khan, Ahmed; Haynes, Mark; Carroll, Ronan; Gibson, Simon
Cc: Weir, Lauren
Subject: RE: FW: Backlog Report - October 2019

Thanks Siobhan.

Simon can I ask that you coordinate a meeting which I am asking you to minute please asap to

1. describe in detail the management plan around this ,
2. the expectation re compliance
3. and the escalation.

It will be important before all of you meet with Mr O'Brien that you have this process well described and documented – process mapping this might be the most useful approach.

centre and any letters that have been addressed to Mr O'Brien and delivered to his office. For these letters it must be ensured that the secretary will record receipt of these on PAS and then all letters must be triaged. The oncall week commences on a Thursday AM for seven days, therefore triage of all referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends.

Red Flag referrals must be completed daily.

All referrals received by Mr O'Brien will be monitored by the Central Booking Centre in line with the above timescales. A report will be shared with the Assistant Director of Acute Services, Anaesthetics and Surgery at the end of each period to ensure all targets have been met.

CONCERN 2

- That, 307 sets of patient notes were returned by Mr O'Brien from his home, 88 sets of notes located within Mr O'Brien's office, 13 sets of notes, tracked to Mr O'Brien, are still missing.

Mr O'Brien is not permitted to remove patient notes off Trust premises.

Notes tracked out to Mr O'Brien must be tracked out to him for the shortest period possible for the management of a patient.

Notes must not be stored in Mr O'Brien's office. Notes should remain located in Mr O'Brien's office for the shortest period required for the management of a patient.

CONCERN 3

- That 668 patients have no outcomes formally dictated from Mr O'Brien's outpatient clinics over a period of at least 18 months.

All clinics must be dictated at the end of each clinic/theatre session via digital dictation. This is already set up in the Thorndale Unit and will be installed on the computer in Mr O'Brien's office and on his Trust laptop and training is being organised for Mr O'Brien on this. This dictation must be done at the end of every clinic and a report via digital dictation will be provided on a weekly basis to the Assistant Director of Acute Services, Anaesthetics and Surgery to ensure all outcomes are dictated.

An outcome / plan / record of each clinic attendance must be recorded for each individual patient and this should include a letter for any patient that did not attend as there must be a record of this back to the GP.

Cc: Hynds, Siobhan
Subject: AOB concerns - escalation

Dear Dr Khan

As requested, please see below which I am escalating to you (emails attached showing where I have been asking him to address)

CONCERN 1 –not adhered to, please see escalated emails. As of today Monday 16 September, Mr O'Brien has 26 paper referrals outstanding, and on Etriage 19 Routine and 8 Urgent referrals.

CONCERN 2 – adhered to – no notes are stored off premises nor in his office (this is only feasible to confirm as there have been NO issues raised regarding missing charts that Mr O'Brien had)

CONCERN 3 – not adhered to – Mr O'Brien continues to use digital dictation on SWAH clinics but I have done a spot-check today and:

Clinics in SWAH
EUROAOB – 22 July and 12 August all patients have letters on NIECR
Clinics held in Thorndale Unit, Craigavon Area Hospital
CAOBTDUR - 20 August 2019 had 12 booked to clinic 11 attendances & 1 CND but no letters at all
CAOBUO – 23 August 2019 – 10 attendance and only 1 letter on NIECR
CAOBUO – 30 August 2019 – 12 booked to clinic, 1 CND, 1 DNA and 0 Letters on NIECR
CAOBUO – 3 September – 8 booked to clinic – 0 letters on NIECR

I have asked Katherine Robinson to double-check that these are not in a backlog for typing and I will advise

CONCERN 4 – adhered to – no more of Mr O'Brien's patients that had been seen privately as an outpatient has been listed,

Should you require anything further, please do not hesitate to contact me.

Regards

Martina

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

From: Khan, Ahmed
Sent: 01 October 2019 16:13
To: OKane, Maria; Hynds, Siobhan
Cc: Gibson, Simon; Haynes, Mark; Weir, Lauren
Subject: RE: AOB concerns - escalation

Maria, I understand we are awaiting more details from Martina. Just spoke to Mark, he think number of non-adherence to agreed action plan.
Thanks, Ahmed

From: OKane, Maria
Sent: 30 September 2019 12:31
To: Khan, Ahmed; Hynds, Siobhan

	situation outside of the scheduled ELA/RO Meetings. See also MHPS and DHSSPS revised "Guidance on the Role of Responsible Officers For Doctors and Employers".		
2. Timing of Referrals:	**2. Timing of Referrals:** It should not be assumed that referrals should only be made to GMC after the conclusion of local investigations. There are many situations where referral should be made at an earlier stage. Where a matter is referred to GMC, the local investigation should of course continue to its conclusion. An example of one situation where a referral should be made to the GMC before the completion of a local investigation is where the doctor could be working elsewhere without your knowledge; an early referral to the GMC will allow for consideration of interim orders to restrict/suspend the doctor's practice, wherever the doctor is working, thus protecting patient safety. Again, the GMC Employer Liaison Adviser is available to discuss any individual situation. See also MHPS and DHSSPS revised "Guidance on the Role of Responsible Officers For Doctors and Employers"		
Dr Urology Consultant	**RW advised:** SAI almost complete and MHPS investigation in progress involving concerns about a urology consultant competence re administration of his urology clinic in the SHSCT- including timeliness of recording of patient contact, referrals, follow up testing required. No actual patient harm, but potential patient harm - the event that triggered the SAI was a late diagnosis; it was initially decided that the doctor would be excluded from work (an alert letter was sent from the Dept. of Health), while the scope of the concerns was explored however exclusion was lifted and he is permitted to work with supervision of his admin responsibilities. However- during the period of the exclusion he was off on sick leave, and remains on sick leave- he had surgery. He is to attend	**ACTION: RW to** send JD a copy of the SAI Report, re Dr Urology Consultant, as soon as he receives it. **ACTION: RW to** double-check (given ROs'	Category Monitor

	there are concerns. GMC expectation is that ROs may wish to discuss these cases with the ELA– to obtain advice/guidance, including advice/guidance on GMC thresholds for referral and thus assure themselves that local procedures alone continue to be the appropriate approach; mindful of course that (1) discussing a case with the ELA does not amount to a "referral" to the GMC and (2) discussions with the ELA may be on an anonymous basis- i.e. the doctor does not have to be identified. The GMC Employer Liaison Adviser is available to discuss any individual situation outside of the scheduled ELA/RO Meetings. See also MHPS and DHSSPS revised "Guidance on the Role of Responsible Officers For Doctors and Employers".		
2. Timing of Referrals:	**2. Timing of Referrals:** It should not be assumed that referrals should only be made to GMC after the conclusion of local investigations. There are many situations where referral should be made at an earlier stage. Where a matter is referred to GMC, the local investigation should of course continue to its conclusion. An example of one situation where a referral should be made to the GMC before the completion of a local investigation is where the doctor could be working elsewhere without your knowledge; an early referral to the GMC will allow for consideration of interim orders to restrict/suspend the doctor's practice, wherever the doctor is working, thus protecting patient safety. Again, the GMC Employer Liaison Adviser is available to discuss any individual situation. See also MHPS and DHSSPS revised "Guidance on the Role of Responsible Officers For Doctors and Employers"		
Dr Urology Consultant	**RW advised previously (8.2.17):** SAI almost complete and MHPS investigation in progress involving concerns about a urology consultant competence re administration of his urology clinic in the SHSCT- including timeliness of recording of patient contact, referrals, follow up testing required. No actual patient harm, but potential patient harm - the event that triggered the SAI was a late diagnosis; it was initially decided that the doctor would be excluded from work (an alert letter was sent from the Dept. of Health), while the scope of the concerns was explored however	**ACTION: RW to** send JD a copy of the SAI Report, re Dr Urology Consultant, as soon as it is completed	Category Monitor

	exclusion was lifted and he is permitted to work with supervision of his admin responsibilities. However- during the period of the exclusion he was off on sick leave, and remains on sick leave- he had surgery. He is to attend SHSCT occupational health. He does not do any other work outside the SHSCT except for seeing private urology patients in his home - first appointments only to advise the patient on whether they need referred for further testing/investigation; undertakes physical examination/takes history only - no testing/medical treatment. RW is currently satisfied that there are no patient safety issues- MHPS investigation is at an early stage. **JD/RW agreed previously (8.2.17):** that RW will send JD a copy of the SAI Report as soon as he receives it. **Agreed previously (8.2.17) - RW will also:** double-check (given ROs' responsibility for whole-practice appraisal) that he is satisfied with the nature of the assurances he has about the doctor's private work - including verification/triangulation of any information provided by the doctor himself about his private work. He will also find out whether the doctor's private clinic is/should be registered with the RQIA. **RW advised:** SAI Investigation is not yet complete - there had been a delay at the start because of difficulties identifying a Chair. Julian Johnston is now acting as chair. **JD asked:** whether issues re private work have been resolved to his satisfaction - do the same restrictions apply to the doctor's private work as apply to his work in the SHSCT; RW, as RO, is responsible for the FTP of the doctor irrespective of where he/she works, arguable, an RO bears a greater risk in respect of a doctor's work outside the doctor's main designated body. JD asked whether RQIA regulates the private medical work that the doctor does from his home.	**ACTION: RW to consider** (given ROs' responsibility for FTP of connected doctors wherever they work) that he is satisfied with the nature of the assurances he has about the/restrictions on the doctor's private work - including verification/triangulation of any information provided by the doctor himself about his private work. **ACTION: JD** to seek confirmation from RQIA re their role re regulation of doctor's who work privately from home. And to update RW.	

Toal, Vivienne

From: Hynds, Siobhan [redacted] >
Sent: 09 January 2019 22:19
To: Toal, Vivienne
Subject: FW: SHSCT - "Dr Urology Consultant"- advice to refer
Attachments: FW: IMPORTANT - Redacted MHPS investigation into AOB (72.7 KB)

Importance: High

FYI

From: Joanne Donnelly ([redacted]) [mailto:[redacted]]
Sent: 09 January 2019 16:56
To: Gibson, Simon
Cc: OKane, Maria; White, Laura; Hynds, Siobhan; Moiza Butt ([redacted]); Support TeamELS
Subject: RE: SHSCT - "Dr Urology Consultant"- advice to refer
Importance: High

Dear Simon,

Thank you for your e-mail. Apologies for the delay in replying to your e-mail- due to annual leave.

I note that the attached report refers to a number of concerns including: (1) issues that may be classed as probity concerns (advantage to patients who had seen him first in a private capacity- which may have resulted in advantage to doctor); (2) actual harm to at least 5 patients and potential harm to a large number of patients (relating to delayed cancer diagnosis and significant delays in commencing appropriate treatment); (3) failure to make contemporaneous notes in patient records; (4) potential breach of patient confidentiality – keeping patient notes at doctor's home.

On the basis of the information you have provided – these concerns appear to me to meet the threshold for referral to the GMC as they are allegations of serious and persistent failures to practise in accordance with the principles set out in Good Medical Practice (I acknowledge that the doctor's practice is currently restricted in the interests of patient safety and that the doctor is complying with a local action plan).

Please do not hesitate to contact me should you wish to discuss further. See GMC guidance **GMC Thresholds**: https://www.gmc-uk.org/-/media/documents/dc4528-guidance-gmc-thresholds_pdf-48163325.pdf

I note the comments in the report about management responsibility and note also the date(s) of the original incident(s)- if you would find it helpful to discuss this also I am of course happy to do so.

Best wishes
Joanne

Joanne Donnelly [redacted])
GMC ELA for NI

[redacted] – Ftp – refer – SHSCT – Dr Urology - advice to refer- probity/record keeping/confidentiality/ - all impacting on clinical competence/patient safety (9.1.19)

From: Gibson, Simon [mailto:[redacted]]
Sent: 18 December 2018 10:53
To: Joanne Donnelly ([redacted])
Cc: OKane, Maria; White, Laura; Hynds, Siobhan
Subject: FW: SHSCT - "Dr Urology Consultant"

Dear Joanne

Following our meeting, please find attached redacted MHPS investigation as discussed.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
[redacted] (DHH)

From: Joanne Donnelly ([redacted]) [mailto:[redacted]]
Sent: 12 December 2018 11:47
To: OKane, Maria
Cc: Support TeamELS; Gibson, Simon; Parks, Zoe
Subject: SHSCT - "Dr Urology Consultant"

Dear Maria,

At the local concerns part of our meeting on 4 Dec 18 we discussed "Dr Urology Consultant"; I understand that Simon advised that he would forward to me the relevant SAI and MHPS reports.

I look forward to hearing from you/Simon in this regard.

Best wishes
Joanne

[redacted] - FTP- monitor – SHSCT - Dr Urology Consultant- concerns re timeliness of management of patient triaging/referrals (12.12.18)