Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 24 of 2022
Date of Notice: 29th April 2022

Witness Statement of: Martina Corrigan

I, Martina Corrigan, will say as follows:-

General

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 commenced as Head of Service for ENT and Urology in September 2009, having previously worked in the Western Trust in various roles from 1987 until 2009 – this is addressed in more detail in Question 4. The Head of Service role was a new post that had been created along with Head of Service for General Surgery, Breast and Endoscopy and Head of Service for Trauma and Orthopaedics and Ophthalmology, which all sat in the Surgery and Elective Care Division in the Acute Directorate.

1.2 I remained in the role of Head of Service until June 2021, when I moved into my current role of Assistant Director for the Public Inquiry and Trust Liaison.

72. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

72.1 Having read through my responses to all of the above questions, and based on the knowledge I have of matters at present, I can confirm that I have nothing further to add.

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: 

Date: 06/07/2022

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 40 of 2022

Date of Notice: 29th April 2022

Witness Statement of: Martina Corrigan

I, Martina Corrigan, will say as follows:-

General

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

I. I refer to and rely upon my answer at paras 1.1, 1.2, 1.7, and 1.8 (up to and including para (k) of my statement in response to Section 21 Notice No.24 of 2022.

2. Provide any and all documents within your custody or under your control relating to paragraph (e) of the Terms of Reference except where those

Statement of Truth

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

Signed: 

Date: 15 July 2022

a. Mr O'Brien – became Chair of the NICAN Urology Group along with the Chair of the local Oncology Multi-disciplinary Team
b. Mr Glackin – became Chair of the Urology Patient Safety Meetings
c. Mr Haynes – became Clinical Director for General Surgery/ENT and Urology
d. Mr Haynes – became Associate Medical Director for Surgery and Elective Care which included (Urology/ENT/General Surgery and Trauma and Orthopaedics 1 October 2017.
e. The Chair of the Oncology MDTs changed from Mr O'Brien to a rotational role among Mr Haynes, Mr Glackin, Mr O'Brien, and Mr O'Donoghue
f. From 1 September 2017 Clinical Nurse Specialists K O'Neill and J McMahon were re-banded from Band 7 Clinical Nurse Specialist to Band 8A and they came out of day to day management and concentrated on clinical work only.

    i Part of the rationale for this re-banding was their move through training to start to undertake nurse-led procedures that had previously been undertaken by consultants and by non-consultant medical staff. Sr McMahon can now do independent nurse-led flexible check cystoscopies for patients who had previous bladder cancer and require regular surveillance. She is also the nurse-lead for urodynamics and can make independent decisions on these diagnostic tests. She also runs and manages the Lower Urinary Tract clinics which takes pressure from consultants in this common urological condition having to treat these patients. Sr McMahon also is the first Clinical Nurse Specialist in Northern Ireland independently to administer Botox into the Bladder for urinary symptoms.
    ii Sr O'Neill has now been trained to do prostate biopsies, a procedure that had always been done by either a consultant, registrar or staff grade doctor. Sr O'Neill is the first Clinical Nurse Specialist in Northern Ireland to do this; she originally was trained

b. Whilst it has greatly improved in recent years, particularly under the leadership of our previous Medical Director, Dr O'Kane, I do feel there needs to be a better inclusion of the non-clinical managers with the clinical managers. This will help to highlight clinical issues as well as the non-clinical issues and, whilst I had a very good working relationship with my clinical managers, I know that this is not necessarily the case for other specialties. Whilst this Public Inquiry is focused on the Urology Service, I think it is obviously important that any lessons or improvements of broader relevance to the Health Service here are captured and implemented.

c. Learning from Serious Adverse Incidents/complaints should not be done in isolation of each individual event and trends should have been picked up earlier, for example, not reading results, delays in contact with patient/family, and lack of correspondence after patient attendance. Also, delay in completing the SAIs and complaints sometimes meant, or at least ran the risk, that another event had occurred before the recommendations could be implemented. The Patient 16 case, *which can be located in Folder – Relevant to Acute, Document Number 51, 51L with or between any patient or family member of a patient,* Patient 16 *- 20200203 Final Report 69133* happened in 2016 but the report was not signed off until 2020, so the learning of this was not available and some of the points were then raised in the SAIs of 2020

Document attached namely;
364. 20210421 - overarching report to HSCB on 9 SAI's
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

d. In my opinion, the governance departments do not have enough human resources. Therefore, more resources should be aligned to governance, particularly support to operational managers who

assistant director to support the director and, as previously mentioned, I requested a secondment, applied for the post, and was successful.

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 I can confirm that most of the documents relevant to my responses have been provided by the Trust. Any additional documents are being provided in response to this Section 21 notice.

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 and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.**

Your position(s) within the SHSCT

4. **Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.**

4.1 Qualifications:

5.1 From September 2009 until June 2021 I was Head of ENT, Urology, Ophthalmology and Outpatients. (Band 8B). This role entailed being responsible for the operational management and strategic development of ENT, Urology, Ophthalmology and Outpatients across the Southern Trust. I was responsible for leadership, service provision and service development of ENT, Urology, Ophthalmology and Outpatients and ensuring high quality patient centred services. I was responsible for achieving service objectives through the implementation of national, regional and local strategies and access targets. I worked in partnership with the Assistant Director, Associate Medical and Clinical Director to define a service strategy, which support the Trust's and Directorate's overall strategic direction and ensures the provision of a high quality responsive service to patients within resources. As a head of service, I was a member of the division's senior management team and contributed to policy development within the division towards the achievement of its overall objectives. It is important to note that, from October 2020 to June 2021, Wendy Clayton shared this Head of Service post with me. She mainly covered the day-to-day operational aspect and I worked with Dr O'Kane, Melanie McClements, Ronan Carroll, Mark Haynes, and Vivienne Toal on the issues emerging from the further concerns about Mr O'Brien that emerged in June 2020.

The following document is attached 1. Head of Urology and ENT Job Description and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

5.2 When I first took up post in September 2009 I was employed as the Head of Service for ENT and Urology. In and about 2011 when the Trust moved to using HRPTS (Human Resource Database) there needed to be a Head of Service responsible for Outpatients and, with my previous history of managing outpatients in the Western Trust, my Assistant Director, Heather Trouton, asked me to take on this role and I agreed as I had a Lead Nurse, Connie Connolly, who managed the day to day running of this area.

and harassment towards Mr O'Brien and that he needed to step back from managing him. I was not present when Mr Mackle was told this but he came straight to me after this happened, told me about it, and was visibly annoyed and shaken and said to me that he would no longer be able to manage Mr O'Brien. I also understand that, in mid-2016, Mrs Gishkori received a phone call from the then Chair of the Trust, Mrs Brownlee, and was requested to stop an investigation into Mr O'Brien's practice. Once again, I did not witness this but I was told later by Mr Carroll that it happened as my understanding is that Mrs Gishkori had told some of her team.

Governance – generally

31. What was your role regarding the consultants and other clinicians in the unit, including in matters of clinical governance?

31.1 My role in governance for all my areas was to promote and ensure that there was high quality and effective care offered to all patients and to ensure that services were maintained at safe and effective levels. I can confirm that I didn't have a direct management role regarding the consultants and other clinicians in the Thorndale Unit.

32. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately?

32.1 The Director of Acute Services had overall responsibility for the governance arrangements in the Urology Service. During my tenure the Directors were:

a. Dr Gillian Rankin;
b. Mrs Debbie Burns - supported by Dr Tracey Boyce (Director of Pharmacy);
c. Mrs Esther Gishkori – supported by Dr Tracey Boyce (Director of Pharmacy);

6. I refer to and rely upon my answer at para 45.2 of my statement in response to Section 21 Notice No.24 of 2022 where I detail concerns regarding staff members (other than Mr O'Brien) where I had some involvement. However, I can confirm that, whilst dealing with these concerns, I did not apply or implement either the MHPS Framework or Trust Guidelines.

7. If you were not aware of or had not previously implemented or applied MHPS and/or the Trust Guidelines, what was your understanding of how you should address concerns relating to the performance of clinicians? How, if at all, did this understanding inform your response to concerns you were aware of regarding urology services?

7.1 I can confirm that I had not previously implemented or applied the MHPS Framework or Trust Guidelines in my role but my understanding, and what I confirm I did during my tenure, was that, if there was a concern with a member of clinical staff highlighted or brought to my attention, I raised this with either the Clinical Lead of Urology (Mr Young), and/or the Clinical Director (Mr Brown), and/or the Associate Medical Director (Mr Mackle from 2009 - 2016; Dr McAllister from April 2016 - October 2016; and Mr Haynes from 2017-2021), and my Assistant Directors (Mrs Trouton from 2009-2016; and Mr Carroll from 2016-2021), who would then have addressed the concerns or issues raised as referenced in Question 6.

Handling of Concerns relating to Mr O'Brien

8. In respect of Mr Aidan O'Brien:

   I. When and in what circumstances did you first become aware of concerns, or received information which could have given rise to concerns?

8.1 I refer to and rely upon my answer at paragraph 54.1 of my statement in response to Section 21 Notice No.24 of 2022. *Please also note in this regard that, in responding to this question and referring to Section 21 Notice No.24 of 2022, I have noticed a numbering error at paragraph 54.1*

From: Avril Frizell [redacted]
Sent: 22 February 2023 12:06
To: Donnelly, Anne [redacted]; Benson, Shauna [redacted]; Murphy, Eoin [redacted]
Cc: Emmet Fox [redacted]; Keeva Wilson [redacted]
Subject: Martina Corrigan URGENT
Importance: High

"This email is covered by the disclaimer found at the end of the message."

Dear All

Further to Ms Corrigan's consultation with Inquiry Counsel on Monday, whereupon Ms Corrigan indicated that's he had drafted a letter to Mr O'Brien which she in turn provided to Mr Mackle and Ms Trouton.

Ms Corrigan has located the draft letter which she emailed to Mr Mackle and Heather Trouton on 18 January 2016. Please see attached copy email and draft letter for the Inquiry's urgent attention.

Kind regards

Avril Frizell

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 18 January 2016 15:22
To: Trouton, Heather; Mackle, Eamon
Subject: Confidential letter to AOB - January 2016
Attachments: Confidential letter to AOB - January 2016.docx

Importance: High
Sensitivity: Confidential

Follow Up Flag: Follow up
Flag Status: Flagged

Dear both,

Apologies for not getting this to you sooner but I wanted to rerun and update the information before including this in this correspondence. I wasn't sure if this was a joint letter but I have put it from a plural perspective, so this may need changed.

Hope it is ok and if there is anything else needed please do not hesitate to give me a shout….

Regards

Martina

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

Telephone: [redacted] (direct dial)
Mobile: [redacted]
Email: [redacted]

Dear Aidan,

There have been a number of areas of your clinical practice that has been brought to our attention and we feel that we need to address these with you in order to have assurance that these will improve. These are as follows:

Untriaged outpatient referral letters

There are currently 253 untriaged letters outstanding from the periods of time when you were oncall; these are dating back to November 2014. We have been advised that whilst the Booking Centre does book these patients onto clinics as their date comes up there is a clinical issue for us in that we do not have assurances that these patient letters have been read so as to give an indication of their priority. Therefore the Trust do not know which waiting list they should actually be on, for example do they remain on Routine, should they have been upgraded to Urgent, Red Flag etc. We have been informed that none of the original 253 letters have not been returned from you to the Booking Centre and the Integrated Elective Access Protocol which governs the turnaround time for triage, states that this should be done within 72 hours (although we recognise that this is not always possible the maximum time to return triage letters is 1 week). At the moment the longest untriaged letter is now 60 weeks!

You will appreciate the issue for us is that we do not know what is within these untriaged letters, as you are the only consultant to have seen these and whilst we have been given assurances that they will be seen within their timescale (therefore not disadvantaged), we are not sure if the priority given by the GP is correct and then from this end the patient is disadvantaged in that their treatment has not been started at an earlier time if that was what had been agreed if the letter had been upgraded.

Current Review Backlog up to 31 December 2015

Total in Review backlog = 753

2013	76
2014	356
2015	321

Aidan, we need assurances that there are no patients contained within this backlog are Cancer Surveillance patients. We have been advised that you have now a separate oncology waiting list but there are currently 276 patients waiting on this with the longest supposed to have had a date in September 2013. We have no assurances that those patients in the ‘older’ backlog are not clinically urgent patients. Therefore we need a plan on how these patients will be validated and how you propose to address this backlog.

Patient centre letters and recorded outcomes from Clinics

The above has been highlighted to us from a few different sources. Firstly, from consultant colleagues from not only Urology but from other specialties, who are frustrated as there is no record for your patients on Patient Centre or on some occasions nothing has been recorded in the Patient notes. This issue has also been picked up whilst trying to validate waiting lists for review backlog patients and also for In and Day Patient Waiting Lists, and the lack of a record means that no decision can be made on whether a patient needs to be reviewed, discharged etc, and when they do come to clinic they have to be treated as a new patient because there is no previous information to base decisions on.

We have also had it escalated that there are no outcomes recorded from your clinics and as there is no letter dictated, staff are not able to record a decision on the patient, e.g. should they be added to a review list, should they be added for urodynamics, Flexible Cystoscopy, inpatient, day procedure or actually discharged back to the GP? I am sure you would agree that this lack of documentation is not fair on the patient nor on the admin staff who are trying to manage this.

Patient Notes at home

Aidan, we are aware that this has been an ongoing issue with you for years and this needs addressed urgently please. All patient hospital notes that you have in your home, needs to be brought to the hospital without further delay. We have been advised that you are being requested a few times a week to bring patient notes in from home, these are needed for clinics, patient admissions or filing. This is a big governance risk and needs addressed and ceased immediately.

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: 028 3861 2025

IX. Following the issuing of the letter, was an action plan to deal with the concerns ever received from Mr O'Brien and if not, were further requests made for its production requested?

9.20 I can confirm that, to the best of my knowledge, Mr O'Brien didn't provide an action plan to deal with these concerns to either Mrs Trouton or Mr Mackle and I can confirm that I was never provided with an action plan from Mr O'Brien.

9.21 I can confirm that I didn't make any further requests to Mr O'Brien for an action plan and, to the best of my knowledge, there were no further requests by any other managers (although this can be definitively confirmed by them).

9.22 In April 2016, due to the Director of Acute Services, Mrs Gishkori, reorganising her structure, Mr Carroll replaced Mrs Trouton as Assistant Director and Mr Mackle resigned from his post of Associate Medical Director. As Mr O'Brien had been issued with the 23 March 2016 letter on 30 March 2016 at our meeting, it is my opinion that this change in personnel meant that the letter of March 2016 was not followed up as it should have been. On reflection, this was a failing on my part and on the part of others, including those who replaced Mrs Trouton and Mr Mackle.

9.23 As part of Mr Carroll's handover, I sent him an email on 28 April 2016 updating him on (amongst other issues) the letter that had been given to Mr O'Brien on 30 March 2016. In this email I advised him that, whilst we had no Associate Medical Director or Clinical Director in post, the Medical Director (Dr Wright) was aware of the issues. I also advised Mr Carroll that Mr O'Brien had been asked to respond within four weeks and that as of the date of the email there had been nothing received.

Meeting with Mr O'Brien, Mr Weir, Mrs Corrigan
11:30am – 9th March 2017 – AMD Office – Admin Floor

Purpose of the meeting was as a follow on from Mr O'Brien's return to work meeting that took place with Mr O'Brien and Mr Weir on Friday 24 February 2017. (Mrs Corrigan was on Annual Leave).

Following topics was discussed:

1. **Enniskillen Clinics**

   Mr O'Brien reiterated his wish to go to the clinics in South West Acute Hospital (SWAH) on a monthly basis as he felt that it wasn't fair that patients had to travel. Mr Weir advised that it wasn't that we would be stopping him from doing these clinics altogether but this was to facilitate his return to work after surgery and that we planned to reinstate them after a few months. However, Mr O'Brien advised that he was feeling much better since his surgery and that the journey would no longer be an issue for him and again this was needed to accommodate the Fermanagh patients and prevent them having to travel.

   It was agreed therefore that he could start back as soon as possible and that Mrs Corrigan would look to see when the next suitable date would be. *Follow-up note: Mrs Corrigan has checked and there are no suitable Monday's available in April:*
   3rd – Review Clinic booked for CAH
   10th – Mr O'Brien is Urologist of the Week
   17th – Easter Monday
   24th – Mr Young has a clinic
   Mrs Corrigan has advised Mr O'Brien of this by email and that the next clinic would be held on Monday 8th May 2017.

   Mrs Corrigan also to check is it possible to for Mr O'Brien to use his laptop in SWAH and do his digital dictation from there.
   Follow-up note: Mr Young is going to SWAH on Monday 13th March and has agreed to trial this on his laptop and report back, if this doesn't work then Mrs Corrigan to contact IT in SWAH to see is there any way that we can link their digital dictation to our systems.

   It was agreed that Mr O'Brien would see 16 patients (8 x AM and 8 x PM) on these clinics and that he would get one hour to dictate at the end of the clinic. Mr O'Brien agreed to this and that he would not leave SWAH until all the charts had been dictated on.

   Mr Weir asked Mr O'Brien was this fair and to which Mr O'Brien replied '*nothing about job plans was fair*'.

Gibson, Simon

From: Carroll, Ronan [redacted]
Sent: 08 May 2017 09:20
To: Corrigan, Martina
Cc: Khan, Ahmed; Hynds, Siobhan
Subject: RE: MHPS case update on 5 May 2017

Importance: High

Martina
I would wish our auditing to continue weekly the reason being if anything starts to slip we can act quickly
Siobhan re notes in his office – what went to AOB regarding this?
Ronan

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

From: Corrigan, Martina
Sent: 05 May 2017 15:11
To: Carroll, Ronan
Subject: RE: MHPS case update on 5 May 2017

Ronan

I have updated this but note that Dr Khan wants monthly update which would be end of next week – do you want to send or will I update again next week?

Concern 1

Mr O'Brien has not been oncall since 6-12 April as per last update. He is due to be Urologist oncall from 18 May and I will update once he has finished this week.

Concern 2

Apart from the 13 already identified missing notes Mr O'Brien has 68 further charts in his office which are all recent and are awaiting for results. There are no other missing charts and no evidence of charts being taken off-site.

Concern 3

I can confirm that all clinics that Mr O'Brien has done since his return to work have been dictated on by digital dictation and all patients have a plan and outcome included.

Concern 4

Mr O'Brien has had theatre lists on 5th and 26th April and on 3rd May
There were a total of 17 patients listed and I can confirm none were previous private patients

Martina

Martina Corrigan

From: Corrigan, Martina [redacted]
Sent: 21 June 2017 15:24
To: O'Brien, Aidan
Cc: Weir, Colin
Subject: charts in office

Dear Aidan

As you are aware I have been asked to monitor the points that were discussed with regards to your return to work.

One of the points was that *Notes should never be stored off site and should only be tracked out and in your office for the shortest time possible*.

I have been monitoring this regularly and note that the amount of notes stored in your office has increased and therefore the length of time they are being kept is increasing:

The below charts are currently the longest tracked to you CAOBO :

Since January 2017

[redacted] – 12 January 2017

Since February 2017

[redacted] – 27 February 2017
[redacted] – 24 February 2017
[redacted] – 24 February 2017
[redacted] – 24 February 2017
[redacted] – 3 February 2017

Since March 2017

[redacted] – 16 March 2017
[redacted] – 23 March 2017
[redacted] – 8 March 2017
[redacted] – 29 March 2017
[redacted] – 29 March 2017
[redacted] – 23 March 2017
[redacted] – 8 March 2017
[redacted] – 23 March 2017
[redacted] – 8 March 2017
[redacted] – 21 March 2017
[redacted] – 23 March 2017.

Also for information according to PAS you have 27 tracked to your office for April 2017, 25 for May 2017 and 16 for June 2017.

I would be grateful if you could work on getting these actioned/returned as I have to report back to the investigating team.

Regards

Martina

Martina Corrigan

Stinson, Emma M

From: Carroll, Ronan
Sent: 15 December 2021 22:32
To: Stinson, Emma M
Subject: FW: triage not returned

Section 21

Ronan Carrroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob - Personal Information redacted by USI .

From: Corrigan, Martina [mailto: Personal Information redacted by USI]
Sent: 11 July 2017 17:40
To: O'Brien, Aidan
Cc: Weir, Colin; Carroll, Ronan
Subject: triage not returned

Aidan

As per your return to work Action Plan:

Concern 1

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 centre and any letters that have been addressed to Mr O'Brien and delivered to his office – for these letters the secretary will have to record receipt of these on PAS and then these letters must all 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.

Any deviation from compliance with the targets will be referred to the MHPS Case Manager immediately.

I have been advised by the booking centre that there are 30 'paper' outpatient referrals not returned from your week oncall and this must be addressed urgently please.

Regards

Martina

Buckley, LauraC

From: Corrigan, Martina
Sent: 25 October 2019 09:28
To: Hynds, Siobhan
Cc: Buckley, LauraC
Subject: FW: triage not returned

Regards

Martina

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

Telephone:
EXT [redacted] (Internal)
[redacted] (External)
[redacted] (Mobile)

From: Corrigan, Martina [redacted]
Sent: 13 July 2017 08:32
To: Carroll, Ronan; Weir, Colin
Subject: FW: triage not returned

Please see Aidan's response below

Martina

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

Changed My Number

INTERNAL: EXT [redacted] if dialling from Avaya phone. If dialling from old phone please dial [redacted]
EXTERNAL [redacted]
Mobile: [redacted]

From: O'Brien, Aidan
Sent: 12 July 2017 13:59
To: Corrigan, Martina
Subject: RE: triage not returned

Martina,

I have just read this email, finding it so demoralising.

I deferred returning these referrals as each day's bundle included patients who needed to be contacted so that the appropriate triage decision could be made.
Whether because of it being the holiday period, it proved difficult, and in some cases, impossible to contact patients.
I therefore returned the referrals, making fail safe decisions, but having kept a record of patients who may require a more immediate management.
One such was Personal Information redacted by the USI who has a stone in her left ureter and who returned my calls this morning to advise that she was in pain, which I expected her to be.
I had returned her triaged referral to have an Urgent Appointment at a New Clinic, whenever that would have happened.
However, I have arranged her admission today for left ureteroscopic lithotripsy on the emergency list.
By virtue of the returned referrals not having been collected today, 12 July, I have been able to amend the triage decision.

I came in to the hospital today to review a couple of patients admitted since their referrals.
Having done so, I thought I would do some work in my office.
Then I read your emails.

I know how referrals are triaged and returned on time!
It is most certainly not by taking the time to ensure that each patient's current state is most appropriately and expeditiously assessed and managed.
As a consequence of my doing so, I have dictated letters to the referring doctors, and to the patients if I have been unable to speak to them by telephone, in over 50 cases, requesting scans, having conditions treated appropriately, and so forth.
By doing so, investigation is progressing and patients are hopefully deriving benefit from treatment.

Having done all of that. I personally would have been better off ticking the box, being at home on my leave.
And Personal Information redacted by the USI, she would also be at home, with persistent colic, awaiting the urgent outpatient appointment.

Aidan.

From: Corrigan, Martina
Sent: 11 July 2017 17:40
To: O'Brien, Aidan
Cc: Weir, Colin; Carroll, Ronan
Subject: triage not returned

Aidan

As per your return to work Action Plan:

Concern 1

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 centre and any letters that have been addressed to Mr O'Brien and delivered to his office – for these letters the secretary will have to record receipt of these on PAS and then these letters must all 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.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 7 of 2022

Date of Notice: 14/04/2022

Witness Statement of: Esther Ann Gishkori

I, Esther Ann Gishkori, will say as follows:-

Paragraph 1.

My name is Esther Gishkori and I was the Director of Acute Services in the Southern Health and Social Care Trust (SHSCT) from August 2015 until June 2020. I graduated from the University of Ulster Jordanstown in 2009 with a masters degree in public administration. I am from a nursing background, and I am also qualified to teach post graduate community nursing students.

This was my first job in the SHSCT. I had previously worked in the South Eastern Health and Social Care Trust (SEHSCT), working there since 1989 when it was Down Lisburn Trust. This was across several operational, governance roles and management roles, the last of which was the Assistant Director of Prison Health Care. A large part of this role was measuring practice in Northern Ireland Prisons against a given set of standards (audit) used elsewhere in the UK. Managing change and conflict as well as education in relation to safe and evidence-based practice was also part of this role. Before this I worked in a governance role (8B) in the "Safe and Effective Care" department of SEHSCT. This involved leading, designing, and completing clinical audit, monitoring trends and patterns in relation to incidents and accidents and leading reparative change. I managed the standards and guidelines team, helping junior doctors design audits and assisted consultants who needed to write or amend policies procedures or guidelines.

Finally, before joining the Southern Trust I had the opportunity to do some consultancy work in The Bahrain Prison System.

Paragraph 2.

Urology Services Inquiry

72. I think the Chief Executive and Medical Director should have a policy on policy writing. I suggested this on numerous occasions as set out in paragraph 2 and 6 above.

73. I have nothing further to add.

74. My employment with the Trust terminated on 30 April 2020 by way of mutual agreement. These terms do not involve anything related to the Terms of Reference of the Inquiry.

75. No.

76. No.

Statement of Truth

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

Signed: EA Gishkori.

Date: 27:6:22

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 35 of 2022

Date of Notice: 29/04/2022

Witness Statement of: Esther Ann Gishkori

I, Esther Ann Gishkori, will say as follows:-

Paragraph 1

My name is Esther Gishkori and I was the Director of Acute Services in the Southern Health and Social Care Trust (SHSCT) from August 2015 until June 2020. I graduated from the University of Ulster Jordanstown in 2009 with a masters degree in public administration. I am from a nursing background, and I am also qualified to teach post graduate community nursing students.

This was my first job in the SHSCT. I had previously worked in the South Eastern Health and Social Care Trust (SEHSCT), working there since 1989 when it was Down Lisburn Trust. This was across several operational, governance roles and management roles, the last of which was the Assistant Director of Prison Health Care. A large part of this role was measuring practice in Northern Ireland Prisons against a given set of standards (audit) used elsewhere in the UK. Managing change and conflict as well as education in relation to safe and evidence-based practice was also part of this role. Before this I worked in a governance role (8B) in the "Safe and Effective Care" department of SEHSCT. This involved leading, designing, and completing clinical audit, monitoring trends and patterns in relation to incidents and accidents and leading reparative change. I managed the standards and guidelines team, helping junior doctors design audits and assisted consultants who needed to write or amend policies procedures or guidelines.

Finally, before joining the Southern Trust I had the opportunity to do some consultancy work in The Bahrain Prison System.

Paragraph 2

My predecessor in the SHSCT was Mrs Debbie Burns. Whilst I had the opportunity to shadow her on occasions throughout the summer of 2015, I didn't receive a handover, neither formal nor informal.

Mine was an operational role, looking after the day-to-day operations of all the acute sites in the Trust. These were Craigavon Area Hospital (CAH) Daisy Hill Hospital (DHH) and South Tyrone Hospital (STH) which did not have an Emergency Department (ED) but had a minor

Urology Services Inquiry

25. I am no longer the Director of Acute Services. I do however believe that the Trust would be more effective and efficient if it observed the fundamentals of multi-disciplinary working and ensuring each individual understands their own role and responsibilities as well as those of others. Throughout my tenure I believed this worked very well within my directorate.
I believe a meaningful, non-judgemental meeting with Mr O'Brien in March 2016 would have been beneficial. This would have allowed attempts to give him the help that was ultimately provided through the formal action plan which was developed months later. The suggestion from Charlie McAllister would again have been a more efficient method to resolve this issue. Operationally therefore, those patients who had not had their referral actioned may have been reviewed at an earlier stage.

Statement of Truth

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

Signed: EA Gishkori.

Date: 27:6:22

Southern Health & Social Care Trust

STRICTLY CONFIDENTIAL

Absence Details for specified staff as at 13 February 2023

Prepared by/HR Contact: Victoria Millar, HR Data Analyst

Prepared for: Emma Stinson, Public Inquiry Team

Ref: ad_2023_056

Date: 13 February 2023

Esther Gishkori Absence Details

Start Date	End Date	Absence Type	Illness
16/03/2017	21/03/2017	Compassionate Leave	
22/03/2017	07/04/2017	Sick Leave	Personal Information redacted by the USI
06/09/2017	08/09/2017	Sick Leave	
20/04/2018	26/04/2018	Sick Leave	
14/06/2018	14/09/2018	Sick Leave	
06/06/2019	30/04/2020	Sick Leave	

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Timeliness Issues & HRPTS Recording - In order to ensure that information is reported correctly from HRPTS, it is essential that on line processes or off line forms are actioned or forwarded for action on HRPTS as soon as possible. Delays will result in reported information not being up to date.

Data Quality - If you believe the information in this report does not accurately reflect the current position, please contact the HR Analytics & Governance Team.

My predecessor in the SHSCT was Mrs Debbie Burns. Whilst I had the opportunity to shadow her on occasions throughout the summer of 2015, I didn't receive a handover, neither formal nor informal.

Mine was an operational role, looking after the day-to-day operations of all the acute sites in the Trust. These were Craigavon Area Hospital (CAH) Daisy Hill Hospital (DHH) and South Tyrone Hospital (STH) which did not have an Emergency Department (ED) but had a minor injuries unit, elective surgery sessions and Out-Patient clinics. There were 4 broad areas I needed to consider as part of my role: Finance, Performance, Governance and Human Resources. In terms of "lines of reporting", I reported to the Chief Executive (who changed 7 times during my tenure) and of course Trust Board who were nonexecutive members and who held the Chief Executive and Directors to account by way of a monthly Trust Board Meeting.

In terms of training, I received a large folder which contained my responsibilities in relation to Trust Board. I no longer retain this folder and expect it is still in the possession of the Trust. I was taken through this folder by the Chair's personal secretary. I also received training on how to deal with the press and how to give an interview to the media. This was delivered by the organisation called "Red Box".

There was no other training of any kind.

My initial objectives were to find out about the Trust and its systems and processes, and what the organisational culture was like.

In terms of guidelines, there was no recognised Trust policy on writing guidelines or policies. A consultant physician decided to write a policy within his field of practice and put it on the Trust website with no problem. This posed many risks at many levels.

I immediately told the CE who agreed that this particular policy should be taken off the website.

I then told the Medical Director and offered to borrow a copy of the policy on the writing of guidelines and policies from the South Eastern Trust. This was an all-inclusive process to the writing, maintaining and monitoring of guidelines and allowed disciplines from all areas to comment and add to the guideline. By means of a systematic process, the author of the policy included /excluded all comments, and this process continued until everyone was satisfied. There were then a strict set of rules as to who can put this guideline onto the intranet.

When Dr Maria O'Kane became Medical Director, I explained the same thing to her and shared the policy from the other Trust. This was not implemented during my tenure.

The Chair of the organisation during my time there was Mrs Roberta Brownlee.

My peers were:

The Director of Human Resources and Organisational Development – Vivienne Toal

The Director of Finance – Stephen McNally / Helen O'Neill

was not usually the issue here. Getting it spent was a recurrent difficulty. Often the Health and Social Care Board (HSCB) allocated money that had to be spent before the end of the financial year in March. This was non recurrent money so staff could not be recruited in time. Every Trust was in the same position so the private sector was saturated and could not facilitate the demand. 3-5 yearly budgets were requested but this was not agreed by the department during my tenure. Another problem was a hospital full of medical patients taking up beds that should have been reserved for surgical patients. Surgery was postponed on a regular basis.

- Human Resources It had always been the case that a senior member of HR was based in and worked solely for the Acute Directorate. Having so many staff in the division, this was an invaluable resource. They dealt with secondments, recruitment, disciplinary issues, job descriptions and anything else that fell within the HR remit

Paragraph 5.

As previously stated, I was responsible for the operational element of delivering the service. To communicate in a meaningful and organised way with my medical colleagues, I met with the Associate Medical Directors (AMD)s monthly. They were appointed by the Medical Director and answered directly to me in terms of operational delivery. They were responsible for the following areas:

Dr Philip Murphy – AMD for medicine and ED

DR Charlie McAllister /Dr Damien Scullian – AMD for anaesthetics (consecutively)

Mr Eamon Mackle / DR Charlie McAllister /Mr Mark Haynes – AMD for surgery (consecutively)

Dr Stephen Hall (now deceased) Dr David Gracey/ Dr Shahid Tariq - AMD for radiology (consecutively)

Dr Martina Hogan – AMD for maternity and women's health.

At the monthly meeting with the AMDs the Assistant Director from that area also attended. It meant that any actions from the meeting would be disseminated to the whole team and go to the appropriate personnel for action. Often the representative from HR or Finance attended depending on what was going to be discussed.

In turn, the AMD had a Clinical Director (CD) reporting to him/her. They were responsible for clinically managing their team. This included training and development, housekeeping issues, collating information to present to the AMD, answering their part in complaints in a timely way and any other business in relation to the smooth running of their section. This was a busy role and they often deputised for the AMD at meetings and as appropriate.

I was insistent on very clear vertical lines of reporting with sound horizontal lines of communication. This was necessary in such a big team. Everyone was required to know what each other's roles and responsibilities were as well as their own.. In a multidisciplinary arena failure to follow this caused chaos and ill feeling between staff members. I had an open-door policy and unless the person was discussing sensitive issues, I always asked if they had discussed things with their manager and if not, why not.

Within the acute directorate and as far as medical staff were concerned, all professional issues including job plans and revalidation were the responsibility of the Medical Director. All operational issues were the responsibility of the Acute Director. Clearly there was a big overlap in the roles with not every issue fitting neatly into either box. It was arranged therefore that the Medical Director and the Director of Acute would meet fortnightly but this was difficult to arrange with ongoing time pressures and the meeting did not always take place.

I agreed to give one of my Assistant Directors to the Medical Director. I was informed by the Director of Finance that this post would still be included in my budget as the medical Director no longer had the money for it.. This was Simon Gibson. He is an 8C but was not a qualified Doctor. His was a senior clerical post and even though he was 8C I understood he was to work to the old 8B Job description with a few other duties added. I never saw this job description.

Paragraph 4.

The Acute Directorate has always been by far, the biggest division in the organisation and spends annually circa 99% of the money. To that end, the following support was part of the Acute structure:

- From Finance - 2 divisional accountants who met all the assistant directors and their teams individually on a monthly basis. Further, the same accountants met the Director separately, also on a monthly basis. At these meetings, any drift from the agreed budget was discussed and reparative measures initiated. I found these meetings extremely useful, especially since such an emphasis was put on the financial health of the Trust. There was often unmet need in terms of finance which I then reported to the corporate Senior Management weekly team meetings which consisted of the Chief executive, all Directors and the Head of Communications. Towards the end of my tenure, the two divisional accountants were removed without explanation or notice.
- From Performance and Reform – 2 members of the performance team (normally the assistant director and an 8B) visited the acute teams separately and discussed all issues of performance. They also visited the Acute Senior Management meeting on a monthly basis. These were long and complex meetings that reflected the harsh reality that there simply wasn't enough staff or space to see patients or for the surgeons to operate. Interestingly, money

Urology Services Inquiry

Paragraph 9

Miscellaneous

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

My Father died very suddenly on 16th March 2017. Subsequently I became very ill [redacted] Personal Information redacted by the USI I was off work for circa 2 months. The case of Mr O'Brien was managed by the oversight group during that time and thereafter. I know that Ms Corrigan, the HOS for Urology, monitored Mr O'Brien's weekly activity in relation to his admin duties. I checked on a weekly basis with the AD and any time I met the HOS. When I went off for surgery at the end of May 2019 I never returned to the Southern Trust.

SCHEDULE
(NO 35 of 2022)

1. Please see paragraph (para) 2, 3, 5 and 8.

2. I have now left the Trust's employment and hold absolutely no documentation of theirs at all.

4. I did not receive any training on either I, II or III.

5. Each division has its own mandatory training as agreed within the teams and verified by HR and then there is training identified by individuals at PDP. This is facilitated by the line manager as being something needed to be able to do the job. For all other training or compliance with guidelines, staff are referred to Trust standards and guidelines. I do not recall specific training I personally organised but PDP would have retained records of training. Generally:

   I. Clinical Managers would have been subject to the rules above. Their line manager was the AMD.

   II. It was necessary for case investigators to have had training before they conducted the investigation.

   III. Designated Board members, if part of an investigation also had to have the training above. This was normally facilitated by the HR director and appointed by the CE.

   IV. Any other relevant person would also be facilitated and trained in line with the chain of command as outlined above.

6. Any steps taken by me would have been recorded in HR records. I do not have access, nor have I retained, any such records.

7. I understood that my role as Director of Acute with the following individuals was:

Southern Health and Social Care Trust

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

23 September 2010

423. One to one discussions were held in either Mr O'Brien's office, Mrs Corrigan's office, my office, Director of Acute Services' office, or Mr Brown's office. These were the areas where one to one meetings would have been held.

424. The content of the discussions were centred around concern regarding the timely response to patient triage, patient notes, and the review backlog.

425. These discussions directly with Mr O'Brien were primarily via the Head of Urology and ENT but on occasion by Mr Young, Mr Brown, Mr Mackle, Dr Rankin, Mrs Burns, Mrs Gishkori, or myself. Following discussion with Mr O'Brien, his practice would improve for a period. However, this improvement was not sustained and, through alert systems, we would have been alerted to delayed triage / missing notes which was then followed up for action. Review backlog numbers were also constantly monitored.

426. Despite conversations at a very senior level with Mr O'Brien and assurances that triage would be undertaken, this issue was regretfully recurrent on an intermittent basis. In January 2016, Mr Mackle and I met with the Medical Director (Dr Richard Wright) to discuss our concerns regarding these recurrent issues. Dr Wright advised at this meeting that it was time to put the concerns in writing to Mr O'Brien and seek a plan to address these concerns. A letter was issued to Mr O'Brien in March 2016. *Please attached letter, document Relevant to PIT, Evidence Added or Renamed 19 01 2022, reference 77, No 77 – Heather Trouton amended emails with attachments attachment 20160822 Email Confidential- AOB SG A.*

Discussions with Mr Young

427. Discussion of concerns relating to patient triage, patient notes, and review backlog took place with Mr Young, Clinical Lead for Urology. Mr Young would have undertaken to speak to Mr O'Brien regarding this unacceptable practice as his medical lead. Mr Young also assisted on a number of occasions to address the triage for Mr O'Brien. Mr Young also, at a point in time, agreed that only named referrals (i.e., those specifically addressed by the referring party to Mr O'Brien) would be sent to Mr O'Brien for triage and that all unnamed referrals would be sent to the other consultants for triage. Mr

same, and I did not make any decisions regarding same during my tenure as Assistant Director.

10. I have now, in light of the subject matter of this section 21 notice, appraised myself as to both the MHPS Policy and the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance 2010. Both refer solely to the responsibilities and role of the clinical manager in the use of these documents. As there is no defined role for the operational manager, I can only assume that is why I was not aware of these documents and why training was not provided for operational managers like me in this policy and guidelines.

11. Following the emerging concern relating to the lack of clinic outcomes recorded on Patient Centre in 2015 as I recall, and following verification of this concern by Mrs. Martina Corrigan, (then) Head of Service for Urology and ENT, advice was sought by Mr. Mackle, Associate Medical Director, and myself from Dr Richard Wright, Medical Director, as to the best next steps in addressing our concerns with Mr. O'Brien. As I recall, it was the notification of another concern regarding Mr. O'Brien's administrative practice that prompted a request for a direct meeting with the Medical Director. I also alerted my Operational Director, Mrs. Esther Gishkori, of this latest concern and I have a note of a one to one meeting with Mrs. Gishkori which records same. This is located in *Relevant to PIT, Evidence received after 4 November 2021, Reference 77, Reference 77 - Heather Trouton, 2015 esther*

12. To the best of my recollection a meeting with Dr Wright took place on 11th January 2016. I have no written record of the meeting with Mr. Mackle and Dr Wright, however, I clearly remember that it took place in the Associate Medical Director's office on the Administration Floor of Craigavon Hospital. The date is noted in my witness statement to Dr Chada and Siobhan Hynds as part of the MHPS investigation held in 2017 *Appendix 22 - Amended Witness Statement - Mrs H Trouton 050617 (Bates number: TRU-00799- TRU-00802).* Following discussion of all the concerns regarding Mr. O'Brien's administrative practices, and all the actions that hitherto had been taken to try to address same and in particular the latest concerns re clinic outcome recording, Dr Wright advised Mr.

1:1 Esther 21/12/15.

- Surgical Workshop - Plan 2016.

- Urology - AOB
  - Charts
  - No PR conte letters.
  - Triage.

  } Plan letter - 1 month improve.

- Emergency surgeon - Interviews 8th Jan
- Breast Surgeon - .. Feb.
- General Surgeons x 2 OHH - In progress advert.
- ENT Mr Hall replacement -

Additional mobile theatre - Ronan advises he will arrange visit Musgrave Jan 2016 - will attend.

[redacted]

- Need to advertise internally 2 Clinical Directors EOI. Jan 2016.

- Finance 677k underspend to date - that will be eroded will Optham retraction + Agency Spend - Still should break even.

- Review + clear policy on core staff moving wards. - Way forward. - Bank staff too great a role at present - my opinion.

- Staffing - Still no additional staff until Feb - limited. - try to flesh up with bank + agency.

8th Feb 2016
Esther 1:1

- Electronic Nurse Record - Try - ~~Anthim~~ arm.
- CD Posts close on Thursday - ✓
- [redacted] ✓
- G/S. ↓ Ins + days activity - advise → O/P h boost numbers on list.
- ENT ✓
- Urol ✓ apart from Review bradeley - working - BOB. plan.
- TO ✓ Trauma - boost - cancel elective activity today.

Lock into the RF Straight h foot - yellow Rms.
=
→

Stinson, Emma M

From: Wright, Richard [redacted]
Sent: 09 February 2016 10:57
To: Gishkori, Esther
Subject: Fw: **URGENT** [redacted]
Attachments: COMMENTS regarding [redacted].docx

Hi Esther. This almost sounds like a cry for help. We should discuss! Richard

---

From: Fitzsimons, Marian
Sent: Tuesday, February 09, 2016 09:41 AM
To: Wright, Richard
Cc: White, Laura
Subject: FW: **URGENT** [redacted] -v- [redacted]

Dr Wright

FOR YOUR INFORMATION

See below and attached the reply received from Mr Aidan O'Brien. He has provided a detailed and comprehensive response to the allegations of negligence noted within the Statement of Claim which I am sure will be of great assistance to the Trust's Barrister.

Marian Fitzsimons

From: O'Brien, Aidan
Sent: 05 February 2016 02:28
To: Fitzsimons, Marian
Subject: RE: **URGENT** [redacted] - [redacted]

Marian,

Once again, I regret the delay in replying to your emails.
I am quite sure that it must be difficult to appreciate that something regarded so important could be so delayed.
I have to advise you that I receive so many email regarding patients each day that it can take me two hours to deal with each day's definitively.
As a consequence, if I have already worked for 12 to 16 hours, I do not get to even open all emails.
I am now sending this email at 02.25 am, Friday, having begun working at 07.00 am yesterday.
As a consequence of spending some hours compiling the attached comments, I have not yet opened yesterday's emails, and I start again at 09.00 am.
And that is how it is, day in, day out.

I do hope that you will find the attached comments to be of assistance,

Thank you for your forbearance,

Aidan.

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

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

Paragraph 7.

Mr O'Brien

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

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

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

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

Paragraph 8.

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

21/3/16 1:1 Esther + Eamon.

→ Flexing of Beds 4N, 3S, Fem Surgical post 31/3/16 ??
Financial agreed.

→ 3 applicants for the CD Post in Surgery.

→ Issue DHH → [redacted] - Colorectal - issue - D/W [redacted]

→ Heads of Service - nervous.

→ OSL → Shaun - with me.

→ Surgical Strategy paper.

→ Need to get letter to DOS this week.

→ Do an independant review to decide if any colorectal surgery should be done on the DHH site. - Eamon to find Someone.

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

Stinson, Emma M

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

Importance: High

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

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

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

Dear All

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

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

Toal, Vivienne

From: White, Laura [redacted]
Sent: 07 September 2016 10:41
To: Toal, Vivienne; Gishkori, Esther; Wright, Richard
Cc: Clegg, Malcolm; Mallagh-Cassells, Heather; Stinson, Emma M; Gibson, Simon
Subject: RE: Oversight Meeting - medical cases

Vivienne

I can confirm that Dr Wright will be available after Governance Committee meeting on Thursday for the above meeting.

Regards, Laura

Laura White
PA to Medical Director
Dr Richard Wright

Direct Line: [redacted]

[redacted]

From: Toal, Vivienne
Sent: 06 September 2016 21:44
To: Gishkori, Esther; Wright, Richard
Cc: Clegg, Malcolm; Mallagh-Cassells, Heather; White, Laura; Stinson, Emma M
Subject: Oversight Meeting - medical cases

Esther / Richard

There are a number of issues which would be good to touch base on – could we meet for an hour or so after Governance Committee on Thursday by any chance?

[redacted]

2) Mr Aidan O'Brien – potential MHPS case

[redacted]

Thanks

Stinson, Emma M

From: Gibson, Simon [redacted]
Sent: 12 September 2016 16:51
To: Toal, Vivienne; Gishkori, Esther
Cc: Wright, Richard
Subject: FW: CONFIDENTIAL Screening Investigation - Mr A O'Brien
Attachments: Screening report.docx

Dear Esther and Viv

Please find attached screening report for tomorrow mornings Oversight Committee meeting at 10am.

Kind regards

Simon

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

From: Gibson, Simon
Sent: 05 September 2016 14:25
To: Wright, Richard
Cc: White, Laura
Subject: CONFIDENTIAL Screening Investigation - Mr A O'Brien

Dear Richard

As requested, please find attached a screening report on Dr O'Brien.

Would you like me to convene a meeting of the Oversight Committee to consider this report?

Kind regards

Simon

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

II. I became aware when Dr. O'Brien was listed on the agenda for a meeting of the Oversight Committee. I was not aware prior to attending that meeting. The agenda for the meeting was circulated one day before but due to a busy work schedule, I had not had sight of the agenda in advance of the meeting.

III. As above

IV. I went to the meeting. Minutes from the meeting could contain detail about the decisions taken.

11. The concerns had been escalated to the CE before I knew the extent of the problem or that AOB was going to be discussed at an oversight meeting. Simon Gibson (AD to the Medical Director) had provided a "screening report" with recommendations in the conclusion even before the oversight committee met. The matter escalated formally after the Oversight Committee meeting. The Chief Executive would have been kept appraised of all matters thereafter by the Oversight Committee generally and the Director of HR.

12. Please see below.

I. Mr Aidan O'Brien just appeared as number 2 on the agenda as a "potential MHPS case" at the Oversight Committee meeting. Simon Gibson provided background and advised that a letter would be sent to Dr. O'Brien Please see minutes for further detail.

II. A letter was to be drafted by Simon Gibson for Colin Weir and Ronan Carroll) to be presented to AOB. Please see minutes for further detail.

III. Please see minutes from the oversight committee meeting for further details in relation to what was decided therein. Following the oversight committee I immediately spoke to Charlie McAllister (the AMD for surgery) and Colin Weir (the Clinical Director). Ronan Carroll was also present at this meeting. As both these individuals were line manages to Aodhan O'Brien I wanted to confirm what information they held in relation to the problems that I had just been informed of. Charlie informed me that he had received one email from Simon. Charlie had suggested a resolution to the problem which I have outlined further at paragraph 8 above.

IV. N/A

13. Please see below.

I. see para 7. I tried to get line managers to deal with Dr. O'Brien informally once the issue game to my attention.

II. see para 7.

III. (Please see paragraph 8. I did not engage with Dr. O'Brien informally as I had to comply with the directions of the Oversight Group. These directions were focussed on formal and structured action, rather than an informal response.

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

2.1 NCAS Good Practice Guide – "How to conduct a local performance investigation" (2010) indicates that regardless of how a is concern in identified, it should go through a screening process to identify whether an investigation in needed. The Guide also indicates that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

2.2 Concerns[1] should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.

2.3 Concerns which may require management under the MHPS Framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.

2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.

2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of

[1] Examples of Concerns may include: - when any aspect of a practitioner's performance or conduct poses a threat or potential threat to patient safety, exposes services to financial or other substantial risks, undermines the reputation or efficiency of services in some significant way, are outside the acceptable practice guidelines and standards.

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.

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

I. Clinical Manager – this, for me was normally the CD or the AMD. In relation to the Clinical Directors, there was one for each department and they reported to Associate Medical Directors (AMDs). AMDs were responsible for all surgery and reported to Medical Directors professionally and me operationally.

II. Case Manager – to support and cooperate with their conclusion.

III. Case Investigator – to support their investigation and encourage my team to cooperate with any requests.

IV. The Chief Executive – irrespective on anything else, this was my line manager, so all my usual responsibilities still applied. I would also respect his decisions and support the whole process as my position in the oversight group and as the Director of Acute.

V. Medical Director – Support and respect his decisions on the Oversight Committee.

VI. Designated Board Members – Their roles were to keep the process moving and I would assist and support when requested.

VII. The clinician – I wrote to him with the conclusion of the SAI and worked in accordance with my duty to keep matters confidential.

VIII. I would support and assist the investigation in any way that I could.

8. In terms of tracking the process, the Head of Service and the Assistant Director would have reviewed and monitored Dr. O'Brien and fed back to me. I would have received the results of audits and recommended further actions where applicable. The actioning of the recommendations would have then been discussed in meetings where a wider group would then discuss whether further action would be taken and if so, what action.

9. I was a member of the oversight group. I therefore followed the TOR, taking part in the meeting, coming to agreed conclusions, completing my agreed actions and supporting the chair in all related matters. The chair was Vivienne Toal.

I. The Assistant Director would have reported to me

II. The Medical Director was, in this case, also the chair of the oversight group. He led the meetings and appointed Dr Khan to be the case manager.

III. The HR Director was my peer and we would liaise with each other where our required actions overlapped.

10. In respect of concerns raised regarding Mr O'Brien:

I. Please see para 7 – from Mr Mackle and Heather Trouton

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

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

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

Paragraph 8.

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

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

Paragraph 9.

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

My Father died very suddenly on [Personal Information redacted by USI]. Subsequently I became very ill with what was thought to be [Personal Information redacted by USI]. I was off work for circa 2 months. The case of Mr O'Brien was managed by the oversight group during that time and thereafter. I know that Ms Corrigan, the HOS for Urology, monitored Mr