Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No.28 of 2022
Date of Notice: 29th April 2022

Witness Statement of: Ahmed Faraz Khan

I, Ahmed Faraz Khan, 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 believe that a full account of my involvement in and knowledge of all matters falling within the scope of the Inquiry Terms of Reference is set out in my answers to Questions 4 to 72 below and in my response to Questions 1 to 25 of the other Section 21 Notice served upon me, namely, No.31 of 2022. I rely upon all of those answers.

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.

2.2 Please see attached documents.

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: ___Ahmed Faraz Khan_____

Date: ____08/07/2022_____

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 31 of 2022

Date of Notice: 29th April 2022

Witness Statement of: Ahmed Faraz Khan

I, Ahmed Faraz Khan, will say as follows:-

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

1.1 Below I set out a summary of chronological account or timeline of my involvement in the MHPS process

1.2 **2016:**

During December 2016

a. On 28th Dec 2016, the Medical director (Dr Richard Wright) contacted me by email for possible nomination as MHPS case manager. Evidence: Confidential email (from Dr Wright to me) **This can be located at Attachment folder S21 31 of 2022- Attachment 1.**

1.3 **2017**

During January 2017:

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: _Ahmed Faraz Khan_____

Date: ___08/ 07/ 2022_____

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notices 28 and 31 of 2022

Date of Notice: 29th April 2022

Addendum Witness Statement of: Ahmed Faraz Khan

I, Ahmed Faraz Khan, will say as follows:-

1. I wish to make the following amendments and additions to my existing responses, each dated 8th July 2022, to Section 21 Notices numbers 28 and 31 of 2022.

Section 21 Notice No. 28 of 2022

2. At paragraph 64.1 (WIT-31119), the sentence which reads, '*In January 2017, Mr O'Brien returned to work after being excluded for 4 weeks from the end of December 2016',* should be amended as follows: '*In February 2017, Mr O'Brien returned to work after being excluded for 4 weeks from the end of December 2016.'*

Section 21 Notice No. 31 of 2022

Paragraphs 1.3.h (WIT-31962), 11.1 (WIT-31983) and 11.6 (WIT-31984)

3. I have attempted to address my involvement with the MHPS investigation Terms of Reference (TOR) at paragraphs 1.3.h (WIT-31962), 11.1 (WIT-31983) and 11.6 (WIT-31984) of this statement. Those paragraphs provide as follows:

> 1.3.h. The MHPS investigation Terms of Reference (TOR) were drafted and approved by oversight committee members. This was then shared with me and, after considering all concerns previously

20200729 E from MO'K re Admin Review Process). Then in October 2020, Mrs Siobhan Hynds shared some initial findings of the admin review however this was to be completed in more detail later. **Evidence : see email with 2 pages of draft findings- URGENT FOR DISCUSSION AT 1.30PM Admin Review document- This can be located at Attachment folder S21 31 of 2022- Attachment 40.**

Miscellaneous

12. An issue that is not strictly an amendment to an existing statement relates to the GMC ELA email of 8th June 2018 (TRU-251519 to TRU-251520) in which she advised that it would be 'prudent … to secure an undertaking … that [Mr O'Brien] will not do any private work from his own home … until you are satisfied that the risk is removed/being managed appropriately'. I had not previously been able to find evidence of my response to this although I had recalled doing something. I have now located my email to Simon Gibson and Norma Thompson of 28 June 2018 (*see attached 3. Email. Communication 28-6-2018*) in which I suggested that Simon discuss the issue with Richard Wright and Vivienne Toal. I believe I went on annual leave soon after this and am unclear about what, if anything, I did to pick the matter up again with Simon upon my return.

Statement of Truth

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

Signed: *Ahmed F. Khan*

Date: 20/03/2023

Urology Services Inquiry

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 My qualifications are as follows:

a. Fellow of Faculty of Paediatrics -Royal College of Physicians in Ireland, 2017
b. Fellow of Royal College of Paediatrics & Child Health (FRCPCH), London - 2010
c. Masters in Medical Sciences - National University of Ireland Galway- 2007
d. Membership- Royal College of Physicians in Ireland (MRCPI Paediatrics) - 2002
e. Diploma in Child Health (DCH)- Royal College of Surgeons in Ireland- 1999
f. Bachelor of Medicine & Bachelor of Surgery (MBBS)- LUMS, Pakistan- 1993 .

4.2 My occupational history prior to commencing employment in SHSCT was as follows:

a. Locum Consultant Paediatrician, Ulster Hospital, SEHSCT, March 2008 to May 2008
b. Locum Consultant Paediatrician, University College Hospital Galway, July 2006 to Feb 2008
c. Locum Consultant Paediatrician, Cork University Hospital, September 2005 to June 2006

d. Paediatric & neonatal specialist training, SHO & Registrar training, In Royal College of Physicians in Ireland training hospitals across Ireland, July 1997 to June 2005.

4.3 My CV is attached. *Relevant document can be located at S21 No 28 of 2022 Attachments, 1. CV – Dr Ahmed F Khan*

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 The posts I have held within SHSCT are as follows:

a. Locum Consultant Paediatrician - Daisy Hill Hospital, SHSCT, From June 2008 to 31st May 2009
b. Consultant General Paediatrician with special interest in Community Child Health - Daisy Hill Hospital & Community Paediatric Services – Southern Health & Social Care Trust - 1/6/2009 to date
c. Clinical Director- Community Paeds Services – SHSCT – 1st Nov 2012 till 31/5/2013
d. Associate Medical Director (AMD), Children & Young People Directorate (CYP) – 1st June 2013 till 31st April 2018, then from 1st Jan 2019 till 30th June 2021
e. Acting Medical Director – 1st April 2018 till Dec 2018
f. On career break from SHSCT - from July 2021 till 30th Sept 2022
g. Consultant Paediatrician with special interest in Community Child Health - Cork University Hospital - July 2021 to date

5.2 My Job Descriptions for the posts of Consultant Paediatrician, *can be located at S21 No 28 of 2022 Attachments, 2. CD CYP Community Paeds JD*, CD *can be located at S21 No 28 of 2022 Attachments, 2. CD CYP Community Paeds JD*, AMD *can be located at Relevant to HR/ 20180300-REF 15- Dr A Khan – Acting Medical Director Job Description* & MD *relevant document can be located at Relevant to HR/ 20180300-REF 15- Dr A Khan – Acting Medical Director Job Description*

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

Urology Services Inquiry

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

6.1 As Associate Medical Director (AMD) in Children & Young People Directorate (CYPD) from 2013 to 2018, I had managed medical staff performance concerns. This was carried out as per the Trust policy of September 2010, mentioned above.

6.2 Prior to this MHPS investigation, I had no previous experience of implementing or applying formal MHPS investigations.

6.3 My line manager, Dr Richard Wright, was aware of this as I informed him during our discussion for Mr O'Brien's MHPS Case Manager nomination in December 2016 & Jan 2017. He asked me to complete upcoming MHPS training in March 2017.

6.4 I did complete MHPS training on 7 and 8th March 2017. I also reviewed the MHPS framework document and Trust Guidelines in detail. This included those parts in respect of the roles and responsibilities of Case Investigator and Case Manager.

7. Outline how you understood the role of Case Manager was to relate to and engage with the following individuals under the MHPS Framework and the Trust Guidelines:

I. Clinical Manager;
II. Case Investigator;
III. Chief Executive;
IV. Medical Director;
V. Designated Board member,
VI. The clinician who is the subject of the investigation; and
VII. Any other relevant person under the MHPS framework and the Trust Guidelines, including any external person(s) or bodies.

7.1 I carried out MHPS Case Manager role as per the MHPS framework and Trust Guidelines. The MHPS Framework describes the Case Manager's role as follows at Section I:

Urology Services Inquiry

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

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3. Unless you have specifically addressed the issues in your reply to Question 1 above, answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the 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. When answering the questions set out below you will need to equip yourself with a copy of *Maintaining High Professional Standards in the Modern HPSS' framework ('MHPS')* and the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' ('Trust Guidelines').*

<u>Policies and Procedures for Handling Concerns</u>

4. In your role as Case Manager what, if any, training or guidance did you receive with regard to:

I. The MHPS framework*;*
II. The Trust Guidelines; and
III. The handling of performance concerns generally.

4.1 I reviewed the MHPS framework document (attached). **This can be located at Attachment folder S21 31 of 2022- Attachment 41.**

4.2 I also reviewed the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance of September 2010 (attached). **This can be located at Attachment folder S21 31 of 2022- Attachment 42.**

4.3 I reviewed General Medical Council, Good Medical Practice guidelines.

4.4 I received MHPS training from 7- 8th March 2017 (Certificate attached). **This can be located at Attachment folder S21 31 of 2022- Attachment 43.**

NHS
National Clinical Assessment Service

CERTIFICATE OF ATTENDANCE

It is hereby certified that

Dr Ahmed Khan

attended

Case investigator training workshop

for Southern Health and Social Care Trust

delivered by NCAS

on Tuesday 07 – Wednesday 08 March 2017

This workshop provides up to 12 hours towards your CPD

Workshop objectives

- *Explore how concerns about a doctor's practice arise and identify the most common factors affecting performance*
- *Explain why the decision to investigate is made and 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 know how to work within them*
- *Collect, review and weight evidence*
- *Conduct an investigative interview using a structured approach, including the PEACE model*
- *Recognise the key skills and attributes of a case investigator*
- *Recognise their own limits of competence and access sources of support and expertise*
- *Reference relevant national/local standards*
- *Write an investigation report with conclusions*
- *Describe the potential legal challenges to an investigation*

c. SHSCT organisation chart 2018 - *Relevant document can be located at S21 No 28 of 2022 Attachments, 4. SHSCT ORG CHART UPDATED09.02.18*

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

7.1 During my role as Consultant Paediatrician, Clinical Director & Associate Medical Director, in Children & Young People directorate (CYP) from 2013 till 2018 & then from 2019 till 2021, I have had no operational, governance & line management responsibilities of Urology services or staff.

7.2 During my role as Acting Medical Director (1st April 2018 till Dec 2018), I wasn't involved in operational or direct governance responsibilities of Urology services.

7.3 However, as an Acting Medical Director I had corporate professional governance responsibilities for the following:

a. For the clinical outcomes and effectiveness of the Trust's services.
b. To lead in the development of a framework to ensure a strong infrastructure of medical leadership within the Trust.
c. I was the Trust's nominated Responsible Officer for General Medical Council (GMC) for referring concerns about a medical practitioner to the General Medical Council to address any concerns about a medical practitioner's fitness to practice.
d. I was responsible for the effectiveness of medical appraisal of the medical workforce and for the quality and standard of CPD.
e. I was Lead Director for the Trust's Medical Negligence and other related committees.
f. I was the Lead, and managed, the Trust's Corporate Governance Team through the Assistant Director of Clinical Governance & Social Care (CGSC), Mrs Marshall. My key responsibilities were:

    i. Working with other operational Directors to inform, support and provide assurance on the systems for the effective identification and management of clinical governance concerns, ensuring that any learning is incorporated into professional practice and systems;
    ii. As a member of the Senior Management Team and Trust Board, as Medical Director I had corporate responsibility for ensuring an effective system of integrated governance within the Trust which delivers safe, high quality care, a

to judge what information needs to be gathered and how (within the boundaries of the law) that information should be gathered;

- must ensure that sufficient written statements are collected to establish the facts of the case, and on aspects of the case not covered by a written statement, ensure that there is an appropriate mechanism for oral evidence to be considered where relevant;
- must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Medical Director with advice from the Director of HR;
- must assist the designated Board member in reviewing the progress of the case.

32. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work. They may not be a member of any disciplinary or appeal panel relating to the case.

33. The Case Investigator has wide discretion on how the investigation is carried out, but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Information gathered in the course of an investigation may clearly exonerate the practitioner, or provide a sound basis for effective resolution of the matter.

The Case Manager's role

34. The Case Manager 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

35. The practitioner concerned must be informed in writing by the Case Manager, that an investigation is to be undertaken, the name of the Case Investigator and the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people whom the Case Investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the Case Investigator and given the opportunity to be accompanied.

36. If during the course of the investigation, it transpires that the case involves more complex clinical issues (which cannot be addressed in the Trust), the Case Manager should consider whether an independent practitioner from another HSS body or elsewhere be invited to assist.

Case Manager

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.

Appendix 5

Restriction of Practice / Exclusion from Work

Formal Exclusion

Decision of the Trust is to formally investigate the issues of concern and appropriate individuals appointed to the relevant roles.

Case Investigator, if appointed, produces a preliminary report for the case conference to enable the Case Manager to decide on the appropriate next steps.

The report should include sufficient information for the Case Manager to determine:

- If the allegation appears unfounded
- There is a misconduct issue
- There is a concern about the Practitioner's Clinical Performance
- The case requires further detailed investigation

Case Manager, HR Case Manager, Medical Director and HR Director convene a case conference to determine if it is reasonable and proper to formally exclude the Practitioner. (To include the Chief Executive when the Practitioner is at Consultant level). This should usually be where:

- There is a need to protect the safety of patients/staff pending the outcome of a full investigation
- The presence of the Practitioner in the workplace is likely to hinder the investigation.

Consideration should be given to whether the Practitioner could continue in or (where there has been an immediate exclusion) could return to work in a limited or alternative capacity.

If the decision is to exclude the Practitioner:

The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

The Case Manager along with the HR Case Manager must inform the Practitioner of the exclusion, the reasons for the exclusion and given an opportunity to state their case and propose alternatives to exclusion. A record should be kept of all discussions.

The Case Manager must confirm the exclusion decision in writing immediately. Refer to MPHS Section II point 15 to 21 for details.

All exclusions should be reviewed every 4 weeks by the Case Manager and a report provided to the Chief Executive and Oversight Group. (Refer to MHPS Section II point 28 for review process.

Timescale and decision

37. The Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days. The Case Manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the Case Investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.

38. The report should give the Case Manager sufficient information to make a decision on whether:

- no further action is needed;
- restrictions on practice or exclusion from work should be considered;
- there is a case of misconduct that should be put to a conduct panel;
- there are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer;
- there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS ;
- there are serious concerns that fall into the criteria for referral to the GMC or GDC;
- there are intractable problems and the matter should be put before a clinical performance panel.

CONFIDENTIALITY

39. Employers must maintain confidentiality at all times, and should be familiar with the guiding principles of the Data Protection Act. No press notice can be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. They may only confirm that an investigation or disciplinary hearing is underway.

40. Personal data released to the Case Investigator for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter.

TRANSITIONAL ARRANGEMENTS

41. On implementation of this framework, the new procedures must be followed, as far as is practical, for all existing cases taking into account the stage the case has reached.

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

-----Original Message-----
From: ClientLiaison, AcutePatient
Sent: 22 December 2016 11:08
To: Reid, Trudy; Connolly, Connie
Subject: Complaint - ?SAI

Hi Trudy and Connie, I am sending this out for investigation as a complaint but copying to you also to see if it needs screened as an SAI.

Kind Regards

David.

Hynds, Siobhan

From: Weir, Colin [redacted]
Sent: 12 January 2017 09:32
To: Hynds, Siobhan; Khan, Ahmed; Gibson, Simon
Subject: Re MHPS investigation. CONFIDENTIAL

Siobhan

I am the lead investigator for an investigation. I know an oversight committee met this week to discuss the issues. I have not yet received any official confirmation to commence the investigation but I have been forwarded several emails explaining the issues

My understanding is the process should be completed within 4 weeks of suspension of the Consultant concerned. From 30th Dec in this case

I also understand I would have assistance from Employee relations.

Can you tell me who is helping me and how we can progress this

Colin

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 [redacted]

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 26 January 2017 11:25
To: Khan, Ahmed
Cc: Weir, Colin
Subject: Preliminary report from Case Investigator 26 January 2017 FINAL
Attachments: Preliminary report from Case Investigator 26 January 2017 FINAL.docx

Importance: High

Dr Khan

Please find attached report for your consideration from Dr Weir.

In line with MHPS, the report is required to provide you with sufficient detail to enable you to determine, firstly, if there is a case to answer and also to enable you to decide on the next appropriate steps, including whether formal exclusion is required or whether there are alternatives to exclusion pending conclusion of the investigation.

It is also a requirement to consult with NCAS where formal exclusion is being considered. Dr Grainne Lynn is the NCAS advisor for this case and can be contacted on [redacted]

If you require any further information to enable you to make the necessary determinations, please contact either Dr Weir or myself.

Kind Regards,

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ

Tel: [redacted] Direct Line: [redacted]
Mobile: [redacted] Fax: [redacted]

Click on the above image for SharePoint: Employee Engagement & Relations information

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

Southern Health and Social Care Trust

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06 February 2017

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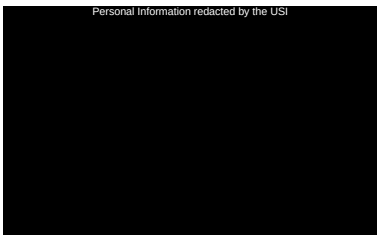
BY E-MAIL ONLY

Mr Aidan O'Brien



Dear Mr O'Brien

Re: Formal investigation under Maintaining High Professional Standards Framework (MHPS)

The purpose of this correspondence is to put on record the decision of the case conference on 26 January 2017.

As per our telephone discussion on Thursday 26 January 2017, following a case conference meeting to review your immediate exclusion from work which had been in place from 30 December 2016.

Mr Weir, Case Investigator provided the case conference with an update from the preliminary scoping exercise into 4 concerns previously notified to you. Based on this information, I have determined that you do have a case to answer in respect of the 4 concerns and that a formal investigation of the issues of concern is required.

The matter of your immediate exclusion form clinical duties was also discussed in detail and a decision was taken to lift the immediate exclusion with effect from 27 January 2017 as a formal exclusion is not required at this time. However this can be implemented at any time if all monitoring requirements are not met after you return to work. This is to ensure patient safety, to safeguard the investigation and to ensure you are protected from any further allegation of concern during the investigation process.

Concerns Regarding the Investigation Process

7th February 2017

1. A letter dated 23rd March 2016 was provided to Mr O'Brien at a meeting on or around that date by Mr Mackle and Ms Corrigan. The letter raises a number of issues which are now the subject of a formal investigation. There are a number of concerns arising from this letter.
    - It does not constitute a formal or informal process under MHPS or any other Trust Guidelines. It included no local action plan to resolve the problems or any suggestions regarding a plan.
    - It was provided by Mr Mackle, an individual in respect of whom Mr O'Brien has extant though stayed formal grievance. Mr O'Brien had previously been provided an assurance by both Dr. Gillian Rankin and Mr Mackle that Mr Mackle would have no further meetings with him.
    - At the meeting Mr O'Brien asked what he should do to resolve the matter. The only response received was a shrug and silence from Mr Mackle.

The letter of 23rd March 2016, gives rise to a number of questions:

- What was the nature of the complaint that led to this letter being issued?
- What investigation occurred prior to the letter being completed?
- Who completed this investigation?
- How have the suggested numbers of untriaged patients and the review backlogs been arrived at?
- Was there a decision taken by a Clinical Manager that the concerns should be approached by the issue of the letter of 23rd March 2016 or by any other individual? In any case, who took this decision?
- Was this decision taken with reference to MHPS?
- Was this decision taken in consultation with the Medical Director, the Director of Human Resources or any other individual?

advising visitors that should they want further information about a relative then they should approach a member of staff and that this will be organised for them. I apologise that you and your families experience in respect to this fundamental process was poor. Finally in regard to your father's weight not being recorded, this was unacceptable. Sr Douglas acknowledged that the scales were broken and the ward was waiting on a replacement but when required the scales from another ward should have been borrowed.

Mrs Henry and Sr Douglas are disappointed and embarrassed that their ward failed to deliver on the core nursing functions of personal hygiene, to monitor progress against treatment plan and to communicate with you as a family. I too share these sentiments.

Mr O'Brien has provided a response to the concerns raised in your correspondence and I have included his comments below;

Mr O'Brien advises that your father was Personal Informati years old when he was found to have an aggressive carcinoma invasive of the muscle of his urinary bladder. It was the decision of the multidisciplinary team that your father was not a candidate for a radical cystectomy (removal of urinary bladder).

Commenting on the primary cause of your father's death being hospital acquired pneumonia, Mr O'Brien advises that your father was on intravenous antibiotic therapy for a chest infection and that was initiated in South West Acute Hospital, and was continued following his transfer to Craigavon Area Hospital. There was radiological evidence of slight worsening of the infection on chest radiography on 25 September 2016.

Mr O'Brien advises that he did visit your father at approximately 6.00 pm on 29 September 2016, when he was feeling well and that there is no doubt that your father's death was sudden and unexpected. Mr O'Brien commented that it is possible that the increased total white cell count and C-reactive protein levels (markers for infection) that day were reflective of an acute worsening of the chest infection, possibly leading to a cardiac arrest.. However, it is Mr O'Brien's belief that it could not be asserted with certainty that his respiratory infection had been the primary cause of your father's death.

Mr O'Brien also advises that in his opinion he has no doubt that the compromised cardiovascular, respiratory and renal function that your father was known to have had for years would have been contributory factors in his death.

Mr O'Brien has emphasised that his consultant colleagues would have been only too willing to meet with your mother at times that would have suited her, if requested. The one time when doctors do not normally wish to meet with relatives is when they are doing ward rounds, so he would like to apologise on behalf of the Urology Medical Team that this was not facilitated for her.

Mr O'Brien is very sympathetic to you and your mother as he feels that it is more difficult for you and your mother as it would appear that you had not been aware of the extent of your father's comorbid status and he accepts responsibility for his failure in adequately advising you of these important issues and he also expresses his regret that his care in his final weeks may not have been optimal.

Case Manager

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.

- if the case can be progressed by mutual agreement consider if an NCAS assessment would help;
- if a formal approach under conduct or clinical performance procedures is required, appoint a case investigator;
- consider whether further action is required under the conduct, clinical performance or health procedures.

PROTECTING THE PUBLIC

5. From the outset, a fundamental consideration is the continued safety of patients and the public. Whilst exclusion from the workplace may be unavoidable it should not be the sole or first approach to ensuring patient safety. Alternative ways to manage risks, avoiding exclusion, include:
   - arranging supervision of normal contractual clinical duties;
   - restricting the practitioner to certain forms of clinical duties;
   - restricting activities to non clinical duties. By mutual agreement the latter might include some formal retraining;
   - sick leave for the investigation of specific health problems.

6. In the vast majority of cases when action other than immediate exclusion can ensure patient safety the clinician should always initially be dealt with using an informal approach. Only where a resolution cannot be reached informally should a formal investigation be instigated. This will often depend on an individual's agreement to the solutions offered. It is imperative that all action is carried out without any undue delay.

DEFINITION OF ROLES

7. The Board, through the Chief Executive, has responsibility for ensuring that these procedures are established and followed. Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the board should only be sufficient to enable the board to satisfy itself that the procedures are being followed. Only the "*designated Board member* "should be involved to any significant degree in the management of individual cases.

8. The key individuals that may have a role in the process are summarised below:-
   - Chief Executive (CE) – **all** concerns must be registered with the CE who, should a formal investigation be required, must ensure that the following individuals are appointed;
   - the "*designated Board member*" – this is a non-executive member of the Board appointed by the Chairman of the Board, to oversee the case to ensure that momentum is maintained and consider any

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24 February 2017

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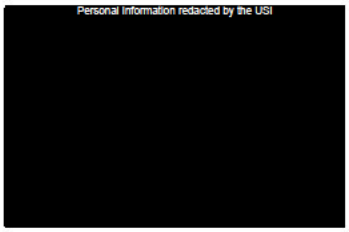
Mr Aidan O'Brien



Dear Mr O'Brien

Re: Formal investigation under Maintaining High Professional Standards Framework (MHPS)

Mr John Wilkinson Non-Executive Director has shared with me details of representations you have recently made to him at a meeting on 7 February 2017 about the formal investigation under the Maintaining High Professional Standards (MHPS) Framework.

Following due consideration of the issues you have raised, I wish to respond to you on these matters.

1. **The letter of 23 March 2016**

I have considered the representations you have made in respect of the letter of 23 March 2016. It is important that I state at the outset, that I was not involved in the conversations or discussions that took place at that time. I understand that concerns were identified by managers within the Acute Services Directorate and the purpose of the March 23rd letter was to set out to you those concerns on an informal basis in order to enable you to put in place measures to rectify the concerns. The issues of concern did not result from a specific complaint.

The letter was not set out to you in the context of an informal process under the Maintaining High Professional Standards Framework but rather was an informal attempt at local resolution of the issues, sent to you through normal line management channels. It was expected that as an experienced and senior Consultant, this notification of concern to you was sufficient to ensure you took all necessary steps to address the concerns and to rectify the identified problems.

You state in your submission to Mr Wilkinson that an agreement was in place that formal contact or meetings would not take place between you and Mr Mackle due to a prior grievance process. I am not aware of this background or the agreement referred to. I understand the Medical Director, Dr Wright is also unaware of this matter. As you will be aware, Dr Gillian Rankin has retired from the Trust. I feel this is a matter best dealt with via the formal investigation process and I would ask that you raise this with the Case Investigator to fully explore the background and history of what preceded the management of the concerns under the MHPS Framework as is relevant to the current investigation.

2. Formal Investigation

You have raised the matter of the circumstances which led to the decision to manage the concerns under the formal process of the MHPS Framework. As you know, there were concerns raised with you in March 2016 about your administrative practices and the impact on patient management and care.

Management follow up is not clear to me at present. It is not my role to investigate the detail of this and I believe this is again a relevant matter for the formal investigation process. I am however aware that Mr Colin Weir was in post as Clinical Director in the period following March 2016 and given your representations to Mr Wilkinson, I feel it is likely Mr Weir may be required to provide information to the investigation on this issue. Therefore I have asked Mr Weir to step down from his role as Case Investigator and I have asked Dr Neta Chada, Associate Medical Director to undertake the role of Case Investigator. Dr Chada will be in contact with you in due course.

The SAI process you refer to in your submission, alerted the Trust to a very serious issue of concern which indicated harm had come to a patient who had not been properly triaged by you as was required. The issue was one of the same issues alerted to you informally in March 2016. You have noted that a decision was made to immediately exclude you from work prior to the finalised report on the SAI. The reason for this decision was due to the very serious nature of the concern. The Trust must ensure patient safety is properly safeguarded and when matters of serious concern arise, consideration is given to any necessary action to immediately ensure the safety of patients. It is for this reason, a decision was made to exclude you and to move to a formal investigation of the concerns.

As a minimum, terms of reference should set out:

- the issues to be investigated;
- the period under investigation;
- the timescale for completion.

It may be that as the investigation progresses the terms of reference are found to be too narrow or that new issues emerge that warrant further investigation. In such cases, the investigator(s) should inform the case manager who should seek the agreement of the responsible manager or DMG to a widening of the terms. Such requests should be decided on promptly so that the investigation is not delayed. The practitioner must be informed of any changes to the terms of reference unless, exceptionally, he is kept unaware of the investigation at all.

3.2 Appoint a case manager

A case manager is normally appointed by the DMG (in primary care) or the responsible manager (in the H&C sector). Usual practice is for a case manager to be a senior member of the organisation's staff, with a role to:

- ensure that the investigation is conducted efficiently;
- ensure that confidentiality is maintained where appropriate;
- act as the coordinator between investigators, the practitioner and anyone who the investigators need to interview;
- obtain any documentation required;
- ensure that the process is properly documented;
- receive the investigator's report;
- make recommendations to the responsible manager or the DMG on what action might follow, having regard to the contents of the investigator's report.

To be seen to be objective, case managers need to be able to demonstrate that they:

- understand the general nature of the concerns raised and the clinical and work contexts in which they occurred;
- are sufficiently senior within the organisation to secure the cooperation of other staff members;
- are familiar with the local policy for investigating concerns and related procedures;
- have, preferably, some training and experience in undertaking performance investigations;
- have access to relevant advice and expertise from colleagues within the organisation;
- have access to relevant external experts and authority to instruct them;
- have the necessary protected time to support the investigation.

The case manager should have no real or perceived conflict of interest in relation to any aspect of the investigation. Given the structure of the NHS and the small size of some organisations, minor conflicts of interest are difficult to avoid. Any reservations about the choice of a case manager ought to be reported to the DMG or responsible officer at the outset so that a decision can be made about their significance. The practitioner's views should also be taken into account.

In England, MHPS requires that the medical director should act as case manager for cases involving clinical directors and consultants.

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 08 February 2017 22:14
To: Khan, Ahmed
Cc: Toal, Vivienne; Gishkori, Esther; Wright, Richard; Weir, Colin
Subject: RE: Terms of Reference for Investigation January 2017 DRAFT FINAL

Dr Khan

The issue of how a successful appraisal has been signed off will certainly be part of the queries needing to be answered by some we interview. However in respect of a TOR for this investigation, it is not a matter of concern for AOB to answer necessarily, which is what the TOR for this investigation needs to focus on.

Siobhan

From: Khan, Ahmed
Sent: 08 February 2017 14:52
To: Hynds, Siobhan
Cc: Toal, Vivienne; Gishkori, Esther; Wright, Richard; Weir, Colin
Subject: RE: Terms of Reference for Investigation January 2017 DRAFT FINAL

Siobhan, As discussed previously should completing successful Appraisals while these ongoing issues be part of investigations TOR?
Thanks,
Ahmed

Dr Ahmed Khan
Consultant Paediatrician
Associate Medical Director
Children & young people Directorate
SHSCT

From: Hynds, Siobhan
Sent: 07 February 2017 20:26
To: Khan, Ahmed
Cc: Toal, Vivienne; Gishkori, Esther; Wright, Richard; Weir, Colin
Subject: Terms of Reference for Investigation January 2017 DRAFT FINAL
Importance: High

Dr Khan

Please see attached draft Terms of Reference for the AOB investigation for your comment / agreement. Once agreed we can share these with AOB at our meeting this week.

Oversight Committee – for your comment / agreement.

Many thanks

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 15 March 2017 00:01
To: Khan, Ahmed
Cc: Chada, Neta
Subject: Terms of Reference for Investigation FINAL
Attachments: Terms of Reference for Investigation FINAL.docx; Witness List - MHPS AO'B.xlsx

Importance: High

Dr Khan

Please find attached final draft of TOR for the AO'B investigation. Please also find the proposed witness list to date although it is likely Dr Chada will need to speak to others. Once we have others determine we will update Mr O'Brien.

If you are in agreement with the drafted TOR can you please share with Mr O'Brien. Dr Chada and I are beginning the first of our meetings with witnesses this week.

Thanks

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: [redacted] Mobile: [redacted] Fax: [redacted]

Click on the above image for SharePoint: Employee Engagement & Relations information

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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)

Investigation under Maintaining High Professional Standards Framework

Witness List

Ms Martina Corrigan	Wednesday 15 March 2017
Mr Michael Young	Thursday 23 March 2017
Mrs Claire Graham	Monday 3 April 2017
Mr Ronan Carroll	Thursday 6 April 2017
Mr Eamon Mackle	Date to be confirmed
Mr Colin Weir	Date to be confirmed

Hynds, Siobhan

From: Khan, Ahmed [redacted]
Sent: 12 April 2017 13:03
To: Hynds, Siobhan
Cc: Chada, Neta
Subject: Re: MHPS Case Update

Siobhan, thanks. Would it be possible to summaries the progress of actions so far on time line. This would help us to keep track of this case's progress.
Thanks,
Ahmed

Sent from my BlackBerry 10 smartphone.

From: Hynds, Siobhan
Sent: Wednesday, 12 April 2017 00:16
To: Khan, Ahmed
Cc: Chada, Neta
Subject: MHPS Case Update

Dr Khan

On behalf of Dr Chada, I am sending you an update on the progress of the investigation relating to Mr A O'B.

To date Dr Chada and I have met with 4 witnesses and have taken comprehensive statements. These are currently being typed for agreement with the witnesses. We have identified a further 11 potential witnesses which we are currently arranging to meet with over the coming few weeks. With Easter holidays some of these meetings may be delayed long than we would ideally like.

We have established that all un-triaged referrals have now been looked at and we have been made aware of a number of referrals which, in the opinion of other Consultant Urologists, required to have been triaged as either red flag or urgent but were dealt with as routine due to non-triage. We currently understand this number to be 24 and of these 3 have been identified as SAI issues. A further 5 aware still unknown at present.

Of the notes that were missing, 13 patient files remains unaccounted for.

There has been slower progress with the undictated clinics as the work required in the review of these cases is significant. We have asked for an update on a sample of the patients to allow us to progress our investigation. As this work is slow, it may be prudent to discuss further with Dr Wright the possibility of getting further assistance with this work to move it forward. Dr Chada and I are happy to discuss further with you if required.

It is unlikely we will have completed our investigation in the next 4 weeks and therefore I will update you again in 4 weeks time. However in the meantime should you require any further information please let me know.

At a meeting with a witness this week, we were alerted to an issue whereby it appears Mr O'Brien is not assigning a clinical priority to his theatre lists causing difficulty in prioritisation of patients when sessions had to be adjusted / cancelled. Given the action plan in place and the issues of concern being investigated, Dr Chada has asked me to bring this to your attention as a matter of priority. Should you require any further detail please give me a call on [redacted]

Regards,

Toal, Vivienne

From: Khan, Ahmed [redacted]
Sent: 14 April 2017 09:09
To: Wright, Richard
Cc: Toal, Vivienne
Subject: Re: urology escalation - [redacted]

Richard, I have spoken to AOB yesterday over the phone and informed him regarding SAIs. He did raised concern regarding time taken for the case so far. Also updated Mr Wilkinson.
Is there a possibility for some more dedicated resource for this case? especially as it is becoming more complex.
Thanks
Ahmed

Sent from my BlackBerry 10 smartphone.

From: Wright, Richard
Sent: Wednesday, 12 April 2017 12:22
To: Khan, Ahmed
Cc: Toal, Vivienne
Subject: Fwd: urology escalation - [redacted]

Hi Ahmed. Can you arrange to meet with AOB to inform him of these two further SAIs ASAP.?
Thanks Richard

Sent from my iPad

Begin forwarded message:

> **From:** "Hynds, Siobhan" [redacted]
> **Date:** 12 April 2017 at 00:25:04 BST
> **To:** "Toal, Vivienne" [redacted], "Wright, Richard" [redacted]
> **Subject: RE: urology escalation -** [redacted]
>
> Vivienne
>
> The second SAI I understand hasn't started yet and this is now a third. I have sent this detail through in my update to Dr Khan and I have asked him to update John Wilkinson. We haven't yet met with AOB so we haven't alerted him to these cases. He will need to be alerted urgently as the case updates will flag it to him and this is not the route he should be hearing this.
>
> I am assuming Dr Khan as Case manager should be alerting him formally in a meeting with AOB??
>
> Siobhan
>
> ---
>
> **From:** Toal, Vivienne
> **Sent:** 11 April 2017 21:44
> **To:** Hynds, Siobhan; Wright, Richard
> **Subject:** FW: urology escalation [redacted]
> **Importance:** High
>
> Siobhan / Richard

Hynds, Siobhan

From: Corrigan, Martina [redacted]
Sent: 07 June 2017 18:25
To: Hynds, Siobhan
Cc: Carroll, Ronan
Subject: undictated clinics
Attachments: OC 1.pdf; OC2.pdf; OC3.pdf; OC4.pdf; OC5.pdf; OC6.pdf; OC8.pdf; OC9.pdf

Hi Siobhan

To update on the findings from the undictated clinics:

There are 110 patients who are being added to a Review OP waiting lists – a number of these should have had an appointment as per Mr O'Brien's handwritten clinical notes before now, however I would add that Mr O'Brien has a Review Backlog issue already so these patients even if they had of been added timely may still not have been seen.

There are 35 patients who need to be added to a theatre waiting lists, all of these patients he has classed as category 4 which is routine and again due to the backlog.

I have attached Mr O'Brien's sheets that he had given me in January after he had returned the charts.

I have now gone through all of the charts that were in the AMD office and will be back in Health Records tomorrow.

Katherine Robinson's team are currently recording the outcomes from these and these will all be backdated to when the clinics happened.

There were 3 patients whom the consultants have concerns on and I had arranged urgent appointments for them. One has since been sorted and no further concerns. The other two have cancelled their appointments themselves and have been rearranged for beginning of July so I will keep an eye on these and make sure there is no more concerns.

Other comments made by the consultant were:

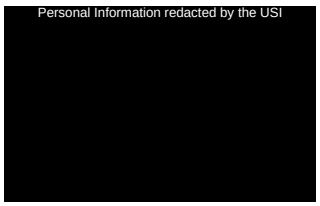
1. Patient seen by 6 times at clinic and notes written in the patients chart but no dictated letter
2. Patient seen initially as a private patient and there is a letter in chart for private visit but none for NHS visit
3. Patient seen x 14 times at clinics (so well looked after) but no letters so how does the GP know what is going on?
4. Patient seen at clinic on 19/9/16 letter dictated retrospectively on 28/02/17.
5. According to PAS the patient attended the clinic but according to handwritten notes they DNA and Mr O'Brien had asked that they be sent for again
6. Patient seen on 11/04/16 but letter was dictated on 22/02/17.

If there is anything further in respect to this please do not hesitate to contact me

Regards

Martina

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



30 July 2017.

Dr. Ahmed Khan,
Associate Medical Director,
Southern Health and Social Care Trust,
Trust Headquarters,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear Dr. Khan,

Re: Formal Investigation.

As you may know, I have been invited to interview by Dr. Chada, the Case Investigator, on Thursday 03 August 2017. I therefore wish to take this opportunity to register the cumulative concerns which I have had regarding the above investigation, the events leading to it and its conduct to date.

First amongst these is the relationship between 'Maintaining High Professional Standards in the Modern HPSS' issued by the Department of Health, Social Services & Public Safety (DHSSPS) in November 2005 and the 'Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' issued by the Southern Health and Social Care Trust (SHSCT) in September 2010. 'Maintaining High Professional Standards in the Modern HPSS' (MHPS) is a framework for the handling of concerns about doctors and dentists in the HPSS. In Paragraph 3 of the Framework, the DHSSPS obliges HPSS organisations to notify the Department of the action they have taken to comply with the framework. In response to that obligation, the SHSCT formulated and issued its Guidelines in September 2010.

Paragraph 1.5 of the Trust Guidelines states that the 'guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about its doctors and dentists,

amended Note to be sent to me, taking consideration of my comments. I sent a further email to Mrs. Hynds on 19 April 2017, advising her that I still awaited receipt of an amended Note of the meeting of 30 December 2016. I have yet to receive a reply, or an amended Note.

As a consequence of my contacting the Case Investigator on 16 January 2017, and of my letter to the Medical Director on 17 January 2017, I was advised by the Case Investigator, by telephone on 19 January 2017, that a meeting was arranged with him and with Mrs. Hynds on 24 January 2017. I was advised that the purpose of the meeting was to discuss alternatives to exclusion. I was then advised by the Case Investigator, in writing on 20 January 2017, that the purpose of the meeting was two-fold, an opportunity to state my case and to propose alternatives to formal exclusion, even though I had not yet been provided an opportunity to discuss alternatives to immediate exclusion. On 23 January 2017, the Medical Director confirmed in writing that a date for the meeting had been proposed. The Medical Director did not advise me of any specific reasons or justifications for immediate exclusion as requested. He did however avail of the opportunity to opine that the Trust Guidelines created an expectation that investigations are completed in four weeks, even though the Guidelines explicitly assert that investigations must be completed within four weeks. That the investigation was in breach of Trust Guidelines was acknowledged at the meeting with the Case Investigator and with Mrs. Hynds on 24 January 2017. That acknowledgement was not included in the Note of the Meeting.

At that meeting, I asked for specific reasons for my immediate exclusion. None could be given. I asked for specific reasons why exclusion should be continued. None could be given. That none could be given was not included in the Note of the Meeting.

It was at that meeting that it was claimed that a fourth issue of concern was identified during the initial scoping exercise and relating to nine patients who had private outpatient consultations, and who then had prostatic resections performed as NHS patients, after waiting times significantly less than for other patients. However, it was not possible for this fourth concern to be identified during scoping of triage of NHS referrals, NHS outpatient consultations and NHS charts retained at my home. I requested how this concern had been raised or who had raised it. I was advised that I would be advised of the source. Six months later, I have still not been advised. I requested the identity of the nine patients concerned. I still have not been advised of their identity. I asked

whether patients who had had private consultations and who still awaited prostatic resection had been identified, or whether NHS patients who had prostatic resections performed after a similarly short waiting time would be included in a comparative manner in such an investigation. Indeed, in a further communication from the Medical Director, dated 30 March 2017, he advised that all nine patients were classified as routine. I do not know how he could have come to such a conclusion, or who did so, on his behalf. Now, six months later and four days before interview by the Case Investigator, I have still not been advised of any further developments in the investigation of this fourth concern.

On 06 February 2017, I received from Mrs. Hynds a Note of the Meeting of 24 January 2017, inviting me to advise her of any amendments required to the factual accuracy of the Note. On 28 March 2017, I submitted to Mrs. Hynds amendments to be made as a consequence of factual errors and omissions. I still have not received an amended Note.

I was provided with the Terms of Reference for the investigation on 16 March 2017, though NCAS guidelines stipulate that the terms of reference be provided to the practitioner when advised of the formal investigation. On the same date, I was provided with a list of seven witnesses. Dr. Chada advised in her letter of 14 June 2017 that I will have received a witness list from her at an earlier date. I have not received any such list from Dr. Chada. I have not been provided with the testimonies of any witnesses. I have not yet been provided an opportunity to see all relevant correspondence, as obliged by Trust Guidelines.

I had considered deferring this record of my concerns until after interview by Dr. Chada. However, I have decided to do so at this time after a recent experience. I had taken annual leave the week commencing Monday 10 July 2017, but had agreed upon request to be on call on Saturday 15 July and Sunday 16 July 2017. On Friday 14 July 2017, I received calls from colleagues advising me of patients acutely admitted for surgery over the weekend. There were a total of eight patients requiring urgent surgery but I was only able to operate on four due to lack of theatre capacity. Some days later, I was approached by a member of staff whom I presume has not known of this investigation but was concerned enough to advise me that an investigation was being conducted into the cases upon whom I had operated, as it had been reported that I had arranged for one or more of these patients to be admitted electively. I was shocked by this revelation. I reported this experience when I

Hynds, Siobhan

From: Chada, Neta [redacted]
Sent: 12 February 2018 10:45
To: Khan, Ahmed; Hynds, Siobhan
Subject: RE: MHPS Case Update

Follow Up Flag: Follow up
Flag Status: Flagged

Hi ahmed

The last we spoke to this doctor he was to get back to us – he had explained he wanted time out to sort out his appraisal. So I think we are waiting for him to get back to us, rather than any delay on our part

neta

From: Khan, Ahmed
Sent: 07 February 2018 13:05
To: Hynds, Siobhan
Cc: Chada, Neta
Subject: RE: MHPS Case Update

Dear Siobhan, I haven't heard any updates for this case in last couple of months. kindly let me know the progress.
Thanks,
Ahmed

Dr Ahmed Khan
Consultant Paediatrician
Associate Medical Director
Children & young people Directorate
SHSCT

From: Hynds, Siobhan
Sent: 20 November 2017 20:00
To: Khan, Ahmed
Cc: Chada, Neta
Subject: MHPS Case Update
Importance: High

Dr Khan

Case Update on behalf of Dr Chada.

Dr Chada met with Mr O'Brien on 6 November to discuss the final issues outstanding as part of her investigation. No further meetings are planned and a report will be completed as soon as possible for your consideration.

Mr O'Brien will require to sign off his statement from the first meeting with him which has not yet been

	patients, whom the doctor had decided were urgent referrals, who were erroneously added to the routine referral list. **AK advised (6.6.18):** Once the problem was identified: (1) an SAI was commenced; (2) an MHPS investigation was commenced; (3) the doctor's referral paperwork was (and still is) closely monitored to ensure that it is completed within the required time frame – this monitoring provides complete assurance that no urgent cases are defaulted into the routine case list. **AK confirmed (6.6.18):** the doctor does not work for any private organisation; however he does do some private work from his own home involving triaging and referring urology patients referred by their GP. **JD advised (6.6.18):** it would be prudent for AK to secure an undertaking from the doctor that he will not do any private work from his own home – as it is impossible for AK to monitor his work there to ensure that there are no patient safety risks around delayed urgent referrals – until AK is satisfied that the risk is removed/being managed appropriately. **AK confirmed (6.6.18):** there is no suggestion that the doctor has health issues that may be contributing to the concerns. AK does not yet have a sense of the doctor's insight, remediation, engagement – this is something the MHPS Report will deal with. AK advised that at this stage he is not able to comment on any adverse impact on patients (prior to the concern being picked up)/need for patient recall –that will be examined by the SAI. AK confirmed: he will update JD on the MHPS investigation as soon as he can. And on the SAI investigation as soon as he can. In the		

Gibson, Simon

From: Joanne Donnelly [redacted]
Sent: 08 June 2018 14:53
To: ahmed.khan [redacted]
Cc: Gibson, Simon; zoe.parks [redacted] Thompson, Norma [redacted]; Support TeamELS
Subject: SHSCT ELA/RO Meeting 6.6.18 - Urology consultant

Dear Ahmed,

Thank you for taking the time to meet with Andy Lewis and I on Wednesday 6 June 18.

Just to confirm our conversation about the WHSCT "urology consultant" in the "local concerns" part of our ELA/RO meeting on Wednesday.

You advised that there are no clinical concerns about this doctor. The concerns relate to administrative delays on his part in completing routine/urgent referral paperwork after he sees urology patients for their first triaging appointment. The problem is exacerbated by the Trust system which defaults patients to "routine referral" automatically if no referral is completed by the doctor within a certain timeframe. The combined result of: (1) delays on the part of the doctor in completing the paperwork for referrals and (2) a system which defaults patients to "routine referral" where no paperwork is received, is that there were patients, whom the doctor had decided were urgent referrals, who were erroneously added to the routine referral list.

You advised that once the problem was identified: (1) an SAI was commenced; (2) an MHPS investigation was commenced (Zoe (Parks) confirmed to me yesterday that this has been completed and that the final report is to go to the Case Manager on Tuesday 12.6.18 then to you); (3) the doctor's referral paperwork is now closely monitored to ensure that it is completed within the required time frame – this monitoring provides complete assurance that no urgent cases are defaulted into the routine case list.

You also confirmed that while the doctor does not work for any private organisation, he does do some private work from his own home involving triaging and referring urology patients referred by their GP. Andy (Lewis) and I advised that in our view it would be prudent for you to secure an undertaking from the doctor that he will not do any private work from his own home – as it is impossible for you to monitor his work there to ensure that there are no patient safety risks around delayed urgent referrals – until you are satisfied that the risk is removed/being managed appropriately.

You also confirmed that there is no suggestion that the doctor has health issues that may be contributing to the concerns. You advised that you are not yet able to give me a sense of the doctors insight/remediation/engagement – this is something you say the MHPS Report will deal with.

You advised that at this stage you are not able to comment on any adverse impact on patients (seen prior to the concern being picked up)/need for patient recall – and that that will be examined by the SAI. Though I expect that there must have been some adverse impact on a patient(s) for a SAI investigation to have been triggered?

We agreed that you would update me on the MHPS investigation as soon as you can. And on the SAI investigation as soon as you can. At that stage we can then have a threshold discussion. In the meantime you are assured there are no patient safety risks – subject to the doctor providing an undertaking in relation to the work he does in his own home. I would be grateful if you would confirm to me, just as soon as you can, that the doctor has provided this undertaking and that you are confident that you can rely on it.

I hope this is helpful. I look forward to speaking to you soon.
Best wishes

Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

	6.00 – 7.00	Administration	CAH	1.0					
Thurs	8.30 – 9.30	Radiology meeting	CAH	1.0					
	9.30 – 12.00	Grand Ward Round + SPA	CAH	1.0	1.5				
	12.00 – 1.30	Departmental Meeting	CAH	1.5					
	1.30 – 2.15	Lunch						9.75	
	2.15 – 5.00	MDM	CAH	2.75					
	5.00 – 5.30	MDM Admin	CAH	0.5					
	5.30 – 7.00	Administration	CAH	1.5					
Fri	9.00 – 12.00	OFF							
	12.00 – 1.00	Admin	CAH	1.0				5.5	
	1.00-1.30	Ward Round	CAH	0.5					
	1.30-5.30	Specialist clinic	CAH	4.0					
			TOTAL HOURS:	38.25	6			44.25	
			TOTAL PROGRAMMED ACTIVITIES:	**9.56**	**1.5**			**11.06**	

4. EMERGENCY WORKLOAD

Type	Day/Time	Location	Allocated PAs
Predictable Emergency on-call Work*			
Unpredictable Emergency on-call Work*	11.4 hours per week		**1.57**
TOTAL PA's for ON-CALL:		**1.57**	

*Please refer to Medical Staffing / Trust Guidance for method for calculating on-call so that prospective cover is included – this means cover will need to be provided for absent colleagues on annual leave and study leave.

On-call availability Supplement	
On-call Category	A
Agreed on-call Rota Frequency	1:3 Prospective
On-Call Supplement	8%

to an agreed action plan with on-going monitoring so that any risks to patients have been addressed.

There were 5 Terms of Reference for the investigation (although the last related to the extent to which the managers knew of or had previously managed the concerns). You told me that having read the report, the factual accuracy of which Dr 18665 has had a chance to comment on, you have concluded that there was evidence to support many of the allegations with regards to Dr 18665. Specifically, following detailed consideration, you noted that:

a) There were clear issues of concern about Dr 18665's way of working and his management of his workload. There has been potential harm to a large number of patients (783) and actual harm to at least 5 patients;
b) Dr 18665's reflection throughout the investigation process was concerning and in particular in respect of the 5 patients diagnosed with cancer;
c) As a senior member of staff within the Trust Dr 18665 had a clear obligation to ensure managers within the Trust were fully and explicitly aware that he was not undertaking routine and urgent triage as was expected;
d) There has been significant impact on the Trust in terms of its ability to properly manage patients, manage waiting lists and the extensive look back exercise which was required to identify patients who may have been affected by the deficiencies in Dr 18665's practice (and to address these issues for patients);
e) There is no evidence of concern about Dr 18665's clinical ability with individual patients;
f) Dr 18665 had advantaged his own private patients over HSC patients on at least 9 occasions;
g) The issues of concern were known to some extent for some time by a range of managers and no proper action was taken to address and manage the concerns;

You told me that the SAI (serious adverse incident) investigation, which has patient involvement, is looking at the issue where patients have, or may have been, harmed as a result of failings. You are aware that patients are entitled to know this.

We discussed the current situation and the overriding need to ensure patients are protected. I note that you have a system in place within the Trust to safeguard patients, but we discussed that this needs to be mirrored in the private sector. You explained that Dr 18665 saw private patients at his home and did not have a private sector employer. I would suggest that as paragraph 22 of Section II MHPS states that *"where a HPSS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer"* Dr 18665 should not currently be working privately.

We discussed that the issues identified in the report were serious, and that whilst there are clearly systemic issues and failings for the Trust to address, it is unlikely that in these circumstances the concerns about Dr 18665 could be managed without formal action. We also discussed that whilst the issues did have clinical consequences for patients, as some of the concerns appear to be due to a failure to follow policies and protocols, and possibly also a breach of data protection law, these might be considered to be matters of conduct rather than capability. We noted therefore that it would be open to you in your

Ahmed Khan (CUH Paediatric Consultant)

From: Khan, Ahmed
Sent: Thursday 28 June 2018 15:37
To: Thompson, Norma; Gibson, Simon
Subject: RE: SHSCT ELA/RO Meeting 6.6.18 - Urology consultant
Attachments: NT Comments SHSCT - draft (15.6.18) Meeting note (6.6.18).docx

Norma, I had brief discussion with Vivienne regarding this however on reflection I am personally leaning towards her advice to request an undertaking from AOB.
Didn't get talking to Vivienne before she left for A/L.

Simon, can you & Richard discuss with Viv and reply to Joanne. We also need to inform her regarding minutes. Amendments, please make another corrections as
"MHPS is due to complete soon"
Thanks
Ahmed

From: Thompson, Norma
Sent: 19 June 2018 17:00
To: Khan, Ahmed
Subject: FW: SHSCT ELA/RO Meeting 6.6.18 - Urology consultant

Ahmed, see below – did you get speaking to Vivienne about this as yet?
N

From: Parks, Zoe
Sent: 19 June 2018 16:59
To: Thompson, Norma
Subject: FW: SHSCT ELA/RO Meeting 6.6.18 - Urology consultant

Actually – on reflection , I know Vivienne was going to speak with Dr Khan about this as she felt very strongly on this issue that it wasn't something we could do at this stage. Dr Khan will hopefully have spoken to Vivienne – and I suspect he will then need to update Joanne Donnelly on these discussions.

From: Thompson, Norma
Sent: 19 June 2018 16:53
To: Gibson, Simon; Parks, Zoe
Subject: FW: SHSCT ELA/RO Meeting 6.6.18 - Urology consultant

Hi Simon / Zoe, re. below – has anyone written to Aidan yet re. undertaking private work at home?

Kind regards
Norma

From: Joanne Donnelly [redacted]
Personal Information redacted by the USI
Sent: 08 June 2018 14:53

Southern Health and Social Care Trust

Quality Care - for you, with you

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

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.

From:	Carroll, Ronan
To:	Wright, Richard; Kerr, Vivienne; Gishkori, Esther; Gibson, Simon; Boyce, Tracey
Subject:	FW: Backlog report - no clinic outcomes
Date:	23 December 2016 10:24:54
Attachments:	Backlog Report - no clinic outcomes as per 15.12.16.xlsx
Importance:	High

Please see updated position re AoB backlog of undictated clinics

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

From: Carroll, Anita
Sent: 22 December 2016 13:59
To: Carroll, Ronan
Subject: FW: Backlog report - no clinic outcomes
Importance: High

Maybe we can get a chat about this

From: Robinson, Katherine
Sent: 20 December 2016 17:07
To: Carroll, Anita
Subject: FW: Backlog report - no clinic outcomes
Importance: High

See attached list. This is a list of clinics that Mr O,Brien has not dictated on and hence no outcome for some of these patients. There is a risk that something could be missed so I am escalating to you, although I know that a lot of the time Mr O'Brien knows himself what is to happen with patients. Unfortunately this was not highlighted on the backlog report. The secretary assumed we knew because there have always been issues with this particular consultant's admin work from our perspective.

As learning from this discovery I have asked all secretaries to provide this information on the backlog report so that we fully understand the whole picture of what is outstanding in each specialty. The secretary also advises that at present Mr O'Brien is working on some of his backlogged admin work as he is off sick recovering.

Regards

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

Corrigan, Martina

From: Haynes, Mark [redacted]
Sent: 17 June 2017 07:05
To: Evans, Marie; Corrigan, Martina; Robinson, Katherine
Subject: RE: CLINICAL CORRESPONDANCE BACKLOG REPORT - MAY 17

Morning Marie / Martina / Katherine

Thanks for continuing to send this round, it is useful to have a clear picture of the pressures on our admin and clerical team. One minor point relates to the clinics to be dictated / clinics to be typed columns – I assume these should read clinic letters to be dictate / clinic letters to be typed?

However, I am concerned regarding the robustness of this data, particularly in relation to 'results to be dictated'.

Could you advise me of the process whereby this data is collected? From recent experiences I would suggest that the data presented in this column is inaccurate. My concern relates to how this information would be used in the event of a significant issue arising due to a delayed / not acted on result – corporately are we kidding ourselves that all results are acted on / dictated on in a timely manner? That is the conclusion you could draw from the information, particularly in relation to some consultants. If a backlog were identified after an issue were to arise, are the staff who collect the data (I presume our secretaries) liable to be found culpable for not highlighting the backlog through this process? One could argue that the information presented whereby some consultants seem to barely ever have any results to dictate is not untrue – not all of us dictate letters on results! An illustration of the inaccuracy of the data may be seen in last years data in relation to number of clinics to be dictated, which has been proven to be inaccurate.

As stated, I think collection of this information is important and I would like it to continue to be circulated to us but would like to ensure that the data collected is robust. I am happy to be involved in any discussion required.

Thanks

Mark

From: Evans, Marie
Sent: 30 May 2017 11:20
To: Young, Michael; O'Brien, Aidan; Jacob, Thomas; Haynes, Mark; Glackin, Anthony; ODonoghue, JohnP
Cc: Carroll, Ronan; Clayton, Wendy; Corrigan, Martina; Robinson, Katherine
Subject: CLINICAL CORRESPONDANCE BACKLOG REPORT - MAY 17

Dear all

Please find attached the backlog reports for May 17.

Any queries let me know.

Kind Regards
Marie

Marie Evans
Service Administrator
Ground Floor
Ramone Building
CAH