seen. The numbers being upgraded were not that many and I felt the risk was relatively small for the one that may slip through. New urology colleagues were not willing to let him not triage.

13. I was involved in the conversation regarding the 23 March 2016 letter which was issued to Mr O'Brien. Mr O'Brien's general way of doing this is maverick. Every Director knew but nothing moved. I felt with the newly appointed Medical Director things might progress. There was a meeting held with Dr Wright on 11 January 2016 at 10 am and the concerns were outlined to him and I took his advice so we formally addressed the issues via a letter.

14. Some time ago Eamon Mackle tried to address the issues but Dr Rankin had said not to do anything further because a complaint had been received accusing Eamon Mackle of bullying and he was told he should not address further issues with Mr O'Brien. Eamon Mackle appointed Robin Brown to be a go between with Urology. Mr Brown made attempts too. Improvements were short term but then he went back to his behaviours again. There was a general view that Eamon Mackle was unable to deal with the issues because he was told not to. In my opinion Mr Young and Mr Brown felt uncomfortable holding Mr O'Brien to account.

15. I feel, their view was that he is a very intelligent man and a good doctor, therefore we could overlook small things. Trying to get peer and medical management support to deal with the issues was difficult to do.

16. The letter was sent to address issues regarding not triaging, his review backlog and notes at home. More recently there has been new appointments made and so there is a bigger urology team and there are members who were willing to peer challenge. The letter was given to Mr O'Brien and the expectation was that he would set out a plan as to how he was going to deal with the outstanding work.

17. I moved post on 1st April 2016, so I left it with Esther Gishkori and Ronan Carroll to deal with the action plan. I got nothing back directly from Mr O'Brien.

18. Mr O'Brien was outwith other Consultants I dealt with. I didn't come across any other surgeon who didn't agree with or partake in triage.

19. I know there was an issue with Mr O'Brien taking notes home because some were missing and Martina Corrigan had to chase these. Mr O'Brien was told he should not have notes at home. He was also told by Mr Young and Mr Brown. I shared an email of 22 January 2015 as an example of this issue which is appended to this statement. Mr O'Brien would bring them back but the process started again. I didn't know the number of charts he had or if it was a constant trickle. He should not have had any at home.

20. In respect of TOR 3, I was unaware that dictation was an issue until March 2016 when colleagues started doing validation of backlog. There has always been a review backlog in Urology but they have tended to hold on to patients to review the clinical decision. The review backlog for Mr O'Brien was particularly long. Others addressed theirs so Tony Glackin and Mark Haynes looked back to try to sort the issues. This was done on Patient Centre not via the notes. During that process they realised that nothing was on Patient Centre so that prompted my concern in March

the 3 categories of referral. Mr O'Brien would have said red flags were important but that others were equally important .~~and the others were not important~~. He didn't agree with the system in place.

6. Many of us were aware that Mr O'Brien didn't agree with the system in place and so on weeks when he was due to do triage it was addressed with the clinical lead – his colleagues often picked up the slack. Despite many requests ~~i~~It was not always possible to get Mr O'Brien to do triage in a timely manner so a default position was adopted to ensure patients weren't waiting to be booked at all. I know it isn't satisfactory but it is what happened. The default position was known and agreed by the Director, the AMD, myself as AD and the Head of Service. It was felt that it was at least some safety measure.

7. I had numerous conversations with Mr O'Brien about triage, notes and his review backlog. He always disagreed with the triage. I would have said to him that that's the system in place and I would have tried to help him. Sometimes there was a change for a short period of time but then he reverted to his own way of doing things.

8. It has been a problem since I came into post, Michael Young was the Clinical Lead, Mr O'Brien the 2nd Consultant and the third person changed regularly so didn't have management input so there was not a lot of clinical challenge to Mr O'Brien. I addressed concerns about Mr O'Brien with Michael Young and he spoke to him. But it was the way it was under both Dr Rankin and Debbie Burns since 2009.

9. Did Mr O'Brien ever say he was not doing triage or clinic dictation, possibly, but it was never agreed he could not do it. Don't know what this means. There was a Urology review during this time and experts made recommendations at consultant level. Mr O'Brien did not agree with them. Mr O'Brien had his own view about things. He was clear about what he did not agree with and felt he needed more admin time generally, he handwrites everything. As an example, the way it generally works is that a Theatre list is agreed and the Consultant will ask their secretary to list the date and to organise and the secretary goes off to do that including arranging for the patient to attend. Mr O'Brien however insists on ringing every patient himself to attend but that is not what we need him to be doing. He wanted admin sessions to fit in with every aspect of what he wanted to do. He is already on a high number of PA's so to give additional time for admin is not sensible because he didn't use the admin support available to him. There was never an issue of other specialities doing triage.

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10. When the issues were raised, Michael Young as the Clinical Lead would have said he would sort it out so it was left with him and he would have helped Mr O'Brien in his practice and so the issues were improved for a period of time.

11. While I was concerned about his practice I was content patients were being seen and red flags were being done. As most referrals came in as red flags I was satisfied patients were being seen. I did have a concern about upgraded referrals but there was no data to show how many were being upgraded so I felt relatively comfortable that patients coming in as red flags were being

Southern Health and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

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

1. Untriaged outpatient referral letters

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

2. Current Review Backlog up to 29 February 2016

Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

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

3. Patient Centre letters and recorded outcomes from Clinics

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

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

4. **Patient Notes at home**

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

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

Yours sincerely,

Eamon Mackle
Associate Medical Director

Heather Trouton
Assistant Director

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

Corrigan, Martina

From: Corrigan, Martina
Sent: 28 April 2016 16:25
To: Carroll, Ronan
Subject: FW: Confidential letter to AOB - updated March 2016
Attachments: Confidential letter to AOB - updated March 2016.docx; Actions from AMD and Mr Suresh Meeting; Actions from AMD and Urology Consultant Meeting

Ronan,

Conscious that we are currently without an AMD and a CD in our division and there were a few issues that were been taken forward by Eamon and I want to make sure that they are not forgotten about. The Medical Director is aware of these.

Attached is joint letter from Eamon and Heather to Aidan. Eamon and I met with him and on 30 March 2016 and discussed the issues and gave him the letter, we were to get a response in 4 weeks (nothing as of yet).

There is also an on-going issue with Ram Suresh and I will update you about this when we next see each other, again Eamon and I have been taking this forward and I attach some emails regarding this, again now that we have no AMD and CD, this still needs to be actioned, because yet again he is oncall this week and no formal cover.

There is also the issue of Job Plans. Mark Haynes has firstly been trying to get his job plan put on Zicardian since he started 2 yrs ago (11 May 2014). It has now been put on and he is waiting for sign-off and there was to be a meeting with Eamon to get this signed off. He is constantly asking me about it as he needs it sorted – again not sure how to progress?

Happy to discuss further but wanted to make sure so that you are aware of these.

Martina

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

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

alternatively allow the patient to wait 1.5 years for an urgent consultation, or some combination of both, and which I believe and have argued is unsafe on both counts. In any case, we were not allocated any predictable time at all in our job plans for triage while urologists of the week, and the Southern Trust does not have a Policy and Procedure on Triage, even though it claimed in writing in 2017 that it did do so, and that I was not compliant with it.

It is the Trust's actions since the beginning of 2016 that are the subject of my grievance.

2.3.1: <u>The Letter dated 23rd March 2016</u>

The Trust only raised the concerns with me once and this was in March 2016. This was in a letter dated 23rd March 2016 signed by Eamon Mackle, Associate Medical Director, and Heather Trouton, Assistant Director, which is attached in the schedule of documents at Tab 8.

The origin of this letter appears to be a meeting held by Heather Trouton and Dr Richard Wright, Medical Director on 11th January 2016 at 10am. I do have any Minutes or other record of this meeting. However, Heather Trouton has provided a witness statement which is attached in the schedule of documents at Tab 9. At Paragraph 13 of her statement, she asserts she addressed the concerns with Dr Wright as he was a newly appointed Medical Director and that at that meeting on 11th January 2018, she outlined the concerns to him and that she "*took his advice so we formally addressed the issues via a letter*".

I attended at a short meeting on or around the 23rd March 2016 with Eamon Mackle and Martina Corrigan, Head of Service. They handed me the letter dated 23rd March 2016 at the meeting. The letter makes reference to four areas of concern;

a) Untriaged outpatient referral letters – it was stated there were 253 untriaged letters dating back to December 2014;

b) Current Review Backlog – it was stated there was a review backlog of 679 patients in addition to a cancer review waiting list of 286 patients;

c) Patient Centre Letters – the Letter stated that there was a concern about frustration that there was no record of consultations / discharges on Patient Centre; and

d) Patient Notes at home – the letter asked for notes kept in my home to be brought back to the hospital.

The letter is not described as a formal letter. It does not refer to the Trust Guidelines. It does not state on the face of the letter that it was issued pursuant to any Trust policy or procedure. It does not refer in any way to any suggestion of misconduct or even to a performance issue. Neither expressly nor impliedly can it be interpreted as a formal warning, or any form of disciplinary sanction. Nor could misconduct or lack of performance be inferred from the letter. In fact, the letter starts by stating, "*We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as Consultant Urologist*". The Trust was indeed fully aware of my workload and was aware that the problems of backlogs could not be related to any lack of effort on my part. I did not have the time to do all that was expected of me to do.

review backlog and cancer review backlog and the number of untriaged referral letters, since these details are included in the letter of 23rd March 2016.

Had the Trust Guidelines been followed, the process may have lead to an informal local action plan that would likely have resolved all of the issues. I believe that such a plan would have resolved all of the issues because I have been the subject of a return to work action plan since February 2017 and it has been confirmed that these issues are no longer of concern. Paragraph 2.7 provides guidance on a local action plan. It states "*MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action".*

Even if the Medical Director had not followed the letter of the Trust Guidelines, the "*General Mutual Obligations*" of my contract of employment ought to have led the Medical Director to seek a collaborative approach. The Trust did not provide any assistance for me whatsoever. No supports were identified, no plan was drawn up.

In failing to follow the Trust Guidelines, the Trust has committed a breach of contract.

2.3.2 Attempts by Clinical Managers

As stated above, there was no follow up with me by the Trust to the letter of 23rd March 2016. Personally, I had been addressing the review backlog issue by taking on *additional* cancer clinics and I was also using any available theatre time to ease the operating waiting lists. My personal initiative was known to Trust management. I did make some headway with the Review Backlog and this was not raised as one of the concerns in December 2016. I have detailed this fully in my response at Tab 5.

Whilst no one spoke to me about the issues, it is clear that Management was considering the issue throughout the summer and autumn of 2016. By around April 2016, Mr Hall had retired and my new Clinical Director was Mr Colin Weir. I was reluctant to speak to any of the individuals who have given statements during the investigation whilst the investigation was ongoing. However, since the investigation has concluded, I have spoken to Mr Weir about a matter raised in his witness statement – which is attached to the schedule of documents at Tab 10.

Mr Weir describes activity in August and September 2016 after he was made aware of the concerns by Dr Charlie McAllister, Associate Medical Director for the Urology Service at that time. Mr Weir has confirmed to me that the concerns had been discussed at least once at the weekly meetings that he had with fellow clinical directors and Associate Medical Director. Both he and Dr McAllister were strongly of the opinion they should address these concerns with me in a constructive and supportive manner in order to see them resolved, *a fortiori* since they had given some thought as to how the backlogs could be addressed.

Mr Weir further described at Paragraph 7 of his statement that he met with Martina Corrigan, the Head of Service around the end of September 2016 and got further information about charts tracked to me, about being behind in triage of GP referrals, and the backlog that needed to be addressed. He was intent on dealing with the matter informally.

Corrigan, Martina

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

Hi Richard,

See updated position below:

1. Untriaged outpatient referral letters

There are currently 174 untriaged letters dating back to May 2016

2. Current Review Backlog up to 31 July 2016

Total in Review backlog = 679

2014	243
2015	244
2016	180

Regards

Martina

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

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

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

Southern Health and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

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

1. Untriaged outpatient referral letters

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2. Current Review Backlog up to 29 February 2016

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

3. Patient Centre letters and recorded outcomes from Clinics

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

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Corrigan, Martina

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

Strictly in confidence.

Hi Mr Weir

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

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

Thanks

Charlie

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

Dear all

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

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

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

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

Kind regards

Simon

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

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

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

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

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

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

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

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

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

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

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

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National Clinical Assessment Service

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13 September 2016

PRIVATE AND CONFIDENTIAL
Sent by email only

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

NCAS ref: 18665 (Please quote in all correspondence)

Dear Mr Gibson

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

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

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

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

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

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

The letter is from Dr Colin Fitzpatrick of NCAS and details a telephone call between Dr Fitzpatrick and Mr Simon Gibson, Assistant Director at the Medical Director's Office, which took place on 7th September 2016. Mr Gibson had advised Dr Fitzpatrick that;

a) I had a long backlog of review patients of about 700 review patients and that this was different from my consultant colleagues who had managed to clear their backlog. The comparison with my colleagues is inaccurate. I have a copy of the performance data from 13th October 2016 attached at Tab 13 of the Schedule of Documents. This shows that my review backlog was comparable to the backlog of Mr Young who is the only comparable colleague owing to his long years as a Consultant;

b) I was very slow to triage referrals. This is an inaccurate and misleading assertion as I did triage Red Flag referrals in a timely manner, but did not triage Urgent and Routine referrals for the reasons already explained and of which Management had been advised

c) I had been taking patient charts home;

d) My note taking has been reported as very poor and on occasions there are no records of consultations. This is a very serious assertion and a grave potentially actionable misrepresentation. There has not been a suggestion throughout this investigation that I have not taken notes. The concern about patient notes was related to the dictation of letters, often letters discharging patients from my care.

Mr Gibson claimed that I had been spoken to on a number of occasions about my behaviour but that no records were kept of these discussions. I have in fact *not* been spoken to on a number of occasions about my behaviour. The only communication I had was a letter on 23rd March 2016.

Despite the misleading information that Mr Gibson provided, Dr Fitzpatrick advised a supportive, remedial approach. In respect of Mr Gibson's assertion that I was guilty of poor note taking, Dr Fitzpatrick suggested that an audit could be undertaken into the notes and offered the assistance of NCAS in such an audit.

Dr Fitzpatrick also advised that the issues with Triage and the review backlog could best be addressed by meeting with me and agreeing a way forward. He suggested that I could be relieved of theatre duties to allow me to clear the backlog. Dr Fitzpatrick recognized that such a significant backlog would be difficult to clear and that I would require significant support. Dr Fitzpatrick also offered to attend this meeting.

Finally, Dr Fitzpatrick had noted that it would be likely that further input from NCAS would be required and he stated that he would keep a file open on the issues and review the matter in one month – setting a date of 7th October 2016. This review did not take place.

A second document that was attached to Dr Kahn's email is a copy of a record of the meeting of the Oversight Committee on 22nd December 2016 (attached in the Schedule of Documents at Tab 14). This was the first time that I had the opportunity to see this document despite having first requested it on 31st July 2017 by email to Ms Siobhan Hynds (see Tab 15). That fact, alone, comprises a breach of clause 3 of my contract of employment, which provides there should be mutual cooperation as between the Trust and me, and the maintenance of goodwill to ensure the efficient running of the Trust's service.

I wanted to see the Minutes of the Oversight Committee because I had been informed by the Medical Director, Dr Wright (at my first meeting with him about this issue on 30th December 2016) that it was at the meeting of the Oversight Committee in December 2016 that it had been decided to commence a formal investigation and to exclude me from work.

The contents of this record have been particularly disturbing. Whilst there are numerous parts of this record that I will refer to later in this grievance, at this point I am referring to one paragraph. It stated the following as a context for the meeting:

> "On the 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 identified further issues of concern".

I have requested the records of the meeting of 13th September 2016 and of the meeting of 12th October 2016. I have not yet been provided with those records.

I am raising the following complaints about these events in this Grievance.

Firstly, the decision to seek advice from NCAS should be taken by a responsible Clinical Manager who is screening the concerns pursuant to the Trust Guidelines at Paragraph 2.6. It is concerning if any manger within the Trust should contact NCAS and open a file related to concerns about a Practitioner without the Practitioner's knowledge and without any explicit authority. I am only aware of the Oversight Committee having met on 13th September 2016 at the earliest. There may well be earlier meetings of which I am not yet aware. I seek clarity on what was the authority pursuant to which Mr Gibson communicated with NCAS about my practice and my behaviour.

Secondly, as any contact with NCAS about my practice should be taken only pursuant to the Trust Guidelines, I should have been informed that a screening process was being undertaken. I was not informed that advice was sought from NCAS in September 2016 for more than two years after the advice was received

Thirdly, I believe that the description of the concerns provided to NCAS was seriously misleading. Mr Gibson described my review backlog as different to my colleagues, who have largely managed to clear their backlog. This is simply false and misleading. Of my four colleagues, only Mr Young is an appropriate comparator since the other three consultants are all more recent appointments. At around that time, Mr Young's review backlog was similar to mine and may have been longer (See Tab 13). Additionally, Mr Gibson was stating that I was not taking on patient consultations. **This is a very serious allegation and it is false. It is not the case and it has never been the case**. Mr Gibson also gave the impression that I had been spoken many times about these issues. **That is also simply untrue**. Mr Gibson also gave the impression that I had received a warning that I was in breach of a Trust Policy on having patient notes at home. This again is manifestly untrue. **I was not warned of a breach of Trust policy.**

Fourth, Mr Gibson received the advice from NCAS to take what could be described as an informal approach. However, the record of the meeting of the Oversight Committee on 22nd December 2016 states that at the meeting of the Oversight Committee on 13th September 2016, a recommendation was made to commence a formal investigation into my practice. This would imply that either the advice from NCAS was not communicated to the Oversight Committee or that the Committee simply ignored the advice.

Fifth, I was not informed about the recommendation that the Oversight Committee made on 13th September 2016. When that recommendation was made, the Trust Guidelines require that a Case Manager is appointed and that the Case Manager would inform me of the investigation in writing. (See Tab 4, Appendix 2)

Sixth, it is stated that a *"different approach"* was to be taken and this was communicated to the Oversight Committee on 12th October 2016. Again, this was not communicated to me.

In any case, **no approach was made to me in line with professional advice from NCAS. I was never approached for a meeting about the concerns to agree a way forward. No offer was made to relieve me theatre duties or any other duties to enable me to clear the backlog**. It is important to note, once again, that I was still working in September and October 2016 and did not in fact take leave for my operation until 15th November 2016. I was reviewing patients and operating on patients and trying to clear an administrative backlog with no assistance or support from the Trust.

Around September 2016, Mr Weir and Mr McAllister, my Clinical Director and Associate Medical Director, had both been minded to formulate a plan to assist me. At around the same time, an independent professional advisory service in NCAS had advised the Medical Director's office that a plan could be agreed for a way forward which could involve relieving me of duties to enable me to clear the backlog. Despite this, a determination was being made to launch a formal investigation into my practice and a determination was made not to communicate with me.

These actions are not the actions of a reasonable employer. They breach the mutual obligations at Clause 3 of my contract of employment (Tab 3) to cooperate with each other and to maintain goodwill as well as breaching Clause 17 which states that "*wherever possible, any issues relating to conduct, competence and behaviour should be identified and resolved without recourse to formal procedures*".

2.3.4. Breach of Agreed Action Plan

Throughout 2016, [redacted]. However, I had undertaken to delay surgery for as long as possible to provide support to a Consultant colleague, Mr Suresh. Mr Suresh was having difficulty with the operation of Urologist of the Week, and my other colleagues and I were requested by Management to provide backup support during his week on call. I was providing that support. Mr Suresh confirmed to me that he was returning to a post in England in October 2016 and it was at that point that I decided that I could undergo my own surgery. I scheduled the surgery for 17th November 2016.

On 14th November 2016, I received an email from Ms Martina Corrigan, Head of Service, which is attached at Tab 16. The email related to a request for a chart that had been tracked out

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

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

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

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

Relevant regulations/guidance:

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

Review date:

7 October 2016.

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

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

I hope the process has been helpful to you.

Yours sincerely

Dr Colin Fitzpatrick
NCAS Senior Adviser

cc: Jill Devenney, Case Officer (N I)

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

AOB:

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

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

ACTIONS:

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

Irrelevant information redacted by USI

Irrelevant information redacted by USI

Southern Health and Social Care Trust

Draft letter

21st September 2016

Dear Mr O'Brien

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

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

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

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

Area 1 – Untriaged letters

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

Area 2 - Outpatient review backlog

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

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

Personal Information redacted by USI

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

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

Sent from my iPad

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

> Dear Richard and Vivienne,
> Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
> I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.
>
> Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
> Now that they both work locally with him, they have plenty of ideas to try out and since they are both relatively new into post, I would like try their strategy first.
>
> I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.
>
> I appreciate you highlighting the fact that this long running issue has not yet been resolved. However, given the trust and respect that Mr O'Brien has won over the years, not to mention his life-long commitment to the urology service which he built up singlehandedly, I would like to give my new team the chance to resolve this in context and for good. This I feel would be the best outcome all round.
>
> Happy to discuss any time and I will of course brief the oversight committee of any progress we make.
>
> Many thanks
> Best
> Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust

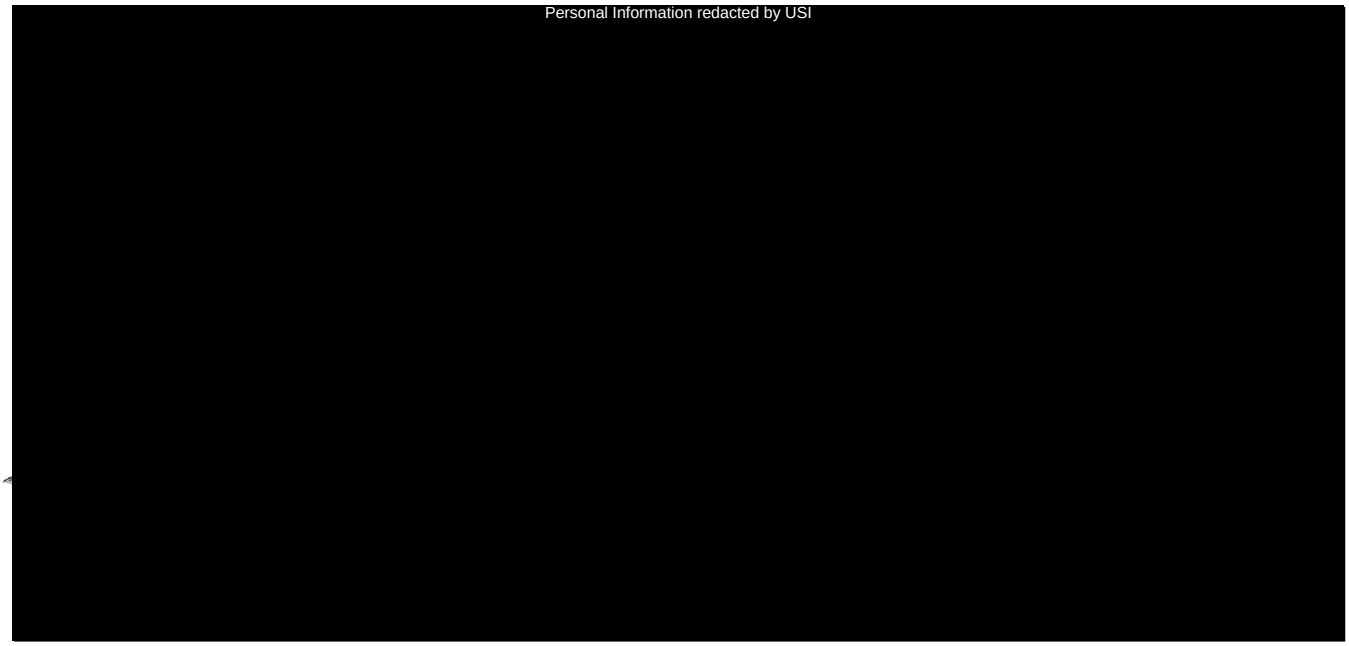
Southern Health & Social Care Trust

Oversight Committee
12th October 2016

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

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

Discussion:



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

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

Personal Information redacted by USI		Personal Information redacted by USI	Closed	
			Closed	
			Closed	
			Closed	
			Closed	
			Closed	
			Closed	

Patient 10 – is a Personal Information redacted by USI female patient diagnosed with renal cancer. There was a 64 week delay from when the referral was received to the patient being seen. This patient also was diagnosed with breast cancer.

Patient 11 – is a Personal Information redacted by USI male patient diagnosed with prostate cancer. There was a 207 day delay from when the referral was received to the patient being seen.

Patient 13 – is a Personal Information redacted by USI male patient diagnosed with aggressive bladder cancer. There was a 179 day delay from when the referral was received to the patient being seen. This patient should have been on the 62 day pathway and with treatment started within that timeframe.

Patient 12 – is a Personal Information redacted by USI male patient diagnosed with prostate cancer. There was a 151 day delay from when the referral was received to the patient being seen.

Patient 14 – is a Personal Information redacted by USI male patient diagnosed with prostate cancer. There was a 238 day delay from when the referral was received to the patient being seen.

UROLOGY RED FLAG OUTCOMES AND DELAY

Patient	Date letter received in Trust	Date Patient would have been seen if triaged (between 10 and 14 days)	Date Patient seen	Number of days delayed
Patient 10	29-Oct-14		06-Jan-16	64 weeks
Patient 14	06-Jun-16	15-20 June 2016	30-Jan-17	238 days
Patient 11	18-Jul-16	28 July- 2 Aug 2016	10-Feb-17	207 days
Patient 13	28-Jul-16	8 – 15 Aug 2016	23-Jan-17	179 days
Patient 12	08-Sep-16	18 – 22 Sept 2016	06-Feb-17	151 days

SAI investigations are on-going in respect of the additional 4 patients with confirmed cancer diagnoses.

All referral documentation was provided to Mr O'Brien for his comment as part of the investigation. His response to this matter is contained within section 6.

Corrigan, Martina

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

Hi Colin

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

Regards

Martina

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

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

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

My view

MY

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

As discussed this afternoon

Martina

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

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

Michael,

Please see email trail and Charlie's comments below.

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

Regards

Martina

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

From: Carroll, Ronan
Sent: 01 September 2016 13:09
To: Corrigan, Martina
Cc: McAllister, Charlie
Subject: FW: Patient 93
Importance: High

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

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

From: McAllister, Charlie
Sent: 31 August 2016 18:37
To: Carroll, Ronan
Subject: Re: Patient 93

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

Then happy to become involved.

C
Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Wednesday, 31 August 2016 17:40
To: McAllister, Charlie
Subject: FW: Patient 93

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

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

From: Corrigan, Martina
Sent: 31 August 2016 13:17
To: Carroll, Ronan
Subject: FW: Patient 93
Importance: High

Can we discuss please?

Thanks

Martina

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

From: Haynes, Mark
Sent: 31 August 2016 09:34
To: Corrigan, Martina
Subject: Fw: Patient 93
Importance: High

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

Sent from my BlackBerry 10 smartphone.

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

Martina

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

From: O'Brien, Aidan
Sent: 14 November 2016 16:09
To: Corrigan, Martina
Subject: RE: MR O'BRIEN AND CHARTS AT HOME

Martina,

As I will be having my surgery on Thursday morning, I expect to be home again over the weekend.

I expect that I will be well enough to dictate correspondence concerning patients and have the charts delivered to Noleen's office for typing.

I would greatly appreciate if I could be afforded this opportunity to have all charts returned in this manner.

Thank you,

Aidan.

From: Corrigan, Martina
Sent: 14 November 2016 07:15
To: O'Brien, Aidan
Subject: FW: MR O'BRIEN AND CHARTS AT HOME

Further emails Aidan.

Thanks

Gibson, Simon

From: Wright, Richard [redacted]
Sent: 06 December 2016 10:52
To: Gishkori, Esther
Subject: RE: Confidential

Thanks Esther. That sounds very reasonable. Any ideas when that is likely to be? Richard

-----Original Message-----
From: Gishkori, Esther
Sent: 06 December 2016 09:31
To: Wright, Richard
Cc: Toal, Vivienne
Subject: RE: Confidential

Dear Richard,
I can confirm that Mr O'Brien has had surgery and that sick lines are being submitted appropriately. I do not think that an occupational health referral is indicated at this point although it may well be in the coming weeks as Mr O'Brien is likely to return before he is well. We shall see in due course.

Patient notes are being returned as requested from Mr O'Brien however, Trudy Reid (governance facilitator) is not sure if all notes taken off the premises have been returned. The governance team are in the process of checking this out. It is difficult to be completely sure until notes cannot be found but we are doing our best.

The SAI review continues and will no doubt produce its own recommendations.

I have been having conversations in relation to Mr O'Brien's "return to work" interview. We thought that this would be a good time to set out the ground rules from the start.
Since Colin and Charlie are both off sick, Mark wondered if you and I could do this. Since there are both professional and operational issues here, I feel that this is entirely reasonable.

Will chat to you about it as we will have until the new year to think about it.

Best,
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] Mobile [redacted]
[redacted]

-----Original Message-----
From: Wright, Richard
Sent: 30 November 2016 09:36
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Confidential

Hi Esther.

Southern Health and Social Care Trust

15 December 2016

Dear Tracey

As you are aware the SAI review and report in relation to Patient 10 reference number W48461 is complete.

The remit of Patient 10's Serious Adverse Incident was to fully investigate the circumstances which contributed to her clinical incident. The Review Team was comprised Mr Anthony Glackin Consultant Urologist, Dr Aaron Milligan Consultant Radiologist, Mrs Katherine Robinson Booking and Contact Centre Manager, and Mrs Christine Rankin Booking Manager. To provide context, part of the work included a look-back exercise for 7 Urology patients who managed in the same manner as Patient 10 in October 2014. This was to satisfy the panel that there was a management plan in place and no harm had come to the other 7 patient (letters) which were not triaged on the week ending 30 October 2014. The manual look-back was done using the 6 available patient charts on 14 November 2016. These 6 patients all have been discharged or management plans in place. The 7th (patient initials Personal Information redacted by USI) chart was not able to be found on Trust property at this time. Personal Information redacted by USI's chart arrived to the Governance office on week commencing 28 November 2016. The look-back exercise was completed on13 December 2016. There is clinical detail within the dictated letter in relation to the Personal Information redacted by USI's consultation which requires clinical validation. This has been given to Mr Anthony Glackin to review on 15 December 2016.

Upon conclusion, the Review Team agree there are a number of relevant and related issues/themes causing concern for the panel which have been exposed during the SAI investigation. The Panel would like to clarify that all relevant enquiries made while undertaking this report have been solely limited to the information which were independently provided by members of the Review panel in conjunction with Mrs Andrea Cunningham, Service Administrator. There have not been any approaches made directly to the Urology Clerical team, the Urology Head of Service or the Assistant Director of Surgery and Elective Care for any information or evidence of communication.

Toal, Vivienne

From: Gibson, Simon <Personal Information redacted by USI>
Sent: 21 December 2016 12:11
To: Toal, Vivienne
Subject: FW: AOB

See below for context

Kind regards

Simon

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

-----Original Message-----
From: Gibson, Simon
Sent: 21 December 2016 11:45
To: Wright, Richard
Subject: RE: AOB

Dear Richard

Yes. I will come in to DHH and web-cam in; I think we should involve Viv, she is in CAH and free all day.

2.30pm?

Kind regards

Simon

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

-----Original Message-----
From: Wright, Richard
Sent: 21 December 2016 11:26
To: Gibson, Simon
Subject: AOB

Hi Simon. Esther rang me re worrying developments re AOB and lost notes. Ronan is to report tomorrow with preliminary findings. I will come in tomorrow. If you are about could we set up a meeting with Ronan and if possible

Mark Haynes to consider findings (Esther is off) and next steps. I don't think we can wait for the formal completion of SAI . Regards Richard

Sent from my iPad

From: Boyce, Tracey
Sent: 22 December 2016 10:31
To: Carroll, Ronan; Gishkori, Esther; Wright, Richard
Subject: FW: Copy of Urology - AOB missing triage.xlsx
Attachments: Copy of Urology - AOB missing triage.xlsx; Level 2 HSC RCA Report Patient 10 Draft Six for litigation.docx; Timeline in preparation for screening Patient 10 .docx; Summary of key points of concern Patient 10 .docx

Hi
Please find attached the final draft SAI report for our discussions today and also the spreadsheet of outstanding triage as created by the secretarial team.

I have also created a shortened summary of the letter sent to myself and Esther by the SAI review team – attached

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Personal Information redacted by USI

Learn more about mental health medicines and conditions on the Choiceandmedication website http://www.choiceandmedication.org/hscni/

From: Connolly, Connie
Sent: 20 December 2016 17:08
To: Boyce, Tracey
Cc: Reid, Trudy
Subject: Copy of Urology - AOB missing triage.xlsx

Tracey- as discussed
Connie

Southern Health and Social Care Trust

Root Cause Analysis report on the review of a Serious Adverse Incident

Organisation's Unique Case Identifier: [redacted]

Date of Incident/Event: [redacted]

HSCB Unique Case Identifier:

Service User Details:
D.O.B: [redacted] Gender: F Age: [redacted]

Responsible Lead Officer: Connie Connolly

Designation: Lead Nurse Acute Governance

Report Author: Review Team

Date report signed off:

Date submitted to HSCB:

I believe that the deliverance of a letter to me on 23 March 2016 by members of Trust management, identifying concerns which they expected me to address and rectify, on my own, without remedial action and support, in breach of Trust Guidelines, is untenable, particularly when those same concerns were deemed to be so grave as to merit a Formal Investigation and Immediate Exclusion nine months later.

In your letter of 24 February 2017, you related how the SAI investigation had 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 me as was required. I had indeed previously raised my concern that a decision had been made to proceed with a formal investigation and immediate exclusion, prior to even a draft final report of the investigating panel having been compiled. I was provided with that draft final report on 13 January 2017. I returned my comments upon the report on 25 January 2017. In doing so, I concluded that the terms of reference for the SAI investigation were prejudicial in that the investigation concerned itself with the period of time beginning with CT scanning on 24 June 2014 and ending with the patient's first urological consultation on 06 January 2016. The SAI investigation therefore failed to include that the renal lesion of concern could have been identified on CT scanning as early as December 2012. Most importantly, the patient did not come to any harm as a consequence of the delay in urological consultation. I believe that it was improper and prejudicial to have concluded that harm had been suffered by a patient before the investigation of the case had even reported. I believe that it was even more improper and prejudicial to have used that presumption of harm, which did not exist, to justify Formal Investigation and Immediate Exclusion, as you asserted.

It is also noteworthy that you made reference to my not having 'properly' triaged the letter of referral. I do believe that there is indeed a distinct difference between triage and proper triage. I believe that most, if not all, clinicians would agree that 'triage' is a process to allocate 'red flag', 'urgent' or 'routine' status to any referral in accordance with the information provided in the letter of referral. As I reported in my response to the draft final report of the SAI investigation, the patient had been a routine referral for assessment of a large, simple, right renal cyst, associated with right renal angle pain. Based upon this information, I asserted that I would have retained the routine referral status. The waiting time then for a routine urological outpatient consultation was then 66 weeks. At present, I believe it to be some 84 weeks.

I believe that 'proper' triage would have resulted in the referral status having been amended to 'Red Flag'. This would have required a review of the patient's entire history by access to NIECR. However, crucially, it would also have required a review of the digitalised imaging on NIPACS. I believe that it is a modest proposal that this would have taken some 15 to 20 minutes to undertake. We receive 120 to 160 referrals per week. Even if the mean time required to 'properly' triage were ten minutes each, that would require 20 to 27 hours during a week when one is responsible for all inpatient care of all urological patients, including emergency and urgent surgery, and all emergency and urgent referrals from elsewhere in Craigavon Area Hospital, Daisy Hill Hospital and South West Acute Hospital. Indeed, as reported in my comments upon the draft final report of the SAI investigation, on the day upon which the referral of the case was delivered for triage, I had additionally spent three hours previewing the cases for MDM discussion that afternoon when I spent a further three hours chairing MDM, followed by further time that evening proof reading and signing letters emanating from MDM, addressed to GPs. The following day, I reviewed ten oncology patients in addition to the continued responsibilities of being urologist of the week. It was precisely for this reason that I had previously advised that I had found it impossible to conduct triage on urgent and routine referrals, as there simply was inadequate time to do so. Indeed, in March 2015, as lead clinician of MDT, I had been unable to secure the commitment of my colleagues to conduct such triage on 'Red Flag' referrals alone, as they found it too time consuming and that there was not enough time as urologist of the week to do so, as documented in the minutes of the Urology MDT Business Meeting of 02 April 2015, and even though Red Flag referrals constitute only 15% to 20% of all referrals.

Also, in relation to triage, you referred in your letter to my having failed to properly triage *as was required*. I have twice requested a copy of, or a link to, the Trust's Policy and Procedure regarding triage, and to which reference has been made. I still await a reply, a copy or a link. Moreover, the ultimate reason why any patient had to wait 66 weeks for a routine consultation following referral is because the Trust provides such an inadequate service. It is worthy of note that the SAI investigation panel did not include that inadequacy at all as a factor in the patient's delay in diagnosis. Lastly, in relation to that SAI investigation, I have yet to receive a copy of the final report of the investigating panel. I have written to the Director of Acute Services requesting a copy.

From: Boyce, Tracey
Sent: 28 August 2019 13:34
To: Buckley, LauraC
Subject: FW: URGENT: INFORMATION REQUEST
Attachments: AOB SAI (45.1 KB); Confidential - AOB (12.0 KB); Confidential - AOB (12.0 KB); CONFIDENTIAL - Confirmation of further oversight meeting re: Dr AOB - 10... (24.2 KB); CONFIDENTIAL - Confirmation of further oversight meeting re: Dr AOB - 10... (24.2 KB); Confidential re AOB (24.7 KB); Copy of Urology - AOB missing triage.xlsx (64.5 KB); FW: Audit of charts re AOB (30.5 KB); FW: Audit of charts re AOB (20.0 KB); FW: Audit of charts re AOB (30.5 KB); FW: Backlog report - no clinic outcomes (24.9 KB); FW: Complaint - ?SAI (6.77 MB); FW: Copy of Urology - AOB missing triage.xlsx (319 KB); FW: Emailing: sc of partial SAI (1.32 MB); FW: Level 2 HSC RCA Report Patient 10 Draft Six (321 KB); FW: Management of PP's / non chronological listing (134 KB); Meeting on Friday with AOB (25.2 KB); RE: Audit of charts re AOB (23.7 KB); RE: Audit of charts re AOB (23.1 KB); RE: Audit of charts re AOB (23.7 KB); RE: Confidential - AOB (14.2 KB); RE: Confidential - AOB (14.2 KB); RE: CONFIDENTIAL - Confirmation of further oversight meeting re: Dr AOB ... (27.5 KB); RE: Meeting on Friday with AOB (26.1 KB); RE: Meeting on Friday with AOB (26.1 KB); RE: Meeting on Friday with AOB (30.2 KB); RE: Meeting on Friday with AOB (31.1 KB); SAI panels concerns AOB.pdf; Strictly Confidential (33.4 KB)

Follow Up Flag: Follow up
Flag Status: Completed

Hi Laura
Please find attached all my emails in relation to the case in question, as promised

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy

Mob: Personal Information redacted by USI
Office: Personal Information redacted by USI

From: Boyce, Tracey Personal Information redacted by USI
Sent: 20 December 2018 16:09
To: Hynds, Siobhan
Cc: Neves, Joana
Subject: RE: URGENT: INFORMATION REQUEST

Hi
Please find attached all my emails from the Trust archive and a copy of the letter I received from an SAI panel raising the initial concern.

CAH	Personal Information redacted by USI	Personal Information redacted by USI	Personal Information redacted by the USI	Personal Information redacted by USI	Personal Information redacted by USI	Personal Information redacted by USI		URO	GURO	URGENT	GPR	ADV	06/05/2016	06/05/2016	N		AC 090816 *MTNL* - 2ND LTR 251116 URGENT		EURONU		32
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Southern Health and Social Care Trust

13th March 2017

STRICTLY PRIVATE AND CONFIDENTIAL

Mr Aidan O'Brien
Personal Information redacted by USI

Dear Mr O'Brien

I write further to your letter of 21st February 2017, in which you have requested that the notes of our meeting on 30th December 2016 be amended. Having reviewed your request, I am clear that at the meeting on 30th December we discussed that the matters to be investigated had previously been raised with you outside of a formal process, with no resolution. Whilst I remain definite about this, I am content to remove the word 'informal' from the notes.

I have also considered the other points that you have made. Whilst written notes taken at the meeting would disagree with what you have written, I am happy to make the requested amendments in the interests of moving forward. The exception to this is with reference to your job plan. I do clearly recall that when I asked if your job plan was unrealistic, your initial response was to state that it was OK but that things were allocated to your SPA time that was not administrative work. I do recollect that in reply to this statement, I said that if the job plan does not cover all work that you have to do, then it mustn't be right and this would need to be reviewed. We then went on to discuss the amount of sessions allocated in your job plan.

Please find enclosed a copy of the notes in which all other requested changes have been made. You had made reference to the note not including the discussion about you being placed on immediate exclusion, however this was always included in the notes (Page 2, Paragraph 2).

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

I hope you feel this resolves the matter in relation to the notes of 30th December, however should you have any queries, please do not hesitate to contact me.

Yours sincerely

Dr Richard Wright
Medical Director

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

Southern Health and Social Care Trust

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

30 July 2020

FILE REFERENCE: 23

MR O'BRIEN
Accompanied by MICHAEL O'BRIEN
SHIRLEY YOUNG
AISLING DIAMOND
(FIRST GRIEVANCE HEARING – PART 1)

Audio Transcription Prepared by:

Personal Information redacted by the USI

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DR DIAMOND: Good afternoon.

MR O'BRIEN: Hello.

DR DIAMOND: Hello, how are you? I am Aisling Diamond.

MR O'BRIEN: Hello, Aisling.

SHIRLEY YOUNG: I'm Shirley Young and I will do a bit more detail on the introductions on how I come to be here. So we will let you get settled and then make a start. There are some housekeeping things to start with so we will make our way through that first of all.

MICHAEL O'BRIEN: It's spread.

SHIRLEY YOUNG: That's okay. I was making the remark to Aisling that I admire her laptop and all her stuff. I am a dyed in the wool person.

MICHAEL O'BRIEN: Sometimes I keep things on the computer and sometimes I like to have (inaudible).

SHIRLEY YOUNG: As I say, when I work home I can work off that but when I am here and there are documents my overwhelming urge to make a mark on them knows no bounds.

So you're very welcome. So a few housekeeping things to start with. As you know we are still in the middle of the Covid-19 pandemic. So we have arranged ourselves unusually very far apart. Obviously, if you travelled together, you can sit where you need obviously. So there is wipes there. I can assure you that all the surfaces here have been wiped. And there is hand sanitisers. If you would prefer to use a mask they are there as well.

That also means that because some of the stuff that has coming through my professional organisation about these face to face or in person meetings, that we have been told about duration. So I am hoping that we will see what we can do in the two-hour slot today. If it needs to go over and it is a few minutes with your permission but if you are concerned at all about the duration just say. I have opened the window and I have carefully looked outside. It does not look like there will be passers-by but if you get cold we will close it but I have it opened just for the reason to keep the circulation going.

The other things that we have checked our phones are off. Obviously it is not the end of the world if your phone is not off but it might distract you from what we are doing. So as long as we don't distract you, that will be the main thing.

MICHAEL O'BRIEN: Okay.

SHIRLEY YOUNG: We are here. We are taking our own notes and I want to make sure, to let you know, we are not recording and I am asking that you are not recording it either.

MICHAEL O'BRIEN: No.

SHIRLEY YOUNG: Because if you were, as long as you let us know, that's fine. So we are

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here today in relation to this stage 1 grievance. As I said at the outset, my name is Shirley Young and I am not employee of the Trust. I am a HR associate from the HSC leadership centre at The ~~Beaches~~ Beeches. You may have heard of them. It is a large, linked organisation. I have been working for them on specific HR inputs for the last four years. Prior to that, I have worked for the Western Health and Social Care Trust as assistant director and I have worked for them for 30 years. So I am here as that type of representative, someone with a HR background. And Aisling your proper title alludes.

DR DIAMOND: So I am Aisling Diamond. I am a consultant in emergency medicine by trade. I have been a doctor for almost 30 years. So I have worked in the Northern Trust, then Belfast, now I have come down into the Southern Trust. I work as deputy medical director as of 7 April, I think. – well somebody has to do it. ~~(Inaudible).~~

SHIRLEY YOUNG: So we are today and your companion, your selected companion is yourself and you are father and son.

MICHAEL O'BRIEN: Yes.

SHIRLEY YOUNG: To avoid any confusion on my part, I am happy very you call me Shirley. But if we have to make a ~~distinguish~~ distinction , if you are happy to be the Michael and if you want to be the Mr O'Brien. We can do it the other way round. It will help me if I am making any notes that Mr AOB won't help.

MICHAEL O'BRIEN: That's not a problem.

SHILREY YOUNG: I didn't want to be rude. So first of all, Michael, just in respect of your email that you had sent to Zoe Parks about some of the preliminary matters and I had gone back to Zoe and ~~says~~ to tell them that we will deal with all of that stuff when we meet. This is a stage 1 grievance hearing under the formal grievance procedure that the Trust has for all of its staff. So this is stage 1. Okay.

The matters that we will consider are everything that you sent in and your -- that had been here from your November 18 submission. We have received that in full and have read it. Then you sent a further submission in on 23 July, last Thursday. That was given to us. Usually we would not deal with new matters. However, given the length of time that it took, and we looked since November nothing had happened, we believe that we should see all of those matters and ~~(inaudible)~~ see them in that context rather than having somebody different looking at the delay when that is all before us. So we, to try and make sure this is as streamlined as possible and the people who are beginning to get the knowledge, we will deal with both submissions. Okay. Here at this stage. So you can be assured of that. Okay.

We want to be clear with you we will consider everything. There may well emerge

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SAI commenced in October 2016, and therefore has coincided with your period of sick leave. The SAI is ongoing, and you will be contacted as part of this process.

2. That there is a backlog of over 60 undictated clinics going back over 18 months and therefore there are approximately 600 patients who may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients.

3. That some of the patients seen by you may have had their notes taken back to your home, and are not available within the hospital. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Given the serious nature of the concerns, we met with you to discuss the matter and the process for managing the complaint.

It was confirmed that the concerns identified will be managed in line with the '*Maintaining High Professional Standards in the Modern HPSS*' Framework (MHPS) and the associated *'Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance'* (copies of both documents were provided to you for your information).

In line with the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance, an Oversight Committee within the Trust has been appointed. It has been agreed that given the serious nature of the concerns a formal investigation will be undertaken.

As discussed, Dr Ahmed Khan, AMD (Paediatrics) has been appointed as the Case Manager for this investigation. Mr Colin Weir, Clinical Director is the Case Investigator and will be assisted by a representative from the Trust's HR Department (HR Representative to be confirmed).

It was explained to you at our meeting that, in accordance with MHPS, a decision has been made to immediately exclude you from the workplace effective from 30th December 2016, with full pay. This is a pre-cautionary measure and is to protect you from any further concerns being raised, to protect the interests of patients, and to assist the investigative process. Please note that NCAS had been informed of this, in advance of the meeting.

This exclusion will be up to but no more than 4 weeks and will allow for further preliminary information to be collated to decide the scope of the investigation, and therefore the Terms of Reference for investigation. The Case Manager will make

contact with you as soon as possible in relation to the progression of the formal investigation process, and to provide you with a copy of the Terms of Reference for same. In the meantime, contact will be made with you to arrange a meeting during the 4 week period of immediate exclusion to allow you to state your case, and propose alternatives to exclusion. You are entitled to be accompanied to all meetings during the course of the investigation as per Section 1 Paragraph 30 of the MHPS Framework.

This 4 week exclusion period should allow sufficient time to determine a clear course of action, including the need for formal exclusion. Any decisions made will, of course, be communicated to you. I would refer you to the MHPS Framework document, Section 1, Paragraphs 18 – 27 and Section II, Page 13 – 20 regarding exclusion.

It was made clear to you that you are required to return any case notes / dictation that you have in your possession. You were requested to return these to Martina Corrigan, Head of Service for Urology by 11.00 am on 3rd January 2017, and I understand that you have now done this. Now that these charts have been returned, they will be recorded and their location tracked on PAS either back to filing, your office or your secretary's office, in line with Trust procedures. A review will be undertaken by the Trust of any actions required for each patient.

I recognise that this will be a stressful time for you and I would therefore reiterate that the services of the Trust's Occupational Health Department or the staff counselling service, Care-call are available to you. An appointment was arranged for you to attend the Trust's Occupational Health Department on Thursday 5th January 2017, and your manager now awaits the report from Occupational Health. Please note that Care-Call services are also available and they can be contacted on 0808 800 0002.

In the meantime, should you have any queries in relation to the content of this letter, please do not hesitate to contact me.

Yours sincerely

Dr Richard Wright
Medical Director

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

Please provide your comments in response to each of the instances cited above by Mr. Wilkinson where he draws attention to your engagement with him in the context of the MHPS process, and your engagement with Mr. O'Brien or his family or others, providing all relevant details, as appropriate.

I had no formal contact made to me by Mr O'Brien or any family member that I can recall, and I never met with Mr O'Brien to discuss this investigation.
I do remember Mr O'Brien (or possibly his wife, my PA was in her adjoining office to me) phoning the office and speaking with me about the long-drawn-out process and Trust not meeting its timescales as outlined in the policies. I then informed John Wilkinson of this. On the call Mr O'Brien was upset and I think his wife may have been listening in and she said how stressful and upsetting this lengthy process was.

This was the only call I received and hence why I informed John Wilkinson. John Wilkinson, like other NEDs who had been involved in MHPS, had concerns about a NEDs role in this process. I spoke at least on two occasions to the CX and then the HR Director for a need for urgent training on their role when conducting the MHPS. This training was then arranged and delivered to all NEDs and myself by June Turkington from DLS on 1 December 2019. I did speak with John Wilkinson on the telephone not only about Esther Gishori but about the length of time the process was taking for Mr O'Brien.

I had asked John Wilkinson to call Mr O'Brien to offer additional support. John explained that he didn't feel that he needed to call Mr O'Brien; that he was overwhelmed with the detail in this case, and that he couldn't push HR any more on Mr O'Brien's behalf. I accepted his position on this and that he wouldn't be calling Mr O'Brien.

Mr O'Brien knows I never could or would advocate on his behalf, so I informed John Wilkinson of this call from Mr O'Brien.

56. As regards paragraph 55 above at point (i), did you play or attempt to play any part in any aspect of the process or decision-making regarding the MHPS or

the availability of the people to answer the questions (a number of individuals were on holiday).

14. On 22nd February 2017 AOB forwarded an email and attached a letter (see appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170222 - E - AOB to J Wilkinson) he had sent to Dr. Wright who was the Medical Director at the time. He had requested that amendments be made to the notes from a meeting which had taken place on 30th December 2016. I was concerned that I would not be able to deal with this matter since I was not appointed at the time and my understanding of the issues would be limited. I took this matter up with VT who subsequently contacted June Turkington ('JT') at the Department of Legal Services ('DLS'). JT provided legal advice. (see appendix located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20170222 - E - V Toal to J Wilkinson and Dr Wright). SH sent me a copy of the letter to be issued to AOB from AK (see appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170224 - E -S Hynds to J Wilkinson).

15. I was aware that VT was to request/had requested a meeting with AOB and I was satisfied that the momentum of the case would be maintained, matters would be addressed and the reasons for the delays outlined.

16. On 23rd February 2017 I was made aware that a new Case Investigator had been appointed, namely, Dr Neta Chada ('NC'). I understand that there had been a conflict of interest with the previous Case Investigator, CW. AOB was content with this change.

17. On 23rd February 2017 I met with VT and Dr Wright to discuss the case. I did not take a note at this meeting.

18. On 24th February 2017 SH sent me a copy of the letter to be issued to AOB from AK (See appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170224 - E -S Hynds to J Wilkinson).

19. On 2nd March 2017 RB telephoned me and expressed her concerns about case progression and timescales. She stated that AOB was a highly skilled surgeon who had built up the urology department and was well respected by service

users. She further expressed concern about the handling of the case by Human Resources. RB pointed out that the case was having an adverse effect on AOB and his wife. She asked me to contact AOB.

20. On 2nd March 2017 I telephoned and texted AOB seeking a meeting to discuss progress and any other concerns that he might have had. I received no response.

21. On 6th March 2017 AOB made contact with myself and raised the following concerns:-

    a. He stated he was disappointed with AK's letter and that he felt that the reply should have come from myself or the Case Manager.
    b. He further explained that he believed that the needs of the process was taking over rather than the needs of the case itself and in particular cited important points of clarity. AOB was concerned about the needs of his patients and he believed that he was taking every possible measure to expedite their needs even though it was causing him significant additional work.
    c. He believed that the process had already come to an opinion.
    d. He stated that the Trust Guidelines re the handling of MHPS were being overlooked and that the Serious Adverse Incident sequence had not been clarified.
    e. He expressed concern that other measures had not been explored prior to him being excluded.
    f. He also believed that the process that he was undergoing was being driven by Human Resources and not clinicians.

    I explained to AOB that I was meeting VT from HR and that I would bring his concerns forward. AOB asked me to also:

    i. Enquire about case progress;
    ii. Request that the Terms of Reference for the Inquiry be shared if they were agreed and available;
    iii. Clarify whether the scoping exercise was complete and if the Inquiry had begun (and, if so, on which date it began). Appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170306 - E - AOB to J Wilkinson

33. On 21st November 2017, 15th and 22nd February 2018, and 4th and 29th March 2018, AK provided updates on the case (see appendix located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20180329 - E - S Hynds to J Wilkinson and located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20180215 - E - S Hynds to J Wilkinson).

34. There were delays in AOB's ability to make a return regarding notified areas so that the report could be completed.

35. On 15th February 2018 RB had made an informal oral inquiry to me regarding the AOB case. (see diary entry located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20180215 - Diary Entry JW)

36. On 10th June 2018, after receiving a copied email from AOB dated 10th June 2018, I was concerned that AOB required to get the information he had requested. As a result I emailed SH, who in turn copied me into an email reply to AOB. (see appendix located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20180610 - E - AOB to S Hynds cc J Wilkinson and 20180610 - E - S Hynds to J Wilkinson)

37. On 14th August 2018 I received an email (see appendix S21 No 38 0f 2022, 20180814 Letter to AOB re Update MHPS Investigation) signalling to AOB the next steps following the conclusion of the investigation report. Dr Khan was going to make his determination after consideration of all of the documentation and information.

38. On 11th September 2018 I received a telephone call from AOB at 12.18 but I was working in a school. I responded as soon as I could at 12.50. The call lasted approximately 40 minutes. I was unsure as to the reason for the call but I was able to distil the following and made a contemporaneous note:

    a. The SHSCT continued to act outside of the legal framework.

b. NED involvement was of no significance. He made clear that he was making all of the contact with the Trust.

c. Any representation made by the NED would be of little or no importance.

d. He was very critical of the process which had lasted 21 months to date.

e. He was going to meet up with RB and he mentioned a previous meeting with her.

f. He described the serious impact the process was having on his wife.

g. He advised that he had made contact with the Chief Executive.

h. He asked me if I was aware of the number of people not being seen in Urology (Waiting List) – he suggested it was around 600 people.

i. He was very critical of the Director of Acute – Esther Gishkori - and the Medical Director – Dr Wright.

j. He inquired when the process would end. I advised him that, from memory, I thought there was an indicative date of October 2018.

At the end of the call I advised AOB that I would bring these concerns to the Trust.

39. On 11th September 2018 at 4 pm, in response to the above, I telephoned VT and made her aware of the details of the call made by AOB. She didn't have at hand a closure date for the case but said she would make inquiries. She returned my call 30 minutes later and provided a closure date estimated to be the end of September 2018. I emailed AOB with this estimated closure date. Appendix – located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20180910 - Diary Entry JW.

40. I continued to be kept updated through emails as to the progress of the investigation. It was apparent that AOB continued to require certain information but this had not been completed. Therefore, I inquired as to the status of the investigation seeking clarification on 26th September 2018, as well as on 1st, 3rd, 21st and 22nd October 2018.

41. On 22nd October 2018 I emailed AK seeking an update on the status of the points raised by AOB. He replied on 23rd October 2018 and indicated that there were further concerns:- 'there have been new concerns emerged last week in relation to outstanding pts made by Mr O'Brien which would cause his deviation from agreed action plan …'. On 23rd October 2018, after receiving notification

were on the same agreement -- and there was major, major changes made. They were trying to prevent them but it was enforced and it was an absolute disaster and it all had to be dismantled again and tried to get back. And I have no doubt in my mind there was resentment there that -- because Aidan fought so hard for it, for it not to happen.

DR WRIGHT: No, I don't know.

MRS O'BRIEN: But I just think -- I just think the way, you know, like Ronan bypassing clinical management. He just went on ahead.

DR WRIGHT: I suppose the problem (inaudible).

MRS O'BRIEN: Clinical management.

DR WRIGHT: Clinical management was Eamon (inaudible).

MRS O'BRIEN: No, Eamon was gone in April. He bypassed Colin. He expressly said -- in the witness statements he expressly told them not to speak to Aidan.

DR WRIGHT: Right.

MRS O'BRIEN: Which I think it's very, very annoying.

DR WRIGHT: Look, what can I say. I am sorry it has taken so long. I hope we get an outcome -- ~~(inaudible).~~

MRS O'BRIEN: Apparently --

DR WRIGHT: I'm sure there'll be a lot of learning (inaudible).

MRS O'BRIEN: The latest is it's going to be October according to -- Aidan rang John Wilkinson yesterday.

DR WRIGHT: Right

MRS O'BRIEN: And, I mean, that's been a complete disappointment as well, the non-executive person. You see, I look at things -- maybe I am a very black and white person. But if I had of been -- if I was a member of a non-executive board and I was appointed to it, once -- I would have been looking through and I would have said, right, okay, all right, there's a room for -- in exceptional circumstances it might go on a bit longer. But do you see when it would have come to March, I, as the non -- I was saying this to Roberta, I would have been saying -- I would have been going down to whoever it be (inaudible). We have to call a halt to this. This is illegal. This is a breach of this employee's terms and conditions of employment. We have to stop this. You have to stop right now.

DR WRIGHT: But then if you had done that, I'm just thinking actually if that had happened that would have left everything hanging (inaudible). In some ways it might be satisfactory to get an outcome.

MRS O'BRIEN: But you see like --

GRAINNE LYNN: Yes.

MR O'BRIEN: I have only had to do it once before some years ago, I think it was 2011, when I couldn't understand it. I kept getting my monthly salary and I had done additional waiting list initiative work. And I thought over a period of a few months that the payments weren't quite right, so I got in touch with the payroll people, who were very, very good, and they looked at all of this. And they said, yes, your claim forms on each one of them the amount has been stroked out and it has been reduced by one-half and there's an initial alongside but they couldn't make it out. They said we will send it to you and you tell us who it is if you recognise it. So they did and I recognised it. And I recognised it as a Mr Eamon ~~McIll~~ Mackle ~~Mackle~~ who had unilaterally, and as a breach of contract, halved my payments. So I issued a formal written grievance. They responded in due course to say, yes, my formal written grievance was upheld and how do I want to take the matter forward. At that time the person about whom I had taken the grievance [Personal Information redacted by USI] and I said I suspend it, preserving the right to initiative it again if I ever have reason in the future.

Now, it is interesting that was same person who shrugged his shoulders. That's the same person who, when I asked in March 2016, how do we address this? He shrugged his shoulders. And yet when I referred to that human resources said they had no knowledge of any formal written grievance. But when I provided them with it, they said (inaudible).

(**Dog barking**)

So I mean, I am asking the question. When we submit a formal written grievance, and if you get stone-walled again, where do you take it from there? It's a very -- you know. I have got to the stage I personally don't expect anything off them other than stone-walling. I don't --

GRAINNE LYNN: Who is the designated board member that you've ~~(inaudible)~~ been told about?

MR O'BRIEN: ~~Useful~~ Useless. Absolutely useless.

GRAINNE LYNN: Have you written to the chair?

MR O'BRIEN: I know the chair of the ~~(inaudible)~~ board personally you know. This is one of my problems. The chair of the board and her [Personal Information redacted by USI] and my wife and I we have been on holiday together. But I am cautious about involving her in a process about which she should be somewhat apart to date anyhow.

I think when I submit my formal written grievance it will be going to the chief executive because there is no point in submitting it to any other person. When I spoke to --

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Note of Meeting with Mr Aidan O'Brien, Consultant Urologist – Tuesday 24 January 2017

Present:
Mr O'Brien (accompanied by his son, [redacted]
Dr Colin Weir, Case Investigator
Mrs Siobhan Hynds, Head of Employee Relations

Introductions were made and Mr O'Brien was thanked for attending the meeting. Mr Weir explained his role as case investigator and that he would be assisted in the investigation by Mrs Hynds.

It was explained that the purpose of the meeting today was to discuss the next steps in the MHPS process following a decision to place Mr O'Brien on a period of immediate exclusion on 30 December 2016. Mr Weir outlined that we had asked to meet with Mr O'Brien to provide him with an opportunity to discuss the next steps in the process, to state his case at this point of the process should he wish to and to provide an opportunity to hear from Mr O'Brien his proposals for alternatives to formal exclusion.

Mr Weir outlined that following the meeting today (24 January) a case conference would be convened on 26 January 2017 with the case manager, Dr Khan and other appropriate members to determine the next steps.

It was noted that at the meeting on 30 December 2016, Mr O'Brien was advised of a decision by the Trust to place him on immediate exclusion and was advised of concerns which had been raised with the Trust's Medical Director, Dr Richard Wright, following a Serious Adverse Incident (SAI) Investigation. The concern related to Mr O'Brien's administrative practices which had the potential to have caused harm to patient/s and / or which had actually caused harm.

It was noted that Mr O'Brien was notified at the meeting on 30 December that an initial scoping of Mr O'Brien's administrative practices identified:

- that, from June 2015, 318 GP referrals had not been triaged in line with the agreed / known process for such referrals. Further tracking and review was required to ascertain the status of all referrals.
- that there was a backlog of 60+ undictated clinics dating back over 18 months amounting to approximately 600 patients, who may not have had their clinic outcomes dictated. It was unclear what the clinical management plan is for these patients.

- that some of the patients seen by Mr O'Brien may have had their notes taken back to his home, and are not available within the hospital. The clinical management plan for these patients is unclear, and may be delayed.

Mr Weir advised Mr O'Brien that the initial 4 week period following immediate exclusion of Mr O'Brien, allowed for scoping to continue within the Acute Services Directorate to determine the scale of the concerns regarding Mr O'Brien's administrative practices, to inform the scope of the investigation under MHPS Framework and the Terms of Reference for the investigation. Mr O'Brien was updated in respect of the initial 3 concerns notified to him on 30 December and was notified of a fourth issue of concern identified during the preliminary investigation.

The update position as at 24 January is:

- that, from June 2015, 783 GP referrals had not been triaged in line with the agreed / known process for such referrals. All referrals require to be tracked and reviewed to ascertain the status of these patients in relation to the condition for which they were referred. This work is being undertaken by 4 Trust Consultants and the review is not yet complete.
- that 668 patients have no outcomes formally dictated from Mr O'Briens outpatient clinics over a period of at least 18 months. Again this review is still on-going.
- 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. Work is continuing to validate this list of missing notes.

The fourth issue of concern identified during the initial scoping exercise relates to Mr O'Brien's private patients. A review of Mr O'Brien's TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients are significantly less than for other patients. Further investigations are on-going.

Mr O'Brien referred to the issue of the triage referrals and advised that since the issue was brought to him in March 2016, he was undertaking his own validation of referrals to him. He advised that prior to this the workload volume made it impossible to do so.

Mr O'Brien discussed the issue of the 13 sets of notes which are tracked to him but are missing. He advised that he wished it noted that he had not returned 307 sets of notes from his home. That some of the notes were in his office and which he left with the notes returned from home. Mr O'Brien further noted that he has a very good memory of his patients and was shocked by a number of patients on the list as he was very sure the notes

I have requested the full file from NCAS under a freedom of information request and it has now been provided to me. It is clear that NCAS made attempts to contact the Trust of 27th January 2017, 30th March 2017 and 30th May 2017. However, the Trust did not cooperate with these requests for a review. This resulted in NCAS closing its file on 30th May 2017. I have attached these emails at Tab 33.

2.6 The Conduct of the Formal Investigation

On 1st October 2018, a decision was made to refer me to a Conduct Panel by the Case Manager. There are many issues that I take with the substantive matters raised during the investigation and the subsequent report and in the Case Manager's determination that I will present during that conduct hearing. However there are several issues or procedural impropriety that I believe are relevant to this grievance and these are addressed below.

2.6.1 Case Conference Determination 26th January 2017

On 26th January 2017, a Case Conference was held to consider my exclusion. I do not have minutes of this meeting. I received a formal notification on 6th February 2017 from Dr Khan setting out the decision of the Case Conference (Tab 34). The Case Conference did lift my exclusion from clinical duties.

The Case Conference also considered a report from the Case Investigator and determined that I had a "case to answer" in respect of all four concerns and that a formal investigation of the issues was required. A decision had already been made by the Oversight Committee to launch a formal investigation and that was ongoing. It is not at all clear what the purpose of this decision was intended to be. There is no part of the Trust Guidelines that mandate this decision.

More concerning, however, is the fact that the Case Manager was involved in the decision that I had a case to answer at an early stage of the investigation and before I had even provided a response as part of that investigation. This was materially prejudicial for clear reasons and makes it impossible for the Case Manager to have an open mind when making a determination at the conclusion of the formal investigation.

2.6.2 Terms of Reference

The Terms of Reference of the Investigation are included at Tab 35.

I was unaware of the advice given by NCAS on 28th December 2016 until I received a copy of the correspondence from Dr Khan on 21st October 2018. It was only upon seeing this advice that I became aware that the Trust had been advised that if there were "concerns that patients may not have received appropriate treatment, or that there are patients with inadequate records, then this could be managed separately with an audit/look back to ensure that patients have received the appropriate standard of care."

The Trust had received advice that a review of the patients could have been conducted separately. This did not have to form part of the investigation into my practice and the Trust has once again taken an approach in conflict with the advice received from NCAS.

Appendix 5

Restriction of Practice / Exclusion from Work (Section II MHPS)

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.
- **NCAS must be consulted where formal exclusion is being considered.**

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.

↓

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 paras 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. (Refer to MHPS Section II para 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 and Social Care Trust

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

23 September 2010

Southern Health and Social Care Trust

Quality care – for you, with you

REPORT SUMMARY SHEET

Meeting: Date:	Governance Committee 26th November 2020
Title:	Bi-Annual Report – Raising Concerns (Whistleblowing)
Lead Director:	Director of HROD
Corporate Objective:	• Making best use of resources • Provide Safe, high quality care
Purpose:	For Assurance

Overview

1. **Cases – Themes and Trends (2018 to 2020) & Emerging Case Themes and Trends in 2020 during the Covid 19 Pandemic.**

This report outlines the cases and trends of Trust Whistleblowing cases over the 2 year period April 2018 to April 2020 and considers the emerging trends from cases during the Covid-19 pandemic in 2020.

2. **Risks associated with the Covid 19 pandemic**

The report reviews the increased risks associated with the Covid-19 pandemic on raising concerns and highlights regional and national work undertaken by experts in the field including the UK Whistleblowing Charity – Protect, Speak Up and the NI Audit

Appendix 2

Formal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the formal process.

Chief Executive, following discussions with the MD and HROD, appoints a Case Manager and a Case Investigator.

Chief Executive, following discussions with the Chair, seeks appointment of a designated Board member to oversee the case.

Case Manager informs the Practitioner of the investigation in writing, including the name of the Case Investigator and the specific allegations raised.

Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence, a list of all potential witnesses and give an opportunity for the Practitioner to put forward their case as part of the investigation.

Case Investigator gathers the relevant information, takes written statements and keeps a written record of the investigation and decisions taken.

Case Investigator must complete the investigation within 4 weeks and submit to the Case Manager with a further 5 days. Independent advice should be sought from NCAS.

Case Manager gives the Practitioner an opportunity to comment on the factual content of the report including any mitigation within 10 days.

Case Manager must then make a decision on whether:

1. no further action is needed
2. restrictions on practice or exclusion from work should be considered
3. there is a case of misconduct that should be put to a conduct panel under the Trust's Disciplinary Procedures
4. there are concerns about the Practitioners health that needs referred to the Trust's Occupational Service for a report of their findings (Refer to MHPS Section V)
5. there are concerns about clinical performance which require further formal consideration by NCAS
6. there are serious concerns that fall into the criteria for referral to the GMC or GDC by the Medical Director/Responsible Officer
7. there are intractable problems and the matter should be put before a clinical performance panel.

- 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

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

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

INVOLVEMENT OF NCAS

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

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

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

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

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.

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?

Neves, Joana

From: Wilkinson, John
Sent: 07 March 2017 18:53
To: Aidan O'Brien
Cc: Wilkinson, John
Subject: RE: Update

Dear Aidan
Further to my meeting today, to receive an update as agreed, I can report the following:

1. I was given assurances that the case is progressing.
2. The terms of reference re the investigation will be issued to you imminently .
3. In addition you will be provided with a list of the people, at this stage, with whom the Case Investigator will interview.
4. I am assured that you will be given the opportunity to state your case as part of the process.
5. As the list of people being interviewed will take place over the next 3-4 weeks you could expect to be interviewed by mid to late April '17.
6. The questions you emailed to me last night I have passed on to HR for a response. The questions will be addressed by appropriate persons. I am assured these will be responded to as quickly as possible.

As per my role I will continue to ensure that the momentum is maintained.
If you have any further representations which you would like me to make on your behalf re the investigation, you should forward them to me using this email or using [redacted]
I hope this is helpful.

Regards
John

From: Aidan O'Brien [redacted]
Sent: 06 March 2017 20:08
To: Wilkinson, John
Subject: Questions to be asked

Dear John,

I thank you for taking my call earlier today and I regret disturbing you during your other work commitments.
I wish to emphasise to you how much I appreciate your efforts on my behalf.

However, I had expected or assumed that I would receive a communication from you informing me of answers which you had received to the questions which we had raised with you when we met on 07 February 2017.
I was entirely taken aback and disappointed that a response should come from the Case Manager.
That it did implied to me that your role on my behalf does not enjoy an autonomy.

Since speaking with you earlier today, I have reviewed the Trust Guidelines forensically.
I have attached a list of questions which I require to be answered concerning the conduct of the Trust in handling the concerns raised prior to the decision to formally investigate and immediately exclude.
As these questions pertain to the period prior to the appointment of the Case Manager, I will regard any reply from the Case Manager to be entirely inappropriate,

Many thanks,

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

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

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

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

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

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

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

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

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

Davis, Anita

From: Carroll, Ronan
Sent: 15 December 2021 23:14
To: Davis, Anita
Subject: FW: Job Plan

Follow Up Flag: Follow up
Flag Status: Flagged

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

From: Carroll, Ronan Personal Information redacted by USI
Sent: 28 September 2018 13:40
To: Corrigan, Martina
Subject: FW: Job Plan

FYI

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

From: Weir, Colin
Sent: 28 September 2018 11:51
To: Carroll, Ronan; Haynes, Mark
Subject: RE: Job Plan

After Lunch today??

From: Carroll, Ronan
Sent: 27 September 2018 14:08
To: Haynes, Mark; Weir, Colin
Subject: FW: Job Plan

Can we chat this though please – I am in cah tomorrow

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

From: Weir, Colin
Sent: 27 September 2018 12:08
To: O'Brien, Aidan; Carroll, Ronan
Subject: RE: Job Plan

Aidan

I have your job plan completed on Monday. I think it is a fair reflection of all the discussions and complexities of your working pattern we discussed.
If triage is to be increased from 6 hours that will have to be for all and done on an equal basis (I cant pay someone more for taking much longer for the same number of triages). That therefore will need an agreed position from all urologists and you as a group will need to decide that and approach me in due course
I cant see that 24 hours of Triaging would be sanctioned

If 3 hours fixed time each Sat and Sun for ward rounds is included again I would need written confirmation from all and all job plans will need rewritten

I expect if this was discussed on Monday then I await confirmation. It will require reopening of all job plans

Colin

From: O'Brien, Aidan
Sent: 27 September 2018 10:01
To: Weir, Colin
Subject: Job Plan

Colin,

Just to informally update you regarding two issues discussed at our departmental meeting on Monday 24 September 2018, and which relate to job planning:

- It was agreed that Consultants would undertake Ward Rounds on Saturday and Sunday mornings, when Urologist of the Week (UOW), provided doing so was included in Job Planning.
  While it was not specified or agreed, I believe that there may be agreement that 3 hours of predictable time be allowed for each rounds, but that may require further clarification.

- Triage was much more complicated.

As has been my consistent view, it was agreed that it has been unfortunate that UOW and Triage have been so linked, particularly as it has been agreed that achieving triage while being UOW has only been possible by compromised quality of triage, and by compromised inpatient management.
It has been acknowledged that triaged actually replaced inpatient management.
With regard to the time expended on triage:

- Michael Young advised that he had been asked how long it took him to do triage, that he had advised that it took him at least six hours, but that it was an off the cuff remark, and that he did not have an accurate time requirement.
- Mark Haynes felt similarly… at least six hours, but he did not have a more accurate assessment of time required.
- Tony Glackin was more specific, advising that he spent two hours on each of the seven UOW days, a total of 14 hours.
- I advised that it took me 20 – 24 hours which when conducting advanced triage during my own time on the Friday, Saturday and Sunday after my UOW week.
- John O'Donoghue did not attend the meeting.

The amount of time required is entirely dependent on the kind of triage being conducted: the ordering of investigations and the initiation of treatment.
It was interesting to learn that the greatest disincentive to ordering investigation is having to deal with the results, requiring more unallocated time.
However, it was acknowledged that if, as we agreed, it would be mandatory for the UOW to conduct ward rounds on each of the seven days as UOW, and if it was the case that advanced triage was required in view of the waiting times for first outpatient consultation, it was impossible to complete triage whilst being UOW.
We discussed possible solutions to that, the most attractive being that the specialty doctors, Saba and Laura, could possibly deal with cohorts of referrals in protected time to do so, etc.

I hope that this may be useful.

Aidan.

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

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

Following topics was discussed:

1. **Enniskillen Clinics**

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

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

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

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

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

One point that hasn't been agreed from this meeting and needs followed up is in respect to returning the notes after the clinic – Mrs Corrigan to action.

2. Admin since return to work

Mrs Corrigan asked on clarification on the backlog that Mr O'Brien's secretary had reported that she was doing and Mr O'Brien advised since his return to work he had been doing any outstanding Admin/Results etc. that had not been done whilst he had been off and this included patient follow-up from his diaries. Mrs Corrigan said that there should be no information kept in diaries and that it all needed to be recorded on PAS. Mr O'Brien assured Mrs Corrigan and Mr Weir that it was all also on PAS.

Note for clarification for MC – can I ask for these diaries to do a cross-check??

3. New Outpatient Clinics

Mr O'Brien advised Mr Weir and Mrs Corrigan that he no longer felt it was fair that he would continue to see New Outpatients. Mrs Corrigan advised that this was not feasible as all Consultants needed to see New Outpatients. Mr O'Brien clarified that the reason he felt this was because he had the most patients waiting to be operated on with the longest waiting times and that it wasn't fair for him to continue to see new patients and adding to his waiting list as he couldn't deal with them.

Mrs Corrigan clarified that Mr O'Brien didn't have the most nor the longest waiting times for In and Day patients:

Mr Young	-	228 patients (162 weeks)
Mr Suresh	-	267 patients (93 weeks)
Mr O'Brien	-	257 patients (152 weeks)
Mr Haynes	-	191 patients (143 weeks)
Mr Glackin	-	146 patients (62 weeks)
Mr O'Donoghue	-	134 patients (101 weeks)

Mrs Corrigan gave further detail on Mr O'Brien's total waiting with their longest waiting times:

Daycases:	37 Urgent (longest waiting 110 weeks)
	25 Routine (longest waiting 137 weeks)
Inpatients	124 Urgent (longest waiting 148 weeks)
	71 Routine (longest waiting 152 weeks)

Mr O'Brien advised that he didn't agree with classifications of an *Urgent* or of a daycase and that whilst these were the numbers waiting they should be classified differently.

him that it was imperative that he dictated on these patients as not only was it away of capturing this activity but it was a record of the decisions that had been made on the patient because again the Trust didn't have any record of this.

6. MDT

Mr O'Brien raised about the Urology Oncology MDT and advised Mr Weir and Mrs Corrigan that he was no longer prepared to operate on a Wednesday until 8pm then go home and preview for the next day's MDT as he had done in the past. He advised Mr Weir and Mrs Corrigan that he hadn't quite made up his mind if he was going to continue with chairing this MDT group but if he did continue then he wouldn't be coming into work on a Thursday morning but the time would be spent previewing for the MDT. Mr O'Brien advised that he spends considerable time preparing for the meeting if he is going to Chair and that he went through all patients in great detail including all their images. He also advised that in the past he had spent considerable time after the MDT correcting the outcomes i.e. grammar etc. He advised that he prided himself on having one of the best-prepared and well-run MDT's.

Mrs Corrigan advised that as Mr Glackin was now the Lead for MDT that he should speak with him to determine his views on this.

Follow-up note: Mrs Corrigan spoke with Mr Young who felt that it Mr O'Brien wants to continue to Chair then he should drop his theatre session once per month and give it to the Locum Consultant and this would allow him to do the preparation for the MDT.

7. Investigation

Mr O'Brien raised the Investigation and the worry it was causing him. He said that he wasn't sleeping and that it was more now the mental stress that this was causing him rather than the physical. He advised that he was suffering from bad headaches and needed to go to bed early (he also advised that he was on antibiotics for a sinus infection). He told Mr Weir and Mrs Corrigan that he had a pain from his neck into his arm and that his eyesight had really deteriorated and that he needed new glasses. Mrs Corrigan asked him did he want to be referred back to Occupational Health? He replied that his wife had mentioned the same but he wasn't sure. Mr Weir discussed with him that he should attend his own GP as it sounded like he was suffering from anxiety. Mr O'Brien said he knew his GP – [redacted] Personal Information redacted by USI

Follow-up: Mrs Corrigan to check with Mr O'Brien on his health and again ask does he want to be referred to Occupational Health.

Mr O'Brien told Mr Weir and Mrs Corrigan that whilst he had had an indication that the Investigation would be complete by mid-April he had no indication on