Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 68 of 2022

Date of Notice: 23 August 2022

Witness Statement of: MR AIDAN O'BRIEN

I, Aidan O'Brien, will say as follows:-

Section 1 – General Narrative (Q 1-2)

1. I am providing this response to the Section 21 Notice (hereinafter "the Notice") doing my best at this time to provide information that will assist the Inquiry to investigate the matters referred to in its Terms of Reference. As the Section 21 Notice is divided into various subject areas, I shall provide my response in relation to each of those areas, insofar as I can. If there are any areas which the Inquiry considers I can provide greater clarity in relation to, I shall be happy to provide such further information that I can on request.

2. The Inquiry will be aware that I have received approximately 217,000 pages of disclosure between late May and mid-August. Neither I, nor my legal team, have been able to consider all the documentation disclosed. Apart from the volume of information to collate, I was also served with Patient Hearing Bundles for hearings taking place in September which related to patients that I had treated, and which included patient records, accounts from patients and/or relatives of the treatment provided and, in addition, correspondence from the Southern Health and Social Care Trust (the "Trust") management and in one case records relating to a Structured Clinical Record Review (SCRR). I obviously needed to consider all of that material, prepare for and attend the patient hearings themselves as well as try and continue to consider the vast amount of material disclosed. Therefore, there

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(Q 88)

716. I do not believe that there is anything more that I wish to add at this time, but I will endeavour to provide any further clarifications that the Inquiry requires.

Statement of Truth

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

Signed: Aidan O'Brien

Date: 2nd November 2022

Respondent Statement

NAME OF WITNESS	Mr Aidan O'Brien
OCCUPATION	Consultant Urologist
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Thursday 3 August 2017
PRESENT AT INTERVIEW	Mrs Siobhan Hynds, Head of Employee Relations Mr Michael O'Brien, son
NOTES	The terms of reference were shared prior to the date of statement.

1. The meeting commenced with welcome and introductions. The format of the meeting was outlined to me and it was explained that the meeting would be based on the previously shared Terms of Reference for the investigation.

2. I asked for a full updated list of witnesses to be sent to me. I also asked for all witness statements to be shared with me. This was agreed.

3. I have been asked to provide this statement in respect of an investigation in response to concerns about my conduct/clinical practice being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework.

4. I agreed to answer questions specifically related to the terms of reference previously shared with me.

5. My name is Mr Aidan O'Brien, I am employed by the Southern Health and Social Care Trust as a Consultant Urologist. I have been in this position for 25 years.

Term of Reference 1

6. I explained that when patient referrals are sent to me there are only a minority which are personalised to me. To my knowledge I have always responded to these referrals.

call I did 60 enhanced. Sometimes it may be 150 but the last period was relatively light because of holiday time.

60. I have no difficulty in reflecting, I haven't had the time to be faultless. Dr Chada asked me if from 2015 I would do anything differently. I advised that I find it difficult to answer that when faced with reality of need I am faced with.

61. I advised that I have already responded to the SAI case of Patient 10 I have read her referral and I would have kept it as routine. If I am criticised for not having triaged, the only way the routine referral from GP could be reasonably upgraded would be to have reviewed the digitalised images. I haven't seen the final report 6 months later.

62. I feel I should have been provided with an opportunity of support to deal with the concerns before it was moved to a formal investigation process.

This statement was drafted on my behalf by Mrs Siobhan Hynds, Head of Employee Relations and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.

This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a conduct or clinical performance hearing. I understand that I may be required to attend any hearing as a witness.

SIGNATURE	
DATE	

AOB-01792
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Comments relating to the Respondent Statement of Thursday 03 August 2017

The following is a list of comments relating to the interview conducted by Dr. Chada on Thursday 03 August 2017:

- The statement did not include my enquiry relating to my failure to receive amended Notes of previous meetings following my submission of those proposed amendments. (This related to the Note of the meeting with Dr. Wright and Ms. Hainey on 30 December 2016 and to the Note of the meeting with Mr. Weir and Ms. Hynds on 24 January 2017.)

- Paragraph 3 relates that I have been asked to provide this statement in respect of an investigation in response to concerns about my conduct / clinical practice being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework. Paragraph 3 is incorrect as I was not asked to provide this statement in accordance with either the Trust Guidelines or the Framework, nor could I have possibly been asked to do so, for the reasons as detailed in my letter of 30 July 2017, addressed to Dr. Khan. Succinctly, the Trust formulated its Guidelines in September 2010 in response to its obligation to do so, in order to implement the Framework. Therefore, such an investigation can only be conducted by the Trust in accordance with its Guidelines, and as the investigation was not completed by 30 January 2017, its continuation since then cannot have been, and has not been, in accordance with its Guidelines.

- Paragraph 7 should read: 'Of the non-personalised referrals allocated to me, i.e., those allocated to me as Consultant Urologist of the week, I triaged all red flag referrals during 2015 and 2016, but did not triage the remaining referrals during 2015 and 2016.

- Even though later paragraphs elaborate further, Paragraph 8 requires some amendment by way of clarification. The practice of allocating referrals to be triaged by the Consultant Urologist of the week, whilst being Consultant Urologist of the week, was introduced concurrent with the introduction of the Consultant Urologist of the week model in 2014. Whilst I did agree with it being so, I soon found it impossible to do, and I did advise by early 2015 that I had found it impossible to do. The possibility or otherwise of doing so was not assisted by the complete lack of any clarity or agreement regarding the detail of the triaging process.

- Paragraph 9 referred to the number of referrals which I had not triaged during 2015 and 2016. I have been provided with the details of 319 referrals which I had not triaged during that time, and agree that that number is factually correct.

- The second sentence in Paragraph 13 should read: 'The *quantity* of referrals is such that you cannot properly triage them'.

- Paragraph 14 is very important. Did I ever say that I was no longer doing this. I believe that I did by advising that I had found it impossible to do. I did not use the words 'I am no longer

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Respondent Statement

NAME OF WITNESS	Mr Aidan O'Brien
OCCUPATION	Consultant Urologist
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Monday 6 November 2017
PRESENT AT INTERVIEW	Mrs Siobhan Hynds, Head of Employee Relations
NOTES	The terms of reference were shared prior to the date of statement.

1. The meeting commenced with welcome and introductions. The format of the meeting was outlined to me and it was explained that the meeting would be based on the previously shared Terms of Reference for the investigation.

2. The purpose of the meeting is to address Term of Reference 4 which had not been previously responded to.

3. Dr Chada explained that this was the final meeting after which she could conclude the process. I explained to Dr Chada that I have a number of priorities in November / December including my Appraisal which I wish to get completed. I advised that I would be concentrating on this in the coming weeks. I outlined that this process is having a significant impact on myself and my wife – it is a difficult time. Dr Chada outlined that once we have agreed statements, a case report can be provided to the Case Manager.

4. I advised that I have a number of issues with and comments to make on the previously shared notes from my first meeting with Dr Chada and also with the witness statements shared with me. I noted I intend to make commentary on both.

5. I advised that of the 9 patients, highlighted to me for response in respect of time being added to the waiting list and when they came in for a procedure, only 2 were TURP patients. The initial information shared with me in respect of these concerns related only to TURP patients. I asked for clarification on this and if there had been a full review of my private patients undertaken – not just TURP patients.

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Comments concerning the Respondent Statement of the Meeting of 06 November 2017

The following are comments regarding the draft Respondent Statement of 06 November 2017, received upon request on 04 March 2018:

- The draft Respondent Statement did not include any reference to a lengthy discussion concerning the difficulty in responding to allegations made of witnesses in their statements without being provided with documentary evidence of those allegations. One such allegation was used to exemplify this difficulty. It has been alleged that I had been allocated more administrative time in my job plan than my colleagues had. Not only was I unaware of having been so, I am unable to clarify whether the allegation is true as I do not have any knowledge of the job plans of my colleagues. It would therefore have been useful to be provided with that clarification in order to be able to make an informed comment upon the allegation.

- Paragraph 5 requires amendment. I was first made aware of a concern having been raised regarding patients who had attended privately and who had subsequently been admitted for TURP after a waiting time that was significantly less than for other patients, when I met with Mr. Weir and with Ms. Hynds on Tuesday 24 January 2017. I was informed in writing that there were nine such patients. The concern had been added to the initial three concerns as Issue Four. It, and the number of patients concerned, were reiterated in the Note of that meeting. Both were again repeated in writing in the Return to Work meeting with Dr. Khan on 09 February 2017. When Dr. Wright wrote to me on 30 March 2017, he claimed that it had been established that there were at least 9 TURP patients who had been seen privately, who were routine in terms of clinical priority, but appeared to have had their NHS procedure done in non-chronological order. Lastly, in his witness statement of 06 April 2017, Mr Carroll reported that he and Martina Corrigan had looked to see if there was a trend for TURP patients to be 'seen out of sequence and there were *(sic)* a number identified'. He did not specify the number.

- As indicated by the draft Respondent Statement, I had been provided, on 03 August 2017, with a list of 11 patients who had procedures performed, having previously had a private consultation. The list included the details of the date upon which each patient had been entered on the waiting list and the date of the procedure performed. It also included a judgement provided by a senior clinician as to whether there had been a clinical reason why each patient had waited such a short period of time. As indicated, I provided copies of a synopsis of each case, including the clinical reasons and circumstances pertaining to the management of each case.

- In doing so, I clarified that the date on which each case had been placed on the waiting list had been correct in only two cases. It did appear that the patients may have been placed on a waiting list on the date upon which their GP was being advised of their admission, with no relation to the date upon which they had had a private consultation. As a consequence, it did appear that one patient was admitted for surgery 54 days after entry on a waiting list rather than 428 days after the consultation when it was agreed to proceed with surgery. However, I also pointed out that another patient had been entered on the waiting list 12 days before he had had any consultation.

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in this general narrative to describe the inadequacy of the urology service provided by the Trust, and the relentless burden carried by me and my too few colleagues to maximally mitigate the risks of patients coming to harm due to that inadequacy. I have worked far beyond any contractual obligations, as has been acknowledged. I have worked when on leave, and even when on sick leave. I have tried to do the impossible, but the impossible proved not to be possible. I hope that any failings on my part may be viewed in this light.

Section 2 – Your Role (Q 3-7)

96. I graduated in medicine from Queen's University Belfast in 1978. Following completion of basic surgical training in Northern Ireland in 1985, including one year as a Demonstrator of Anatomy at Queen's University, Belfast, I was appointed a Registrar in Urology at the Meath and St. James's Hospital in Dublin. Following two years as a Registrar and one year as a research fellow, I was appointed a Senior Registrar in Urology in Dublin in 1988. I completed Higher Professional Training in Urology in Dublin in June 1991. I took up a locum consultant post at Craigavon Area Hospital in July 1991 for two months, prior to taking up the post of Clinical Fellow in Paediatric Urology in Bristol Royal Hospital for Children from September 1991 until 30 June 1992 and returned to Craigavon Area Hospital in July 1992 as a consultant urologist. Details of my early career are contained in the CV which I have recently provided to the Inquiry and is awaiting a Bates number [see supplemental October bundle pages 1 - 34] Following my appointment to Craigavon Area Hospital I worked there and at a number of other hospitals (given the changing requirements of the various Trusts I worked for). I was a consultant urologist from 6 July 1992 through until 17 July 2020. When my employment ended on 17 July 2020, my employer was, and had been for some time the Southern Health and Social Care Trust (SHSCT). Throughout this statement when I refer to "the Trust" that shall refer to the SHSCT and its predecessors.

97. Throughout my time at the Trust, I worked as a urologist, with special interests in the fields of oncology, lower urinary tract dysfunction and paediatric urology. I shall refer further below to my job plan which may assist the Inquiry in understanding the

the period 1998 until the new contract [AOB-00039- AOB-00040]. The 2006 contract is at AOB-00048 – AOB-00058.

101. The Inquiry may be further assisted by considering document AOB-03504 which was prepared in the process of an Awards Round Application. It provides information in relation to the duties and roles I was undertaking at that time and how I assisted in the establishment of the Urology Service between 1992 and 2007. I was awarded a local clinical excellence award in 2009 [see AOB-00121].

102. In April 2012 I was appointed Lead Clinician of the Southern Trust Urological Cancer Multidisciplinary Team (MDT) and Chair of the weekly Urological Cancer Multidisciplinary Meetings (MDM). I remained as Lead Clinician until December 2016. I did not receive a job plan for the post of Lead Clinician, nor was any provision made for it in any proposed job plan during the period of tenure, even though the responsibilities of the MDT Lead Clinician were such as those outlined in the Urology MDT Operational Policy Brief for the AGM in 2014 [see AOB-00734-AOB-00757, page 12]. In doing so, I also identified each week those patients at greatest risk of breaching cancer timeline targets, ensuring that their management was progressed, thereby succeeding in having had only three patients breaching targets prior to peer review in June 2015.

103. I remained as Chair of the MDM which took place each Thursday afternoon from April 2012 until September 2014 when it became necessary to introduce a rotating Chair in advance of the introduction of Urologist of the Week (UOW), as it would not have been possible to prepare for or chair the MDM if also UOW. Two of my colleagues agreed to rotate as Chair with me from then. I remained one of the rotating Chairs from September 2014 until December 2019. Chairing MDMs required the Chair to preview all of the cases to be discussed before each MDM. As the number of patients to be discussed at each MDM ranged from 25 to 40 cases, previewing the cases required some 2.5 to 4 hours. I previewed all cases each Wednesday evening, after an operating list, prior to MDM the following day. I regularly worked into the early hours of a Thursday morning to enable me to do so. Following each MDM chaired by me, I reviewed the accuracy of the outcome for

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each patient prior to sign off. While the actual chairing of the MDM was included in proposed job plans, there was inadequate provision in proposed job plans for previewing cases in preparation for MDM and none for reviewing and signing off the MDM outcomes.

104. In January 2013 I was appointed as Clinical Lead and Chair of the Northern Ireland Cancer Network (NICaN) Clinical Reference Group in Urology and continued to hold that post until December 2015. I was not given a specific job plan/description in relation to that, however, it would be in keeping with the Clinical Lead's responsibilities outlined in the Constitution of the Northern Ireland Cancer Regional Network Groups, February 2009 [see AOB-00119- AOB-00120].

105. The role with NICaN was not a Trust post, but a Northern Ireland wide post. The Trust however was well aware that I was undertaking this role. NICaN comprised consultants from throughout Northern Ireland. NICaN is split into nine different cancer areas, urology being one of them. It is a forum for specialists to provide advice to the Department of Health (DoH) by way of the HSCB, which commissioned urological cancer services throughout Northern Ireland. The usual, ongoing function of a Clinical Reference Group is to provide updated advice regarding the factors and features giving rise to a suspicion of, or increased risk of, cancer, referral pathways for such persons, investigative and diagnostic procedures, in addition to multidisciplinary, clinical management guidelines, all with reference to national and international guidelines and evidence. In doing so, such advice enables the HSCB to be informed of current service capacity, its deficiencies and investment requirements. On my appointment in January 2013, the Group was additionally aware that the Urology MDTs throughout Northern Ireland would be subject to National Peer Review for the first time, and which occurred in June 2015. It was therefore my additional responsibility to have the Group's Clinical Management Guidelines for all urological cancers drafted for peer review, as those were the guidelines which would be used by all MDTs.

106. In fulfilling the above role, I had to chair meetings which included clinicians from other specialities such as oncology, pathology, radiology and clinical nurse

specialist etc. NICaN meetings were held once every two or three months and a full afternoon was devoted to them. As Chair there was a substantial amount of preparation for the meetings and also work which I carried out closely with Mary Jo Thompson (who herself previously had been a Urology Staff Nurse but was by that time seconded to work for NICaN). I regularly liaised and met with her throughout my tenure as Lead Clinician and Chair of the Group in relation to actions which had been decided at the NICaN meetings and in preparation for follow up meetings. In retrospect, I would have spent a mean of one hour per week doing so, in addition to the actual chairing of meetings.

107. During the years I held these additional roles of Lead Clinician and Chair of NICaN's Clinical Reference Group in Urology and Lead Clinician of the Trust's Urology MDT, they were not accounted for in terms of time commitment in my job plan. Whilst I took on additional duties, I was not given additional time by the Trust to perform them.

108. Mr Akhtar had been Chair of the Trust Urology MDM from April 2010 to March 2012. With his departure I volunteered to take over the role. Mr Young had other commitments and the only other available consultant at that time was newly appointed, Mr Glackin. Mr Young and I considered that it was unfair to expect a recently appointed consultant to assume such an additional burden

109. I also undertook the role of Lead Clinician of the MDT from April 2012 to December 2016. Please see letter dated 10 April 2012 from Rory Convery, Clinical Director of Cancer Services, to me in relation to my appointment as the Lead Clinician for Urology Cancer Services. It notes that the role and responsibilities of Lead Clinician "*are detailed in the Operational Policy for the Service*". Please see document AOB-22874. The Operational Policy is at AOB-231126 noted in the following terms:-

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available for the Peer Review. Again, this role was not reflected in my job plan.

111. A further function which I carried out was as an Intercollegiate Surgical Curriculum Progamme (ISCP) Clinical Supervisor. As trainees came towards their six-monthly appraisal, one would receive requests for reports. The time spent on those reports is an example of a further commitment I had during my time as a consultant, again it was not reflected in my job plan nor was time made available to carry out this function.

112. I shall refer in greater detail below to the inadequacy of resources for the Urology Department at the Trust. During the period I held these posts there were ongoing resourcing issues. It was also a period of significantly increased demand for urology services. Performing these extra roles, without time being provided to do so, put me under additional strain during this period.

113. In terms of medical line management, when my employment ended with the Trust it was as follows:-

(i) Medical Director
(ii) Associate Medical Director
(iii) Clinical Director
(iv) Lead Clinician
(v) Consultant

114. I would request that the Inquiry liaise with the Medical Director's Office and/or Human Resources in relation to individuals who occupied those posts throughout my tenure as they should be able to give more accurate dates than me. That structure was in place for many years, although I cannot now recall exactly when the role of Associate Medical Director was introduced, as I do not recall the post having existed in the early years of my consultancy.

115. Of the various roles I have referred to above, the medical management post I had most interface with was the Lead Clinician for Urology. As I have mentioned

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activities I undertook in that role (insofar as I have been able to identify relevant documents in relation to same to date).

98. I was the only consultant urologist at the Trust until January 1996 when a second consultant, Mr Wahid Baluch, took up post. He remained in place until December 1997 and thereafter I was the sole consultant urologist again until May 1998. At that stage Mr Young was appointed.

99. During the initial years, I fulfilled the role of Lead Clinician in Urology. I cannot recall having a specific job description or contract in relation to that and I have not, as yet, been able to identify one in the Inquiry papers. Mr Young took over that role from me in or about 1999 and remained in post as Lead Clinician until my employment with the Trust ended in July 2020. (Consultant Urologist Job Description, 1992 [AOB-00001 – AOB-00006], Consultant Urologist Job Contract, 1992 [AOB-00007 – AOB-00010])

100. During the period from taking up the post of consultant urologist in July 1992 until the appointment of a second consultant in 1996, I provided a continuous acute urological service and an almost continuous elective urological service, as related in my letter to the Directorate of Human Resources in March 1996 [AOB-00018 – AOB-00022]. That letter gives a clear picture of the scale of the role I was appointed to. At the time of my appointment the ratio of urologists to patient population was the worst in Western Europe. I was the only urologist providing a service for a population of approximately 290,000 in the Southern Health Area. The service was rudimentary, and I committed myself wholeheartedly to the task of enhancing and improving it. With the administration entailed in coping with increasing demand, superimposed upon the underlying clinical commitments, I was regularly working 80 hour weeks. In four years I had only four weeks of holiday with my family. The extent to which I was working beyond contractual obligations during these and subsequent years was recognised in 2006 when both Mr Michael Young and I were awarded an extra 5.5 PAs in recognition of the additional workload "*over and above the 10 programmed activities that constitute your standard contractual duties".* An ex-gratia payment of £30,000 was made in respect of my extra contribution from

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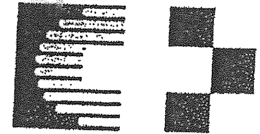
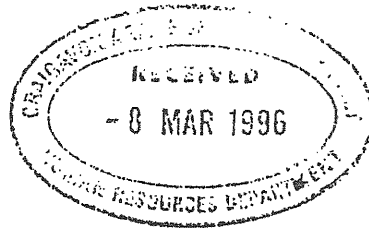
AOB-00018



CRAIGAVON
AREA HOSPITAL
GROUP TRUST
Caring Through Commitment



7 March 1996

Urology Department

Ms Helen Walker
Directorate of Human Resources
Craigavon Area Hospital Group Trust

Dear Helen

You will remember my speaking with you one year ago on the subject of remuneration for work performed in excess of contractual obligations and expectations. I had been advised and requested to do so by Mr. Templeton, Chief Executive. You requested that I submit to you an outline of the reasons for and the nature of this additional work. The delay in doing so is directly related to the amount of extracontractual work performed.

The genesis of the necessity to work significantly in excess of contractual obligation lies in the fact that on my appointment as a Consultant Urologist in July 1992, I was the only Urologist providing a service for the population of 300,000 of the Southern Health and Social Services Board Area. At the time of my appointment, I was the sixth Urologist appointed to Northern Ireland, resulting in a Urologist : population ratio of 1:250,000. This is the worst Urologist : population ratio in Western Europe, where the ratio is consistently 1:50,000. There are now still only eight Urologists in Northern Ireland, an improvement in the ratio to 1:200,000, but still far short of that which has been proven for years to be necessary. The Northern Ireland ratio, which is identical to that of the Republic of Ireland, is the worst in the UK. The UK ratio is currently 1:130,000, six years after the Ministry of Health accepted the recommendations of the Collins Report that each unit of population of 250,000 - 300,000 should be serviced by a urological unit staffed by three Consultant Urologists. The Southern Health Board should have appointed three Consultant Urologists in 1992 to meet the Government's modest standards. The Southern Board Area requires six Urologists to meet international standards.

These standards are in sharp contrast to those which have pertained in the Southern Board area to date. My appointment in 1992 was the culmination of a successful struggle between Craigavon Area Hospital and the Southern Health Board. Given international standards, it is quite incredible that that struggle should have centred around the issue of whether the area required the appointment of even one Urologist. However, given that the Board would still probably balk at accepting British, never mind international, standards, then their stance was not

....2/

Headquarters:
Craigavon Area Hospital Group HSS Trust
68 Lurgan Road, Portadown
Craigavon, BT63 5QQ
Tel: Irrelevant Information Redacted by the USI Fax: Irrelevant Information Redacted by the USI

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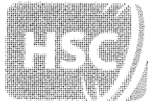


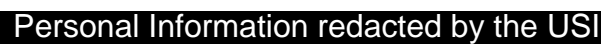
Southern Health
and Social Care Trust

Medical Directorate

Our Ref: PL/RF

12 April 2009

PRIVATE AND CONFIDENTIAL



Personal Information redacted by the USI

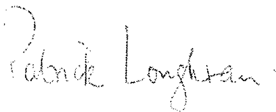
Dear Mr O'Brien

Re: Southern Trust Clinical Excellence Awards 2008/09

The Local Clinical Excellence Awards Committee met on 23 March 2009 to consider all Consultants who submitted an application for a Clinical Excellence Award.

I am very pleased to formally confirm that as a result the Committee have decided that you should receive one award. The effective date of the award is 1 April 2008, and the necessary adjustment will be made to your salary.

Yours sincerely,



P.G. LOUGHRAN
Medical Director (obo)
MR EDWIN GRAHAM
Non-Executive Director SHSCT/
Chair Clinical Excellence Awards Committee

CC Zoe Parks, Medical Staffing Manager, Trust Headquarters, Craigavon Area Hospital

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population ratio of approximately 1:180,000. I was shocked to appreciate that Northern Ireland, having 5 consultants, had a consultant urologist / population ratio of 1:300,000, the worst in these islands.

23. In April 1991, I received a telephone call from Mr Ivan Stirling, then a consultant general surgeon at Craigavon Area Hospital, to advise me that his general surgical colleague, Mr Graham, was due to retire on 30 June 1992, that he had provided a urological service for a number of years, and that he and his colleagues had been giving consideration as to whether he should be replaced by a general surgeon or by a urologist. He asked for my view. With the above insight into the inadequacy of specialist urological services in Northern Ireland, I proffered my view that his colleague should be replaced by both a consultant general surgeon *and* a consultant urologist.

24. I was scheduled to complete Higher Professional Training in Urology on 30 June 1991, and I had been successful in being appointed a Clinical Fellow in Paediatric Urology at the Bristol Royal Hospital for Children, commencing 1 September 1991. As Mr Graham was retiring, leaving 77 patients on a list awaiting admission for TURP, I was asked whether it would be possible for me to undertake some of these patients' operations. I agreed and completed all 77 TURPs in seven weeks.

25. I was then offered the possibility of remaining at Craigavon Area Hospital as a Locum consultant urologist, with the prospect of being appointed a consultant urologist, if approval for such a post could be secured. I declined as I was keen to go to Bristol and had given an undertaking that I would do so. I was asked by Mr John Templeton, then the Chief Executive, if I would assure him that I would apply for the post of consultant urologist if approval were secured. He explained that he would not be prepared to go out on a limb to secure approval without a guarantee of having one appointable person apply if successful. I gave him that undertaking, though I could not understand how or why it could be so difficult to secure approval for the post.

26. I did suspect, indeed anticipated, that there would be opposition from the

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Department of Urology at Belfast City Hospital as its monopoly over specialist urological services would be dented. However, I did not anticipate that the dominant opposition to the approval of a post would come from the Director of Public Health of the Southern Health & Social Services Board, who did not believe that there was a need for even one consultant urologist, even though it had a resident population of approximately 269,000 at that time. It took a further eight months to convince her otherwise. I duly applied for the post, was competitively interviewed on 11 June 1992 and took up the post as a consultant urologist at the Trust on 6 July 1992.

27. I have related the above experience to identify at least one of the several putative reasons for the inadequacy of staffing and of resources that persisted throughout my tenure as a consultant urologist during the subsequent 28 years. I believe that there are others. I believe that there was a reluctance by others to acknowledge that there was an endemic need which would be best served by a specialty separate from and independent of the generalists who previously provided that service, coupled with their resentment of and resistance to the diversion of resources previously allocated to them. Secondly, I have remained convinced throughout my career that the inadequate commissioning, staffing and resourcing cannot be dissociated from the fact that approximately 70% of adult urological patients are male.

28. Nevertheless, the foundation upon which the Department and Service was initiated was one of a lack of awareness of the urological need which was not serviced, and particularly by those who should have known otherwise. I was immediately concerned that the provision of a service, no matter how inadequate, would result in the transformation of urological need into demand, and that the demand would always exceed the capacity of the service to provide effectively and safely for it. I believe that has been the destiny which has plagued the urological services provided by the Trust since 1992.

29. My concerns were reinforced by the accumulation of data from the 22-member, associate member and affiliated member countries of the European Board of

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Urology in 1998 which found that the mean urologist / population ratio was 1:36,654, ranging from 1:15,150 to 1:184,210, as reported in 2000 (The European Board of Urology Survey of Current Urological Manpower, Training and Practice in Europe. E.A.Kiely. BJU International (2000) 85, 8-13) [see supplemental October bundle pages 35 - 41].

30. In providing this response to Questions 21 to 25 of the Notice, comprising the section entitled ‘Staffing’, I wish to avail of the opportunity to address the issue which, as I have already indicated, I believe has been, overwhelmingly, the fundamental, underlying cause of all that was wrong with the Urology Service, of all that did go wrong and of all that could have gone wrong, were it not for the commitment and efforts of those charged with the provision of it. That issue has been its inadequacy since 1992. I will endeavour in this and subsequent sections of the Notice to outline to the best of my ability and recall, within the time allotted to me, how the inadequate capacity of the service has impacted its various aspects and components, its consequences, how the latter have affected those providing the service, and most importantly, those dependent upon it for their well-being. In doing so I will endeavour to make reference to data and documentation which I consider the Inquiry may find to be of relevance. However, as the Inquiry may appreciate, I have not had adequate time to review more than a small proportion of the documentation disclosed by the Inquiry.

31. I have related in other documentation provided to the Inquiry and to which I have referred in my response to Question 8 of this Notice the difficulties and challenges I experienced in establishing the Department and the Service it provided. The deficiencies were to be seen and experienced in every respect. The Service was provided by one consultant from July 1992 until January 1996. I was assisted by a share of one of the surgical registrars until August 1993. I was then allocated that registrar until July 1994. I was then successful in having his work visa extended for a further year by having him appointed as a clinical research fellow until July 1995. This post was designed to enable him to provide a clinical service limited to two to three days per week, while having a minimum of two days of protected time for research. The clinical service provided justified the Trust

be allocated to my consultant colleague so that we each would have one session each week. However, my request was declined on the grounds that it was being reserved for the intended appointment of another consultant gynaecologist who would need it.

42. Thereafter, my colleague, Michael Young and I shared the Tuesday morning session in Day Surgery on alternate weeks. This arrangement particularly affected Michael Young as this session ran in a physically separate Day Surgical Unit concurrently with his inpatient operating sessions every Tuesday. This arrangement did not lend itself to patient safety.

43. Alongside the inadequacy of operative capacity and increasing acute urological admissions, the number of elective referrals continued to increase. By the second complete year following my appointment, there had been over 1,000 referrals. In his witness statement to the Formal Investigation, dated 23 October 2017 [see AOB-10123 – AOB-10126], Mr Mackle related that I had a ring binder containing over 200 referrals which may or may not have been triaged. In fact, when I was the single urologist, I had four ring binders for referrals received, each for a separate category of urgency. A small folder contained those referred patients who required to be provided appointments as soon as possible, at the next available clinic, if not directly admitted. As a consequence, this folder contained few referrals at any time. The other three folders were for referrals of patients triaged as 'urgent', 'soon' and 'routine'. I continued to have outpatient appointments allocated to my clinics in addition to Mr Baluch's clinics following his appointment in 1996, and I also continued to have patients allocated to my clinics in addition to Mr Young's clinic following his appointment in 1998. However, Mr. Young soon appreciated that he had inherited a significant cohort of patients from Mr. Baluch requiring review, and so I then no longer had referred, triaged patients appointed to his clinics. I think that Mr. Mackle subsequently referred to the single ring binder containing the 'routine' referrals yet to have been appointed, all the other more urgent referrals having been so. It was an effective and safe method of triage and appointment in the pre-digital era.

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he required 65 hours of operating time to attend to those patients at most risk of coming to serious harm, but had been provided with only 28 hours of operating time. He did so again in January 2020, similarly identifying that he required 59 hours of operating time during February 2020, but had only been allocated 24 hours of operating time for that month [WIT-34356]. I make reference to these communications as Mr. Haynes reported that:

"Another surgical specialty in another NI Trust has come under significant criticism for treatment delays and subsequent adverse outcomes for not highlighting the waiting times to the Trust (genuinely bizarre given that the waiting times were known to the Trust) and in order to protect ourselves, we have been advised to highlight treatment delays!"

75. While it would indeed appear to be "*bizarre*" to the uninitiated or those without longer experience, I find it entirely familiar and consistent with the success with which Trusts have been able to transfer all responsibility for the consequences of inadequacy to clinicians. Secondly, I have so often listened to the refrain that *"it is well known that urology waiting lists are very long".* It has appeared to me that Commissioners and Trusts have been so aware of long waiting lists for such a long time that they have become complacent to the extent that they become absolved of any responsibility or accountability for them.

76. By December 2019, there were 883 patients waiting longer than one year for inpatient and day case urological admission, the exact same number as the total number of patients awaiting urological admission in June 2013. The number waiting longer than one year for admission surpassed 1,000 for the first time, at 1,066 patients in June 2020, and some patients had been waiting since August 2014, almost six years, for urgent admission. By June 2021, there were 2,078 patients awaiting admission. Sixty five per cent of these, 1,356 patients, were waiting more than one year. It was then reported in mainstream media that the Southern Trust's patients were waiting up to 365 weeks (7 years) for admission for urological treatment, including urgent urological treatment. The Southern Trust's urology waiting list was then the longest urology waiting list in the United

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harm to multiples of those patients and I would ask that the Inquiry investigates the extent to which actual harm has been caused. The Trust has failed to provide a urological service equitable to other specialist services which it has provided. It has not only failed to address and resolve the concerns that its consultant urologists have had for years, but it has also avoided and evaded sharing the responsibility for the clinical consequences, transferring that responsibility to the inadequate numbers of clinicians who have overworked, beyond their contractual obligations, to mitigate the risks of patients coming to harm.

93. I do not know of the extent of autonomy, if any, that the Trust has had in relation to the commissioners, or the extent to which the Trust has been able to diverge from a Service & Budget Agreement. If none, then the HSCB and / or the Department of Health have not only failed to commission an adequately funded service to prevent such harm, but it has also funded measures that additionally enhanced the risks of harm. In September 2019, the Trust continued to implement ‘validation’ of outpatient waiting lists, again without clinically informed consent.

94. I have attempted in this narrative to describe the inadequacy of the urology service provided by the Trust during my tenure as a consultant urologist since 1992. The extent and severity of that inadequacy barely requires description as the data defines it perfectly. I could never have anticipated thirty years ago that the resourcing of the service would persist to the extent that patients could ever possibly wait seven years for elective surgery for conditions which may have since progressed to the extent that they have become life threatening. The inadequacy in staffing has been so chronically severe that periods of posts remaining vacant had little further negative impact on those remaining in post. Most importantly, the demonstrable futility of raising concerns regarding patients certainly left me permanently carrying the burden of worry for their well-being.

95. Since my appointment in 1992, I have endeavoured to the very best of my ability to provide the best care that I could possibly give to the maximum number of patients whom I considered were in most need of it at any particular time. I regarded it as a vocation and a privilege to do so. However, I have endeavoured

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in this general narrative to describe the inadequacy of the urology service provided by the Trust, and the relentless burden carried by me and my too few colleagues to maximally mitigate the risks of patients coming to harm due to that inadequacy. I have worked far beyond any contractual obligations, as has been acknowledged. I have worked when on leave, and even when on sick leave. I have tried to do the impossible, but the impossible proved not to be possible. I hope that any failings on my part may be viewed in this light.

Section 2 – Your Role (Q 3-7)

96. I graduated in medicine from Queen's University Belfast in 1978. Following completion of basic surgical training in Northern Ireland in 1985, including one year as a Demonstrator of Anatomy at Queen's University, Belfast, I was appointed a Registrar in Urology at the Meath and St. James's Hospital in Dublin. Following two years as a Registrar and one year as a research fellow, I was appointed a Senior Registrar in Urology in Dublin in 1988. I completed Higher Professional Training in Urology in Dublin in June 1991. I took up a locum consultant post at Craigavon Area Hospital in July 1991 for two months, prior to taking up the post of Clinical Fellow in Paediatric Urology in Bristol Royal Hospital for Children from September 1991 until 30 June 1992 and returned to Craigavon Area Hospital in July 1992 as a consultant urologist. Details of my early career are contained in the CV which I have recently provided to the Inquiry and is awaiting a Bates number [see supplemental October bundle pages 1 - 34] Following my appointment to Craigavon Area Hospital I worked there and at a number of other hospitals (given the changing requirements of the various Trusts I worked for). I was a consultant urologist from 6 July 1992 through until 17 July 2020. When my employment ended on 17 July 2020, my employer was, and had been for some time the Southern Health and Social Care Trust (SHSCT). Throughout this statement when I refer to "the Trust" that shall refer to the SHSCT and its predecessors.

97. Throughout my time at the Trust, I worked as a urologist, with special interests in the fields of oncology, lower urinary tract dysfunction and paediatric urology. I shall refer further below to my job plan which may assist the Inquiry in understanding the

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Aimee Crilly

From:	Hunter, Catherine [Personal Information redacted by the USI]
Sent:	12 November 2015 09:18
To:	Gishkori, Esther
Cc:	Haynes, Mark; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Young, Michael; Suresh, Ram; Hall, Sam; Korda, Marian; Reddy, Ekambar; Farnan, Turlough; McNaboe, Ted; McCaul, David; Leyden, Peter
Subject:	3 South Concerns
Attachments:	Ward 3 South Concerns 2015.docx
Importance:	High

Esther,

I refer to my recent e-mail correspondence with Heather Trouton, a copy of which I attach.
I have also raised my concerns with Mr Hayes and at his request, I have copied this e-mail to all the consultants attached to the ward.
While I appreciate the need to keep 36 beds open on the ward, I am gravely concerned with the lack of staff and skills mix at present. While I am very grateful for the help given to me in recent days by Heather and Trudy Reid in getting us staff to cover unfilled shifts, I feel this is only a short-term measure and a medium to longer term solution needs to be developed and I would be keen to discuss this with you and my clinical sisters.
Currently, the standard of care being given to patients is being compromised and I would consider the ward to be clinically unsafe at times. I am also responsible for the welfare of my staff and feedback from them indicates an environment of desperation with many of them coming to see me in tears and unsure how long they can continue to work in such conditions.
In such circumstances, I am obliged by my NMC Code of Conduct to escalate my concerns to senior management and I would request an urgent meeting with you to discuss a plan of action to address the situation.

Catherine Hunter
Ward Manager
3 South

Received from Tughans OBO Mr Aidan O'Brien on 01/05/22. Annotated by the Urology Services Inquiry.

AOB-75762

Ward 3 South – Craigavon Area Hospital

I have now been in the position of Ward Manager for 8 weeks and have assessed the operation of the ward during that time.

Overall View:- My overall assessment is that the ward is clinically unsafe due to severe staff shortages owing to high sickness levels and vacant posts.

Main Issues

1) Staff Shortages – At present, due to sick leave and vacant posts, the ward is operating with a deficit of approximately 1/3 of its full staffing compliment prior to requesting cover from the bank/agency. My experience is that the bank/agency is not always reliable, with only about 50% of the hours covered.

Band	Current Deficit	Deficit after Sickness
Band 7	0	0
Band 6	7.5	7.5
Band 5	209.25	366.25
Band 2/3	184.875	214.875
Total	**401.625**	**588.625**

366.25 hours deficit of Band 5 nurses equates to almost 3 full 24 hour periods without cover, prior to going to the Bank/Agency,

214.875 hours deficit of Band 2/3 nurses equates to just over 4 full 24 hour periods without cover, prior to going to Bank/Agency.

If we only get 50% of this time covered, there is still a significant shortfall in staffing which is compromising patient safety and staff morale.

Even when booked, bank/agency staff are not always reliable. For example, I have been made aware of an incident that took place on Friday night (6/11/15), when the bank night-time auxiliary did not turn up for work and despite the staff requesting cover from the bed manager, no additional staff were provided. A patient fell twice on the ward as there were not sufficient staff members available to help him. Appropriate forms have been filled in and this incident will now have to be investigated. This is an example of patient safety being compromised and it is one of many issues that have been highlighted to me in recent weeks.

At present, as ward manager, I am having to regularly look after a quota of patients to ensure the safety of all patients on the ward, as a result of staff shortages and patient dependency. As a result of this, I have been unable to discharge a large percentage of my managerial responsibilities and have not been able to meet with

Received from Tughans OBO Mr Aidan O'Brien on 01/05/22. Annotated by the Urology Services Inquiry.

Aimee Crilly

From:	Trouton, Heather Personal Information redacted by the USI
Sent:	13 November 2015 14:40
To:	McCaul, David; Hall, Sam; Haynes, Mark; Hunter, Catherine; Gishkori, Esther; Sheridan, Patrick; McElvanna, Ciara
Cc:	O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Young, Michael; Suresh, Ram; Korda, Marian; Reddy, Ekambar; Farnan, Turlough; McNaboe, Ted; Leyden, Peter; Corrigan, Martina; Reid, Trudy
Subject:	RE: 3 South Concerns

Dear all

Thank you for your responses and any other views are welcome.

Please be assured that Martina, Trudy and I are working with Cathy , Ciara and Patrick to address concerns. However please be aware that there is a very real shortage of qualified staff nurses regionally and nationally and it is currently a real challenge to recruit qualified nurses permanently to this or any ward. There are however further recruitment strategies planned and we would hope that this will yield successful recruitment soon. That said we do have some options for improvements to the current situation in the intervening period.

The other very real challenge is the winter pressures activity and while it would be ideal to cap the ward at 31 patients , and this we will try to do, it will prove I suspect very difficult to maintain as the winter progresses as part of a daily risk assessment plan.

Cathy , Patrick , Ciara , Trudy and I are meeting on Monday to go through plans for improvement and we will of course keep you informed.

The estate works have now provided a much improved structural facility and while that is welcome , there is no doubt that the upheaval has added to the general workload of the ward. That should settle once we complete the storage areas . The other change is as outlined in your responses in that the acuity of patients has most definitely increased in 3 South.

Any other suggestions for improvement from yourselves would be very welcome as we all want a ward that provides a high standard of medical and nursing care that is a good place to work.

Best regards
Heather

From: McCaul, David
Sent: 13 November 2015 13:46
To: Hall, Sam; Haynes, Mark; Hunter, Catherine; Gishkori, Esther; Trouton, Heather
Cc: O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Young, Michael; Suresh, Ram; Korda, Marian; Reddy, Ekambar; Farnan, Turlough; McNaboe, Ted; Leyden, Peter
Subject: RE: 3 South Concerns

Hi all

With reference to tracheostomy/laryngectomy patients a band 6 nurse/head and neck clinical nurse specialist is to be appointed full time very soon, I hope, part of this persons job remit would be care of/teaching about tracheostomy patients.
This was already discussed and agreed with our previous acute services manager.
This may help in some bit to increase confidence of staff to manage the more difficult ENT patients.

David McCaul

Received from Tughans OBO Mr Aidan O'Brien on 01/05/22. Annotated by the Urology Services Inquiry.

RESPONSE TO REPORT OF FORMAL INVESTIGATION

I am writing this report in response to the report of formal investigation from Dr Neta Chada. My response is structured in parallel to the Dr Chada's report. In responding to the report, I have considered to set the reasons for the investigation in an historical context. Thereafter, I have commented upon the investigative process and the report itself. Lastly, I respond directly to the five terms of reference.

Historical Context

I graduated in Medicine from the Queen's University of Belfast in 1978. After basic, postgraduate surgical training in Northern Ireland, including a year as Demonstrator in Anatomy, and during which time I had spent some time in every surgical specialty, except for Urology, I applied for a post as a Registrar in Urology at Belfast City Hospital in 1984. During my tenure in that post from August 1984, I became increasingly impressed with Urology as a surgical specialty for a number of reasons: the greater ability to apply objective diagnostic tools to assessment of urinary tract pathology, such as renography and urodynamic studies; the rapidly increasing role of endoscopic and minimally invasive surgery, and most importantly at that time, the varied spectrum of malignancies of the urinary tract. I became increasingly interested in new diagnostic tools in the assessment of bladder carcinoma, such as nuclear image analysis and DNA flow cytometry.

As DNA flow cytometry was unavailable in Northern Ireland at that time, I applied for and was appointed to the post of Registrar in Urology at St. James' Hospital, Dublin in July 1985, followed by a Research Fellowship at the Meath Hospital, Dublin, in 1986. I was appointed a Senior Registrar in 1988, and completed Higher Surgical Training in Urology on 30 June 1991. During that training, I was particularly aware that it pertained exclusively to adult Urology. As a consequence, I applied for and was appointed Senior Registrar in Paediatric Urology at the Royal Hospital for Sick Children in Bristol, taking up that post on 01 September 1991.

In May 1991, I received a phone call from Mr. Ivan Stirling, (now retired) Consultant Vascular Surgeon at Craigavon Area Hospital, to advise that Mr. W. Graham, Consultant Surgeon at Craigavon Area Hospital, was due to retire on 30 June 1991. He was a general surgeon who had developed an interest in urological surgery. Mr. Stirling advised me that there had been some discussion among colleagues as to whether he should be replaced by a general surgeon or by a urologist, and sought my view. I immediately advised that he should be replaced by a general surgeon and by a urologist. Some days later, I was invited to meet with him, his consultant colleagues and with the Chief Executive, Mr. John Templeton, over lunch. It was during that meeting that they appreciated that I had a two month hiatus prior to taking up the post in Bristol. I was asked whether I would spend some time during that two month period as a Locum Consultant at Craigavon Area Hospital, as Mr. Graham had 77 patients on his waiting list for elective admission for prostatic resection (TURP). After a one week break, I came to Craigavon Area Hospital, performing 77 TURPs, and a left ureteric reimplantation for ureteric stenosis, in seven weeks.

On Wednesday 28 August 1991, I was invited once again to meet with the Chief Executive and the remaining three Consultant General Surgeons, Mr. John O'Neill, Mr. Osmond Mulligan and Mr.

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unilaterally advised Payroll to halve agreed, remunerative payments for additional clinical work. The grievance was upheld. I suspended further action as his wife was terminally ill at the time.

In Section 8, page 36, the Report states that Mr. O'Brien acknowledged that there were 66 undictated clinic and no dictated outcomes for these. This is untrue. As stated above, the number of clinic incompletely dictated was 51, and the number of patients affected was 189. Even though this information had been submitted to the Case Investigator on 06 November 2017, the Report still includes the wrong information, and claims that I had agreed with it.

In Section 9, Page 45, the Report states that Mr. O'Brien has worked rigidly to the action plan out in place and has met all of requirements of the action plan on an on-going basis. However, this has been at considerable cost. IAs I have continued to find it impossible to complete triage while Urologist of the Week, I have had to take an Annual Leave Day on the Friday following completion of the Week to enable me to complete the week's triage. That has also resulted in a reduction in the number of cancer review clinics, normally conducted on Fridays.

Lastly, The Report states that Mr. O'Brien displayed some lack of insight and reflection into the potential seriousness of the above issues. This I would completely dispute this contention. I believe that this impression has been gained due to my disbelief at the lack of insight on the part of the Trust into the harm and risk of harm suffered by patients already on the longest waiting list. It has also been disappointing to read the Report, after 18 months of investigation, concluding that I did not agree with triage anyway.

Terms of Reference

1. Triage

I do accept that I was not undertaking triage of non-red-flag referrals. I have been clear since the outset of this investigation that I was not doing so because I found it impossible to do so. The background to that is explained above in detail.

I agree that triage is a vitally important process to ensure that patent management is initiated effectively and to ensure that patients are correctly categorised. It is my belief that some time with triage is necessary if the Consultant Urologist is to bring the value of his/her specialist expertise to the process and this means that triage becomes time consuming. I believe that it would be beneficial for the department to allocate sufficient time for the Consultants to complete triage effectively. I have raised this issue as part of my response to the SAI and I hope that the Trust will address the issue as soon as possible.

The investigation report states that the issue of concern relates to the fact that I failed to properly highlight to the Trust that I was not undertaking this aspect of the role. I accept that there are steps that I could have taken to more clearly state that I was not undertaking triage of routine or urgent referrals. I regret not having done so. That said, it is relevant to point out that senior management were aware of the fact that I was not completing Triage of non-red-flag referrals. This is demonstrated by the fact that everyone acknowledges that I repeatedly raised the fact that I found it impossible to complete triage, that they knew that triage was not being done and in fact a process was introduced to deal with the fact that it was not being done through the

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standard that a Consultant should triage GP referrals (which Cons1 helped to construct) along with his stated view of the crucial importance of triage and Cons1's actual practice.

Cons1's chosen method of triage was beyond what is required. His triage is the equivalent of a virtual clinic where he reviews NIECR and books investigations for patients. While the Review Team recognised this was a detailed triage process, they concluded that his prioritisation of work and attention to detail meant that some patients got a higher standard of triage/care, while, crucially, others were not triaged, leading to a potentially critical delay in assessment and treatment for those patients. Cons1 is aware of this.

The Review Team concluded that Cons1's prioritisation of work and attention to detail led to some patients receiving a high standard of care, while others ran the real risk of having a cancer diagnosis delayed till it was dangerously late.

Contributory factor

Work load/scheduling

In 2008, when the IEAP was published, there was a maximum waiting time of 9 weeks for a first Outpatient appointment. On 30th September 2016, there were 2012 patients on the routine Urology outpatient waiting list, with 597 patients showing as waiting 52 weeks and over. The longest waiting time was 554 days (80 weeks). Therefore, if patient referrals are incorrectly referred, or not triaged and continue to use the GP's classification of urgency, there will be a significant wait. Cons1 is aware of this reality.

The Review Team considered the Consultant of the Week (CoW) work load, including ward rounds, clinics, emergency theatre sessions as a contributory factor. Cons1 has consistently argued that he cannot triage non-red flag referrals and carry out the duties of the CoW. He has not indicated who else should carry out the triage duties. However, the Review Team note that the other Consultant Urologists were able to manage this work load and triage referral letters in a timely fashion, with other members of the consultant team also ordering investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons1's 'advanced triage'.

Contributory factor

Organisational

The Review Team concluded that the non-triage of Urology referrals by Cons1 has been an ongoing problem in the Trust for many years, possibly decades. While there were pockets of non-compliance by other Consultants, when escalated, compliance improved. However, the Review Team note that Cons1 consistently did not return triage information on referrals thus not allowing the appropriate prioritisation of appointments by clinical need.

Interviews with 2 previous and the current Director of Acute Services, AMD1 and the Head of Surgery Service have highlighted that on many occasions, over a prolonged period, attempts had been made by the Trust's officers to address Cons1's non-compliance with triage. These

5.0 DESCRIPTION OF INCIDENT/CASE

The referral was not triaged on receipt.
30/09/2016 - added to W/L Urgent.
18/01/2017 - as part of an internal review #2, upgraded to R/F. Therefore, this was an incorrect GP referral.
20/02/2017 (D207) seen at R/F appointment. Sent for MRI and prostate biopsy.
11/04/2017 (D258) - diagnosed with a confirmed low risk prostate cancer and there was a recommendation for treatment of a prostate cancer by surveillance protocol.

Conclusions

Resultant 9-month delay in obtaining diagnosis.
Following Review Team consideration, deemed not to be a clinically significant delay.

Patient 13 28/07/2016 - Personal Information redacted by the USI referred to Urology by GP following an episode of haematuria.
The referral was marked Routine by the GP.
The letter was not triaged.
30/09/2016 - Patient 13 was placed on a Routine waiting list.
19/01/2017 - As part of an internal review #2, upgraded to a R/F referral. Therefore, this was an incorrect GP referral.
31/01/2017 (188d) - reviewed at OPD and flexible cystoscopy.
22/02/2017 TURBT/TURP - diagnosed with bladder (locally advanced) and prostate cancer and there was a recommendation of treatment for his bladder cancer.

Conclusions

Resultant 6-month delay in obtaining diagnosis.
Following Review Team consideration, it is probable that the delay is clinically significant; time will tell*.

* The Review Team referred to an expert for advice.

Delay in definitive surgical treatment beyond 12 weeks conferred an increased risk of disease-specific and all-cause mortality among subjects with stage II bladder cancer. He remains disease free as of September 2018.

1. John L. Gore, Julie Lai, Claude M. Setodji, Mark S. Litwin, Christopher S. Saigal, and the Urologic Diseases in America Project. Mortality increases when radical cystectomy is delayed more than 12 weeks. Results from a surveillance, epidemiology, and end results–Medicare analysis. Cancer March 1, 2009.
2. Nader M. Fahmy, Salaheddin Mahmud, Armen G. Aprikian. Delay in the surgical treatment of bladder cancer and survival: Systematic Review of the Literature. *European Urology 50 (2006) 1176–1182.*

Patient 12 08/09/2016 - Personal Information redacted by the USI was referred to Urology Outpatients on for assessment and advice on lower tract symptoms and elevated PSA.
The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
27/01/2017 – further GP letter – please upgrade to R/F.
30/01/2017 - as part of the internal review #2, upgraded to R/F.

implementation of the default system. I can quite honestly state that I believed that management knew that I was not completing triage.

The final point I wish to make about triage relates to the fact that I am completing triage since my return to work in February 2017. It is important that I point out that, in order to comply with management plan by returning triage within three days of urologist of the week, I have been taking a day off on annual leave following my week on call in order to use that Friday and the following weekend to complete triage. Therefore, whilst I am completing triage and I will continue to do so, it comes at a significant personal cost.

2. Patient Notes stored at Home

I accept that I had significant number of charts at my home. This was well known to the Trust. At the time of my meeting on the 30th December 2016, I had 288 sets of patients' notes at home which dated back to April 2015. 99 of these charts were for private patients. I accept that this could be considered not to be best practise. I have assured the trust that I have discontinued this practice and that I will not do this in the future.

3. Undictated Outcomes

I accept that it was sub-optimal practice to not have dictated letters on outpatient consultations in a timely manner. In particular, I recognize that this is important so that GP will be aware of the management plan.

I had endeavoured to ensure that the clinically urgent patients were dictated upon and had succeeded in doing so in the majority of cases. As stated above, the number of undictated outcomes was 189, markedly less than the 688 which was been informed to the case investigator. I had provided the documentation that sets this out. I am unaware of harm or risk of harm of any of the 189 patients who had not had letters dictated.

4. Private Patients

Initially, it was alleged that 9 TURP patients, who had previously attended privately, had had their operations after a significantly shorter period of time than the remaining TURP patients who had not attended privately. I have provided a thorough comparative analysis of TURP patients during 2016 which conclusively demonstrates that this was not the case. I have also provided a detailed explanation of the subsequent list of 11 patients who had attended privately. There has been no comparative analysis done as part of this investigation that indicates that there has been any preferential treatment to patients who have seen me privately. I have not given any preferential treatment to any patient because they have seen me privately.

5. The Role of Management

It is my belief that Management knew of the problems that I was having with these administrative practices for all of the reasons that are detailed above. Management did not take the opportunities to assist me and it is apparent from the witness statements that when some members of management indicated that they would wish to address these issues with me

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

MHPS RESPONSE
APPENDIX 12

Received from Tughans OBO Mr Aidan O'Brien on 06/12/21. Annotated by the Urology Services Inquiry.

DATE	CLINIC	CLINIC CODE	PATIENTS	COMPLETED	UNDONE
24/11/2014	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
22/12/2014	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
12/01/2015	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
23/02/2015	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
09/03/2015	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
13/04/2015	SWAH	EUROAOB	15	8	7
11/05/2015	SWAH	EUROAOB	17	10	7
22/06/2015	SWAH	EUROAOB	16	7	9
06/07/2015	SWAH	EUROAOB	15	5	10
28/09/2015	SWAH	EUROAOB	15	6	9
19/10/2015	SWAH	EUROAOB	15	8	7
02/11/2015	ARMAGH CLINIC	AAOBU1	RETURNED BEFORE 30TH DECEMBER 2016		
06/11/2015	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
24/11/2015	NEW CLINIC	CAOBTDU	RETURNED BEFORE 30TH DECEMBER 2016		
30/11/2015	SWAH	EUROAOB	16	9	7
04/12/2015	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
0[illegible]2/2015	ARMAGH CLINIC	AAOBU1	RETURNED BEFORE 30TH DECEMBER 2016		
22/12/2015	NEW CLINIC	CAOBTDU	7	4	3
08/01/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
11/01/2016	SWAH	EUROAOB	17	10	7
15/01/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
08/02/2016	SWAH	EUROAOB	18	10	8
07/03/2016	SWAH	EUROAOB	16	5	11
21/03/2016	ARMAGH CLINIC	AAOBU1	16	13	3
01/04/2016	UROONCOLOGY CLINIC	CAOBUO	9	8	1
04/04/2016	REVIEW CLINIC - CAH	CAOBTDUR	13	7	6
08/04/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
15/04/2016	UROONCOLOGY CLINIC	CAOBUO	7	5	2
18/04/2016	ARMAGH CLINIC	AAOBU1	13	8	5
19/04/2016	NEW CLINIC	CAOBTDU	6	3	3
22/04/2016	UROONCOLOGY CLINIC	CAOBUO	5	4	1
27/04/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
2[illegible]04/2016	UROONCOLOGY CLINIC	CAOBUO	9	3	6
29/04/2016	URODYNAMICS CLINIC	CAOBUDS	3	1	2
03/05/2016	REVIEW CLINIC - CAH	CAOBTDUR	RETURNED BEFORE 30TH DECEMBER 2016		
06/05/2016	HOT CLINIC		2	0	2
23/05/2016	REVIEW CLINIC - CAH	CAOBTDUR	16	12	4
27/05/2016	UROONCOLOGY CLINIC	CAOBUO	10	8	2
27/05/2016	URODYNAMICS CLINIC	CAOBUDS	5	4	1
03/06/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
10/06/2016	UROONCOLOGY CLINIC	CAOBUO	12	11	1
13/06/2016	ARMAGH CLINIC	AAOBU1	15	7	8
20/06/2016	SWAH	EUROAOB	21	13	8
04/07/2016	REVIEW CLINIC - CAH	CAOBTDUR	17	10	7
22/07/2016	UROONCOLOGY CLINIC	CAOBUO	12	11	1
26/07/2016	NEW CLINIC	CAOBTDU	7	4	3
09/08/2016	NEW CLINIC	CAOBTDU	10	6	4
12/08/2016	UROONCOLOGY CLINIC	CAOBUO	9	7	2
19/08/2016	URODYNAMICS CLINIC	CAOBUDS	3	2	1

Received from Tughans OBO Mr Aidan O'Brien on 06/12/21. Annotated by the Urology Services Inquiry.

19/08/2016	UROONCOLOGY CLINIC	EUROAOB	5	4	1
22/08/2016	SWAH	EUROAOB	16	4	12
19/09/2016	SWAH	EUROAOB	18	7	11
07/10/2016	URODYNAMICS CLINIC	CAOBUDS	3	2	1
11/10/2016	NEW CLINIC	CAOBTDU	9	8	1
14/10/2016	URODYNAMICS CLINIC	CABOUDS	3	2	1
14/10/2016	UROONCOLOGY CLINIC	CAOBUO	5	3	2
21/10/2016	URODYNAMICS CLINIC	CAOBUDS	4	2	2
28/10/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
28/10/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
04/11/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
04/11/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
			PATIENTS	COMPLETED	NOT PROCESSED
	TOTAL OF 41 CLINICS		450	261	189

BREAKDOWN OF UNPROCESSED	REVIEW	DISCHARGES	DNA	THORNDALE	DAY SURG	INPATIENT W/L
189	110	35	10	13	7	14

Received from Tughans OBO Mr Aidan O'Brien on 06/12/21. Annotated by the Urology Services Inquiry.

Issues and Themes of concern include:

- In May 2014, there was an informal process was implemented to monitor/manage Urology letters which had not been returned with management advice (not triaged). It appears that this process was created in an effort to limit risk of harm to the patient. The presence of this process implies that it was accepted that triage non-compliance was to be expected by a minority of consultants within the Urology specialty. On 6 November 2015, an email from the AD of Functional Service formally implementing this process. The Review Panel are anxious that the current process does not have a clear escalation plan which evidences inclusion of the Consultant involved. In addition, this process has not been effective in addressing triage non-compliance. From 28 July 2015 until 5 October 2016, there are 318 patient letters which were not triaged. Currently the Trust cannot provide assurance that the Urology non-triaged patient cohort are not being exposed to harm while waiting 74 weeks for a Routine appointment or 37 weeks for an urgent appointment.

- During the manual look-back exercise on 14 November 2016, Personal Information redacted by USI's patient chart could not be found on Trust premises. Personal Information redacted's chart did appear in the Acute Governance office the week commencing 28 November 2016. After informal queries, it is understood that patient notes are not transported via Trust vehicles to or from Dr 6's outlying clinics (inc SWAH). This could compound efforts to establish any chart location or outstanding dictation. The Review panel acknowledge that processes should not be drafted to address one issue with one specialist team. On balance, the Review team agree there is sufficient cause for concern that Trust documentation may be leaving Trust facilities and the process of record transportation for this Specialty does need urgently addressed.

- There is clear evidence that this patient Personal Information redacted by USI's letter was not triaged by week ending 30 October 2014. Personal Information redacted by USI was seen in SWAH by Dr 6 in January 2015. The outpatient letter was dictated 11 November 2016 and typed 15 November 2016. The Review panel have grave concerns that there are other Urology patient letters not being dictated in a timely manner. Upon further investigation, the Panel have found that the Trust does monitor the number charts needing audio-typing of dictation but there does not appear to be a robust process to monitor if post-consultation patient dictation has been completed. This has the potential to be compounded if patient charts are leaving the Trust facilities. The SAI Panel are anxious that assurance is sought that there is reasonable compliance in relation to the timely dictation letters by Dr 6.

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From:	Haynes, Mark Personal Information redacted by the USI
Sent:	11 January 2017 12:45
To:	Boyce, Tracey
Subject:	FW: PATIENT Personal Information redacted by the USI

As discussed below is correspondence between Dr Beckett, Martina Corrigan and me regarding a patient who had no letters from previous consultations. The letter Dr Beckett refers to stating that the patient was to have her non functioning kidney removed was an e-discharge from 15/10/15. She had been seen in OP on 7/9/15 and 7/12/15.

I first saw her when admitted 12/4/16 and she had her surgery later that month.

Mark

-----Original Message-----
From: Haynes, Mark
Sent: 12 April 2016 13:28
To: Corrigan, Martina
Cc: 'Peter.Beckett Personal Information redacted by the USI
Subject: RE: PATIENT Personal Information redacted by the USI

I saw this lady this morning on my ward round.

I have not been involved in her care to date, I have not received a referral, there are no letters on ECR and her notes detailing previous consultations were not available to me on the ward..

I have discussed a plan going forward that will depend upon how her current pain settles. If it does not settle she will get a nephrostomy, either way I will be looking to arrange an urgent lap nephrectomy. I cannot at present be certain of the date but would hope that it'll be before the end of May.

Mark

-----Original Message-----
From: Corrigan, Martina
Sent: 12 April 2016 08:08
To: Peter Beckett
Cc: Haynes, Mark
Subject: RE: PATIENT Personal Information redacted by the USI
Importance: High

Good morning,

This patient was admitted this morning via A&E under Mark Haynes. I have copied Mark into this email.

Thanks

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Martina

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

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

-----Original Message-----
From: Peter Beckett Personal Information redacted by the USI
Sent: 11 April 2016 12:19
To: Corrigan, Martina
Subject: FW: PATIENT Personal Information redacted by the USI

Martina,
Just to update this girl was at ED in DHH and with me this AM.There was some suggestion of a further uss but I have defererd organising that until I hear what the IUROLOGISTS ARE DOING.

Thanks,
PB

From: Peter Beckett
Sent: 08 April 2016 10:19
To: Corrigan, Martina Personal Information redacted by the USI
Subject: FW: PATIENT Personal Information redacted by the USI

From: Peter Beckett
Sent: 08 April 2016 10:01
To: martina.cottigan Personal Information redacted by the USI
Subject: PATIENT Personal Information redacted by the USI

Martine
Sorry to ask you qabout this patient.I have a letter stating she is to have a non functioning kidney removed.However i am not sure if she is under the care on Mr Haynes or O'Brien and ECR does not help.Could you direct me twhoever might know if she is on a waiting list and if so which one and how long is the wait.
many thanks
PB

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

implementation of the default system. I can quite honestly state that I believed that management knew that I was not completing triage.

The final point I wish to make about triage relates to the fact that I am completing triage since my return to work in February 2017. It is important that I point out that, in order to comply with management plan by returning triage within three days of urologist of the week, I have been taking a day off on annual leave following my week on call in order to use that Friday and the following weekend to complete triage. Therefore, whilst I am completing triage and I will continue to do so, it comes at a significant personal cost.

2. Patient Notes stored at Home

I accept that I had significant number of charts at my home. This was well known to the Trust. At the time of my meeting on the 30th December 2016, I had 288 sets of patients' notes at home which dated back to April 2015. 99 of these charts were for private patients. I accept that this could be considered not to be best practise. I have assured the trust that I have discontinued this practice and that I will not do this in the future.

3. Undictated Outcomes

I accept that it was sub-optimal practice to not have dictated letters on outpatient consultations in a timely manner. In particular, I recognize that this is important so that GP will be aware of the management plan.

I had endeavoured to ensure that the clinically urgent patients were dictated upon and had succeeded in doing so in the majority of cases. As stated above, the number of undictated outcomes was 189, markedly less than the 688 which was been informed to the case investigator. I had provided the documentation that sets this out. I am unaware of harm or risk of harm of any of the 189 patients who had not had letters dictated.

4. Private Patients

Initially, it was alleged that 9 TURP patients, who had previously attended privately, had had their operations after a significantly shorter period of time than the remaining TURP patients who had not attended privately. I have provided a thorough comparative analysis of TURP patients during 2016 which conclusively demonstrates that this was not the case. I have also provided a detailed explanation of the subsequent list of 11 patients who had attended privately. There has been no comparative analysis done as part of this investigation that indicates that there has been any preferential treatment to patients who have seen me privately. I have not given any preferential treatment to any patient because they have seen me privately.

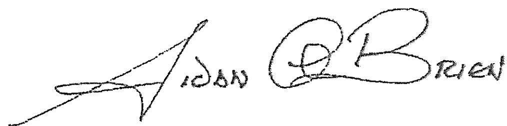
5. The Role of Management

It is my belief that Management knew of the problems that I was having with these administrative practices for all of the reasons that are detailed above. Management did not take the opportunities to assist me and it is apparent from the witness statements that when some members of management indicated that they would wish to address these issues with me

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

informally, they were instructed not to do so. Additionally, when the issues were raised in the meeting of March 2016, I asked for some guidance on what I could do and I received no assistance. I believe that after 25 years of employment by the Trust and contribution that I have made to the development of urological services as described in the historical context section of this response, I would have considered it reasonable to expect that the Trust would have made efforts to deal with the concerns in a collegiate and supportive manner.

This did not happen.



Aidan O'Brien
10th July 2018

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

It is important to make clear that I am required to comply with Trust Policies and Procedures. Disciplinary procedures should only be used or invoked where it is considered that I am in breach of Trust policies or where my professional competence has been called into question.

The most relevant Trust Policy is entitled *Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance,* dated 23 September 2010 (hereafter referred to as the "Trust Guidelines". These guidelines were updated in October 2017. However, it is the 2010 guidelines that are relevant to the events of 2016 and the formal investigation. I will make extensive reference to the Trust Guidelines throughout this grievance. It is attached in the Schedule of Documents at Tab 4. It is this document and the processes established within it that form part of my contract of employment.

The document entitled *Maintaining High Professional Standards in Modern HPSS* issued by the English Department of Health, Social Services and Public Policy in November 2005 is **not** part of my contract. This is made clear by Clause 32 of my contract outlined above.

2.3 Events before 30th December 2016

I have provided an extensive historical context for the concerns about my administrative backlog to the Case Investigator, Dr Chada. This response is attached in the Schedule at Tab 5. I do not intend to repeat the full context in this correspondence. In summary, I have provided detail of the pressures that I was under for many years with waiting lists for both in-patient treatment and review, and how I was using available time to ease that backlog. There had been times when I fell behind in administrative work in the past and would have worked additionally to ease that backlog. **This was always known to the Trust and the Trust was always aware that the volume of work was overwhelming**. It is clear from the witness statements provided in the investigation that my administrative backlog was known to Trust managers for a very considerable period of time prior to 2016.

The problems became more acute owing to additional pressures that built up between 2012 and 2016. I was provided with 2 hours and 40 minutes of patient related, administration time per week in 2015 (Tab 6) and 2 hours per week in 2016 (Tab 7) in my job plan. I described in my response, the additional commitments required following appointment as Lead Clinician of the Southern Trust Urology Multidisciplinary Team and Chair of Urology MDM in April 2012, and as Lead Clinician of the Northern Ireland Cancer Network (NICaN) Clinical Reference Group in Urology in January 2013. These appointments were followed by a two year period of time when both the Southern Trust's and Northern Ireland's regional urological oncology services were preparing for National Peer Review in June 2015.

I was not provided with or allocated any time for any of these undertakings during the years 2012 to 2014. The most onerous and time consuming was previewing all cases to be discussed at MDM which I chaired every Thursday afternoon. This required three to four hours of work, which I typically had to undertake from 10 pm each Wednesday evening, having operated to 8 pm. To relieve the burden, I introduced a rotating chairmanship of MDM with two of my colleagues, beginning in November 2014. Thereafter, I was provided with an additional 3 hours to prepare for chairing MDM as were my two colleagues, from 2015 onwards.

However, no time was allocated in my job plan for the remaining commitments at all during the years 2012 to 2016. By the time that the Southern Trust MDT was subjected to National

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Corrigan, Martina Personal Information redacted by the USI
Sent: 20 May 2014 08:54
To: Trouton, Heather
Subject: RE: Missing Triage

Heather

Aidan and Monica are on Annual Leave this week but he normally does this sort of admin when he is off so I will advise next week if this has not been sorted.

Thanks

Martina

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

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

From: Trouton, Heather
Sent: 19 May 2014 19:12
To: Corrigan, Martina
Subject: RE: Missing Triage

Martina

If you don't get a response by Wednesday can you please advise / escalate?

Thanks
Heather

From: Corrigan, Martina
Sent: 16 May 2014 08:51
To: O'Brien, Aidan
Cc: McCorry, Monica; Trouton, Heather; Robinson, Katherine; Carroll, Anita
Subject: FW: Missing Triage

Aidan,

Can you advise please when these will be triaged?

Thanks

Martina

Martina Corrigan

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

MHPS RESPONSE
APPENDIX 11

Received from Tughans OBO Mr Aidan O'Brien on 06/12/21. Annotated by the Urology Services Inquiry.

Inpatient Operating 2013 - 2016

2013:	Job Plan	70 sessions
	Actual done	113
2014:	Job Plan	70 sessions
	Actual done	101.25
2015:	Job Plan	70
	Actual done	95.5
2016:	Job Plan	61
	Actual done	83.25

All of this additional operating was directed to those patients in most need.

All of this additional operating resulted in scores of patients having less poor outcomes than they would have had otherwise.

There remain 30 patients on my waiting list at risk of suffering poorer clinical outcomes as a consequence of their delayed admissions.

Received from Tughans OBO Mr Aidan O'Brien on 06/12/21. Annotated by the Urology Services Inquiry.

Elective Inpatient Operating 2016

			Sessions
Wednesday	06 January	Urologist of the Week	
Wednesday	13 January	9 am – 8 pm	2.75
Wednesday	20 January	12 noon – 8 pm	2.0
Wednesday	27 January	12 noon – 8 pm	2.0
Wednesday	03 February	12 noon – 8 pm	2.0
Wednesday	10 February	12 noon – 8 pm	2.0
Wednesday	17 February	Urologist of the Week	
Wednesday	24 February	9 am – 8 pm	2.75
Friday	26 February	1.30 am – 5.30 pm	1.0
Saturday	27 February	9 am to 1 pm	1.0
Wednesday	02 March	Professional Leave: expert witness	
Wednesday	09 March	12 noon – 8 pm	2.0
Saturday	12 March	9 am – 1 pm	1.0
Wednesday	16 March	9 am – 8 pm	2.75
Wednesday	23 March	12 noon – 8 pm	2.0
Wednesday	30 March	Urologist of the Week	
Wednesday	06 April	12 noon – 8 pm	2.0
Wednesday	13 April	9 am – 8 pm	2.75
Wednesday	20 April	Audit	
Wednesday	27 April	12 noon – 8 pm	2.0
Wednesday	04 May	12 noon – 8pm	2.0
Wednesday	11 May	Urologist of the Week	
Wednesday	18 May	12 noon – 8 pm	2.0
Wednesday	25 May	12 noon – 8 pm	2.0
Wednesday	01 June	12 noon – 8 pm	2.0
Wednesday	08 June	Urologist of the Week	
Wednesday	15 June	12 noon – 8 pm	2.0
Wednesday	22 June	Professional Leave: expert witness	
Wednesday	29 June	9 am – 8 pm	2.75

Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

Wednesday	06 July	9 am – 8 pm	2.75
Wednesday	13 July	9 am – 8 pm	2.75
Monday	18 July	1.30 pm – 5.30 pm	1.0
Wednesday	20 July	9 am – 1 pm	1.0
Wednesday	27 July	9 am – 8 pm	2.75
Wednesday	03 August	Urologist of the Week	
Wednesday	10 August	9 am – 8 pm	2.75
Wednesday	17 August	12 noon – 8 pm	2.0
Wednesday	24 August	9 am – 8 pm	2.75
Friday	26 August	9 am – 5 pm	2.0
Saturday	27 August	9 am – 1 pm	1.0
Wednesday	31 August	9 am – 8 pm	2.75
Wednesday	07 September	12 noon – 8 pm	2.0
Wednesday	14 September	Urologist of the Week	
Wednesday	21 September	9 am – 8 pm	2.75
Wednesday	28 September	9 am – 8 pm	2.75
Wednesday	05 October	12 noon – 8 pm	2.0
Wednesday	12 October	12 noon – 8 pm	2.0
Wednesday	19 October	Audit	
Wednesday	26 October	Urologist of the Week	
Wednesday	02 November	9 am – 8 pm	2.75
Wednesday	09 November	9 am – 8 pm	2.75

Total = 83.25 sessions

Plus 1.5 hours of perioperative patient care for each date: 58.5 hours

= 14.625 sessions

Plus 1 hour of administration time per session: 83.25 hours

= 20.8125 sessions

Total =118. 6875 sessions

Number of elective inpatient sessions contracted at per Job Plan = 58

Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

morning and had used his SPA time to undertake operations or reviews of patients in an attempt to keep on top of his workload.

Proposals for alternatives to exclusion

Mr O'Brien was provided with an opportunity at the meeting on 24 January 2017 to propose alternatives to his exclusion for consideration by the Case Manager.

- Mr O'Brien outlined that at present his main priority was to return to work. He stated that if the investigation is going to take longer than 4 weeks to complete he is concerned at the potential for reputational damage.
- Mr O'Brien reported that the immediate exclusion and the investigation was a very stressful situation for him which has resulted in Personal Information redacted by the USI. He stated that both mentally and physically it is important to him to be able to get back to work.
- Mr O'Brien outlined that there are various aspects of his work that have never been in question and he is of the view that he could continue to operate, he could undertake urologist of the week, undertake on call duties and triage referrals.
- Mr O'Brien noted he was accepting of and entirely happy to return to work within a defined framework to circumvent the concerns under investigation. He further outlined that he has no desire to impede or interfere with the investigation. He outlined that in due course he will provide a 'good contextual reason as to why this has happened'.
- Mr O'Brien would be accepting of working within normal time constraints for both operating lists and clinics. He agreed that any clinics would have outcomes recorded and dictation done by the end of that clinic. He was entirely open to regular review and monitoring of this.
- Mr O'Brien stated, if he had been advised in March that the concerns could lead to this i.e. immediate exclusion and formal investigation, he would have taken time out to clear the backlog and wouldn't be in this situation.
- Mr O'Brien reported that he had undertaken work not included in his job plan and for which he was not remunerated. He stated that the period of immediate exclusion was psychologically, mentally and physically draining and went on to advise that he 'feared' for himself if he was not able to return to work.
- He concluded by stating he was happy to work with a defined framework set by the Trust, to comply with hospital policies/procedures, to work to pre-determined defined timescales and he gave an assurance that no patient files would be removed from the Trust. He reiterated he had no desire to impede or interfere in the investigation in anyway. Mr O'Brien stated that the concerns centred around his

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

inappropriate and, more importantly, was unsafe, exposing patients to significant risks of harm.

411. The concerns I had in respect of DARO, and the steps I took to raise such concerns, are detailed above in my response to Question 9. Again, this was presented as a patient safety measure to address service inadequacy by the Trust. However, it was clearly an unsafe and inappropriate response and posed an obvious risk to patient safety.

412. I have provided my comments in respect of the quoracy of urology MDMs above (see paragraphs 292 – 293, paragraph 303 & paragraph 305). The Trust failed to take adequate action to ensure the quoracy of MDMs, which potentially exposed patients to risk where their care was being discussed at such non-quorate MDMs.

413. While my concerns in respect of staffing are dealt with in detail in my response to Questions 21-25, a further example of the inadequacy of staffing is that which I have highlighted in my comments on Nursing and Ancillary Staff relating to the email sent by Sr Catherine Nurse Hunter on 12 November 2015 [see paragraph 240]. Suffice it to note that, over many years, the approach taken by the Trust to address staffing issues was inadequate and that, along with a lack of resources, certainly impacted patient safety within the Urology Service.

414. I raised various concerns over many years during my appraisals, and that is detailed in my response to Question 46.

415. Overall, I did not feel that I received much support from the Trust in respect of concerns raised. Over the years, the concerns that I had remained largely unchanged, having not been adequately addressed and resolved. It proved to be a frustrating and concerning experience. It gave rise to a sense of fatigue and disillusionment with regard to raising concerns. I did often wonder whether repeatedly raising the same concerns which were not resolved made it

Received from Tughans OBO Mr Aidan O'Brien on 02/11/2022. Annotated by the Urology Services Inquiry

even more difficult for them to be resolved. I was certainly left with the belief that raising concerns was no longer productive. I have no doubt that my experience has been the experience of many others, and which has resulted in experienced, skilful staff of differing disciplines leaving their posts, their commitment to caring exhausted.

(Q 66 (i) – (xiv))

416. Please see attached a chronology relating to concerns regarding my practice. The chronology includes relevant documents that my legal team and I have been able to identify to date. I have tried to identify as broad a range of documents as possible which may be relevant to the matters referred to under this Question of the Notice. If there is any item arising from the chronology in respect of which the Inquiry would be assisted with further input from me, please let me know and I shall provide further comment if I can. For the purposes of this statement, however, I shall concentrate on the sub-paragraphs identified in Question 66.

(i)

417. When patients are acutely admitted under the Urology Department, they initially attend the A&E Department and it is the A&E Department that makes a decision on whether or not the patient should be admitted. Urinary tract infection is one of the most common infections in society, most frequently diagnosed in women. Such infections may occur only once or occasionally during the course of a lifetime, but they may recur more frequently or become chronic. Irrespective of their frequency, they may have a wide range of severity, from minimally symptomatic to the life-threatening. They may be all the more severe due to other urinary tract pathology which may not have been diagnosed.

418. Over a period of years, my colleague, Mr Michael Young, and I had patients being repeatedly admitted to our department with severe urinary tract infections. If they had been acutely admitted to our department once or twice previously, they

Received from Tughans OBO Mr Aidan O'Brien on 02/11/2022. Annotated by the Urology Services Inquiry

AOB-00308

COMMENTS AND CONCERNS REGARDING PROPOSED JOB PLAN

In preparation for Meeting of Facilitation

There are several areas of concern arising from the proposed Job Plan, giving reason for my being unable to agree to it. These are

- Inadequate time for administration relating to direct patient care
- Lack of lunch / rest breaks
- Specialist clinics on Friday mornings
- Availability whilst on – call
- Date of effect of Job Plan

Inadequate time for administration relating to direct patient care

The total amount of time allocated, in the proposed Job Plan, to administration relating to direct patient care is grossly inadequate for the provision of an effective, efficient and safe service, and is markedly divergent from the reality of the total time required. Moreover, the severity of that inadequacy is reflected in there being days when no time at all is allocated for administrative tasks that cannot or should not be deferred. Indeed, the Job Plan includes weeks when several days will pass before time is allocated to administration that needed to be carried out previously. In order to appreciate the totality of administration required, I have detailed below the range of administration required of the Job:

Arrangement of Admissions and Attendances

This consists of the arrangement of all

- Inpatient admissions
- Admissions to Day Surgical Unit
- Flexible cystoscopies
- Urodynamic studies
- Ward attenders for
  - Intravesical therapies
  - Intravenous therapies
  - Trial removals of catheter

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Quality Care - for you, with you

Mr Aidan O'Brien – Facilitation Meeting on 28 September 2011

Dr Philip Murphy welcomed Mr O'Brien and outlined the purpose of the Facilitation meeting.

Mr O'Brien was then asked to outline his position on the proposed job plan.

1. Admin time

Mr O'Brien stated that the substantive issue for him was admin time. There was an inadequate allocation of admin time in the proposed job plan. This was grossly detached from reality for him and his colleagues.

He had been allocated 4.25 hours for admin, however ½ hour of this relates to MDT specific admin and ½ hour for Thorndale queries. This leaves 3.25 hours per week, which is unrealistic.

Dr Murphy informed Mr O'Brien that some aspects of his administrative work are done by his support staff e.g. where contact with patients is required, he organises his secretary to do some of this. Mr O'Brien stated that his secretary could not organise ultrasounds, etc.

Dr Murphy then asked Mr O'Brien to explain what happens at the specialist clinic in the Thorndale Unit. Mr O'Brien explained that this was an ICATS clinic which included for example

- Outpatient /+diagnostic – "One stop clinic"
- Specialist assessments
- LUS
- Prostate diagnostic
- Haematuria

Assessments are done by Nurse Specialist / SPRs / GPsWSI e.g. prostate cancer cases. If positive, SPRs will organise scans and the Consultants would review these.

Whilst the other consultants in Urology have agreed their jobs plans, they are not happy but they have accepted this. In some ways they felt pressurised to sign e.g. Mr Young was going on leave and accepted on the Friday afternoon before going on leave.

Mr Akhtar intends to keep a diary card to quantify what admin time is actually required. He believes there is a deal whereby if the diary card indicates that greater admin time is required, this will then be allocated. Part of this acceptance is avoidance of more hassle and arguments – avoidance of confrontation. Mr O'Brien explained that he had thought about doing the same.

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

Southern Health
and Social Care Trust

Quality Care - for you, with you

12th October 2011

Mr A O'Brien
Consultant Urologist
Craigavon Area Hospital

PRIVATE & CONFIDENTIAL

Dear Mr O'Brien,

I am writing to advise you that following your facilitation meeting on Wednesday 28 September 2011 and a subsequent meeting held with Mr Mackle on Friday 7 October 2011, I have considered the issues raised and reviewed all the necessary information.

I have compared your proposed job plan with those of your colleagues in Urology and am content that the time you have been allowed for administration seems appropriate. One of your colleagues has been allowed slightly more time; however he has agreed to undertake an additional clinic which will generate more administration.

I do accept however, that you have historically worked significant amounts of administrative time and as a result I feel it is appropriate for me to agree a transitional period to allow you time to adjust your working practices. I am therefore recommending that you should be offered an additional 0.75 PA per week for administration until 28 February 2012. This will result in a total of 2.75 PAs over and above 10 programmed activities. From 1 March 2012 however, you will reduce to 12 PAs per week.

This will undoubtedly require you to change your current working practices and administration methods. The Trust will provide any advice and support it can to assist you with this.

In the meantime, it is important for you to be aware that if you are not satisfied with the outcome of the facilitation process and wish to proceed to a formal appeal, you must notify the Chief Executive in writing by Tuesday 25 October 2011.

Yours sincerely

Dr PP Murphy
Associate Medical Director
Medicine & Unscheduled Care

Received from SHSCT on 01/02/2022. Annotated by the Urology Services Inquiry.

Subject: Post Facilitation
From: Mackle, Eamon <Personal Information redacted by USI>
To: O'Brien, Aidan <Personal Information redacted by USI>, McCorry, Monica <Personal Information redacted by USI>
Cc: Trouton, Heather <Personal Information redacted by USI>, Rankin, Gillian <Personal Information redacted by USI>, Corrigan, Martina <Personal Information redacted by USI>, Clegg +1 More
Sent: 12/5/2011, 4:46:43 PM

Dear Aidan

As you are aware in the letter post your job plan facilitation it was stated: "This will undoubtedly require you to change your current working practices and administration methods. The Trust will provide any advice and support it can to assist you with this."

I as a result, organised a meeting to discuss same. I note however, that you cancelled said meeting. I am therefore concerned that we haven't met to agree any support that you may need. I would appreciate if you would contact me directly this week to organise a meeting. If however you are happy that you can change your working practice without need for Trust support then you obviously do not need to contact me to organise a meeting.

Kind Regards

Yours Sincerely

Eamon Mackle

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

MICHAEL O'BRIEN: That's exactly.

JOHN WILKINSON: Okay.

MICHAEL O'BRIEN: There is also another issue with regard to this meeting and that is that, whilst we don't want to personalise the issue, Mr Mackle~~eIll~~ should not have been involved at all because my father had had a formal grievance against Mr Mackle~~eIll~~. Now that grievance was stayed effectively.

MR O'BRIEN: I suspended it because [Personal Information redacted by the USI] and with the -- on condition that I could initiate it again at any time in the future, which I haven't done. And, you know, one can only speculate as to whether this letter would have been followed up with some kind of informal attempt to resolve the issues had it been someone other than Eamon Mackle~~eIll~~, but, in a sense, that's secondary to the fact that there was no informal process.

JOHN WILKINSON: Okay. But so you're -- I've got the first scenario. The second scenario is that there was a case sitting with regards -- as it were, suspended by you against Mr Mackle~~eIll~~ and he was -- is he your direct line manager?

MR O'BRIEN: Not my first line manager. The lead clinician is Mr Young.

JOHN WILKINSON: Sorry, I do know him. That's a problem for you?

MR O'BRIEN: No, it's not at all. No.

JOHN WILKINSON: I taught his [redacted]. In fact I met [redacted] today. She's over here doing something, counting cars or something. I do a bit of talking in churches and did a faith and education thing for Michael down at his own church. So I know him as a parent and I know him well. So as long as there is no problem for you.

MR O'BRIEN: No. None whatsoever.

JOHN WILKINSON: Okay. Right. So there was -- if we look at it then, he was a couple of --

MR O'BRIEN: People about that, yes, associate medical director, yes.

JOHN WILKINSON: All right.

MR O'BRIEN: At that time. He's no longer.

JOHN WILKINSON: Right. Okay

MICHAEL O'BRIEN: But it had also been agreed at that time of the -- around that time the grievances were being issued that he would have no dealings with him again.

MR O'BRIEN: Yes. I sought and obtained an assurance from Dr Rankin and from Eamon Mackle~~eIll~~ himself, particularly from Dr Rankin, that I would have no more dealings or meetings with him because I was on the point of breakdown as a consequence of his treatment over a period of years. But anyhow, as I said to you --

Received from Tughans OBO Mr Aidan O'Brien on 28/01/2022. Annotated by the Urology Services Inquiry

either routine, urgent, or red flag if they had symptoms indicative of a potential cancer diagnosis. As a secondary safeguard, each consultant in the specialty team took it in turn to triage these referrals again to ensure they, with their specialist knowledge, agreed with the referral category or if they felt it needed either upgraded or downgraded. It was expected that Mr O'Brien would undertake his share of the consultant triage process. It is notable that Mr O'Brien often declared that he didn't agree with this system and felt that red flag referrals should not get precedence over urgent referrals. While in 2017 Urology moved to electronic triage, between 2009 and 2016 triage was paper-based. All red flag referrals were managed through the cancer tracking team who organized the consultant triage process and, while there were occasions where they had difficulty in retrieving completed triage from Mr O'Brien, a dedicated cancer tracker was in place who ensured they were returned in a timely manner.

57. Urgent and routine referrals were managed through the booking centre. They too shared the referrals with the relevant consultant on a rotational basis and sought return to the booking centre for patient booking. Intermittently, the booking centre team had great difficulty in securing timely return of triaged letters from Mr O'Brien. An escalation process was put in place if initial action through normal administrative processes had not proven effective. The issue was escalated both through the 'admin' management lines and directly to the Head of Urology and ENT. The Head of Urology and ENT would have contacted Mr O'Brien directly and requested urgent return of triage. This was usually effective but, on occasion, it was escalated to myself and the Director of Acute Services for action. On intervention at senior level, Mr O'Brien would then have completed and returned his triage. He would then have managed it appropriately for a time and then the cycle of delayed triage would start again. This concern was highlighted to his clinical lead as well as the Clinical Director for the service for peer intervention.

58. There were 2 primary concerns with the delayed triage. While the booking centre waited for Mr O'Brien to return the triage, the longer the delay the longer the patient waited to be added to the waiting list. The second concern was if the patient was deemed appropriate to be upgraded to a red flag

Received from Mrs Heather Trouton on 15/04/22. Annotated by the Urology Services Inquiry.

Meeting re Urology Service

Tuesday 1 December 2009

Action Notes

Present:
Mrs Mairead McAlinden, Acting Chief Executive
Dr Patrick Loughran, Medical Director
Mr Eamon Mackle, AMD – Surgery & Elective Care
Mrs Paula Clarke, Acting Director of Performance & Reform
Mrs Deborah Burns, Assistant Director of Performance
Mrs Heather Trouton, Acting Assistant Director of Acute Services (S&E Care)
Dr Gillian Rankin, Interim Director of Acute Services

1. Demand & Capacity

Service model not yet agreed, outpatients and day patients not finalised, no confidence that this will be finalised. Theatre lists not currently optimised and recent reduction in number of flexible cystoscopies per list. Recent indication that availability for lists in December 2009 will be reduced.

Action

- Sarah Tedford to be requested to benchmark service with UK recognised centres regarding numbers, casemix, throughput (eg cystoscopies per list). **Action – urgent within 1 week.**

- Team/individual job plans to be drafted – Debbie Burns/Mr Mackle/Zoe Parks, for approval at meeting on 11 December 2009. To be sent to consultants and a meeting to be held within a week with consultants, Mr Mackle, Heather Trouton and Dr Rankin.

2. <u>Quality & Safety</u>

<u>Key Issues</u>:-

1. Evidence-base for current practice of IV antibiotics for up to 7 days repeated regularly requires urgent validation. Current cohort of 38 patients even though this clinical practice appeared to change after commitment given to Dr Loughran at end July 2009.

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

Action:-

- Dr Loughran to have phone discussion with Mr Mark Fordham to get urgent professional opinion on appropriateness and safety of current practice. Mr Mackle will meet Mr Fordham next week (w/c 7 December 2009) and report to be ready for discussion

- Discuss outcomes at meeting to be arranged for 11 December 2009

- Depending on the outcome of the professional assessment, management actions may be required as follows:-

    - Commissioner to be informed if practice not safe
    - Letter to be issued to relevant consultants regarding requirement to change clinical practice, with clear indication of sanctions if this change were not to happen
    - Professional assessment of full cohort of patients (38)

2. Triage of Referrals
   Undertaken by 1 of the 3 consultants within required timescale. 1 consultant's triage is 3 weeks and he appears to refuse to change to meet current standard of 72 hours.

3. Red Flag Requirements for Cancer Patients
   1 consultant refuses to adopt the regional standard that all potential cancers require a red flag and are tracked separately. This results in patients with potential cancers not being clinically managed within agreed timescales.

4. Chronological Management of Lists for Theatre
   1 consultant keeps patients' details locked in the desk and refuses to make this available. Current breaches of up to 24 weeks which may or may not include urgent patients, while non-urgent vasectomies are booked for 2 weeks after listing.

   Actions for Points 2, 3 & 4:-

    - Written approach from Dr Gillian Rankin, Interim Director of Acute Services to consultants to require patient lists/details to be made available immediately, in order that all urgent patients can be booked (Debbie Burns to draft). Safe management of patients is a requirement in the consultants' contracts.
    - If no compliance, further written correspondence to be drafted on issues of lack of conformance with triage and red flag requirements, clearly setting out the implications of referral to NCAS if appropriate clinical action not taken.

    - Dr Loughran, Kieran Donaghy & Dr Rankin to agree relevant correspondence

2. Other Issues

- Dr Loughran to ensure circulation of recently adopted policies to all consultants (SPA, full job planning, WLI)
- Funding base and recruitment process for Clinical Fellows in Urology to be reviewed before proceeding to any further appointments

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

Thanks

Martina

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

Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: O'Brien, Aidan
Sent: 26 November 2013 02:08
To: Corrigan, Martina
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Martina,
I really am so sorry that I have fallen so behind in triaging.
However, whilst on leave, I have arranged all outstanding letters of referral in chronological order, so that I can passed them to CAO via Monica in that order, beginning tomorrow.
I know that I have fallen behind particularly badly (except for red flag referrals which are up to date) and I do appreciate that this causes many staff inconvenience and frustration, and that all have been patient with me!
I can assure you that I will catch up, but am determined to do so in a chronologically ordered fashion,

Aidan

From: Corrigan, Martina
Sent: 24 November 2013 17:28
To: O'Brien, Aidan
Cc: McCorry, Monica; Robinson, Katherine; Glenny, Sharon
Subject: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Importance: High

Dear Aidan,

Please advise, this is holding up picking patients for all clinics as these letters have not been triaged and I know that this will need to be escalated early this week if not resolved.

I would be grateful for your action/update

Thanks

Martina

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

Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

467. At a consultant's meeting on 18 July 2013, it was recorded that "*The current triage process was discussed with its dangers of patients being delayed in triage due to current workloads. Tony has suggested we develop a similar system to that used in Wolverhampton and Guys hospital which we will take forward with our IT and booking centre colleagues"* [AOB-06748]. This demonstrates that others had concerns in relation to the triage system at that time, yet the Trust failed to address and change the system.

468. On 8 October 2013 Ms Trouton noted the serious delay in triage at that stage, whilst understanding the pressures within urology [AOB-06960 – AOB-06962]. I made the Trust aware in an email of 26 November 2013 that I was sorry I was behind in triage and had arranged to catch up on it during leave [TRU-01666-TRU-01672]. Surely the response to that should have been to provide adequate time to carry out the tasks within my job plan, rather than simply raise the issue, know the cause was overwork, yet do nothing substantive to address it, leaving me to address and resolve the backlog while on leave.

469. In early 2014 temporary measures to relieve me of triage commenced [AOB-00611] as Mr Young had agreed to help out at that time [AOB-00646]. That, however, was not only temporary but failed to address the underlying cause, which was progressively exacerbated by the additional burden of my roles with NICaN and with the Trust's Urology MDT and MDM at that time.

470. I was not the only consultant who struggled with the demands of triage whilst on call [see email 13 March 2014 AOB-70484 - AOB-70485].

471. I highlighted a number of issues in relation to red flag triage to colleagues on 16 March 2014 [see AOB-70487 - AOB-70488].

472. In March 2014 I again referred to pressure of work in the context of the referring to the triage backlog [see AOB-70605 - AOB-70606].

Received from Tughans OBO Mr Aidan O'Brien on 02/11/2022. Annotated by the Urology Services Inquiry

Mackle, MR E

From: Mackle, MR E
Sent: 02 June 2009 13:10
To: 'Simon.Gibson [Personal Information redacted by the USI] Youart, Joy; O'Brien, Aidan
Subject: Request for leave to clear administration

Simon

Thanks for discussing with me Aidan's request to cancel all clinical work during July to allow him to clear the backlog of paperwork.

I have several serious concerns regarding the request:

1. I think approximately 2 years ago the trust funded a similar exercise to allow Aidan to catchup. It was agreed then that this was a one off and it was his responsibility (as per consultant contract) to prevent such a baglog developing again.

2. There are already 3.87 PAs of admin time in his current job plan. This is way in excess of any other consultant in the trust and is excessive when compared to eg Mr AKhtar (Cons Urologist) who has 1.12 PAs in his job plan for admin.

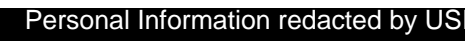
3. To expect the trust to fund the shortfall in clinical activity in light of Aidan's baglog (despite an over generous allowance of PAs in his job plan) would thus be unreasonable. If his colleagues feel that the request from urology is reasonable then I would expect the sessions to be covered at no additional cost from within the speciality.

4. If as you state Aidan feels there is now a clinical risk because he has allowed the backlog to develop then there is a serious governance issue regarding his practice. I am copying this email to him so as to get an urgent response to the clinical risk issues he has raised and I may also need to consult with the Medical Director regarding the performance issues raised.

Eamon

Eamon Mackle
Associate Medical Director
Surgery / Elective Care
Southern Trust

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.



12 June 2009.

Mr. Eamon Mackle,
Associate Medical Director,
Surgery and Elective Care,
Southern Health and Social Care Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear Eamon,

Two days ago, I opened and read the copy of the email that you sent to Simon Gibson and to Joy Youart on 02 June 2009, and the accompanying cover slip from you, addressed to me. I did so only then as I had mistakenly gathered from you that it had something to do with the arrangements for ward configuration in July. I was shocked beyond words, appalled and flabbergasted on reading both.

In your email addressed to Simon (and sent to Joy), you thank Simon for discussing with you 'Aidan's request to cancel all clinical work during July to allow him to clear the backlog of paperwork'. I certainly did not make or submit to anyone any request to do so.

These past three months have been the most stressful and distressing that I (and everyone else caring for urological patients) have had to endure since I was appointed 17 years ago. Not only have we had to cope with the imposed loss of our ward, and the fragmentation of inpatient urological services posing a potential existential threat to care, we have also had to cope with the reality of the deliberate lack of information and consultation with those most directly and intimately involved in the delivery of the care. Worse still, we additionally had to cope with the reportage that we had not only been informed and consulted, but were in agreement with the plans. Not only have I endeavoured to seek compromise, I have gone to every length to restore some degree of confidence in the credibility of management, when that was at an unprecedented low.

Then I read your email!

I do believe that it would be reasonable to request and expect an acknowledgement, in writing, that I did not make or submit the request recorded in your email,

Yours Sincerely,

Aidan O'Brien.

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Burns, Deborah <Personal Information redacted by USI>
Sent: 21 February 2014 19:13
To: Mackle, Eamon; Young, Michael; Corrigan, Martina
Subject: Yesterday

I had a very helpful meeting with Mr O'Brien yesterday (Martina also attended). Mr O'Brien has agreed to not triage new referrals (with exception of those named to himself). He is also to think about if any additional admin support would assist him.

Michael I know this may place an additional burden on the rest of the team but appreciate you accommodating

Thanks for your help with this situation D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by USI
Email: Personal Information redacted by USI

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

the 3 categories of referral. Mr O'Brien would have said red flags were 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 picked up the slack. It was not 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. 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.

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

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

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

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

19. I know Mr O'Brien finds triage arduous and he would often say he had difficulty completing triage on a timely basis. Mr O'Brien would raise issues at departmental meetings however I was unaware that the triage was not being done. I knew he didn't necessarily agree fully with all of the new introductions to the service but it was the process within the Department that we had all agreed to at prior meetings. He never said he was not going to do triage, he was very much part of the meetings when it was agreed. Mr O'Brien was very much an advocate of advanced triage and complained that others may not have done it properly. The level of triage he was aspiring to achieve was difficult to attain possibly, some may comment that he was almost trying to do it in too much detail, and as such the totality took too long.

20. My experience of Mr O'Brien is that if he was not wanting to do something he wouldn't be pushed into doing it. Mr O'Brien would be the first to politely say when he didn't agree with something. I am not aware of Mr O'Brien saying he wasn't doing triage. I knew he may have been behind with triage but not that he wasn't doing it.

21. It was only in December 2016 that I became aware of the extent to which Mr O'Brien was behind on doing triage. Again as commented upon before I appreciate that he was vocal about saying he had difficulty and didn't have enough time. I know he felt he didn't have time to do advanced triage in the way he wished. He however did not say the extent to which he was behind. I recall seeing the bundle of referrals which were not triaged in December 2016 and being particularly surprised by the volume.

22. I would have expected Mr O'Brien to have come to me and alerted me about the referrals not being triaged. I hadn't spotted that it was such an issue. I'm not in charge of his practice but I thought he would have afforded me the opportunity to speak to him. There was no reason why he couldn't approach me. I had helped him in the past. We have always had a good relationship and speak openly about a wide variety of things. We have had only 'two cross words' in the 20 years we've worked together.

23. In respect of TOR 1, I was unaware of the scale of the issue and was not told by Mr O'Brien or anyone else that triage was not being done, just that there was a delay in it being done. I was informed in late December 2016 that there was approximately 700 letters dating back to June 2015 that had not been triaged.

24. I was involved, along with my urology colleagues, in reviewing the referrals that hadn't been triaged. Of those I triaged several were upgraded to red flag. Some were clearly red-flag referrals. I am also aware my colleagues also upgraded some referrals.

25. All un-triaged referrals had the potential for patients to come to harm. During the look back exercise, I didn't see any GP coded red-flag referrals among the un-triaged referrals. i.e it seems the red flag letters were triaged. These are printed on yellow paper to make them stand out. I'm not sure if Mr O'Brien screened the routine letters, this is not for me to comment upon. However if he had, it is unlikely he would have missed an evident red-flag referral. I am not sure if he

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Mackle, Eamon

From: Corrigan, Martina
Sent: 05 September 2013 07:24
To: Burns, Deborah; Mackle, Eamon
Subject: RE: CHARTS TO CONSULTANT'S HOME

Debbie

I will speak with him again today and then let Robin follow up on this?

One of the things that was said to me before is that he is not the only consultant who brings a chart home, but I suppose with Aidan it is more the amount he brings home and the length of time he keeps them for, I will let you both know how I get on

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Burns, Deborah
Sent: 05 September 2013 06:38
To: Mackle, Eamon; Corrigan, Martina
Subject: FW: CHARTS TO CONSULTANT'S HOME

? We need this addressed
D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Brown, Robin
Sent: 04 September 2013 21:17
To: Burns, Deborah
Subject: RE: CHARTS TO CONSULTANT'S HOME

I will try to get to meet Aidan week after next. I am Sow next week.

Robin

From: Burns, Deborah
Sent: 03 September 2013 15:11
To: Corrigan, Martina; Mackle, Eamon; Brown, Robin
Subject: FW: CHARTS TO CONSULTANT'S HOME

Received from Mr Eamon Mackle on 12/04/22. Annotated by the Urology Services Inquiry.

Willis, Lisa

From: Corrigan, Martina
Sent: 26 October 2014 14:51
To: Trouton, Heather
Subject: RE: NOTES WITH AOB

Follow Up Flag: Follow up
Flag Status: Flagged

Heather

It had improved but I feel it may be slipping again and I will talk to Aidan again

Martina

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

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

From: Trouton, Heather
Sent: 15 October 2014 15:28
To: Corrigan, Martina
Subject: FW: NOTES WITH AOB
Importance: High

Martina

Are you aware that this is still a problem ? has it improved at all ?

Heather

From: Carroll, Anita
Sent: 14 October 2014 14:40
To: Trouton, Heather
Subject: FW: NOTES WITH AOB
Importance: High

From: Forde, Helen
Sent: 14 October 2014 13:52
To: Carroll, Anita
Subject: FW: NOTES WITH AOB
Importance: High

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Hynds, Siobhan

From: Young, Michael [Personal Information redacted by the USI]
Sent: 26 November 2015 12:03
To: Haynes, Mark; Corrigan, Martina
Subject: RE: Queue jumpers

I had spoken before to the person in question re this issue in general and the justification of urgency – and I agree since the waiting list for some things are so long eg urodynamics.
Will have to speak again then

MY

From: Haynes, Mark
Sent: 26 November 2015 06:42
To: Young, Michael; Corrigan, Martina
Subject: Queue jumpers

Morning Michael

I emailed you on 2nd June 2015 about the ongoing issue of patients on waiting lists not being managed chronologically and in particular private pa

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