



# Urology Services Inquiry

**Note:** An addendum amending this statement was received by the Inquiry on 8 September 2023 and can be found at WIT-100354 to WIT-100366. Annotated by the Urology Services Inquiry.

## UROLOGY SERVICES INQUIRY

**USI Ref:** Section 21 Notice Number 16 of 2023

**Date of Notice:** 6<sup>th</sup> July 2023

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### Witness Statement of: David Cardwell

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I, David Cardwell, will say as follows:-

**1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include:**

**(i) an explanation of your role, responsibilities and duties within the Southern Health and Social Care Trust (“the Trust”), and**

- 1.1 I began working in the NHS in August 1993 and held a number of administrative posts, which are set out in my response to question 4, before being appointed to the post of Administration and Complaints Manager with the then Craigavon Area Hospital Group Trust in February 2004. My employment transferred to the Southern Health and Social Care Trust on its formation in April 2007 and I remained in my role as Administration and Complaints Manager until the Governance Structures were agreed and staffed in October 2008. From then until July 2011, my role as a Patient Client Liaison Manager primarily involved the management of complaints (receiving complaints by phone, in writing or in person, allocating to an operational team for investigation, co-ordinating and drafting a response for approval by the Assistant Director of Acute Services and signature by the Director) for the Directorate of Acute Services and leading a team of complaints staff. Thereafter my role broadened, as a result of a 2010/2011 Clinical Governance review, to a Governance Officer assisting the newly appointed role of Directorate Governance Co-Ordinator, Mrs Margaret Marshall, with the administration of the Datix system for reporting of incidents, running reports and keeping risk registers up to date on the Datix system.
- 1.2 Prior to appointment to my current post of Band 7 Clinical Governance Manager in April 2019, which primarily involves the management of Serious Adverse Incidents, (to include the screening of incidents, notification of SAI's to



## Urology Services Inquiry

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

### Statement of Truth

Signed: David Cardwell

Dated: 15 August 2023

**UROLOGY SERVICES INQUIRY**

**USI Ref:** Section 21 Notice Number 16 of 2023

**Date of Notice:** 6<sup>th</sup> July 2023

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**Addendum Witness Statement of: David Cardwell**

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I, David Cardwell, will say as follows:-

I wish to make the following amendments to my existing response, dated 15<sup>th</sup> August 2023, to Section 21 Notice number 16 of 2023:

Throughout my Section 21 response I have referred to other paragraphs within my response. However, due to the formatting process, these references are incorrect. I would therefore seek to amend the following paragraphs:

1. At paragraph 7.5 (WIT-99192), I have stated *'Since April 2019 it is the multi-disciplinary screening team listed at my response to point 15 above,'* This should state *'Since April 2019 it is the multi-disciplinary screening team listed at my response to paragraph 7.4 above,'*
2. At paragraph 7.13(c) (WIT- 99194), I have stated *'Those who carried out this role before I commenced my Clinical Governance Manager role in 2019 are listed at point 13.* This should state *'Those who carried out this role before I commenced my Clinical Governance Manager role in 2019 are listed at paragraph 7.2.'*
3. At paragraph 8.1 (WIT-99197), I have stated *'This role would have taken up at least 80% of my time. I was also required to provide governance training, referenced in point 28, (circulating dates of training, keeping an attendance register, delivering a 2 hour training session, follow up with staff afterwards and circulation of training material) to staff and ensure that regular reports in relation to complaints, incidents and risks were being produced.'* This should state *'This role would have taken up at least 80% of my time. I was also required to provide governance training, referenced in paragraph 7.14,*



## Urology Services Inquiry

*and patient/client liaison for the Directorate of Acute Services. I led a team of complaints staff for the Directorate of Acute Services.'*

9. At paragraph 7.14 (WIT-99195), I have stated *'In 2018 a number of specific training sessions (15. Incident Management) were organised and delivered for staff who had responsibility for the investigation of incidents. Staff who attended the generic Incident, Risk and Complaints Training, post 2016 would also have access to a prompt sheet (16. Acute Services Incidents) which they could use as an aide memoir to investigation.'* This should state *'In 2018 a number of specific training sessions (15. Incident Management) were organised and delivered for staff who had responsibility for the investigation of incidents. Staff who attended the generic Incident, Risk and Complaints Training, post 2016 would also have access to a prompt sheet (16. Acute Services Incidents) which they could use as an aide memoire to investigation.'*

10. At paragraph 10.2 (WIT-99203), I have stated *'An audit trail of the incident on Datix indicates that I logged onto the incident on 26 November 2015 and moved it from the Surgery and Elective Care Division to the Functional Support Services Division to allow Mrs Forde, Head of Health Records, to investigate it as she would not have had access to this Datix.'* Please see attached audit trail referred to at this paragraph (1. Datix\_ SHSCT GOVERNANCE TEAM (IR2) Form - NEW June 2018 Personal Information redacted by the USI with audit details)

11. At paragraph 10.3 (WIT-99201), I have stated *'Often this was not followed by the operational teams and I would have received an email asking me to move and incident from one area to another for investigation.'* This should state *'Often this was not followed by the operational teams and I would have received an email asking me to move an incident from one area to another for investigation.'*

### **Statement of Truth**

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

Signed: David Cardwell

Date: 7<sup>th</sup> September 2023

**Line Management, Roles and Reporting Arrangements**

Role	To whom I reported	Departments, services, systems I whom I managed	Staff I had responsibility for
Patient/Client Liaison Manager	Ms Gill Smith Senior Manager – Medical Directorate	<p>Responsible for the management of patient/client complaints, user views and patient/client liaison for the Directorate of Acute Services. The post holder will lead a team of complaints staff for the Directorate of Acute Services.</p> <p>The post holder will ensure that best practice is adopted with regard to the management of patient/client complaints, ensuring that the complaints process is managed in an open and responsive manner. The post holder will also manage the implementation and administration of the Southern HSC Trust 'Being Open' policy for the Directorate of Acute Services and the processes associated with the collation and actioning of user views.</p>	Mrs Vivienne Kerr (Band 4) Mrs Roisin Farrell (Band 3)
Governance Officer	Mrs Margaret Marshall CSCG Co-Ordinator  Dr Tracey Boyce Director of Pharmacy Services	Responsible for the provision of a high quality clinical and social care administrative service to the Directorate. This will include management of administrative staff within the Directorate Clinical and Social Care Governance (CSCG) office, the administrative system management of Directorate complaints, incidents and other sensitive CSCG issues and the monitoring and management of the Directorate information system to support CSCG. The post holder will also provide significant support to the Directorate Governance Coordinator in the management of the incidents and complaints process, including tracking of responses, liaising with clinical teams, patients, clients and their families. The role will also incorporate production and analysis of reports from the CSCG information system,	Mrs Roisin Farrell (Band 3) Miss Lynn McKenzie (Band 3) – replaced by Mrs Pamela Truesdale (Band 3)



## Urology Services Inquiry

- 5.4 I remained in the Senior Governance Officer Band 6 post until I took up the post of Clinical Governance Manager Band 7 in Acute Services on 29 April 2019 (*please see 4. Clinical Governance Manager Job Description*). I became responsible for monitoring and improving the delivery of patient care services within the SHSCT, supporting the clinical governance agenda within the Acute Directorate, in Medicine and Unscheduled Care and/or Surgery and Elective Care and ATICS which includes the management of complaints, clinical audit, clinical effectiveness and multi-disciplinary education and training. The post holder will effectively support the implementation of principles and practice of clinical governance and risk management, in the clinical setting within a framework which uses information to guide reflection, leading to action and outcomes monitoring. This remains my current post. In May 2023, I was successful at interview for the post of Acting Clinical Governance Co-Ordinator Band 8b for the Medicine and Unscheduled Care Directorate, however I choose to decline this offer of employment.
- 5.5 Reflecting on the content of the job descriptions, I do not consider these are an accurate reflection of the duties and responsibilities. There were a lot of duties in these and given the volume of work within the Directorate, it was not possible, without a workable structure below the level I was at, to have completed all of the duties listed. I consider this remains the current situation, especially with my current post which does not detail the day to day responsibilities that I have. I consider that I was and still am frequently working above the level that was described in the job descriptions.

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

- 6.1 In my Role of Patient/Client Liaison Manager I reported to Ms Gill Smith, Senior Manager Medical Directorate. I had two staff reporting to me, Mrs Vivienne Kerr (Band 4) and Mrs Roisin Farrell (Band 3). In my role as Governance Officer I reported to Mrs Margaret Marshall, Directorate Governance Co-Ordinator and when her post was not replaced, Dr Tracey Boyce, Director of Pharmacy. I had three staff reporting to me who were Mrs Roisin Farrell, Miss Lynn McKenzie and Mrs Pamela Truesdale (all Band 3). In my role of Senior Governance Officer I reported to Mrs Trudy Reid, Directorate Governance Co-Ordinator and I had five staff reporting to me, Mrs Vivienne Kerr, Mrs Roisin Farrell and Mrs Barbara Joyce (all band 5), Mrs Pamela Truesdale Band 4 and Miss Danielle Canning Band 2). In my current role I have reported to Mrs Patricia Kingsnorth, Mr Chris Wamsley and now to Mrs Clair Quin and Ms Lisa

**Process for the Reporting of  
Serious Adverse Incidents (SAI) & Reporting Early Alerts – December 2017 update**

**When a Serious Adverse Incident (SAI) occurs:**

1. **The Staff member, on becoming aware of the incident, must telephone their Line Manager who will notify their Head of Service, Assistant Director and Acute Governance Coordinator. The Staff member must also immediately complete a Trust Adverse Incident Reporting Form (IR1) online via Datix Web.**

\*NB some incidents (e.g. high media profile incidents / homicide / inpatient suspected suicide etc. will require immediate meeting/conference call between AD/ Director/AMD/HoS/Governance Coordinator and subsequent contact with the Chief Executive's Office and Public Relations Department.

**An adverse incident is defined as: "Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation", arising during the course of the business of a HSC organisation / Special Agency or commissioned service: The following regional criteria will determine whether or not an incident constitutes an SAI. This list is not exhaustive: (if in doubt report!)**

- 4.2.1. serious injury to, or the unexpected/unexplained death of:  
- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)  
- a staff member in the course of their work  
- a member of the public whilst visiting a HSC facility;
- 4.2.2. unexpected serious risk to a service user and/or staff member and/or member of the public;
- 4.2.3. unexpected or significant threat to provide service and/or maintain business continuity;
- 4.2.4. serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;
- 4.2.5. serious self-harm or serious assault (including homicide and sexual assaults)  
- on other service users,  
- on staff or  
- on members of the public  
by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and / or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and / or learning disability services, in the 12 months prior to the incident;;
- 4.2.6. suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and / or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;
- 4.2.7. serious incidents of public interest or concern relating to:  
- any of the criteria above  
- theft, fraud, information breaches or data losses  
- a member of HSC staff or independent practitioner

**CONTACTS:**

**Acute Governance Coordinator: Trudy Reid**

Tel: [Personal Information redacted by the USI] or [Personal Information redacted by the USI]  
E-mail: [Personal Information redacted by the USI]

**Medicine & Unscheduled Care:-**

**Anne McVey (Asst Dir):** [Personal Information redacted by the USI]

**Heads of Service**

(HoS) Mary Burke: [Personal Information redacted by the USI]  
(HoS) Kay Carroll: [Personal Information redacted by the USI]  
(HoS) Katriona McGoldrick: [Personal Information redacted by the USI]  
(HoS) Louise Devlin: [Personal Information redacted by the USI]

**Surgery & Elective Care and Anaesthetics  
Theatres Intensive Care Services**

**Ronan Carroll (Asst Dir):** [Personal Information redacted by the USI]

**Heads of Service**

(HoS) Martina Corrigan: [Personal Information redacted by the USI]  
(HoS) Wendy Clayton: [Personal Information redacted by the USI]  
(HoS) Brigeen Kelly: [Personal Information redacted by the USI]  
(HoS) Helena Murray: [Personal Information redacted by the USI]

**Integrated Maternity & Womens Health and  
Cancer & Clinical Services:**

**Heather Trouton (Asst Dir):** [Personal Information redacted by the USI]

**Heads of Service.**

(HoS) Patricia McStay: [Personal Information redacted by the USI]  
(HoS) Geoff Kennedy: [Personal Information redacted by the USI]  
(HoS) Fiona Reddick: [Personal Information redacted by the USI]  
(HoS) Jeanette Robinson: 028

**Function Services:**

**Anita Carroll (Asst Dir):** [Personal Information redacted by the USI]

**Pharmacy:**

**Dr Tracey Boyce (Asst. Dir):** [Personal Information redacted by the USI]

**3. ROLES & RESPONSIBILITIES****All Staff**

Report the incident immediately & verbally to line management & also via Datix, after taking all immediate, appropriate, reasonable and proportionate actions to minimise the likelihood of the incident recurring. The situation must be made safe.

**Assistant Director / Heads of Service via their Team Leaders / Ward & Facility Managers will ensure that:**

- Ensure isolation & centralization of healthcare notes / all relevant documentation (if applicable). Original notes are to be sent to the Acute Governance Department, CAH.
- Where appropriate and where it would be beneficial to assist in the investigation of the incident, photographs should be taken and retained as evidence – this is particularly useful in Health and Safety type incidents or where damage had occurred to property
- CCTV footage should be sourced and a copy made for all cases which would be subject to PSNI investigation or where CCTV can assist with immediate review of events e.g. AWOLs etc.
- Security staff and/or the PSNI should be informed immediately, where appropriate. PSNI advice should be followed until directed otherwise by them e.g. where they advise to cordon off a specific area/room etc. Staff should document the content of conversations/interaction with PSNI.
- Consideration should be given to the need to activate site based emergency / contingency plans if necessary (in line with current emergency procedures).
- An immediate debrief is conducted and any staff support requirements are identified, offered and /or provided in a timely manner.(see Appendix 1)
- In liaison with the Governance Coordinator ensure that the SAI review is completed and a report is provided to the Director / Assistant Director for submitting to all relevant agencies where applicable e.g. RQIA/HSC Board/Coroner.
- Ensure that any SAI review action plan/recommendations are implemented & monitored and that any learning is disseminated appropriately. The HOS will provide regular updates to the relevant governance fora on the implementation of recommendations.

**The Acute CSC Governance Office in liaison with the reporting staff member(s) / Head(s) of Service / Assistant Director / Director / AMD will:-**

1. Notify Chief Executive's office and Communications Department \*where appropriate.
2. Assist the Assistant Director / Director in reporting an Early Alert, if required.
3. Report the SAI to all relevant bodies within the required timescales via the Corporate Governance Office.
4. Coordinate **all stages** of the SAI review process including service user/family engagement and report compilation/submission process.
5. Maintain central coordination function between Acute and other departments/agencies e.g. Litigation Dept. (who process requests from coroner for statements/casenotes); Health & Safety Dept.; nominated PSNI liaison person etc.; HSCB/RQIA/DHSS. All communications with external agencies should be issued via the Governance Office.
6. Liaise with the Trust's Lead Social Worker for Adult Safeguarding, Professional Governance and external agencies where appropriate.



**numbered paragraphs and in chronological order.**

1.21 I commenced post as Acute Governance Coordinator on 4<sup>th</sup> April 2016 (*please see 2. Job Roles*).

1.22 My appointment was to be one of a number of appointments to improve the clinical governance structures within the Acute Directorate. The roles and responsibilities included:

- a) Corporate liaison
- b) Level 3 investigations
- c) Level 2 investigations
- d) Lessons learnt implementation
- e) Allocation of SAIs
- f) Development of report the Directorate and individual Divisions...
- g) Preparation of Agendas for AD and AMD governance meeting
- h) Quality assurance of SAI reports
- i) SAI screening process

1.23 From commencement of my role I highlighted that the resources available within the governance team did not allow for development of robust governance systems and processes and did not allow for timely screening, reviews or report writing. Limited staffing resource prevented proactive work streams to support changes required to reduce risk or monitor implementation of actions from learning. This risk was consistently escalated during my tenure.

1.24 In September 2016 I note from email with information of incidents relating to delays to Dr Boyce, Mrs Trouton and Mr Conway the commencement of work in relation to delays in treatment and care: I refer to *9a.-9b. Delays in appointments diagnosis or treatment data Tracey 09 30 2016, A1*. In relation to the administrative issues, administrative teams produced and circulation of reports to escalate risks including triage reports, dictation reports, typing backlog reports: I refer to email *11. Delays meeting checking re triage with* Personal information redacted *02 10 2017*. To help address some of the risks relating to delays I progressed a number of meetings including meetings



**SCREENING TEMPLATE**  
**HCN:**

<b>Directorate:</b>	
<b>Reporting Division:</b>	
<b>Date of Incident:</b>	
<b>Date of Screening</b>	
<b>Incident (IR1) ID:</b>	
<b>Grade of Incident:</b>	
<b>Screening Team:</b>	
<b>Summary of Incident</b>	
<b>Summary of Discussions</b>	
<b>Level and Type of Review</b>	
<b>Review Team</b>	

## ACUTE DIRECTORATE

**Process for the Reporting of  
Serious Adverse Incidents (SAI) & Reporting Early Alerts – June 2016 update**
**When a Serious Adverse Incident (SAI) occurs:**

1. The Staff member, on becoming aware of the incident, must telephone their Line Manager who will notify their Head of Service, Assistant Director and Acute Governance Coordinator. The Staff member must also immediately complete a Trust Adverse Incident Reporting Form (IR1) online via Datix Web. Irrelevant information redacted by the USI

\*NB some incidents (e.g. high media profile incidents / homicide / inpatient suspected suicide etc. will require immediate meeting/conference call between AD/ Director/AMD/HoS/Governance Coordinator and subsequent contact with the Chief Executive's Office and Public Relations Department.

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4.2.1. Serious injury to, or the unexpected/unexplained death of:

- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2. Unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.3. Unexpected or significant threat to provide service and/or maintain business continuity;

4.2.4. Serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.5. Serious self-harm or serious assault (including homicide and sexual assaults)

- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) **and / or known to/referred** to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and / or learning disability services, in the 12 months prior to the incident;;

4.2.6. Suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) **and / or known to/referred** to mental health and related services (Including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;

4.2.7. Serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner

**CONTACT DETAILS:**
**Acute Governance Coordinator: Trudy Reid**

Tel: Personal Information redacted by the USI or Personal Information redacted by the USI  
E-mail: Personal Information redacted by the USI

Connie Connolly: Personal Information redacted by the USI

**Medicine & Unscheduled Care:-**

**Anne McVey (Asst Dir):** Personal Information redacted by the USI

**Heads of Service**

(HoS) Mary Burke: Personal Information redacted by the USI  
(HoS) Kay Carroll: Personal Information redacted by the USI  
(HoS) Katriona McGoldrick: Personal Information redacted by the USI  
(HoS) Louise Devlin: Personal Information redacted by the USI

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Theatres Intensive Care Services**

**Ronan Carroll (Asst Dir):** Personal Information redacted by the USI

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(HoS) Amie Nelson: Personal Information redacted by the USI  
(HoS) Brigeen Kelly: Personal Information redacted by the USI  
HoS) Mary McGeough: Personal Information redacted by the USI

**Integrated Maternity & Womens Health and  
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**Heather Trouton (Asst Dir):** Personal Information redacted by the USI

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(HoS) Patricia McStay: Personal Information redacted by the USI  
(HoS) Brian Magee: Personal Information redacted by the USI  
(HoS) Fiona Reddick: Personal Information redacted by the USI  
(HoS) Jeanette Robinson: Personal Information redacted by the USI

**Function Services:**

**Anita Carroll (Asst Dir):** Personal Information redacted by the USI

**Pharmacy:**

**Tracey Boyce (director of pharmacy):** Personal Information redacted by the USI



**Southern Health  
and Social Care Trust**  
*Quality Care - for you, with you*

# **Policy for Shared Learning**

<b>Lead Policy Author &amp; Job Title:</b>	Stacey Hetherington, Corporate Clinical and Social Care Governance Co-Ordinator
<b>Directorate responsible for document:</b>	Medical Directorate
<b>Issue Date:</b>	28 July 2022
<b>Review Date:</b>	29 July 2024

**Introduction**

The Southern Health and Social Care Trust (SHSCT) acknowledges the importance of assuring patient, service user and staff safety as a priority within the organisation. In order to achieve this assurance it is necessary to thoroughly investigate and extrapolate learning where opportunities to do this are presented, such as from incidents, all methods of service user feedback (complaints and compliments), audit, litigation (claims and coroners findings), mortality and morbidity meetings, professional fora, whistleblowing etc. (*this is not an exhaustive list*). Analysis of this information will contribute to facilitating pro-active risk management to help ensure the potential of similar events happening again is reduced.

This policy has been developed to demonstrate the SHSCT's commitment to continually improve from lessons learned and covers learning identified from internal sources and, in addition, learning obtained from external sources such as other HSC Trusts, NIAIC, regional learning shared by the Department of Health, particularly that shared from the Strategic Planning and Performance Group (SPPG).

This policy has been developed with the intention to capture and disseminate learning relating to SHSCT Corporate issues and not exclusively to Clinical and Social Care Governance issues only.

This policy and the formal process for sharing learning are intended to strengthen dissemination of identified learning and should not replace any form of direct communication or discussion that occurs in a one to one, team meeting or professional basis.

Safety Alerts issued on a regional or national level, will be issued and circulated separate to this policy and shared learning pathway.

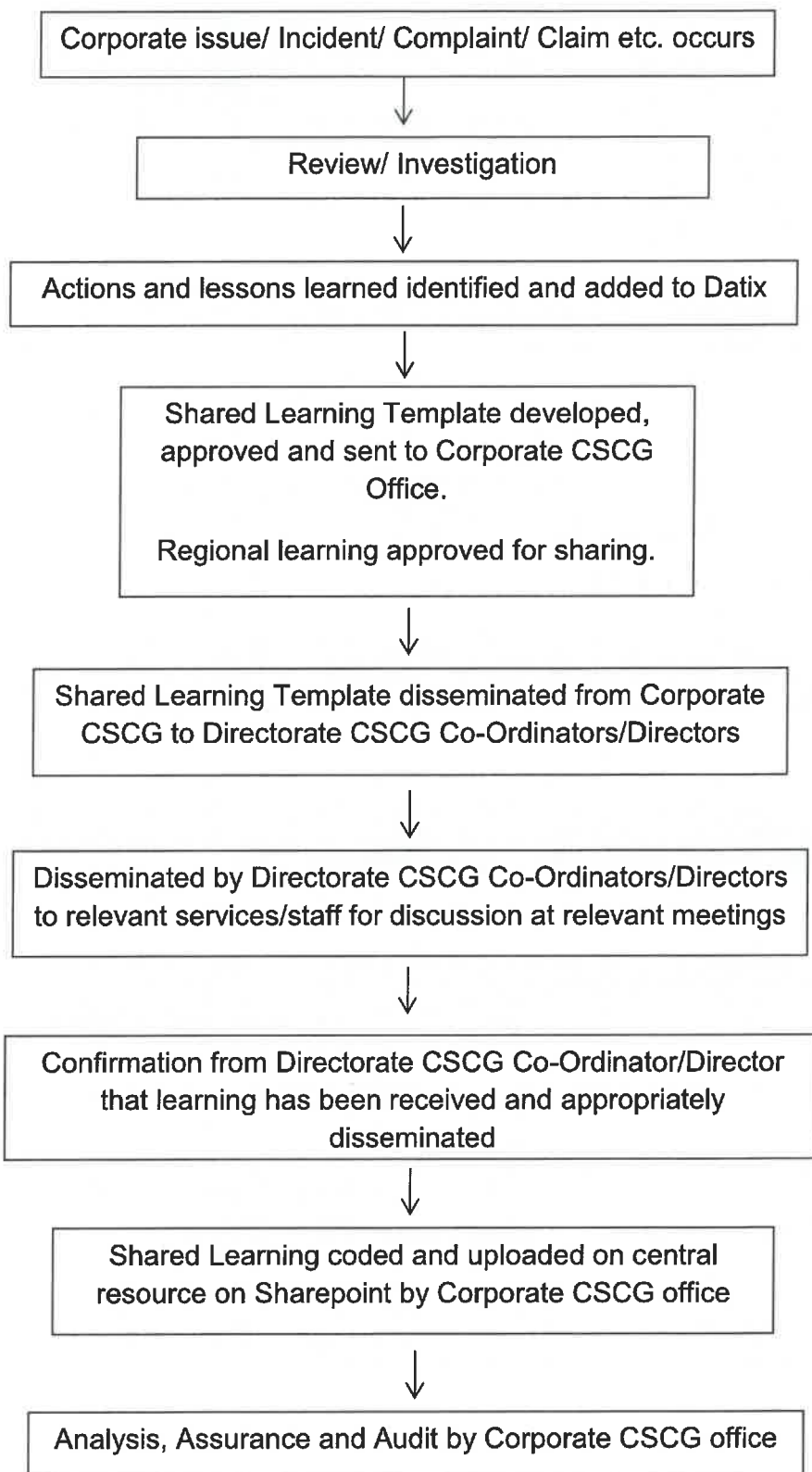
**Purpose and Aims**

The purpose of this policy is to ensure that the safety lessons learnt, from internal and external sources, are appropriately and widely shared across the SHSCT. Any improvements required in response to lessons learnt will be implemented through an action plan and compliance audited.

**Objectives of this Policy**

- To ensure learning from internal and external sources is shared with all staff across SHSCT
- To make improvements in response to lessons learnt to reduce the potential of recurrence using a systematic and coordinated approach to solve a problem using specific methods and tools with the aim about bringing about measureable improvement
- To share best practice to enable continuous improvement

**Appendix 1 – Flowchart for Sharing Learning**



## Appendix 2 – SHSCT Shared Learning Template

<b>Shared Learning Template</b>	
<b>Date issued:</b>	<b>Ref. No.</b>
<b>Area learning identified:</b> (Please highlight, in the case of 'Other' please identify source)	<i>Corporate Issue / Incident / SAI / SJR / SEA / Adverse Incident / Complaint / Compliment / Audit / Litigation / M&amp;M / External Learning Letter / Other</i>
<b>Shared Learning Title:</b>	
<b>Summary – what happened?</b>	
Please provide a brief, confidential summary of the event	
<b>What went well?</b>	
Please provide details of positive actions/outcomes	
<b>What, if anything, could we improve?</b>	
Please make any suggestions you think may improve this situation or prevent it from reoccurring	
<b>What have we learned?</b>	
In bullet form, please provide details of any immediate, urgent learning to be shared	
<b>Shared Learning to be disseminated:</b>	
Locally, where event occurred: <input type="checkbox"/>	To other services within Directorate: (Please specify) <input type="checkbox"/>
To other Directorate(s): (please specify) <input type="checkbox"/>	Trustwide: <input type="checkbox"/>
Regionally: (please complete HSCB form) <input type="checkbox"/>	Professional Specific Practice: (please specify) <input type="checkbox"/>
Other: (please specify) <input type="checkbox"/>	
<b>Coding:</b>	
<b>Director Signature:</b>	<b>Date:</b>



**Stinson, Emma M**

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**From:** Cardwell, David  
**Sent:** 16 March 2021 10:27  
**To:** Stinson, Emma M; Kingsnorth, Patricia; McClements, Melanie  
**Cc:** Farrell, Roisin  
**Subject:** RE: letters to families  
**Attachments:** Cover letter for draft SAI report <sup>Patient 7</sup> amended 160321.doc; Cover letter for draft SAI report <sup>Patient 2</sup> amended 160321.doc; Cover letter for draft SAI report <sup>Patient 4</sup> amended 160321.doc; Cover letter for draft SAI report <sup>Patient 75</sup> amended 160321.doc; Cover letter for draft SAI report <sup>Patient 6</sup> amended 160321.doc; Cover letter for draft SAI report <sup>Patient 3</sup> amended 160321.doc; Cover letter for draft SAI report <sup>Patient 9</sup> amended 160321.doc; Cover letter for sharing draft report amended 160321.doc

Dear Emma, please see attached the 9 letters for electronic signature.

Regards.

David.

---

**From:** Stinson, Emma M  
**Sent:** 16 March 2021 10:05  
**To:** Kingsnorth, Patricia; McClements, Melanie  
**Cc:** Farrell, Roisin; Cardwell, David  
**Subject:** RE: letters to families

Yes of course Patricia, I'll do that asap.

Many thanks  
Emma

*Emma Stinson*

**PA to Mrs Melanie McClements, Director of Acute Services  
SHSCT, Admin Floor, Craigavon Area Hospital**



**Direct Line:**

Personal Information redacted by USI



**EmmaM.Stinson**

Personal Information redacted by USI



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<p>Wash your hands regularly</p>	<p>Keep your distance 2m</p>	<p>Wear a face covering</p>	<p>Download the app StopCOVID NI</p>
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**From:** Kingsnorth, Patricia  
**Sent:** 16 March 2021 10:04  
**To:** Stinson, Emma M; McClements, Melanie  
**Cc:** Farrell, Roisin; Cardwell, David  
**Subject:** letters to families

David Cardwell


**SHSCT GOVERNANCE TEAM (IR2) Form - NEW June 2018.**
**Incident Details  
ID & Status**
Incident Reference ID Personal Information

Submitted time (hh:mm) 20:25

**Incident IR1 details**
Notification email ID number Personal Information

Incident date (dd/MM/yyyy) 20/11/2014

Time (hh:mm) 17:00

Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)

Does this incident involve a Staff Member?

Description  
Enter facts, not opinions. Do not enter names of people

Patient discussed at Urology MDM on 20th November 2014. Recorded outcome Patient 102's Re-staging MRI scan has shown organ confined prostate cancer for direct referral to Dr H for Radical Radiotherapy. For OP Review with Mr O'B.' Was reviewed by Mr O'B in OP on 28th November 2014. No correspondence created from this appointment. Referral letter from GP received 16th October 2015 stating that Patient 102 had not received any appointments from oncology.

Connie Connolly 18/11/2015 14:31:09 PATIENT DISCUSSED AT UROLOGY M

Action taken  
Enter action taken at the time of the incident

Patient 102 has now been referred to Oncology. This has been done by email and letter. Investigation with MDM team, direct referral was generated at CAH but no record of being received in Belfast.

Learning Initial

Reported (dd/MM/yyyy) 21/10/2015

Reporter's full name Mark Haynes

Reporter's SHSCT Email Address

Opened date (dd/MM/yyyy) 18/11/2015

Were restrictive practices used?

Does this incident involve a safeguarding concern which is alleged/confirmed?

Has safeguarding been considered?

Has an APP1 been completed?

Last updated Andrew Noble 01/31/2023 13:50:39

Andrew Noble 31/01/2023 13:50:39 David Cardwell 06/17/2016 09:17:40

Name Patient 102

This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.

**Location of Incident**

with staff / update care plan / review risk assessment (corrective and preventative action)

Connie Connolly 18/11/2015 <no value>  
14:30:36

**Action Plan Required?**  
A formal action plan is required for all Moderate to Catstrophic incidents. If you tick yes an "Action plan" section will appear below. Use this to create your action plan.

**Action Plan**

**No actions**

**Lessons learned**

**Lessons learned**  
If you think there are any lessons from an incident which could be shared with other teams please record here. If not please type "none".

Date investigation completed (dd/MM/yyyy)

Was any person involved in the incident? No

Was any equipment involved in the incident? No

**Notepad**

**Notes**  
Use this section to record any efforts you have made as part of your investigation e.g. phonecalls / requested patient / client's chart / awaiting staff to return from sick leave. This will inform Governance staff who will be monitoring timescales for the completion of investigations etc, and reduce the amount of phone calls/emails to you requesting same information

**Communication**

**Recipients**

**Message**

Message history				
Date/Time	Sender	Recipient	Body of Message	Attachments
22/03/2016 12:08:10	Kerr, Vivienne	martina.corri gan <small>Personal Information redacted by the USI</small>	This is a feedback message from Vivienne Kerr. Incident form reference is <small>Personal Information redacted by the USI</small> . The feedback is: Please see Datix which is now coded under urology. Please go to <a href="http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=">http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=</a> <small>Personal Information redacted by the USI</small> to view the incident	
11/12/2015 14:55:26	Cardwell, David	martina.corri gan <small>Personal Information redacted by the USI</small>	This is a feedback message from David Cardwell. Incident form reference is <small>Personal Information redacted by the USI</small> . The feedback is: Hi Martina, Helen Forde has asked me to send this to you with the following message: <small>Personal Information redacted by the USI</small> – I think it should go to Martina Corrigan as it say	

if the incident is NIAIC reportable;

- design or manufacturing problems
- inadequate servicing and maintenance
- inappropriate local modifications
- unsuitable storage and use conditions
- selection of the incorrect device for the purpose
- inappropriate management procedures
- poor user instructions or training (which may result in incorrect user practice)

## Investigation

Investigator	Andrea Cunningham
Connie Connolly 18/11/2015 14:30:36	<no value>
David Cardwell 26/11/2015 16:24:31	Andrea Cunningham, Connie Connolly
Date started (dd/MM/yyyy)	18/11/2015
Connie Connolly 18/11/2015 14:30:36	<no value>
Actual Impact/Harm This has been populated by the reporter. To be quality assured by the investigating manager.	Major

Risk grading  
Click [here](#)

When the incident has a Severity (actual impact/harm, grading of insignificant to moderate, you need to plot on the matrix opposite the Potential impact/harm. Deciding what are the chances of the incident happening again under similar circumstances. (Likelihood) and multiply that by the potential impact if it were to reoccur (consequence) The overall risk grading for the event will be determined by plotting: consequence multiplied by likelihood = risk grading. Refer to impact table here:

	Consequence				
Likelihood of recurrence	Insignificant	Minor	Moderate	Major	Catastrophic
<b>Almost certain (Expected to occur daily)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Likely (Expected to occur weekly)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Possible (Expected to occur monthly)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Unlikely (Expected to occur annually)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Rare (NOT expected to occur for years)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<b>Grade:</b> <input style="width: 150px;" type="text"/>				

Action taken on review  
Enter here any actions you have taken as a result of the incident occurring; e.g. communicating

181115cc- preliminary review by FSS established that there was no dictation done on this patient. Incident returned to SEC and will be escalated to HOS and AMD

			s there was no correspondence for the appointment – so it wasn't that the secretary didn't type it – I think it was that it wasn't dictated so that would need to go to Head of Service for urology to discuss with consultant. Regards David Cardwell Please go to <a href="http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]">http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]</a> to view the incident
18/11/2015 14:29:44	Connolly, Connie	Carroll, Anita	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Martina- i have taken this back to SEC as it appears no dictation was done. Will need review by yourself and governance will support if needed. Connie Please go to <a href="http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]">http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]</a> to view the incident
18/11/2015 14:29:44	Connolly, Connie	Mark.Haynes [redacted]	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Martina- i have taken this back to SEC as it appears no dictation was done. Will need review by yourself and governance will support if needed. Connie Please go to <a href="http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]">http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]</a> to view the incident
18/11/2015 14:29:43	Connolly, Connie	Corrigan, Martina	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Martina- i have taken this back to SEC as it appears no dictation was done. Will need review by yourself and governance will support if needed. Connie Please go to <a href="http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]">http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]</a> to view the incident
18/11/2015 14:29:43	Connolly, Connie	Robinson, Katherine	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Martina- i have taken this back to SEC as it appears no dictation was done. Will need review by yourself and governance will support if needed. Connie Please go to <a href="http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]">http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]</a> to view the incident
18/11/2015 11:41:44	Connolly, Connie	Mark.Haynes [redacted]	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasn't sure so i gave access to all. Moved to review Connie Please go to <a href="http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]">http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]</a> to view the incident
18/11/2015 11:41:43	Connolly, Connie	Robinson, Katherine	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasn't sure so i gave access to all. Moved to review Connie Please go to <a href="http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]">http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]</a> to view the incident
18/11/2015 11:41:43	Connolly, Connie	Forde, Helen	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasn't sure so i gave access to all. Moved to review Connie Please go to <a href="http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]">http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]</a> to view the incident
18/11/2015 11:41:42	Connolly, Connie	Carroll, Anita	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasn't sure so i gave access to all. Moved to review Connie Please go to <a href="http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]">http://vsrdatixweb/Datix/Development/index.php?action=incident&amp;recordid=[redacted]</a> to view the incident

**Medication details**

Stage

incident has been escalated to them.

Date of final approval (closed date) (dd/MM/yyyy) 17/06/2016

David Cardwell 17/06/2016 09:17:40 <no value>

Incident Grade

Date Notification Sent to External Agency

Date Terms of Reference Due

Date SAI Report Due

SAI Level (1,2 or 3)

External Agency SAI Ref No.

Date SAI Report Sent to External Agency

Date SAI Report Shared with Family/NOK

Date HSCB/RQIA/Coroner Queries Received

## Reasons for Rejection - History

No records to display.

## Linked records

No Linked Records.

## Coding

### Datix Common Classification System (CCS)

Category Access, Appointment, Admission, Transfer, Discharge

Andrew Noble 31/01/2023 13:50:39 <no value>

Sub Category Transfer

Andrew Noble 31/01/2023 13:50:39 <no value>

Detail Transfer - delay/failure

Andrew Noble 31/01/2023 13:50:39 <no value>

### Datix CCS2

Type Patient Incidents

Andrew Noble 31/01/2023 13:50:39 <no value>

Category Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)

Andrew Noble 31/01/2023 13:50:39 <no value>

Sub-Category Monitoring/On-going Assessment of Patient Status

Andrew Noble 31/01/2023 13:50:39 <no value>

**Issue two**

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

**Action**

**Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10<sup>th</sup> January 2017**

**Lead: Ronan Carroll**

**Issue three**

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

**Action**

**A written action plan to address this issue, with a clear timeline will be submitted to the Oversight Committee on 10<sup>th</sup> January 2017**

**Lead: Ronan Carroll/Colin Weir**

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

**Action: Tracey Boyce**

**Consideration of the Oversight Committee**

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

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

**Action: Dr Wright/Simon Gibson**

The following was agreed:

Case Investigator – Colin Weir

Case Manager – Ahmed Khan

Cardwell, David

**From:** Cardwell, David  
**Sent:** 11 May 2016 11:31  
**To:** Corrigan, Martina  
**Cc:** Carroll, Ronan  
**Subject:** RE: [Redacted] Patient 110

*Fite + Close.*

*9-8-16.*

**Importance:** High

Hi Martina, can you please update me in relation to [Redacted] Patient 110

Kind Regards

David Cardwell



Clinical and Social Care Governance Team | Directorate of Acute Services  
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ  
Tel: [Redacted] | Email: [Redacted]

**From:** Cardwell, David  
**Sent:** 04 April 2016 15:52  
**To:** Corrigan, Martina  
**Subject:** RE: [Redacted] Patient 110

Hi Martina, I haven't heard anything back from the family but I suppose for completeness sake we do need to provide a response.

Regards

David.

**From:** Corrigan, Martina  
**Sent:** 25 March 2016 16:45  
**To:** Cardwell, David  
**Cc:** Farrell, Roisin  
**Subject:** RE: [Redacted] Patient 110

Believe it or not David I think Mr O'Brien and I must have put this back into your head ☺ as we had a conversation about this patient on Wednesday! Mr O'Brien has the chart in his office and he had said to me what should we do about it? We left that we would discuss again after Easter. Just wondering if the family ever came back to us??

Thanks

Martina

Martina Corrigan  
Head of ENT, Urology and Outpatients



Southern Health and Social Care Trust  
Craigavon Area Hospital

Telephone: [Personal Information redacted by USI]

Mobile: [Personal Information redacted by the USI]

Email: [Personal Information redacted by the USI]

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**From:** Cardwell, David  
**Sent:** 25 March 2016 10:45  
**To:** Corrigan, Martina  
**Cc:** Farrell, Roisin  
**Subject:** [Patient 110]

Hi Martina, what will we do about [Patient 110]?

As you know we met them in February 2015 and there were issues that needed to be followed up with Mr O'Brien has not yet provided a response to. I think we stopped reminding you around Christmas but we really need to draw this matter to a close.

Can I have your thoughts please.

Kind Regards

*David Cardwell*



Clinical and Social Care Governance Team | Directorate of Acute Services  
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ  
Tel: [Personal Information redacted by the USI] | Email: [Personal Information redacted by the USI]

**Cardwell, David**

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**From:** Cardwell, David  
**Sent:** 17 January 2019 14:17  
**To:** Carroll, Ronan; Corrigan, Martina Personal Information redacted by the USI  
**Cc:** Gurbanova, Esmira  
**Subject:** Patient 110 Complaint  
**Importance:** High

Dear Ronan and Martina, I would appreciate your assistance in moving this complaint forward.

At this time we are waiting on Mr O'Brien reviewing the notes again before we arrange the meeting with the family.

This complaint has been ongoing now for over 4 years and we need to make all necessary efforts to expedite its closure as soon as possible.

If we are unable to meet the family I believe it would be better to write to them and explain the reason why rather than keeping them lingering. If the matter progresses to the Ombudsman I can imagine any report produced would not make good reading.

Thanking you in anticipation of your response.

Kind Regards

*David Cardwell*



Senior Governance Officer | Acute Services Clinical and Social Care Governance Team |  
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |  
Tel: Personal Information redacted by the USI | Email: Personal Information redacted by the USI

Personal Information  
redacted by USI

19<sup>th</sup> September 2016

Corporate Complaints Officer  
Trust Headquarters  
Craigavon Area Hospital  
68 Lurgan Road  
Portadown  
BT63 5QQ

Dear Sir/Madam,

Patient 84

DOB: Personal Information  
redacted by USI

H&C No.: Personal Information redacted by  
USI

I am writing to make an official complaint about the neglect towards myself resulting in my total dissatisfaction on how I have been treated over the past few months.

To give you the background into my situation, I was phoned by a consultant (Mr Puyson I believe) on Friday 25<sup>th</sup> March 2016 (Good Friday) to say that I had a blockage in my ureter, noticed on a recent CT scan, and that it would be best that I come into hospital as soon as possible to get surgery. I was informed that the Easter weekend would be a good time as there was some capacity to do the surgery as I was on an emergency list. I was obviously a bit alarmed and was in the middle of packing for the Easter weekend away. Of course, I realised the seriousness of my condition so I cancelled my plans and the consultant and I agreed that I would receive a telephone call on the Saturday morning to confirm bed availability. I didn't receive this call and then had to do some chasing myself. The staff currently on weren't aware of the plans for surgery. I eventually got confirmation on Easter Sunday morning to come to hospital for the surgery planned on Monday but when I arrived the staff were surprised as I shouldn't have needed to stay pre-operatively and therefore could have just come to hospital on Monday morning. This is just to highlight the severe lack of communication from the start and the fact that my weekend plans were cancelled unnecessarily. However, in saying all that, what followed is the real reason for this letter.

After the surgery by Mr O'Brien, I was told that the blockage had been removed (although the stone escaped back up to the kidney) and that I did have a lot of stones in both kidneys and a stent was placed in the right ureter. I understood the logic for a stent and I was informed that it will be uncomfortable at first and that I may feel the urgency to pass urine a bit more frequently as the stent protrudes inside the bladder slightly. I was informed that the stent should be removed in 6 weeks' time. I felt that this was fine and that this would be good timing for my pre-booked holiday at the end of May.

Unfortunately, from the beginning I had persistent pain with the stent at the tip of my penis particularly when passing urine, and I was passing fresh red blood post exercise and had severe urgency and severe frequency. This clearly had a major impact on my life both at home and in work. I was on regular Ibuprofen and Paracetamol to alleviate the pain but the pain was not being controlled. I was worried about my severe signs and symptoms so I contacted Mr O'Brien's secretary and asked could I speak to him or a member of his team for some medical advice and to discuss the symptoms I was

20<sup>th</sup> September 2016**Our Ref:** AS206.16/17**Your Ref:****Private & Confidential**

Patient 84

Personal Information  
redacted by the USI

Dear Patient 84

I refer to your complaint in respect of the quality of care and lack of communication you faced when attending Craigavon Area Hospital. Thank you for taking the time to highlight your concerns.

The Trust will investigate the issues which you have raised, in accordance with the Trust's Policy and Procedure on the Management of Complaints. It would be our intention to advise you of the findings of the investigation within 20 working days or as soon as possible thereafter. In the meantime, I enclose for your attention a copy of our "What Happens Next" leaflet.

If for whatever reason we are unable to provide you with a response within the timeframe above, a member of our team will contact you again to keep you fully advised.

Should at any point you wish to discuss your complaint, please do not hesitate to contact us on Personal Information redacted by the USI. Alternatively you may wish to seek independent support and/or advice by contacting the Patient Client Council on 0800 9170222.

Yours sincerely

**DAVID CARDWELL**  
**Clinical and Social Care Governance Officer**

enc



1 December 2016      **Our Ref:**    AS206.16/17

**Private & Confidential**

Patient 84

Personal Information  
redacted by the USI

Dear Patient 84

I refer to your complaint in respect of the care provided to you by the Urology Department at Craigavon Area Hospital. Thank you for taking the time to highlight your concerns and for providing me with the opportunity to address them.

Firstly may I begin by apologising for the delay in responding to your letter. As part of the investigation into your concerns I have spoken to Mr O'Brien Consultant Urologist, about your complaint.

Mr O'Brien advises me that you had haematuria assessed in 2002 and 2003 at which times you were found to have renal calculi associated with a left hydronephrosis. In September 2015, the radiology department received a referral from your GP requesting a plain radiograph of your urinary tract; this xray was performed on 25 September 2015 and reported on 17 November 2015. The reporting radiologist suggested that most likely you had bilateral renal calculi with a probable right upper ureteric calculus. On 29<sup>th</sup> January 2016 your GP made a referral to the Urology Department for further management.

On receipt of this referral, Mr Glackin triaged the letter and then wrote to you on 2<sup>nd</sup> February 2016 advising that he had requested a CT scan of your urinary tract to assess for stones and that you would be sent an appointment to attend as an outpatient to the stone clinic. On the 4 March 2016 you were seen by Mr Young Consultant Urologist. You had an xray done during this appointment and whilst the bilateral renal calculi were evident on this xray, the right ureteric calculus was not. So when you had your CT scan on 22 March 2016 it was reported that you had a gross right hydronephrotic kidney and hydroureter. It was from this report that Mr O'Brien deemed that you needed to be admitted to have a ureteroscopy performed as an emergency.

Mr O'Brien asked for his Registrar, Mr Tyson to contact you and ask that you come in for admission on the Sunday. Mr O'Brien then emailed the Ward to give them your details and advise them that you would be admitted on the Sunday for your procedure on Monday. I would like to apologise for the misunderstanding when you arrived on the Ward as Mr O'Brien's email hadn't been picked up on this occasion and therefore the ward were not expecting you. As learning from this I have asked that Mr O'Brien and his Registrars follow up with a phone call to the Ward and also that the ward ensures that they check their emails at least a few times daily.

I am advised that on Monday 28 March 2016 you had a right ureteric stenting performed following an ureteroscopy and migration of the obstructing stone into the hydronephrotic right kidney.

Mr O'Brien confirms that ideally patients who have a stent inserted should have this removed and have an ureteroscopic lithotripsy performed four to six weeks later. However, the demand on the Urology Service is unrelenting with an increased number of patients with suspected and confirmed cancer diagnoses requiring progression along their cancer pathway. The result of cancer urgent demand is that the waiting times for other procedures such as yours are increasing on a monthly basis. For this wait we would like to apologise and whilst not ideal nor what we want for you or any of our patients it is something that is currently outside of our control.

I note from your complaint that you have contacted Mr O'Brien's secretary on a number of occasions. Mr O'Brien confirms this and advises me that an email was sent to him via his secretary advising that you had a Personal Information redacted by the USI and that you were enquiring whether you could have surgery performed before then. Unfortunately as explained in the previous paragraph with the clinical prioritisation of patients, Mr O'Brien unfortunately could not accommodate your request. At the time of your request Mr O'Brien had 232 patients awaiting inpatient admission of which 136 of them were categorised as urgent. Mr O'Brien apologises that you had to contact him on a number of occasions but with his clinical commitments and the number of patient enquiries that he receives daily it is not possible for him to respond to them all individually, but advises that you did the correct thing by going to your own GP for advice.

I understand that you had two emergency admissions to 3 South in August 2016 under the care of Mr O'Donoghue and Mr Glackin who were the Urologists oncall during these admissions. I would like to apologise that you had to fast unnecessarily whilst you were in the first time but I have been advised that this was a precaution in case you were well enough to go to theatre and there was a slot available on the Tuesday and I am sorry that this wasn't communicated properly with you at the time.

The Urology Department are currently working at improving the pathway for patients experiencing similar symptoms such as yours. This will involve having a 7 day week stone service with detailed information leaflets for patients with more access to health care professionals if advice is needed. It is hoped through the development of this service it will mean that patients will have their treatment and follow-up done in a timelier manner and hopefully avoid the poor experience that you had endured.

On behalf of the Urology Service I would like to apologise again for your poor experience and I am advised that you have a follow-up outpatient appointment with Mr Glackin on 20 December 2016 and I hope that your health issues have improved.

I hope that you will find this response has addressed the issues that you raised. However, if you are unhappy with any aspect of this response you should contact a member of our Clinical & Social Care Governance Team on Personal Information redacted by the USI or email: [AcutePatient.ClientLiaison@southerntrust.hscni.net](mailto:AcutePatient.ClientLiaison@southerntrust.hscni.net) within 3 months of the date on this letter so that we can attempt to resolve any outstanding issues.

1 that was for me a huge bonus just, you know, the  
 2 quality of life and all that after that and stuff, just  
 3 to be able to get on with things. So after that, that  
 4 will take its due course or whatever.

5 28 Q. You did get then the response on the 1st or dated the 10:24  
 6 1st of December. You weren't happy with that?

7 A. No. It was, I just sort of felt, they focussed on the  
 8 wee smaller parts and really didn't really deal with  
 9 the main issue of the communication and the plan and  
 10 stuff. 10:24

11

12 They sort of focussed on wee things that I did, in  
 13 fairness mention in the letter about admission times  
 14 and communication and that kind of stuff, but for me  
 15 that's fine, that's not the end of the world you know 10:24  
 16 like. Things get misplaced and whatever like. But it  
 17 was the over, yeah, they just didn't address the main  
 18 concerns.

19

20 Obviously then they brought in the cancer patient stuff 10:24  
 21 and, you know, while obviously I have sympathy with  
 22 them, life-threatening conditions and things, but that  
 23 wasn't, I suppose you shouldn't be made feel guilty.  
 24 All the more reason for me to, get me dealt with and  
 25 then you can focus your time and efforts and energy on 10:25  
 26 those people that need it and stuff like. But yeah, it  
 27 just seemed a bit of a sort of a weak argument.

28 29 Q. Can I just check, you say that once the stent was  
 29 removed that your quality of life improved. Can I just

**DIRECTORATE OF ACUTE SERVICES**  
**Weekly Report on Formal Complaints - 18 October 2016**

Ref	Record name	Div	Loc (Exact)	Date Received	Investigation due	Reply due	Current Stage	Handler
AS120.16/17	Personal Information redacted by the USI	SEC	Theatre	20/07/2016	03/08/2016	17/08/2016	Returned to Amie Nelson for further investigation 17.10.16.	DC
AS139.16/17		MUC	Male Medical	09/08/2016	23/08/2016	06/09/2016	Returned to Kay Carroll for further investigation 18.10.16.	DC
AS143.16/17		MUC	Emergency Department	10/08/2016	24/08/2016	08/09/2016	To Esther Gishkori for signature 18.10.16.	DC
AS166.16/17		MUC	Emergency Department	23/08/2016	07/09/2016	21/09/2016	Returned to Mary Burke for further investigation 01.10.16.	DC
AS158.16/17		IMWH	Admissions/Assessment Unit	24/08/2016	08/09/2016	22/09/2016	Awaiting response from Sr J O'Hagan	VK
AS161.16/17		CCS	Audiology Clinic	24/08/2016	08/09/2016	22/09/2016	To Heather Trouton for approval 27.09.16	VK
AS167.16/17		IMWH	1 West Gynae	24/08/2016	08/09/2016	22/09/2016	To Heather Trouton for approval 17.10.16	VK
AS169.16/17		MUC	2 South Stroke	26/08/2016	12/09/2016	26/09/2016	Response being drafted.	DC
AS176.16/17		SEC	Ophthalmology Clinic	01/09/2016	15/09/2016	29/09/2016	Awaiting response from Belfast Trust.	DC
AS188.16/17		SEC	Orthopaedic Clinic	03/09/2016	15/09/2016	29/09/2016	Awaiting response from Brigeen Kelly.	DC
AS179.16/17		MUC	MAU	05/09/2016	19/09/2016	03/10/2016	Response being drafted.	DC
AS183.16/17		SEC	4 North	07/09/2016	21/09/2016	05/10/2016	To Esther Gishkori for signature 17.10.16.	DC
AS189.16/17		SEC	3 South	08/09/2016	22/09/2016	06/10/2016	Awaiting response from Martina Corrigan.	DC
AS191.16/17		MUC	General Male Medical, Level 5	12/09/2016	26/09/2016	10/10/2016	Awaiting response from Sr Rooney.	DC
AS192.16/17		SEC	Theatre	13/09/2016	27/09/2016	11/10/2016	Awaiting response from Dr Maguire, Dr Mathers and Dr Kadhim	VK
AS193.16/17		MUC	Dermatology Clinic	14/09/2016	28/09/2016	12/10/2016	To Anne McVey for approval 11.10.16.	DC
AS198.16/17		MUC	1 South Medical	16/09/2016	30/09/2016	14/10/2016	To Esther Gishkori for signature 14.10.16.	DC
AS205.16/17		SEC	4 South	20/09/2016	04/10/2016	18/10/2016	Awaiting response from Mr Lewis, Sr McGuigan and Amie Nelson.	DC
AS206.16/17		SEC	3 South	20/09/2016	04/10/2016	18/10/2016	Awaiting response from Mr O'Brien, Martina Corrigan and K Robinson.	DC
AS207.16/17		SEC	Pain Management Clinic	20/09/2016	04/10/2016	18/10/2016	Awaiting response from Mary McGeough, Dr McConaghy and W Clayton.	DC
AS212.16/17		CCS	X-ray	21/09/2016	05/10/2016	19/10/2016	Awaiting response from J Robinson.	VK
AS214.16/17		SEC	3 South	27/09/2016	12/10/2016	26/10/2016	Awaiting response from Martina Corrigan and Cherith Douglas	DC
AS215.16/17		SEC	Trauma Ward	29/09/2016	13/10/2016	27/10/2016	Awaiting response from Brigeen Kelly	DC
AS216.16/17		MUC	Minor Injuries Unit	29/09/2016	13/10/2016	27/10/2016	To Esther Gishkori for signature 18.10.16.	DC
AS217.16/17		IMWH	EPPC	29/09/2016	13/10/2016	27/10/2016	Awaiting response from David Sim and Joanne McGlade	VK
AS218.16/17		CCS	Prosthetics	30/09/2016	14/10/2016	28/10/2016	Awaiting further details from patient	VK
AS219.16/17		SEC	4 North	30/09/2016	14/10/2016	28/10/2016	Awaiting response from Mr Yousaf and Amie Nelson	DC
AS220.16/17		MUC	Emergency Department	30/09/2016	14/10/2016	28/10/2016	Awaiting response from Mr McCann, G Hampton, P Sheridan, S Rooney	DC
AS221.16/17		FSS	Booking Centre	04/10/2016	18/10/2016	01/11/2016	To Anita Carroll for approval 17.10.16.	VK
AS222.16/17		MUC	1 North Cardiology	05/10/2016	19/10/2016	02/11/2016	Under investigation.	DC
AS223.16/17	MUC	Emergency Department	06/10/2016	21/10/2016	04/11/2016	Under investigation.	DC	
AS224.16/17	SEC	3 South	06/10/2016	20/10/2016	03/11/2016	Under investigation.	DC	
AS225.16/17	FSS	Silverwood Ward	06/10/2016	20/10/2016	03/11/2016	Under investigation.	VK	
AS226.16/17	CCS	Day Procedure/Day Surgery Unit	10/10/2016	24/10/2016	07/11/2016	Under investigation.	VK	
AS227.16/17	CCS	X-ray Dept (Radiology)	10/10/2016	24/10/2016	07/11/2016	Under investigation.	VK	
AS229.16/17	SEC		10/10/2016	24/10/2016	07/11/2016	To Esther Gishkori for signature 14.10.16.	DC	
AS231.16/17	FSS	Car Park	11/10/2016	25/10/2016	08/11/2016	To Esther Gishkori for signature 14.10.16.	VK	
AS228.16/17	MUC	Winter Pressures Ward(Ramone)	12/10/2016	26/10/2016	09/11/2016	Under investigation.	DC	
AS230.16/17	FSS	Booking Centre	12/10/2016	26/10/2016	09/11/2016	To Anita Carroll for approval 17.10.16.	VK	



## DIRECTORATE OF ACUTE SERVICES

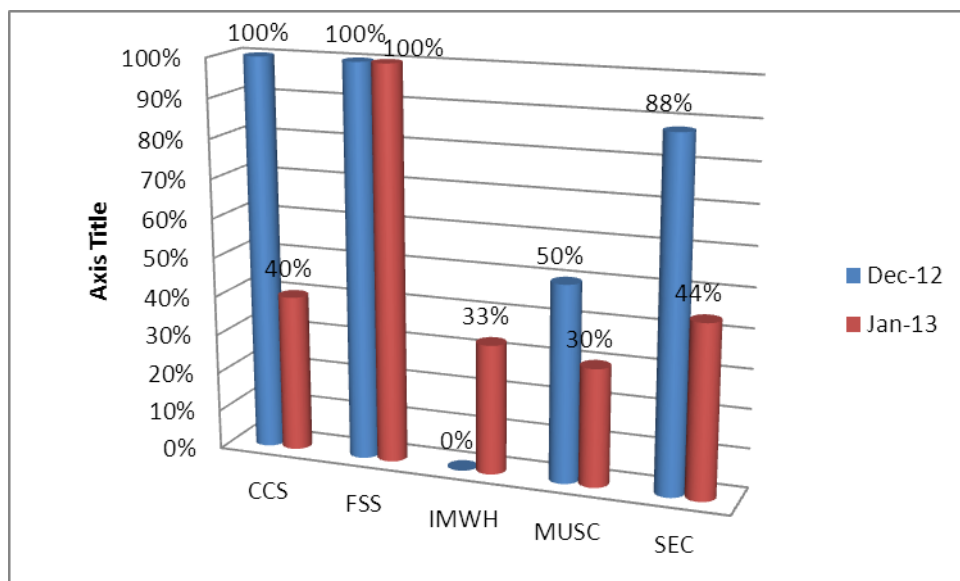
### Statistical Report on Complaints – January 2013

#### Purpose of Report

The purpose of this report is to inform senior staff within the Directorate about the complaints activity within the Directorate in January 2013. A summary for each formal complaint is attached.

#### Summary

- 44 formal complaints were received, which was an increase of 17 from the previous month. These have been generated by 30 complainants.
- In addition 18 complaints/enquiries were dealt with at the point of service delivery and have been resolved.
- 100% of formal complaints have been acknowledged within 2 working days
- 32% of formal complaints were responded to within 20 working days compared to 55% in the previous month and 79% in January 2012. The graph below shows the individual divisional response rate for the past two months.



- 115 compliments have been noted for the month compared to 709 for the previous month.

- The top 5 subjects for complaint in January 2013 are noted below.

<b>Top 5 Subjects of Complaint</b>	<b>2012</b>	<b>2013</b>
Treatment and care quality	9	9
Communication/Information to Patients	4	9
Discharge/Transfer arrangements	1	5
Professional Assessment of need	2	4
Staff Attitude/Behaviour	4	4

- The top 5 wards/departments which have received complaints in January 2013 are:

<b>Top 5 Ward/Departments</b>	<b>2012</b>	<b>2013</b>
ED CAH	7	9
1 North CAH	0	3
Day Surgery Unit DHH	0	3
4 North CAH	1	2
4 South CAH	0	2

- The top 3 professions which have been complained about in January 2013 are:

<b>Top Profession</b>	<b>2012</b>	<b>2013</b>
Medical and Dental	14	19
Non staff	11	13
Nursing and Midwifery	7	12

**THE HEALTH AND PERSONAL SOCIAL SERVICES  
(SPECIAL AGENCIES) (NORTHERN IRELAND) ORDER  
1990**

**THE HEALTH AND PERSONAL SOCIAL SERVICES  
(NORTHERN IRELAND) ORDER 1991**

**THE HEALTH AND SOCIAL CARE (REFORM) ACT (NORTHERN  
IRELAND) 2009**

**The Health and Social Care Complaints Procedure Directions  
(Northern Ireland) 2009**

The Department of Health, Social Services and Public Safety, in exercise of the powers conferred by Section 8 (1) (b) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 (a), Article 10 of, and paragraph 6 of Schedule 3 to, the Health and Personal Social Services (Northern Ireland) Order 1991 (b) and Article 4 of the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 (c), hereby direct as follows:

**ARRANGEMENT OF DIRECTIONS**

**PART I**

**CITATION, COMMENCEMENT, INTERPRETATION AND APPLICATION**

1. Citation and commencement
2. Interpretation
3. Application of Directions

**PART II**

**HANDLING AND CONSIDERATION OF COMPLAINTS BY HSC BODIES**

4. Requirements to make arrangements
5. General Duty to Co-operate
6. Responsibility for arrangements and complaints manager
7. No investigation of complaint

**PART III**

**THE INITIAL COMPLAINT**

8. Requirement to deal with the complaint
9. Person who may make a complaint

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(a) 2009 c.1 (N.I.)  
(b) S.I. 1991/194 (N.I.1)  
(c) S.I. 1990/247 (N.I.3)

**Response**

14.—(1) The complaints manager must ensure a written response is prepared to the complaint which summarises the nature and substance of the complaint, describes the investigation and summarises its conclusions.

(2) The response must be signed off by the Chief Executive of the relevant HSC body. A copy shall be provided to the complainant and any person subject to complaint.

(3) The Chief Executive of the relevant HSC body can delegate responsibility for responding to a complaint, where in the interests of a prompt reply a designated executive director of the relevant HSC body undertakes this task on the Chief Executive's behalf.

(4) The response must be sent to the complainant within 20 working days beginning on the date on which the complaint was made or, where that is not possible, the complainant must be notified of the delay and the full response issued as soon as reasonably practicable.

(5) The response must notify the complainant of his right to refer the complaint to the NI Commissioner for Complaints should he remain dissatisfied with the outcome of the HSC complaints procedure.

(6) Copies of the response mentioned in sub-paragraph (1) must be sent to any other person to whom the complaint was sent under paragraph 12(3).

(7) Responses should not be made electronically.

**PART IV****MONITORING AND PUBLICITY****Monitoring**

15.—(1) For the purposes of—

- (a) monitoring the arrangements made for the handling and consideration of complaints;
- (b) considering the nature, volume and outcome of complaints;
- (c) taking remedial action following investigation of complaints; and
- (d) organisational learning,

the relevant HSC body shall prepare reports at quarterly intervals for consideration by its board.

(2) The reports mentioned in sub-paragraph (1) must—

- (a) specify the number of complaints received;
- (b) identify the subject matter of those complaints;
- (c) summarise how they were handled including the outcome of the investigations;
- (d) specify the number of complaints that have been referred to the NI Commissioner for Complaints; and
- (e) identify any complaints where the recommendations of the NI Commissioner for Complaints were not acted upon, giving the reason why.

(3) For the purposes of ensuring the efficient use of resources HSC bodies will monitor the effectiveness and usage of independent experts, conciliation and lay person assistance.

(4) HSC trusts must provide the HSC Board with such information relating to complaints as the HSC Board reasonably requests for the purposes of monitoring and performance management, and only to the extent that it is not in contravention of the Data Protection Act 1998.