Note: Two addendums to this statement were received by the Inquiry on 17 Oct 2023 and they can be found at WIT-103270 to WIT-103272. Annotated by the Urology Services Inquiry.

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No. 61 of 2022

Date of Notice: 7th June 2022

Witness Statement of: Kothandaraman Suresh

I, Kothandaraman Suresh, will say as follows:-

General

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

1.1 Formally, I came to know about this inquiry on 9th June 2022 by email from the DLS.

1.2 I worked as a consultant urologist in Craigavon Area Hospital from 11/12/2013 until 9/10/2016. The duties and responsibilities were as in my job description, a copy of which has been emailed separately. **This can be located at S21 61 of 2022 Attachments, 1. 73813043 CONSULTANT UROLOGIST SURGEON - CAH - UPDATED 11 MARCH 13.**

1.3 Apart from this notice, I did not receive any notification. No issue was raised with me about me or anybody else during my tenure or afterwards.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

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

Signed: __  **_____**

Date: __ 1/9/2022_____

Received from Kothandaraman Suresh on 02/09/22. Annotated by Urology Services Inquiry

UROLOGY SERVICES INQUIRY
USI Ref: Section 21 Notice No. 61 of 2022
Date of Notice: 7th June 2022

Second Witness Statement of: Kothandaraman Suresh

Addendum and Corrections

I, Kothandaraman Suresh, will say as follows:-

1. This is my second statement to the Inquiry and is by way of clarification and amendment to my earlier statement dated 1st September 2022.
2. On page 24 of the bundle with the reference WIT- 50334 where I refer to "MBBS – December 1990" the date should read December 1991
3. At WIT-50339 (page29) where it reads: "8.1 In my view, the roles and responsibilities of those who had governance responsibilities are" I would ask that it now reads " *8.1 In my view, the roles and responsibilities of those who had operational and governance responsibilities are"*
4. At WIT-50360 (page 50) it says (v) the Associate Medical Director; 47.5 To have my job plan approved. The interactions were through emails. I had no issues. I would wish to add:

   "After an incident in Autumn 2015, during my on- call day, when a patient had to undergo an emergency nephrectomy, for which I had to seek help from another senior consultant- Mr O'Brien, there was a meeting with Mr Mackle and Ms Corrigan. During the meeting, I raised my apprehension about open major urological operations. It was recognised that my main scope of work was endo-urology. I was assured that support would be available from another senior consultant whom I could contact if needed. I was also encouraged to attend other theatres and relevant course to build up my confidence. I fully engaged with what were discussed in the meeting. After that incident, I was accompanied by another consultant during the ward rounds on ad-hoc basis and to my knowledge, they were satisfied with my approach and no concern was raised."

5. At WIT-50365 (Page 55) where it states 51.1. Personally, I did not feel any need for any extra support. But, to boost up my confidence in major open surgeries, when I asked for support, the support was provided by facilitating me to join theatres with other consultants and to attend a cadaveric course.

   I would like to amend this to say

   Should be : 51.1 *Personally, I did not feel any need for any extra support except for emergency major open urological operations. To boost up my confidence in major open surgeries, when I asked for support, the support was provided by facilitating me to join theatres with other consultants and to attend a cadaveric course. Also, I was assured support would be available, if needed, for major open urological operations.*

Statement of Truth

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

Signed. 

Dated. 16/10/23

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No. 61 of 2022

Date of Notice: 7th June 2022

Third Witness Statement of: Kothandaraman Suresh

I, Kothandaraman Suresh, will say as follows:-

1. This is the third statement made by me to the Inquiry. In it I want to provide further detail on an issue which arose during discussions with the Inquiry Counsel which are relevant to the issues before this Inquiry.

2. While in practice outside of Northern Ireland I became aware of a gentleman who was found to have localized intermediate risk prostate cancer in 2013.Gleason 7; rT2 Ca prostate.

3. In the local and regional MDT in the relevant hospital the case came up for discussion and for proposals as to how we should treat his condition. The consensus was to offer him curative treatment in the form of surgery or radiotherapy.

4. The various options were discussed with him and the patient opted for active surveillance. In 2015 he indicated that he wanted only hormonal therapy. He declined the various curative treatment options discussed with him. He was started on monotherapy with Bicalutamide 150 mg, by another consultant who was his treating consultant.

5. Sometime later the patient reduced the dose he was taking by himself to only 50 mg due to the side effects he was experiencing.

6. He was seen by a different consultant in 2016 who explained to him the treatment he was on was not a suggested treatment from any point of view and suggested either he could have proper treatment or active surveillance.

7. When I saw him first in 2017 the patient was taking tablet bicalutamide on intermittent basis- a few months on and a few months off. I explained to him that monotherapy with low dose bicalutamide (50mg) was not recommended by any guidelines and went through other recommended treatment options. He was not keen on any of the recommended treatments available nor for repeat prostate biopsy.

8. He was later seen by two other colleagues who also counselled him appropriately but he again indicated that he was not keen on any other treatments.

9. I did a telephone consultation with him in Feb 2021. As his liver function test was indicating derangements and as a result of this discussion he agreed to stop bicalutamide and agreed to attend for prostate biopsies.

10. However, within a few days he wrote to me saying that he did not wish to have biopsies. I discussed again in the Urology MDT meeting and wrote to him confirming the consensus from the meeting that he should not continue bicalutamide and a review would be set up in two months with PSA.

11. A month later, we received a letter from GP that the patient wanted cyberknife surgery, (not offered by NHS). I intended to see him within two weeks to discuss his request before making the referral. Unfortunately due to COVID his follow up appointment was delayed until May 2021.

12. After the telephone consultation in May 2021 I referred him to oncologist, my consultant colleague who has subspecialty interest in radiotherapy.

13. The patient made a complaint that his bicalutamide treatment was stopped and around the delay in his follow up appointment, which was beyond my control and was triggered by the Covid situation.

14. The case records were reviewed by my clinical lead. His report was supportive of my actions and he refuted all the allegations made by the patient.

15. No-one, neither I nor any other urologist, prescribed a low dose bicalutamide treatment. This patient made a decision, having been advised of alternative treatments, to stay on this monotherapy and elected to take a low dose because of side effects.

16. The patient made a complaint to the GMC and a formal investigation was conducted. The report obtained by the GMC from another expert also was all supportive of my actions. The case was closed with no action.

Statement of Truth

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

Signed. 

Dated. 17/10/2023

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

5.1 **Consultant in Urology** **11 Dec 2013 to 09 Oct 2016**
Craigavon Area Hospital, Craigavon

5.2 My duties and responsibilities as consultant involved conducting Urology clinics, endoscopy sessions and theatre sessions and ward rounds, constantly guiding and supervising trainees, administrative work directly related to the care of patients like reviewing the results and acting on them, triaging the referrals which was later upgraded to advanced triaging, attending Urology multi-disciplinary team meetings, engaging in Quality Improvement projects by involvement in audits (I did participate in a few audits but do not have the records of them), participation in clinical audit meetings, Morbidity & Mortality meetings.

5.3 Advanced triaging means while vetting the referral letters from the GPs or from another department, based on the need, requesting appropriate investigations like ultrasound or CT scan before seeing the patients in the clinic so that the results would be available when the patients were seen in the clinic. It also involved dictating letters to the patients and the GPs/ referrer about the investigations requested. The purpose of this is to speed up the process of assessing the patients.

5.4 My role as a consultant urologist was in accordance with the job description. The job description was an accurate reflection of my duties and responsibilities.

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,

staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

64.1 I do not think he was offered any extra support during my tenure when compared to other colleagues. I do not think anyone consultant received any extra support when compared to others.

65. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to, unless already provided. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

65.1 Not applicable.

Learning

66. Are you now aware of governance concerns arising out of the provision of Urology Services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

66.1 Yes. I now understand that there were issues with Mr O'Brien in triaging GP referrals. I was not aware of it during my tenure. Had the issue been noticed by anyone I feel it should have been highlighted straightaway, by reporting the incident online or by directly informing the clinical lead, the head of services and if needed to the medical director, as a matter of clinical governance.

67. Having had the opportunity to reflect, do you have an explanation as to what went wrong within Urology Services and why?

67.1 The triaging issue should have been picked up earlier on. I now understand that there were issues with Mr O'Brien in triaging GP referrals. I was not aware of it during my tenure. Had the issue been noticed by anyone I feel it should have been

Angela Kerr

From: Kothandaraman Suresh [redacted]
Sent: 13 March 2014 21:42
To: Corrigan, Martina
Cc: (Aidan [redacted] Glackin, Anthony; Young, Michael; O'Brien, Aidan; Suresh, Ram; Tony Glackin [redacted]
Subject: Re: Triage of Red Flags

Dear all,
I do go to the office every day, particularly while on call, esp to triage the referrals. But, I have been able to do this only after 5or6 p.m, ie after finishing my clinical commitments. I think, we may have to cut down our clinical activities during the on call week, so that we can clear the desk in a timely fashion and will be able to assess the emergency admissions.
Eager to see your views.
Regards
Ram

Sent from my iPad

Sent from my iPad

On 13 Mar 2014, at 18:33, "Corrigan, Martina" <[redacted] wrote:

> Dear all
>
> As you are aware I am currently looking at ways to shorten the time for the red flag patients getting to their first appointment and one of the delays in the system is the time it takes to get red flags letters triaged.
>
> We previously had a system that on the week that you were on call that a member of the red flag team will come to you on a daily basis and wait while you triage the letters, this will mean that there should be no delay in this first part of the pathway.
>
> If you were in agreement with this I could give the red-flag team your daily availability whilst you are oncall and this would hopefully shorten the first part of the process.
>
> Happy to discuss but I do think that this would be a good way forward and if in agreement I would really like to implement this as soon as possible?
>
> Many thanks in advance
>
> Martina
>
> Martina Corrigan
> Head of ENT, Urology and Outpatients
> Southern Health and Social Care Trust
> Telephone: [redacted] (Direct Dial)
> Mobile: [redacted]
> Email: [redacted]
>
> The Information and the Material transmitted is intended only for the person or entity to which it is addressed and may be Confidential/Privileged Information and/or copyright material.

Received from Tughans OBO Mr Aidan O'Brien on 29/04/2022. Annotated by the Urology Services Inquiry.

(ii) What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?

(iii) Whether, in your view, any of the concerns raised did or might have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If no steps were taken, explain why not.

(iv) Any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements? What was your involvement, if any?

(v) How you assured yourself that any systems and agreements put in place to address concerns were working as anticipated?

(vi) How, if you were given assurances by others, you tested those assurances?

(vii) Whether, in your view, the systems and agreements put in place to address concerns were successful?

(viii) If yes, by what performance indicators/data/metrics did you measure that success? If no particular measurement was used, please explain.

49.1 a. On the clinical aspects there were some discrepancies in the practice of individuals in terms of choice and usage of antibiotics.

49.2 i. & ii. For example, Mr Aidan O'Brien admitted a patient for administration of intravenous antibiotic just based on the symptoms. I do not recall the exact date or month. I directly discussed with him, during the joint ward rounds, about seeking the advice of microbiologist. He paid attention to my suggestion and acted accordingly. I recall Mr O'Brien contacting the microbiologist over the telephone on the same day and decided to withhold the antibiotic and to wait for culture reports. I cannot recall the exact date nor the details of the patient.

49.3 a. 2 I can also recall of a patient under the care of Mr. O'Brien, being on unconventional treatment for prostate cancer – being treated with low dose tablet bicalutamide, over a few years. I noticed it when a patient turned up in my clinic for the follow up. I do not recall the exact date.

49.4 I copied my clinic letter to Mr. O'Brien with my concern that it was unconventional treatment and added in the agenda of the next Urology Multi-disciplinary team meeting. The consensus was that treatment with long term low dose bicalutamide was unconventional and that Mr O'Brien was to review the patient in the clinic and to discuss the appropriate options with the patient. I remember the presence of Mr. Aidan O'Brien in the meeting but cannot recall the entire attendance.

49.5 iii. In my view, the deviation from the antibiotic policy or long term treatment of prostate cancer with low dose bicalutamide could have had negative impact on patient's care and safety. That's why I acted promptly by discussing the issues directly with Mr Aidan O'Brien and in the relevant meetings as mentioned previously.

49.6 iv. Mr Aidan O'Brien was in agreement with views of all other consultants and therefore there was no need for me get involved further. I do not know whether any measures were taken to monitor implementing the changes. However, there was antibiotic stewardship undertaken by pharmacists reviewing prescriptions of antibiotics for inpatients.

49.7 v. I recall, circulation of emails by pharmacists the data on prescription of antibiotics and any breaches in compliance. These emails were circulated to all the consultants. So, I presumed, it would be the duty and responsibility of individual consultants to ensure compliance with the policy. I do not know any further measures taken in this regard.

49.8 vi. I was not given any assurance by anybody. But, I was aware of ongoing antibiotic stewardship by pharmacists.

49.9 vii. I can just recall that, with continued antibiotic stewardship, the breaches from compliance in antibiotic prescription across the trust were getting less and less.

49.10 viii. I do not know who monitored the antibiotic stewardship. I think, the chief pharmacist may be able to answer this question.

50. Having regard to the issues of concern within Urology Services which were raised by you, with you or which you were aware of, including deficiencies in

(ii) When did any concern in that regard first arise?

(iii) What risk assessment, if any, did you undertake, to assess potential impact? and

(iv) What, if any, steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person?

57.1 As in section 53. Deviation from microbiology policy is a potential risk to patients as it can cause antimicrobial resistance and side effects from the antibiotics.

57.2 Treating prostate cancer with long term low dose bicalutamide is not recommended by any guidelines.

57.3 I do not recall exactly when I first noticed it.

57.4 But, soon after I noticed the deviation in his practice, I promptly discussed it directly with him and brought up the issues in the relevant meetings (weekly departmental meeting and in the MDT meeting). Mr Aidan O'Brien paid attention to these two concerns and agreed with the views of all others and consensus was reached.

58. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr. O'Brien and others, given the concerns identified.

58.1 Mr. O'Brien did reflective practice by complying with trust antibiotic policy. Once a concern was raised by me about the usage of antibiotic just based on symptoms without microbiological proof, Mr. O'Brien paid attention to my concern and discussed about the patient with consultant microbiologist and agreed to follow the advice of microbiologist.

58.2 Regarding the low dose bicalutamide, after the discussion in the MDT meeting, Mr Aidan O'Brien agreed to review the patient in the clinic to discuss the alternative options.

6 monthly antibiotic ward round summary Urology (January to June 2014)

- Mr Glackin: 17 patients.
  - **Indication** not recorded in 2 patient.
  - **Choice** non-compliant in 5 patients.
  - **Frequency** non-compliant in 1 patient.

- Mr O'Brien: 20 patients.
  - **Indication** not recorded in 2 patients.
  - **Choice** non-compliant in 5 patients.

- Mr Suresh: 10 patients, CURB score n/a.
  - **Indication** not recorded in 4 patients.
  - **Choice** non-compliant in 7 patients.

- Mr Young: 21 patients.
  - **Indication** not recorded in 4 patients.
  - **Choice** non-compliant in 5 patients.

Received from SHSCT 03/10/2023 Annotated by the Urology Services Inquiry.

I had been referred a few prostate cancer patients by Mr O'Brien who had been commenced on an unlicensed dose of Bicalutamide hormone therapy prior to referral to oncology.

1(ii) b *prescribing outside guidelines*

The licenced doses for Bicalutamide are either 150mg once daily as a monotherapy, or 50mg once daily when used in combination with hormone therapy injections known as luteinizing hormone releasing hormone agonists. There are no licenced indications that I am aware of for Bicalutamide 50mg once daily as a monotherapy. As such I viewed the used of the Bicalutamide 50mg once daily as a monotherapy as being outside the licenced indications.

Mr O'Brien in his position as chair of the NICAN Urology group in 2015 had asked for guidelines to be written for each urology disease sub-site. I wrote the androgen deprivation therapy guidelines in 2015 to accurately define our regional use of hormone therapy at that stage in line with the licenced indications. I hoped that this would standardise practise with the appropriate of dose Bicalutamide being used within our regional guidance document. Following discussion at the NICAN urology group meeting on a number of occasions in 2015 a final version was sent to Mr O'Brien on 10/10/2016 (***AOB3***)

1(ii) c *Bicalutamide*

As outlined above

(iii) How, in your view, did these issues differ from normal medical practice?

1(iii) Normal practise would have been to prescribe a dose of Bicalutamide that was within the licenced indications or to refer to oncology for discussion and allow the oncology team to discuss treatment options including the use of hormone therapies such as Bicalutamide.

(iv) If they differed, what, if any, action was taken by you or others? If none, why not?

1(iv) Firstly - I emailed Mr O'Brien in November 2014 (***AOB1***) highlighting a case that had been passed to me as the new chair of the regional urology MDM. The patient had been commenced on Bicalutamide 50mg once daily as a monotherapy. In that email I outlined the standard of care that we as oncologists would have offered in terms of hormone therapy. I advised that I was writing the regional guidelines to standardise the approach to hormone therapy prescription across the region, and pasted a link to guidance on off label prescription, good practise recommendations and our responsibilities within that. I offered further discussion on this.

Secondly I wrote the regional guidelines on androgen deprivation therapy and passed these through to Mr O'Brien as the NICAN urology chair and the NICAN urology group for sign off. These guidelines reflected the licenced indications and doses of hormone therapy.

Urology Services Inquiry

4. Were you aware of the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance'* published 23 September 2010? If so, when you were aware of concerns, did you implement those Guidelines? If so, set out in full how you did so on every occasion and with whom you engaged. If not, why not?

4.1 Bearing in mind that this was quite some time ago – yes, I was aware of these guidelines and the MHPS guidelines, published in 2005. These were two of a tsunami-like wave of guidelines, policies and protocols produced by the Trust, the Department of Health and various other relevant regional and national bodies disseminated to staff via the intranet with increasing frequency between 2005 and 2016.

4.2 Shortly after assuming the role of AMD for surgery in April 2016 I was specifically made aware of issues in Urology. The issues pertaining to Mr. O'Brien predated my involvement and had been most recently addressed via a letter to him (dated the 23rd March 2016) by the previous AMD for Surgery (Mr. Mackle) and the previous Assistant Director for Surgery (Heather Trouton) with the full knowledge and support of the Director of Acute Services, Esther Gishkori, as per the Trust Guidelines 23rd September 2010, and the Medical Director (Dr Richard Wright). This was shared with me shortly after my becoming AMD for Surgery by Mr. Mackle, Heather Troughton and Head of Service for Urology (Martina Corrigan). I do not recall being told that HR were involved at this stage but would have assumed so especially as so many senior managers were involved and issues had been on-going for so long. Consequently, I did not, that I can recall, assure myself that HR were involved. On reflection this was out-with the Guidelines and a mistake on my part. Please see 11.3 below on the monitoring process and feedback I requested at the time. Please see 8.1 for another case where I was involved in implementing the Guidelines.

4.3 There was also an issue with another recently appointed Urology Consultant at that time who was reputedly uncomfortable with open urological surgery (as opposed to endoscopic surgery) and whose judgement in management plans for the more complex urological cases was a point of concern. I was informed (I believe by Martina Corrigan, HoS for Urology, Heather Trouton, outgoing AD for Surgery but it may have been by Mr

Mackle), that before I started the surgical management role, this had also been escalated to the Service Director and a management plan had been put in place that this Surgeon would be shadowed by another Consultant Urologist and a second Consultant Urologist would be on call when this Surgeon was on call. I do not know if this had been shared with the Medical Director but I assumed so. That Consultant left the Trust later that year.

The highlighted text below should read "at the end of April/beginning of May" as per email received 20/02/2023 (TRU-320005 to TRU-320006 refers). Annotated by the Urology Services Inquiry.

4.4 I set about trying to get my head around as many of the issues in Surgery as quickly as I could by talking with many relevant parties ~~over the month of April~~ 2016 on both the Craigavon Area Hospital and Daisy Hill Hospital sites. This included several surgeons, the Heads of Service for General Surgery (Amie Nelson), Head of Service for Urology and ENT Surgery (Martina Corrigan), Heather Trouton (the preceding Assistant Director for Surgery) Ronan Carroll (Assistant Director for Surgery) and Esther Gishkori (Director of Acute Services).

4.5 Since Dr. Richard Wright had been appointed to the role of Medical Director SH&SCT from the Belfast Trust in July 2015, Esther Gishkori had been appointed Director of Acute Services to the SH&SCT from the Prison Service in October 2015 and Ronan Carroll had been appointed as Assistant Director Acute Services on the 1st April 2016, I thought it wise to ensure that Esther Gishkori, (as per Trust Guidelines, 2010, paragraph 2.3), her AD Ronan Carroll and the Medical Director were aware of the issues that I had become aware of at that point. Hence, I sent the following email (9th May 2016 15:41) (S21 No 32 of 2022 Attachments, 1. 20160509 email re problems from RC):

From: McAllister, Charlie Personal Information redacted by the USI
Sent: 09 May 2016 15:41
To: Carroll, Ronan Personal Information redacted by the USI Gishkori, Esther Personal Information redacted by the USI Wright, Richard Personal Information redacted by the USI
Subject: Problems

Dear All

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

Mackle, Eamon

From: Corrigan, Martina
Sent: 04 March 2016 13:40
To: Mackle, Eamon; Haynes, Mark; Glackin, Anthony; O'Brien, Aidan; Young, Michael; ODonoghue, JohnP
Subject: Actions from AMD and Urology Consultant Meeting

Importance: High
Sensitivity: Confidential

Dear all,

To formalise, please see the notes/actions arising from today's meeting.

Present: Mr Mackle, Mr Young, Mr Glackin, Mr O'Donoghue, M Corrigan. Apologies : Mr O'Brien, Mr Haynes

Mr Mackle advised that the purpose of the meeting today was to follow on from the last meeting which was held on 17 December 2015 as he has a meeting with Medical Director at end of March and he will need to update him on what has been put in place.

Actions agreed:

1. Mr Young to meet with Mr Suresh this week/early next week and explain what processes are being put in place for cover/support/mentorship for him and also to explain to him why the Team are doing this for him. (Mr Young to update when this happens)
2. Mr Mackle to meet with Mr Suresh on Wednesday 16 March 2016 at 2:30pm in AMD office, M Corrigan to organise
3. Mr Mackle and Mr Young to advise him that he should be seeking appropriate courses that will assist him in building up his surgical and decision making skills and that Mr Mackle will approve if these are appropriate.
4. A Multi-disciplinary feedback questionnaire should be completed and collated within the Team (not linked to the 360 feedback) – M Corrigan to organise and will collate responses. This will be used as constructive feedback for Mr Suresh
5. Formalise evening cover and the purpose of this will be explained to Mr Suresh in his meeting with Mr Mackle and Mr Young.
   Mr Young to formalise after discussions with the rest of the Team and that this should be shared with all the Team, Mr Mackle and M Corrigan. Mr Suresh is going back oncall on Thursday 17 March (Bank Holiday), Mr Young has agreed that he will do the handover Ward Round and cover Mr Suresh on this day.
6. Formalise the Ward rounds with one of the Consultant Team accompanying Mr Suresh each day (except Thursday) Weekends to be agreed on what cover needs to be provided and the team are going to work this up and share with Mr Mackle and M Corrigan.
7. The Consultants involved in the 'second on call' and Ward Rounds will be renumerated by ½ PA – M Corrigan to organise.

A further meeting in 3 months to be organised in order to update on progress – M Corrigan to confirm date.

Regards

Martina

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

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

Stinson, Emma M

From: Corrigan, Martina
Sent: 02 April 2016 19:09
To: Suresh, Ram
Cc: Mackle, Eamon
Subject: Actions from AMD and Mr Suresh Meeting

Importance: High
Sensitivity: Confidential

Dear Ram

To formalise, please see the notes/actions arising from your meeting with Eamon and I on 23 March 2016.

Present: Mr Mackle, Mr Suresh, Mrs Corrigan.
Venue: Associate Medical Directors Office, Admin Floor, Craigavon Area Hospital

Mr Mackle advised that the purpose of the meeting was to follow up from the meetings that Mr Young and Mr O'Brien had with Mr Suresh.

Actions agreed:

1. Mr Mackle asked Mr Suresh to source appropriate courses that will assist him in building up his surgical and decision making skills and that Mr Mackle will approve if these are appropriate.
   Mr Suresh to Source and provide details of courses to Mr Mackle/Mrs Corrigan by Friday 22 April 2016 so that arrangements can be made to approve/attend if deemed appropriate.
2. A Multi-disciplinary feedback questionnaire should be completed and collated within the Team (not linked to the 360 feedback) – Mrs Corrigan to organise and will collate responses. This will be used as constructive feedback for Mr Suresh and will be strictly confidential.
3. Formalise evening cover for all oncall weeks for Mr Suresh.
   Mr Young has agreed to formalise after discussions with the rest of the Team and that this will be shared with all the Team, Mr Mackle and Mrs Corrigan.

   Formalise the Ward rounds with one of the Consultant Team accompanying Mr Suresh each day (except Thursday) Weekends to be agreed on what cover needs to be provided and the team are going to work this up and share with Mr Mackle and Mr Suresh and Mrs Corrigan.
4. Mr Suresh to arrange to attend theatres with the other consultants in order to train in his surgical skills. The details of when and what cases he is involved in should be logged and shared with Mr Mackle/Mrs Corrigan – this should be provided on a monthly basis.

A further meeting in 3 months to be organised in order to update on progress – Mrs Corrigan to confirm date.

Regards

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

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

preparation for Urology MDMs which he chaired, and in the chairing of them. I had no doubt that he did not adequately preview cases for MDM. On enquiring why he had not adequately previewed a case while that case was being discussed, he explained that he did not have adequate time to do so. In that regard, he could hardly be faulted as we did not have adequate time to prepare for MDM as Chairs, if at all. The lack of adequate preview probably also contributed to the quality of his chairing, as his dictation of the outcomes of MDM discussions was often truncated, or incorrect, as in the case of Service User A (SUA) [see AOB-40064 – AOB-40074].

401. I did not have any reason for concern regarding the clinical practices of Mr Anthony Glackin or of Mr Mathew Tyson, Consultant Urologists, or of Mr Derek Hennessey or of Mr Thomas Jacob, Locum Consultant Urologists. However, the assessment and management of an inpatient by Mr Ram Suresh, Consultant Urologist, following the transfer of the patient from South West Acute Hospital in late 2015 with evidence of a significant intra-abdominal, secondary haemorrhage following an earlier partial nephrectomy did give rise to concern regarding his clinical acumen and ability to undertake emergency surgery in a life-threatening situation when UOW. This case was discussed with me and his remaining colleagues by Mr Mackle, then Associate Medical Director and Mrs Corrigan, Head of Service, in early 2016 when we were requested by them to provide back-up support for Mr Suresh when UOW. As can be seen from the email from Martina Corrigan dated 4 March 2016 [AOB-76726] a meeting took place on 17 December 2015 following the above incident and then a follow up meeting took place on 4 March 2016. I was not present at that meeting, but the email indicates that Mr Mackle, Mr Young, Mr Glackin, Mr O'Donoghue, and Ms Corrigan were present. The following support measures were agreed to be put in place to assist Mr Suresh:

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Actions agreed:

1. Mr Young to meet with Mr Suresh this week/early next week and explain what processes are being put in place for cover/support/mentorship for him and also to explain to him why the Team are doing this for him. (Mr Young to update when this happens)
2. Mr Mackle to meet with Mr Suresh on Wednesday 16 March 2016 at 2:30pm in AMD office, M Corrigan to organise
3. Mr Mackle and Mr Young to advise him that he should be seeking appropriate courses that will assist him in building up his surgical and decision making skills and that Mr Mackle will approve if these are appropriate.
4. A Multi-disciplinary feedback questionnaire should be completed and collated within the Team (not linked to the 360 feedback) – M Corrigan to organise and will collate responses. This will be used as constructive feedback for Mr Suresh
5. Formalise evening cover and the purpose of this will be explained to Mr Suresh in his meeting with Mr Mackle and Mr Young.
   Mr Young to formalise after discussions with the rest of the Team and that this should be shared with all the Team, Mr Mackle and M Corrigan. Mr Suresh is going back oncall on Thursday 17 March (Bank Holiday), Mr Young has agreed that he will do the handover Ward Round and cover Mr Suresh on this day.
6. Formalise the Ward rounds with one of the Consultant Team accompanying Mr Suresh each day (except Thursday) Weekends to be agreed on what cover needs to be provided and the team are going to work this up and share with Mr Mackle and M Corrigan.
7. The Consultants involved in the 'second on call' and Ward Rounds will be renumerated by ½ PA – M Corrigan to organise.

402. On 23 March 2016, Mr Suresh met with Mr Mackle and Ms Corrigan, and the following note of that meeting is available at AOB-77453:

To formalise, please see the notes/actions arising from your meeting with Eamon and I on 23 March 2016.

Present: Mr Mackle, Mr Suresh, Mrs Corrigan.
Venue: Associate Medical Directors Office, Admin Floor, Craigavon Area Hospital

Mr Mackle advised that the purpose of the meeting was to follow up from the meetings that Mr Young and Mr O'Brien had with Mr Suresh.

Actions agreed:

1. Mr Mackle asked Mr Suresh to source appropriate courses that will assist him in building up his surgical and decision making skills and that Mr Mackle will approve if these are appropriate.
   Mr Suresh to Source and provide details of courses to Mr Mackle/Mrs Corrigan by Friday 22 April 2016 so that arrangements can be made to approve/attend if deemed appropriate.
2. A Multi-disciplinary feedback questionnaire should be completed and collated within the Team (not linked to the 360 feedback) – Mrs Corrigan to organise and will collate responses. This will be used as constructive feedback for Mr Suresh and will be strictly confidential.
3. Formalise evening cover for all oncall weeks for Mr Suresh.
   Mr Young has agreed to formalise after discussions with the rest of the Team and that this will be shared with all the Team, Mr Mackle and Mrs Corrigan.

   Formalise the Ward rounds with one of the Consultant Team accompanying Mr Suresh each day (except Thursday) Weekends to be agreed on what cover needs to be provided and the team are going to work this up and share with Mr Mackle and Mr Suresh and Mrs Corrigan.
4. Mr Suresh to arrange to attend theatres with the other consultants in order to train in his surgical skills. The details of when and what cases he is involved in should be logged and shared with Mr Mackle/Mrs Corrigan – this should be provided on a monthly basis.

A further meeting in 3 months to be organised in order to update on progress – Mrs Corrigan to confirm date.

of urologists completing their training would be able, or expected, to do so. Overall, I felt that Mr Suresh had made excellent progress and was keen to improve his surgical competence. I felt that he deserved and had earned the ongoing support of the Urology Service and his colleagues.

405. I continued to provide support to Mr Suresh until he returned to take up another post in England in October 2016. I did not receive any remuneration for having done so. I have since had reason to contrast the support offered to him in 2016 to that offered by the same persons to me in 2016.

406. I attach a chronology entitled "*Trust Concerns / Consultant Concerns*" which cross references documents my legal team and I have been able to review to date which are relevant to issues related to the questions above in terms of complaints about the practice of others. Some contain summaries and extracts from various documents. The documents have been cross referenced and should be read in full as the summaries may not fully reflect all relevant matters. If the Inquiry has any further queries in respect of any concerns raised in respect of any medical practitioner referred to within the attached chronology, I would be happy to provide further details as required.

407. My response at Questions 1, 9, 10, and 21-25 sets out in detail my concerns in relation to patient safety in urology services and clinical governance in urology services, as well as concerns being raised and not being adequately addressed by the Trust.

408. I have no doubt that the concerns identified and raised by me, and others, impacted on patient safety, and indeed I have provided various examples above of individual patients coming to harm as a result of the issues underlying these concerns. While I believe that concerns were identified, both by me and by others, I do not believe that their nature and impact were adequately appreciated by the Trust, nor do I believe that their potential risk to patient safety was adequately considered by the Trust, and steps were not taken to adequately address and mitigate the risks posed to patients.

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22. Did you feel supported by the nursing and ancillary staff in the Unit? Please describe how and when you utilised nursing staff in the provision of clinical care for Urology patients. Did you consider that the nursing and ancillary staff complement available was sufficient to reduce risk and ensure patient safety?

22.1 Yes. Nursing staff fulfilled their role within their capabilities. Starting from chaperoning in the clinical areas, supporting cancer patients, joining ward rounds to assisting in theatres, the nursing staff fulfilled their roles. The presence of nursing and ancillary staff were sufficient to reduce risk and ensure patient safety.

23. Please set out your understanding of the role of the (a) specialist cancer nurse(s) and (b) Urology nurse specialists, and explain how, if at all, they worked with you in the provision of clinical care. How often and in what way did you engage with those nurses in your role as Consultant? Did you consider that the specialist cancer nurse, and all nurses within Urology, worked well with (Consultants? Did they communicate effectively and efficiently? If not, why not.

23.1 The specialist cancer nurses offered support to cancer patients at every step- Vetting the two week pathway referrals, supporting the newly diagnosed cancer patients in the clinic by giving them their contact details, information leaflets and addressing their emotional and mental health issues and any personal need that would help the patients in making the decision on their definitive treatment.

23.2 We had constant interactions with the specialist cancer nurses. They joined the clinics while seeing newly diagnosed cancer cases and while breaking bad news.

23.3 The urology nurse specialist had the role of performing urodynamic tests, teaching the patients self-catheterisation and arranging trial without catheter. The job description for the (a) specialist cancer nurse(s) and (b) Urology nurse specialists can be obtained from the Human Resources, if needed.

23.4 As a consultant I worked as a team with specialist cancer nurse and Urology nurse specialists. I believe, all other consultants were also in good working relationships with specialist cancer nurse and Urology nurse specialists. I did not

26.2 There was an effective clinical governance system. As far as I was aware all staff had access to the incident reporting system through which any concern by any staff could be notified. However, I did not get any automated feedback on the actions taken for the incidents. I did highlight the issue in one of the governance meetings of the surgical division, but cannot recall the exact date.

26.3 I felt the clinical governance system was effective in that all staff had access to an online reporting system of any incident or concern. Patients had access to PALS (Patient Advice and Liaison Services) and the complaint system.

26.4 I do expect to get the feedback/ report on actions taken on review of incidents and complaints as we all have to learn from the mistakes. We are obliged to know what went wrong, why did it happen and how to prevent such incidents happening again.

26.5 But, during my tenure, I did not receive the reports of the incidents I filed. I raised this issue in the combined surgical division audit/ governance meetings but do not recall the dates. Most of my colleagues echoed my concern in that meeting. We were told by the chair, cannot recall the name, that any learning point from the incident would be circulated to all the relevant staff. However, I do not think, the final reports on all incidents were circulated.

27. Who was in overall charge of the day to day running of the Urology unit? To whom did that person answer? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure. Identify the person/role to whom you were answerable.

27.1 The clinical lead- Mr Michael Young.

27.2 Operational manager/ Head of Service Ms. Martina Corrigan.

27.3 I was directly answerable to the above two. I believe, they were answerable to the Associate Medical Director/ Medical Director. (Their names already provided in previous section).

44.1 I had regular annual appraisals.

44.2 There was significant delay in getting my job plan approved, more so when it was switched to electronic system. After my job plan meeting with the clinical lead and agreeing my job plan, there were some miscommunication and misunderstandings about signing off the job plan. After the meeting with my clinical lead and verbally agreeing my job plan, I was informed by medical staffing (do not recall the name) that I need not do anything but to wait for approval from the Associate medical director. But, I did not know that I had to sign off first – "First sign off" in small prints in the e-job plan. I recall contacting medical staffing twice over phone enquiring about my job plan and I was asked just to wait. This led to a delay of over a year for the final approval of my job plan **(relevant document can be located at S21 62 of 2022 3. 20160801-Ref15-SKothandaraman-Urology-JobPlan)** I had to escalate it to the medical director. Except for that substantial delay in signing off my job plan, I think the cycle of job planning and appraisals were effective.

45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns, having the potential to impact on patient care and safety, arose within Urology Services. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how issues were escalated (if at all) and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

45.1 As far as I was aware, there were several ways to raise concerns. Direct reporting to the lead, line manager, operational manager, Medical director or chief executive. (Their names already provided. Please see section 8). There were also PALS (Patient Advice and Liaison Service) and the complaints office to whom the patients or relative could directly contact.

45.2 My understanding of the clinical governance system is that once any concern was raised or an incident reported, the complaint team asked for a statement /

explanation from the staff/ team concerned. These were further analysed by the clinical lead and head of services. If it was found to be a minor issue without any harm to any one, the issue would be closed. But, if it was anything more that it would warrant ordering Root Cause Analysis and escalation to the Associate medical director and the medical director.

45.3 If any further details needed about the process of clinical governance, I suggest to obtain the details from the Governance lead or the medical director, please.

45.4 There was also an online incident reporting system.

46. Did you feel supported in your role by your line management and hierarchy? Whether your answer is yes or no, please explain by way of examples.

46.1 Yes.

46.2 The clinical lead and the head of service were always contactable and approachable. Therefore, I felt I was supported by my line managers. For example, when there was planning to switch to bipolar resection from the conventional monopolar resection, I, like other consultants, suggested trying the equipment of different manufacturers before finalising the purchase. The clinical lead and the head of services made all the arrangements so that all the consultants could try the different models available in the theatre to weigh the pros and cons of each model.

Concerns regarding the Urology unit

47. The Inquiry is keen to understand how, if at all, you engaged with the following post-holders:-

(i) The Chief Executive(s);

47.1 There was no need for me to have any interaction. So, I did not directly engage with the Chief Executive.

Aimee Crilly

From: Glackin, Anthony [redacted]
Sent: 26 May 2015 12:54
To: Suresh, Ram
Cc: Young, Michael; O'Brien, Aidan; Haynes, Mark; ODonoghue, JohnP; Corrigan, Martina
Subject: Re: Governance meeting - Stent registry

Ram,
I'd be most grateful if you could present these cases formally so that we can share learning and plan some action points. please let me know the dating codes associated with the cases.
The next meeting is on 16th June.

Tony

AJ Glackin
Consultant Urologist
SHSCT

Secretary: Elizabeth Troughton
[redacted]

On 26 May 2015, at 12:39, Suresh, Ram [redacted] wrote:

> Dear Mr. Glackin,
> I have seen a couple of patients recently, with 'forgotten stents', with no mention about the stents in the discharge letter. I have filled in incident forms.
> Can we discuss about this issue in the next governance meeting please, particularly, about the need for stent registry.
>
> Thanks
> Ram Suresh

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