Nothing came to Trust Board about the practice of Mr O'Brien after the MHPS reference in 2016/2017. I was aware that an investigation had been at that time. I was assured by the Interim CX and Medical Director that the investigation was being processed through proper process. I was not aware of any further details as Mr O'Brien returned to work from my recollection after a short period of absence. This was confirmed by the HR Director as the process concluded. I cannot recall when this was, but my recollection was it was informed to the Board.

In July / August 2020 I recall the CX (SD) walking into my office (again my personal assistant was in the inner office), and he briefly mentioned that an investigation was ongoing into Mr O'Brien regarding triage of patients notes and delays in seeing patients not being followed up. The CX knew on that occasion that I had been a patient of Mr O'Brien, it was common knowledge at the Board of my past illness. I recall informing the CX then that I assumed due process and proper investigation was being followed.

Because of what could have been perceived a conflict of interest I spoke around July / August 2020 in a conversation with Pauline Leeson (NED) to explain that I did not wish to attend Board meetings where Mr O'Brien was going to be discussed – I asked Pauline Lesson as a NED would she Chair the Board meeting when this topic arose about Mr O'Brien. I reminded Pauline of the importance of following due process in a timely manner and asked her to check when Mr O'Brien had his appraisal completed and about his revalidation.

I also asked Pauline to check whether his PA had any comments on lack of administration and if there were any other concerns raised by medical colleagues who worked alongside Mr O'Brien. I questioned what the GPs had prescribed for the same conditions because I knew there was an issue about what medicines Mr O'Brien had been prescribing.
This conversation with Pauline was not for the purposes of advocating on behalf of Mr O'Brien but to protect the Trust and to ensure that due process was being followed in

Received from Roberta Brownlee on 29/11/2022. Annotated by the Urology Services Inquiry

procedures and governance adhered to. I was alerting Pauline re the systems in place. I never asked the outcome, only if these questions had been asked. Pauline was merely asking for advice, and I was helping her prepare for the Board meeting in August 2020 (SHSCT Board do not meet in July).

Board meetings in 2020 were Virtual meetings due to Covid. A Board meeting was held on 27 August 2020 and during this Confidential Section of the meeting the Medical Director gave an update of a SAI regarding a retired Consultant Urologist. I was not in attendance due to the conflict.

The next meeting of the Board was held on 24 September 2020 – I declared an interest in Item 7 (mindful the Board had asked for a written update at the August meeting to be brought to the September meeting) and I left the meeting for this Urology agenda item.

Pauline Leeson took the Chair in my absence. Prior to receiving USI discovery documents on 17/11/22 I never had seen the paper prepared for this agenda item in September 2020. I knew none of this detail of the allegations regarding Mr O'Brien

I attended the Board meeting on 22 October 2020. I had sent an earlier email to the NEDs and the CX explaining I planned to attend this meeting and declared my interest (Exhibit RB-02). The decision to attend was influenced by the second conversation I had with Richard Pengelly, in late September 2020, referenced to above at Q28. I was mindful of my obligations and accountability as Chair of the Board.

I decided to attend the October 2020 Board meeting. I can confirm that I declared an interest by email to NEDs and the CX prior to the date of this meeting.

Bolstering my decision to attend this meeting was a conversation I had with the CX a few days prior to the October meeting. Shane Devlin had explained with no notice of the Press announcement regarding Mr O'Brien. I asked what was this about and he referenced how this had been done in the same way for the Dr Watt case. I did ask had we followed due process and to make sure the Trust was not at risk.

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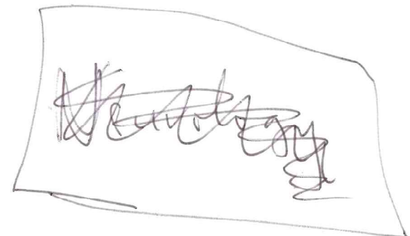
SBNI



Take chair

Conflict of
interest

Urology

If there were concerns,
why weren't they
flagged before?

Comac, Jennifer

From:	Brownlee, Roberta [Personal Information redacted by the USI]
Sent:	23 September 2020 07:17
Subject:	Fwd: Additional Paper for Confidential Trust Board - Item 7
Attachments:	Summary for Trust Board Clinical Concerns 24th August 2020 vt.pdf; ATT00001.htm

NEDs

You are aware I am removing myself from this agenda item. However I still have very serious responsibility for this. The CX and I discussed this yesterday and I asked many Qs. I have read this paper and have noted many areas that need further explained.
This paper references many HR areas. I am would have liked to see in this paper in chronological order of clinical events listed with Medical input as well for ease of reference
Why has an alert/ paper on this area never come to Trust Board before or to Governance - Eileen did this ever or any aspect of it come /get discussed at Governance? You will note an early alert only went to DoH in recent weeks (during CX most leave) sorry don't have actual date at hand.
This is also a Performance issue again did it ever come to be discussed? I am not aware of this coming to performance even in relation to one consultant with such long waiting lists? Or did we miss this ? Have we missed anything on reporting?
At performance was there a comparison of all consultant urologist Individual waiting lists ?
Have we had any concerns raised by GPs Primary Care in relation to long waits and outcomes of referrals?
Have we had any complaints concerns raised by patients Re waiting and pre and post op treatments?
In this paper, I did ask CX, there is NO mention of other consultant urologist colleagues observations, intervening or escalating. Did they ever notice anything and if so what did they do about this.
Also there is no mention of Consultant A performance management by line management clinically? Where is Continuous Professional Development/ Appraisal process and Revalidation mentioned. Again this is all part of clinical supervision in its widest content.
I would be looking to the Medical Director (their deputy at the meeting) to answer these Qs.
When you read this extremely serious situation we are now in as Chair I feel this is coming to Trust Board late. I note time delays and the involvement of many senior Medics. Noting CW initially and then was removed why? Then Dr AK then Dr AC. Would need to know in the time line why so long for intervening from when first noted and the action taken and supervision. Who was supervising medically at AMD/ Medical Director level? There involvement.

I also would like to see what is the immediate learning and what action taken to prevent reoccurrences? How was learning shared.

Have the longest waits of high risk patients been spoken to and now planned to be seen by Urologist as matter of urgency. Again not listed in this paper. I read the first paper yesterday and asked for changes due to Consultant A named in pages and then his name named fully in many others. I have not fully check your attached version now.

Whilst I'm stepping out of this item, not due to any aspect of content included, I still wish to know many of these answers. I will be looking to NEDs To challenge this and have well recorded the answers.

Please be mindful of the BHSCT and their challenges around similar.
We would need to discuss with CX 1:1 meeting at 8.30 due to its seriousness.

Roberta

Sent from my iPad

Begin forwarded message:

Received from Pauline Leeson on 16/08/2023. Annotated by the Urology Services Inquiry.

I have been asked to comment on the observations made by Prof. Roger Kirby on the management of two further patients at the Southern Health & Care Trust.

I can see no reason to amend my assessments and conclusions regarding the care provided by AO and the Southern Trust as detailed in my original submission and the subsequent responses to AO's commentaries.

My concerns remain:

1. The inability to engage with the MDT, which was at least in part due to the apparent under development of the urology MDT. However, I would assert that the principles of good practice are not contingent on the presence of a working MDT, but on the principles laid out succinctly in Good Medical Practice published by the General Medical Council.
2. The unjustified use of unconventional treatment options.
3. The delays in the pathways may, in part, have been due to inadequate capacity, but were also caused by a failure to proactively manage and prioritise these patients. Furthermore, there was no demonstrable engagement with Cancer Nurse Specialists whose input might have reduced the delays.

My credentials remain unchanged since my last submission to the Urology Services Inquiry. For 23 years I was a general urologist with a sub-specialist interest in urological cancers and was based in a district general hospital that hosted a Cancer Centre. As such my practice has been directly equivalent to Mr O'Brien's and I have direct experience of the difficulties encountered in managing the investigation and initial treatment of urological patients from their presentation to their referral, whenever necessary, to a specialist provider.

My consultant career coincided with the establishment and development of multi-disciplinary review (MDTs) of everyone with urological cancer. I was largely responsible for the process and administration of both local and specialist team working. In addition, I have been responsible for successfully designing patient pathways to expedite and improve the patients' cancer journeys.

As stated in response to the accounts of care submitted by Mr O'Brien, I would not wish to query, or indeed challenge, any part of the described case histories. The comments below are limited to addressing Professor Kirby's observations.

SUE

In this case, I can see no rationale for dismissing the concerns I raised in my initial commentary.

By failing to refer this patient to the specialist oncology service for testicular cancer, his treatment, which would normally be expected to commence within 6 weeks of the orchidectomy was delayed to 12 weeks. The causes cited are, first, AO's family circumstances and, second, that the pathology indicated a more favourable prognosis.

To support my opinion, first, I would cite the GMC's Good Medical Practice:

Paragraph 1

Received from Mr Hugh Gilbert on 02/08/2023. Annotated by the Urology Services Inquiry.

Patients need good doctors. Good doctors make the care of their patients their first concern.

Paragraph 2

You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

b. promptly provide or arrange suitable advice, investigations or treatment where necessary
c. refer a patient to another practitioner when this serves the patient's needs.

Secondly, review in out-patients has at least two functions: to arrange and review management options; and to inform the patient regarding this pathway and to explain the prognosis. By not being proactive in fulfilling these duties – the staging CT scan could have been requested to be done before the first review so that the result was available at the appointment - the patient remains uninformed of their prospects; a state that is generally more difficult to cope with, psychologically and socially, than knowing their pathway and prognosis.

SUH

In the light of RK's commentary, which is largely conjectural and on occasions contradictory (see paragraphs 4 and 5 of the opinion), I can see no reason to alter my own observations and conclusions regarding the management of this patient; I maintain that this fell well below that expected of a reasonable doctor and urologist.

RK points out that the principal delay – and hence the poorer prognosis – may be attributed to the patient's late presentation. From this, it is reasonable to infer that RK believes the subsequent delays caused by AO were inconsequential and justifiable. Delayed presentation in penile cancer is common – patients are embarrassed – and this should reinforce the need for the urgency and prioritisation that was clearly lacking.

Tha failure of the urological service in Northern Ireland to establish a supra-regional MDT in no way absolves AO from the duty to obtain the best possible care for his patients. The specialist service at The Christie Hospital in Manchester has long been established as a tertiary referral centre and, at that time, was best placed to offer advice and management for this patient. Only if AO felt that he held the equivalent expertise could his actions be described as reasonable (Good Medical Practice, Paragraph 15).

The word 'promptly' is used frequently in this review., which is not entirely appropriate. For example, the decision to request a CT scan, made at the MDT of 17th October 2019, and the communication of the scan's results with the patient on 14th February as prompt. Most reasonable urologists would have prioritised this request over any other of their activities by contacting a radiologist directly and explaining its urgency; in most urology units the CT scan would have been expedited.

I would be grateful if RK could provide the evidence used to refute the premise that the likely 5-year survival rate was not substantially diminished. I would refer the enquiry to the European Association of Urology's Guidelines on the management of penile cancer. Whist I acknowledge that these are merely guidelines, they have been derived by experts in the field, so any deviation from them should have been explained and documented. In the same way any verbally obtained consent should have been documented in the patient's notes, ideally on the form provided for that purpose.

training scheme at any one time, but possibly at different stages of the 5 years of training.

10. From August 1998 to February 2000, I was based in the Urology Department in Belfast City Hospital. The Urology Department in Belfast is the regional Urology unit for Northern Ireland and at that time had 6 consultants. The first 6 months was doing general core urology, but the next year was in urological oncology where I gained extensive exposure to nephrectomy for kidney cancer, cystectomy for bladder cancer, retroperitoneal lymph node dissection for testis cancer, and early exposure to radical prostatectomy for prostate cancer. It was during this year that I decided I wanted to do oncological surgery.

11. Between February 2000 and August 2000, I was rotated to the Urology Department in Craigavon Area Hospital for 6 months as part of the Urology training rotation. At that time, I was a second year higher surgical trainee. This is when I first worked with Mr. O'Brien who, at that time, was an experienced Consultant Urologist. I speak further about this (rotational traineeship) later in this statement. There would have been higher surgical trainees in CAH before and after me, and on an ongoing basis, in line with the rotation plan of the training scheme.

12. In 2003 I was appointed a Consultant Urologist with special interest in Uro-oncology and Renal Transplantation in the Belfast Trust.

13. Between 2005 and 2009 I was the Clinical Lead for Urology Surgery in the Belfast Trust. I continued to perform complex surgery, but was also responsible for the local management and clinical governance of the Urology service in the Belfast Trust.

14. In 2009 I was appointed Clinical Director of Urology and Renal Services in the Belfast Trust. In 2010, following the 2009 Review of Urology (discussed below), the role evolved and I became Clinical Director for Urology in Belfast and South Eastern Trusts as part of what was known as "Team East". This lasted until 2013 when "Team East" was dissolved. Thereafter, I held the role of Clinical Director in Urology in Belfast Trust until 2015. I continued to perform complex surgery between 2009 and 2015, but was also responsible for the local management and clinical governance of the Urology

Received from Mr Christopher Hagan on 9 August 2023. Annotated by the Urology Services Inquiry.

and Renal service in the Belfast Trust until 2010, and from 2010 a similar role across the Urology units of Team East until 2013, and then, following the dissolution of Team East, the Belfast Trust until 2015.

15. In 2015 I was appointed an Associate Medical Director within the Belfast Trust with responsibility for Children's, Maternity and Orthopaedic services. I undertook this role into 2016. I continued to perform complex surgery, but also had a senior management role and was responsible for the local management and clinical governance of the children's, maternity and orthopaedic services in the Belfast Trust.

16. In 2016 I was appointed Chair of Division for Children's Services within the Belfast Trust. I continued to perform complex surgery, but was also in a senior management role, responsible for the leadership, local management and clinical governance of the children's services in the Belfast Trust.

17. Between 2018 and 2020 I held the role of Deputy Medical Director for Risk and Governance within the Belfast Trust. I continued to perform complex surgery, but also had a senior management role with responsibility for risk and governance that included adverse incident reporting, complaints, coroners work and litigation, I was also responsible for standards and guidelines, emergency planning and Human Tissue Authority (HTA) licenses.

18. As indicated above, in January 2020 I was appointed Executive Medical Director of the Belfast Trust. This role has two main functions – a statutory role as Responsible Officer to around 1400 doctors, and as the lead for patient safety in the Belfast Trust, which is also a statutory function. In addition, I am also the professional medical lead for the Belfast Trust and have overall lead responsibility for integrated clinical governance, risk management, management of concerns in respect of doctors, appraisal and revalidation, undergraduate and postgraduate medical education, job planning, research and development, quality improvement, implementation of standards and guidelines. I also contribute to corporate planning, policy and strategic decision making within the Belfast Trust.

Received from Mr Christopher Hagan on 9 August 2023. Annotated by the Urology Services Inquiry.

The formal investigation report does not highlight any concerns about Mr O'Brien's clinical ability. The concerns highlighted throughout the investigation are wholly in respect of Mr O'Brien's administrative practices. The report highlights the impact of Mr O'Brien's failings in respect of his administrative practices which had the potential to cause harm to patients and which caused actual harm in 5 instances.

I am satisfied, taking into consideration advice from Practitioner Performance Advice (NCAS), that this option is not required.

6. There are serious concerns that fall into the criteria for referral to the GMC or GDC

I refer to my conclusion above. I am satisfied that the concerns do not require referral to the GMC at this time. Trust processes should conclude prior to any decision regarding referral to GMC.

7. There are intractable problems and the matter should be put before a clinical performance panel.

I refer to my conclusion under option 6. I am satisfied there are no concerns highlighted about Mr O'Brien's clinical ability.

6.0 Final Conclusions / Recommendations

This MHPS formal investigation focused on the administrative practice/s of Mr O'Brien. The investigation report presented to me focused centrally on the specific terms of reference set for the investigation. Within the report, as outlined above, there have been failings identified on the part of Mr O'Brien which require to be addressed by the Trust, through a Trust conduct panel and a formal action plan.

The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O'Brien. No-one formally assessed the extent of the issues or properly identified the potential risks to patients.

Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there are wider issues of concern, to be considered and addressed. The findings of the report should not solely focus on one individual, Mr O'Brien.

In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes

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

with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings.

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

Consultant A was therefore asked to refine and clarify the specifics of his request in respect of a number of points.

Consultant A responded on 24th June 2019, clarifying the information plus seeking 2 additional items. The request for information was still significant in nature, and took significant time and resources for the Trust to compile. The requested information was delivered to Consultant A's Secretary for his attention on 30th October 2019.

Since Consultant A had indicated that, following receipt of the requested information, he would advise whether or not his formal grievance was to be amended, the Trust awaited hearing from him in this regard. However, no further correspondence was received from Consultant A in respect of his grievance, or any amendments to it.

At this stage, from November 2019 through to end of January 2020, the Trust suffered significant disruption to its services and its HR function by reason of widespread Industrial Action by health service trade unions.

Furthermore, work was ongoing to finalise the SAI (Serious Adverse Incident) processes in respect of the patients affected by the original concerns in respect of Consultant A's practise.

In recent months the Trust's services and normal HR processes has been very severely impacted by the Covid – 19 pandemic. This prevented any employee relations work, including the hearing of grievances, being taken forward for a 3 month period from March to start of June.

On 26th April 2020, Consultant A wrote to the Trust's HR Director again, highlighting that a number of pieces of information from original requests had not been provided, and he requested these by 15th May 2020. On 15th, 22nd May and also on 8th June the Director of HR wrote to Consultant A with responses to these requests. The Trust believes that all substantial and detailed information requests have now been responded to.

June 2020 – September 2020

Grievance process ongoing. The grievance panel is due to conclude by mid October 2020.

Received from Pauline Leeson on 16/08/2023. Annotated by the Urology Services Inquiry.

As Consultant A is no longer employed, the Conduct Hearing under MHPS cannot be concluded. The GMC processes will continue regarding Consultant A's fitness to practise in light of both the previous concerns and the most recent concerns.

Summary of previous Serious Adverse Incidents – from 2016 onwards

Following the SAI Index Case Patient 10 which triggered the first MHPS case, the Trust identified a number of GP Urology referrals who were not triaged by Consultant A. 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient, discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed. These five cases were subject to a further SAI review process.

Lessons Learned from the 5 SAI's

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.

2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.

3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.

4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.

5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.

6. Despite it being absolutely clear to Consultant A (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The

procedures and governance adhered to. I was alerting Pauline re the systems in place. I never asked the outcome, only if these questions had been asked. Pauline was merely asking for advice, and I was helping her prepare for the Board meeting in August 2020 (SHSCT Board do not meet in July).

Board meetings in 2020 were Virtual meetings due to Covid. A Board meeting was held on 27 August 2020 and during this Confidential Section of the meeting the Medical Director gave an update of a SAI regarding a retired Consultant Urologist. I was not in attendance due to the conflict.

The next meeting of the Board was held on 24 September 2020 – I declared an interest in Item 7 (mindful the Board had asked for a written update at the August meeting to be brought to the September meeting) and I left the meeting for this Urology agenda item.
Pauline Leeson took the Chair in my absence. Prior to receiving USI discovery documents on 17/11/22 I never had seen the paper prepared for this agenda item in September 2020. I knew none of this detail of the allegations regarding Mr O'Brien

I attended the Board meeting on 22 October 2020. I had sent an earlier email to the NEDs and the CX explaining I planned to attend this meeting and declared my interest (Exhibit RB-02). The decision to attend was influenced by the second conversation I had with Richard Pengelly, in late September 2020, referenced to above at Q28. I was mindful of my obligations and accountability as Chair of the Board.

I decided to attend the October 2020 Board meeting. I can confirm that I declared an interest by email to NEDs and the CX prior to the date of this meeting.

Bolstering my decision to attend this meeting was a conversation I had with the CX a few days prior to the October meeting. Shane Devlin had explained with no notice of the Press announcement regarding Mr O'Brien. I asked what was this about and he referenced how this had been done in the same way for the Dr Watt case. I did ask had we followed due process and to make sure the Trust was not at risk.

Received from Roberta Brownlee on 29/11/2022. Annotated by the Urology Services Inquiry

WIT-99863

AOB

Consultant A

MHPS case commenced on 30th Dec 2016

Maintaining High Professional Standards

June 2020

↓

Patients assessed 11th Sept 2019 + 11th Feb 2020

but not added to inpatient list

↓

potentially very serious clinical risks

17 Period - 1st Jan 2019 - May 2020

1st Review 147 emergency patients
3 patients had not had start management plan enacted } emergency
147 patients No notes for 46 patients

2nd Review Elective in-patients - same time period

120 patients experienced delay in dictation from 2 - 41 weeks

36 patients → no notes of care

Received from Pauline Leeson on 16/08/2023. Annotated by the Urology Services Inquiry.

WIT-99867

Some private patients added to HSC waiting lists ahead without greater clinical need

27th Nov 2018 - grievance lodged
to SAIs

- Clinical concerns / patient safety
- Process of decision making

(1) 1st time this has been brought to Trust Board

(2) John - for the record - how long have you been involved & when did it terminate?

(3) What level is this SAI? at outset 2016
What level of SAI is it now? - 2020

(4) What determined level of SAI?

(5) Why no formal action in 2016?

(6) AKW identified in 2016, why did it take until 2020?

(7) Was there any evidence to state that patients suffered harm?

(8) Look at decision making
Who made the decision
What evidence
[illegible] allowed to continue to practice?

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and advised that this position assumes that full funding will be secured for the cost of Covid-19 incurred to date at a value of £20m and that Transformation funding will be received for all schemes supported by DoH to continue with the exception of the known pay pressure associated with 20/21 Pay uplifts.

Mrs Rutherford reported that Pay expenditure exceeds budget by £6.7m and this is largely between medical and nursing. Flexible payroll arrangements have now cost the Trust £28.6m with 1133wte employed in August 2020. Mrs Rutherford also reported that Non Pay expenditure was under budget by £5.9m and explained that this unplanned expenditure benefit has accrued as a direct result of the Trust's response to Covid-19.

Members noted that Prompt payment performance, at 94.03% in August, has improved on July and is significantly better than the prior year.

Mrs Rutherford advised that the Trust is predicting a year-end deficit of £7m at this stage and a draft financial plan has been submitted to the HSCB on this basis. Mrs McCartan referred to the predicted year end deficit and asked that the large variances are highlighted on the report summary sheet in future. In response to a question from Mrs McCartan on the possibility of additional funding from the Department, Mrs Rutherford advised that discussions are ongoing with the Department and HSCB in this regard.

Board members approved the Finance Report.

The Chair left the meeting for the discussion on the next item.

Mrs Leeson took over as Chair.

7. <u>UROLOGY</u>

The Chief Executive set the context to this item by advising that there is likely to be significant media interest and reputational issues with this case.

Received from SHSCT on 01/07/2022. Annotated by the Urology Services Inquiry.

Dr Gormley stated that the situation remains fluid and he spoke to a paper which outlines a summary of the clinical concerns relating to Consultant A, the actions taken to review aspects of their practice and the development of appropriate management plans to minimise the risk of harm to patients. Mrs Leeson raised the previous SAIs from 2016 and asked about new SAIs to which Mrs McClements spoke of the potential for an additional 6 SAIs at this point. Dr Gormley advised that an External Chair has been appointed and Terms of Reference are in the process of being drafted. Mrs Leeson asked how far back the review process would go. Mrs McClements advised that the focus of the review has been on immediate concerns, but as the Trust has worked through these, other concerns have arisen, leading to further scrutiny. Ms Donaghy asked at which point was the Early Alert to the Department submitted. The Chief Executive undertook to clarify.

Action: Chief Executive

Mrs Toal referred members to the timeline included with the report. She advised that as the Consultant was no longer employed in the Trust, the Conduct Hearing under the MHPS process, cannot be concluded. The Grievance process remains ongoing with the Grievance Panel due to conclude by October 2020. Ms Donaghy asked about Consultant A's appraisals. Mrs Toal stated that there were issues relating to Consultant A's appraisals not being completed in a timely manner, Mrs McCartan asked about the timeline for this case to be in the public domain. The Chief Executive advised that the Minister is required to share details of this case with the Assembly and this is likely to be mid October 2020, subject to the outcomes of the review exercise.

In terms of future reporting to Trust Board, members asked that where there had been progress/actions taken by the Trust since the previous Board meeting, that the paper would be updated accordingly and presented to Trust Board.

The Chair returned to the meeting at this point.

Received from SHSCT on 01/07/2022. Annotated by the Urology Services Inquiry.

WIT-90675

Quality Care - for you, with you

Maintaining High Professional Standard All Cases

October 2022

CONFIDENTIAL

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

FORMAL MHPS CASES – OCTOBER 2022

Ref	Case Opened	Summary	Case Manager	Case Investigator	NED assigned	Any restrictions/ exclusions?	Is PPS involved ?	Has GMC been informed?	Impact on Patients/ SAI	Timescales
Persona	23/7/20 MHPS Complete 27.9.21 Disciplinary sanction.	Personal Information - Irrelevant	Mr D Gilpin Consultant Surgeon (retired) *Trained Jan & Oct 2020*	Dr N Chada Consultant Psychiatrist (retired) *Trained Mar 17*	Mrs G Donaghy	Personal Information - Irrel	Yes Ref Personal Information redacted by USI	No	No	MHPS completed. Personal Informa ion - Irrelevant
Persona	16/3/21 MHPS Complete 19.10.21		Dr P Murphy DMD Medicine *Trained Oct 20*	Dr C Clarke Consultant ICU *Trained Jan 20*	Mr M McDonald	Currently under direct supervision	Yes Ref Personal Information redacted by USI	GMC restrictions Stood down 21.9.22 GMC Two year warning from 16.9.2022 – 16.9.2024	SAI Level 1 **REF** Personal Information redacted by USI	Personal Information - Irrelevant
Persona	24/7/20 **MHPS Paused pending PSNI**		Dr P Murphy DMD Medicine *Trained Oct 20*	Dr T Kane Consultant Psychiatrist *Trained Jan 20*	Ms E Mullan	Not currently working in SHSCT	Yes Ref Personal Information redacted by USI	Yes Trust referred concerns to GMC 30.6.21 GMC is investigating	SAI in relation to clinical case. SAI **REF** Personal Information redacted by USI Completed.	
Persona	20.5.22 **Formal MHPS Open**		Dr G Hampton, DMD Emergency Medicine *Trained Oct 20*	Dr T Kane, Consultant Psychiatrist *Trained Jan 20*	Mrs P Leeson	No restrictions. Currently at work	Yes advice given Ref Personal Information redacted by USI	Yes – the doctor has self-referred to GMC GMC Investigating Patient Reversal of sterilisation completed	SPPG SAI reference Personal Information redacted by USI Level 3 SAI notification submitted 27/05/2022	

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

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

FORMAL MHPS CASES – OCTOBER 2022

Registering **NEW FORMAL CASE to seek appointment of Case Manager, Case Investigator and NED assigned*

Ref	Case Opened	Summary	Case Manager	Case Investigator	NED assigned	Any restrictions/ exclusions?	Is PPS involved ?	Has GMC been informed?	Impact on Patients/ SAI	Timescales
Personal	14.10.22	Personal Information - Irrelevant	*To be appointed*	*To be appointed*	*To be assigned*	DMD currently considering restrictions in consultation with NHS resolution	Yes REF Personal Information redacted by USI	ELA Advice 15.9.22 No referral	N/A	Personal Information - Irrelevant

Personal Information - Irrelevant

Ref: Personal Informa	
Case Manager	
Case Investigator	
NED Assigned	

CONFIDENTIAL

MHPS INITIAL SCREENING STAGE, INFORMAL or LOW LEVEL CONCERNS – October 2022 CHANGES

Changes from Sept Report:

**Ref* Personal Information *– Removed from list. Doctor no longer employed and all necessary actions taken*

**Ref* Personal Information - I *– Removed from list. DMD confirmed at Sept 22 Oversight Screening report completed and no further action required. Screening outcome discussed, and confirmation NHS Resolution advice sought by DMD.*

**Ref* Personal Information *– Removed from list. DMD confirmed at Sept 22 Oversight managing well informally.*

**Ref* Personal Information *– Removed from list. DMD confirmed at Sept 22 screening complete with no further action required for SAS doctor.*

GREY SHADING DENOTES DOCTOR NO LONGER WORKING IN TRUST

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

Southern Health and Social Care Trust

Quality care – for you, with you

BOARD REPORT SUMMARY SHEET

Meeting: Date:	Trust Board - Confidential
Title:	Clinical Concerns within Urology – Southern Trust
Lead Director:	Dr Maria O'Kane Melanie McClements
Purpose:	Update
Key strategic aims: Safe and Effective Care	
Key issues/risks for discussion: This report is an update to the report that was shared at the September Confidential Board meeting, this report was shared with the Department of Health on the 14th October. It outlines a summary of the clinical concerns relating to Consultant A, the actions taken to review aspects of his practice and the development of appropriate management plans to minimise risk or harm to patients. There is likely to be significant media interest in this case. Plans need to be put in place to respond to primary care colleagues and to establish a targeted help line for patient concerns. There is likely to be impact on other patients who are awaiting urological appointments/follow up. Consultant A is no longer employed as of 17th July 2020, having given his notice of his intention to retire from his substantive post as at 30th June 2020. The Trust declined his request to return given outstanding employment matters relating to a previous MHPS case commenced on 30th December 2016. Although Consultant A initially challenged this matter, following correspondence exchange between his solicitor (Tughan's) and DLS, he is no longer employed as of 17th July 2020. There has been no legal challenge in respect of this matter, to date.	

Received from Pauline Leeson on 16/08/2023. Annotated by the Urology Services Inquiry.

WIT-99847

Southern Health and Social Care Trust

Report to Department of Health on Consultant A

Date:	14 October 2020
Title:	Clinical Concerns within Urology – Southern Trust
Lead Directors:	Mrs Melanie McClements – Director of Acute Services Dr Maria O'Kane – Medical Director
Key Strategic aims: Delivery of safe, high quality effective care	
Key Issues/risks: This report outlines a summary of the clinical concerns relating to Consultant A, the actions taken to review aspects of his practice and the development of appropriate management plans to minimise risk or harm to patients. Consultant A is no longer employed as of 17th July 2020, having given his notice of his intention to retire from his substantive post. The Trust declined his request to return given outstanding employment matters relating to a previous MHPS case commenced on 30th December 2016. Any patients identified where clinical concerns have been raised will be reviewed and followed-up. Due to capacity issues there is likely to be impact on other patients who are awaiting urological appointments/follow up. Plans have been put in place to respond to primary care colleagues and to establish a targeted help line for patient concerns.	

Received from Pauline Leeson on 16/08/2023. Annotated by the Urology Services Inquiry.

Background

On 7th June 2020, the Trust became aware that 2 out of 10 patients listed for surgery under the care of Consultant A were not on the hospital's Patient Administration System at this time. As a result of these potential patient safety concerns a review of Consultant A's work was conducted to ascertain if there could be wider service impacts.

As a result of these potential patient safety concerns a review of Consultant A's work was conducted to ascertain if there were wider patient safety concerns and service impacts. The internal reviews, which considered cases over an 18 month period (period 1st January 2019 – 30 June 2020), identified the following:

- The first internal review concentrated on whether the patients who had been admitted as an emergency had had a stent inserted during procedure and if this had been removed. There were 160 emergency patients listed as being taken to theatre. 3 patients had not had their stent management plans enacted. Clinical Management has been subsequently arranged for these 3 patients.

- The second internal review was for 343 elective-in patients taken to theatre. Out of the 343 patients reviewed there have been **2 of these patients who have been identified as meeting the threshold of needing a Serious Adverse Incident Review**.

The following areas have been identified that immediately need to be reviewed and actions taken on these patients to mitigate against potentially preventable harm

1. **Jan 2019- June 2020** - Pathology and Cytology results: 168 patients with 50 patients needing reviewed. From this there has been **3 confirmed SAI with a further 5 requiring a review follow-up** to determine if they have come to harm.

2. This exercise has also now identified concerns of clinical practice in the prescribing of Bicalutamide drug has revealed examples of poor practice, delay in following up the recommendations from results/MDM's and delay in dictation to other health care professionals in the ongoing care and treatment of the patients. The full extent of this is not yet clear.

3. **Jan 2019- June2020** - Radiology results –1536 patients listed on NIECR. These patients may have had the results manually signed off and actioned but as we have identified cases where this hasn't happened we need to review all of these records to reassure ourselves that these have all been actioned. This exercise is ongoing.

4. **Jan 2019-July 2020** - MDM discussions – there are 271 patients who were patients of Consultant A and who were discussed at MDM, a review of these patient records is being undertaken. There are currently **2 confirmed SAI's and a further 2 needing a review follow-up** to determine if they have come to harm. This exercise is ongoing.
5. **Oncology Review Backlog** – 236 review oncology outpatients will be seen face to face by a retired Urologist in the independent sector. This consultant will either discharge or make appropriate plans for ongoing management

overcrowded Emergency Department at Craigavon Area Hospital. Mrs McClements acknowledged that the biggest risk period was between the swab test and the result and she spoke of measures in place such as more fast swabs, optimising community care and discharge, promoting safety in hospital flow etc.

ii) SAI Outbreak

The Chief Executive reported that the Panel Chair has given a commitment to feedback any immediate learning to the Trust. An early learning report has been produced and shared. Mrs McClements highlighted three key learning points; i) communication with families and relatives; ii) restricting visiting and iii) looking after staff.

7. **UPDATE ON CLINICAL CONCERNS WITHIN UROLOGY**

The Chief Executive informed members of discussions with the Department in relation to an intended statement by the Minister for Health to the NI Assembly. The Trust has advised that a public statement at this stage would be premature as the Trust has not completed a review of processes to the detail it requires. The Chief Executive therefore sought Trust Board approval to request a delay in the Ministerial announcement.

Members discussed the fact that there is likely to be significant media interest in this case with the potential for significant reputational risk to the Trust. Members emphasised the Trust's duty of care to patients and the importance of the Trust completing its investigative work to ensure that the information it provides is complete and accurate.

Dr Gormley spoke to a report which provides a summary of the clinical concerns relating to Consultant A, the actions taken to review aspects of his practice and the development of appropriate management plans. He reminded members that Early Alerts submitted to the Department of Health have been part of this process advising them of the professional performance and patient safety concerns. Dr Gormley advised that in relation to the SAI process, the Panel Chair has been appointed as well as a Subject Matter Expert.

Received from SHSCT on 01/07/2022. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From: Devlin, Shane
Sent: 21 October 2020 00:29
To: OKane, Maria
Cc: McClements, Melanie; McKimm, Jane; Toal, Vivienne
Subject: RE: TB Confidential item 7

Maria

Happy to discuss, although the chair has Not been a patient in recent years, she was a patient nearly 20yrs ago.

I think as chair she needs to be part of the conversation and the whole board need to be in the middle of this.

Catch up tomorrow

Shane

On 20 Oct 2020 23:54, "OKane, Maria" <Personal Information redacted by the USI> wrote:
Shane my understanding from what the Chair has disclosed openly is that she has been a patient of this doctor in recent years. Given that we will be discussing the impact on patients potentially I am concerned. Maria

---

From: Devlin, Shane
Sent: 20 October 2020 10:52
To: OKane, Maria; McClements, Melanie; McKimm, Jane
Subject: FW: TB Confidential item 7

Please see below.

Can we have clear answers to the Chair's comments for the meeting

Thanks

Shane Devlin
Chief Executive
Southern HSC Trust
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Tel: Personal Information redacted by the USI

From: Brownlee, Roberta
Sent: 20 October 2020 10:48
To: Devlin, Shane
Cc: Judt, Sandra; Comac, Jennifer; Donaghy, Geraldine; Leeson, Pauline; McCartan, Hilary; McDonald, Martin; Mullan, Eileen; Wilkinson, John
Subject: TB Confidential item 7

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

Shane

I wish to confirm that I will be staying in for this item as Chair (item 7). This is an extremely serious matter for the Board and I need to be present. I have no conflict with this particular matter. My past personal illness I will try to overcome the emotions.

As mentioned when we last spoke of this at 1:1 will Dr Damian (as Dr Maria not coming to TB) be able to confirm that one Urologist Dr Mark (only) having reviewed files is adequate and acceptable under process. Just want to be sure we don't need other specialist opinions of assessment on patients conditions/notes etc on such serious matters (stents/medications). Also are we sure legally (and by DoH CMO) that AOB must not be informed of this all taking place to date and not until the morning of the press release??

We need to be assured that process is as perfect and robust as possible. I appreciate the Dr Watt legal information but was there any learning from it when he wasn't told to the morning of – any legal difficulties. Hope you understand where I am coming from – protecting patients is paramount and the Board too.

Roberta

Mrs Roberta Brownlee
Chair
Southern Health and Social Care Trust

Tel: Personal Information redacted by the USI **(External);** Personal Information redacted by **(Internal)**
Email: Personal Information redacted by the USI

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

He informed members of an issue that has recently arisen regarding the Consultant's prescribing of the medication Bicalutamide which appears to be outside established NICE guidance. A review is underway to identify patients receiving this treatment.

The Chair advised that Consultant A had written to herself in June 2020, the content of which she had shared with the Non Executive Directors in which Consultant A raised concerns at how the HR processes were being managed and requesting that his formal grievance and its included Appeal are addressed. The Chair was advised that this matter was being progressed through HR processes. The Chair also raised the fact that a number of different Urology Consultants had been in place over the years and asked why they had not raised concerns about Consultant A's practice and similarly, why had his PA not raised concerns regarding some delays in dictation of patient discharges. The Chair also asked should a GP not have recognised the prescribing of Bicalutamide as an issue?

Dr Gormley stated that patients remained under this one Consultant's care and this will be examined under the SAI process. The Chair then asked about Consultant A's appraisals and asked if performance issues had been identified through this process and if so, were professional development and training needs then identified. Dr Gormley advised that Consultant A's appraisals were also part of the review process.

In terms of systems and processes, Mrs McClements spoke of the SAI process since 2016 when a robust action plan was put in place at that time to address such issues as triaging, communication etc. and the work since June 2020 to scope and review the patient records of Consultant A's cases. Mr McAnuff noted that when performance issues were identified, additional measures were put in place and asked if these additional measures had not effected positive change, what further controls would need to be put in place should there be concerns raised about other Consultants. Mrs McClements referred to the query as to whether such clinical concerns could happen elsewhere and she advised that the Trust required more time to conduct its review and scoping exercises.

In response to a question from the Chair as to whether one Consultant Urologist reviewing the patient files was sufficient, Mrs

Received from SHSCT on 01/07/2022. Annotated by the Urology Services Inquiry.

TRU-131855

McClements provided assurance that in addition to Mr Mark Haynes' involvement, there is some clinical nurse specialist input and the Head of Service is involved in reviewing systems and pathways. She referred to the multi-disciplinary aspect of this work as detailed in the paper. In addition, there has been Independent Sector Consultant sessions reviewing oncology patients and Subject Matter Experts engaged as part of SAI process.

Mr Wilkinson stated that this was a complex case with various strands. He advised that whilst he supported the Trust's request for a delay in a Ministerial announcement, it was important that this was not a prevaricated delay.

Ms Donaghy referred to this case coming into the public arena and asked about natural justice and Consultant A's right of reply. She raised her concern at the issues Consultant A had raised in his grievance around his appraisals, pressure of work etc. and she asked that these are addressed as part of any review. Mrs McCartan restated the importance of the Trust releasing information only when it is assured it is accurate. Mrs Leeson highlighted the importance of due process being followed with SAIs completed as a priority to ensure learning from this case for the benefits of patients.

Following discussion, the consensus view of Trust Board was to approve the Trust's request to seek a delay in the Ministerial announcement. Members emphasised the importance of a robust timeline to conclude the review processes. It was agreed that following the Trust Board meeting, the Chief Executive would informally advise the Department of Health of the Trust Board's decision followed by a formal letter.

Action: Chief Executive

8. FINANCE REPORT

Ms O'Neill presented the Finance report for the 6 months ending 30 September 2020. Ms O'Neill reported a deficit at month 6 of £1.6m and advised that this position assumes that full funding will be secured for the cost of Covid-19 incurred to date at a value of £24m and that Transformation funding will be received for all schemes

Received from SHSCT on 01/07/2022. Annotated by the Urology Services Inquiry.

32.1 The governance arrangements were fit for purpose but they were not robust enough to deal with the practice of Mr O Brien. MHPS cases were not reported to Governance Committee so we not able to make any comparisons with length of time with other cases. The monitoring and reporting of SAIs was particularly poor so we weren't able to monitor if they were coming from one specific area or if they were clustered around one individual clinician. NEDs did not have sight of Early Alerts nor were they reported to the Governance Committee. There was no reporting on appraisals or validation so the Committee had no idea where there were issues/concerns about individual's practice. The Review of Clinical and Social Care Governance in 2019 was a significant improvement bringing indicators together in a more coordinated and corporate manner including information on SAIs, Early Alerts and MHPS cases coming to Governance Committee giving us a more rounded view of where there were issues in the system. Governance is more robust since the Review particularly the inclusion of reports on MHPS to Governance Committee and the monitoring of appraisals and validation of clinical staff but it was clearly not robust enough to deal with Mr O Brien. As a NED I rely on staff bringing information to me as a Board member so that I can ask questions. There were no issues in relation to Urology brought to Governance Committee or Trust Board by the Medical Director from January 2017 until August 2020. The Trust Board should have been made more aware of the complexity of the MHPS case involving Mr O Brien by the Medical Director, Richard Wright, who should have advised Trust Board of the length of time that it was taking as well as providing information on any associated SAIs. If issues/concerns/processes are invisible or not accountable to the Board, there is greater risk to our patients.

33. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during the period covered by the Inquiry's Terms of Reference? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

33.1 I am more aware of the importance of the role of the cancer nurse specialist as an operational matter. I am more aware of the need for the Board to monitor appraisals and SAIs. The Board should have been made more aware of the issues by the Medical Director, Richard Wright, in relation to Mr. O'Brien's MHPS case as it was more complex than other cases. We should have been made aware of any associated SAIs or concerns about potential patient harm. If there were issues or concerns regarding governance in Urology, they should have been brought sooner to the attention of both

Received from Pauline Leeson on 16/08/2023. Annotated by the Urology Services Inquiry.

Aimee Crilly

From:
Sent:
To:

-----Original Message-----
From: O'Brien, Aidan <Personal Information redacted by the USI>
To: (Aidanpobrien Personal Information redacted by the USI) (Aidanpobrien Personal Information) <Aidanpobrien Personal Information>
Sent: Tue, 16 Jun 2020 16:23
Subject: FW: URGENT COMMUNICATION

From: Brownlee, Roberta
Sent: 11 June 2020 17:48
To: O'Brien, Aidan
Cc: Devlin, Shane; Comac, Jennifer; Donaghy, Geraldine; Leeson, Pauline; McCartan, Hilary; McDonald, Martin; Mullan, Eileen; Rooney, SiobhanNED; Wilkinson, John
Subject: RE: URGENT COMMUNICATION

Aidan

Confirming receipt of your email and this has been copied as requested to all the NEDs. I have also spoken to the CX on your correspondence and he too has received a copy.

Roberta

From: O'Brien, Aidan
Sent: 10 June 2020 23:26
To: Brownlee, Roberta
Subject: URGENT COMMUNICATION
Importance: High

Dear Mrs. Brownlee,

I attach a letter addressed to you as Chair of the Southern Health & Social Care Trust Board.
I also attach letters sent to Mr. Devlin on 10 June 2020, and to Mrs. Toal on 09 June 2020.
I would be most grateful if you would bring the contents of these letters to the attention of the non-Executive members of the Board.
I would be grateful if you would acknowledge receipt of this communication.

Aidan O'Brien

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Received from Tughans OBO Mr Aidan O'Brien on 25/02/2022. Annotated by the Urology Services Inquiry