Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 26 of 2023

Date of Notice: 22 November 2023

Witness Statement of: Richard Pengelly

I, Richard Pengelly, will say as follows:-

1. On 1st July 2014, I took up post as Permanent Secretary in the then Department of Health, Social Services and Public Safety – renamed in 2016 as the Department of Health. I remained in this post until 4 April 2022, when I moved to the post of Permanent Secretary in the Department of Justice.

2. Prior to July 2014, I had been Permanent Secretary in the Department for Regional Development (now the Department for Infrastructure) (since 1 January 2013), and before that had held a number of roles in the (then) Department of Finance and Personnel (now the Department of Finance).

3. The key issue on which I have been asked to comment is the potential conflict of interest on the part of the then Chair of SHSCT, Mrs Roberta Brownlee. A number of specific questions have been put to me (in paragraphs 1, 2, 3, 4 and 5 of the Schedule) in this regard, and I have set these out, together with my responses, below.

1 (a) Please outline your recollections about any discussions which took place between yourself and Mrs Brownlee in 2020 including a description of the

Urology Services Inquiry

6 The Inquiry has received evidence from Peter May (now Permanent Secretary to the Department of Health) and Ryan Wilson (Director of Secondary Care). On review of that evidence, please provide any comments, revisions, or additional information which may assist the Inquiry within its Terms of Reference.

41. I have reviewed the evidence provided by Peter May and Ryan Wilson and have no comments to make on it, nor anything further to add to it.

Statement of Truth

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

Signed: _

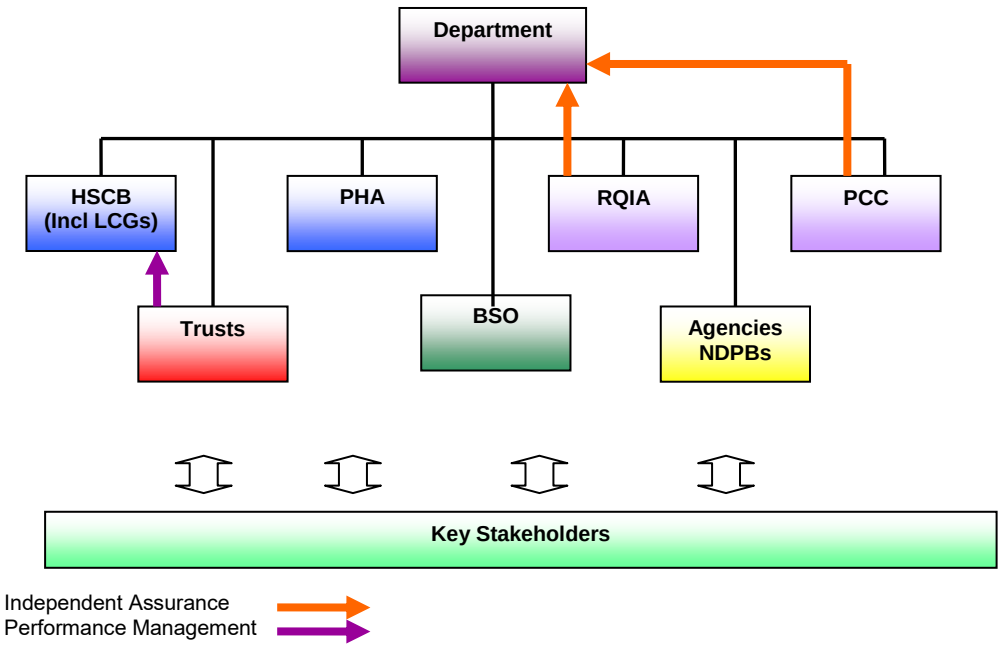
Date: _____20 December 2023_____

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

FRAMEWORK DOCUMENT

2. STRUCTURES, ROLES AND STATUTORY RESPONSIBILITIES

2.1. This section outlines the roles, responsibilities and relationships between the Department and health and social care (HSC) bodies. The diagram below shows the structure of the health and social care system.



Key: HSCB = Health and Social Care Board
LCGs = Local Commissioning Groups
PHA= Public Health Agency
BSO = Business Services Organisation
RQIA = Regulation and Quality Improvement Authority
PCC = Patient and Client Council
Agencies = Special Agencies (Northern Ireland Blood Transfusion Service, Northern Ireland Medical and Dental Training Agency and Northern Ireland Guardian ad Litem Agency)

Department of Health, Social Services & Public Safety

2.2. Section 2 of the Reform Act places on the Department a general duty to promote an integrated system of:

16.5 An Annual Board Governance Self-Assessment is required to be undertaken and a copy of the report shared with the Department of Health. Once in every three years, this exercise should be conducted via an external provider. In 2019 and 2022 therefore the Business Services Organisation's Internal Audit undertook the assessment as part of the internal audit programme of work. *Please see:*

97. 1819 IA Board Effectiveness
98. IA Final Report - Board Effectiveness 21-22
99. See Management Statement SHSCT

16.6 The 2021/2022 Board Governance Self-Assessment recognised the risk to the stability and effectiveness of Trust Board as a direct consequence of vacancies at Senior Executive and Non-Executive Director level. Actions to address this included: all Senior Executive positions to be advertised and appointed by December 2022 and Non-Executive Director positions competition programme, including SH&SCT vacancies, to be advertised by Public Appointments Unit in October 2022.

16.7 In my experience, having instability in the Board and Senior Executive Team directly impacts on the effectiveness of the governance structures. During the period 2016 – 2018 there were interim Chief Executives and interim Executive Directors who were members of the Trust Board. In addition, six out of eight Non-Executive Directors were newly appointed during the 2016/2017 year. The appointment of Mr Shane Devlin as Chief Executive in 2018 allowed for the beginning of a process to make substantive appointments to the Senior Team. August and November 2020 saw the end of tenures for two long-standing Non-Executive Directors. This created two vacant positions which, as I write, remain vacant. The appointment of Dr Maria O'Kane as Chief Executive in 2022 has seen the follow through on completing the restructure and recruitment of permanent and substantive posts across the Senior Leadership Team. *Please see 100. 20230802 Trust Board Membership 2010 – Present.*

16.8 In relation to the Health and Social Care Board (the former commissioner of services), reporting on governance of the Trust goes directly from the Trust to the

DoH Policies

There is no stand alone DoH policy. Hospital Services Reform Directorate are taking forward an assessment/review of urology services as part of a number of Task & Finish Groups established to oversee the implementation of a regional network of Daycase Elective Care Centres.

Cancer-related urology services are considered as part of cancer policy.

Structure and delivery of urology services

HSC Trust	Hospital Site	Beds	Clinics/Services
Belfast	Belfast City	Ward 3 South – 26 inpatient beds	General anaesthetic and local anaesthetic surgery; Outpatient clinics; Urology Day Care; Radiology (including unfunded regional IR service, mainly out of hours nephrostomy insertion, provided by IR).
	Mater	No beds	1x DPU GA session & 1x LA Flex Cu session
	Antrim Area	No beds	1x DPU GA session & 1x OP session.
	Whiteabbey	No beds	2x One-Stop Flex Cu Haem Clinics. (UNFUNDED)
	Lagan Valley Hospital (SET SBA Activity)	No beds	1x DPU GA session & 1x OP session.
South Eastern	Ulster Hospital	Inpatient urology is only in the Ulster Site. Urology emergency and elective beds are included within the total bed complement for General Surgery which is 24 elective and 48 emergency – No specified bed count dedicated to Urology.	Inpatient Operating Day Case Lists Outpatient Clinics
	Lagan Valley	No beds	Day case lists
	Downe	No beds	Day lists/ Outpatient Clinics
	Ards	No beds	Outpatient Clinics
	Bangor	No beds	Outpatient clinics

Urology (reviewed Sept 2019)

Assessment of policy review commencement priority: High

Recommended date for next policy review: 2019

Rationale: There is no stand-alone departmental policy for urology services.

Definition

Urology deals with diseases, trauma and congenital abnormalities of the kidney, bladder, genitalia and urinary tract as well as male sexual and reproductive health. Urology combines management of many non-surgical problems, such as urinary infections, and surgical problems such as the correction of incontinence, prostate problems and the treatment of cancer. Urology is closely linked with cancer services due to the cross related areas of prostate and bladder cancer. There are also linkages with both gynaecology and GUM/sexual health specialties.

Legislative Context

In common with HSC services generally the principal legislation underpinning the delivery of urology services in Northern Ireland is the Health and Social Care (Reform) Act (NI) 2009.

UK National Policy context

No current UK wide government policy is known of.

NICE Guidance

A wide range of NICE guidance is available on a range of urology related conditions. A general search for these can be carried out through the following link:
https://www.nice.org.uk/search?q=urology

Northern Ireland Policy Framework

PfG Commitments

There are no current or draft PfG commitments specifically related to urology.

HSCB/PHA commissioning plan deliverables for 2018/19

Per HSCB/PHA's 2018/19 Commissioning Plan Direction, page 131 refers to the urology ongoing challenge of delivering the 62-day waiting time.
http://www.hscboard.hscni.net/download/PUBLICATIONS/COMMISSIONING%20PLANS/Draft-Commissioning-Plan-2018-19.PDF

A regional review of urology services was completed in March 2009 by HSCB. The main recommendations of the review, which aimed to improve capacity for the delivery of urology services, included:

- An increase in consultant urologists from 17 to 23;
- All radical pelvic surgery to be carried out in BCH;
- At least 5 clinical nurse specialists should be employed;
- An increase the proportion of elective surgeries undertake as day cases; and
- Reconfigure the service into a three team model, covering northern, southern and eastern areas respectively.

Secondary Care Directorate (SCD) wrote to the HSCB in January 2019 to provide a PPE of the implementation of the review, and to inform a department-led review of current service provision (see HPRM HE1/19/74183). A response was requested by March 2019, it appears there has been no response to date.

The Department has established a series of Task & Finish (T&F) Groups to oversee the development, planning and implementation of a regional network of Daycase Elective Care Centres (DECCs). Hospital Services Reform Directorate, Project Manager – Joanne Elliott, has had responsibility for the establishment of the Urology T&F Group. The initial main tasks of this group included:

- assessing current and projected demand and capacity for daycase assessment and treatment for Urology;
- identifying the preferred self-contained sites for the delivery of daycase assessment and treatment for Urology, and
- assessing initial workforce considerations.

The Task & Finish Group is being supported by Ernst & Young (EY). EY will gather and analyse the available data to support the demand/capacity exercise. EY's final report was received by the Department in July 2019 (HPRM HE1/19/217410).

Robotic surgery – Prostate Cancer

In 2018, the HSCB and the Department approved the 2016 BHSCT business case for the introduction of a robotically assisted laparoscopic surgical service in urology (mainly for radical retropubic prostatectomy surgery) at the Belfast City Hospital. Capital funding for the service is being provided by the "Men Against Cancer (MAC)" charity.

Urology medical workforce planning report

A 'Urology Medical Workforce Planning Report Northern Ireland 2017 – 2024' was drafted by HSCB/PHA on behalf of DoH in May 2017, see HPRM HE1/18/135939.

Lines to take

- A regional review of urology services was completed in 2009 which resulted in a number of recommendations. The Department is awaiting an implementation report from the HSCB.
- A robotically assisted laparoscopic surgical service in urology has been introduced by BHSCT at the Belfast City Hospital site. The Department gratefully acknowledges the generous funding provided by MAC to establish this service.
- A review of urology medical workforce planning has been carried out in 2017 by HSCB/PHA on behalf of the Department (**check with Workforce Planning for update**).

Other related-policy issues

Due to the issues of prostate and bladder cancer, urology services are closely linked with cancer services and policy (see cancer services core brief).

There are also links with both gynaecology and GUM/sexual health specialties (see gynae and GUM/sexual health core briefs).

Relevant Clinical Guidance

As mentioned above, a wide range of NICE guidance is available on a range of urology related conditions and can be accessed through the following link: https://www.nice.org.uk/search?q=urology

The leading professional body in the UK for urological surgeons is the British Association of Urological Surgeons which organises continuing professional development education and training for urologists.

HPRM Containers

SCD Urology container – HE1-18-627

SCD Standard policy brief – record HE1/17/11050

By E-Mail

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Ms Valerie Watts
Chief Executive
Health and Social Care Board
12-22 Linenhall Street
Belfast BT2 8BS

Secondary Care Directorate
Room 1, Annexe 1
Castle Buildings
Upper Newtownards Road
BELFAST
BT4 3SQ

Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Date: 23 January 2019

cc. Lisa McWilliams, HSCB
Joan Hardy, DoH
Joe Magee, DoH

Dear Valerie,

Evaluation of Adult Urology Services

I am writing to you in regard to the HSCB's 2009 Review of Adult Urology Services. Please find attached a copy of the 26 recommendations as agreed in the Review, along with a post-project evaluation (PPE) pro forma.

The Department would be grateful if the HSCB could now complete the pro forma, and also separately set out the extent to which the 26 recommendations have been met. Where they have not been met, please provide details as to why.

The Department has a target in place to ensure that this PPE is completed by the end of the 2018/19 financial year. I would be grateful if the HSCB could please respond to me by **25 March 2019** to allow this deadline to be met.

If you need to discuss, please feel free to contact me as above.

Many thanks and kind regards,

Michelle Connor.

UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS
(Southern Trust)

Section 2 – Introduction and Context

	Recommendation	Update for stocktake
1 P8	Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.	General Surgery team in DHH undertake M codes specifically bladder tumour resection this is done by one General Surgeon with a specific specialism in urology and who partakes in MDT. Note: Daisy Hill Hospital have stopped performing TURP's
2 P9	Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.	General Surgeons in CAH and DHH are gradually transferring N codes over at referral source; for example, this surgical team now provides the vasectomy service, the effect of which releases more slots for our Urology team's day surgery list. Fermanagh Work is still and will remain with general surgery in Fermanagh, however Team South are getting referrals on specialist services and we are happy to continue with this arrangement.
3 P10	A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.	This work was commenced in 2012 and was being led by OPPC Directorate with Acute input. With the introduction of revised guidelines in Sept 2013 this will be revisited and completed and this may be helped by the appointment of our 6th Consultant who has an interest in Female Urology

Section 3 – Current Service Profile

	Recommendation	Update for stocktake
4 P15	Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.	This is work in progress with the biggest issue being delays in typing however there is emphasis being put on the importance of identifying at clinic other *consultant to consultant* referrals so that these letters can be picked up through digital dictation. Triage and MDT delays are a factor also to be considered and further streamlining of activity is ongoing.

5 P15	Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.	. NICaN Issue
6 P17	Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.	Consultant turnover only just settled with a consistent one-person deficit to date. Consideration will also be given to planning future replacements for those due to retire.
7 P17	Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.	Although there were meetings held with members from various Trusts to define care pathways, this was not followed through or funded by HSCB; this has halted completion of this project. There is little evidence of use of the aforementioned pathways instead traditional routes of referral appear to be used. We are hoping to move towards a consultant of the week model and this should improve such aspects of improved care both for quality and timeliness of treatment.
8 P17	Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.	As above This will not take too much to address, currently there is easy access by phone for advice and arrangement of transfer7-days per week. We receive such referrals from DHH and SWAH, and the current arrangements appear satisfactory but could be enhanced by printed pathways.
9 P18	Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.	As above 7 and 8
10	In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current	ICATS in SHSCT has fallen apart due to middle grade doctor and GPwSI staffing issues. This has resulted in a deficit in

P20	ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.	activity. In the longer term parts of this model do not appear to be sustainable in SHSCT. Our nursing team are not completely in a position to fill this void alone. We have tried unsuccessfully on several occasions to fill or retain the middle grade post which has resulted in intermittent ICATS clinic provision which then results in a long waiting list appearing for such services. The Urology team are in the process of redesigning these clinic services. The GP services have not to date engaged adequately in the redesign of these services.

Section 4 – Capacity, Demand and Activity

	Recommendation	**Update for stocktake**
11 P23	Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.	This remains an issue due to the deficit in staffing both at consultant and middle-grade level. However there are areas such as Day of Admission, Pre-operative Assessment that have improved and the Team are delivering on.

Section 5 – Performance Measures

	Recommendation	**Update for stocktake**
12 P27	Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.	The Trust have recently invested in expanding the Urology Outpatient Unit (Thorndale) and this has meant that we can redesign our services uncompromised by other activities in outpatients. Examples are aspects of Haematuria and Prostate clinics can be accommodated on a single visit. But issues with demand still remain a challenge.
13 P13	Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.	The Elective Admission Ward and preoperative assessment service have been a major advantage to the Urology service in that patients are admitted on day of surgery with few cancellations on the day of surgery, which previously had been an issue to due to lack of beds, and patients being unfit. The standalone day surgery unit in CAH and STH limits the type of patients that can have their surgery carried out in these specific day units and therefore means that the main theatre lists have to be used for the rest of the day case patients which is not a good use of theatre time and limits the

		team to what they can record as a daycase
14 P29	Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.	Not undertaken as yet, but willing to partake in when we have full team in place.
15 P30	Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.	As above number 13.
16 P31	Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.	Trusts have implemented a defined clinic template which is dependent on clinic type (e.g general or specific clinic such as Haematuria, prostate, stones etc...) The Trust are currently implementing the proposed NICaN cancer projects which should help from 2014 onwards. With the difficulties in the ICATS services we are redefining our nurse-led clinics. Clinics are consultant only with no junior support and therefore ensures that patients are not being reviewed inappropriately The Trust have attempted to engage GP's to help with reviewing patients in the community but to date there has been a reluctance from the GP colleagues to take this on.

17 P32	Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.	The Urology departments DNA rate is always below 5% and this is due to the booking system. However there is still a major problem with backlog reviews which is both for cancer and non-cancer patients. This is not being solved within the existing templates and the Urology team are struggling with this as the clinic template is weighed in favour of new to review ratio which is 1:1.5 as per original review.

Section 7 – Urological Cancers

	Recommendation	**Update for stocktake**
18 P37	The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.	NICaN issue
19 P38	By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.	Complete
20 P38	Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).	Complete

Section 8 – Clinical Workforce Requirements

	Recommendation	Update for stocktake
21 P41	To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.	Still ongoing and hopefully resolved by the summer.
22 P41	Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.	Operating session time is limited and impeding meeting the 31 and 62 day cancer targets. This has a knock on affect for the non-cancer patients who are waiting in access of the 13 week target and this is therefore resulting in patient complaints. The Team always endeavours to backfill theatre lists to ensure optimisation of all theatre time.
23 P43	At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.	On the back of the NICaN pathways the Trust are currently reviewing the CNS and their roles.

Section 9 – Service Configuration Model

	Recommendation	Update for stocktake
24 P44	Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.	Complete
25 P46	Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.	No Comment
26 P46	Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia,	This is not complete due to the delay in recruitment of the full teams.

Data source: BOXI CH3 Universe, run date 16/05/16

ref 5 (i)- OP NEW CONS LED UROLOGY REG SPEC WAITS (SUBMISSION)

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Number of Patients Waiting on a Consultant Led First Outpatient Appointment for Regional Urology Specialty by Consultant and Waiting Time Bands AS AT: #REF!

Sum of Total Waiting	Weeks Waiting										
Consultant Name	**0-9Wks**	**9+ to 13Wks**	**13+to 18Wks**	**18+ to 21Wks**	**21+ to 26Wks**	**26+ to 31Wks**	**31+ to 36Wks**	**36+ to 41Wks**	**42+ to 52Wks**	**52+Wks**	**TOTAL**
YOUNG	114	3	63	22	16	45	47	11	78	74	473
O'BRIEN	40	67	34	1	61	43	42	6	63	51	408
SURESH	73	46	4	39	45	31	31	11	40	65	385
GLACKIN	86	35	25	46	19	20	3	42	22	80	378
O'DONOGHUE	73	53	48	4	55	41	25	16	17	26	358
HAYNES	71	9	29	0	32	37	37	27	35	76	353
GENERAL UROLOGIST	120	36	24	11	18	24	19	17	26	48	343
UROLOGY CONSULTANT	40	2	0	0	0	0	0	0	0	0	42
A HAEMATURIA CONSULTANT	2	0	0	0	0	0	0	0	0	0	2
BROWN	1	0	0	0	0	0	0	0	0	0	1
TOTAL	**620**	**251**	**227**	**123**	**246**	**241**	**204**	**130**	**281**	**420**	**2743**

Produced by Directorate of Performance and Reform, Informatics Division, Information Team

Data source: BOXI CH3 Universe, run date 13/05/19

ref 5 (i)- OP NEW CONS LED UROLOGY REG SPEC WAITS (SUBMISSION)

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Number of Patients Waiting on a Consultant Led First Outpatient Appointment for Regional Urology Specialty by Consultant and Waiting Time Bands AS AT: **30/04/2019 (Run date 13/05/19)**

Consultant Name	0-9Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 41Wks	41+ to 52Wks	52+Wks	TOTAL
UROLOGIST (E)	428	103	81	40	42	7	0	0	0	77	778
HAYNES	26	4	9	3	7	26	46	13	78	372	584
YOUNG	35	8	13	5	9	10	17	17	42	341	497
GENERAL UROLOGIST	176	38	15	4	8	9	11	11	17	192	481
GLACKIN	11	3	2	3	16	23	1	23	31	365	478
O'DONOGHUE	19	4	14	3	24	16	22	19	15	315	451
O'BRIEN	13	7	6	3	2	21	5	9	17	253	336
SURESH	0	0	0	0	0	0	0	0	0	74	74
JACOB	0	0	0	3	1	1	1	1	2	12	21
HENNESSEY	16	0	0	0	0	0	0	0	0	0	16
BROWN	0	0	0	0	0	0	0	0	0	11	11
TYSON	3	1	0	0	0	0	0	0	0	0	4
HUGHES	0	0	0	0	0	0	1	0	2	0	3
GENERAL HAEMATURIA CONS	1	0	0	0	0	0	0	0	0	0	1
TOTAL	**728**	**168**	**140**	**64**	**109**	**113**	**104**	**93**	**204**	**2012**	**3735**

Produced by Directorate of Performance and Reform, Informatics Division, Information Team

Coroners Service for Northern Ireland

JOHN L LECKEY LL.M.
SENIOR CORONER
FOR NORTHERN IRELAND

Dr Tony Stevens, Medica Director, BHSCT
Dr Charlie Martin, Medical Director, SEHSCT
Dr John Simpson, Medical Director, SHSCT
Dr Alan McKinney, Medical Director, WHSCT
Dr Calum MacLeod, Medical Director, NHSCT
Dr Carolyn Harper, Executive/Medical Director of Public Health
Ms Charlotte McArdle, Chief Nursing Officer

HSC Belfast Health and Social Care Trust
25 OCT 2013

Our ref: 1791-2011

21st October 2013

Dear Medical Director
and Chief Nursing Officer,

Re: Lynn Lewis, deceased

On 16th October 2013 I concluded an inquest into the death of a 38 year old woman, Mrs Lynn Lewis, who died in the Ulster Independent Clinic on 7th July 2011.

I believe sufficient background information is contained in the Verdict to which is annexed a copy of a statement on behalf of Professor Neil McClure the Surgeon, Dr Damien Hughes the Anaesthetist, the Ulster Independent Clinic and the nursing staff (copies enclosed). Also, I am enclosing a copy of a letter I have sent to the Minister for Health together with copies of the enclosures therein referred to.

At the conclusion of the inquest I stated that in addition to making a report pursuant to the provisions of Rule 23(2) of the 1963 Coroners Rules to the Minister, the Chief Medical Officer, the Regulation and Quality Improvement Authority and the Director of Public Health I would be writing to the Medical Director of all Northern Ireland Hospitals and the Northern Ireland Chief Nursing Officer. I would ask the Medical Directors to provide me with a collegiate response to the surgical and anaesthetic failings that the inquest has identified and I would ask for a similar response from the Northern Ireland Chief Nursing Officer in relation to nursing issues.

I should be grateful if you would acknowledge receipt of this letter and confirm that you will be responding in the manner I have requested. I, and no doubt the family also, require reassurance that all steps have been taken to ensure patient safety and

Tel: 028 9044 6800 Fax: 028 9044 6801
May's Chambers, 73 May Street, Belfast. BT1 3JL
www.coronersni.gov.uk

everything possible has been done or will be done to prevent the occurrence of a similar fatality or other serious adverse incident that has not resulted in a fatality.

I am sending a copy of this letter to the Minister, CMO, RQIA, Director of Public Health and the legal representatives.

I will look forward to hearing from you.

Yours sincerely

J L LECKEY
Senior Coroner for Northern Ireland

Encs

From the Deputy Chief Medical Officer
Dr Paddy Woods

HSS(MD)14 /2015

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Castle Buildings
Stormont
BELFAST
BT4 3SQ

Tel: Personal Information redacted by USI
Fax: Personal Information redacted by USI
Email: Personal Information redacted by USI

Your Ref:
Our Ref: HSS(MD)14 /2015
Date: 18 August 2015

For Action:

Chief Executives HSC Trusts
Chief Executive HSCB
Chief Executive PHA
Chief Executive RQIA *(for dissemination to independent sector organisations)*

Dear Colleague

POLICY ON THE SURGICAL MANAGEMENT OF ENDOSCOPIC TISSUE RESECTION

ACTION REQUIRED

1. HSC Trusts and independent providers should process this regional policy template for endorsement by the organisational board, or equivalent;

2. HSC Trusts and independent providers should develop action plans to implement the various elements of the endorsed policy;

3. HSC Trusts should work with commissioners to address resource issues arising from these implementation plans in a phased, consistent and timely manner; and

4. the Public Health Agency should report on progress by 30 November 2015.

As a result of the verdict of the Coroner into the cause of death of Mrs Lynn Lewis in October 2013, work was commissioned on ensuring the safe and effective management of procedures involving the use of distending fluids in endoscopic procedures. In recognition of the limited guidance available on the management of these procedures, local work was commissioned, led by Dr Julian Johnston, Assistant Medical Director in Belfast Health and Social Care Trust.

The attached outline policy is the product of that work and we are now commending it for regional implementation.

Southern Health and Social Care Trust

ACTION PLAN

Reference	HSS (MD) 14/2015
Title of Clinical Guideline / Standard	Policy on the surgical management of endoscopic tissue resection, for example during urological, gynaecological and other relevant surgery
Date of Endorsement and Issue from External Agency:	18/08/2015
Submission Date for Assurance Response / Action Plan to HSCB:	31/10/2015 was the initial deadline date Letter from Dr Little (DHSSPSNI) received 03/11/2015 requesting an update Two week extension given – new deadline for submission 23/11/2015
Directorate/s affected by guideline recommendations	Acute Services
Operational Director	Mrs Esther Gishkori
Identified Change Leader	Mrs Mary McGeough – Head of ATICS Mrs Wendy Clarke – Acting Head of Midwifery & Gynaecology Dr G. McCracken – Clinical Director IMWH Mrs Martina Corrigan – Head of ENT and Urology Mr Young – Lead Consultant Urologist

Actions for Trusts					
Recommendation	**Current Control Measures**	**Current level of compliance (%)**	**Action plan**	**Designated Lead**	**Deadline for completion**
1. Preoperative workup **must** be geared towards prevention of the TUR syndrome.	All of these patients are optimised for surgery and as part of the pre-operative work up, the risk factors pertaining to TUR syndrome are identified and managed. Within Urology all patients are provided with a BAUS information Leaflet and at clinic appointment are advised verbally of the risk factors. All patients have standard haematology and electrolyte analysis completed and have careful consideration regarding blood grouping and cross matching.		An audit will be carried out to review the consent process for patients to determine if the patients have been "*truly made aware of the hazards of endoscopic resection using irrigation fluids*". Patients will be identified from Theatre Management System. Recent Investigations aimed at establishment of pathological anatomy and degree of Surgical risk to be scoped Availability of reports of such investigations prior to commencement of surgery to also be scoped	Mrs Mary McGeough (Head of ATICS)	31/12/2015
2. Introduce Bipolar resection equipment. During the switchover to bipolar equipment, limit the use of glycine following careful risk assessment of individual patients. If glycine is still being used, strictly monitor as detailed in recommendation 5.	Within Gynae services bipolar resection equipment is in place within CAH and DHH (with the exception of one Consultant). Glycine is not used at all. The only exception to this is when there is a failure of the bipolar equipment		Ensure robust and monitored control measures are in place for the use of Glycine within urology services	Mrs Mary McGeough (Head of ATICS)	Ongoing

Corrigan, Martina

From: O'Brien, Aidan [redacted]
Sent: 30 March 2016 16:17
To: Young, Michael; Corrigan, Martina
Cc: Glackin, Anthony; Suresh, Ram; Haynes, Mark; ODonoghue, JohnP
Subject: Bipolar Resection

Michael and Martina,

I wish to take the opportunity to update you on my experience of trying bipolar resection systems.
I have tried the models on trial to date, and did so having disabused myself of any prejudice against their use.
As reported previously, I found their performance inferior to monopolar mainly as a consequence of the intermittency of the current, the lack of any small vessel fulguration whilst cutting and the much reduced rate of continuous irrigation.
I last use bipolar two weeks ago to resect the moderately enlarged prostate gland of an elderly patient.
I had to abandon bipolar resection after 10 minutes because of bleeding, poor irrigation and visualisation.
The intraoperative comparison of both systems was remarkable.
Bipolar resection placed this patient in intraoperative danger, and salvaged by monopolar resection.

I have therefore pledged not to do so again.
I will not use or try bipolar resection again,

Aidan.

Corrigan, Martina

From: Young, Michael <[redacted]>
Sent: 16 November 2017 17:55
To: Carroll, Ronan
Cc: Corrigan, Martina
Subject: saline TURP issue

Dear Ronan
I write with regards to the saline TURP issue.
As you are aware the DoH had undertaken a review of irrigation fluid used for TURP surgery a few years ago after a significant adverse event in which a young lady died. As a result a clearly documented pathway noted that hospitals in Northern Ireland should move to using saline as opposed to glycine for irrigation. In the Southern Trust we have been using glycine and therefore it has been necessary for us to convert over to new equipment for our Consultants and team to be compatible with DoH guidelines.

Several saline resectoscope systems are available. We have proceeded through a process of trialling each of these. We have considered several factors, including efficiency of use through to the financial impact, before coming to a conclusion. We as a department felt this was important to undertake as there would be long term implication to our decision. In saying all of this, we still felt that a defined date to transfer over to the new system was needed. We defined this date as 1st January 2018. This date was defined as fitting a timeline that allowed for the trail period, quotes to be received, assessment and providing the Trust a reasonable period of time to purchase the equipment.

The move to using Saline for TURP resection has been dictated by the DoH. The consequences of not moving to its use will leave Consultant Urologists at risk as if another significant adverse incident occurs they will feel very much exposed. I am not sure the Southern Trust would be able to cover them properly if such an event occurred when it is clear the DoH had made their stipulation.

We were under the distinct impression that having gone through our selection process and giving adequate notice, as discussed at the Theatre Users group, that this date was reasonable and would be compliant with the DoH documentation and hence for the Trust to be able to report back to DoH on the same.

It has now come to my attention that the Trust is not able to or in a position to proceed with the purchase of this equipment. It is not clear why this is the case as we have been instructed to move over to this system by the Trust itself.

Urologists in the department will be maintaining their position for a switch to using saline to perform TURP as of 1st January 2018. If the new equipment is not available the Urologists will cease the current type of TURP surgery. I am sorry this appears a little dogmatic, but the DoH and Coroners case that has sparked this course has been clearly set out and leave Consultants vulnerable if they do not attempt to comply.

M Young
Lead Clinician Urology

Belfast Health and Social Care Trust

caring supporting improving together

Chief Executive
Mr. Martin Dillon

Chairman
Mr. Peter McNaney, CBE

Ref: DMAO 18/02

3 January 2018

Mr. Andrew Dawson
Interim Director of Workforce Policy
Castle Buildings
Stormont Estate
BELFAST BT4 3SQ

Dear Andrew

Maintaining High Professional Standards in the Modern HPSS

You will be aware that the above guidance was developed in 2005 to assist in the management of issues of personal and professional conduct pertaining to all medical and dental staff within the Health and Social Care system. I believe the guidance document that was issued within NI largely mirrors that which was developed for use within the NHS elsewhere in the UK.

I am writing to ask that consideration be now given to a review of the documentation and its content. I believe that while the clear intent of the guidance is being, and has been, fulfilled by its operation over time, in reality its practical application in parts has become increasingly more difficult to the result that cases are now taking an inordinate and unacceptable amount of time to progress.

I would welcome a discussion about this at a forthcoming HRD Forum and I have copied to Dr Paddy Woods and my Trust HR Colleagues for information.

Yours sincerely

Damian McAlister
Director of Human Resources and Organisational Development

Copy List: Dr P Woods – Deputy CMO, DoH
Trust HR Directors
Mrs J Kennedy – HR Co-Director, BHSCT

respect & dignity openness & trust leading edge learning & development accountability

From the Director of Corporate Management
La'Verne Montgomery

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Room C5.18
Castle Buildings
Stormont Estate
Belfast BT4 3SQ

Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Chairs of HSC ALBs & NIFRS

Date: 24 March 2017

Dear Chairs

CONFLICTS OF INTEREST

In response to a query raised at the Departmental Board, I wish to take the opportunity to remind Non Executive Directors (NEDs) of the requirement for Board members of Public Bodies to act appropriately when a conflict of interest situation arises. All NEDs must discharge their duties in line with the seven principles of public life and any conflict of interest must be identified and managed in a way that safeguards the integrity of Board members and maximises public confidence in the organisation's delivery of Public Services.

I would draw your attention to the attached Codes of Conduct and Accountability that all NEDs will have received on appointment. In particular I draw your attention to paragraph 8 on Public Business and Private Gain. I ask that all your Non Executive Directors take the opportunity to re-familiarise themselves with the contents of the codes. More detailed guidance on conflicts of interest is available at: https://www.niauditoffice.gov.uk/sites/niao/files/media-files/conflicts_of_interest_good_practice_guide.pdf

If you require any further information on this matter, please contact Joanne Elliott Personal Information redacted by the USI in the first instance.

Yours sincerely

LA'VERNE MONTGOMERY
DIRECTOR OF CORPORATE MANAGEMENT

cc Chief Executives ALBs & NIFRS
Sponsor Branches
Deborah McNeilly

Public Business and Private Gain

8. Chairs and board members should act impartially and should not be influenced by social, political or business relationships. They should not use information gained in the course of their public service for personal gain or for political purposes nor seek to use the opportunity of public service to promote private interests or those of connected persons, firms, businesses or other organisations. Where there is a potential for private, voluntary, charitable etc interests to be material and relevant to HSC business, the relevant interest should be declared and recorded in the board minutes and entered into a register which is publicly available. When a conflict of interest is established, the board member should withdraw and play no part in the relevant discussion or decision.

Hospitality and Other Expenditure

9. Board members should set an example to their organisation in the use of public funds and the need for good value when incurring public expenditure. The use of HSC monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. All expenditure on these items should be capable of justification as reasonable in light of approved practice in the public sector. HSC boards should be aware that expenditure on hospitality or entertainment is the responsibility of management and is open to challenge by the internal and external auditors. Ill-considered actions can diminish public respect for the HSC.

Relations with Suppliers

10. HSC boards should have an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and decisions should be recorded. HSC boards should be aware of the risks in incurring – or seeming to incur – obligations to suppliers at any stage of a contracting relationship.

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

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

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 the USI **(Internal)**
Email: Personal Information redacted by the USI
'You can follow us on Facebook and Twitter'

28. Please provide full details of all contact between you and any other person or third party (including the HSCB and the Department of Health) regarding or touching upon the issues of concern about Mr. O'Brien and his practice.

I had spoken to the Permanent Secretary, Mr Richard Pengally on two occasions: my first call was sometime in Summer 2020, and it was regarding my replacement as Chair. I remember I was interviewing in the Seagoe Hotel Portadown and stood out of the meeting to take this call. I asked Richard Pengelly when my replacement was being announced. I was advised that interviews were completed, and he would push to get an announcement. I explained then the investigation into Mr O'Brien, the situation that I was in, and that I did not wish to be involved in any meetings.

The second telephone call with Richard Pengelly was late September, again cannot recall the exact date and I did not take notes. Mr Pengelly phoned me to ask about the CURE Charity. I explained the history behind the foundation and management of this charity. I told Mr Pengelly that I had not been attending Board meetings with an agenda item on Mr O'Brien.
Mr Pengelly told me that - whilst I had a conflict of interest - it still was extremely important that I fulfilled my role and responsibilities as Chair. He reminded me that I should be careful that, in my absence from Board meetings, I was kept well informed and maintained control as Chair.

Richard stated to me that he knew me well enough to know I would act professionally. I had a particularly good meaningful conversation with Richard.

Board actions regarding urology and Mr. O'Brien

29. Please provide full details of when, how and by whom (i) you and (ii) the Board (if different or at different times) were first made aware of issues and concerns regarding the practice of Mr. O'Brien, to include all information about what was said and/or documentation provided?

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.

Jackie 15/10/20

Urology at Southern

SHSCT - concerns about doing statement next week

concerns about prescribing practice (unlicensed and sub therapeutic medicines)

Meeting this afternoon

SHSCT wanted meeting with CMO – not happy.

'Comprehensive' report in but not been reviewed yet. Sense they want to do their own internal review.

Statement prob be week after next (rather than next week)

? set up Perm Sec Assurance Group to oversee work on this?

Southern Trust Urology 22/10/20

- Early alert in summer
- Concerns escalated as Trust investigated.
- Private practice conducted in own home
- Previous issues about same consultant in 2016 (? and 2009?)
- Managing patients
- Investigating doctor
- Overview of process/learning
- Maintaining high

? What (external to SHSCT) process do we need to oversee this

? Has 'maintaining high' worked (link to Michael Watt)

? Ministerial statement week after next?

Trust has been identifying patients and trying to provide care.

Ring Shane

Jackie 26/10/20

CURE – Roberta Director/Secretary - Shane was not aware. Roberta had not ever disclosed.

I spoke to Shane – he will speak to Roberta and get back to me.

Roberta 4/97 – 7/12

Aidan O'Brien

Craigavon Urology Research and Education company

GP [unclear]

- Managing patients
- notifying doctor
- use of powers/[illegible]
- Ranking high

Southern Trust Urology 23/10/20

- Early alert in summer
- concerns escalated as Trust investigated
- private patients contacted in own time
- previous issues at same consultant in 2016 (2 and 2009?)

? What (related to SHSCT) powers do we need to assure this

? Is 'maintaining high' worked (look to Michael Watt)

? Medical staffed [illegible] after rest?

Trust has been identifying patients + trying to provide care

(R) Ring Shane

circumstances leading up to the discussions and a summary of what was discussed.

4. I have no recollection or record of any conversation with Mrs Brownlee at any time in 2020 on the issue of Mr Aidan O'Brien or Urology Services at Craigavon Area Hospital. I do recall (but cannot attribute a date to) a brief conversation with Mrs Brownlee on the timeline for her replacement as Chair of the Trust Board.

1 (b) Please comment on Mrs Brownlee's evidence above, indicating in which respects you agree or disagree with it, and why.

5. As set out in 1(a) above, I have no recollection of any conversations on the issue of Mr Aidan O'Brien or Urology Services at Craigavon Area Hospital taking place with Mrs Brownlee.

6. I do have a clear recollection that the first time I was made aware of any potential conflict of interest issue involving Mrs Brownlee was when my departmental colleague, Jackie Johnston, advised me that Mrs Brownlee had been listed as a Director of CURE. I was unaware of this before this conversation. My notebooks from the time record this conversation as taking place on 26 October 2020 (copy attached titled RP1, page 5).

7. Later that same day, I telephoned the then Chief Executive of SHSCT, Shane Devlin, about the issue. In the course of my call with Mr Devlin on 26 October 2020, he advised me that he had not been aware of the CURE link. Mr Devlin also made me aware of the further potential conflict of Mrs Brownlee being both a friend and a former patient of Mr O'Brien. I was not aware of this before that conversation. Mr Devlin advised that he was uncomfortable with this, and particularly the specific fact that Mrs Brownlee had not formally declared this as part of any Board discussion of the Urology issue (including as regards her participation in the Board meeting on 22 October). I indicated to Mr Devlin that I agreed with his view that the issue should have been disclosed, and I recall outlining my further view that, in light of the potential conflict, Mrs Brownlee should not be a party to any discussion of the issue. To resolve this going

forward, I suggested that Mr Devlin should speak to Mrs Brownlee as a matter of urgency and make this view clear to her.

8. I do not recall, nor have a record, of any follow up call by me with Mrs Brownlee on this issue.

9. The fact that 26 October 2020 was the first time I was made aware of any potential conflict of interest is clearly at odds with the suggestion of me being part of any conversation with Mrs Brownlee prior to that date (she has indicated both discussions pre-dated October 2020).

10. Notwithstanding my view that such a conversation did not take place, if, as Mrs Brownlee suggests, in Discussion 1 (in "Summer 2020") she indicated to me that she "did not wish to be involved in any meetings", it is odd that she subsequently participated in the Board discussion on the issue on 22 October 2020. My view is that it would have been entirely open to her to withdraw from such a discussion, and I am unaware of any assertion that she was compelled to participate.

11. I firmly believe that, had I been part of any discussion with Mrs Brownlee as regards a potential conflict of interest, my clear advice would have been that this should have been formally disclosed and recorded, and that she should not have participated in Board level discussions of the matter.

1 (c) Please also provide any and all documents within your custody or under your control relating to these discussions.

12. It is my normal practice to use a personal notebook as part of my work routine. This notebook is used to capture points that arise during meetings/discussions etc to assist me in managing the flow of those meetings/discussions – i.e.it is not intended to be a complete record of every meeting/conversation I have, nor a comprehensive record of every component of those discussions that are recorded. The main aim is to help me in the flow of the meetings as they take place, and the notes are not intended to be a substitute for the official record of such meetings/discussions, where one is appropriate. I have attached the

Southern Health and Social Care Trust

30th December 2016

Dr Michael McBride
Chief Medical Officer
DHSSPS
C5.15 Castle Buildings,
Stormont Estate,
Belfast,
BT4 3SQ

Dear Dr McBride

Notification of immediate exclusion of Mr Aidan O'Brien GMC No: 1394911 Consultant Urological Surgeon, Southern Health & Social Care Trust

I am writing to inform you that, under the terms of Maintaining High Professional Standards (MHPS), the Southern Trust has today excluded the above doctor.

The reason for the exclusion, taken following advice from NCAS, was to allow a four week period to scope out the scale of potential problems in relation to Mr O'Briens administrative practices, which may have led to patients coming to harm, and form the Terms of Reference of a formal investigation.

The scoping exercise will be considering:

1. Potential delays in triaging GP referral letters
2. Potential delays in recording the clinical outcome of outpatient clinics
3. Potential adverse impact of patients notes being kept at home for unreasonable periods of time

The decision was taken by the Southern Trust's Oversight Committee on the basis that, if Mr O'Brien's administrative practices have potentially led to patients coming to harm, should he return to work, the potential that his administrative practices could continue to harm patients would still exist.

In line with MHPS guidance, this scoping exercise will be completed within four weeks, and I will update you upon its conclusion. If the exercise identifies significant concerns during its progress, I will of course alert you earlier.

Yours sincerely

Dr Richard Wright
Medical Director

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

To note.
ANNEX A

☒ **Initial call made to** CMO OFFICE **(DoH) on** 01.08. 20 **DATE**

Follow-up Pro-forma for Early Alert Communication:

Noted 13/8/20

Details of Person making Notification:

Name: Dr Maria O'Kane | Organisation: Southern Health and Social Care Trust

Position: Medical Director | Telephone: [redacted]

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: **If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.*

On 7th June 2020 the Trust became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of a Trust employed Consultant Urologist. As a result of these potential patient safety concerns a lookback exercise of the Consultants work was conducted to ascertain if there were wider service impacts. The lookback which considered cases over a 17 month period (period 1st January 2019 - 31st May 2020), the following was found:

- The emergency lookback concentrated on whether the patients had a stent inserted during procedure and if this had been removed. 147 patients taken to theatre that was listed as being under the care of the Consultant during the lookback period with concerns identified in 46 of these cases.
- There were 334 elective-in patients reviewed where 120 of cases were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, a further 36 patients who had no record of care noted on the regional NIECR system. To date one of the elective in-patient cases has been identified for screening for Serious Adverse Incident review.

In addition two recent cases managed by this consultant have been identified which are being screened as Serious Adverse Incidents involving two prostatic cancer patients that indicate potential deficiencies in care provided by the consultant in question where these deficiencies potentially had an impact on patient prognosis. The following actions have been taken:

- Discussions with the GMC employer liaison service have been conducted
- This case has been discussed with NHS Resolutions who have recommended restrictions of clinical practice including a request to the Consultant not to undertake private practice in his own home or other premises pending further exploration
- Restrictions have been placed by the Trust that they no longer to undertake clinical work and that they do not access or process patient information either in person or through others either in hard copy or electronically. A request has also been made they voluntarily undertake to refrain from seeing any private patients at their home or any other setting and confirm the same in writing.
- A preliminary discussion has been undertaken with the Royal College of Surgeons invited Review Service regarding the consultants practice and potential scope and scale of any lookback exercise

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Stephen Wallace / Zoe Parks

Contact details:

Email address (work or home): [redacted] ; [redacted]

Mobile (work or home) Telephone (work or home: [redacted]

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: ..... Date: .....

Devlin, Shane

From: Devlin, Shane < Personal Information redacted by the USI >
Sent: 09 October 2020 14:17
To: Pengelly, Richard
Subject: AOB - Urology
Attachments: Item 7. Urology - Summary for TB Clinical Concerns 24.92020 vt.pdf

Richard

Further to your telephone call this morning with regards to Urology consultant AOB I was concerned that there was a view that the DOH were not fully briefed or aware of the situation.

I have spoken with the team and they are preparing a detailed brief for next Wednesday. I had also asked for an assurance that DOH staff have been fully briefed throughout this process. As you can see from the table below there has been a process of engagement and I hope DOH officials do feel informed.

For your own records I have also attached the paper that was discussed at my Trust Board. However given the continuously developing situation the information is clearly only correct at the time is was prepared.

Very happy to discuss further

Shane

31st July 2020	Early Alert issued to DoH and HSCB as per regional protocol
31st July 2020	Copy Email of Early Alert issued directly to CMO Office – Dr Maria O'Kane
6th August 2020	Dr Maria O'Kane discussion re case with Deputy CMO
18th August 2020	Email to CMO to request further advice on review / lookback requirements and issues relating to professional early alerts – advised to discuss with Jackie Johnston
24th August 2020	Meeting with Jackie Johnston DoH to discuss case
27th August 2020	Meeting with Paul Cavanagh and Brid Farrell to discuss case on DoH advice
3rd September 2020	Weekly Meeting with DoH – Ryan Wilson - David Gordon
10th September 2020	Weekly Meeting with DOH –Paul Cavanagh and Brid Farrell
17th September 2020	Weekly Meeting with DOH - Ryan Wilson, Paul Cavanagh and David Gordon
24th September 2020	Weekly Meeting with DOH - Ryan Wilson, Paul Cavanagh,
1st October 2020	Weekly Meeting with DoH – Ryan Wilson
8th October 2020	Weekly Meeting with DOH – Jackie Johnston, Ryan Wilson, Paul Cavanagh & Brid Farrell

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

Jackie 9/10/20

Craigavon urology O'Brien

- 5 SAIs a week ago
- going to pull together TOR (based on central finding) for future urological scrutiny to review
- might take them to recall
- consultant urologist stopped and said given range of work this work tenable.
- Done a look back review – several hundred records
- Now identified 9 SAIs – potential for another 9-15
- Setting up expert panel to look at all SAIs as a group
- 2 main issues
    - time for onward referral not good (some areas waiting up to 12 weeks to refer)
    - Prescribing of a potential drug (re prostate) maintain sexual function but could shorten life. Patients not aware of trade off. Prescribed to one 82 year old.
- Jackie has asked for comprehensive report for next Wednesday.
- same group had 5 previous SAIs. May need to go back to their families.
- Looks like Michael Watt all over again.
- Jackie feels Trust has tried their best to manage this. Have talked to Belfast Trust about Watt case.
- But – don't feel they have sense of what is coming down the track towards them.

Shane 9/10/20

- To send comprehensive report that was recently presented to Trust Boards
- Up until recently, looked just like administrative failings. Now finding concerns about clinical treatment.
- Feels like they need another couple of weeks to bottom out all the detail. Up to 8 SAIs at most.
- Potentially 1700 unread diagnostic reports.
- Feels to Shane like Michael Watt
- Not picking up any external noise at moment
- Trust speaking to individual families as issues arise. Has plans to go public, but not ready yet.

Southern Health and Social Care Trust

Quality care – for you, with you

BOARD REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 24th September 2020
Title:	Clinical concerns within Urology
Lead Director:	Dr Maria O'Kane Medical Director
Purpose:	Confidential – For Information

Key strategic aims:

Delivery of safe, high quality effective care

Key issues/risks for discussion:

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.

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.

Consultant A was provided with a letter dated 23 March 2016 detailing their concerns and asking him to respond with an immediate plan to address the concerns. Four broad concerns were identified:

- **Un-triaged outpatient referral letter**
  It was identified at that time that there were 253 un-triaged referrals dating back to December 2014.

- **Current Review Backlog up to 29 February 2016**
  It was identified at that time that there were 679 patient's on Consultant A's review backlog dating back to 2013, with a separate oncology waiting list of 286 patients.

- **Patient Centre letters and recorded outcomes from clinics**
  The letter noted reports of frustrated Consultant colleagues concerned that there was often no record of consultations / discharges made by Consultant A on Patient Centre or on patient notes.

- **Patient's hospital charts at Consultant A's home**
  The letter indicated the issue of concern dated back many years. No numbers were identified within the letter.

April to October 2016
During the period April to October 2016, discussions were on-going between Acute Directorate and Medical Director about how best to manage the concerns raised with Consultant A in the letter of 23 March 2016. It was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally. Consultant A advised the review team he did not reply to the letter but did respond to the concerns raised in the letter by making changes to his practice.

November 2016
Consultant A was off work on sick leave from 16 November 2016 following surgery and was due to return to work on 2 January 2017.

An on-going Serious Adverse Incident (SAI) investigation within the Trust identified a Urology patient Patient 10 who may have a poor clinical outcome because the GP referral was not triaged by Consultant A.

An SAI investigation was commenced in Autumn 2016. Through the SAI it was identified that the referral for patient Patient 10 had not been triaged by Consultant A. An initial look back exercise was undertaken and a number of other patients were identified as not having been triaged by Consultant A. Further assessment of the

Where the reviewing consultant feels that there is a possible issue with care provided, a Datix will be completed by the Consultant Urologist.

3. A further review of inpatients who had stent procedures performed by Consultant A from January 2018 to December 2018 is being carried out to ascertain if any further patients require stent management plans.

In addition, a significant number of patients who are overdue follow up on Consultant A's Oncology Outpatient Review Waiting List (patients who are past their review date) are having their outpatient assessment provided by a recently retired Urologist who has been engaged by the Trust - 235 patients.

A preliminary discussion has been undertaken with the Royal College of Surgeons Invited Review Service regarding Consultant A's practice and potential scope and scale of any independent external review, if required.

Timescales

The above reviews and scoping exercises are either completed or under way so timescales still need to be clarified. The Department of Health is keen to manage the oversight of the review process. The Minister will be required to share details of this with the Assembly and this is likely to be mid- October, subject to the outcomes of the review exercises. A resource plan is in development to identify clinical capacity for communication, patient information and clinical assessment and management plans. This will present significant challenge given the current workforce issues within the Urology speciality.

Previous concerns relating to Consultant A

Previous concerns relating to Consultant A were being addressed since March 2016, and under Maintaining High Professional Standards from December 2016. The timeline for these previous concerns is detailed below:

March 2016

On 23 March 2016, Mr EM, the then Associate Medical Director (Consultant A's clinical manager) and Mrs HT, Assistant Director (Consultant A's operational manager) met with Consultant A to outline their concerns in respect of his clinical practice. In particular, they highlighted governance and patient safety concerns which they wished to address with him.

26 March 2018
No comments were received from Consultant A.

29 March 2018
A final opportunity was provided to Consultant A to provide comments by 12 noon on 30 March 2018. It was advised that the investigation report would be thereafter drafted.

30 March 2018
No comments were received from Consultant A.

2 April 2018
Comments on the statements from the meetings of 3 August and 6 November were received from Consultant A. Consultant A also queried requested amendments to notes of meeting on 30 December 2016 and 24 January 2017.

21 June 2018
In the interests of concluding the investigation report without further delay, all comments from Consultant A were considered and a finalised report was provided to Consultant A on 21 June 2018 for comment.

14 August 2018
The Case Manager, Dr AK wrote to Consultant A acknowledging receipt of his comments and advising he would consider these along with the final report and reach his determination in terms of next steps.

1 October 2018
Dr AK, Case Manager met with Consultant A to outline outcome of his determination that the case should be forwarded to a Conduct Panel under MHPS.

The Findings from the investigation

There were 783 un-triaged referrals by Consultant A of which 24 were subsequently deemed to need upgraded and a further 4 with confirmed diagnoses of cancer (plus the original SAI patient.) There was therefore potential for harm of 783 patients.

Consultant A stored excessive numbers of case notes at his home for lengthy periods. 288 charts were brought by him from his home and returned in January 2017. This is outside normal acceptable practice. There were 13 case notes missing

7. Concerns about Mr O'Brien's practice were known to senior managers within the Trust in March 2016 when a letter was issued to Mr O'Brien regarding these concerns. The extent of the concerns was not known. No action plan was put in place to address the concerns. It was found that a range of managers, senior managers and Directors within the Acute Service Directorate were aware of concerns regarding Mr O'Brien's practice dating back a number of years. There was no evidence available of actions taken to address the concerns.

Other findings / context

Other important factors in coming to a decision in respect of the findings are:

Triage

1. Mr O'Brien provided a detailed context to the history of the Urology service and the workloads pressures he faced. Mr O'Brien noted that he agreed to the triage process but very quickly found that he was unable to complete all triage. Mr O'Brien noted that he had raised this fact with his colleagues on numerous occasions to no avail. Mr O'Brien accepts that he did not explicitly advise anyone within the Trust that he was not undertaking routine or urgent referral triage. Mr O'Brien did undertake red-flag triage.

2. It was known to a range of staff within the Directorate that they were not receiving triage back from Mr O'Brien. A default process was put in place to compensate for this whereby all patients were added to the waiting lists according to the GP catergorisation. This would have been known to Mr O'Brien.

3. Mr Young is the most appropriate comparator for Mr O'Brien as both have historical long review lists which the newer Consultants do not have. Mr Young managed triage alongside his other commitments. Mr Young undertook Mr O'Brien's triage for a period of time to ease pressures on him while he was involved in regional commitments.

Notes

1. There was no proper Trust transport and collection system for patient notes to the SWAH clinic in place.

2. There was no review of notes tracked out by individual to pick up a problem.

3. Notes were returned as requested by Mr O'Brien from his home.

4. It was known that Mr O'Brien stored notes at home by a range of staff within the Directorate.

Undictated clinics

1. Mr O'Brien's secretary did not flag that dictation was not coming back to her from clinics. Mr O'Brien's secretary was of the view that this was a known practice to managers within the Directorate.

2. Mr O'Brien indicated that he did not see the value of dictating after each care contact.

3. Mr O'Brien was not using digital dictation during the relevant period and therefore the extent of the problem was not evident.

5.0 Case Manager Determination

My determination about the appropriate next steps following conclusion of the formal MHPS investigation:

- There is no evidence of concern about Mr O'Brien's clinical ability with patients.

- There are clear issues of concern about Mr O'Brien's way of working, his administrative processes and his management of his workload. The resulting impact has been potential harm to a large number of patients (783) and actual harm to at least 5 patients.

- Mr O'Brien's reflection on his practice throughout the investigation process was of concern to the Case Investigator and in particular in respect of the 5 patients diagnosed with cancer.

- As a senior member of staff within the Trust Mr O'Brien had a clear obligation to ensure managers within the Trust were fully and explicitly aware that he was not undertaking routine and urgent triage as was expected. Mr O'Brien did not adhere to the known and agreed Trust practices regarding triage and did not advise any manager of this fact.

- There has been significant impact on the Trust in terms of its ability to properly manage patients, manage waiting lists and the extensive look back

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

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.

RP – the work up to now has ben regarding the scope and recall. A big part of this response will be how was this allowed to happen. Issues that are systemic will be addressed via neurology enquiry. RP had a conversation with Brett from neurology. He felt that these two elements will be fairly closely tidied together. Brett was nervous regarding bringing both these elements together as this will slow the work up greatly. RP this is going to be discussed further with Brett next week. JJ – learning from neurology was there was too many strands, the clinical review and professional reviews should sit together. RP – taking the independent element under an inquiry will help the Trust focus on the task of patient recall. SD – this would be good to allow the Trust to get on with work and allow the Trust to get on with the work this will be a good thing. Ultimately the importance of independence is crucial. RP – MMcB and Lourda – this is a formidable process. The neurology report will allow us opportunities to improve things. LG – long discussions with Brett and the panel, discussed a range of issues. RP – both issues started around the same time, the systems required to identify deviations is required. JJ – I don't think we should proceed without some form of independent review. RP – decision will be required by Tuesday at the latest. Even if there is discomfort in widing the scope of the panel there are more barristers who could assist in revisiting similar issues going forward.

Private Practice – JJ – proposing to ask BSO internal audit in terms of the patients AOB was transferring into the HSC system, this is the only way we will be able to get a handle on this though is not completely thorough. PC – spoke re this with the GP lead yesterday, GP's may have information on this that may assist in the identification of relevant private patients. In terms of the private practice there are two issues. Did his Private patients come to any advantage – the other issue is an assessment of the quality of care, is this GMC are of responsibility. MOK – we have made the GMC aware of concerns regarding this. Only the GMC are in the position to ask him to hand over private practice notes. MOK – GMC had asked AOB to halt private practice. MMcB Trust should ask DLS if it is appropriate to ask for notes of private practice from AOB caseload. RP – the HSC will be expected publically to pick up the strain of this private practice. MMcB – the Trust may consider contacting the MPS to gain access to the patients. **The Trust writes to Tughans asking for copies of his private patient records, also make it clear that there is liability cover in place with regard to those patients.**

- Will AOB put in place arrangements for private practice patients to be reviewed
- MPS required to cover costs of Trusts

BF – mentioned the CURE charity – MOK is live but appears dormant. Doesn't appear anything current. Aspiration was to build a research profile within the SHSCT, no evidence of anything happening since 2018. JJ – can we get a categorical position on this not involving patient treatment.

Communications – working on FAQ with Jane McKimm. There is an expectation the SHSCT will provide some media availability following the minister statement. BHSCT put in counselling support for families going through the process. DG – Should we ask David Galloway to provide learned experience information. BHSCT underestimated the role of psychological support, have to be mindful of this. MMcC – discussions have happened with BHSCT regarding their learning. So far the SAI patients and families have been understanding regarding the SAI process. Started detailing out the IPT and build that into a workplan. MO'N The ministers statement will name the consultant on the 17th November. BF people will raise questions surrounding deceased patients, this happened regarding neurology patients. This took at least 8-9 months or more about how we would obtain notes and access to these. We will learn from the neurology inquiry. Caution that we keep the panel open, we don't know the full scale at this time. Deceased patients may be included at some stage. JJ – need to note potential redress, might require a rapid arrangement to be agreed with DLS as we go forward.