

**UROLOGY SERVICES INQUIRY**

USI Ref: Notice 4 of 2023

Date of Notice: 30th March 2023

Witness Statement of: Dr Maria O’Kane

I, Maria O’Kane, will say as follows:-

1. The following extract is taken from your evidence on Day 15 of the Inquiry hearings:

TRA-01438, Lines 11 - 29

Q. Do you see that then as a failing, from you as Medical Director, in having proper oversight to ensure that you got proper information on which you could assess whether the action plan was effective or something else needed to be done?

A. In hindsight, I would do things differently. Right? I would have asked probably different questions in that context. But I think the context is important. I had just arrived in an organisation. It takes a year to get into a job like that properly. I didn't know anybody. I didn't know the systems and processes. One of the experiences I had was that when I asked questions, you know, I think some people felt that those were critical rather than curious, and that was a really difficult environment to work in. In hindsight, if I were doing this again I would do it differently, but at the time what I was reliant on was people who had worked in the organisation for a long time, understood how it worked, to give me information

TRA-01438, Lines 1 - 29



Urology Services Inquiry

Yes, as outlined above. I also discussed the challenges generally with Shane Devlin, the Chief Executive, in the context of how different staff could be approached to access information without them perceiving this as an attack on their performance rather than curiosity to improve.

NOTE:

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

Statement of Truth

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

Signed: 

Date: 18th April 2023

1 from Mr. O'Brien's AOB-01929. I am not sure exactly
 2 which case this is, but its emails from W Clayton,
 3 R Carroll and Martina Corrigan dated 16th October 2018.
 4 You'll see there, there are 82 charts tracked out
 5 specifically to Mr. O'Brien. There were other issues 10:53
 6 about the action plan. We might have to go down 01936.
 7 These are a series of emails from Ronan Carroll. These
 8 are emails back and forward. Did you work much with
 9 Ronan Carroll?

10 A. Only with him being Assistant Director in Surgery. 10:54

11 74 Q. I'm not sure what that means. Did you have much
 12 contact with him?

13 A. Not a huge amount. No.

14 75 Q. Did he ever speak to you about Mr. O'Brien?

15 A. My contact with Mr Carroll would have been through any 10:54
 16 of the surgical meetings or any of the discussions that
 17 we would have had in relation to Mr. O'Brien. He would
 18 have mentioned him then. But I think he found -- my
 19 sense was, certainly, he found him difficult to manage.

20 76 Q. I ask you that because it's clear from emails, as the 10:54
 21 Inquiry will hear, that Mr. Carroll had considerable
 22 knowledge of issues around Mr. O'Brien. I'm just
 23 wondering, in his position did he ever come to you and
 24 say, you know, that action plan isn't effective?
 25 We have had to highlight some issues along the way and 10:55
 26 chase him up. Did that conversation ever take place?

27 A. No. He didn't volunteer that information to me.

28 77 Q. This is an update from Martina Corrigan. This is an
 29 example of the updates that were provided before the

1 A. No.

2 110 Q. Did you work with Ronan Carroll? You said you did work
3 with him.

4 A. Yes.

5 111 Q. You worked with Martina Corrigan. 11:22

6 A. Yes.

7 112 Q. These are names that are all very familiar over the
8 years. You never thought of approaching them to find
9 out a fuller picture beyond what you were able to read
10 in the paperwork? 11:22

11 A. The history that was given about Mr. O'Brien was that
12 he had always been problematic. That, basically, he
13 was difficult to manage. He felt that the system was
14 always to blame. Didn't take any personal
15 responsibility for anything going wrong at any point in 11:22
16 time. I think the sense I got from people was they
17 were hugely frustrated with having to manage him.
18 I suppose my reading of the -- there were bits and
19 pieces of information but no coherent story. Right?
20 I would have heard about the antibiotics and 11:23
21 cystectomy. Then there was some point in 2020 there
22 was something about him having thrown notes into a bin
23 that caused a bit of alarm. But, again, in terms of
24 getting a clear picture of what that was about or what
25 the working out of it was about, you know, there was 11:23
26 a sense that he was told to stop doing that, he did,
27 and it didn't happen again. Same with the antibiotics,
28 that's what happened.

29

ATTACHMENT – GMC GUIDANCE ON SUPPORTING INFORMATION FOR APPRAISAL AND REVALIDATION document located at S21 No 29 of 2022, 81. GMC GUIDANCE ON SUPPORTING INFORMATION FOR APPRAISAL AND REVALIDATION

ATTACHMENT –1-1 AGENDAS WITH CHIEF EXECUTIVE document located at S21 No 29 of 2022, 83. 20201218 CX 1-1 – A10, 84. 20210308 CX 1-1 – A16, 85. 20210505 CX 1-1 – A16, 86. 20210608 CX 1-1 – A19

Engagement with unit staff

28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

- 28.1 The Urologists form approximately 1% of the Medical Workforce in the Southern Trust.
- 28.2 Prior to the concerns that were raised in June 2020 in relation to Mr O'Brien, I had limited engagement with all of the staff in the Urology Unit.
- 28.3 My main points of contact in relation to Urology Services were with the 1:1 and monthly AMD Group meetings with the then AMD for all Surgical Specialities, and now DivMD for Urology Improvement, Mr Mark Haynes.
- 28.4 I had regular weekly contact with the Director for Acute Services through the Senior Management Team Meeting and intermittent contact with the Assistant Director of Surgery, Mr Ronan Carroll, and the Head of Service, Mrs Martina Corrigan.
- 28.5 Since the Ministerial announcement of the Public Inquiry (24th November 2020) and the out-workings of the Lookback Review, I have had more frequent and focused contact.

29. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

29.1 I refer to my answer for question 28.

30. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

30.1 From my limited interactions with them, my sense is that they did and do work well together, with the exception of the working relationship with Mr O'Brien.

30.2 My impression is that the remaining staff had the greatest respect for each other, regardless of discipline, and were very professional in their interactions with their patients and each other. They appeared to work well together outside the challenges of having to manage and work with Mr O'Brien.

30.3 My impression (based upon reading the MHPS papers – including witness statements – and SAI documents) was that, over the years, Mr O'Brien's colleagues had developed ways of not confronting him for fear of having to deal with unpleasantness but had found ways of constantly working around him to avoid antagonising him and to get the work of treating patients done.

30.4 I was also aware that Mr O'Brien had the support of the Chair of the Trust, Mrs Roberta Brownlee. At my first meeting with her after taking up post as Medical Director, on the 11th January 2019, she advised me against pursuing him in the way that she believed my predecessors had done and she intimated that she believed that he was an excellent surgeon and that he had saved her life.

1 in relation to the SAI in relation to the use of EGRESS
2 to respond to that just to let me know that that had
3 happened. Those, I think, were the different times
4 I spoke to Dr. Hughes.

5 139 Q. At that point then you became aware that there were 11:56
6 actually verifiable or potential clinical concerns
7 around the practice?

8 A. Yes.

9 140 Q. These are new issues, as it were, for you?

10 A. Yes. 11:56

11 141 Q. At that stage did you think it might be best to take
12 some action or to do something around clinical practice
13 of Mr. O'Brien at that point?

14 A. Mr. O'Brien retired from the Trust on 17th July. When
15 we had discovered the difficulties after -- I think 11:56
16 I was informed on 11 June and the Clinical team,
17 principally Mr. Haynes and Mrs Corrigan had been
18 working on an email that they had received that
19 suggested there was a discrepancy in two waiting lists,
20 and that caused them a bit of concern. When they 11:57
21 worked their way through that they realised there
22 wasn't a discrepancy, but what they also discovered on
23 the back of those explorations were the concerns then
24 around the cancer multi-disciplinary team meeting.

25 142 Q. I think Mr. Haynes explained the issue around the 11:57
26 waiting list and the two patients.

27 A. Yes.

28 143 Q. If we go back to 2019, there was a bit more
29 information, if I can put it that way, a bit more

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
<u>Key Strategic aims:</u> Delivery of safe, high quality effective care	
<u>Key Issues/risks:</u> 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.	

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.

11 July 2020

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien

Personal Information redacted by USI

Via E-Mail only

Personal Information redacted by USI

Dear Mr O'Brien

I am writing to advise you of a number of concerns that have arisen in respect of your practice as a Consultant Urologist.

On 7th June 2020 at 22.25, you sent an email which was copied to me, in which you explained that you had added 10 patients to the Trust's list for urgent admission. On my initial review of the list of patients in my capacity as AMD, I noted that 2 of the patients were stated to have been listed on 11th September 2019 and 11th February 2020, both requiring *"Removal/Replacement of Stent and Right Flexible Ureteroscopic Laser Lithotripsy"*.

It appeared to me that these patients had been assessed on the dates given by you, but the outcomes of these assessments did not appear to have been actioned by you as required with the patients being added to the inpatient waiting list on the Trust's Patient Administration System. These patients therefore appeared on the face of it to fall outside the Trust's systems with all the potentially very serious clinical risks attendant on that.

Since this has come to light, the Trust has been seeking as a matter of urgency to establish the position in relation to these 2 specific patients and also to clarify whether any other patients are similarly affected. A review of records back to January 2019 has been undertaken.

At this stage, I enclose a summary of the concerns following initial review of patient records dating back to January 2019.



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Southern Health & Social Care Trust
Craigavon Area Hospital
68 Lurgan Road, PORTADOWN BT63 5QQ
 Personal Information redacted by USI

- **Personal Information redacted by the USI** old Male Prostate Cancer – Potential issues regarding diagnosis and timely management. Patient subsequently presented with complications of local progression and may have metastatic disease.

Supporting evidence in connection with these concerns

Lookback on Emergency Care Provided (1st January 2019 – 31st May 2020) - this lookback concentrated on whether the patients had a stent inserted during procedure and if this had been removed

There were 147 emergencies taken to theatre that was listed as being under the care of Mr O'Brien during the lookback period, the following table illustrates the breakdown of the findings.

No Concerns Identified (101 Patients)	<ul style="list-style-type: none"> • 60 patients NOT requiring a stent in their procedure • 41 patients who'd had their stent removed
Patient treatment complete but issues highlighted (14 Patients)	<ul style="list-style-type: none"> • 13 patients were not added to the waiting lists when they should have and were mostly done a few days before Mr O'Brien had the patients admitted • 1 patient readmitted as emergency and had their stent removed under different consultant, there appeared to be no plan to admit them by Mr O'Brien. The patient had been waiting 7 months
Concerns and or follow-up issues identified (32 Patients)	<ul style="list-style-type: none"> • 11 patients who have been readmitted but we were unable to determine if they had stent removed as there is no letter dictated on NIECR. However, all 11 notes were requested and there is a record written in the notes showing that the stents have been removed. • 9 patients will need to be followed up due to only having had their stent inserted and require a future date for removal of stent • 6 patients that appear to have been electively treated on an emergency list • 6 patients who had a delay and were added late to the Patient Administration System (PAS) but have since been seen

63. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:

(a) outline the nature of concerns you raised, and why it was raised

(b) who did you raise it with and when?

(c) what action was taken by you and others, if any, after the issue was raised

(d) what was the outcome of raising the issue?

If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not.

63.1

Nature of Concern	Raised With and When	Actions Taken	Outcome
Mr O'Brien deviated from the 2017 action plan formulated following MHPS investigation (as referred to in my answer to Q54)	<ul style="list-style-type: none"> • MHPS Case Manager (16.09.2019) • NHS Resolutions • Directors' Oversight Group • Chief Executive • Oversight Group • GMC • Trust Board 	<p>Dr Khan Case Manager discussed with those involved including Mr O'Brien, Dr Grainne Lynn NCAS and the GMC on 24.09.2019 who asked for update by 07.10.19</p> <p>This was discussed at an oversight group on the 03.10.19 and updated by Mr Haynes by email on 07.10.19.</p> <p>This in turn was discussed with the Chief Executive at 1-1 meetings and at Trust Board Confidential Sections as outlined in answer to question 40.</p>	<p>Before my tenure, a decision was made that monitoring using the MHPS Action Plan would continue with recognised additional time for Mr O'Brien to complete triage following his Surgeon of the Week. It was understood that he had deviated from the plan following the email of the 16th September 2019 time because his Personal Information redacted by USI was unwell and required attention in hospital.</p>
Patients found to not have been added to lists for required surgery 07.06.2020	<ul style="list-style-type: none"> • Trust Board • HSCB / SPPG • Directors' Oversight Group for Doctors in Difficulty 	<p>When this was discovered a review of Mr O'Brien's clinical work was immediately commenced by Mrs Corrigan to determine the extent of this problem. Ongoing discussions were</p>	<p>The developing awareness of the issues discovered as a result of the email of the 7th June 2020 and summarised in my</p>

1 been mentioned all the way through in terms of
2 Mr. O'Brien's nonengagement with the job planning
3 process, until he retired. Part of the discussion then
4 was in relation to asking Mr. McNaboe just to speak to
5 him about the Maintaining High Professional Standards, 14:27
6 concerns in relation to the records and how those were
7 being recorded, but also to speak to him then about his
8 job plan. There are other emails in the system about
9 that. I think Mr. McNaboe and Mrs Corrigan wrote to
10 Mr. O'Brien offering to meet with him in November. He 14:28
11 came back to say he didn't have enough notice and
12 cancelled the meeting, but that would have been
13 Mr. O'Brien's pattern. Then, I think, to try to have
14 the conversation with him Mr. McNaboe had met him in
15 passing one day, and I think had raised these issues 14:28
16 with him, basically to make him aware and also to raise
17 with him again that I was still wondering where this
18 job plan was, as was the rest of the system. The
19 assurance Mr. O'Brien, as I understood, gave to
20 Mr. McNaboe at that point in time was in relation to 14:28
21 the job plan that was in hand, and by the time,
22 I think, Mr. McNaboe got to speak to Mr. O'Brien we
23 were farther through in relation to this in
24 understanding that there had been a gap in the
25 proceedings because of his leave, and that we were -- 14:28
26 again the system was assuring itself that in terms of
27 results we were getting reporting on that.
28 266 Q. Just for the Inquiry note, Mr. O'Brien has included in
29 his bundle various emails. I'm just going to read out

1 and Children's Services if they had anything further
 2 that they needed to inform the Board about which was
 3 not on the agenda. Minutes will confirm this monthly
 4 meeting and this question posed to each I have
 5 mentioned.

15:06

6
 7 The Board always wished to learn and follow up on SAls,
 8 near misses and any governance issues that they were
 9 made aware of. Follow-up reports would come to
 10 Governance Committee for assurance of action and
 11 completion. I ensured that there was always
 12 a provision of clear reporting, ensuring the correct
 13 structures and reporting lines were in place and
 14 adequate time to discuss such issues. The CXs and the
 15 SMT at every meeting always had the time allowed to
 16 inform the Board of any Governance issues or concerns.
 17 This was strongly encouraged and challenged by NEDs and
 18 me. "

15:06

15:07

19
 20 Is that your recollection of the culture of the Board?

15:07

21 A. Certainly at the end of Trust Board each of the
 22 Executive Directors - so that's Medicine, Nursing,
 23 Social work and Finance - are asked for any comments.
 24 Up until that point I hadn't brought anything to the
 25 Board because it wasn't anything particularly outside
 26 the confidential section that needed to be raised,
 27 until August 2020, when I was asked the question and
 28 I raised it in relation to Mr. O'Brien. I think the
 29 feedback that I got indirectly at that point in time

15:07

The Chair left the meeting at this point.

Dr O’Kane brought to the Board’s attention SAI investigations into clinical concerns involving a recently retired Consultant Urologist. Members asked that this matter be discussed at the confidential Trust Board meeting following the Workshop.

The Chair returned to the meeting at this point.

Dr O’Kane drew member’s attention to staffing issues within the Infection Prevention Control (IPC) team along with a significant increase in workload due to Covid-19. She also alerted members to particular medical workforce challenges in the GP Out of Hours Service and Acute Physicians.

The Chair thanked Executive Directors for providing updates on important issues within their areas of responsibility.

7. ANY OTHER BUSINESS

None.

The workshop concluded at 12 noon

and non RRL anticipated income of £42.8m, the Trust has a total maximum income of £760m available and hence the spending allowance for the Trust is currently £760m in 2020/21.

Ms O'Neill reported total forecasted expenditure 2020/21 of £774.3m as detailed in Table 7 of the document, leaving a forecasted gap of £14.3m. She advised that measures of £7m have been identified, these include pharmacy prescribing measures and natural slippage on some full year allocations, leaving at this stage an unresolved gap of a maximum of £7m.

Ms O'Neill stated that the financial plan will be further refined, with the Department of Health planning meetings to take place in September 2020. Directors will continue to review what additional savings measures are possible in the event that additional funding is not secured. Mrs McCartan asked if it was permissible to submit an Interim Financial Strategy without a balanced budget. Ms O'Neill stated that Directors of Finance were asked to submit a plan which identified the impact of the indicative allocations. This is merely the first stage and at present this shows an unresolved gap of £7m. The Interim Financial Strategy being discussed at Trust Board is to seek approval to set an unbalanced budget to support the appropriate stewardship and accountability of public funds. As discussions evolve with both the HSCB and DoH, the position may change, to include either potential additional unplanned expenditure benefits or some further funding support. Mrs McCartan noted the Trust's statutory duty to breakeven and stated that hopefully additional funding support would be secured.

Trust Board approved the setting of an unbalanced interim budget for 2020/21

3. ANY OTHER BUSINESS

i) SAI

Dr O'Kane brought to the Board's attention SAI investigations into concerns involving a recently retired Consultant Urologist. Members requested a written update for the next confidential Trust Board meeting.

QUESTION	RESPONSE
<p>48A. What were the concerns raised with you, who raised them and what, if any, actions did you or others, please name direct, to be taken as a result of those concerns? Please provide details of all meetings including dates, notes, records etc and attendees and detail what was discussed and what was planned as a result of these concerns?</p>	<p>For the purpose of the answers to Question 48, I will address only urology concerns outside those which relate to Mr. O'Brien. I will deal with these Mr O'Brien concerns separately from Question 52 onwards.</p> <p>I was aware of issues relating to capacity and demand in Urology in the context of service pressures since my arrival in December 2018. I had understood these were longstanding since 2009 in the Trust area.</p> <p>Mrs Corrigan has recently outlined to me when she took up post in September 2009 as Head of Service (HoS) that the waiting time for outpatient urology was 9 weeks and within IEAP guidance but that the that waiting time for inpatient and daycase was 26 weeks. This has continued to deteriorate since then.</p> <p>Red Flag referral patients were assessed within a few days in 2009 but in recent times for some the waiting time has reached as high as 60 weeks. These were not raised with me as specific concerns in relation to individual patient's safety although I have been acutely aware throughout that long waits for patients in receiving care and investigation is harmful, as these conditions can be time critical.</p> <p>There were frequent discussions formally and informally in relation to the demand in Urology and active steps put in place to manage waiting lists locally and regionally through initiatives such as Team South. I had not been part of the development of these as they predated my tenure. Mrs Corrigan and Mr Carroll as HoS and AD (Assistant Director) respectively will have access to this data in a more complete form.</p> <p>On my arrival I was aware that for patients about whom there were concerns these could be placed in "hot clinics" (same or next day clinics Monday to Friday). Consultants had the opportunity to use these hot clinics on their weeks as Urologist of the Week (UoW) to review any patients about whom there were imminent concerns.</p> <p>These patients came either through the Emergency Department as urgent new referrals or as patients who had been on waiting lists and had deteriorated, patients who rang the consultants' secretaries to raise concerns about their conditions and who were booked in for review and patients about whom the consultant or their secretary was contacted by the patient's GP raising concern about deterioration in a patient's condition and requesting for them to be seen.</p> <p>It would appear that despite having long waiting lists with the propensity then for patients to deteriorate these Hot Clinics were not used as intensively by Mr O'Brien as they were by other consultants.</p>

A

MR O'BRIEN: Hello, Mark.

MARK HAYNES: Hey, Aidan. Sorry, I took another call after I texted you so I missed you.

MR O'BRIEN: No bother.

B

MARK HAYNES: I've got Ronan in the room with me as well. Ronan Carroll.

MR O'BRIEN: Hello, Ronan.

MARK HAYNES: So just following on. Obviously I know you have spoken to myself and you have spoken to Martina about coming back after July, haven't you?

MR O'BRIEN: Yes, I have, and Michael.

C

MARK HAYNES: Yes. I've taken that forward with a number of conversations within the Trust, with HR and at medical director level. Okay. Unfortunately, the practice of the Trust would be that they don't re-engage people while there's on going HR processes.

MR O'BRIEN: I see.

D

MARK HAYNES: Which means from my perspective I can't take it any further forwards at present.

MR O'BRIEN: So the reason for -- so who has made that decision?

MARK HAYNES: But that's what I have been advised by both the medical director and by enquiring in-enquiry with HR.

E

MR O'BRIEN: Okay. So it's because of -- because they haven't yet the grievance and all of that thing?

MARK HAYNES: Yes. So as I understand it there's the grievance and there's also -- so the grievance is it from you to the Trust I think, isn't it?

F

MR O'BRIEN: Yes.

MARK HAYNES: And there was a Trust thing as well ~~(inaudible)~~ was it the maintaining professional standards investigation and everything. That's not closed off as yet.

MR O'BRIEN: Well, the investigation has been closed off. Yes.

G

MARK HAYNES: Yes. And there's -- from Maria I was advised there's a GMC issue process as well, that's in process.

MR O'BRIEN: Okay. So that's very disappointing. I didn't expect that at all, particularly in view of the amount of need that there is. It is very ironic, and you know that, and somewhat poignant, I returned to Northern Ireland from Bristol 28 years ago today for interview to be appointed on 8 June 1992. So, Mark, can I have that decision made submitted to me in writing?

H

MARK HAYNES: Yes. I can get that sorted for you.

MR O'BRIEN: And when can this be reviewed?

Stinson, Emma M

From: OKane, Maria
Sent: 26 June 2022 20:04
To: Stinson, Emma M
Subject: FW: HOT clinics

Please upload

From: Corrigan, Martina <[REDACTED]>
Sent: 26 June 2022 13:34
To: OKane, Maria <[REDACTED]>
Subject: HOT clinics

Maria

As discussed please see below attendances at Urology HOT Clinics from April 2015-June 2020 (I have not included locum consultants or Matthew Tyson as he was only in post from 26 Feb 2019-June 2019 before he went on his fellowship – he seen 70 patients in these 4 months)

**Urology Hot Clinic
attendances
1 April 2015 - 30 June 2020**

Consultant	Attendances
Mr Glackin	311
Mr O'Brien	142
Mr O'Donoghue	249
Mr Haynes	585
Mr Young	591

Anything further please let me know
Kind regards

Martina

Martina Corrigan
Assistant Director – Public Inquiry and Trust Liaison
Mobile: [REDACTED]

53.2 Currently, the process for second signoff on Job Plans sits with the Medical Director / Operational Director.

53.3 It was reported to me in October 2019 that the first sign off of Mr O'Brien's Job Plan was not completed in a timely fashion as Mr O'Brien would not agree what was being offered, despite the fact he was given the administration time on a Tuesday morning that he requested. He was also described as spending long hours on the ward at times that he was neither required nor expected to be there and then was asking for additional payment recognition for this. By the time I arrived in 2018, there was a pattern of him agreeing to sign off Job Plans and then not following through. When I specifically requested that this was done, he agreed with Mr McNaboe in November 2019 that this would be done but then only signed these before he retired to allow his pension to be finalised. There was limited process for escalation across the Trust because this was not clearly delineated in the Clinical Director and Associate Medical Director job descriptions across the Trust which were not standardised and so escalation was difficult to enforce for one doctor when the levels of job planning were not optimal across the Trust. With the review of medical management structure, there is now greater clarity in the CD and DivMD posts in relation to responsibility for this and, now that these posts are in place and the Deputy Medical Director for workforce has been able to establish oversight at my request, the level of Job planning has markedly increased.

ATTACHMENT: 23062022 MEDICAL DIRECTOR'S REPORT TO TRUST BOARD document located *at S21 No 29 of 2022, 133. Trust Board Cover Sheet Urology 23 June MO'K*

53.4 As a result, the process is being strengthened with timescales and processes for escalation and mediation if these are not achieved to reduce the likelihood of this recurring for other doctors in the future and the protocol for this is being agreed with the BMA and reviewed by SMT.

53.5 In the circumstances, the level of job-planning (despite the impact of the pandemic on this process) has improved markedly.

- 62.1 Mr O'Brien has never been in contact with me about matters of patient safety, care, risk, governance or administration.
- 62.2 I am not aware of Mr O'Brien raising any specific patient concerns in relation to patient care, risk, governance or administration.
- 62.3 His appraisals document that he raised concerns about workload and administration time. This was dealt with through Job Planning when he engaged with this.
- 62.4 I am led to believe that In the course of the development of the 2017 Action Plan Mr Obrien was given a Tuesday morning 4 hours as extra Supporting Programmed Activity (SPA) to allow him time to complete his dictation from the Enniskillen clinic on a Monday.
- 62.5 In addition to this he was repeatedly encouraged to engage in job planning through his clinical director Mr McNaboe throughout 2019.
- 62.6 As outlined in my response to question 65 concerns about waiting lists were recorded on the Acute and Corporate Risk Registers, and have been brought to the attention of the SPPG currently and the HSCB previously.

Mr. O'Brien

52. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

52.1 I refer also to my answer at Question 7(i) and (ii).

52.2 From January 2019 until his retirement on 17th July 2020, I was Mr O'Brien's Responsible Officer and Medical Director. Since his retirement, the function of his Responsible Officer has moved to the GMC.

52.3 I have never met Mr O'Brien and communications with him were through his operational and professional line managers, namely, the Director for Acute Services and Assistant Director for Surgical Services, as well as his Clinical Director and Associate Medical Director. Currently, communications with him are by email through his legal team. The GMC continues to request information in relation to Mr O'Brien and this has been provided.

53. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

53.1 Mr O'Brien's Job Plans were formulated and agreed with the Operational Manager, Clinical Director and Associate Medical Director.

55.4

Date of discussions	Event	Detail of the content and nature of all discussions including meetings in which I was involved which considered concerns about Mr O'Brien	Name those present
4.12.18	Meeting with GMC (as described above)	On 4 th December 2018, a few days after I commenced in the Southern Trust as Medical Director, and before I assumed the role of Responsible Officer on the 1 st January 2019, I attended a meeting between the GMC Employment Liaison Adviser (note: the ELA is a GMC employee who provides liaison between the Trust and the GMC – he/she can be medical, legal or lay) and Dr Ahmed Khan, Responsible Officer. It was advised during this meeting that the MHPS and SAI investigations had been completed and reports were finalised and would arrange for the final MHPS Report and final SAI Report to be sent to Joanne Donnelly. A Trust Disciplinary Hearing was to take place in early January 2019. Mr Gibson reported that the doctor still had local restrictions on his practice, the 2017 Action Plan, and these were being kept under review. Mr Gibson was to update Joanne Donnelly on the Trust Disciplinary Hearing. Because of local restrictions and changes to local systems he stated that there were no patient safety concerns and gave an assurance the doctor did not do any work outside of SHSCT	Joanne Donnelly Dr Ahmed Khan Simon Gibson

55.5

<i>When and in what context did you first become aware of issues of concern regarding Mr. O'Brien?</i>
MHPS update meeting with Mrs Vivienne Toal
<i>What were those issues of concern and when and by whom were they first raised with you?</i>

Toal, Vivienne

From: Hynds, Siobhan (Personal Information redacted by the USI) >
Sent: 09 January 2019 22:19
To: Toal, Vivienne
Subject: FW: SHSCT - "Dr Urology Consultant" - advice to refer
Attachments: FW: IMPORTANT - Redacted MHPS investigation into AOB (72.7 KB)
Importance: High

FYI

From: Joanne Donnelly (Personal Information redacted by the USI) [mailto: (Personal Information redacted by the USI)]
Sent: 09 January 2019 16:56
To: Gibson, Simon
Cc: OKane, Maria; White, Laura; Hynds, Siobhan; Moiza Butt (Personal Information redacted by the USI); Support TeamEL
Subject: RE: SHSCT - "Dr Urology Consultant"- advice to refer
Importance: High

Dear Simon,

Thank you for your e-mail. Apologies for the delay in replying to your e-mail- due to annual leave.

I note that the attached report refers to a number of concerns including: (1) issues that may be classed as probity concerns (advantage to patients who had seen him first in a private capacity- which may have resulted in advantage to doctor); (2) actual harm to at least 5 patients and potential harm to a large number of patients (relating to delayed cancer diagnosis and significant delays in commencing appropriate treatment); (3) failure to make contemporaneous notes in patient records; (4) potential breach of patient confidentiality – keeping patient notes at doctor's home.

On the basis of the information you have provided – these concerns appear to me to meet the threshold for referral to the GMC as they are allegations of serious and persistent failures to practise in accordance with the principles set out in Good Medical Practice (I acknowledge that the doctor's practice is currently restricted in the interests of patient safety and that the doctor is complying with a local action plan).

Please do not hesitate to contact me should you wish to discuss further. See GMC guidance **GMC Thresholds:** https://www.gmc-uk.org/-/media/documents/dc4528-guidance-gmc-thresholds_pdf-48163325.pdf

I note the comments in the report about management responsibility and note also the date(s) of the original incident(s)- if you would find it helpful to discuss this also I am of course happy to do so.

Best wishes
Joanne

Joanne Donnelly (Personal Information redacted by the USI)
GMC ELA for NI

(Irrelevant information redacted by the USI) – Ftp – refer – SHSCT – Dr Urology - advice to refer- probity/record keeping/confidentiality/ - all impacting on clinical competence/patient safety (9.1.19)

From: Gibson, Simon [mailto: (Personal Information redacted by the USI)]
Sent: 18 December 2018 10:53
To: Joanne Donnelly (Personal Information redacted by the USI)
Cc: OKane, Maria; White, Laura; Hynds, Siobhan
Subject: FW: SHSCT - "Dr Urology Consultant"

58.7 It outlines the concerns and in relation to :

- a) Concern (1) - it states all referrals received by Mr. O'Brien will be monitored by the Central Booking Centre in line with timescales and a report will be shared with the assistant director of Acute Services, Anaesthetics and Surgery at the end of each period to ensure all targets are met.
- b) Concern (2) - that notes must not be stored in Mr. O'Brien's office and should be tracked out to him for the shortest period of time for the management of the patient.
- c) Concern (3) - that a plan or record for each clinic attendance must be recorded for each individual patient and this should include a letter for any patient who did not attend as there must be a record of this back to the G.P. and that in relation to
- d) Concern (4) - the scheduling of the patients must be undertaken by the secretary who will check the list with Mr. O'Brien and then contact the patient for their appointment.

58.8 This process was in keeping with the practices established within the Urology team.

58.9 It also then states that any deviation from compliance with this action plan must be referred to the MHPS case manager immediately.

How did I know this was working as it should?

58.10 When Mr O'Brien was found to have defaulted on aspects of the Action Plan on the 16th September 2019, he was offered support in clearing the backlog and it was understood that this had come about at a time he had been supporting his family when his mother in law was unwell.

55.9

<i>When and in what context did you first become aware of issues of concern regarding Mr. O'Brien?</i>
11th March 2019, I received Mr O'Brien's appraisals for 2014-2016.
<i>What were those issues of concern and when and by whom were they first raised with you?</i>
I ascertained that, in the course of these, he had not raised reflections about the concerns raised about him leading to MHPS and the recent SAls involving his patients.
<i>Do you now know how long these issues were in existence before coming to your or anyone else's attention?</i>
There was no clear evidence in the Appraisals that his appraiser had been made aware of any concerns. In addition to this, his 2017 Appraisal had not been completed nor had his 2018 Appraisal (for which 360 degree feedback was required) and his Revalidation date was due for renewal on the 4th April 2019. I requested any complaints, SAls, and medicolegal and coroners' court involvement in relation to Mr O'Brien since his last revalidation. These did not appear to indicate any specific clinical concerns that could be differentiated from long waits at that time.
<i>Please provide any relevant documents</i>
Attach medicolegal excel spreadsheet emailed 8.7.22. Document located at S21 No 29 of 2022, 211. 20211005 Open Urology Claims ATTACH COMPLAINTS EXCEL SHEET. Document located at S21 No 29 of 2022, 176. UROLOGY COMPLAINTS SINCE 2009

55.10

Date of discussions	Detail of the content and nature of all discussions including meetings in which I was involved which considered concerns about Mr O'Brien	Name those present
11 th March 2019	<p>Discussion with Dr Scullion appraiser by phone to confirm that what was contained in the Appraisals was what was known to him and to ascertain whether he had patient safety or other concerns on the basis of the appraisals. He stated that he did not.</p> <p>Received and reviewed all complaints in relation to Mr O'Brien- theme in relation to waiting list</p> <p>Appraisals 2014,15,16 received - Failure to mention and reflect on complaints concerns re probity, insight.</p>	Dr Damian Scullion

From: Parks, Zoe [mailto:Personal Information redacted by the USI]
Sent: 18 May 2021 15:08
To: therese.mckernan [Personal Information redacted by the USI]
Subject: RE: Review -AOB
Importance: High

Therese,

Apologies for the delay in coming back to you. I have attached our guidance document that would have been in place at the time. It has since been updated – however I suspect this is the version you will need given this was what would have been used at the time for AOB. This is the process that would have been followed. I can send you a more up to date version and/or our current TOR for Oversight if this is required – however these are more recent documents.

In relation to the Oversight Committee, the core membership are the Medical Director, HR Director and relevant service Director for the doctors being discussed. There may be others attending as support or as appropriate, such as Senior Manager within the Medical Directors office, additional HR support.

I have spoken to our Appraisal/Revalidation lead who has confirmed for me that Dr AOB completed the following appraisals

2014 – completed on 16/12/15

2015 – completed 23/12/16

2016 – completed 1/12/17

2017 – completed 31/10/18

2018 – completed 17/10/19

Angela Kerr

From: Scullion, Damian <[REDACTED]>
Sent: 11 March 2019 10:09
To: O'Brien, Aidan
Subject: Colleague feedback questionnaire

Follow Up Flag: Follow up
Flag Status: Completed

Aidan

I have forwards you the Colleague Feedback questionnaire.

As you can see someone has scored you as “completely disagree” for Patient confidentiality , trustworthiness and ill health.

Since all your comments have been very supportive and commendable, I think this is a case of misinterpretation of the question and I think it is reasonable to ignore this outlier Feedback.

Otherwise an excellent colleague feedback survey.

Regards

Damian

Quality Care - for you, with you

12th August 2020

Ref: MOK/ec

Via email Personal Information redacted by the USI

Chris Brammall
Investigation Officer
General Medical Council
3 Hardman Street,
Manchester

Dear Mr Brammall,

RE: GENERAL MEDICAL COUNCIL - MR AIDAN O'BRIEN GMC NO. 1394911

Further to your email dated 30th July 2020 requesting further information regarding concerns raised in relation to Mr Aidan O'Brien, Consultant Urologist employed by the Southern Health and Social Care Trust, please see below itemised responses and where required, attached items.

A copy of Mr O'Brien's job plan	Copies of the last two electronic job plans that are held in our job planning system for Mr O'Brien are attached in Appendix 1. Please note that they were not signed off by Mr O'Brien. These were previously sent to the GMC in response to this communication by Zoe Parks on 30 th July 2020.
Any update that you may have about contacting the RCS for advice on the	The Trust has hosted a discussion with the Royal College Surgeons Invited Review Service on the 28 th July 2020 which explored the options for and extent of

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Tel: [028] Personal Information redacted by the USI Email: Personal Information redacted by the USI

<p>originally sent to the GMC.</p> <ul style="list-style-type: none"> • Patient 10 (Personal Information redacted by the USI) • Patient 14 (Personal Information redacted by the USI) • Patient 11 (Personal Information redacted by the USI) • Patient 13 (Personal Information redacted by the USI) • Patient 12 (Personal Information redacted by the USI) 	
<ul style="list-style-type: none"> • Please could you provide details of the circumstances of the cancellation of the meeting in September 2018 and the lack of senior management availability in December 2018 including details of any plans that were put in place for Mr O'Brien / other consultants to raise their concerns to senior management 	<p>The meeting that was scheduled to take place between Urology Consultants and management in September 2018 was cancelled following the unexpected sickness absence of the Head of Service for Surgery. The Consultant body agreed that in the absence of the head of service the meeting should not progress.</p> <p>The meeting scheduled for December 2018 did not progress as 3 of the 6 Consultant Urology staff were unable to attend.</p>

I trust this provides the necessary detail required. Should you have any queries, please do not hesitate to contact me.

Yours sincerely



Dr Maria O'Kane
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Tel: (Personal Information redacted by the USI)

Email: (Personal Information redacted by USI)

A

3 December 2018

B

FILE REFERENCE: 20

C

AIDAN O'BRIEN
(MANAGEMENT MEETING)
TONY GLACKIN
MICHAEL YOUNG
MARK HAYNES
JOHN O'DONOGHUE
MARTINA CORRIGAN

D

Audio Transcription Prepared by:

Angela Harte
Personal Information
redacted by the USI

E

F

G

H

A

MR O'BRIEN: Good morning.

MR GLACKIN: Good morning. ~~(Pause)~~

MR YOUNG: (Inaudible)

B

MR GLACKIN: You also have to provide ... there's a huge amount of documentation to be
put through the procedure route

MR YOUNG: (Inaudible)

MR GLACKIN: (Inaudible)

C

MR YOUNG: Would you rather the Parker Knoll, Mr O'Brien?

MR O'BRIEN: I think so.

MR YOUNG: Is Mark coming?

MR GLACKIN: I looked at the rota....

MR O'BRIEN: This is his usual seat ...

D

MR GLACKIN: What the story was, and if you are already a UK consultant, it's very
straight forward, but if you were starting from scratch coming in from a non-EU country.
They charge a huge fee for that assessment.

MR YOUNG: Do they? Very good. Anyway (inaudible) I am just trying to have a look
at the rota there....

E

MR O'BRIEN: Michael, I am summoned to the same court case.

MR YOUNG: Oh, sugar.

MR O'BRIEN: It's for the five days for the two of us. It's not for three days.

MR YOUNG: (Inaudible). You have been actually? When did you hear that?

F

MR O'BRIEN: I got an e-mail on Friday. Well, it was sent on Friday and I got it yesterday.

MR YOUNG: What date is that?

MR O'BRIEN: Monday 21 January.

MR YOUNG: It's that week there then.

MR O'BRIEN: The same case.

G

MR YOUNG: (Inaudible).

MR O'BRIEN: Apparently I must have missed out on it because it was --

MR YOUNG: It was (inaudible).

MR O'BRIEN: It was forwarded from June of last year.

H

MR YOUNG: Yes, I just kept on forgetting about it.

MR O'BRIEN: I must have. I've forgotten all of the issues.

MARTINA CORRIGAN: Hi.



Urology Services Inquiry

and responses to the questions that I asked in relation to systems and processes. I think, you know, one of my concerns in referring Mr. O'Brien to the GMC was in relation to insight. I also think, looking back on all of that, we didn't have full insight either in terms of how we managed that process.

Q. You have mentioned you didn't know anybody at the time. Sometimes that can be an advantage in a new job where you don't have friends or enemies. You are coming in as a new brush and that gives you the opportunity to do things that are more difficult had you been promoted from within. Essentially your answer is you got a little bit of push back from some staff. You felt they thought your queries were criticisms. Did that play a part in your decision making as to how to manage this situation?

A. I don't think so, but I do think it made it a bit more difficult.

Q. Can you expand a little bit more on what that criticism was aimed at and how it may have impacted your choice of behaviour at that time?

A. There were, certainly, on a number of occasions, when I was very robustly challenged by middle managers within the Trust -- not Martina Corrigan and not any of the other people who worked to her -- in relation to what my role and function was, why I was asking these questions, and I think were a bit alarmed, I think, about the level of curiosity in relation to how this worked. That didn't stop me asking the questions but

TRA-01439, Lines 1 – 20

it did make it more difficult in that I had to keep coming back and back and back to try to get the answers that I needed.

Q. Did you consider that to be a difficult working environment, that the culture of being robust towards the Medical Director –



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A. Yes.

Q. -- *probably a little bit ambitious for people to take on the most senior medic in the SMT. Did you see that as a sign there was some reluctance to do things differently?*

A. Yes.

Q. *You've mentioned who it wasn't. You haven't mentioned who it was in your Section 21. You're clearly not going to say any names. You're very free to do so now if you wish to, but obviously the Inquiry would like the opportunity to ask certain individuals, if we had the information, how their behaviour may have impacted on clinical decision making. I'll leave that thought with you.*

2. The Inquiry asks that you:

- (i) **Identify by name and position the *middle managers* to whom you referred in your oral evidence.**

Mrs Anne McVey Assistant Director Acute Medicine;

Mr Ronan Carroll Assistant Director ATICS and Surgery and Elective Care.

- (ii) **Set out the detail of your interactions with these individuals, including:**

- (a) **the content of discussions and dates/times/locations as appropriate,**



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she would not engage with me. I spoke to Vivienne Toal, Director of HR, and explained the situation and was then asked to the office of Melanie McClements, Director of Acute Services. Melanie was angry that Anne had been “upset” and reiterated that I had to stop asking questions. I discussed this with the Chief Executive, Mr Devlin, and his view was aligned with mine: that as Medical Director I should be curious in relation to patient care. I discussed this at a later stage with Melanie when she was less irritated and explained that she had only been given one side of the story and that I was disappointed that she would choose to give credence to an Assistant Director and none to an Executive Director with a responsibility for Patient Safety and Governance. I reminded her that I would not be able to do my job if I didn’t try to understand how systems worked. She accepted this and acknowledged this and stated that she had not had a full appreciation of the role of Medical Director.

Until she retired the relationship with Anne was professional but not warm. This was disappointing. I don’t believe that she recognised the impact that her behaviours had on the relationship. I also was aware that she had the capacity to be extremely kind towards others, particularly patients.

I was very mindful of the fact that, as someone who was recently new into the role of Acute Director with limited experience in that Directorate, Melanie was extremely dependant on the support of the ADs in order to get the job done. Particularly before the onset of the pandemic, the organisation felt quite split at times. Acute held onto its own information under the guise at that time of managing its own governance, which is a system that had been instigated in the past. As a result of this it was very difficult for the Director of Nursing and me, as Medical Director, to access the governance information we required in order to provide accurate assurance to the organisation. By the same



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token, Acute regularly believed that it was left to fend for itself in isolation while regularly being wary of those of us trying to support it.

On another occasion, while Director on Call soon after my arrival, the Emergency Department was under pressure, I asked Ronan about processes with surgical patients. He became extremely angry on the phone with me, told me that none of this was my business and that he would be complaining about me to his Director.

As time went on, particularly as we have progressed through the process of the Urology Services Inquiry, the relationship with Ronan improved.

When I spoke to others in the organisation about these behaviours by the Assistant Directors in Acute Services there seemed to be an acceptance that this was the way in which individuals behaved and business was done and everyone worked around them. I hadn't encountered attitudes like these from middle managers in previous organisations in which I worked where the approach to patient management was more collective and less defensive.

(c) what, if any, impact these interactions and reluctance to do things differently had on your:

- 1. ability to obtain answers to your queries and**
- 2. respond appropriately to issues, make decisions and take actions?**

These interactions and the reluctance to share information resulted in slowing me in identifying and piecing together relevant information and understanding governance in the organisation. At times I seemed only to be given information on a 'need to know' basis, rather than as a complete narrative and I didn't always know what I didn't know.

Vivienne Toal advised the meeting that Heather Trouton had chaired the Sub-Groups on 8 November 2023. She explained that the meeting had been on a “virtual meeting”. She advised that 20 colleagues from across the membership of the four Sub Groups had attended the meeting. She added that Elaine Wilson the Director of Planning, Performance and Information had been also joined the meeting. At the outset of the meeting, Heather Trouton said she had shared information detailing the Programme of work undertaken by the External Reference Group (ERG) she had done this she said by taking the meeting through Presentation she had prepared. She said she had explained to the meeting that the purpose of the ERG is to fulfil the role of a “Critical Friend” by providing independent challenge and support to the Chief Executive and Directors who were leading the Southern Trust’s Improving Organisational Effectiveness Programme. She explained she had advised the Sub Groups representatives that the central aim of this Programme is to improve organisational health, maximise safety, quality and the experience for patients / service users and staff by identifying areas of concerns highlighted by the Inquiry into Urology services. Heather continued that she also explained to the meeting that the External Reference Group (ERG) had identified four themes which had led to the formation of the four Sub Group:

- Patient Safety and Quality, this Sub-Group led by Heather Trouton and Mary

Hinds

- Governance, this Sub-Group led by Dr Stephen Austin and Robbie Pearson
- Data Analytics, this Sub-Group led by Dr Stephen Austin and Simon Watson
- Culture and Leadership, this Sub-Group led by Vivienne Toal and Hugh McCaughey

Heather advised the ERG that the Trust representative who had led each of the Sub Group had then provided the meeting of 8th November with updates on the progress of each of the Sub Group. She also informed the ERG that during the meeting she had asked Vivienne Toal to share with the Sub Groups the “compelling narrative” the Chief Executives had presented to the Trust Board. Vivienne informed the ERG that she had elaborated on the information contained on each slide of the Chief Executive’s presentation to the Trust Board.

Following the Briefing on the work of the ERG, to the Sub Groups Elaine Wilson was invited to make her presentation on the proposed approach to the Development of the Trust Vision and related “Five Years Strategy”. Heather informed the ERG that Elaine had shared with the meeting the following key points:-

Strategy Development – some Guiding Principles.

- All stakeholders must have a clear understanding of the proposed Vision – what will be the same/what will be different.

STERG – 28/7/2023 – agenda item (postponed to 29/9/2023)**Suggested themes and considerations for the SLT – Days 42 - 49****The aim:**

- to build public trust and confidence in patient safety and person-centred quality care
- to raise professional standards within the Trust
- to address and make provision for good staff wellbeing and morale.

Transcript notes and analysis

- to listen and identify some learning as the PI is in progress, to support Maria in helping her to keep in touch with the emerging themes and to assist the Trust in using this lens to consider modifying practice.
- to reassure the staff, patients and the public that the Trust is listening and is making efforts in real time to improve the standard of care for patients and raise the bar in terms of professional standards. Some of this intelligence gathering may already be happening within the Trust as well and it would be interesting to compare notes.
- we are not sure when the PI Report will be published with its conclusions and recommendations, in the meantime the Trust can be seen to be proactive.

STERG - the emerging themes from the PI transcripts.

- can strategy, practice and evaluation be considered in response and some guidance given on a possible route map for the next steps and potential medium-term goals?

(Note – please refer to the documents Part 4.0 ‘Public Inquiry – notes and reflections’ to give wider context to the points in the themes below. These papers have been circulated with ‘Suggested themes and recommendations for the SLT’)

THEMES

1. Leadership and Governance - Tracking, clinical decision-making, and audit; Quorate; Job description, appraisal, and handover; Trust Board; Silo mentality – segregation operationally as opposed to integrated working; Priorities; Training; MHPS; Oversight Group; Management; Trust Improvements.

2. Quality and patient safety

3. Culture and behaviour

4. Communication

1. Leadership and Governance

Tracking, clinical decision-making, and audit

Q. Could I just bring you then to the overarching SAI report. If we go to the section on governance and leadership, WIT-84302. It says in the third bullet point, it largely repeats the sentiment we've already seen, that: "There was no system to track if recommendations were appropriately completed". Can you see the sense, from a tracking perspective and from a patient's safety perspective, of having a tool, whether it is a live tracking device or whether it's some form of audit to be in place, to bring the monitoring of the treatment further along the line?

A. I can definitely see the benefits of it. If it was properly resourced and the functionally within CaPPS expanded to allow you to track a patient through -- say, they had a bladder cancer through maybe multiple occurrences or stuff like that, there definitely would be a benefit for the patient.

Q. In light of what we heard from you in evidence earlier this morning, would I be correct to form the impression that given the resources that you had at that time within tracking, it wouldn't have been feasible to do much more given the resources you had?

A. I would agree, that's totally right. The tracker were under immense pressure with increased workload. They were struggling to track what they were commissioned to track, you know, 31-day and 62-day to first definitive, let alone a whole patient's pathway for years.

[How are the realistic expectations of staff working in the Trust set, monitored, reviewed, and adjusted?](#)

Q. The incident report which I showed you there, the essence of it was that it appeared that a direct referral had been generated in your place in the Southern Trust but hadn't been received or dealt with in Belfast, and it took a GP to write in a year later and raise the alarm. Can you help us to understand what might have gone wrong there?

A. I suppose because -- I don't know the case exactly but I suppose one thing that could have went wrong is they had hormones commenced, their first definitive, then oncology referral was generated from the Southern Trust. Therefore, because they have been closed in CaPPS, they wouldn't have been tracking that to see that they had got the referral. It's the only explanation that I can give.

Q. But again, not knowing the case --

A. Yes.

Q. -- and I know we're in a sense speculating, but in terms of any case going that route, you've outlined the kind of correspondence that must be generated --

A. Yep.

Q. -- at your end, at the Southern end?

A. Yep.

Q. If that is not responded to for whatever reason, Belfast Trust have a computer problem or somebody is not doing their job properly or whatever it might be, what is the alarm bell in that situation; what is the safety net?

A. In my time I don't believe there was a safety net there, but looking back now, there needs to be one, you know, to follow up those patients that aren't being actively tracked. But once we have done

Category	Learning / Observations November 2023	USI Terms of Reference (A – G)
1.Trust Board	<p>1.1 The role of Trust Board – what and how information is reported to the Board;</p> <ul style="list-style-type: none"> a) Are the correct issues brought to the Board, and are they fully and properly discussed? b) Is every Trust Board member clear on their role? c) Are issues alerted to the Board appropriately followed up? How is this reported on? d) Is the challenge/improvement function of the Board applied consistently and appropriately? e) The function of the Trust and understanding of the discharge of legal duty of care. f) The role of Trust committees – reporting, accountability, scope of responsibility. Are these functions clear, and understood by Trust Board members? How does committee business feed into Trust Board? <p>1.2 Role of Head of Service – scope of service responsibility; ability to manage (particularly Drs). How the role is defined and what is expected of staff? Is the HOS role clearly and realistically defined and is it reasonable?</p> <p>1.3 How often is the narrative and focus at Trust Boards monitored to make sure there is a balance between the quality of patient experience and performance?</p> <p>1.4 Is there more clarity now about the Trust Board being kept in touch with progress in an investigation?</p> <p>1.5 Is the SLT confident that the Trust Board is now receiving and reviewing all the relevant reports and papers in accordance with the Trust’s brief?</p> <p>1.6 How frequently is the importance of raising concerns addressed in the Trust? How robust and secure is the whistle blowing route to the Chief Executive?</p> <p>1.7 Is there currently Trust guidance on effective monitoring arrangements of action plans in informal and formal investigations?</p>	<p>Terms of Reference B</p> <p>To evaluate the corporate and clinical governance procedures and arrangements within the Trust in relation to the circumstances which led to the Trust conducting a “lookback review” of patients seen by the urology consultant Mr Aidan O’Brien (for the period from January 2019 until May 2020). This includes the communication and escalation of the reporting of issues related to potential concerns about patient care and safety within and between the Trust, the Health and Social Care Board, Public Health Agency and the Department. It also includes any other areas which</p>

- Vivienne further advised that Dr O’Kane had indicated to the Board that the Findings contained in the Staff Survey platform would also be shared with everyone affected by the potential action that would now be developed from the insights emerging from the survey. Vivienne explained to the Meeting that there were three Questions contained in the Staff Survey, which she believed were particularly important for the meeting to note.

1. Is the care of the Patients and Service Users in my Organisation its top priority?
2. Would I recommend my organisation as a place to work?
3. Would you be happy for your friend or relative to receive care in this Trust?

Vivienne explained that Dr OKane had indicated to the Trust Board in her Presentation that the graphic charts contained in the Survey Report reflected that the staff responses to these questions (percentages) are slightly under the NI HSC average.

- Vivienne shared with the meeting the Findings from the Culture and Leadership Sub Group which Dr O’Kane had shared with the Trust Board. She explained that the Findings were derived from the meeting between the Senior Leadership Team (SLT) and a number of staff. The staff Dr O’Kane had explained to the Board, reflected that the Southern Trust needed to “draw a line in the sand” in relation to this very difficult and challenging period. The view of the staff was that the Trust needed to move forward to what had the potential to be a much more positive future. To build

such a future however, the staff had indicated it was essential that the culture of the Trust needed to change. A transition that would be central to such a change, it was agreed at the meeting with staff would be a change of culture from a Performance driven top down culture to a Safety and Quality Culture built on commitment by leadership of the Trust Board and Senior Management engaging with staff at every level of the Trust.

- Vivienne continuing with her account of Dr O’Kane’s Presentation said that the Chief Executive had informed the Board that she had now asked Elaine Wilson the Director for Planning, Performance and Informatics to begin to draft a new Organisational Vision for the Trust that would be underpinned by a new 5 years Strategic Plan. She advised the meeting that the Chief Executive had asked the Trust Board to agree that these two critical pieces of work should be commenced immediately. She said that Dr O’Kane had emphasised to the Board that we needed to commit leadership to co-produce the Vision and Strategy by involving **all Stakeholders**.
- Vivienne advised the meeting that the Senior Leadership Team were now examining the development of the Principles that should inform how this important strand of work would be developed. She advised that in progressing this discussion that to date Senior Leadership had agreed the following Key Principles:
 - Safe and Quality Care
 - Investing our resources where they add most value

- A commitment to following through all actions that are agreed
- All underpinned by intelligent use of data

In closing her Report to the meeting Vivienne advised that Dr O’Kane had concluded her Presentation with the following two quotes:

“Those who cannot remember the past are condemned to repeat it.”

“The first step towards getting somewhere is to decide that you are not going to stay where you are”.

Reflecting on the Presentation, Vivienne said that she believed that the Presentation had been very impactful because it had been candid, open and honest. Robbie Pearson supporting this comment also reflected that the acknowledgement of past failures was very powerful. Both advised that in focusing on issues emerging from the Urology Public Inquiry there now had to be a clear commitment to Transparency and importantly that this commitment were evidenced in the Presentation. Robbie also suggested that the Leadership Team might consider including “Sustainability” as another important principle to be adopted by the Senior Leadership Team in moving these important issues forward. This was particularly relevant in light of the staff having expressed a clear view that the Senior Leadership Team needed to draw a line in the sand and move forward to a more hopeful future.


Dr Watson commenting that he believed the Urology Public Inquiry Proceedings had identified similarities and parallels with the other Inquiries that had been convened across

- Veryan acknowledged there was an appropriate recognition that the analysis that informed the Vision was based on evidence but she also advised that it would be critical to consider and agree the Values that would inform the Trust's approach. This narrative, she suggested was currently absent from the meetings and discussions that had taken place to date as far as she aware.
- Veryan concluding her comments said it was essential that a "protected resource" is agreed to support the process and also that an updated narrative was developed on the Trust's Website. For example, she suggested Dr O'Kane's presentation to the Trust Board could be shared with staff by uploading it to Trust's website.

2.0 Next Steps for Trust Engagement Plan

As an outcome of the meeting of the 4 Sub-Groups, both Heather and Vivienne advised that there is they believe a genuine consensus around the 4 Sub-Groups that an Internal Reference Group (IRG) needs to be established going forward to provide the necessary Updates and information on the process in a structured and evidence based format. It was also suggested that an IRG could fulfil a critical role in monitoring the progress of the implementation of the Engagement Plan. It was agreed that if an Internal Reference Group was established it should have a schedule of meetings across 2024.

PEOPLE & CULTURE GROUP TERMS OF REFERENCE

VERSION	1.0
ASSURANCE	SECOND LINE ASSURANCE
PURPOSE	<p>The People & Culture Steering Group is part of the second line of assurance within the revised Integrated Governance and Assurance Framework. It will support the delivery of the Trust's Vision, Corporate Objectives and Priorities, identifying the gaps in controls and the constraints that prevent their achievement.</p> <p>Assurance The purpose of the People & Culture Steering Group (the Group) is to provide support to the Trust Strategy & Transformation Committee by obtaining assurance that:</p> <ul style="list-style-type: none"> the Trust has plans with ambitious but realistic goals and targets relating to workforce, education, organisational development and culture, so as to enable the Trust to meet its Strategic Objectives. the plans to achieve those goals and targets are being implemented. our people are reporting that our plans are making a difference to their working lives. <p>For example, they will initially oversee and support the implementation of the Trust's People Framework 2022-2025 to enable the Trust to achieve our ambition.</p>  <p>Alerting The Group will alert the Trust Strategy & Transformation Committee where assurance cannot be given or further work or consideration is required by the Senior Leadership Team or at Committee Level.</p> <p>Advising The Group will advise the Strategy & Transformation Committee on matters within the scope of the Group's Terms of Reference.</p> <p>Accountability The Group is accountable to the Trust Strategy & Transformation Committee who in turn is accountable to the Trust Board.</p>
MEMBERSHIP	<p>Membership will initially consist of the Director of HROD, Deputy Director of HROD, 3 Executive Directors and Assistant Directors for the other directorates not represented.</p> <p>Chair: Director of Human Resources & Organisational Development</p>

**UROLOGY SERVICES INQUIRY**

USI Ref: Notice 4 of 2023

Date of Notice: 30th March 2023

Witness Statement of: Dr Maria O’Kane

I, Maria O’Kane, will say as follows:-

1. The following extract is taken from your evidence on Day 15 of the Inquiry hearings:

TRA-01438, Lines 11 - 29

Q. Do you see that then as a failing, from you as Medical Director, in having proper oversight to ensure that you got proper information on which you could assess whether the action plan was effective or something else needed to be done?

A. In hindsight, I would do things differently. Right? I would have asked probably different questions in that context. But I think the context is important. I had just arrived in an organisation. It takes a year to get into a job like that properly. I didn't know anybody. I didn't know the systems and processes. One of the experiences I had was that when I asked questions, you know, I think some people felt that those were critical rather than curious, and that was a really difficult environment to work in. In hindsight, if I were doing this again I would do it differently, but at the time what I was reliant on was people who had worked in the organisation for a long time, understood how it worked, to give me information

TRA-01438, Lines 1 - 29



Urology Services Inquiry

and responses to the questions that I asked in relation to systems and processes. I think, you know, one of my concerns in referring Mr. O'Brien to the GMC was in relation to insight. I also think, looking back on all of that, we didn't have full insight either in terms of how we managed that process.

Q. You have mentioned you didn't know anybody at the time. Sometimes that can be an advantage in a new job where you don't have friends or enemies. You are coming in as a new brush and that gives you the opportunity to do things that are more difficult had you been promoted from within. Essentially your answer is you got a little bit of push back from some staff. You felt they thought your queries were criticisms. Did that play a part in your decision making as to how to manage this situation?

A. I don't think so, but I do think it made it a bit more difficult.

Q. Can you expand a little bit more on what that criticism was aimed at and how it may have impacted your choice of behaviour at that time?

A. There were, certainly, on a number of occasions, when I was very robustly challenged by middle managers within the Trust -- not Martina Corrigan and not any of the other people who worked to her -- in relation to what my role and function was, why I was asking these questions, and I think were a bit alarmed, I think, about the level of curiosity in relation to how this worked. That didn't stop me asking the questions but

TRA-01439, Lines 1 – 20

it did make it more difficult in that I had to keep coming back and back and back to try to get the answers that I needed.

Q. Did you consider that to be a difficult working environment, that the culture of being robust towards the Medical Director –



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A. Yes.

Q. -- *probably a little bit ambitious for people to take on the most senior medic in the SMT. Did you see that as a sign there was some reluctance to do things differently?*

A. Yes.

Q. *You've mentioned who it wasn't. You haven't mentioned who it was in your Section 21. You're clearly not going to say any names. You're very free to do so now if you wish to, but obviously the Inquiry would like the opportunity to ask certain individuals, if we had the information, how their behaviour may have impacted on clinical decision making. I'll leave that thought with you.*

2. The Inquiry asks that you:

- (i) **Identify by name and position the *middle managers* to whom you referred in your oral evidence.**

Mrs Anne McVey Assistant Director Acute Medicine;

Mr Ronan Carroll Assistant Director ATICS and Surgery and Elective Care.

- (ii) **Set out the detail of your interactions with these individuals, including:**

- (a) **the content of discussions and dates/times/locations as appropriate,**



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I had contact with both Anne and Ronan through clinical directorate meetings throughout the overlap in their tenure and mine, usually in different formats and on average about 1-2 times weekly.

(b) what you took to be being communicated to you by these middle managers, and

They both adopted a defensive approach to my questions around clinical and social care governance. The general explanation for this appeared to be that when staff were asked about any activity in the past that they had felt criticised. This then seemed to have set the tone across the Acute Directorate. I was left with a strong sense that they viewed me as interfering and that inquisitiveness was viewed as questioning with a negative agenda rather than curiosity in a bid to understand. Comments were made about me being an outsider. The approach to me at times was of sarcastic comments being made particularly by Anne to me in front of others if I asked questions even as a relatively new person learning my way in a new organisation. When I drew others' attention to this there seemed to be an acceptance that this was the way business was done in the Trust and couldn't be challenged. This was disappointing as, when I worked in a previous Trust and had studied together with Anne (Ulster University Business School – MSc in Health and Social Services policy Management), I had thought the working relationship was constructive.

On one memorable occasion in 2019 I was in the patient flow control room with senior nurses and Anne reviewing patient activity in the context of overcrowding and waits in Craigavon Emergency Department. I asked why pathways that had been agreed the previous week were not being implemented. Anne abruptly left the room demanding to speak to me in her office stating that she had "had enough of" me and she wouldn't be asked questions like this again. I spoke to her but her determined attitude was that I was interfering and



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she would not engage with me. I spoke to Vivienne Toal, Director of HR, and explained the situation and was then asked to the office of Melanie McClements, Director of Acute Services. Melanie was angry that Anne had been “upset” and reiterated that I had to stop asking questions. I discussed this with the Chief Executive, Mr Devlin, and his view was aligned with mine: that as Medical Director I should be curious in relation to patient care. I discussed this at a later stage with Melanie when she was less irritated and explained that she had only been given one side of the story and that I was disappointed that she would choose to give credence to an Assistant Director and none to an Executive Director with a responsibility for Patient Safety and Governance. I reminded her that I would not be able to do my job if I didn’t try to understand how systems worked. She accepted this and acknowledged this and stated that she had not had a full appreciation of the role of Medical Director.

Until she retired the relationship with Anne was professional but not warm. This was disappointing. I don’t believe that she recognised the impact that her behaviours had on the relationship. I also was aware that she had the capacity to be extremely kind towards others, particularly patients.

I was very mindful of the fact that, as someone who was recently new into the role of Acute Director with limited experience in that Directorate, Melanie was extremely dependant on the support of the ADs in order to get the job done. Particularly before the onset of the pandemic, the organisation felt quite split at times. Acute held onto its own information under the guise at that time of managing its own governance, which is a system that had been instigated in the past. As a result of this it was very difficult for the Director of Nursing and me, as Medical Director, to access the governance information we required in order to provide accurate assurance to the organisation. By the same

Comac, Jennifer

From: Wallace, Stephen [Personal Information redacted by the USI]
Sent: 03 August 2020 10:29
Subject: CONFIDENTIAL - Early Alert - Urology July 2020
Attachments: 31072020 EA JULY 2020 20.pdf

Dear Roberta,

Please find attached an early alert regarding Urology for your information. As per regional Early Alert processes the Board and Department have been provided with the attached information, Dr O’Kane has spoken to the CMO office to advise of the content, the CX has also been made aware.

Please note given the sensitivities and ongoing processes surrounding this issue the internal circulation list has been limited and we ask that this is not shared wider at this stage.

Regards
Stephen

Stephen Wallace
Interim Assistant Director of Clinical and Social Care Governance
Mob: [Personal Information redacted by the USI]



Initial call made to

CMO Office

(DoH) on

31.07.2020

DATE

Follow-up Pro-forma for Early Alert Communication:**Details of Person making Notification:**

Name

Dr Maria O'Kane

Organisation

Southern Health and Social Care Trust

Position

Medical Director

Telephone

Personal Information redacted by the USI

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)

Personal Information redacted by the USI

Personal Information redacted by the USI

Mobile (work or home)

Telephone (work or home)

Personal Information redacted by the USI

Forward pro-forma to the Department at:

Personal Information redacted by USI

and the HSC Board at:

Personal Information redacted by USI

FOR COMPLETION BY DoH:

Early Alert Communication received by: Office:

Forwarded for consideration and appropriate action to: Date:

Detail of follow-up action (if applicable)

Working for a Healthier People



Summary of Trust Board Workshops 2023 - 2024

21 st February 2023	<ul style="list-style-type: none"> - Financial Planning 2023/24 - Financial Sustainability and Productivity review
23 rd March 2023	<ul style="list-style-type: none"> - Update from the IHRD Team - In conversation with the IHRD Team - Implementation of IHRD recommendations in the SHSCT
27 th April 2023	<ul style="list-style-type: none"> - Draft Report from the Board Development Day on 25th August 2022 - Review of Clinical and Social Care Governance Action Plan (Champion Recommendations) - Update on the Clinical and Social Care Governance Structures - Update on the Corporate Governance Structure including Steering Groups - MHPS Training (<i>Full Board session</i>) - MHPS – A facilitated discussion for Non-Executive Directors
18 th May 2023	<ul style="list-style-type: none"> - Communication and Complaints - Overarching view from the Ombudsman - What is the Trust doing to improve communication? <ul style="list-style-type: none"> ○ Patient and Client Experience/ Care Opinion/Bereavement Service ○ Improving Communication with patients ○ Organisational Development perspective ○ What more can we do? - Setting the Trust Board's Risk Appetite
18 th September 2023	<ul style="list-style-type: none"> - Risk Appetite - Board Governance Self Assessment Tool - Draft Partnership Agreement
29 th November 2023	<ul style="list-style-type: none"> - Southern Trust Financial Position - Response to the Department of Health
14 th December 2023	<ul style="list-style-type: none"> - Meeting between SHSCT and the Comptroller and Auditor General
15 th January 2024	<ul style="list-style-type: none"> - Southern Trust Financial Recovery Plan
8 th February 2024	<ul style="list-style-type: none"> - Trauma Informed Practice
27 th February 2024	<ul style="list-style-type: none"> - Southern Trust Financial Recovery Plan
21 st March 2024	<ul style="list-style-type: none"> - Strategy Development