Urology Services Inquiry

SCHEDULE

[No 6A of 2022]

General

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

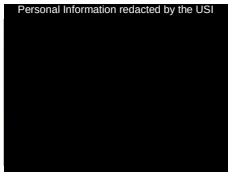
1.1 A response is provided within this statement to each individual question with regard to the nature of my knowledge of the matters which fall within the scope of the Terms of Reference of the Inquiry, including my role and responsibilities. With regard to timelines, I have provided a commentary of my memory of relevant events, prompted by my review of documentation provided by the Trust to the Inquiry to date. Relevant documents are referenced within the individual responses below. I have not been able to review all emails sent or received by me during the relevant period (2014 onwards) and, as such, it is possible that my responses inadvertently overlook some aspect of my involvement. A table summarising some key aspects of my role in relation to events that are of relevance to the Terms of Reference of the Inquiry is set out below. A more detailed account of my involvement in and/or knowledge of specific matters is, however, provided in my answers from Q4 onwards below.

1.2

Date (month/ year)	**Description**
May 2014	Commenced employment in Southern Trust as Consultant Urologist.

Statement of Truth

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

Signed: 

Date: 16th September 2022

GMC/GDC Registration

Registration Type:	Full
Registration:	Specialist Register Urology 4th Mar 2010
GMC/GDC Number:	Personal information redacted by the USI
Medical Defence Union Number	None (Indemnity with other provider)

No doctor may be employed unless he/she is registered or holds limited registration with the General Medical/Dental Council. Evidence of this must be produced prior to commencement of employment.

Specialist Register Status

I am currently on the Specialist Register?	Yes
I have applied for entry onto the Specialist Register?	Yes
My expected date of issue of CCST is:	04/03/2010
Speciality in which now engaged:	Urology

Membership of Learned Societies

BAUS Member

Under-Graduate/Post-Graduate Prizes/Distinctions/Research/Publications

Undergraduate; Dr Ken Wheeler Presidents Prize 1998 MB BCh: Merit in Community Medicine, Anatomy, Biochemistry, Physiology and Sociology Postgraduate; BUF / Schroder Scholarship 2004/5 Research; As a consultant I am involved in recruitment of eligible patients to clinical trials including POUT, SORCE, RADICALS, CARMINA, and STAMPEDE. Period of laboratory based research (MD), data collection for patients in the CAPRIx trial. Audit; As MDT Chair I am responsible for data collection/outcomes monitoring and subsequent submission to the cancer registry, COSD, and BAUS database. I supervise FY1, CST and SpRs in clinical audits which have been presented regionally. Publications; Transurethral resection biopsy as part of a saturation biopsy protocol: a cohort study and review of the literature. Urol Oncol. 31(5): 542-8, 2013 Claudin-11 decreases the invasiveness of bladder cancer cells. Oncol Rep. 25(6): 1503-9, 2011. Renal Cancer. Surgery. 28(12): 605-609, 2010.

relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

5.1 Since commencing employment in the Southern Trust I have held the following trust posts (in addition to my position as Consultant Urologist, which I have held since May 2014, *please see 2. 20131000 - REF15 - MR M HAYNES Job Description).* The job descriptions are attached and are, I believe, an accurate outline of my duties and responsibilities;

a. Clinical Director (Surgery CAH / T&O); 1st June 2016 – 30th September 2017 (please see *3. 20160600 - REF2b - CD SEC CAH Job Description)*

b. Associate Medical Director (Surgery and Elective Care); 1st October 2017 – August 2017 *(please see 4. 20170600 - REF2b - AMD SEC Job Description)*

c. Divisional Medical Director (Surgery and Elective Care) – 1st August 2021 (3-year fixed term) *(please see 5. DIVISIONAL MEDICAL DIRECTOR SURGERY AND ELECTIVE CARE)*

d. Divisional Medical Director (Secondment to Urology Improvement) – (1st December 2021) *(Please see 6. DIVISIONAL MEDICAL DIRECTOR UROLOGY IMPROVEMENT)*

5.2 In addition I undertake the following external role;

a. NICAN Urology Clinical Reference Group Chair – Chaired first meeting September 2017 and continue in this role.

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

47. 20210719 Approved Action Plan to HSCB A1 and 119. 20190331_RE Urology backlogs Confidential.

62.7 When I commenced as AMD, I did not receive any handover from the outgoing AMD and so was not aware of any prior issues or investigations relating to Mr O'Brien. Relatively soon after starting as AMD, Mr O'Brien had a period of sick leave. I recall that it was during this period of sick leave that the concerns regarding non-triage of referrals escalated with a significant number located in Mr O'Brien's office. It is my memory that this was identified as a potential issue in the course of the Patient 10 SAI investigation (following an IR1 submitted by me relating to a patient who was referred with regards a renal lesion - the primary issue of this IR1 was a misreported MRI scan but it was noted during the SAI that the referral had not been triaged). At this time and following on from this, I recall a number of meetings with urology consultants (primarily operationally identifying capacity for triage of all the untriaged referrals and the subsequent patient assessments required). I also had a number of conversations with the HoS (Martina Corrigan), AD (Ronan Carroll), Director of Acute Services (Esther Gishkori), and the Medical Director (Richard Wright) regarding this issue and the additional concerns relating to absence of dictations, medical records being in Mr O'Brien's house, and preferential management of private patients were also investigated. I do not have notes from these informal meetings / discussions.

62.8 As a result of these concerns an MHPS investigation was opened and I was interviewed as part of that investigation. I do not recall when the discussion was held but, as part of the conversations with the Medical Director, it was agreed that, given my proximity to Mr O'Brien as a working colleague and given that I was the individual who had raised IR1s and concerns regarding Mr O'Brien, it would not be appropriate for me to be party to the MHPS process for Mr O'Brien. As a result, I was not part of the MHPS discussions nor was I party to the subsequent report, recommendations and monitoring.

62.9 Soon after commencing as Medical Director, in early 2019 Maria O'Kane spoke to me regarding Mr O'Brien and the MHPS investigation and concerns being escalated to the GMC. However, I do not know/recall whether this

Southern Health and Social Care Trust

Quality Care - for you, with you

TITLE: Associate Medical Director

DIRECTORATE/ DIVISION: Acute Services – Surgery / Elective Care

REPORTS OPERATIONALLY TO: Director of Acute Services

REPORTS PROFESSIONALLY TO: Medical Director

ACCOUNTABLE TO: Chief Executive

COMMITMENT: Maximum of 3 PAs - to be agreed with Director

LOCATION: Craigavon Area Hospital / Daisy Hill Hospital

JOB SUMMARY

The Associate Medical Director (AMD) will as a member of the Directorate Senior Management Team, play an active role in contributing to the strategic direction and the on-going provision of high quality services which are safe and efficient.

Specifically, the AMD will be responsible and accountable for the medical staff within the specialty and their role in the provision of services. As a senior medical leader within the Trust the AMD will work closely with the Director / Assistant Directors of Acute Services to provide medical management within the Directorate and contribute to the overall vision, direction and performance of the organisation with respect to the medical staff and their role in service delivery. The AMD will also be responsible for the safety and capability of the medical workforce within the specialty, providing the Director of Acute Services with defined information for assurance purposes to the Medical Director. The AMD will demonstrate a commitment to lead by example with regard to clinical and social care governance.

The post will be appointed for one year and may be extended at annual performance reviews up to a period of 3 years. After this period, the post will be re-advertised.

KEY RESPONSIBILITIES

1. LEADERSHIP & MANAGEMENT RESPONSIBILITIES

The AMD will work closely with the Director/ Assistant Directors of Acute Services to provide effective leadership within the Directorate**.**

The AMD Surgery & Elective Care will work closely with the AMD's MUSC, ATICs and Cancer & Clinical Services to ensure effective clinical interfaces and patient pathways for out of hospital care, ambulatory care and admission for inpatient care are in place, reviewed and actioned.

- Liaise with the Associate Medical Director for Education and Training and College Tutors to ensure a plan is in place by specialty for the training of junior doctors in keeping with NIMDTA and GMC requirements (including managing the balance between service delivery and training demands).
- Provide leadership in implementing and achieving compliance with the European Working Time Directive.

2. CLINICAL GOVERNANCE RESPONSIBILITIES

The AMD in conjunction with the Assistant Directors and Director of Acute Services will be responsible for having systems and processes in place to review and manage remedial action emerging from incidents, complaints, risk identification and assessment, litigation, audit and clinical indicators. The AMD will have responsibility for the specialty M&M meetings and to ensure emergency medicine contributes to other specialty M&M meetings.

The AMD will be directly responsible to the Director Of Acute Services for patient safety. This includes ensuring processes are in place to identify, review and take remedial action when patient safety issues arise.

The AMD will be responsible for managing potential underperformance of medical staff within the Directorate. With full assistance from HR, the AMD will be responsible for leading the Trust's process for Maintaining High Professional Standards within the Division.

OTHER CLINICAL GOVERNANCE RESPONSIBILITIES

Divisional Governance Forum

- Chair the Divisional Specialty Governance Group and participate as agreed in Directorate governance arrangements.
- Work with the Trust / Directorate Governance Co-Ordinator to ensure effective governance of services.

Standards

- Provide advice to the Director of Acute Services and colleagues on the application of existing and new standards and guidelines e.g. NICE, NSFs, Royal College Guidelines etc.
- Work with relevant managers and colleagues on required implementation plans and lead the implementation of such plans in relation to the medical workforce and clinical practice.
- Act upon the recommendations of any external audits/ reviews (e.g. RQIA, CMO's office, Child Protection etc) working on the development and roll out of an implementation plan in conjunction with the Director/ Assistant Director of Acute Services.
- Assist in the preparation for external inspections.

Public Health and urgent operational issues

33.3 As a medical manager, as Clinical Director, I did not have any direct line management responsibility for the urology team and so I remained a team member and not a line manager; I was not responsible for job planning and had no role in appraisal for the urology consultant team.

33.4 I have actively engaged with, in particular, our Clinical Nurse Specialist team, developing their skills and, as a result, the services offered and delivered by the CNS team. Examples of skills developed include; TRUS biopsy and more recently US guided transperineal prostate biopsy, flexible cystoscopy and botox injection, and flexible cystoscopy and stent removal.

33.5 As Associate Medical Director I was not the direct line manager for the urology consultant team (the Clinical Director was Mr Colin Weir). When I commenced this role there rapidly became a 'live' issue in relation to Mr O'Brien and, due to the proximity of my direct day-to-day working relationship with him and my role in relation to the identification of concerns, the Medical Director (Dr Richard Wright) did not directly involve me in this process, with the Clinical Director and Medical Director continuing this. I have been involved in the management of other medical staff issues within urology. These have been of a personal, health-related, and therefore confidential nature, and are unrelated to the subject matter the Inquiry and I have therefore not included any detail. The matters have been managed in a satisfactory manner from mine, and the concerned individuals', perspectives.

34. ~~**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.**

34.1 My personal attendance at the departmental meetings over the past 4 years has been impacted by my working across 2 Trusts, with Belfast Trust activity taking place on Thursdays. In general, the urology team had Departmental Meetings weekly on Thursdays (lasting approx. 1 hour). In addition, there were

From: Haynes, Mark
To: Gishkori, Esther
Subject: RE: AMD
Date: 05 October 2018 16:49:09
Sensitivity: Confidential

Hi Esther

I have a clinic Monday morning and theatre in the afternoon. [redacted] I will hold off until I speak to you but would not anticipate a change of heart I'm afraid. May find it difficult to meet next week as on Tuesday I have a meeting at HSCB with the PHA and prostate cancer UK following up concerns raised by PCUK about inequity of provision of prostate cancer services in NI compared to the rest of the NHS, I will be in CAH briefly before heading to Belfast and then it will depend upon the meeting / fallout as to when I leave Belfast, Wednesday I have theatre then OP, Thursday Theatre and then MDM, Friday theatre BCH am and theatre CAH pm.

Mark

From: Gishkori, Esther
Sent: 05 October 2018 13:51
To: Haynes, Mark
Subject: RE: AMD
Sensitivity: Confidential

Mark,
How are you?
I have been trying to contact you over the past week but accept that I have been extremely busy myself. I have been dealing with some of my own issues but nothing like what you have had to deal with.
Can you defer your decision until after we have a chat?
I would really miss you and always value your views and opinions.
I will of course respect any decision you wish to make and really understand how manic your week is. Really want a catch-up soon.
How are you fixed on Monday?
Best,
Esther.

From: Haynes, Mark
Sent: 05 October 2018 13:01
To: Gishkori, Esther
Subject: AMD
Sensitivity: Confidential

Hi Esther

I wanted to contact you before I let others know. I am going to resign from my position as AMD (I will remain as a Southern Trust urology consultant). I will be putting together a resignation letter over the weekend and trust you will keep this decision to yourself until I have sent it to all.

[redacted]

Personal Information redacted by the USI

[redacted].

Over the past week I have re-appraised my current situation. Looking at my workload it is apparent that I have been performing far in excess of what can be considered a realistic or sustainable level of activity. My typical week as AMD has evolved to become as below;

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
05:15 – 08:00 Admin / results / email (at home)	05:15 – 08:00 Admin / results / email (at home)	05:15 – 08:00 Admin / results / email (at home)	05:15 – 07:00 / 08:00 (alt weeks) Admin / results / email (at home)	05:15 – 07:00 Admin / results / email (at home)	05:00 – 08:30 Admin / NICAN CRG chair activity	20:00-22:00 Admin / results / email / OP clinic prep
09:00-13:00 New outpatient clinic CAH	09:00-16:00 AMD activity	08:30-13:30 Pre op ward round / theatre / post op ward round CAH	08:00-13:00 Pre op ward round / theatre / post op ward round BCH (week 2, 4) AMD activities weeks 1,3,5	08:00-13:00 Pre op ward round / theatre / post op ward round BCH (week 2, 4)		
13:00-17:30 Pre-op ward round / theatre / post op ward round CAH		13:30-17:30 Review OP clinic CAH	13:00-17:00 Travel to CAH then MDM CAH	13:00-17:00 Travel to CAH Admin with secretary / plan theatre lists / increasingly AMD activity		

In addition to this activity I have been making / receiving phone calls most evenings, attempting to keep up with my own CPD (which I am not getting done at any point during the week), work our 1:6 on-call rota, am clinical supervisor to 2 trainees at CAH, do my 1:6 weeks as Urologist of the week and perform triage during both my week as UoW and during our locum week (this all occurs outside of standard hours and at home). Personal Information redacted by the USI I didn't get any admin done over the weekend / Monday. The result was that on Tuesday 1 'caught up' with 138 radiology / pathology / blood results dictating >80 letters.

18/09/14		**Dr 1 update to family** Explained information above Known concerns with ongoing antibiotics regarding infective diarrhoea. Discussion re feeding Dr 1 explained IV not appropriate + danger of aspiration with Naosgastric feed. Re-iterated patient may not survive. Advised medical decision not to resuscitate patient.
19/09/14	10.30	**Dr 10 Ward Round** Much brighter answering questions, denies pain, chest clear. **Plan** Continue current treatment
19/09/14	13.00	**Dr 1 Ward Round** Slightly better having small amount of ice cream Chest clear, denies pain. **Plan** Continue current antibiotic and slow IVF. Oral feeding when alert + sitting upright-safest consistencies. If swallow safe can convert IV medications to oral. O2↓ 1litre-wean completely , aim for sats ≥ 94%
19/09/14	13.20	**Dr 1** Discussion with daughter re above and re-iteration re feeding. At present continue oral feeding at softest consistencies when alert. Update re DNACPR status-in agreement.
20/09/14	12.40	Family approached re moving patient from side-ward to accommodate an "infective control patient". Family refused Consultant aware.
21/09/14	09.00	Branden Scale MUST tool
22/09/14		**Patient Manual Handling Risk Assessment form completed**
22/09/14	12.45 1600	**Dr 1 Ward Round** Managed breakfast today Sats 99% on O2 . Apyrexic. Chest clear **Plan** Slow IVF. Oral Epilim+ Paracetamol O2 as required (PRN). Continue Menopenem for 7 days (7/7) Physiotherapy/OT as able Repeat bloods CRP 87 (850) WCC 9.87
23/09/14	12.05	**Dr 12** Tired. Chest clear. **Plan** Continue with current management Antibiotic due to end 3/7
24/09/14	10.50	**Dr 16** Finishing Meropenem 2/7 left. Managed good intake yesterday.

At consultant level numbers of PA's have been calculated based upon capacity requirements as above and the following hours calculations;

Session	Consultant Hours per session (including admin time)	Weekly sessions required	Weekly Hours	Weekly PA's
Theatres (Inpatient and daycase)	5	14	70	17.5
Outpatients clinics (New, FU, Off site)	5	17.6	88	22
Urodynamics	5	1	5	1.25
ESWL	1	4	4	1
Multidisciplinary team meetings (oncology and non oncology)	5	6	30	7.5
Acute care	4.75	12.2	57.9	14.5
Unpredictable out of hours work	4	6	24	6
Supporting Professional Activities	6	7	42	10.5
Total			320.9	80.25

In order to deliver the anticipated demand the service will therefore require funding for 7 consultants (11.4 PA's) in addition to the expansion in the outpatients nursing team. Without this we will not be able to meet projected demand as consultant capacity would be reduced.

Summary

We have reviewed the Urology service wihtin SHSCT and examined every aspect from the perspective of aiming to provide a sustainable service. We believe the plan as described will enable us to provide this while maximising the efficiency of utilisation of consultant time. In order to do this there is a need for expansion of the clinical nurse specialists within the team. This expansion will require training and funding, without this the service cannot be provided in a sustainable manner. However, even with this expansion and maximisal efficiency of consultant time there is no currently sufficient consultant time available to provide capacity for projected demand. Without providing this capacity we will also not be able to deliver any backlog reduction.

Demand reduction will be a major aspect of delivery of the service. This requires support in our engagement with primary care and in the principle of secondary care defining the criteria for referral and rejection of referral which have not followed agreed primary care investigation and management guidance. The currently available mechanisms for this process will require significant consultant input. The proposed electronic mechanism for this process would be preferable and

From: Haynes, Mark [Personal Information redacted by the USI] >
Sent: 11 October 2019 08:24
To: Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; Glackin, Anthony; Tyson, Matthew
Cc: Carroll, Ronan; Corrigan, Martina
Subject: Emergency admissions of patients on waiting lists

Importance: High

Morning all

As we are all aware, waiting times for our patients are considerable. For some patients this results in them being admitted as emergencies, with in particular urosepsis, and these admissions would likely have been avoided if the patient had received timely elective surgery.

Amongst the key trusts targets set by the DoH is a reduction in healthcare associated gram negative bloodstream infections.

Going forwards, can we each submit an IR1 form for any patient who has waited longer than a time we consider 'reasonable' for elective treatment and is subsequently admitted as emergencies, in particular those with positive gram negative blood cultures, but including any patient whose emergency admission would have been avoided if they had received timely elective surgery? This will clearly document to the trust and HSC the patient risk and harm.

What constitutes 'reasonable' is up for debate and has to be left to each of our clinical judgement. As an initial thought I suggest;

>1 month delay for planned change of long term stent or beyond planned timescale for ureteroscopy for stone in stented patient.
>3 month wait for treatment for catheterised man awaiting TURP/incomplete bladder emptying awaiting TURP, stone disease for ureteroscopy, PCNL or nephrectomy (in non-functioning kidney), pyeloplasty.
>1 year wait for routine elective treatment

As onerous as it may be completing these forms, the documentation will heighten the recognition of our patients needs and suffering due to the lack of capacity. It will also protect us to some degree, I am aware that a speciality (not urology) in an NI trust has come in for criticism because it did not flag / document delays in cancer treatments which are felt to have resulted in patients coming to harm.

Hope this is OK with all. The IR1 form link is;

[Irrelevant information redacted by the USI]

Mark

arose in relation to the various concerns that were raised within the context of the formal investigation.

(Q 72)

584. Issues which arose in relation to my practice were inextricably linked to the inadequate system I was working within. That led to recurring issues, for example, in relation to triage as detailed above in my response to Questions 66-67. These issues could have been prevented had the Trust ensured that the Urology Service had adequate staffing and capacity so that a practicable system could have been put in place to deal appropriately with triage.

585. During my tenure, there was a recurring issue with records being kept at my home and office as well as non-dictation of clinics. Again, that could have been prevented had the system within which I was working been adequately staffed and properly run by the Trust.

586. If there was any recurrence in the failure to ensure oncology patients had access to a Clinical Nurse Specialist (CNS), that could have been prevented by those responsible, namely the MDT Lead Clinician and the MDT Core Nurse Member, complying with their responsibilities as stated in the MDT Operational Policy to ensure that such patients had access to a CNS.

587. It could not be said that any issue in respect of my prescribing Bicalutamide recurred during my tenure, as no issue was ever raised with me in respect of my prescribing that medication during my tenure as a consultant urologist with the Trust. As stated elsewhere in this statement, the use of Bicalutamide was known to both the Urology and Oncology Service and no issue was ever raised in respect of Bicalutamide until after the termination of my contract with the Trust.

11. **Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, or any subsequent protocol (please specify) provided to or disseminated in any way to you or by you, or anyone else, to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?**

11.1 I was not in employment in Northern Ireland at the time of the publication of the 'Integrated Elective Access Protocol'. I became aware of the existence of the 'IEAP' at a later date through reference to such a document by others in meetings, but have no recollection of having been provided with a copy, either on my initial appointment or subsequently. However, as the document principally addresses the 'rules' for monitoring provider (NHS Trust) performance against quality indicators (targets) set by the commissioner (HSCB) I would not consider it to be a document that I require a significant working knowledge of, except where aspects directly impact on how I deliver care. Where aspects of monitoring place expectations on a member of staff or staff group, I would anticipate that this staff member / staff group would be made aware of the expectations relating to their role (e.g., time limits) and who / how to escalate when this is not achievable.

11.2 However, despite not recalling having ever been provided with the IEAP, I have always been aware of the existence of cancer waiting times targets and many of the rules relating to the monitoring of these. I would also be aware that it is my responsibility to return triage promptly, with recognition that Red Flag referral triage should assume a higher priority than urgent and routine referrals. While I was not made directly aware of the precise triage time aspects of the IEAP, having read the document as part of the process of responding to this question, I would consider these to be a reasonable expectation in general, with some recognition of flexibility around bank holidays / weekends and that, on occasion, competing workload pressure may also impact. I would also be aware of my responsibility to act on results and correspondence received by me in a timely manner and a requirement on me to ensure I work within available processes to ensure correspondence / results do not get overlooked. I would

also consider it absolutely expected that, if I am unable to meet an aspect of my workload, it is my responsibility to escalate this within my line management structure. When conducting triage during my Urologist of the week activity I aimed to as much as possible keep up to date on a daily basis, in particular with Red Flag referral triage, and ensured at the end of my week all was up to date for the incoming consultant taking over as Urologist of the Week. On rare occasions emergency activity was such that I subsequently completed the triage over the Thursday / Friday after handing over.

12. **How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) or any subsequent protocol impact on your role as a Consultant urologist, and, as Associate Medical Director, in the management, oversight and governance of Urology services? How, if at all, were the time limits for urology services monitored as against the requirements of that protocol or any subsequent protocol? What action, if any, was taken (and by whom) if time limits were not met?**

12.1 Trust performance is monitored against the targets as outlined in the IEAP and these access targets are reported through the trust performance teams to the Trust Senior Management Team and HSCB, and the directorate management teams. As has regularly been outlined in news articles, cancer access targets have not been met in Northern Ireland for a significant length of time. The primary issue in this is recognised as capacity. Operationally, actions have been taken to prioritise access such that patients referred on suspected cancer pathways are seen as a priority, such as changing the templates of outpatient clinics, increasing the proportion of available appointments for 'Red Flag' referrals, but this 'cancer focus' inevitably means that patients not referred on suspected cancer pathways (urgent or routine) wait many years for initial outpatient assessment and then wait many more years for surgery when indicated. In addition, operationally Waiting List Initiative sessions (additional extra contractual work) are regularly funded to provide both outpatient and inpatient / day case clinical activity to attempt to address waiting times.

12.2 The triage times outline in IEAP were not to my knowledge monitored for any clinicians. I do not have any recollection of being contacted as a consultant with

76.2 In addition, I am aware from colleagues in the oncology team that concerns had been raised directly with Mr O'Brien previously with regard to his management of prostate cancer and, in particular, his use of low dose bicalutamide in patients with early prostate cancer but, as has become evident, Mr O'Brien did not change his practice. To the best of my knowledge these concerns did not come to the Southern Trust governance systems / processes.

77. ~~71.~~ **Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?**

77.1 I regret not recognizing in late 2017/early 2018 that, in addition to the factors investigated in the MHPS investigation, there was a likelihood of additional issues that had not been identified but which required investigation. The fact that some aspects of good clinical practice were absent in Mr O'Brien's working patterns I feel, in retrospect, ought to have raised the concern that other deficiencies of good practice may also have been present. If this had been recognized, and a comprehensive review of practice been carried out at the time, I feel it is likely that the clinical practice which was identified in 2020 (and which led to the Lookback exercise) would have been identified earlier.

77.2 I am currently developing monitoring processes for data collection / monitoring for the factors monitored for Mr O'Brien in order to roll out across services to provide reassurances that, for the future, similar issues, particularly with regard to clinic outcomes, clinical correspondence, triage, and results management, do not go unidentified in any other clinicians.

78. ~~72.~~ **Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those**

From: Haynes, Mark <[redacted]>
Sent: 11 January 2017 12:45
To: Boyce, Tracey
Subject: FW: PATIENT [redacted]

As discussed below is correspondence between Dr Beckett, Martina Corrigan and me regarding a patient who had no letters from previous consultations. The letter Dr Beckett refers to stating that the patient was to have her non functioning kidney removed was an e-discharge from 15/10/15. She had been seen in OP on 7/9/15 and 7/12/15.

I first saw her when admitted 12/4/16 and she had her surgery later that month.

Mark

-----Original Message-----
From: Haynes, Mark
Sent: 12 April 2016 13:28
To: Corrigan, Martina
Cc: 'Peter.Beckett[redacted]
Subject: RE: PATIENT [redacted]

I saw this lady this morning on my ward round.

I have not been involved in her care to date, I have not received a referral, there are no letters on ECR and her notes detailing previous consultations were not available to me on the ward..

I have discussed a plan going forward that will depend upon how her current pain settles. If it does not settle she will get a nephrostomy, either way I will be looking to arrange an urgent lap nephrectomy. I cannot at present be certain of the date but would hope that it'll be before the end of May.

Mark

-----Original Message-----
From: Corrigan, Martina
Sent: 12 April 2016 08:08
To: Peter Beckett
Cc: Haynes, Mark
Subject: RE: PATIENT [redacted]
Importance: High

Good morning,

This patient was admitted this morning via A&E under Mark Haynes. I have copied Mark into this email.

Thanks

Martina Corrigan

SHSCT Adverse Incident Reporting (IR2) Form -December 2020

The new Regional CCS2 codes which will replace 'Type', 'Category', 'Subcategory', and 'Detail' have been updated.

A full list of these codes can be found here for review.

Incident Details
ID & Status

Incident Reference ID	Personal Information redacted by the
Submitted time (hh:mm)	20:25

Incident IR1 details

Notification email ID number	Personal Information redacted by the USI
Incident date (dd/MM/yyyy)	20/11/2014
Time (hh:mm)	17:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient discussed at Urology MDM on 20th November 2014. Recorded outcome Patient 102 Re-staging MRI scan has shown organ confined prostate cancer for direct referral to Dr H for Radical Radiotherapy. For OP Review with Mr O'B.' Was reviewed by Mr O'B in OP on 28th November 2014. No correspondance created from this appointment. Referral letter from GP received 16th October 2015 stating that Patient 102 had not received any appointments from oncology.
Action taken Enter action taken at the time of the incident	Patient 102 has now been referred to Oncology. This has been done by email and letter. Investigation with MDM team, direct referral was generated at CAH but no record of being received in Belfast.
Learning Initial	
Reported (dd/MM/yyyy)	21/10/2015
Reporter's full name	Mark Haynes
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	18/11/2015
Last updated	David Cardwell 06/17/2016 09:17:40
Were restrictive practices used?	
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 102

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Outpatient Clinic
Loc (Exact)	Urology Clinic
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	General Surgery

61. ~~55.~~ **When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?**

61.1 Fairly soon after commencing work in Southern Trust I became aware that Mr O'Brien had different ways of working compared with others. It was apparent that many of these were embedded in his working patterns and widely accepted across the Trust as 'his way'.

61.2 Concerns were regularly voiced by all members of the consultant team regarding the frequent lack of clinical information (in the form of letters) following outpatient consultations as this had the potential to impact on us when patients had unplanned (emergency) admissions. This voicing of concerns would have occurred during informal conversations and within departmental meetings including with the HoS. I also recognised that, regularly, patient notes were unavailable in the hospital when patients were admitted and this, coupled with the lack of dictated letters (which would have been available on the patient's electronic care record even if their notes were unavailable), presented a potential for risk during a patient's emergency care.

61.3 I submitted an IR1 regarding such a case ([redacted]) in October 2015 (please see *87. 20141120 -IR1* [redacted] , and also commented in an email regarding another patient ([redacted]) who, in addition, did not appear to have been added to the waiting list after outpatient appointments *(please see 88. 20170111 E re PATIENT* [redacted]*).* These concerns were also voiced by other members of the urology consultant team and, in discussions, it was apparent to me that these were long-standing issues and were essentially recognised as normal practice for Mr O'Brien. I did not receive any feedback following submission of the IR1.

61.4 There were also issues in relation to timely responses from Mr O'Brien regarding complaints and litigation. I recall these were an issue at the time Dr

Recipients

Message

Message history

Date/Time	Sender	Recipient	Body of Message	Attachments
22/03/2016 12:08:10	Kerr, Vivienne	martina.corrigan [redacted]	This is a feedback message from Vivienne Kerr. Incident form reference is [redacted]. The feedback is: Please see Datix which is now coded under urology. Please go to http://vsrdatixweb/Datix/Development/index.php?action=incident&recordid=[redacted] to view the incident	
11/12/2015 14:55:26	Cardwell, David	martina.corrigan [redacted]	This is a feedback message from David Cardwell. Incident form reference is [redacted]. The feedback is: Hi Martina, Helen Forde has asked me to send this to you with the following message: W45 991 – I think it should go to Martina Corrigan as it says there was no correspondence for the appointment – so it wasn't that the secretary didn't type it – I think it was that it wasn't dictated so that would need to go to Head of Service for urology to discuss with consultant. Regards David Cardwell Please go to http://vsrdatixweb/Datix/Development/index.php?action=incident&recordid=[redacted] to view the incident	
18/11/2015 14:29:44	Connolly, Connie	Carroll, Anita	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Martina- i have taken this back to SEC as it appears no dictatation was done. Will need review by yourself and governance will support if needed. Connie Please go to http://vsrdatixweb/Datix/Development/index.php?action=incident&recordid=[redacted] to view the incident	
18/11/2015 14:29:44	Connolly, Connie	Mark.Haynes [redacted]	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Martina- i have taken this back to SEC as it appears no dictatation was done. Will need review by yourself and governance will support if needed. Connie Please go to http://vsrdatixweb/Datix/Development/index.php?action=incident&recordid=[redacted] to view the incident	
18/11/2015 14:29:43	Connolly, Connie	Corrigan, Martina	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Martina- i have taken this back to SEC as it appears no dictatation was done. Will need review by yourself and governance will support if needed. Connie Please go to http://vsrdatixweb/Datix/Development/index.php?action=incident&recordid=[redacted] to view the incident	
18/11/2015 14:29:43	Connolly, Connie	Robinson, Katherine	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Martina- i have taken this back to SEC as it appears no dictatation was done. Will need review by yourself and governance will support if needed. Connie Please go to http://vsrdatixweb/Datix/Development/index.php?action=incident&recordid=[redacted] to view the incident	
18/11/2015 11:41:44	Connolly, Connie	Mark.Haynes [redacted]	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasnt sure so i gave access to all. Moved to review Connie Please go to http://vsrdatixweb/Datix/Development/index.php?action=incident&recordid=[redacted] to view the incident	
18/11/2015 11:41:43	Connolly, Connie	Robinson, Katherine	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasnt sure so i gave access to all. Moved to review Connie Please go to http://vsrdatixweb/Datix/Development/index.php?action=incident&recordid=[redacted] to view the incident	
18/11/2015 11:41:43	Connolly, Connie	Forde, Helen	This is a feedback message from Connie Connolly. Incident form reference is [redacted]. The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasnt sure so i gave access to all. Moved to review Connie Please go to http://vsrdatixweb/Datix/	

Corrigan, Martina

From: Haynes, Mark <Personal Information redacted by the USI>
Sent: 31 August 2016 09:34
To: Corrigan, Martina
Subject: Fw: Patient 93
Attachments: aob 050516.pdf

Importance: High

Ignore the hcn but the story here is raised PSA referred by GP on 4th may. GP referral as routine. Not returned from triage so on wl as routine. If had been triaged would have been RF upgrade (PSA 34 and 30 on repeat). Saw Mr Weir for leg pain and CT showed metastatic disease from prostate primary. Referred to us and seen yesterday. As a result of no triage delay in treatment of 3.5 months. Wouldn't change outcome.
SAI?

Sent from my BlackBerry 10 smartphone.

From: Coleman, Alana Personal Information redacted by the USI
Sent: Wednesday, 31 August 2016 08:34
To: Haynes, Mark
Subject: FW: Patient 93

From: Coleman, Alana
Sent: 31 August 2016 08:34
To: Haynes, Mark
Subject: RE: Patient 93
Importance: High

Ah I found Patient 93 !!

This referral went for triage to Mr O'Brien on the 05/05/2016 – and was not returned.
We have been advised that if we get no response after chasing missing triage that we are to follow instruction per referral – the GP originally referred Patient 93 as Routine.
I have attached what was sent for triage – Patient 93 referral is pg25-31.

Thanks
Alana

From: Coleman, Alana
Sent: 31 August 2016 08:14
To: Haynes, Mark
Subject: RE: Patient 93

Morning Mr Haynes,

The HCN is for a Personal Information redacted by the USI – referral we got yesterday from SWAH?

If it is definitely Patient 93 your querying do you have a date of birth?

From: Corrigan, Martina
Sent: 16 September 2016 18:08
To: Weir, Colin
Subject: FW: Urgent for investigation please

Hi Colin

I am not sure if I had forwarded this to you already?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

From: Young, Michael
Sent: 08 September 2016 17:32
To: Corrigan, Martina
Subject: RE: Urgent for investigation please

Few points
1/ GP probably should have referred as RF in first place. A PSA of 34 is well above normal
2/ if booking centre has not received a triage back then I agree that they follow the GP advice
3/ if recent scan had shown secondaries then they were present at referral. As such then this was at an advanced non curable stage even then.
4/ I think the point here is that although non-curable I would have thought that treatment would still have been offered in the form of anti-androgen therapy at some stage over the subsequent few months.
5/ So to follow this to the next step means that if still following our current Routine waiting time would have resulted in the patient not being seen for a year. Some clinicians would have regarded this as resulting in a delay in therapy.
6/ It is not clear if arrangements were made, but the triage letter was not returned ?
7/ The patient was in fact seen within a few months.
8/ The apparent delay of just a few months has however not impinged on prognosis.

My view

MY

From: Corrigan, Martina
Sent: 07 September 2016 12:14
To: Young, Michael
Subject: FW: Urgent for investigation please
Importance: High

As discussed this afternoon

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 02 September 2016 14:51
To: Young, Michael
Cc: Weir, Colin
Subject: Urgent for investigation please
Importance: High

Michael,

Please see email trail and Charlie's comments below.

Can you please discuss with Colin when you are back from Annual Leave and advise course of action ?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 01 September 2016 13:09
To: Corrigan, Martina
Cc: McAllister, Charlie
Subject: FW: Patient 93
Importance: High

Martina
Please see Charlie's comments and direction of travel for this issue – can I leave with you to progress and feedback to Charlie and myself when action/decisions have been reached/need to be taken – can we address this asap
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: McAllister, Charlie
Sent: 31 August 2016 18:37
To: Carroll, Ronan
Subject: Re: Patient 93

My thoughts are that this should go through Mr Young (as Urology lead) first and Mr Weir second (as the CD).

Then happy to become involved.

C
Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Wednesday, 31 August 2016 17:40
To: McAllister, Charlie
Subject: FW: Patient 93

Charlie
Please can you read the series of emails. Suffice to say that although the outcome for the pt would not be any different, this as you know is not the issue that needs to be dealt with.
Await your thoughts
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 31 August 2016 13:17
To: Carroll, Ronan
Subject: FW: Patient 93
Importance: High

Can we discuss please?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

From: Haynes, Mark
Sent: 31 August 2016 09:34
To: Corrigan, Martina
Subject: Fw: Patient 93
Importance: High

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Subject: FW: Patient 93

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To: Haynes, Mark
Subject: RE: Patient 93
Importance: High

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Subject: RE: Patient 93

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If it is definitely Patient 93 your querying do you have a date of birth?

Thanks
Alana

From: Haynes, Mark
Sent: 31 August 2016 07:08
To: Coleman, Alana
Subject: Patient 93

Morning Alana

Could you find out what happened at triage to the referral from 4th May 2016 on this man and let me know please?

Mark