

**Statement of Truth**

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

Signed:

Personal Information redacted by the USI

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Date: 28<sup>th</sup> March 2022

NOTE:



## Urology Services Inquiry

36. <sup>Patient 6</sup> [REDACTED] was also placed on Prof Sethia's list for review and he identified similar difficulties and was screened in for SAI screening by the Acute Governance Screening Team.

37. <sup>Patient 6</sup> [REDACTED] then was identified by 2 independent consultants working separately as requiring an SAI process.

### **Statement of Truth**

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

Signed: \_\_\_\_\_

Personal Information redacted by the USI

Date: 29<sup>th</sup> March 2022



## Urology Services Inquiry

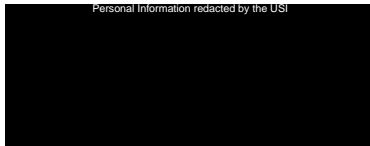
Relevant attachment - Understanding of system wide strengths and weaknesses which has been obtained by the Trust on the basis of the findings of the review.

*This file can be located in Section 21 No 3 of 2022 - 20220401 v2 Spreadsheet of Positives and Negatives\_*

### **Statement of Truth**

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

Signed:



Date: 1 April 2022

**Statement of Truth**

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

Signed:

Personal Information redacted by the USI

Date: 13th May 2022

NOTE:



## Urology Services Inquiry

36. <sup>Patient 6</sup> [REDACTED] was also placed on Prof Sethia's list for review and he identified similar difficulties and was screened in for SAI screening by the Acute Governance Screening Team.
37. <sup>Patient 6</sup> [REDACTED] then was identified by 2 independent consultants working separately as requiring an SAI process.

### **Statement of Truth**

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

Signed: 

Date: **13<sup>th</sup> May 2022**

**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:** \_\_\_\_\_

Personal Information redacted by the USI

**Date:** 23 August 2022



# Urology Services Inquiry

## **Statement of Truth**

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

Signed: \_\_\_\_\_

Personal Information redacted by the USI

Date: 22<sup>nd</sup> September 2022



## Urology Services Inquiry

- a. The need to ensure communication with Trust Board on these matters - An update to Trust Board on MHPS cases is planned for the Confidential Section of Trust Board in September.
- b. The need for training - In addition, an MHPS Training Plan is being submitted to Trust Board in September.
- c. The need for better communication and capture of learning - The Terms of Reference of the Doctors' and Dentists' Oversight Group will be reviewed to ensure that learning is captured, particularly in relation to ensuring that MHPS cases are communicated in a timely fashion to the Chief Executive, SMT Governance meetings, and regularly updated to Trust Board and that there is clear communication in relation to the Appraisal processes.
- d. The need to update guidance - The Trust Guidelines on MHPS will be updated in 2022.

15.6 Documentation regarding all of these developments will be provided as discovery to the Inquiry as they become available.

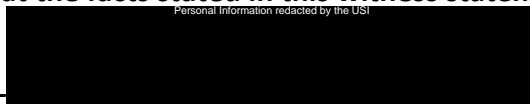
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### **Statement of Truth**

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

**Signed: \_\_\_\_\_**







# Urology Services Inquiry

Date: 26<sup>th</sup> September 2022

1.5 Over the course of the next few weeks, I familiarised myself with Mr O'Brien's hard copy Maintaining High Professional Standards (MHPS) files. These outlined that, as a result of concerns raised in a letter to him by Mrs Heather Trouton, Assistant Director for Surgery, and Mr Eamon Mackle, Associate Medical Director in Surgery, on the 23<sup>rd</sup> March 2016, that further investigation had revealed that Mr O'Brien had not been compliant with the usual administrative processes that support timely and appropriate care, as a result of which patients had not been triaged in keeping with regional guidance and there were concerns that patients had come to harm as a result of delay.

1.6 Further investigation following this had revealed 4 concerns regarding Mr O'Brien: that there were significant numbers of unprocessed triage referral forms, patients' charts stored in Mr O'Brien's home and office, that a number of private patients had been prioritised on surgical lists, and that clinics had not been dictated leading to delays in referrals and procedures. After a period of exclusion from his role from December 2016 until January 2017, an administration action plan was implemented.

ATTACHMENT – MHPS ACTION PLAN 2017 document located at *Relevant to HR/reference no 33/GRIEVANCE PANEL 1/20170200 - Return to Work Action Plan DR AOB*

1.7 When I arrived in the Trust the action plan was being monitored and reported to Dr Khan as MHPS Case Manager until December 2018, when Dr Khan requested that reporting should be by exception.

*Document can be located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20181123 - Email - RE AOB Action plan 2*

1.8 Before my arrival, Serious Adverse Incident Reviews had been instigated regarding the concerns raised and were chaired by Dr Julian Johnston. These were subsequently published in May 2020.

***An explanation of your role, responsibilities and duties***

1.2 As outlined in the extensive documentation and narrative contained in the ensuing answers to questions, I have been employed as Chief Executive of the Southern Health and Social Care Trust since the 1<sup>st</sup> May 2022, as Temporary Accounting Officer since the 14<sup>th</sup> February 2022, and as Medical Director since the 1<sup>st</sup> December 2018. Prior to this, I have been employed in the NHS in various medical and senior managerial posts throughout Northern Ireland since graduating as a Medical Doctor in August 1990. The details of these are contained in the body and attachments of this submission and I will not repeat them here.

***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.***

1.3 Further details of these matters are provided below in my answers from question 52 onwards. However, an overview is set out in the following paragraphs.

1.4 As outlined in the narrative described throughout Answer 54, Mr O'Brien was unknown to me prior to my arrival in the Southern HSC Trust in December 2018. Following a meeting, as part of the arrival handover to me of information, at which I was present between the then Interim Medical Director, Dr Ahmed Khan, and the GMC ELA, Joanne Donnelly, I learned that a Maintaining High Professional Standards Investigation had been carried out in relation to a Urology Consultant, the result of which was an action plan in relation to administrative activity, and that there were not thought to be any concerns about his clinical practice and that he did not require formal referral to the GMC. Corrected minutes attached;

*The relevant documents can be located in S21 29 OF 2022, 1. MEDICAL DIRECTOR HANDOVER FROM DR KHAN, 2. 20220616 E GMC Meeting Minutes and Corrections, 3. 20220616 E GMC Meeting Minutes and Corrections 2, 4. 20220616 E GMC Meeting Minutes and Corrections 2 A1*



# Job Description

<b>JOB TITLE</b>	Medical Director
<b>LOCATION</b>	Trust Headquarters, Craigavon Area Hospital
<b>ACCOUNTABLE TO</b>	Chief Executive

## JOB SUMMARY

The Medical Director is an Executive Director and is responsible for providing assurance to Trust Board that effective systems and processes for good governance, including those arrangements to support good medical practice, are in place.

S/he will provide strong professional leadership and direction, support high standards of medical practice and provide resolved advice for medical matter across Directorates. S/he will take a leadership role in the provision of safe, high quality services, support the reform and modernisation programme and drive initiatives for continuous quality improvement. The postholder will have lead responsibility for clinical governance.

As Responsible Officer (RO), s/he has a statutory duty to make recommendations to the General Medical Council with regard to a doctor or dentist's fitness for revalidation, for those doctors and dentists who have a prescribed connection with the Southern HSC Trust.

As a member of the Trust Board and the Senior Management Team s/he will have both individual and corporate leadership responsibility for the governance of the Trust and compliance with legal requirements and contribute fully to the development, delivery and achievement of the Trust's corporate objectives.

## KEY RESULT AREAS

### PROFESSIONAL LEADERSHIP

1. Provide highly visible and inspiring clinical leadership for medical and dental staff throughout the Trust, championing a professional and open culture which empowers staff to consistently deliver high quality, safe and effective care, acting as a role model for the behaviours and high professional standards expected.

2. Develop and maintain effective relationships with GMC that supports the registration and regulation of the medical workforce.
3. Work closely with colleagues to enhance communication and working relationships between clinical leaders and senior managers and ensure that opportunities to improve services are harnessed.
4. As Responsible Officer, ensure the following are in place:
  - an appraisal policy that meets the requirements of revalidation
  - effective clinical governance systems that can provide doctors with the supporting information they need for appraisal and revalidation
  - a system which ensures all doctors are given the opportunity to take part in an annual appraisal and which tracks participation
  - regular briefing for Trust Board on progress
  - a process for recognising and responding to concerns about doctors in line with *'Maintaining High Professional Standards in the Modern HPSS'*.
5. Provide professional leadership and guidance to support Associate Medical Directors, Clinical Directors and Lead Clinicians throughout the Trust in relation to governance of the medical workforce, including clinical practice and service change.
6. Provide medical leadership to attract, educate, develop and retain a quality workforce from both local and international pools.
7. Ensure sound working relationships with the Director of Public Health, other Medical Directors and the Public Health Agency

## **CLINICAL GOVERNANCE**

1. As a member of the Senior Management Team and Trust Board, assume corporate responsibility for ensuring an effective system of integrated governance within the Trust which delivers safe, high quality care, a safe working environment for staff and appropriate and efficient use of public funds.
2. Provide professional advice to the Senior Management Team as to the appropriate indicators of safety, quality and performance, to inform and commission the measurement of such indicators as part of Senior Management Team Governance, to regularly review this information, and to provide assurance or expert input into necessary next steps to address any issues arising from same.

1.5 Over the course of the next few weeks, I familiarised myself with Mr O'Brien's hard copy Maintaining High Professional Standards (MHPS) files. These outlined that, as a result of concerns raised in a letter to him by Mrs Heather Trouton, Assistant Director for Surgery, and Mr Eamon Mackle, Associate Medical Director in Surgery, on the 23<sup>rd</sup> March 2016, that further investigation had revealed that Mr O'Brien had not been compliant with the usual administrative processes that support timely and appropriate care, as a result of which patients had not been triaged in keeping with regional guidance and there were concerns that patients had come to harm as a result of delay.

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**From:** Clayton, Wendy  
**Sent:** 16 October 2018 19:41  
**To:** Carroll, Ronan; Corrigan, Martina  
**Subject:** RE: Return to Work Action Plan February 2017 FINAL.

I have check PAS and there are 82 charts tracked out specifically to Mr O'Brien

I will ask Collette for an update typing backlog report which will show clinic/results to be dictated, hopefully this will be through tomorrow.

Wendy

Wendy Clayton  
Acting HOS for G Surg, Breast & Oral Services  
SEC

Ext: [Personal Information]  
External number: [Personal Information redacted by the USI]  
Mob: [Personal Information redacted by the USI]



**EXT** [Personal Information] if dialling from Avaya phone.  
If dialling from old phone please dial [Personal Information redacted by the USI]

External No. [Personal Information redacted by the USI]

**From:** Carroll, Ronan  
**Sent:** 15 October 2018 23:01  
**To:** Clayton, Wendy; Corrigan, Martina  
**Subject:** FW: Return to Work Action Plan February 2017 FINAL.  
**Importance:** High

Wendy

Can i ask you as a matter of urgency to update the position re Notes checked out to AOB (74) & Digital Dictation  
Iso 91 letters pls  
Ronan

Ronan Carroll  
Assistant Director Acute Services  
Anaesthetics & Surgery

Mob [Personal Information redacted by the USI]  
Ext [Personal Information]

**From:** Corrigan, Martina  
**Sent:** 04 October 2018 16:09  
**To:** Carroll, Ronan  
**Subject:** FW: Return to Work Action Plan February 2017 FINAL.  
**Importance:** High

Ronan

Please see below. if there is anything else needed I am happy to discuss

Regards

**Buckley, LauraC**

**From:** Corrigan, Martina  
**Sent:** 29 September 2019 05:18  
**To:** Hynds, Siobhan  
**Cc:** Buckley, LauraC  
**Subject:** FW: Return to Work Action Plan February 2017 FINAL.  
**Attachments:** FW: Return to Work Action Plan February 2017 FINAL. (151 KB)  
  
**Importance:** High

Regards

*Martina*

Martina Corrigan  
 Head of ENT, Urology, Ophthalmology & Outpatients  
 Craigavon Area Hospital

Telephone:

EXT [Personal Information redacted by the USI] (Internal)

[Personal Information redacted by the USI] (External)

[Personal Information redacted by the USI] (Mobile)

**From:** Carroll, Ronan [mailto:[Personal Information redacted by the USI]]  
**Sent:** 18 October 2018 20:42  
**To:** Gibson, Simon; Weir, Colin; Khan, Ahmed; Haynes, Mark  
**Cc:** Clayton, Wendy  
**Subject:** RE: Return to Work Action Plan February 2017 FINAL.  
**Importance:** High

Wendy has pulled this together. Martina went off June

Month	Dictation backlog (patients)	Longest date with no dictation
June 18	54	10/4/18
July 18	-	
Aug 18	44	8/5/18
Sept 18	-	
Oct 18	91	15/6/18

Martina also provided this update also. Looks like Mr O'Brien was away most of September which could explain the jump from Aug to October

Mr O'Brien was on AL in September on 4<sup>th</sup>, 17-21<sup>st</sup> and on study leave 10-12 September

**CONCERN 1** –during September Mr O'Brien was not on call, I have checked today and there is only one routine referral for Mr O'Brien added on 28 September, he does have until tomorrow evening (Friday) to clear all triage.

**CONCERN 2** – I have checked as of today on PAS there are 74 charts tracked to Mr O'Brien's office, I have asked Maria to go to his office to check and she confirms that there are a large number of charts in his office, sitting in bundles on the floor, on his desk and in his pigeon holes, so this is in breach of his Action plan

*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 (24<sup>th</sup> November 2020) and the out-workings of the Lookback Review, I have had more frequent and focused contact.

**Aimee Crilly**

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**From:**  
**Sent:**  
**To:**



-----Original Message-----

From: OKane, Maria <[redacted]>  
To: Aidan O'Brien <[redacted]>  
Sent: Thu, 2 May 2019 0:01  
Subject: Re: Overdue Revalidation Recommendation

Mr O'Brien,  
Thank you for your email. The GMC has been informed. Regards.

Dr Maria O'Kane  
Medical Director

On May 1, 2019 9:30 PM, Aidan O'Brien <[redacted]> wrote:  
Dear Dr. O'Kane,

I have received the below email from the GMC advising that a recommendation regarding my revalidation is overdue.  
I have been advised to contact my responsible officer.  
I would be grateful if you would communicate your recommendation to the GMC,

Aidan O'Brien

-----Original Message-----

From: revalidation-support <[redacted]>  
To: aidanpobrien <[redacted]>  
Sent: Mon, 29 Apr 2019 8:00  
Subject: Important - your revalidation recommendation is overdue

Your GMC reference number: [redacted]  
Dear Mr O'Brien  
Your revalidation submission date was 27/04/2019.  
We have not received a recommendation about your revalidation.

**What should I do now?**

You should contact your responsible officer or suitable person immediately to arrange for them to submit a recommendation for you.

**Your information**

Our records show that your designated body is Southern Health and Social Care Trust. You can find their email address if we hold one on our [A-Z list of designated bodies](#).

**My designated body is wrong**

If your designated body is not the one shown above then you need to update your connection details in your [GMC Online account](#). You can check your designated body by using our [connection tool](#).

If your designated body has changed, you should contact your new designated body immediately.

If you **do not** have a connection to a designated body you must contact us immediately.

**Contacting us**

If you have a disability and require us to make any adjustments in our communications to help you please contact us as soon as possible. If you have any questions or need any advice, please email us at Personal Information redacted by the USI or call us on Personal Information redacted by the USI and we will do our best to help.

Yours sincerely  
General Medical Council

Working with doctors Working for patients

The General Medical Council helps to protect patients and improve medical education and practice in the UK by setting standards for students and doctors. We support them in achieving (and exceeding) those standards, and take action when they are not met.

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General Medical Council

Personal Information redacted by the USI

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Southern Health & Social Care Trust IT Department

Personal Information redacted by the USI

**Aimee Crilly**

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**From:**  
**Sent:**  
**To:**



-----Original Message-----

**From:** Personal Information redacted by the USI  
**To:** Personal Information redacted by the USI  
**Sent:** Tue, 14 May 2019 16:00  
**Subject:** Your new revalidation submission date

Your GMC reference number: Personal Information redacted by the USI

Dear Mr O'Brien

Your Responsible Officer submitted a recommendation to defer your revalidation. We have approved their recommendation.

This decision has no impact on your licence to practise.

Your new revalidation submission date is 04/11/2019.

**What you need to do now**

- Work with your Responsible Officer to prepare for your new submission date.
- If your practice circumstances change in the meantime please log in to your [GMC Online](#) account and update your designated body.
- If you do not have a GMC Online account, you can [set one up](#).

**Need more help?**

You can find more information about [revalidation](#) on our website.

Please [contact us](#) if you have any questions. We will do our best to help.

Yours sincerely

General Medical Council

Working with doctors Working for patients

The General Medical Council helps to protect patients and improve medical education and practice in the UK by setting standards for students and doctors. We support them in achieving (and exceeding) those standards, and take action when they are not met.

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55.7

<b><i>When and in what context did you first become aware of issues of concern regarding Mr. O'Brien?</i></b>
On 19th February 2019, Mr Haynes brought SAI 82964 to my attention.  On the same date, I contacted Mrs Gishkori, Director for Acute Services, about my concerns, based on my review of the SAI and MHPS paperwork. She did not identify any ongoing concerns and expressed the view that he was a "well respected surgeon".
<b><i>What were those issues of concern and when and by whom were they first raised with you?</i></b>
Concerns were raised in relation to lack of perioperative assessment, lack of cardiology workup and procedural consent not clearly documented. There was no specific criticism of Mr O'Brien but the patient had been under his care.
<b><i>Do you now know how long these issues were in existence before coming to your or anyone else's attention?</i></b>
Patient's admission was 9 <sup>th</sup> May 2018.
<b><i>Please provide any relevant documents</i></b>
Attachment: sai 82964 document located at <i>Relevant to Acute/Document Number 54/AC/20190409 Final Report</i>

55.8

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
19 <sup>th</sup> February 2019	Concerns arising from SAI as outlined above. Mr Haynes and I discussed the current difficulties generally in accessing timely preoperative assessment and the complexity of the consent process. We discussed the limitation of CHKS data in relation to identifying trends in perioperative blood loss. We discussed whether there were other specific concerns outside the comments made in the SAI and at that point could not identify further outside what was known already through MHPS.	Mr Haynes
19 <sup>th</sup> February 2019	Concerns arising from SAI as outlined above in the context of previous MHPS process	Mrs Gishkori



11/3/19. meeting w/ AOB / mark.

- complaints
- appraisals
- Comm - litigation dep.
- litigation dep.

AOB never replied to email from Rose  
Complaint from [redacted]  
governance office.

Personal Information redacted by the USI

Patient 110

→ not on list +  
not responding.  
? Appraisal.





**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 11<sup>th</sup> 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.

***46. Did you feel supported in your role by the medical line management hierarchy?  
Whether your answer is yes or no, please explain by way of examples, in particular  
regarding urology.***

- 46.1 When I commenced as Medical Director, Medical Leaders (Associate Medical Director and Clinical Director) had limited time in their respective job plans to deliver on their areas of responsibility. There has been a constant tension between the delivery of medical leadership and management and the demands of their clinical roles. Medical leaders also had not traditionally had much in the way of formal training or induction to their roles and as such at times have struggled to provide leadership. This has been developed over the last 3 years but progress has been greatly hampered by the Covid19 pandemic.
- 46.2 In addition to this, doctors tend to be hesitant to speak up or give an opinion unless they are very fully informed and can formulate their thoughts, for fear of giving a wrong opinion. As a result, they often have to be encouraged to speak up.
- 46.3 Within these limitations, I felt that Medical Leaders have supported me as best they could while I was Medical Director and also, currently, as Chief Executive.
- 46.4 Furthermore, when concerns were raised they were very receptive and supportive in exploring these further and implementing improvement. In particular, Mr Mark Haynes was the medical leader who brought the initial concerns regarding Urology assurance to my attention in June 2020 and he has been very constructive throughout in relation to developing solutions albeit that, given the pressures in his speciality, he is always under time constraints.



## (viii) Clinical and Social Care Governance Coordinators

455. When I commenced in Acute Services in June 2019, the Clinical and Social Care Governance Coordinator (coordinator) was Patricia Kingsnorth until July 2021, with a short period of sick leave covered by Connie Connolly (October 2019 – February 2020). Currently, Chris Wamsley is in post as coordinator since July 2021.

456. I offer weekly supervision to the coordinator to discuss all elements of clinical and social care governance embracing all elements and issues for consideration, discussion or escalation. The coordinator supports the operational teams to progress the operational aspects including incident recording and management, screening for serious adverse incidents, carrying out Serious Adverse Incident reviews, report writing and interface discussions with patients, service users, families and HSCB/SPPG.

457. With regard to urology services, the Coordinator has an active role to play in supporting the external panel chaired by Mr Dermott Hughes with the 9 SAI's. The follow up recommendations, action plans and embedded learning is the responsibility of both the coordinator and the clinical/operational team. On 1:1 meetings with both Assistant Director and the Coordinator, I get updated on progress and the opportunity to escalate any concerns. The Coordinator also attends the Acute Governance meetings monthly and the Acute Clinical Governance meeting which the DMDs and CDs attend with the operational team.

**Q49. During your tenure, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters:**

- i. **What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or 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.**

458. On 27 August 2019, I first became aware of issues regarding Mr O'Brien. It followed a communication from the GMC Triage Team seeking further information from Dr O'Kane following Dr O'Kane's referral of Mr O'Brien to them on 3 April 2019. 10 points were raised by the GMC seeking a response in advance of 6 September 2019. Dr O'Kane forwarded the email to Mr Simon Gibson, Assistant Director Medical Director's Office, Siobhan Hynds, Deputy Director Human Resources, and Mark Haynes, Divisional Medical Director. I was copied into the email alongside Mrs Vivienne Toal, Director of Human Resources and Organisational Development. On 10 September 2019, I was further copied in to an email reminder for the requested information to the same email recipient as above.



## Urology Services Inquiry

459. One of the main problems that was brought to my attention related to the numbers of concerns that resulted in SAI's, into patients under the care of Mr O'Brien. Patricia Kingsnorth, Acute Clinical and Social Care Governance Coordinator, sent an email on 9 September 2019 to the members of the Acute Clinical Governance Group, including myself as chair. In it she stated that a draft SAI report on <sup>Patient 16</sup> was to be re-presented at the planned meeting on 13 September 2019. Mr Haynes and Mr Carroll agreed to present that report at that meeting. It had first been presented on 7 June 2019, prior to my commencement in Acute Services. At the meeting, there were discussions about the recommendations which needed further consideration by the SAI panel, and it was now ready for further consideration. On 10 September 2019, Mrs Patricia Kingsnorth brought to my attention, for the first time, that there were five 2016 Serious Adverse Incident reviews, relating to urology which had not yet been completed by the external panel. These were subsequent to an Index case <sup>Patient 10</sup> (2016), all were Mr O'Brien's patients.
460. Patricia Kingsnorth liaised with Trudy Reid, previous Acute Clinical Social Care Governance Coordinator, who had been in post before Patricia and at the time when the external Serious Adverse Incidents relating to urology patients had been commissioned. Mr Julian Johnson (previously BHSCT) was the Chair of the external panel for the 5 aggregated reviews – all of whom had been patients of Mr Aidan O'Brien, Consultant Urologist. There was liaison with Mr Johnson which I recall was undertaken by Trudy Reid to enable the completed reports to be received by the Trust. These were on the agenda for approval at subsequent ACG meetings.
461. The sequence of the urology presentations at ACG was as follows:
- June 2019 – <sup>Patient 91</sup> & <sup>Patient 16</sup>; (prior to my tenure which commenced on 10 June 2019)
  - September 2019 – <sup>Patient 16</sup> re-presentation;
  - October 2019 – <sup>Patient 91</sup> re-presentation;
  - January 2020 – <sup>Patient 92</sup> new and <sup>Patient 16</sup> re-presented;
  - February 2020 – <sup>Patient 92</sup> re-presented, 6 new reports – <sup>Patient 12</sup>, <sup>Patient 15</sup>, <sup>Patient 14</sup>, <sup>Patient 13</sup>, <sup>Patient 11</sup>, 5 individual and 1 collective representing the 5;
  - March 2020 – <sup>Patient 92</sup> re-presented;
  - October 2020 – <sup>Patient 92</sup> and the recommendations contained within the 1 collective SAI (relating to the 5 urology SAI's presented in February 2020)
  - November 2020 – <sup>Patient 107</sup> new and <sup>Patient 92</sup> re-presented.
  - April 2021 – the 9 new Urology SAI's were presented in form of Recommendations only
462. Following the 11 June 2020 concerns raised by Mr Haynes, some of the patient's reviews resulted in the need for further investigation including the 9



## Urology Services Inquiry

SAI's (presented in April 2021) and at time of writing now 71 patients that have been screened as meeting the threshold for the alternative process to Urology SAI's, the Structured Clinical Judgement Review. This reinforces the appropriateness of the concerns that had been raised.

463. The general governance concerns raised with me from June 2019 related to workforce challenges, capability issues, nursing staff vacancies, inability to deliver quality nursing care at an expected standard, consultant urologist vacancies, delay in accessing services for assessment or treatment and non-compliance with the key performance indicators outlined in the IEAP. These are outlined earlier in this submission.
464. Mr Carroll raised in an email to me on 21 August 2019 highlighting ongoing staffing issues and the lack of senior cover for 3 South ward (urology). I shared the concerns and plan with Heather Trouton, Executive Director for Nursing, Midwifery and Allied Health Professionals, with regard to assurances in relation to nursing practices and patient safety. On 5 September 2019, Mr Carroll further updated me on the position in 3 South and included the Risk Assessment due to staffing deficits which showed a deficit of 15.98 staff nurses, the bed complement had been reduced to compensate for this deficit, from 36 to 32 beds (ENT and Urology of which 19 were urology beds). There had been an open advert for additional band 5s to work specifically in 3 South, but no applicants for the post. The Core Trust Nurse to Agency ratio was 60% agency staff and 40% Trust staff (daytime) with 50-50% split for night duty which he highlighted was affecting the ability for patient's needs to be fully met.
465. On 11 September 2019, I received a related email from Mrs Helen Walker, (Assistant Director Human Resources) who was supporting the management and nursing team, to advise that the substantive ward manager had gone off sick with work related stress and shared an appropriate managerial action plan to address the workforce challenges. These escalations highlighted the ongoing difficulty with recruiting and retaining staff, high level of agency nurse dependence, capability issues and safety indicators of specific concern within the ward.
466. On 16 September 2019 when the breaches in Mr O'Brien's administrative agreed Return-to-Work action plan were escalated, these were sent from Mrs Corrigan to Dr Ahmed Khan, Case Manager and copied to Siobhan Hynds, Deputy Director Employee Relations and Engagement. A follow-up included Mr Gibson, and subsequently Dr Khan informed Dr O'Kane on 18 September 2019. By 30 September 2019, Mr Haynes was copied in and I was informed by Dr O'Kane about the breaches on 4 October 2019 as a meeting had been called to respond to the concerns. This was the first that I was aware that there was some ongoing monitoring with regard to Mr O'Brien, following issues identified in 2015/16 with non-compliance with Trust Policies and Procedures in relation to triaging of referrals, contemporaneous note



## Urology Services Inquiry

keeping, storage of medical records and private practice. Mrs Martina Corrigan, HOS, was monitoring his administrative processes. An oversight meeting took place on 8<sup>th</sup> October 2019 chaired by Dr O'Kane with Dr Ahmed Khan, Mrs Siobhan Hynds, and Mr Mark Haynes to consider the concerns raised and the previous MHPS case determination report.

467. On 7 February 2020, Mrs Hynds, emailed myself, Dr O'Kane, Mrs Toal, Mr Gibson, Mr Carroll, Mrs Corrigan and Dr Khan highlighting that there were a range of matters which needed to be discussed and progressed in respect of Mr O'Brien's case and requested a meeting. She highlighted we had correspondence from the GMC which needed a response. Mr Gibson replied on 10 February 2020, that Trudy Reid and Stephen Wallace were coordinating a response to RQIA (who had been provided with the Case Manager report by Dr O'Kane) in relation to a number of issues including Mr O'Brien. He referred to an email from Mr Wallace, where he noted that RQIA were seeking information on any plans to undertake a review of administrative processes within the Trust or rationale underpinning a decision not to proceed with review if this was the case. Mr Simon Gibson (Assistant Director) clarified in an email on the same day that the draft Trust response to RQIA referenced the backlog report as evidence of assurance, even though it was noted to have had significant weaknesses within it, at a meeting that he chaired on 24 January 2020 where the backlog report was discussed.
468. On the 10 February 2020, Mrs Trudy Reid, Interim Assistant Director, Clinical and Social Care Governance (Medical Director's Office), responded with some comments and suggestions regarding previous processes and potential review going forward. On the same day, Mrs Hynds responded that she felt the recommendation regarding an independent review of relevant administrative processes was being read somewhat out of its full context as it was a line at the end of a range of conclusions and needs read in conjunction with the conclusions.
469. This recommendation followed the Case Manager's Determination following the MHPS Investigation which was completed by Dr Khan. As Dr Khan had moved to the post of Acting Medical Director, the case determination was sent to Mr Shane Devlin, Chief Executive. The process was stalled In November 2018 soon after the determination report had been issued (28 September 2018) as Mr O'Brien raised a grievance about the investigation. Mrs Hynds noted that a substantial Subject Access Request on the investigation had been submitted by Mr O'Brien causing a delay and noted it was now about to be progressed. She wished all of this to be discussed at the planned oversight meeting and of note she asked Dr Khan in the email to provide clarity on what he was seeking as an outcome of the said recommendation mentioned in the determination report.
470. I responded to this email trail on 10 February 2020 to say;  
*"Dear All, I would prefer to discuss this in person where clear roles and remits need identified. There was a lot of background information that I am not fully aware of."*





## Urology Services Inquiry

471. Mr Carroll responded on 11 February 2020 to say how frustrating he found this. The Aidan O'Brien process was controlled by Headquarters/Governance (MDO). He stated that the outcome and recommendations of the MHPS Case Determination Report were not shared with operational AD's, yet the recommendation affected all Acute Services. He stated that there were ongoing emails from the Medical Director's office with regard to Acute Services processes and signed it "*Disconnect.com*".
472. I responded to Mr Carroll, to confirm that I had requested an urgent meeting the previous evening to agree roles and remits and clarity on who is owning this. I then stated:  
*"Unfortunately as operational managers we can't disconnect.com but we need to address the governance arrangements and our commitment to monitoring etc. as previously detailed. Talk later."* I then forwarded Mr Carroll's email to me to Mrs Toal and Mrs Hynds (Human Resources) to state:  
*"A lot of strength of feeling, we need to resolve and get clarity urgently"*.
473. On 12 February 2020, I attended the Oversight Meeting which Mrs Hynds had requested to get clarity as stated above. Actions agreed at that meeting:—
- Dr O'Kane agreed to have a meeting/ conversation with Mr McNaboe, Clinical Director, regarding him having a meeting with Mr O'Brien regularly and seeking assurances through that supervisory process that Mr O'Brien was working in accordance with the triage process, was not holding notes at home and was undertaking all digital dictation immediately following each individual contact with the patient (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, that this was discussed and agreed with Mr McNaboe);
  - Dr O'Kane to speak with Mr McNaboe and Mr Haynes to ensure an agreed job plan was in place for Mr O'Brien as a matter of priority or to escalate to the next stage of the job planning process (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, that this was discussed and agreed with Mr McNaboe and Mr Haynes);
  - Dr O'Kane to seek assurance from Dr Damian Scullion to ensure Mr O'Brien was completing annual appraisals (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, that Dr Scullion had assured her of this);
  - Dr O'Kane to draft a response to the GMC and RQIA in respect of their recent correspondences to the Trust seeking additional information about the case (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, that this was being completed by Mr Gibson for 27 February 2020. She also noted the recent update shared with the GMC ELA who had requested the SAI's and Dr O'Kane stated that this will need agreement. The Case Manager report had been shared with RQIA;
  - Mrs Hynds to draft the Terms of Reference for the Independent Review of the SAI recommendations and the MHPS Review Recommendations and send the TOR to the Oversight Group for agreement;

meeting re AOB.

GMC.

- waiting lists. Patient Safety Concern & when he raised this.
- letters / emails concerns re patient safety concerns.
- AOB did not appear to raise specific concerns.
- He did not provide concrete evidence.

- organisational part discussed
- meeting c Shane. → after report Virenne / Shane.

- Systemic diff.

- Eshler wasn't @ meeting.

- System + under load not monitored.

→ not addressed.

- NED advised

- Trust position

- Feedback on his feedback to casemanager.

WIT-90981

- Head of Service.

- management action plan.

- Feb 2012 Mx action plan.

→ (N) line management

+ to escalate to case manager by exception to Dr Khan.

→ expectation that usual line management will report by exception.

→ are we confident that this is robust?

→ Shane + Virenne.

→ I will email Eshler re assurance that

→ how are charts travelling

update) Did we ever get assurance from him that not doing pp from home? [trage]

minutes from home not to practice from home.

Shane advised him to desist from PP @ home.

Never received written assurance



**Corrigan, Martina**

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**From:** Haynes, Mark <[REDACTED]>  
**Sent:** 11 March 2019 17:03  
**To:** OKane, Maria  
**Subject:** FW: Urology backlogs Confidential

Scroll down for details – result not actioned.

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**From:** Haynes, Mark  
**Sent:** 15 December 2018 05:57  
**To:** Robinson, Katherine; McCaul, Collette  
**Subject:** RE: Urology backlogs Confidential

Thanks Katherine.

The issue for me is not whether or not it was ever received.

My concern that there are individuals who think that the reported 'results for dictation' data is robust. It isn't. The number is generated at best for some as a guess. Because this regular report is taken by senior personnel in the trust as robust it is seen as a monitoring tool within governance processes that results are being actioned and communicated to patients in a timely manner with no risk of unactioned significant results. I fear your team are at risk if we have a situation where a patient comes to harm because a result isn't actioned and subsequent investigation reveals a large number of unactioned results. Your team would be open for criticism for reporting inaccurate information.

For Tony and me Liz / Leanne look at e-sign-off and the number outstanding on here, plus any sets of notes with hard copy reports and this is the number reported. Ironically although we are the most up to date with our admin, we regularly appear to be the ones who are most behind.

A question to all secretaries asking them how they get the numbers that they report would be a starting point, along with a meeting to highlight why this information is collected and the potential consequences of misreporting.

Mark

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**From:** Robinson, Katherine  
**Sent:** 14 December 2018 15:27  
**To:** Haynes, Mark; McCaul, Collette  
**Subject:** RE: Urology backlogs Confidential

Mark

We have looked into this. We cannot establish if the result ever came back to AOB either hard copy or email. I thought Radiology flagged these up to be looked at, am I correct? We cannot find it in Noelene's office. That said the secretary has a huge issue with her management ie collette and I asking her questions etc and is extremely upset and feels we are harassing her. I am trying to get Trudy as I don't know how we can possibly get proper info without the secretary helping. The secretary does not want to be involved but I suspect like all of us there is no choice.

K

*Mrs Katherine Robinson*  
*Booking & Contact Centre Manager*  
*Southern Trust Referral & Booking Centre*

**49. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -**

**(a) properly identified,**

**(b) their extent and impact assessed,**

**(c) and the potential risk to patients properly considered?**

49.1 I refer to my answer to Question 48 in respect of the general urology concerns (i.e., not specific to Mr O'Brien).

49.2 The concerns relating specifically to Mr O'Brien are addressed in Questions 52-65. However, my considered view on the issues raised by Questions 49a to 49c in respect of these particular concerns can be expressed as follows:

49.3 I believe that the issues of concern were eventually properly identified and fully acknowledged, but not all at the same time. Until 2019 and the referral to the GMC, I think that the system as a whole found it difficult to identify the seriousness of the concerns, despite the fact that a number of individuals over the previous 10 years in particular had been trying to draw attention to these. In the context of the prevailing view that Mr O'Brien was a good surgeon, it was difficult for the system to believe that his behaviours could be causing harm. This view of his ability appears to have been driven by the long hours he spent on the ward with some of his patients and his helpfulness towards some staff rather than being evidence-based in relation to patient outcomes. Based on their interaction with him, patients appear to have believed that he had saved their lives although I am not clear what the actual outcomes evidence for this was. In addition, because there was the perception that he was a "good surgeon" who appeared to make himself indispensable at times, his failings were not then robustly challenged. This perception seemed to resonate

with a rather outdated archetype of the brilliant but flawed doctor who has to be tolerated and forgiven readily because of their special status. When their concerns were not taken seriously enough by the system, and in particular by Mr O'Brien, the colleagues had to resort to workarounds to make the process work for patients. This had the unfortunate and unintended impact (I believe) of helping to minimise the impact of the behaviours and governance failings and thus inadvertently hiding and prolonging the difficulties in plain sight as various personnel changed and the narrative and memory of the concerns were thus diluted as a result. The next stepwise change was following Mr O'Brien's email to Mr Haynes on 7th June 2020. Until this point, the intelligence was that the difficulties were in relation to non-triage, non-dictation, withholding of clinical information and records, and prioritisation of private patients, and also that there had been time-limited difficulties in the past with prescribing of IV antibiotics and opiates, an episode of throwing charts in the bin, and concerns re cystectomies. The 7th June 2020 email led to a review of clinical practice and then a Lookback helped further identify difficulties with preoperative assessment, non-dictation and non-referral to and from MDM, non-engagement with MDM, and non-involvement of CNSs.

49.4 Through the process of Lookback, the clinical extent and impact have been identified in the areas of concern outlined in my answer to Question 54 below.

49.5 The potential risk to patients is being identified increasingly as we progress through the last 18 months of Mr O'Brien's clinical practice. Up to 11<sup>th</sup> July 2022, 82 patients from within this cohort meet the criteria for SAI and are being managed through the SCRR process.

***50. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 will ask about any support provided to Mr O'Brien).***

**Stinson, Emma M**

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**From:** OKane, Maria  
**Sent:** 08 October 2019 14:51  
**To:** Haynes, Mark; McClements, Melanie; Khan, Ahmed; Hynds, Siobhan  
**Subject:** AOB OVERSIGHT MEETING - UPDATED  
**Attachments:** URGENT :AOB concerns - escalation- oversight meeting request please ; Action plan

Discussion- draft notes :

1. Concerns re escalation
  2. Concerns re process
  3. Concerns re pp and making arrangements for investigation through the NHS -?Interface with pp policy – letters no longer on NIECR – now the patients are on list without letter- consider how tracking
  4. Plan point :1: How can each be monitored and how is this escalated if concerns? Monitor through the information office
2. concerns re notes at home – weekly spot check? Meant to sign notes out – he has a condition on his action point that he is not to take notes home – make assumption that if notes not in his office or clinic or theatre they are in his home? No transport to take notes between cah and swah. Monitoring difficult
3. Martina can only monitor what she is given – his secretary has not engaged. Martina has had to go onto ECR to check if notes uploaded.
5. IR1 went in from MDT on Wednesday last re 1<sup>st</sup> delayed cancer patient – AOB letter on patient sent Friday
6. 2<sup>nd</sup> patient did not come to harm following escalation to MDT by trackers which builds contingency checks in to system for all clinicians in urology
- Plan :
1. Will ask Mr McNaboe to discuss concerns with AOB to make aware that this has been raised with the MHPS case manager – on leave until Monday
  2. Will consider escalation plan including option to exclude
  3. Will consider the full system review September 2018 and progress



Southern Health  
and Social Care Trust

Medical Directorate

Our Ref:

Date:

Joanne Donnelly  
ELC Liaison Officer  
GMC

Dear Joanne

**RE: SHSCT - Dr O'Brien GMC -**

Personal Information  
redacted by the USI

I am writing in response to your e-mail dated 12<sup>th</sup> November regarding the above, within which you asked three questions. My response to these questions is as below:

**Can you advise whether there is have any evidence to demonstrate that Dr O'Brien was complying with his agreed local action plan (up to September 19 when the recent deviation occurred)?**

The February 2017 action plan was put in place following Mr O'Brien's return to work following an immediate exclusion process in January 2017. The action plan was shared with Mr O'Brien at a meeting on 9 February 2017 and was to be monitored on-going with any deviation from the action plan to be immediately escalated to the MHPS Case Manager. See attached action plan for information.

A summary e-mail was sent weekly by the service manager to the Case Manager (an example is attached). There were occasions when the backlog reports identified small deviations but given the complex nature of the monitoring process, we could not be confident that these were true deviations but actually resulted from delays in transcription of clinic letters by administrative staff and so continued to assess compliance. These small deviations were not showing consistently from one month to the next. In or around November 2018, the Case Manager sought only to be advised on significant deviations from the action plan as he determined that Dr O'Brien was reasonably compliant.

In terms of evidence of compliance with the action plan the following monitoring arrangements were, and remain, in place. The details of the monitoring arrangements are as follows:

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

Tel:

Personal Information redacted by the USI

Action Plan Monitoring Element	Details
<b>Triage of Referrals</b>	<p>Compliance regarding triage of referrals is monitored via two mechanisms;</p> <ul style="list-style-type: none"> <li>• The service manager reviews electronic referrals received via NIECR to ensure appropriate triage management</li> <li>• The Trust Referral and Booking Centre Team monitor hardcopy referrals received, and if not returned within the agreed timescale, escalate this to the service manager.</li> </ul> <p>In respect of Red flag triage, the action plan initially set out that triage should be completed by 4pm on the Friday following being Mr O'Brien Urologist of the Week. It was amended slightly through monitoring to an understanding that Mr O'Brien would complete all Red Flag triage referrals from his week on call by the end of the working day on the Thursday and the rest by the following Monday morning after he finished the week (handover is Thursday morning).</p> <p>Mr O'Brien had been meeting this expectation however in August and September the completion dates have extended to Tuesday or Wednesday of the following week that he has finished his triage. As the waiting times to first appointments for urology are significant (recently was 67 days), this has not impacted on patient pathways, and so this minor deviation was not considered material.</p>
<b>Clinical Dictation</b>	<p>Completed dictations from each clinic are monitored by the service manager by random checks on NIECR of outpatient sessions and checking if letters have been done. In addition the secretarial staff report backlog data to the admin team and a report is generated monthly. This details any outstanding dictation from outpatient clinics.</p> <p>Escalation occurred at the end August 19 when it appeared that dictations were not done and awaiting transcription. Following further investigation this matter was resolved and no action was</p>

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

Tel: [redacted] / Email: Richard.wright@[redacted]



# Southern Health and Social Care Trust

	necessary.
<b>Keeping Patient Notes at Home</b>	<p>The process whereby Mr O'Brien is expected to transport patient notes on behalf of the Trust to outpatients clinics in South West Acute Hospital (SWAH) remains the same as previous.</p> <p>No patient notes have been tracked out to Mr O'Brien's home and no reports of notes being unavailable at the location they have been tracked to (e.g. Mr O'Brien's secretaries office), or instances of notes being unavailable as not found following a consultation with Mr O'Brien have been noted.</p> <p>Notes are present at Mr O'Brien's home overnight on any Monday that he conducts an outpatient clinic in SWAH. This is for logistical reasons as Mr O'Brien lives in Moy and would not return to Craigavon Area Hospital until Tuesday morning.</p>
<b>Private Practice</b>	Mr O'Brien complies with the trust private practice policy regarding transfer from private care to NHS care and there have been no identified occasions where patients transferring from private care had their treatment expedited more patients of the same urgency from NHS clinics.

**Has Dr O'Brien made any comments to the Trust in response to the recent deviation from his agreed action plan in September 19?**

Mr O'Brien has made comments to the Trust (letter attached)

**Regarding the recent incident in September 19, can you provide an update on what actions the Trust plan to take against Dr O'Brien? Specifically, are any measures being put in place to support Dr O'Brien and help him to address his current deficiencies?**

The Trust has offered a meeting with Mr O'Brien on 12<sup>th</sup> December for further discussions on his job plan, which will include measures to support him in his working practices. As this meeting has not yet taken place, we have not yet had the opportunity to discuss the issues raised in his letter to clarify expectations, agree an action plan and consequence of continued non-compliance. Once an action plan has been agreed, it will be monitored and non-compliance will lead to the implementation of appropriate Trust disciplinary processes.

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

Tel: Personal information redacted by the UGI

I hope the above is useful.

Yours sincerely,

Personal Information redacted by the USI

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**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: **Richard.wright@stn-trust.nhs.uk**