91. As detailed in Questions 16-18 above, Consultant numbers varied until 2014 and this had an effect on the percentage of emergency work for each individual surgeon to the detriment of their elective work.

[21] Did your role change in terms of governance during your tenure? If so, how?

92. In 2012 (I am unsure of the exact date) I was informed that that the Chair of the Trust (Mrs Roberta Brownlee) reported to Senior Management that Aidan O'Brien had made a complaint to her that I had been bullying and harassing him. I was called into an office on the Administration floor of the hospital to inform me of the accusation. I was advised that I needed to be very careful where he was concerned from then on. I recall being absolutely gutted by the accusation and I left and went down the corridor to Martina Corrigan's office. Martina immediately asked me what was wrong, and I told her of what I had just been informed. In approximately 2020, I truthfully had difficulty recalling who informed me. Martina Corrigan said I told her at the time that it was Helen Walker, AD for H.R. I now have a memory of same but can't be 100 percent sure that it is correct. I recall having a conversation with Dr Rankin who advised that, for my sake, I should step back from overseeing Urology and I was advised that Robin Brown should assume direct responsibility. I was also advised to avoid any further meetings with Aidan O'Brien unless I was accompanied by the Head of Service or the Assistant Director. As a result, I instructed Robin Brown to act on all Governance issues regarding Urology and in particular any issue concerning Aidan O'Brien. At my next meeting with John Simpson, I advised him of the issue and the change in governance structure in Urology. There was no formal investigation of the complaint, and I have checked with Zoe Parks (Head of Medical HR) and she says that there is no record on my file of the accusation.

multiple objections when it was suggested that he should be reviewing all results therefore an instruction was issued to all consultants informing that it was their responsibility to review all the results of investigations on their patients once they are available.

25. This issue is addressed in more detail below, in particular in my answers to Questions 54-57.

Patient Outcomes and Charts at Home

26. In 2013 Medical Records complained that an ongoing problem with Aidan O'Brien was patient hospital charts in his house and he was advised that this was not permitted. Following the expansion of the urology service to become Team South, outpatient clinics were provided in Enniskillen and patient records therefore needed to be transported to the clinic and back to Craigavon afterwards. The Trust transport was used for all other peripheral surgical clinics but for this service it had been arranged that, after the clinic, the consultant would bring the charts back to the Craigavon. Following dictation of the letter to the GP the outcome for the patient would be recorded (e.g., put on waiting list for surgery, discharged, or review arranged). Aidan O'Brien, however, was bringing the charts to his house after the clinic but not completing the dictation which also meant patient outcomes were not recorded. The Trust became aware in late 2015 of it as a problem but only discovered the extent of the problem, when following Heather Trouton's and my letter in March 2016, he returned the charts.

27. This issue is addressed in more detail below, in particular in my answers to Questions 58-61.

Bullying and Harassment

28. In 2012 I was informed that Aidan O'Brien had spoken to Roberta Brownlee, then Chair of the Trust Board, complaining that I had been bullying and harassing him. I consider this to have been a false accusation and, on reflection, I believe it may have been malicious. Prior to 2012, I had acted as a major challenge to Aidan O'Brien' opinions and views regarding

development and modernisation of the urology service and I think he resented my input.

29. The modernisation of the service meant that I was expected to challenge traditional practice to bring it in line with the modern model, for example: admission on the day of surgery, utilisation of pre-operative assessment service, target for new patient to review ratio at outpatients, fixed length of consultations, number of patients at a clinic, etc. In addition, I hadn't accepted Aidan O'Brien's suggestions for a job plan and I referred him to the facilitation process which ultimately reduced his pay by 3 PAs. Furthermore, I helped organise the benign cystectomy review and I challenged him re breaches of the protocol for managing the IV fluids and IV antibiotics patients. I had also challenged him over failure to triage and had been involved in the discussion to refer him to HR re disposal of patient records in a bin. I also had actively supported Gillian Rankin regarding the necessity for Aidan O'Brien to review the results of patients' investigations once they are available.

30. While I was reassured that management did not believe the false accusation, on reflection it should have been investigated. The failure to investigate and exonerate me meant I had to be careful about acting in any sort of challenge role and my oversight of Aidan O'Brien's practice was reduced for fear that it could be misconstrued as evidence of harassment. On reflection, I now feel that he achieved his intended objective.

31. This issue too is addressed at various points in my answers below, particularly at Question 21.

32. Aidan O'Brien was considered by many to be old fashioned in his outlook and style of consultant practice. Once he saw a patient, he had a reputation for being very attentive and approachable. His patient feedback was excellent and many of his nursing and consultant colleagues held him in very high esteem. I was never informed of any issues or concerns arising from his appraisals. He had a reputation for being hard working and one who would

no formal investigation of the complaint, and I have checked with Zoe Parks (Head of Medical HR) and she says that there is no record on my file of the accusation."

The Inquiry asks that you address the following:

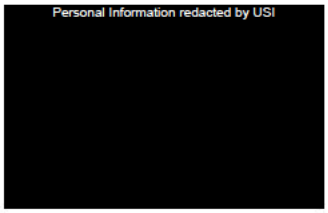
(i) Please respond to the detail provided by Mr. Mackle in paragraph 92, specifically as they relate to you, setting out whether you agree with all or some Mr. Mackle's version of events (identifying where you agree and providing full details as you recall them).

1.1 The context of this is that Mr Mackle was informed by someone that the Chair of the Trust (Mrs Roberta Brownlee) reported to Senior Management that Mr O'Brien had made a complaint to her that Mr Mackle had been bullying and harassing him. I have no recollection of ever hearing this and nor have I had any discussion or correspondence with Mrs Brownlee about any matter concerning Mr O'Brien or Mr Mackle. I have no recollection of having any discussion in the context described by Mr Mackle. In light of this Section 21 I double checked with Mrs Zoe Parks, Medical Staffing Manager, and she confirmed there was no such complaint on record.

(ii) If Mr. Mackle is correct in his recollection, please set out your recollection of events, including why you spoke to Mr. Mackle, what was said, and whether you spoke to or discussed this with anyone else.

1.2 I would refer to answer (i) above. I have no recollection of such an event.

(iii) If Mr. Mackle is correct in his recollection, please set out why there was no formal investigation of the complaint of bullying and harassment. In addressing same, outline all actions, of which you are aware, which were taken by yourself or others within HR Directorate or Trust more broadly concerning this complaint and provide any and all relevant documents.



30 January 2012.

Dr. Gillian Rankin,
Director of Acute Services,
Southern Health and Social Care Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear Dr. Rankin,

I wish to take this opportunity to formally submit, in writing, a grievance regarding the deductions made to the payments owed to me on foot of a claim for extra contractual work. These deductions amount to a breach of agreement with management regarding the rate of remuneration for the sessions claimed, a rate subsequently reaffirmed to me by management.

In the autumn of 2010, it was agreed by the Head of ENT and Urology that I would be remunerated one additional sessional payment for conducting combined urodynamic studies and oncology reviews all day Fridays in the Thorndale Unit. I enclose a copy of the claim form submitted 2nd March 2011, consisting of a claim for 15 such sessions in addition to 4 sessions of Inpatient Operating and 2 sessions of Urodynamic Studies completed on Saturdays.

When I received payment of £Irrelevant information gross in April 2011, I was unable to recognise the amount. In contacting the Payroll Department, I was advised that payments for additional Friday sessions had been halved, whilst the remaining sessions had not been paid at all. When I enquired why deductions had been made, the Payroll personnel informed me that they were unable to decipher the signature of the person who had made the deductions. For that reason, I was provided with a copy of the claim form (enclosed). It was evident to me that the deductions were made by Mr. Eamon Mackle. I subsequently received payment for the unpaid Saturday sessions in May 2011.

To date, I have not received full payment in respect of these sessions, nor have I received any communication regarding same, apart from verbal confirmation of the agreement.

Agreed it is appropriate

Misunderstanding
should not have happened

Parks, Zoe

From: Parks, Zoe [redacted]
Sent: 24 February 2012 14:51
To: Gannon, Oonagh; Porter, Pamela
Subject: Waiting List Initiative Claims - Mr A O'Brien
Attachments: SKMBT_C22012022415080.pdf

24 February 2012

Mr A O'Brien,

Re: Waiting List Initiative Claims

You will see from the attached correspondence that Mr A O'Brien recently wrote to Dr Rankin about some changes that had been made to WLI claims that he had submitted for work undertaken between July 2010 to February 2011. These claims were changed by the AMD Mr E Mackle but I have spoken to Mr Mackle and Heather Trouton and it seems there was some misunderstanding about what had been agreed against his job plan. However they have agreed to concede as changes shouldn't have taken place without prior discussion with Mr O'Brien.

Therefore I wish to confirm that it has been agreed that Mr O'Brien should have been paid what was originally included on the WLI forms. I would therefore be grateful if you could arrange to reimburse Mr O'Brien £[redacted] x 15 occasions – as shown on the attached forms.

If you have any queries please do not hesitate to contact me.

Many thanks

Mrs Zoë Parks
Medical Staffing Manager
Southern Health & Social Care Trust
Craigavon Area Hospital
68 Lurgan Road, Portadown

Phone: [redacted]
Blackberry: [redacted]
Fax: [redacted]
Email: [redacted]

From: [redacted]
Sent: 24 February 2012 15:09
To: Parks, Zoe
Subject: Message from KMBT_C220

Willis, Lisa

From: Trouton, Heather
Sent: 26 November 2013 11:40
To: Young, Michael; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Attachments: image001.png

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Both

In confidence please see below.

I personally have spoken to Mr O'Brien about this practice on various occasions and Martina has also much more often. While we very much appreciate Aidan's response, I suspect that without further intervention by his senior colleagues it will happen again.

I also spoke to him not more than 4 weeks ago both about timely triage and having charts at home and he promised me he would deal with both, however we find today that patients are still with him not triaged from August , he would have known that at the time of our conversation yet no action was taken. I am also advised today that a further IR1 form has been lodged by health records as 6 charts cannot be found.

As stated by Aidan we have been very patient and have offered any help in the past with regard to systems and processes to assist Aidan with this task but it has not been taken up and the delays continue.

Despite the fact that patients sitting not triaged from August mean that we have breached the access standard before we even start to look for appointments I am more concerned about the clinical implications for patients who need seen urgently and possibly even needing upgraded to a red flag status.

We really need you to speak with Mr O'Brien both in the capacity of a colleague but also in your capacity of Clinical lead and Clinical Director for Urology as well of course as patient advocates.

I also really need a response within 1 week on how this is being addressed for now and the future or I will be forced to escalate to Debbie and Mr Mackle as Director and AMD for this service. It has already been suggested that Dr Simpson be involved which I have not progressed to date but it may have to come to that unless a sustainable solution can be found.

Thank you for your assistance

Heather

From: Corrigan, Martina
Sent: 26 November 2013 08:02
To: Robinson, Katherine; Glenny, Sharon
Cc: Trouton, Heather
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear both

Please see below – Katherine can you advise if you receive these?

Willis, Lisa

From: Carroll, Anita
Sent: 02 May 2014 16:52
To: Trouton, Heather
Subject: FW: Missing Triage

Follow Up Flag: Follow up
Flag Status: Flagged

Don't panic as you know we are going with gp triage anyway

From: Robinson, Katherine
Sent: 02 May 2014 16:19
To: Browne, Leanne; Carroll, Anita
Cc: Rankin, Christine
Subject: RE: Missing Triage

As you can see these have all been chased several times. Due to the lengthy target now these patients are not due appts yet. When they are we are going to be booking without triage result.

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre Ramone Building Craigavon Area Hospital

t: Personal Information redacted by USI
e: Personal Information redacted by USI

From: Browne, Leanne
Sent: 02 May 2014 16:11
To: Carroll, Anita
Cc: Robinson, Katherine; Rankin, Christine
Subject: Missing Triage

Hi Anita

Can you arrange for the following Urology referrals to be returned from triage as soon as possible please

Hosp

CHI Number

Casenote

Forenames

Surname

Age

Telephone

Telephone Work

Stinson, Emma M

From: Young, Michael
Sent: 15 December 2021 09:49
To: Stinson, Emma M
Subject: FW: Personal Information redacted by USI

Section 21

From: Young, Michael
Sent: 22 December 2015 18:35
To: Corrigan, Martina
Subject: RE: Personal Information redacted by USI

This is a r/v case not necessarily a new referal

From: Corrigan, Martina
Sent: 30 November 2015 07:47
To: Young, Michael
Subject: FW: Personal Information redacted by USI
Importance: High

Michael,

Please see attached. I have got 8 more of these similar emails this morning asking for my action. I am only forwarding this to you as an example
and I will really need help at getting this resolved as there are currently 277 not triaged letters from when AOB has been oncall dating back to October 2014!!

I have told the booking centre to continue booking these patients in as their date comes up but just to say that these are letters that have no indication to the booking centre which waiting list they should be on.

I have no doubt that Aidan does look at these whilst he is oncall but it would just appear that he doesn't return them with instructions to the booking centre.

I have no choice but to escalate this to Heather as the longest is going back 58 weeks!

Happy to discuss

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by USI
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: Cunningham, Andrea
Sent: 27 November 2015 12:27
To: Corrigan, Martina

O'Brien in a written form for his response. The Director of Acute Services was also made aware of the concerns and agreed with the advised plan of action.

Use/Non-use of MHPS and or Trust Guidelines

26. I address the use or non-use of the MHPS and Trust Guidelines in respect of each of the above issues below.

(I) IV Fluids and IV Antibiotics

(a) This issue was discussed with the Medical Director, who then took control of the process to be followed. Paddy Loughran engaged an independent opinion and then set up a multidisciplinary team and introduced a protocol which was required to be followed. In light of the Medical Director's direct involvement and instructions regarding management, I do not recall any consideration being given regarding applying the MHPS Framework.

(II) Benign Cystectomies

(b) Paddy Loughran was made aware of the issue by Diane Corrigan. He then advised Dr Rankin and myself of the process to be followed. I was instructed to seek assistance from Mark Fordham (Clinical advisor to the NI Urology Review) regarding a suitable expert to review a selection of the cases. When the results of Marcus Drake's review were obtained, Dr Loughran determined that there were no gross errors or faults.

(III) Delayed Triage

(c) As acknowledged above, I accept that, in the context of the persistent and recurring issues regarding triage, I do not recall ever considering the MHPS Framework. As far as I can tell, none of the Acute Directors or Medical Directors considered the MHPS Framework either. As also acknowledged above, I now believe, on reflection, that the repeated failure by Aidan O'Brien to complete timely triage should have triggered an investigation under the MHPS Framework.

(IV) Patient Records in a Bin

Mackle, Eamon

From: Brown, Robin
Sent: 22 September 2013 12:40
To: Corrigan, Martina
Cc: Mackle, Eamon; Trouton, Heather; Nelson, Amie
Subject: RE: Datix Incident Report Number W19270

[redacted]

Debbie emailed me about this a couple of weeks before I went off [redacted].
I texted Aidan but he didn't reply
Last time there was a problem like this I drove over to CAH and waited for him to finish a clinic in Thorndale
It did look a bit like an ambush and might have been a bit counter-productive
I think it might be better if I could catch him at the beginning or end of an MDM.
I have an OPD appt on Tuesday morning - What does Aidan do on Tuesdays - Is that his list day?

[redacted]

What about the Thursday lunchtime meetings?
I don't know if they are still happening [redacted]

Robin

-----Original Message-----
From: Corrigan, Martina
Sent: 21 September 2013 22:05
To: Brown, Robin
Cc: Mackle, Eamon
Subject: FW: Datix Incident Report Number W19270

Robin

[redacted]

Below is another DATIX received in respect to charts being in Aidan's home. This was the second one last week and I am receiving at least one of these each week as Health Records are continuing to spend time looking for charts that they discover are in Aidan's house.

I would be grateful if you could speak with him as it has now been escalated to Debbie.

Many thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: [redacted] (Direct Dial)
Mobile: [redacted]

Corrigan, Martina

From: Mackle, Eamon < Personal Information redacted by USI >
Sent: 20 February 2014 11:30
To: Burns, Deborah
Subject: Fw: CHARTS AND aob

From: Carroll, Anita
Sent: Wednesday, February 12, 2014 04:47 PM GMT Standard Time
To: Trouton, Heather; Mackle, Eamon
Cc: Corrigan, Martina
Subject: FW: CHARTS AND aob

Sharing as requested
A

From: Lawson, Pamela
Sent: 12 February 2014 16:46
To: Carroll, Anita
Subject: RE: can i have an update on mr o brien ?

Anita – please see below – these are details of the IR1 forms submitted re charts Mr O'Brien has had to bring in from his home for clinics and admissions.

08/05/13 – 1 chart
20/05/13 – 1 chart
16/05/13 – 1 chart
31/05/13 – 2 charts
14/06/13 – 1 chart
22/08/13 – 3 charts
23/08/13 – 2 charts
27/08/13 – 3 charts
30/08/13 – 2 charts
16/09/13 – 1 chart
18/09/13 – 1 chart
20/09/13 – 1 chart
03/10/13 – 6 charts
14/10/13 – 1 chart
15/10/13 – 1 chart – AOB forgot to bring chart in – pages and labels had to be made up for CDSU procedure
15/10/13 – 1 chart
04/11/13 – 1 chart – chart did not arrive in time for clinic
25/11/13 – 6 charts
11/12/13 – 6 charts
08/01/14 – 2 charts
09/01/14 – 2 charts
21/01/14 – 3 charts – not able to get these charts as AOB was out of the country and his secretary was on leave
24/01/14 – 3 charts
12/02/14 – 3 charts

From: Carroll, Anita
Sent: 12 February 2014 16:38

Willis, Lisa

From: Carroll, Anita
Sent: 27 January 2015 12:54
To: Trouton, Heather
Subject: RE: Aob and charts at home

Follow Up Flag: Follow up
Flag Status: Flagged

I know A

-----Original Message-----
From: Trouton, Heather
Sent: 27 January 2015 12:28
To: Carroll, Anita
Subject: RE: Aob and charts at home

I spoke to Mr Young about this last week and he is going to speak to Aidan again.

I will consider the Risk register although with that you are supposed to address the risk and eliminate it. This is down to a personal way of working which seems impossible to stop.

Heather

-----Original Message-----
From: Carroll, Anita
Sent: 27 January 2015 11:55
To: Trouton, Heather; Corrigan, Martina
Cc: Forde, Helen
Subject: Aob and charts at home

Heather

Do you think you ? Should have something on risk register in relation to this

Anita

XIII. **Outline how the concerns were raised, registered or escalated to the Service Director and the Medical Director?**

39. When I was made aware by Heather Trouton of the issues we agreed that we should seek advice from the Medical Director. I informed Richard Wright of our concerns and he then organized to meet us in the Administration Floor of Craigavon Area Hospital in, I believe, January 2016, at which stage he advised the course of action for us to follow. Esther Gishkori was also informed of the issues by Heather Trouton and myself and of Richard Wright's advice.

XIV. **Outline how the correspondence and the outcome from the meeting were raised, registered or escalated to the Service Director and the Medical Director?**

40. Esther Gishkori was appraised of the correspondence and of the discussion with Aidan O'Brien. I cannot recall if I discussed it with Richard Wright before I stepped down as AMD.

[10] When, and in what circumstances, did you first became aware of concerns, or receive any information which could have given rise to a concern that Mr O'Brien may have been affording advantageous scheduling to private patients.

41. I cannot recall being presented with any evidence that Aidan O'Brien was prioritising patients for scheduling on the basis of them having seen him privately. I believe the issue was raised as a possibility with Heather Trouton on a few occasions but that, when challenged by Heather Trouton or Martina Corrigan, Aidan O'Brien had sound clinical reasons for his prioritisation. I cannot recall when I was informed of this and, for the avoidance of doubt, I had no direct or first-hand involvement in the matter.

Corrigan, Martina

From: Haynes, Mark <[redacted]>
Sent: 27 May 2015 20:54
To: Young, Michael; Corrigan, Martina
Subject: FW: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15
Attachments: UROLOGY LONGEST URGENT WAITERS WITHOUT DATE FOR SURGERY - FOR SCHEDULING - 27.05.xlsx; UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15.xls

Importance: High

Dear Michael / Martina

I feel increasing uncomfortable discussing the urgent waiting list problem while we turn a blind eye to a colleague listing patients for surgery out of date order usually having been reviewed in a Saturday non NHS clinic. On the attached total urgent waiting list there are 89 patient listed for an Urgent TURP, the majority of whom will have catheters insitu. They have been waiting up to 92 weeks.

However, on the ward this week is a man ([redacted]) who went into retention on 16th March 2015, Failed a TROC on 31st March 2015. He was seen in a private clinic on Saturday 18th April and admission arranged for 25th May with a view to Surgery 27th May. The immorality of this is astounding and yet this is far from an isolated event, indeed I recognise it every time I am on the wards and discussing with various members of the team it is 'accepted' as normal practice. I would not disagree with any argument that this patient got the treatment we should be able to offer to all but it is indefensible that this patient waited 5 weeks while another patient waits 92 weeks. Both with catheters insitu for retention. An argument that this man was very distressed with his catheter does not hold with me. All of our secretaries can vouch for many patients in this situation being in regular contact because of catheter related problems.

This behaviour needs to challenged a stop put to it. I am unwilling to take the long waiting urgent patients while a member of the team offers preferential NHS treatment to patients he sees privately. I would suggest that this needs challenging by a retrospective audit of waiting times / chronological listing for all of us and an honest discussion as a team, perhaps led by Debbie. The alternative is to remove waiting list management from all of us consultants and have an administrative team which manages the waiting list / pre-op / filling of waiting lists in a chronological order.

Happy to discuss and plan a strategy for taking this forward.

Mark

From: Glenny, Sharon
Sent: 27 May 2015 14:32
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Cc: Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Robinson, NicolaJ; Troughton, Elizabeth
Subject: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15
Importance: High

Hi Everyone

Following the departmental meeting last week and discussion re urgent waiting times and volumes with consultants for elective surgery – I have attached a total urgent waiting list for your review.

Corrigan, Martina

From: Haynes, Mark <[redacted]>
Sent: 26 November 2015 06:42
To: Young, Michael; Corrigan, Martina
Subject: Queue jumpers

Morning Michael

I emailed you on 2nd June 2015 about the ongoing issue of patients on waiting lists not being managed chronologically and in particular private patients being brought onto NHS lists having significantly jumped the Waiting List. As I have been through our inpatients in preparation for taking over the on-call today I have once again come across examples of this behaviour continuing. Specific patient details are;

[redacted] AOB
Referred Sept 2015, Seen OP ([redacted]) Sat 10/10/15, Urodynamics @thorndale unit 6/11/15, Cystodistension 25/11/15.

[redacted] AOB
Referred 28/10/15, Seen OP ([redacted]) Sat 7/11/15, GA cystoscopy 25/11/15 (?recurrent stricture)

I have expressed my view on many occasions. This is Immoral and unacceptable. Aside from the immorality of patients who have the means to seek private consultations having their operations on the NHS list to the detriment of patients without the means, who sit on the waiting list for significant lengths of time, the behaviour is apparent to outsiders looking in. The HSC board can see it when they look at our service and any of our good work is undone by this.

Can you advise me what action has been taken since I raised this?

Mark

Willis, Lisa

From: Trouton, Heather
Sent: 02 November 2015 15:33
To: Corrigan, Martina; Mackle, Eamon
Subject: FW: UROLOGY DSU LIST 03/11/15
Attachments: MR O'BRIEN IN PATIENT THEATRE LIST 04/11/15.eml

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Dear martina

Have you the lists for this week?

Heather

From: McGeough, Mary
Sent: 02 November 2015 13:51
To: Donnelly, Rachel; Kelly, Brigeen; Corrigan, Martina
Cc: Trouton, Heather; Carroll, Ronan
Subject: RE: UROLOGY DSU LIST 03/11/15
Importance: High

Martina

Please see email below regarding Mr O'Brien's patients for his day surgery list tomorrow. As you will see 3 out of the 5 patients have not been to pre-op. Could you please investigate and advise why these patients were never sent to pre-op as to get this level of notification of their surgery is as I am sure you will agree unacceptable. We are now in a position where we are unable to get these 3 patients pre-assessed due to the extremely tight timeframe before their surgery. I have also attached a second email from Rachel with regard to Mr O'Brien's inpatient list on 4th November and again there are a couple of patients on this list who have not been to pre-op. Have all of these patients been seen somewhere other than at his outpatient clinic? If yes then a system will need to be put in place ASAP in order to ensure that these patients are pre-assessed well in advance of their surgery being scheduled.

Happy to discuss

Mary

Mary McGeough
Head of Anaesthetics, Theatres and ICU
Craigavon area Hospital
Tel: Personal Information redacted by USI

From: Donnelly, Rachel
Sent: 02 November 2015 12:42
To: Kelly, Brigeen; McGeough, Mary
Subject: UROLOGY DSU LIST 03/11/15

Dear Brigeen and Mary

Linda came to me this morning with the attached list – Mr O'Brien DSU AM list for 03/11/15.

the Directorate did review results of investigations on a regular basis, we could not be certain they all complied.

225. Following further discussions with Gillian Rankin my recollection is that an instruction was then issued to all the consultants in the Directorate reminding / informing them that it was their responsibility to review the results of investigations on their patients once they are available. Secretaries were informed that results of investigations were not to be filed in the chart unless they had been reviewed and signed / initialled by a consultant.

Patient Outcomes

226. My recollection is that at the end of 2015 we started to become increasingly aware of an issue regarding patient centre letters and outcomes. Some of the urologists were undertaking waiting list work / validation and found that, in many of Aidan O'Brien's patients, their clinic outcomes and letters were not recorded and there was no record in the chart. It was also noted that many of the hospital charts were not available for clinics.

Charts at Home

227. A recurring issue since I came to the trust was consultants at times taking charts home. On request from Medical records they would be returned to the hospital. Aidan O'Brien was not unique in this respect and from time to time all consultants would be reminded not to bring them home. In September 2013 Helen Forde, Head of Health Records flagged the issue with Heather Trouton and Anita Carroll and through Anita Carroll to Debbie Burns. *Document located in Section 21 4 of 2022, 20130905 E re Charts to Consultants Home.* Debbie Burns identified it as a governance issue and Robin Brown was instructed to discuss with Aidan O'Brien and if not did it need escalated. 22 September 2013 Robin Brown emailed to say he would deal with it. *Document located in Section 21 4 of 2022, 20130922 E re Datix Incident Report*. I do not recall the issue of charts at home being discussed with me until the end of 2015. At the end of 2015 / early 2016 as part of an overall investigation Heather Trouton made me aware that it had started to

Cc: Browne, Leanne; Robinson, Katherine
Subject: FW: Personal Information redacted by USI
Importance: High

Hi Noleen,

This patient was seen in June at SWAH, patient has not been discharged or reinstated for a review following last attendance. Please advise of Mr O'Brien's decision on attached referral. Is the referral for Info or Urgent/Routine review?

Thanks
Alana

From: Coleman, Alana
Sent: 21 August 2015 12:29
To: Elliott, Noleen
Cc: Browne, Leanne
Subject: FW: Personal Information redacted by USI
Importance: High

Hi Noleen,

Please see below email, please advise of triage. Does this patient require a review or is this just info?

Thanks
Alana

From: Coleman, Alana
Sent: 14 July 2015 17:53
To: Elliott, Noleen
Cc: Browne, Leanne
Subject: Personal Information redacted by USI
Importance: High

HI Noleen,

Please see attached referral – please forward to Mr O'Brien and advise of outcome.

Many Thanks
Alana Coleman
Registration and Booking Clerk
Referral and Booking Centre
Ramone Building
CAH

(moved from AHP office to main office)
Tracking Code: Personal Information redacted by USI
Tel : Personal Information redacted by USI

Martina,

See below -Consultant does not use clinic outcome sheets. Clinical decision outstanding.

Regards
Andrea

Andrea Cunningham
Service Administrator
Ground Floor
Ramone Building
CAH

E: Personal Information redacted by USI
T: Personal Information redacted by USI

From: Browne, Leanne
Sent: 27 November 2015 11:58
To: Elliott, Noleen
Cc: Cunningham, Andrea; Coleman, Alana
Subject: FW: Personal Information redacted by USI
Importance: High

Hi Noleen

Personal Information redacted by USI attended EUROAOB 22nd June, no follow-up has been arranged. Can you check the outcome sheet to see if he needs reviewed or discharged please.

Thanks

Leanne

From: Coleman, Alana
Sent: 24 November 2015 12:05
To: Browne, Leanne
Subject: FW: Personal Information redacted by USI
Importance: High

Hey,

No response to below queries.

Thanks
Alana

From: Coleman, Alana
Sent: 14 October 2015 16:03
To: Elliott, Noleen

Stinson, Emma M

From: Young, Michael
Sent: 15 December 2021 09:48
To: Stinson, Emma M
Subject: FW: Personal Information redacted by USI

Section 21

-----Original Message-----
From: Young, Michael
Sent: 03 December 2015 22:29
To: Corrigan, Martina
Subject: RE: Personal Information redacted by USI

Appears to have been seen
No letter
Us request notes clinically benign prostate and not emptying bladder Psa is really much the same as in 2011

I would suggest that this is not serious but pt and gp are not in the loop Two options - put on to AOB review clinic (as this is probably what AOB thinking when is note benign feeling gland) or send email to AOB asking for his outcome of the consult and if no response gained then pt will be added to one of his clinics

From: Corrigan, Martina
Sent: 02 December 2015 19:36
To: Young, Michael
Subject: FW: Personal Information redacted by USI
Importance: High

Can we discuss please?

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by USI
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: Cunningham, Andrea
Sent: 02 December 2015 13:56
To: Corrigan, Martina
Subject: FW: Personal Information redacted by USI
Importance: High

37. Did those systems or processes change over time? If so, how, by whom and why?

37.1. Once Mr Haynes was appointed as Associate Medical Director in Autumn 2016, I had confidence that professional issues were being appropriately escalated to me. Prior to that it now seems clear that such issues were not being appropriately highlighted. The turnover of Associate Medical Directors and Assistant Directors in the months preceding this was not helpful for continuity of approach.

37.2. Mrs Gishkori (Acute Service Director) met with me on a regular basis to discuss issues within her directorate. Some of these issues were related to concerns within the urology team but we also took the opportunity to share many positive developments. In addition, there were structured opportunities at each of the weekly Senior Management team meetings to share concerns and also at the monthly Trust Board meetings in either the open or confidential sessions.

38. How did you ensure that you were appraised of any concerns generally within the unit?

38.1. The Acute Services Director or the Associate Medical Director would have informed me directly regarding professional governance concerns in our regular 1:1 meetings or on an ad hoc basis when required. For operational matters the Acute Services Director (Mrs Gishkori) would speak at Senior Management Team each week on any relevant issues bringing reports when appropriate through her governance team. Governance data was collected centrally by, and produced in annual governance reports to, the governance sub-committee of Trust Board. I would have received reports from inspecting agencies such as NIMDTA, GMC and RQIA which could on occasions raise concerns.

38.2. I don’t believe any significant concerns were raised in relation to Urology at the time. I had an open door policy for any Doctor to meet with me personally should they have concerns. The Clinical Director (Mr Weir) would have

48.1.

(a) I was not aware of significant problems within team urology until early September 2016 when Mr Haynes highlighted the issues around the patient administration performance of Mr O'Brien. These had come to the fore because Mr O'Brien was on sick leave and the directorate had appropriately arranged for his patients to be reviewed by other consultants.

(b) The issues raised are outlined in the meetings of the Oversight team meetings from September 2016 onwards and the subsequent report presented initially by Mr Weir. This report initially outlined the extent of the initial concerns. Mr Weir (Clinical Director) assured the Oversight team that there were no immediate safety concerns for patients.

(c) Reassurance was provided via Mrs Gishkori's operational team to the Oversight team meeting. The Acute Services Director was asked to develop a return to work plan for Mr O'Brien that included close monitoring of patient triage, clinic dictation and the other issues raised in Mr Weir's report.

(d) See (c).

(e) Reassurance was provided by the Acute Services Director and this was tested by the weekly monitoring of compliance carried out by the Head of Service, Mrs Corrigan.

(f) See (e).

(g) The initial monitoring of the return to work plan revealed good compliance with Mr O'Brien's restrictions and support measures. I was involved up until February 2018 during which time the MHPS Case Manager was of the opinion that compliance continued to be good. I understand these arrangements were subsequently less successful.

(h) See (g).

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 -

Willis, Lisa

From: Trouton, Heather
Sent: 16 March 2016 15:28
To: Corrigan, Martina
Subject: RE: Confidential letter to AOB - January 2016

Sensitivity: Confidential

Martina

Eamon went through this today,

Would it be possible just to refresh the latest figures so that we can send?

Thanks
Heather

From: Corrigan, Martina
Sent: 18 January 2016 15:22
To: Trouton, Heather; Mackle, Eamon
Subject: Confidential letter to AOB - January 2016
Importance: High
Sensitivity: Confidential

Dear both,

Apologies for not getting this to you sooner but I wanted to rerun and update the information before including this in this correspondence. I wasn't sure if this was a joint letter but I have put it from a plural perspective, so this may need changed.

Hope it is ok and if there is anything else needed please do not hesitate to give me a shout….

Regards

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by USI (direct dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

21/3/16 1:1 Esther + Eamon.

→ ~~Flexing~~ of Beds 4N, 3S, Fem Surgical post 31/3/16 ??
Financial agreed.

→ 3 applicants for the CD post in Surgery.

→ Issue DHH → D. McCoy - Colorectal - issue - D/W Eam

→ Heads of Service - nervous.

→ OSL → Shaun - with me.

→ Surgical Strategy paper.

→ Need to get letter to DOS this week.

→ Do an independant review to decide if any colorectal surgery should be done on the DHH site. - Eamon to find Someone.

Southern Health and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you.

1. Untriaged outpatient referral letters

There are currently 253 untriaged letters dating back to December 2014. Lack of triage means we do not know whether the patients are red-flag, urgent or routine. Failure to return the referrals to the Booking Centre means that the patients are only allocated on a chronological basis with no regard to urgency.

2. Current Review Backlog up to 29 February 2016

Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

3. Patient Centre letters and recorded outcomes from Clinics

Consultant colleagues from not only Urology but also other specialties are frustrated that there is often no record of your consultations/discharges on Patient Centre or in the patients' notes. Validation of waiting lists has also highlighted this issue. If your

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Irrelevant information redacted by USI

patient is reviewed at another Urology Clinic a new appointment slot is required due to the lack of documentation.
This lack of documentation combined with no record of clinic outcomes means further investigations/follow-up may not be organised by admin staff.

4. Patient Notes at home

This has been an ongoing issue for years and needs addressed urgently. We request that all SHSCT charts that are in your home or in your car be brought to the hospital without further delay.

You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

Yours sincerely,

Eamon Mackle	**Heather Trouton**
Associate Medical Director	**Assistant Director**

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Irrelevant information redacted by USI

VII. **How did Mr O'Brien respond to being informed of the concerns and presented with the letter?**

33. My recollection is that, when Aidan O'Brien attended the meeting, I thanked him for coming and explained I had a letter to discuss with him. Upon informing him of the issues, I asked him to respond with a commitment to address the issues and to produce a plan to address all the issues. Aidan O'Brien took the letter and my recollection is that all he then said was that he would have to consider the points in the letter. I believe I also asked him to let us know if he needed any help.

VIII. **What action was Mr O'Brien to take in respect of the matters referred to at the meeting and letter, and was a time-frame for compliance specified for him?**

34. Aidan O'Brien was requested to bring back to the hospital all the charts in his house and or car. He was requested to respond with a commitment to address the other issues and to respond to the Trust with a plan as to how to implement the plan. No specific time frame for response and compliance was specified.

IX. **What, if any, support or assistance was offered to Mr O'Brien to ensure that he was enabled to comply with the stipulated actions?**

35. I do not recall any specific support or assistance being offered to Aidan O'Brien nor do I recall him requesting any from the Trust. As stated in (VII) above, however, I believe I did ask him to let us know if he required any help. As I stepped down in April 2016 I am unaware if he ever requested any help or assistance.

12. Between 2012 and 2016 I was as a result very cautious in my dealings with Mr O'Brien. I was shocked to be accused of bullying / harassment. I felt any challenge I had made to Mr O'Brien was legitimate and the challenges were designed to encourage new ways of working in urology and were only raised at meetings in the presence of senior managers. I didn't challenge the advice I was given by the Dr Rankin.

13. In 2013/14 there was a Northern Ireland urology review undertaken by Mark Fordham. Mark expressed to me that he felt we had a significant problem in trying to get Aidan to develop /modernise his practice

14. In July 2012 or 2013, not sure exactly of the date, Mr O'Brien had a huge backlog of patients and he stopped seeing new patients to clear the backlog. 18 months later he asked for another month free of Out-patients, on that occasion the Trust felt it couldn't be supported. Michael Young also took on triaging for Mr O'Brien for over 6 months at a point.

15. Mr O'Brien was supported within his specialty and so no problems were being flagged in the specialty. However it appeared at management level that indeed there were problem and this was partly behind the reason to have regular Monday meetings with urology.

16. In respect of TOR 1 I understood there was a problem but I would have had no idea of the numbers involved. Charts were the main issue of concern. I expect there would be delay to patient care but I have no specific knowledge of harm to patients.

17. Other Consultants within surgery would have triaged within a week. This is certainly the case within general surgery. I don't know of any triage issues with any of the other urologists.

18. In terms of notes, Mr O'Brien transferred notes to and from clinics especially in Erne. I know Mr O'Brien would have had large numbers of notes at home. Medical records staff would have spent considerable time looking for charts. I don't know the extent of the numbers involved however. This could have led to serious governance issue however with NIECR a lot of the risks with charts not being available for OP Clinics has been mitigated.

19. I understand that there was a problem with Mr O'Brien and his undictated outcomes as this had been an on-going issue. I do not know the extent of the issue. I would suspect patient care was delayed because he did not dictate outcomes or letters at the end of the clinic, hence the charts were taken home. Staff should be doing dictation as they see patients. I would never leave a clinic without dictating it and I don't know anyone else who leaves clinics undictated.

20. In respect of concerns about private patients, this is something I heard recently but I would have no other knowledge of that.

21. On 24 March 2016 a letter was sent to Mr O'Brien regarding concerns about triage, backlog, letters not being done and notes at home. As AMD I took the letter and went to speak with Mr

O'Brien. I didn't go through the letter but it set out to him the actions he needed to take and I asked him to address the issues. We did not discuss any supports to address the issues. My role as AMD ceased around this time and so I was not involved in the follow up after the letter went. My involvement ended at that point.

This statement was drafted on my behalf by Mrs Siobhan Hynds, Head of Employee Relations and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.

This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a conduct or clinical performance hearing. I understand that I may be required to attend any hearing as a witness.

SIGNATURE	
DATE	

38.2 I am aware from reading the material in preparation for this public inquiry that a letter was issued to Mr O'Brien in March 2016 by his Clinical Management team raising concerns, particularly around administrative practice and current review backlog. I understand HR were not informed of these concerns at that time. I was off on Personal Information redacted by USI leave but I believe it would have been helpful to have sought specialist HR advice at that time.

38.3 I believe this initial concern should have prompted immediate preliminary enquiries by the clinical manager to take a deeper dive and scope to establish the full nature of the concern. The fundamental consideration within the MHPS Framework is the continued safety of patients and the public. Action when a concern first arises requires the clinical manager to consider if urgent action needs to be taken to protect the patients and if a precautionary restriction/exclusion on practice is required, until they can clarify the nature of the concern. The key Governance question I am asking is that no one seemed to understand or take accountability for determining the full extent of the problem, to ensure any necessary protective measures for patients could be put in place immediately and properly monitored.

39. **Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?**

39.1 On very first receipt of the prompt/concern, the response should have been for the clinical manager to very quickly ascertain what had happened. They needed to establish the facts, determine if there was a continuing risk and decide if there was action needed to manage any risk to ensure the ongoing protection of patients. It is not clear to me what action was taken following the meeting in March 2016. I note the request was to ask Mr O'Brien for an immediate plan to address the issues highlighted. I don't believe this was appropriate, given these were significant concerns which I believe met the threshold for formal investigation at that time. It may also have warranted an immediate interim review of Mr O'Brien's Job plan to ensure the necessary corrective reviews being asked of Mr O'Brien were possible.

39.2 More rigorous and robust action at this early stage may well have been a missed opportunity to ensure preliminary enquiries triangulated and documented all available data at that time. Had a robust review been undertaken, this may have allowed an earlier link between

2018) data gleaned by the Head of Service (Mrs Corrigan) and her team highlighted the difficulties around patient triage. The Datix IR1 incident reporting system was in place across the Trust. It seems that it is through this mechanism the incident (Patient 10) which subsequently became was upgraded to the first SAI (Serious Adverse Incident) was identified.

42. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

42.1. The Acute Services Governance Manager, Dr Tracey Boyce, or the central Governance Lead at the time, Margaret Marshall, may be in a better position to comment on this. I have no detailed knowledge of the data collection systems within urology at the time. My involvement ceased in February 2018 when I Personal Information redacted by the USI and then retired. However, I note that the central data governance team in the Trust won the UK award for best data governance team within the UK among 200 trusts from the CHKS peer comparator system 2017.

42.2. In my opinion, and with hindsight, it seems there was significant data available regarding many of the key issues. As I see the issue, the main factor was a reluctance to formally address the issues identified, rather than a lack of data.

42.3. Incident reporting moved from a paper-based system to an online system (Datix). This allowed for more timely collection of statistics and analysis but was dependent to some degree upon access to input terminals and appropriate training to use the system.

42.4. During this period the central governance team were piloting a new system of understanding complaints data with the London School of Economics. This eventually provided much more useful information around relevant themes rather than simple response time information.

UROLOGY SERVICES INQUIRY

USI Ref: S21 No 2 of 2022

Date of Notice: 3rd March 2022

Witness Statement of: Heather Trouton

I, Heather Trouton, will say as follows:-

1. I currently occupy the role of Executive Director of Nursing, Midwifery and Allied Health Professionals within the Southern Health and Social Care Trust ('the Trust').

2. This statement is made in response to Section 21 Notice No.2 of 2022. It is made to the best of my recollection at this point in time and on the basis of the documents available to me. I therefore acknowledge that I may not have a complete view of all relevant matters.

3. In making this statement, I have also had the benefit (with the express permission of the Inquiry) of assistance from the following persons in obtaining documents and information: Martina Corrigan, Katherine Robinson, Sharon Glenny, Eamon Mackle, Lesley-Anne Reid, Andrea Turbitt, Lynn Magee, Emma Stinson and Lynn Lappin.

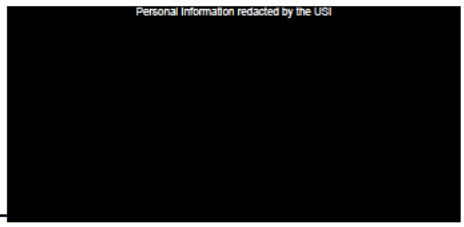
4. As required by Question 1, I have had regard to the Terms of Reference of the Inquiry and I consider that those which appear to be most relevant to my involvement in matters being investigated by the Inquiry are the first two (particularly the first one).

to grow and with an aging demographic, so we see Urology demand increasing. The Covid-19 pandemic has detrimentally affected all services including Urology.

519. With regard to the standard of clinical practice within the Urology team today, I have no reason to believe that the concerns regarding triage, record keeping, or patient notes at home are still issues. However, information on these issues does not currently come to the Senior Management Team or Trust Board for oversight. This should be considered.

Statement of Truth

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

Signed: _____ 

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Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 37 of 2022
Date of Notice: 3rd May 2022

Witness Statement of: Heather Trouton

I, Heather Trouton, will say as follows:-

1. Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. 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 using the form provided.

2. Provide any and all documents within your custody or under your control relating to paragraph (e) of the Terms of Reference except where those documents have been previously provided to the Inquiry by the SHSCT. Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

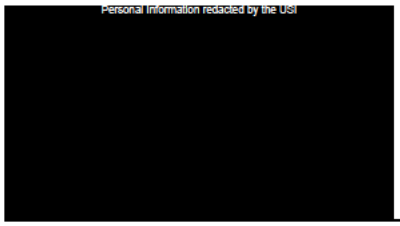
1. I currently occupy the role of Executive Director of Nursing, Midwifery and Allied Health Professionals within the Southern Health and Social Care Trust ('the Trust').

However I am given to understand that it was not able to be concluded prior to Mr. O'Brien's retirement and the MHPS processes and relevant Human Resources processes, such as the grievance procedure, took so long to complete that a conclusion was not reached.

Reviewing the process from December 2016 and June 2020 from the perspective of not being involved and with the benefit of hindsight, it would seem there was a missed opportunity through the process to fully investigate the consequences of Mr. O'Brien's administrative practices on the patient outcome, clinical journey, and experience. I think, on reflection, the process could have been used better to investigate more widely the implications of the concerns on patient safety.

Statement of Truth

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

Signed: ____ 

_____

Date: 8th June 2022

48. To the best of my knowledge the final letter was not shared with the Service Director or the Medical Director as they both were involved in agreeing the content, knew what it contained, and therefore there was no need to give them a copy of the letter at that point. I am unaware if the outcome of the meeting was shared with the Service Director or the Medical Director as I was not present at the meeting and therefore did not report back on same.

As per email from SHSCT to USI dated 30/01/2023 Mrs Trouton advises the following:-
"I now know that Mr Mackle did send the letter to Dr Wright on the 30th March 2016 (TRU-282022) although I wasn't copied into that email so I wouldn't have known." Annotated by Urology Services Inquiry.

10. When, and in what circumstances, did you first became aware of concerns, or receive any information which could have given rise to a concern that Mr O'Brien may have been affording advantageous scheduling to private patients.

49. To the best of my recollection, on occasion on receipt of a theatre list the Head of Theatres, Mrs Mary McGeough (now retired), would have noted to the Head of Service for Urology and ENT that there were patients listed for surgery with a very short wait from date of listing for a surgical procedure and the date of surgery and that these were also listed as private patients. This would have been a minority of patients and would have been noted on an intermittent basis. It is difficult to recall a date when this was brought to my attention but I believe it was later in my role as Assistant Director and it was not particularly frequently. However, in the interests of equality, on these occasions Mrs Corrigan would have asked Mr O'Brien regarding the short time frame between listing and surgery for these patients. I understand from Mrs Corrigan that Mr O'Brien was always able to justify to her, from a clinical perspective, the urgency for the surgical intervention. All theatre schedules are listed by the individual surgeon based on clinical acuity and urgency. In the majority of cases generally, patients designated as Red Flag are listed as a priority, followed by patients designated as urgent and then those designated as routine. As indicated above, I cannot recall precisely when I first became aware of these concerns during my tenure; however, I am content that, when raised as a concern, this was raised with Mr O'Brien by Mrs Corrigan for clinical validation.

Witness Statement

NAME OF WITNESS	**Mrs Heather Trouton**
OCCUPATION	Assistant Director of Acute, Integrated maternity women's health, cancer and clinical services
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Monday 5 June 2017
PRESENT AT INTERVIEW	Mrs Siobhan Hynds, Head of Employee Relations
NOTES	The terms of reference were shared prior to the date of statement.

1. My name is Mrs Heather Trouton. I am employed by the Southern Health and Social Care Trust as Assistant Director of Acute, Integrated maternity women's health, cancer and clinical services. I was appointed to this role in April 2016. I previously worked as Assistant Director of Surgery and Elective Care between September 2009 and 31 March 2016.

2. I have been asked to provide this witness statement in respect of an investigation into concerns about the behaviour and / or clinical practice of Mr Aidan O'Brien, Consultant Urologist being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework.

3. I agreed to answer questions specifically related to the terms of reference previously shared with me.

4. I explained that a new Director had taken up post within Acute Services in August 2015 and she decided to change the structure at a senior level within the Directorate. She wanted to have 3 clinical staff to operationally manage the Directorate. This resulted in an internal move and reduced Assistant Director roles from 7 to 5. Tracey Boyce and Anita Carroll remained in their roles. Simon Gibson went to the Medical Director's office and Barry Conway took up a role dealing with strategic reform. Anne McVey went to Medicine, I got women's services and Ronan Carroll got Surgery.

5. In respect of TOR 1, I advised that I wouldn't know the detail about un-triaged referrals but I am aware that MR O'Brien did not agree with triage and he made it clear that he didn't agree with

the 3 categories of referral. Mr O'Brien would have said red flags were important and the others were not important. He didn't agree with the system in place.

6. Many of us were aware that Mr O'Brien didn't agree with the system in place and so on weeks when he was due to do triage it was addressed with the clinical lead – his colleagues picked up the slack. It was not possible to get Mr O'Brien to do triage in a timely manner so a default position was adopted to ensure patients weren't waiting to be booked at all. I know it isn't satisfactory but it is what happened. The default position was known and agreed by the Director, the AMD, myself as AD and the Head of Service. It was felt that it was at least some safety measure.

7. I had numerous conversations with Mr O'Brien about triage, notes and his review backlog. He always disagreed with the triage. I would have said to him that that's the system in place and I would have tried to help him. Sometimes there was a change for a short period of time but then he reverted to his own way of doing things.

8. It has been a problem since I came into post, Michael Young was the Clinical Lead, Mr O'Brien the 2nd Consultant and the third person changed regularly so didn't have management input so there was not a lot of clinical challenge to Mr O'Brien. I addressed concerns about Mr O'Brien with Michael Young and he spoke to him. But it was the way it was under both Dr Rankin and Debbie Burns since 2009.

9. Did Mr O'Brien ever say he was not doing triage or clinic dictation, possibly, but it was never agreed he could not do it. There was a Urology review during this time and experts made recommendations at consultant level. Mr O'Brien did not agree with them. Mr O'Brien had his own view about things. He was clear about what he did not agree with and felt he needed more admin time generally, he handwrites everything. As an example, the way it generally works is that a Theatre list is agreed and the Consultant will ask their secretary to list the date and to organise and the secretary goes off to do that including arranging for the patient to attend. Mr O'Brien however insists on ringing every patient himself to attend but that is not what we need him to be doing. He wanted admin sessions to fit in with every aspect of what he wanted to do. He is already on a high number of PA's so to give additional time for admin is not sensible because he didn't use the admin support available to him. There was never an issue of other specialities doing triage.

10. When the issues were raised, Michael Young as the Clinical Lead would have said he would sort it out so it was left with him and he would have helped Mr O'Brien in his practice and so the issues were improved for a period of time.

11. While I was concerned about his practice I was content patients were being seen and red flags were being done. As most referrals came in as red flags I was satisfied patients were being seen. I did have a concern about upgraded referrals but there was no data to show how many were being upgraded so I felt relatively comfortable that patients coming in as red flags were being

seen. The numbers being upgraded were not that many and I felt the risk was relatively small for the one that may slip through. New urology colleagues were not willing to let him not triage.

13. I was involved in the conversation regarding the 23 March 2016 letter which was issued to Mr O'Brien. Mr O'Brien's general way of doing this is maverick. Every Director knew but nothing moved. I felt with the newly appointed Medical Director things might progress. There was a meeting held with Dr Wright on 11 January 2016 at 10 am and the concerns were outlined to him and I took his advice so we formally addressed the issues via a letter.

14. Some time ago Eamon Mackle tried to address the issues but Dr Rankin had said not to do anything further because a complaint had been received accusing Eamon Mackle of bullying and he was told he should not address further issues with Mr O'Brien. Eamon Mackle appointed Robin Brown to be a go between with Urology. Mr Brown made attempts too. Improvements were short term but then he went back to his behaviours again. There was a general view that Eamon Mackle was unable to deal with the issues because he was told not to. In my opinion Mr Young and Mr Brown felt uncomfortable holding Mr O'Brien to account.

15. I feel, their view was that he is a very intelligent man and a good doctor, therefore we could overlook small things. Trying to get peer and medical management support to deal with the issues was difficult to do.

16. The letter was sent to address issues regarding not triaging, his review backlog and notes at home. More recently there has been new appointments made and so there is a bigger urology team and there are members who were willing to peer challenge. The letter was given to Mr O'Brien and the expectation was that he would set out a plan as to how he was going to deal with the outstanding work.

17. I moved post on 1st April 2016, so I left it with Esther Gishkori and Ronan Carroll to deal with the action plan. I got nothing back directly from Mr O'Brien.

18. Mr O'Brien was outwith other Consultants I dealt with. I didn't come across any other surgeon who didn't agree with or partake in triage.

19. I know there was an issue with Mr O'Brien taking notes home because some were missing and Martina Corrigan had to chase these. Mr O'Brien was told he should not have notes at home. He was also told by Mr Young and Mr Brown. I shared an email of 22 January 2015 as an example of this issue which is appended to this statement. Mr O'Brien would bring them back but the process started again. I didn't know the number of charts he had or if it was a constant trickle. He should not have had any at home.

20. In respect of TOR 3, I was unaware that dictation was an issue until March 2016 when colleagues started doing validation of backlog. There has always been a review backlog in Urology but they have tended to hold on to patients to review the clinical decision. The review backlog for Mr O'Brien was particularly long. Others addressed theirs so Tony Glackin and Mark Haynes looked back to try to sort the issues. This was done on Patient Centre not via the notes. During that process they realised that nothing was on Patient Centre so that prompted my concern in March

2016. It was relatively close to when the 23 March letter went out. There was nothing recorded in the notes or on Patient Centre. This in my view was the most serious issue as we cannot have patients treated without records.

21. I cannot remember if this prompted me to look at the clinics, I'm sure Martina Corrigan did a review. Patients were still being treated but recoverable information was a problem. It was certainly outside of acceptable practice not to dictate. I don't know if there was a delay with clinical management plans for patients, he may have had his own way of managing things.

22. In respect of TOR 4, on some occasions when scrutinising lists because of pressures there were some patients on the list earlier than you would have expected but Mr O'Brien always had a clinical rationale as to why a particular patient was on the list. They were not necessarily all private patients but some were.

23. Mr Mackle, Dr Rankin, Debbie Burns, the AD, the HOS all had discussions with Michael Young and Robin Brown. The issues were repeatedly addressed but no lasting change resulted. There seemed to be no way of enforcing him to comply. I think the formal process did not happen because when the previous issue arose, Mr Mackle was warned off by Dr Rankin at that point and Mr Mackle then took a back seat.

24. From I came into post, it was very well known that Mr O'Brien did not comply with the management way of managing patients. There were repeated informal attempts to resolve with no real action happening. When addressing clinical practice we rely largely on peer support. I think he has some sympathy with some colleagues as he is really good with his patients. But more recently there is a bigger team able to stand up and say this is not good clinical practice.

This statement was drafted on my behalf by Mrs Siobhan Hynds, Head of Employee Relations and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.

This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a conduct or clinical performance hearing. I understand that I may be required to attend any hearing as a witness.

SIGNATURE	
DATE	

From: Trouton, Heather
Sent: 24 February 2021 13:50
To: Hynds, Siobhan
Subject: FW: Witness Statement - Mrs H Trouton 050617.pdf
Attachments: Witness Statement - Mrs H Trouton 050617.pdf

Siobhan just for noting as an appendix please .

Comments on statement by Heather Trouton 23/2/21

Correction - Point 5 – Mr O'Brien believed all categories of referral were important and that red flag referrals were of no greater importance than urgent referrals. He did not agree with the system in place .

Correction Point 9 – last sentence ' There was never an issue of other specialties NOT doing triage .

Correction Point 11 – I believe there was a clinical view at that time , there were very few referrals that were upgraded . As this process was discussed and agreed by the Clinical Director , AMD and Director we felt the risk was minimal and the balance of others being listed for an appointment was , on balance better .

Point 24 – Correction – I think he had the sympathy of some colleagues as he is really good with patients .

Thankyou

Heather

From: Hynds, Siobhan
Sent: 23 February 2021 11:21
To: Trouton, Heather
Subject: Witness Statement - Mrs H Trouton 050617.pdf

Heather

Patricia Kingsnorth asked me to send this to you.

Siobhan

Southern Health and Social Care Trust
Quality Care - for you, with you

Witness Statement

NAME OF WITNESS	**Mrs Heather Trouton**
OCCUPATION	Assistant Director of Acute, Integrated maternity women's health, cancer and clinical services
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Monday 5 June 2017
PRESENT AT INTERVIEW	Mrs Siobhan Hynds, Head of Employee Relations
NOTES	The terms of reference were shared prior to the date of statement.

1. My name is Mrs Heather Trouton. I am employed by the Southern Health and Social Care Trust as Assistant Director of Acute, Integrated maternity women's health, cancer and clinical services. I was appointed to this role in April 2016. I previously worked as Assistant Director of Surgery and Elective Care between September 2009 and 31 March 2016.

2. I have been asked to provide this witness statement in respect of an investigation into concerns about the behaviour and / or clinical practice of Mr Aidan O'Brien, Consultant Urologist being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework.

3. I agreed to answer questions specifically related to the terms of reference previously shared with me.

4. I explained that a new Director had taken up post within Acute Services in August 2015 and she decided to change the structure at a senior level within the Directorate. She wanted to have 3 clinical staff to operationally manage the Directorate. This resulted in an internal move and reduced Assistant Director roles from 7 to 5. Tracey Boyce and Anita Carroll remained in their roles. Simon Gibson went to the Medical Director's office and Barry Conway took up a role dealing with strategic reform. Anne McVey went to Medicine, I got women's services and Ronan Carroll got Surgery.

5. In respect of TOR 1, I advised that I wouldn't know the detail about un-triaged referrals but I am aware that MR O'Brien did not agree with triage and he made it clear that he didn't agree with

the 3 categories of referral. Mr O'Brien would have said red flags were important but that others were equally important , He didn't agree with the system in place.

Deleted: and the others were not important

6. Many of us were aware that Mr O'Brien didn't agree with the system in place and so on weeks when he was due to do triage it was addressed with the clinical lead – his colleagues often picked up the slack. Despite many requests it was not always possible to get Mr O'Brien to do triage in a timely manner so a default position was adopted to ensure patients weren't waiting to be booked at all. I know it isn't satisfactory but it is what happened. The default position was known and agreed by the Director, the AMD, myself as AD and the Head of Service. It was felt that it was at least some safety measure.

Deleted: I

7. I had numerous conversations with Mr O'Brien about triage, notes and his review backlog. He always disagreed with the triage. I would have said to him that that's the system in place and I would have tried to help him. Sometimes there was a change for a short period of time but then he reverted to his own way of doing things.

8. It has been a problem since I came into post, Michael Young was the Clinical Lead, Mr O'Brien the 2nd Consultant and the third person changed regularly so didn't have management input so there was not a lot of clinical challenge to Mr O'Brien. I addressed concerns about Mr O'Brien with Michael Young and he spoke to him. But it was the way it was under both Dr Rankin and Debbie Burns since 2009.

9. Did Mr O'Brien ever say he was not doing triage or clinic dictation, possibly, but it was never agreed he could not do it. Don't know what this means. There was a Urology review during this time and experts made recommendations at consultant level. Mr O'Brien did not agree with them. Mr O'Brien had his own view about things. He was clear about what he did not agree with and felt he needed more admin time generally, he handwrites everything. As an example, the way it generally works is that a Theatre list is agreed and the Consultant will ask their secretary to list the date and to organise and the secretary goes off to do that including arranging for the patient to attend. Mr O'Brien however insists on ringing every patient himself to attend but that is not what we need him to be doing. He wanted admin sessions to fit in with every aspect of what he wanted to do. He is already on a high number of PA's so to give additional time for admin is not sensible because he didn't use the admin support available to him. There was never an issue of other specialities doing triage.

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10. When the issues were raised, Michael Young as the Clinical Lead would have said he would sort it out so it was left with him and he would have helped Mr O'Brien in his practice and so the issues were improved for a period of time.

11. While I was concerned about his practice I was content patients were being seen and red flags were being done. As most referrals came in as red flags I was satisfied patients were being seen. I did have a concern about upgraded referrals but there was no data to show how many were being upgraded so I felt relatively comfortable that patients coming in as red flags were being seen. , New urology colleagues were not willing to let him not triage.

Deleted: The numbers being upgraded were not that many and I felt the risk was relatively small for the one that may slip through

13. I was involved in the conversation regarding the 23 March 2016 letter which was issued to Mr O'Brien. Mr O'Brien's general way of doing this is maverick. Every Director knew but nothing moved. I felt with the newly appointed Medical Director things might progress. There was a meeting held with Dr Wright on 11 January 2016 at 10 am and the concerns were outlined to him and I took his advice so we formally addressed the issues via a letter.

14. Some time ago Eamon Mackle tried to address the issues but Dr Rankin had said not to do anything further because a complaint had been received accusing Eamon Mackle of bullying and he was told he should not address further issues with Mr O'Brien. Eamon Mackle appointed Robin Brown to be a go between with Urology. Mr Brown made attempts too. Improvements were short term but then he went back to his behaviours again. There was a general view that Eamon Mackle was unable to deal with the issues because he was told not to. In my opinion Mr Young and Mr Brown felt uncomfortable holding Mr O'Brien to account.

15. I feel, their view was that he is a very intelligent man and a good doctor, therefore we could overlook small things. Trying to get peer and medical management support to deal with the issues was difficult to do.

16. The letter was sent to address issues regarding not triaging, his review backlog and notes at home. More recently there has been new appointments made and so there is a bigger urology team and there are members who were willing to peer challenge. The letter was given to Mr O'Brien and the expectation was that he would set out a plan as to how he was going to deal with the outstanding work.

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the notes or on Patient Centre. This in my view was the most serious issue as we cannot have patients treated without records.

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SIGNATURE	
DATE	

and with one child). Prior to entering nurse training, I worked in the electronics industry, Bloomer Electronics Craigavon, where I was qualified to HNC level in Electrical and Electronic Engineering. I have 8 GCSEs and 3 A levels (grades AAB).

[5] Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

86. My employment history with the Trust can be summarized as follows.

    a. I commenced employment on 20th May 1996 as a registered staff nurse in the Stroke Unit in Lurgan Hospital. I also worked as a staff nurse in the Nursing Development Unit in Lurgan Hospital (30th December 1996 to 14th December 1997) before transferring to Craigavon Area Hospital on 15th December 1997 to work in the Winter Ward (an acute medical ward) in Craigavon Area Hospital. When the Winter Ward closed on 6th April 1998, I returned to Lurgan Hospital to work as a staff nurse in the Continuing Care Ward until I went on maternity leave in June 1998. During my maternity leave I was offered a post in Ward 4 North, Surgical ward in Craigavon Area Hospital and returned from maternity leave on 18th October 1998 to take up that post. On 5th April 1999, due to family responsibilities, I asked for a reduction in contracted hours and was duly offered a part-time post in the neighbouring ward of 4 South in the hospital, another surgical ward. Neither ward managed urology patients but specialized in bowel and breast surgery. All of these nursing posts were at grade D level which is the equivalent of the current band 5 level and is the entry level for all registered nursing posts. The main duties of these posts were as follows - assessing, planning, implementing, and

Southern Health and Social Care Trust

Job Description

JOB TITLE	Assistant Director of Acute Services - Surgery and Elective Care Division
BAND	8C
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Director of Acute Services
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The jobholder will be responsible to the Director of Acute Services for the delivery of high quality care to patients in the Trust's Surgery and Elective Care Division. He/She will be responsible for the operational management of all specialties in the division. This will incorporate all surgical specialties: general surgery, ENT, breast, vascular, urology and T&O, colorectal, and outpatient services including Pre Operative Assessment in Craigavon Area Hospital, Daisy Hill Hospital and other settings as appropriate. He/She will collaborate closely with senior clinicians and other disciplines to implement the objectives of the Trust's Delivery Plan and ensure effective multidisciplinary working. He/She will provide clear leadership to all staff in the division and will be responsible for effective financial management and the efficient use of all resources. The jobholder will also support the Director of Acute Services with long term planning and service reform initiatives.

As an Assistant Director, the jobholder will be a member of the directorate's senior management team and will therefore contribute to policy development in the directorate and the achievement of its overall objectives.

KEY RESULT AREAS

Service Delivery

1. Lead multidisciplinary teams and oversee the co-ordination of all processes to ensure the delivery of high quality and equitable care to patients in the Trust's surgery and elective care division.

2. Ensure the successful implementation of all DHSSPS, HSSA and commissioning priorities and targets in the division with a particular emphasis on those relating to waiting times and the establishment of agreed treatment schedules.

3. Work closely with senior clinicians and other senior managers in the Trust to secure an appropriate balance between hospital and community based services and

Southern Health and Social Care Trust

Human Resource Management Responsibilities

37. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

38. Maintain staff relationships and morale amongst the staff reporting to him/her.

39. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

40. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

41. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

42. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

The post holder will be required to:

43. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

44. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

45. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

46. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

achieve an integrated approach in reducing inappropriate hospital admissions and lengths of stay.

4. Contribute to the development of robust clinical and professional networks within the division and across the Trust.

Quality and Governance

5. Ensure that the needs of patients and their carers are at the core of how all specialties in the division deliver their services and are in accordance with DHSSPS *Quality Standards for Health and Social Care* and other relevant requirements.

6. Ensure high standards of governance in the division to include compliance with controls assurance standards, the assessment and management of risk and the implementation of the DHSSPS's *Safety First* framework.

7. Ensure the division complies with all professional, regulatory and requisite standards.

8. Ensure the division meets all targets for the prevention and control of healthcare associated infection and standards of environmental cleanliness.

9. Ensure all recommendations from the RQIA and other regulatory bodies are implemented within requisite timescales.

10. Ensure the management of complaints within the division comply with HPSS and Trust complaints procedures and are underpinned by transparency and a culture of continuous improvement.

11. Lead on the implementation of quality initiatives such as Investors in People and Charter Standards in the division.

12. Ensure that the quality of the patient journey and experience is enhanced and improved by the Patient Support Service, working across all acute services/sites.

13. Provide leadership of the Quality and Patient Support Officer to ensure the Public and Personal Involvement and Health and Wellbeing Strategies are implemented to continually improve the quality of patient/client experience by involving users in shaping services and improving the health of the Trust's clients/patients.

14. Provide an early intervention service in the management of potential patient/client complaints and dissatisfaction by advocating independently on behalf of the patient/client and enhancing experiential learning by interfacing with the Acute Service Governance system.

patients, ensuring all appropriate Information Technology, staffing, systems, processes, planning, monitoring, provision of data, complaints management, and the management of all other team members was in place to support delivery of their clinical activity.

169. The primary interface in supporting the consultants/ clinicians in this work was through the Head of Urology and ENT.

170. I was a member of the Acute Clinical Governance Forum which met monthly and was chaired by the Director of Acute Services and was made up of all Acute Associate Medical Directors, Operational Assistant Directors and Governance leads. This forum reviewed clinical governance data, including serious adverse incidents investigation reports.

171. While I worked with Mr Mackle (AMD) to oversee the Urology Unit and its clinical governance as a whole, a key responsibility of the AMD role was regarding the clinical governance of the consultants and clinicians. Please see attached job description with relevant extracts detailed below. *See attached located in S21 No.2 of 2022, Associate Medical Director jd.*

172. The job description of the Associate Medical Director provides as follows:-

The appointee will provide clinical leadership in the Acute Services Directorate, Surgery/Elective Care Division for medical people management; reform and modernisation, patient and client safety, quality and standards; medical education and research governance.

• To contribute strategically as a member of the Directorate Management Team

• To provide clinical leadership to relevant medical staff in the Directorate and promote the corporate values and culture of the Trust.

• Ensure excellent communication between clinicians, Directorate management team and the Medical Directors Office

• To take responsibility for performance management including appraisal of designated clinicians

We will have to closely monitor the returns of the named referrals though and Anita can you please ask Katherine to let us know early if there are any problems arising?

Re charts at home, I think we all agree this is just not acceptable.

Thankyou all for your help

Heather

From: Young, Michael
Sent: 02 December 2013 15:28
To: Brown, Robin; Trouton, Heather
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Have spoken and offered help with the triage issue – will reinforce again this week

---

From: Brown, Robin
Sent: 30 November 2013 14:00
To: Young, Michael; Trouton, Heather
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Heather
I wonder if could you call me on the phone to discuss this
I had a lengthy one-to-one meeting with AOB in July on this subject and I talked to him again on the phone about it week before last.
I agree that we are not making a lot of headway, but at the same time I do recognise that he devotes every wakeful hour to his work – and is still way behind.
Perhaps some of us – maybe Michael Aidan and I could meet and agree a way forward.
Aidan is an excellent surgeon and I'd be more than happy to be his patient (that could be sooner than I hope!), so I would prefer the approach to be "How can we help".

Robin

From: Young, Michael
Sent: 26 November 2013 12:35
To: Trouton, Heather; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Understand
I will speak

From: Trouton, Heather
Sent: 26 November 2013 11:40
To: Young, Michael; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear Both

In confidence please see below.

I personally have spoken to Mr O'Brien about this practice on various occasions and Martina has also much more often. While we very much appreciate Aidan's response, I suspect that without further intervention by his senior colleagues it will happen again.

I also spoke to him not more than 4 weeks ago both about timely triage and having charts at home and he promised me he would deal with both, however we find today that patients are still with him not triaged from August , he would have known that at the time of our conversation yet no action was taken. I am also advised today that a further IR1 form has been lodged by health records as 6 charts cannot be found.

As stated by Aidan we have been very patient and have offered any help in the past with regard to systems and processes to assist Aidan with this task but it has not been taken up and the delays continue.

Despite the fact that patients sitting not triaged from August mean that we have breached the access standard before we even start to look for appointments I am more concerned about the clinical implications for patients who need seen urgently and possibly even needing upgraded to a red flag status.

We really need you to speak with Mr O'Brien both in the capacity of a colleague but also in your capacity of Clinical lead and Clinical Director for Urology as well of course as patient advocates.

I also really need a response within 1 week on how this is being addressed for now and the future or I will be forced to escalate to Debbie and Mr Mackle as Director and AMD for this service. It has already been suggested that Dr Simpson be involved which I have not progressed to date but it may have to come to that unless a sustainable solution can be found.

Thank you for your assistance

Heather

From: Corrigan, Martina
Sent: 26 November 2013 08:02
To: Robinson, Katherine; Glenny, Sharon
Cc: Trouton, Heather
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear both

Please see below – Katherine can you advise if you receive these?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: O'Brien, Aidan
Sent: 26 November 2013 02:08
To: Corrigan, Martina
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE