Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No.41 of 2022
Date of Notice: 29th April 2022

Witness Statement of: Dr Neta Chada

I, Neta Chada, 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.

1.1 Response: My name is Neta Chada. I was awarded a medical degree in June 1988 from Queens University Belfast and progressed to Membership of the Royal College of Psychiatrists in 1994 and then was appointed Fellow of the College in 2008.

1.2 I have previously held posts as the Northern Ireland Medical and Dental Training Agency/ Royal College of Psychiatrists Regional Advisor for Postgraduate Studies in Psychiatry, the Deputy Chairman of the NI Division of the Royal College of Psychiatrists and have been a member of the NI Mental Health Review Tribunal.

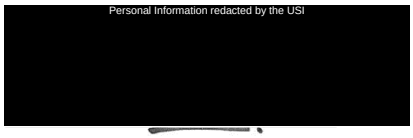
during the investigation were the emails to Dr Khan from the Service Manager Mr Carroll in May or June 2017.)

18.5 I was not involved with this process beyond the conclusion of the Investigation Report in the spring of 2018. The following year I was advised that, whilst the MHPS Case Manager Determination notified to Mr O'Brien in October 2018 had been that a referral to the GMC was not appropriate until internal processes were concluded, (as the Case Manager was awaiting outcomes of further SAI reviews), I received an email in September 2019 indicating discussion with the Trust's GMC Liaison Officer led to the Trust being asked to make a referral to the GMC. Subsequently, there were further queries from the GMC about the investigation, some of which I was asked to provide answers for. (*20190609 - Email - URGENT FOR RESPONSE TOMORROW Letter to GMC from Medical Director, 20190609 - Attachment - Letter to MD from GMC 23 May 2019, 20190609 - Attachment - Draft letter from MD to GMC 10 June 2019 located at Relevant to HR, Evidence after 4 November HR, Reference 77, S Hynds No 77*)

18.6 I am not aware of anything else that would assist this Inquiry.

Statement of Truth

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

Signed: 

Date: ___24.6.2022_____

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No.41 of 2022
Date of Notice: 29th April 2022

Addendum Witness Statement of: Dr Neta Chada

I, Neta Chada, will say as follows:-

1. I wish to make the following amendments to my existing response, dated 24th June 2022, to Section 21 Notice number 41 of 2022.

2. At paragraph 8.4 WIT-23774 I have stated, '*I had no direct contact with the Medical Director (Dr Richard Wright) other than when I was asked to engage in the investigation process when the previous Case Investigator had to be replaced*'. Having considered the extract from Dr Wright's witness Statement to the Inquiry at 7.3 iii (which can be found at TRU18427- TRU 18428), Dr Wright states, '*Dr Chada (the new case Investigator) was an Associate Medical Director with extensive experience in carrying out similar MHPS investigations. I would have interacted with her on multiple occasions over the relevant time period, however, not specifically in relation to the Urology MHPS investigation. I do recall asking her on at least one occasion how the MHPS investigation was proceeding and hearing that the investigation was behind schedule because of difficulty in agreeing interview dates with Mr O'Brien. I was not surprised or unduly concerned as in my experience this is a common area of difficulty with MHPS investigations*.'

3. I did not recall this discussion until I read Dr Wright's statement. I do, however, now recall that I did speak to Dr Wright informally about how the investigation was progressing at an AMD meeting (Associate Medical Directors/Management meeting) that we were both attending. I explained that it was slow and outlined

the reasons for this. This was not an in-depth discussion and was essentially a mention 'in passing'.

Statement of Truth

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

Personal Information redacted by the USI

Signed: Dr N Chada., FRCPsych.
Consultant Psychiatrist

Date: 20.03.2023

Urology Services Inquiry

11. Outline all steps you took, information you considered and advice you received from the designated HR Manager, NCAS or any other person in preparing the investigation report into concerns relating to Mr. O'Brien dated 12th June 2018.

11.1 I met with Mrs Hynds and we considered the Terms of Reference and the information that was required in order for us to be able to fully address the issues raised in the Terms of Reference. I established what audits and reviews were being undertaken/needed to be undertaken to gather the information. We discussed the timeframe and the fact information needed to be gathered to ensure we could appropriately put questions to Mr O'Brien. Mrs Hynds and I went through the Maintaining High Professional Standards process and Guidelines. Mrs Hynds clarified the training I had received. She advised me NCAS had already been consulted.

11.2 As part of the investigation, face-to-face interviews were carried out with a number of witnesses. Statements were produced and the witnesses were asked to factually check their statements. The information gathered from audits, reviews, SAIs, clarification about undictated clinics and missing records was gathered. The information about Mr O'Brien's private patients was gathered and Consultants were asked to comment on whether those patients should have been added to theatre lists at that particular time, and to consider what triage rating they would have given to referral letters which had been allocated to Mr O'Brien for triage but which had not been triaged by Mr O'Brien.

11.3 Mrs Hynds advised me of the timeline of the investigation to date and outlined the meetings that had already been undertaken with Mr O'Brien. She advised me Mr O'Brien had initially been immediately excluded and had been asked to return all casenotes and undictated charts/dictation from his home. She indicated Mr O'Brien's exclusion was subsequently lifted and it was planned that Mr O'Brien would return to work with a clear management plan for supervision and clear monitoring arrangements. Mrs Hynds also advised me Mr O'Brien had been off work due to unrelated health problems. I am not aware of the parameters under which Mr O'Brien returned to work, or whether they were adhered to. This was not my role under MHPS.

Unfortunately, with Case Investigators, Case Managers, and SAI Chairs facing the prospect of being called to a Coroner's Court or Public Inquiry, it seems likely these roles are going to have to be formalized, as it would be difficult to imagine people would continue to volunteer. There is a significant amount of time involvement in these processes which is time taken away from frontline services, at a time when Trusts are under so much pressure. Answering these 17 questions alone has taken many hours of reviewing notes and records and away from other work. That is not to say we don't strive to improve and to learn, but how we do that more efficiently along with addressing increasing clinical demand is the conundrum.

18.3 In providing my answers above I have not gone into the detail which is contained in the investigation report itself which I understand is already available to the Inquiry Team, nor the detail provided in the witness statements, which are lengthy and detailed. (The Inquiry Team has also been provided with all the witness statements.) Whilst I believe a number of different people knew there were issues with Mr O'Brien's practice, I formed the impression different people knew different things at different times, and the pressures on workload, waiting lists and changes of personnel meant that no-one (in my opinion) appeared to be aware of the full extent of the issues. Once the extent of the issues became more apparent it does seem the Trust management system attempted to address those issues with Mr O'Brien, and my impression was that he thwarted them by making complaints, hinting at legal action and trying to deflect/distract. At interview he was arrogant at times, and I believe there were subtle attempts to intimidate, for example, by bringing along a relative who was a practicing barrister and sending an email enquiring about my qualifications to lead such an investigation, whether I had revalidated, was up-to-date with my CPD, etc. (I believe the email was sent to Medical Director or Dr Khan, which I think was after the investigation was completed.)

18.4 I understand Mr O'Brien was allowed to return to work under supervision and with monitoring. I was copied into some emails during the process of the investigation indicating that the supervision and monitoring was progressing reasonably well, though I note other managers had indicated when they had raised issues with Mr O'Brien in the past in an informal way his practice would often improve for a period but then slip back. I am unaware of how he progressed on his return as I was not advised of that. (I believe emails of progress

Southern Health and Social Care Trust

Medical Leadership Network

Handling Concerns Workshop
24th September 2010

Southern Health and Social Care Trust

Objectives

- To understand the Trust's guidance on Handling Concerns
- To discuss the internal and external support available for CDs and AMDs
- To clarify the CD and AMD roles in applying the Guidance

Workshop Outline

- Background to workshop – Dr Loughran
- NCAS – Dr Colin Fitzpatrick
- Trust Guidance– Vivienne Toal and Siobhan Hynds
- Case Studies to explore CD and AMD roles

National Clinical Assessment Service

Case investigator training workshop

For Southern Health and Social CareTrust

Tuesday 07 – Wednesday 08 March 2017

09:15-16:45 (Day 1) and 09:00-16:00 (Day 2)

Seagoe Parish Centre, 46 Seagoe Road, Portadown, BT63 5HS

DRAFT DELEGATE PROGRAMME

This two-day workshop has been designed specifically for anyone who undertakes the case investigator role in investigations about practitioners, which may emerge from the processes underpinning revalidation or from concerns raised about performance. The workshop is interactive and uses case studies to explore and develop the key skills and knowledge required by case investigators.

Learning objectives

By the end of the two-day programme, delegates will be able to:

- Explore how concerns about a practitioner's practice arise and identify the most common factors affecting performance
- Explain why the decision to investigate is made and suggest other options to resolve performance concerns
- Describe roles and responsibilities of those involved in investigations
- Plan for an investigation which meets national requirements
- Describe the principles of robust and meaningful terms of reference and know how to work within them
- Collect, review and weight evidence
- Conduct an investigative interview using a structured approach
- Recognise the key skills and attributes of a case investigator
- Recognise their own limits of competence and access sources of support and expertise
- Reference relevant national/local standards
- Write an investigation report with conclusions
- Describe the potential legal challenges to an investigation.

Pre-reading

Questions to consider prior to attending the workshop:

- What is the role of the Case Investigator?
- When might an investigation of a concern be necessary?
- What is the purpose of an investigation?

the doctors involved showed good insight into the issue and a willingness to accept and address the issue.

6.3 I have been provided with the following detail from the Medical HR Manager, Mrs Zoe Parks:- (Her email in full to me May 2022)

To the best of my knowledge, I have you down for the following (6 cases). There were also a few other investigations that I know you were involved with, but they weren't managed/investigated under MHPS as such, such as the Dr AS queries into training in O&G DHH.

1.	Dr XX 2021 ********	CI: N Chada	CM: ******* HR *****	NED
2.	Dr XX 2019 GMC	CI: ****	CM: N Chada HR *****	Bank Locum so referred
3.	DR XX 2016 ********	CI: N Chada	CM: ****** HR *****	NED:
4.	Dr XX 2013 assigned	CI: N Chada	CM ***** HR ******	NED
5.	Dr XX 2013 assigned	CI: N Chada	CM ***** HR *****	NED
6.	Dr XX 2013 assigned	CI: N Chada	CM: ****** HR ******	NED

7. If you were not aware of or had not previously implemented or applied MHPS and/or the Trust Guidelines, what was your understanding of how you should address concerns relating to the performance of clinicians?

7.1 Not applicable.

8. Outline how you understood the role of Case Investigator was to relate to and engage with the following individuals under the MHPS Framework and the Trust Guidelines:

- **I. Clinical Manager;**
- **II. Case Manager;**
- **III. Chief Executive;**
- **IV. Medical Director;**

26. At any point in the process where the Medical Director has reached a judgment that a practitioner is to be the subject of an exclusion, the regulatory body should be notified. Guidance on the process for issuing alert letters can be found in circular HSS (TC8) (6)/98. This framework also sets out additional circumstances when the issue of an alert letter may be considered.

27. Section II of this framework sets out the procedures to be followed should a formal investigation indicate that a longer period of formal exclusion is required.

FORMAL APPROACH

28. Where it is decided that a formal approach needs to be followed (perhaps leading to conduct or clinical performance proceedings) the CE must, after discussion between the Medical Director and Director of HR, appoint a Case Manager, a Case Investigator and a designated Board member as outlined in paragraph 8. The seniority of the Case Investigator will differ depending on the grade of practitioner involved in the allegation. Several Case Investigators should be appropriately trained, to enable them to carry out this role.

29. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its' costs and resulting action.

30. At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied to any interview or hearing by a companion. The companion may be another employee of the HSS body; an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but he or she will not, however, be acting in a legal capacity.

The Case Investigator's role

31. The Case Investigator:

- must formally, on the advice of the Medical Director, involve a senior member of the medical or dental staff[3] with relevant clinical experience in cases where a question of clinical judgment is raised during the investigation process;
- must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided. Patient confidentiality needs to be maintained. It is the responsibility of the Case Investigator

[3] Where no other suitable senior doctor or dentist is employed by the HSS body a senior doctor or dentist from another HSS body should be involved.

to judge what information needs to be gathered and how (within the boundaries of the law) that information should be gathered;

- must ensure that sufficient written statements are collected to establish the facts of the case, and on aspects of the case not covered by a written statement, ensure that there is an appropriate mechanism for oral evidence to be considered where relevant;
- must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Medical Director with advice from the Director of HR;
- must assist the designated Board member in reviewing the progress of the case.

32. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work. They may not be a member of any disciplinary or appeal panel relating to the case.

33. The Case Investigator has wide discretion on how the investigation is carried out, but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Information gathered in the course of an investigation may clearly exonerate the practitioner, or provide a sound basis for effective resolution of the matter.

The Case Manager's role

34. The Case Manager is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority

35. The practitioner concerned must be informed in writing by the Case Manager, that an investigation is to be undertaken, the name of the Case Investigator and the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people whom the Case Investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the Case Investigator and given the opportunity to be accompanied.

36. If during the course of the investigation, it transpires that the case involves more complex clinical issues (which cannot be addressed in the Trust), the Case Manager should consider whether an independent practitioner from another HSS body or elsewhere be invited to assist.

Timescale and decision

37. The Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days. The Case Manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the Case Investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.

38. The report should give the Case Manager sufficient information to make a decision on whether:

- no further action is needed;
- restrictions on practice or exclusion from work should be considered;
- there is a case of misconduct that should be put to a conduct panel;
- there are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer;
- there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS ;
- there are serious concerns that fall into the criteria for referral to the GMC or GDC;
- there are intractable problems and the matter should be put before a clinical performance panel.

CONFIDENTIALITY

39. Employers must maintain confidentiality at all times, and should be familiar with the guiding principles of the Data Protection Act. No press notice can be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. They may only confirm that an investigation or disciplinary hearing is underway.

40. Personal data released to the Case Investigator for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter.

TRANSITIONAL ARRANGEMENTS

41. On implementation of this framework, the new procedures must be followed, as far as is practical, for all existing cases taking into account the stage the case has reached.

1.3 I was appointed as a Consultant Psychiatrist to the Southern Health and Social Care Trust on 1st February 1999. I remained in that role until 2nd March 2020 when I retired, though I returned on 25 March 2020 for a further period (until June 2021) to assist through the Covid pandemic.

1.4 I had successfully interviewed for the Clinical Director in Mental Health and Disability post and then later the Associate Medical Director post. I believe my Associate Medical Director in Mental Health and Disability role started in approximately 2011.

1.5 I was unaware of any issues with Mr O'Brien's practice until I was approached by the Medical Director, Dr Richard Wright in late February 2017 and asked to take over as a Case Investigator under the Maintaining High Professional Standards Framework (MHPS). I was assisted as Case Investigator by Mrs Siobhan Hynds a senior member of staff from Employee Relations.

1.6 I was advised issues had first been raised by clinical and non-clinical managers with Mr O'Brien in March 2016 in relation to areas of his practice. I was advised after that meeting Mr O'Brien was sent a letter detailing the concerns discussed and asking him to respond with a plan to address the issues. (Later Mr O'Brien advised me at interview that he did not reply to the letter but did respond to concerns by making changes in his practice.) Subsequently Mr O'Brien was off with unrelated sickness absence. I was provided with the paperwork related to the investigation to date including the Preliminary Report by the previous Case Investigator, Mr Colin Weir dated January 2017, the letters sent to Mr O'Brien by the Mr Weir in his role, and the letters to him from Dr Richard Wright the then Medical Director. (I understand all of these have been provided to the Inquiry.)

1.7 Through the investigation I was advised a Serious Adverse Incident (SAI) carried out towards the end of 2016 identified an untoward patient outcome in a patient whose referral letter had not been triaged by Mr O'Brien as per Trust processes. I later discovered through information provided and his statement, the SAI had been chaired by one of the other urologists, Mr Glackin, who realised during the review that the patient's referral letter had not been triaged. The concerns arising from the SAI were brought to the attention of the Medical Director and an investigation was progressed.

1.8 I was informed by Dr Wright that Mr Colin Weir, Consultant Surgeon, was initially appointed as a Case Investigator assisted by Mrs Siobhan Hynds. I was told Dr Wright sought advice from the National Clinical Assessment Service in December 2016, noting there had been a failure to resolve issues informally. Following advice from the National Clinical Assessment Service, Mr O'Brien was immediately excluded in line with Maintaining High Professional Standards Framework to allow for preliminary inquiries/investigation to be undertaken. Dr Khan, Associate Medical Director in Maternity and Children's Services was appointed as the Case Manager and Mr Weir as the Case Investigator.

1.9 I was told Mr O'Brien was asked to return all case-notes and all undictated outcomes from clinics. Mr O'Brien did so, though there remained some missing sets of case records which the Trust continued to pursue with him.

1.10 I was advised to speak to Mrs Hynds who had been involved and was aware of details of the process to date. I was advised at the end of the four-week immediate exclusion period, and the completion of the preliminary investigation by Mr Weir, it was felt there was a case to answer in respect of the concerns identified. The matter of the immediate exclusion was also considered, and it was felt this could be lifted provided there was a clear management plan in place to supervise and monitor particular aspects of Mr O'Brien's work. (This is all information I was told by either Dr Khan or Mrs Hynds, and then later confirmed from reading the file information that was provided.)

1.11 I was appointed as Case Investigator in place of Mr Weir in approximately February 2017. I was advised Mr Weir had been a manager within the specialty and therefore might have been required to be interviewed, and therefore it was felt appropriate he should step aside.

1.12 The Terms of Reference (ToR) had already been formulated and were shared with me. These are included in the Trust's discovery and in my Investigation Report. Mrs Hynds asked the Case Manager, Dr Khan, to share these ToR with Mr O'Brien.

Corrigan, Martina

From: Hynds, Siobhan [redacted]
Sent: 02 March 2017 23:53
To: Chada, Neta
Subject: MHPS Case Correspondence
Attachments: 17 01 JAN.6th.ltr to Mr O'B following meeting on 30th Dec.pdf; 17 02 FEB.7th.Note of Meeting with Mr AOB JW.docx; 17 02 FEB.7th.Note of Meeting with Mr AOB_AOB submission JW.pdf; Action note - 10th January - AOB FINAL.docx; Action note - 22nd December - AOB.docx; Action note - 26th January - AOB FINAL.docx; Confidential - NCAS Letter - AOB (201 KB); Draft letter from Case Manager re initial meeting 19 January 2017.docx; RE: Confidential - AOB (39.1 KB); Final letter from Medical Director re AOB letter of 17th January.docx; Letter from Case Investigator to Mr A O'B 20 January 2017.docx; Letter from Case Investigator to Mr A O'B 23 January 2017.docx; Letter from Case Manager to Mr A O'B 06 February 2017.docx; Letter from Case Manager to Mr A O'B 24 February 2017.docx; Letter from NED to Mr A O'B 10 February 2017 DRAFT1.docx; Letter to A O'Brien from E Mackle 23 March 2016.pdf; letter to aob 18 january 17 enclosing notes of 30 dec meeting.docx; letter to aob 30 Dec.docx; Note of Meeting with Mr Aidan O'Brien 24 January 2017.docx; Note of Meeting with Mr Aidan O'Brien 30 December 2016.docx; Preliminary report from Case Investigator 26 January 2017 FINAL.docx; Return to Work Action Plan February 2017 FINAL.docx; Update from preliminary investigation - 24 January 2017.docx

Dr Chada

Please see attached for your information. I will send through a series of e-mails with all relevant information.

I think perhaps you should give Mr O'Brien a call to introduce yourself as the case investigator and to re-assure him that we are moving forward with the investigation.

Regards,

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: [redacted] Mobile: [redacted] Fax: [redacted]

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

NHS
National Clinical Assessment Service

NCAS
N I office
HSC Leadership Centre
The Beeches
12 Hampton Manor Drive
Belfast
Co Antrim
BT7 3EN

Tel: 028 90 690 791

www.ncas.nhs.uk
Personal information redacted by the USI

13 September 2016

PRIVATE AND CONFIDENTIAL
Sent by email only

Mr Simon Gibson
Assistant Director
Southern Health and Social Care Trust
Craigavon Area Hospital
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ

NCAS ref: 18665 (Please quote in all correspondence)

Dear Mr Gibson

I am writing following our telephone discussion on 7 September. Please let me know if I have misunderstood anything as it may affect my advice.

You called to discuss a consultant urologist who has been in post for a number of years. You described a number of problems. He has a backlog of about 700 review patients. This is different to his consultant colleagues who have largely managed to clear their backlog.

You said that he is very slow to triage referrals. It can take him up to 18 weeks to triage a referral, whereas the standard required is less than two days.

You told me that he often takes patient charts home and does not return them promptly. This often leads to patients arriving for outpatient appointments with no records available.

You told me that his note-taking has been reported as very poor, and on occasions there are no records of consultations.

To date you are not aware of any actual patient harm from this behaviour, but there are anecdotal reports of delayed referral to oncology.

The doctor has been spoken to on a number of occasions about this behaviour, but unfortunately no records were kept of these discussions. He was written to in March of this year seeking an action plan to remedy these deficiencies, but to date there has been no obvious improvement.

We discussed possible options open to you. The Trust has a policy on removing charts from the premises and it would appear that this doctor is in breach of this policy. This could lead to disciplinary action. He was warned about this behaviour in the letter sent to him in March so it would be open to you to take immediate disciplinary action; however, I would suggest that he is asked to comply immediately with the policy.

With regard to the poor note-taking it would be useful to conduct an audit. If there is evidence of a substantial number of consultations for either inpatients or outpatients with no record in the notes, this is a serious matter which may merit disciplinary action and possible referral to the GMC. If, after the audit, it appears that the concern is more about the quality of the notes rather than whether there are any notes at all, a notes review by NCAS may be appropriate. If you wish us to consider that, please get back to me.

The problems with the review patients and the triage could best be addressed by meeting with the doctor and agreeing a way forward. We discussed the possibility of relieving him of theatre duties in order to allow him the time to clear this backlog. Such a significant backlog will be difficult to clear, and he will require significant support. I would be happy to attend such a meeting, if this was considered helpful.

Relevant regulations/guidance:

- Local procedures;
- General Medical Council Guide to Good Medical Practice;
- Maintaining High Professional Standards in the Modern HPSS (MHPS).

Review date:

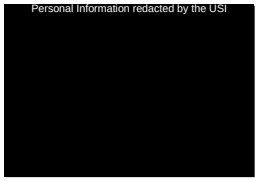
7 October 2016.

As it seems likely that further NCAS input will be required, we will keep this case file open and review the situation in about one month. If you require further advice in the meantime, please do not hesitate to contact me.

If you have any further issues to discuss, or any difficulties with these arrangements, please contact the Northern Ireland office on the direct line above.

I hope the process has been helpful to you.

Yours sincerely



Dr Colin Fitzpatrick
NCAS Senior Adviser

cc: Jill Devenney, Case Officer (N I)

Please ensure that any information provided to NCAS which contains personal data of any type is sent to us through appropriately secure means.

1.13 A list of witnesses was agreed by Mrs Hynds and I after reviewing the Terms of Reference. I quickly realized this would only be a few of the people who would need to be interviewed. The list was shared with Mr O'Brien with the information that this was an initial list, and we may identify others in the course of the investigation as it progressed. I am unable to recollect exactly how the witness list was put together. Certainly, I am aware of having input into the witness list, in that I realised we needed to speak to the current managers of the service to begin with (Mr Ronan Carroll and Ms Martina Corrigan), as well as the Clinical Director (Mr Young) to understand how the service functioned and his account of the issues. Having read the investigation and chronology to date, I felt it was important also to interview Mr Eamon Mackle, who had previously been the Clinical Director and whom I understood had raised issues with Mr O'Brien previously, as well as Mr Weir who also had clinical managerial responsibility more recently.

1.14 The list of witnesses grew as I gained more information from the first interviews and, by April, a further eleven (approximately) witnesses had been identified whom I believed could inform the investigation.

1.15 Dr Khan regularly emailed Mrs Hynds and me about the investigation to ask about progress and to keep track of the investigation timeline. Mrs Hynds kept Dr Khan updated with the interviews and the progress of the other information-gathering that was being undertaken, for example, the information on untriaged referrals and whether they had been examined by other urologists and what the outcome was, and the undictated clinics, etc.

1.16 I realized this was creating a lot of additional work for the urologists, and I suggested via Mrs Hynds that Dr Khan should approach Dr Wright and discuss the possibility of further assistance to move that part of the investigation on more quickly. I felt it was important we had as much information as possible before we met Mr O'Brien so that he would know the extent of the issues and have an opportunity to address those concerns. This information is all included in emails from Mrs Hynds to Dr Khan through the course of the investigation and I understand the Inquiry Team has been provided with those.

1.17 It became clear this was a complex and far-reaching investigation and we would not meet the (frankly totally unrealistic) timeframes suggested by the MHPS framework. The

Case Manager was advised of this, and we agreed to keep him updated on at least a monthly basis.

1.18 If issues were raised by witnesses which we felt pertained to the service and needed to be addressed even before the Investigation was completed, we raised these with Dr Khan. An example of this is when one of the witnesses indicated Mr O'Brien was not assigning clinical priorities to his theatre list, making it difficult to know how to sort the lists if theatre sessions to be cancelled to adjusted for some other reasons. I was advised this clinical prioritization was routine with the rest of the Surgeons. (Paragraphs 1.15-1.17 are covered in an email dated 12 April from Mrs Hynds to Dr Khan *located in Relevant document can be located at Relevant to PIT/ Evidence Added or Renamed 19 01 2022/ Evidence no 77/ No 77 – Dr Neta Chada/ 20170412 – E MPHS Case Update).* I understand Dr Khan, as Case Manager, asked for updates on Mr O'Brien's compliance with the action plan which had been put to him by the Trust. Oversight of this part of the process was not in my remit as the Case Investigator as outlined in MHPS.

1.19 In parallel to the witness interviews, I was also given regular updates on the progress of the gathering of the information in relation to each of the Terms of Reference, as this assisted in some of the questions I had for witnesses and was needed to understand the extent of the concerns. I was also copied into updates to Dr Khan from managers on whether any further charts had been removed/clinics not dictated etc.

1.20 When I took over as Case Investigator, I believe I was advised of four Terms of Reference, as outlined in the Trust's discovery documents. However, as the information was being gathered it became clear to me that a further Term of Reference needed to be considered. ToR 5 was to determine to what extent any of the above matters were known to managers within the Trust prior to December 2016, when the outcome of the SAI was shared with the Medical Director, and to determinate what actions were taken to manage any concerns. I believe I added this ToR by mid-March 2017.

1.21 Some witnesses wanted details of the agenda of the meetings and were sent the Terms of Reference when they were invited to the interview.

NHS
National Patient Safety Agency
National Clinical Assessment Service

How to conduct a local performance investigation

3. Managing the investigation

The investigation starts once its terms of reference are finalised and when a case manager and investigator(s) have been appointed. Once the decision is taken to hold an investigation there should normally be discussion with the practitioner to secure as much engagement as possible. The practitioner should be made aware of the terms of reference and who the proposed case manager and investigator(s) are so that any objections can be raised.

The organisation can then:

- **finalise terms of reference;**
- **appoint a case manager;**
- **appoint case investigator(s).**

The investigator(s) will:

- **collect evidence;**
- **interview the practitioner;**
- **weigh the evidence and identify the facts of the case.**

3.1 Finalise terms of reference

These will have been agreed in outline at the time a decision was made to carry out the investigation, but some final drafting may be needed. The terms of reference as finally drafted should be agreed by the organisation's relevant decision-maker(s). The case manager and investigator(s) appointed to manage and carry out the investigation (see next sections) would not normally be involved in this process.

Terms of reference should be tight enough to prevent an unfocused general investigation of everything concerning the practitioner. It may be appropriate to specify areas not to be investigated as well as the areas where evidence and commentary are expected. Box 4 suggests a format.

Box 4 – Terms of reference for an investigation

An investigation is commissioned into the performance of [practitioner's name], working as a [practitioner's job title] for [organisation's name], at [workplace address].

The matters to be investigated are [ ].

The following matters are excluded from the investigation [ ].

It is expected that the investigation will be completed by [date] and that a report will be submitted to [named manager] by [date].

The report should detail the investigation's findings of fact and include a commentary on how the performance of [practitioner's name] compares with that expected from a practitioner working in similar circumstances.

Corrigan, Martina

From: Hynds, Siobhan [redacted]
Sent: 03 March 2017 00:19
To: Khan, Ahmed
Cc: Chada, Neta
Subject: MHPS Case
Attachments: Terms of Reference for Investigation January 2017 DRAFT FINAL.docx

Dr Khan

Please see attached draft Terms of Reference for your agreement. These need to be issued to Mr O'Brien when agreed.

Did you get speaking with Grainne Lynn, NCAS about the action plan?

Thanks

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: [redacted] Mobile: [redacted] Fax: [redacted]

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TERMS OF REFERENCE FOR INVESTIGATION

January 2017
A formal investigation has been initiated into concerns relating to Mr Aidan O'Brien, Consultant Urologist. The concerns relate to Mr O'Brien's administrative practices, and the potential for patients to have come to harm as a result of those administrative practices. The under noted terms of reference set out the scope of the investigation.

Grade:	Consultant, Urology
Base Hospital:	Southern Health & Social Care Trust Craigavon Area Hospital
The matters to be investigated:	***The below outlines the issues of concern to be investigated, this does not preclude investigation of any further issue of concern which may arise during the course of the investigation.*** ***Matters to be investigated:*** **1. (a) To determine whether there have been unacceptable and/or unreasonable delays in the triaging of outpatient/GP letters by Mr O'Brien, and whether patients have come to harm, or had un-necessary delays in treatment, as a result.** **(b) To determine if triaging delays would be considered well outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.** **2. To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust. To determine whether patient notes have been stored at home by Mr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties. To determine if any patient notes are missing.** **3. To determine whether there has been an unreasonable delay or a delay well outside acceptable practice by Mr O'Brien in dictating outpatient clinics, and whether there may have been delays in clinical management plans for these patients as a result.** **4. To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority.**

Corrigan, Martina

From: Hynds, Siobhan [redacted]
Sent: 15 March 2017 00:01
To: Khan, Ahmed
Cc: Chada, Neta
Subject: Terms of Reference for Investigation FINAL
Attachments: Terms of Reference for Investigation FINAL.docx; Witness List - MHPS AO'B.xlsx

Importance: High

Dr Khan

Please find attached final draft of TOR for the AO'B investigation. Please also find the proposed witness list to date although it is likely Dr Chada will need to speak to others. Once we have others determine we will update Mr O'Brien.

If you are in agreement with the drafted TOR can you please share with Mr O'Brien. Dr Chada and I are beginning the first of our meetings with witnesses this week.

Thanks

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: [redacted] Mobile: [redacted] Fax: [redacted]

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TERMS OF REFERENCE FOR INVESTIGATION

A formal investigation has been initiated into concerns relating to Mr Aidan O'Brien, Consultant Urologist. The concerns relate to Mr O'Brien's administrative practices, and the potential for patients to have come to harm as a result of those administrative practices. The under noted terms of reference set out the scope of the investigation.

Grade:	Consultant, Urology
Base Hospital:	Southern Health & Social Care Trust Craigavon Area Hospital
The matters to be investigated:	***The below outlines the issues of concern to be investigated, this does not preclude investigation of any further issue of concern which may arise during the course of the investigation.*** ***Matters to be investigated:*** **1. (a) To determine if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process.** **(b) To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay in treatment as a result.** **(c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.** **(d) To determine if any un-triaged patient referrals or delayed triages in 2015 or 2016 resulted in patients being harmed as a result.** **2. (a) To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust.** **(b) To determine if any patient notes have been stored at home by Mr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.** **(c) To determine if any patient notes tracked to Mr O'Brien are missing.** **3. (a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'Brien in 2015 or 2016.** **(b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'Brien in dictating outpatient**

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TERMS OF REFERENCE FOR INVESTIGATION

	clinics. **(c) To determine if there have been delays in clinical management plans for these patients as a result.** **4. To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.** **5. To determine if any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.**
Case Investigator:	**Dr Neta Chada, Associate Medical Director** supported Mrs Siobhan Hynds, Head of Employee Relations [redacted]
Case Manager: Designated	**Dr Ahmed Khan, Associate Medical Director (Paediatrics), Daisy Hill Hospital** [redacted]
Board Member	Mr John Wilkinson, Non-Executive Director (contactable via the Chair's Office)

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INVESTIGATION REPORT
Under the Maintaining High Professional Standards Framework

Mr Aidan O'Brien, Consultant Urologist

Case Investigator
Dr Neta Chada, Consultant Psychiatrist / Associate Medical Director
Assisted by
Mrs Siobhan Hynds, Head of Employee Relations

3. The initial concern

A Serious Adverse Incident (SAI) investigation was commenced within the Trust in April 2017 in respect of Patient 10, a patient of the Urology service. A referral had been received by the Trust in 2015 however the patient was not seen until February 2016. The patient was seen by Mr Mark Haynes, Consultant Urologist.

Mr Haynes reviewed the patient and the referral and was concerned about the delay for the patient. As a result Mr Haynes completed a Datix form to alert the Trust to the issue of concern.

Mr Anthony Glackin, Consultant Urologist chaired the SAI investigation which commenced in Autumn 2016. Through the SAI it was identified that the referral for Patient 10 had not been triaged. An initial look back exercise was undertaken and a number of other patients were identified as not having been triaged. Further assessment of the issue identified a significant number of patients who had not been triaged.

The issues of concern relating to Patient 10 were wider than the referral delay. There were issues of concerns in respect of the radiology reporting on diagnostic images however from a urology perspective, it was felt that the symptoms recorded by the patient's GP on the initial referral should have resulted in the referral being upgraded to a 'red-flag' referral and prioritised as such

4. Timeline of the Investigation

The dates below outline the key dates in respect of the background to the concerns and the management of the concerns under the Maintaining High Professional Standards (MHPS) Framework:

March 2016

On 23 March 2016, Mr Eamon Mackle, Associate Medical Director (Mr O'Brien's clinical manager) and Mrs Heather Trouton, Assistant Director (Mr O'Brien's operational manager) met with Mr O'Brien to outline their concerns in respect of his clinical practice. In particular, they highlighted governance and patient safety concerns which they wished to address with him.

Mr O'Brien was provided with a letter detailing their concerns and asking him to respond with an immediate plan to address the concerns. **(Appendix 1)**

Four broad concerns were identified:

- Untriaged outpatient referral letters

It was identified at that time that there were 253 untriaged referrals dating back to December 2014.

- Current Review Backlog up to 29 February 2016

It was identified at that time that there were 679 patient's on Mr O'Brien's review backlog dating back to 2013, with a separate oncology waiting list of 286 patients.

- Patient Centre letters and recorded outcomes from clinics

The letter noted reports of frustrated Consultant colleagues concerned that there was often no record of consultations / discharges made by Mr O'Brien on Patient Centre or on patient notes.

- Patient's hospital charts at Mr O'Brien's home

The letter indicated the issue of concern dated back many years. No numbers were identified within the letter.

April to October 2016

During the period April to October 2016, considerations were on-going about how best to manage the concerns raised with Mr O'Brien in the letter of 23 March 2016. It was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally. Mr O'Brien advised the review team he did not reply to the letter but did respond to the concerns raised in the letter by making changes to his practice.

November 2016

Mr O'Brien was off work on sick leave from 16 November 2016 Personal Information redacted by USI and was due to return to work on 2 January 2017.

An on-going Serious Adverse Incident (SAI) investigation within the Trust identified a Urology patient who may have a poor clinical outcome because the GP referral was not triaged by Mr O'Brien. The SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason.

December 2016

The concerns arising from the SAI were notified to the Trust's Medical Director, Dr Richard Wright in late December 2016. As a result of the concerns raised with Mr O'Brien on 23 March 2016 and the serious concern arising from the SAI investigation by late December

The above issues were raised in the correspondence to Mr O'Brien in March 2016. However there appears to have been no management plan put in to place at that time and Mr O'Brien seems to have been expected to sort this out himself with no arrangements for monitoring if changes to practice were being made and sustained.

Mr O'Brien indicated he had raised issues about triage and the fact it could not be done in the manner expected, at various meetings over many years. He felt he was not listened to. Other consultant urologists interviewed reported the triage role could be very demanding, especially if the emergency work was busy, but they were completing it within a reasonable time frame. It would seem Mr O'Brien continually complained about the difficulties with triage but it remained unknown to his colleagues that he was not undertaking all triage.

Senior managers appear not to have known about the undictated letters. Reliance on a medical secretary to flag that dictation was not being done was not appropriate or sufficient. This is now hopefully addressed through use of digital dictation.

Senior managers also appear not to have known that private patients may have been scheduled with greater priority or sooner outside their own clinical priority in 2015 and 2016.

9. Conclusions

Having considered the information as outlined above I have concluded:

Mr O'Brien is an experienced and highly respected senior colleague. He is a dedicated doctor who strives to provide a high quality service to all patients. He is frustrated by the lengthy waiting times for assessment and treatment/surgery.

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

It does seem that Mr O'Brien liked to do things his own way. He was in agreement with the triage process initially but found he was unable to manage it and stopped doing so. He believed advanced triage should be done instead. He raised the issues about triage at meetings but at no time did he advise anyone that he was not doing it. Nonetheless, it is

The purpose of screening is to identify whether there are *prima facie* grounds for an investigation and, if there are, to set terms of reference which are sufficiently detailed for the investigation to proceed. It is essential that managers set aside dedicated time to progress initial screening so that it can be completed properly and quickly.

1.3 What should be considered in making a decision to investigate?

Before deciding whether a performance investigation is necessary, consider what other relevant information is available. This could include:

- clinical or administrative records;
- serious untoward incident reports or complaints;
- earlier statements or interviews with people with first-hand knowledge of the concern;
- clinical audit and clinical governance data;
- the views of appropriate professional advisers;
- earlier occupational health reports.

The objective is to determine whether an investigation would be likely to produce information which is not already available, not to begin the investigation process itself.

There will normally need to be input from the practitioner too. As a general principle, NCAS encourages employers and contracting bodies to be transparent and to communicate and engage early with the practitioner whose performance is causing concern. NCAS suggests that the case manager or other appropriate person should have a preliminary meeting with the practitioner, explain the situation and what might happen next, and explain that they will be available to answer questions if the case progresses. The practitioner's initial comments can be taken into account in evaluating what further action should be taken. The practitioner should be offered the opportunity to be accompanied by a colleague or a union or defence society representative. A note should be taken and copied to the practitioner as a record of discussions and any case handling decisions.

Exceptionally, contact with the practitioner may have to be deferred if a counter fraud agency or the police advise that early meetings or early disclosure could compromise subsequent investigations. But generally, the practitioner's response will be helpful in deciding whether to carry out an investigation.

1.4 What are the alternatives?

Investigation should be judged unnecessary where:

- the reported concerns do not have a substantial basis or are comprehensively refuted by other available evidence;
- there are clear and reasonable grounds to believe that the reported concerns are frivolous, malicious or vexatious. While very few complaints fall into this category it is important that those that are not genuine are identified as soon as possible to avoid distress to the practitioner and waste of the organisation's time.

Even where there is evidence of concern, the decision may still be to dispense with investigation under the following circumstances:

- The practitioner may agree that the concerns are well-founded and agree to cooperate with required further action. However, if the issues raised are serious enough to suggest that if upheld they might warrant consideration of termination of employment or removal from a performers list, then the organisation may still need to conduct an investigation. The action to be taken subsequently would then be decided in the normal manner.

I will need assistance when replying to this email.

Thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

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

From: aidanpobrien Personal Information redacted by the USI
Sent: 25 August 2011 15:37
To: Corrigan, Martina
Subject: Re: Results and Reports of Investigations

Martina,

I write in response to email informing us that there is an expectation that investigative results and reports to be reviewed as soon as they become available, and that one does not wait until patients' review appointments. I presume that this relates to outpatients, and arises as a consequence of patients not being reviewed when intended. I am concerned for several reasons:

- Is the consultant to review all results and reports relating to patients under his / her care, irrespective of who requested the investigation(s), or only those requested by the consultant?
- Are all results or reports to be reviewed, irrespective of their normality or abnormality?
- Are they results or reports to be presented to the reviewer in paper or digital form?
- Who is responsible for presentation of results and reports for review?
- Will reports and results be presented with patients' charts for review?
- How much time will the exercise of presentation take?
- Are there other resource implications to presentation of results and reports for review?
- Is the consultant to report / communicate / inform following review of results and reports?
- What actions are to be taken in cases of abnormality?
- How much time will review take?
- Are there legal implications to this proposed action?

I believe that all of these issues need to be addressed,

Aidan.

-----Original Message-----
From: Corrigan, Martina < Personal Information redacted by USI >
To: Aidanpobrien Personal Information redacted by the USI ; Personal Information redacted by USI >; Akhtar, Mehmood Personal Information redacted by USI >; O'Brien, Aidan < Personal Information redacted by USI >; Young, Michael < Personal Information redacted by USI >
CC: Dignam, Paulette < Personal Information redacted by USI >; Hanvey, Leanne < Personal Information redacted by USI >; McCorry, Monica < Personal Information redacted by USI >; Troughton, Elizabeth Personal Information redacted by USI >
Sent: Wed, 27 Jul 2011 5:30
Subject: FW: Results
Dear all

Corrigan, Martina

From: Hynds, Siobhan [redacted]
Sent: 06 March 2017 23:22
To: Khan, Ahmed
Cc: Chada, Neta
Subject: Witness List

Importance: High

Dr Khan

Dr Chada and I have identified the following individuals as potential witnesses to the investigation and we have made plans to interview these staff. It is likely as the investigation progresses we will identify others we may need to speak with also.

Mr Ronan Carroll, Assistant Director
Ms Martina Corrigan, Head of Service
Mr Michael Young, Consultant Urologist / Lead Clinician
Ms Claire Graham, Head of Information Governance

It is a requirement of MHPS for the case manager to share a list of witnesses with Mr O'Brien. I would be grateful if you could notify Mr O'Brien of this witness list and advise him that there may be others identified as the investigation progresses.

Many thanks

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: [redacted] Mobile: [redacted] Fax: [redacted]

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Investigation under Maintaining High Professional Standards Framework

Witness List

Ms Martina Corrigan	Wednesday 15 March 2017
Mr Michael Young	Thursday 23 March 2017
Mrs Claire Graham	Monday 3 April 2017
Mr Ronan Carroll	Thursday 6 April 2017
Mr Eamon Mackle	Date to be confirmed
Mr Colin Weir	Date to be confirmed

Personal Information redacted by USI	Personal Information redacted by USI	Personal Information redacted by USI HCN Datix Personal Information redacted by the USI	Personal Information redacted by USI	Personal Information redacted by USI	
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	AOB	Interface incident with Belfast	Chart went with patient to RVH Personal Information redacted by USI chart has been returned.		
	Personal Information redacted by USI		Personal Information redacted by USI	only 1 adrenaline on Trolley.	

Received from SHSCT on 02/02/22. Annotated by the Urology Services Inquiry.

April, May and June 2017

During April, May and June 2017 the Case investigator met with all witnesses relevant to the investigation. Witness statements were prepared and issued for agreement.

Name	Job Title	Date
Mrs Martina Corrigan	Head of Service	15 March 2017
Mr Michael Young	Consultant Urologist	23 March 2017
Mrs Claire Graham	Head of Information Governance	03 April 2017
Mr Ronan Carroll	Assistant Director	06 April 2017
Mr Eamon Mackle	Consultant Surgeon	24 April 2017
Mr Anthony Glackin	Consultant Urologist	3 May 2017
Ms Anita Carroll	Assistant Director	19 May 2017
Mr Colin Weir	Clinical Director	24 May 2017
Mr Mark Haynes	Consultant Urologist	24 May 2017
Ms Noeleen Elliott	Personal Secretary	24 May 2017
Mrs Helen Forde	Head of Health Records	05 June 2017
Mrs Heather Trouton	Assistant Director	05 June 2017
Mrs Katherine Robinson	Referral & Booking Centre Manager	05 June 2017

(Appendix 11 to 23)

14 June 2017

Dr Chada, Case Investigator wrote to Mr O'Brien requesting to meet with him on 28 June 2017 for the purpose of taking a full response in respect of the concerns identified. **(Appendix 24)**

19 June 2017

Mr O'Brien requested to reschedule the meeting to secure his preferred accompaniment to the meeting. This was facilitated. A meeting on 29 June, 30 June and 1st July was offered. Mr O'Brien requested to defer the meeting until later in July until after a period of planned annual leave, and a meeting was confirmed for 31 July 2017.

05 July 2017

Mr O'Brien advised the date of 31 July was not suitable and a date of 3 August 2017 was agreed.

03 August 2017

A first investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern. **(Appendix 25)**

15. In December 2016, I was sent an email by Catherine Robinson to say she had become aware of undictated clinics and patient outcomes not being completed. I am not aware if this led to delays in treatment.

16. I am not aware of any issues relating to Mr O'Brien's private patients.

17. I didn't attend many of the acute performance issues so I wouldn't necessarily have been aware about issues of concern. Katherine Robinson would have attended these meetings and so would have been more aware of the issues.

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	

Neves, Joana

From: Aidan O'Brien [redacted]
Sent: 31 October 2017 15:53
To: Hynds, Siobhan
Cc: Chada, Neta; Wilkinson, John; Khan, Ahmed
Subject: Witness Statements

Follow Up Flag: Flag for follow up
Flag Status: Flagged

Siobhan,

I would be grateful if you would provide me with the outstanding statements from the following three witnesses:

- Heather Trouton
- Kathryn Robinson
- Mark Haynes

prior to the interview with Dr. Chada on Monday 06 November 2017,

Thank you,

Aidan.

Corrigan, Martina

From: Hynds, Siobhan [redacted]
Sent: 11 May 2017 10:04
To: Chada, Neta; Khan, Ahmed
Subject: FW: AOB April theatre lists
Attachments: Arranged admission list TCI on 05.04.17 for Theatre List on 05.04.17.xlsx; APRIL 2017 AA LIST.XLSX; AAlist Mr Haynes Main Theatre 100417 PM.XLSX; AA list 21.04.17.xlsx; Arranged admission list TCI on 05.04.17 for Theatre List on 05.04.17.xlsx; APRIL TEMPLATES.XLSX; PAL WC 03 APRIL 17 1WEA.DOC

Importance: High

FYI

From: Carroll, Ronan
Sent: 07 April 2017 10:34
To: Hynds, Siobhan; Gupta, Nidhi
Subject: FW: AOB April theatre lists
Importance: High

Nidhi/Siobhan
Please see attached the operating theatre lists for all urology consultants this week. In summary all but AOB reference the clinical status on their lists
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: Clayton, Wendy
Sent: 07 April 2017 10:07
To: Carroll, Ronan
Subject: AOB April theatre lists

As requested.

Wendy

Wendy Clayton
Operational Support Lead
ATICS/SEC
Ext: 61597
External number: [redacted]
Mob: [redacted]

EXT [redacted] ***if dialling from Avaya phone.***
If dialling from old phone please dial [redacted]

External No. [redacted]

no dictation done except by a registrar on one occasion. The GP cannot know what the clinical management plan was for their patient without an outcome.

22. From SWAH there appeared to be no dictation, no outcome sheets and no notes brought back.

23. It appeared to me to be accepted practice that a senior member of the team did not do dictated outcomes from clinics. Many people knew Mr O'Brien stored notes at home but there was no action taken. It was also accepted that Mr O'Brien would transport files in his car from clinics and then would have these at home. We have created this issue. It was the Trust process and is still the Trust process. Everyone knew they were with him and were having to get him to bring the notes in if they were needed. It only applies to the SWAH clinics as there is transport to all other clinics. Mr Young does the SWAH clinic also but I think he takes the notes home and then drops them back again.

24. You can't run a safe practice without contemporaneous notes. I have looked up the duties of a doctor as required by the GMC and it doesn't specifically state a doctor has to do a letter for every attendance. I thought however it was accepted practice by the Trust. Maybe they didn't know the extent of it. The impression I have is that management knew about the issue of notes. The secretaries knew. Medical records knew.

25. My impression is that when a patient needed something done it was done but there have definitely been delays for patients. There certainly has been the potential for the delay of clinical management plans.

26. In terms of Mr O'Brien's private patients, it seemed to me that Private patient's appeared not to wait very long. I was aware of patient's seen privately who then had their operation out with the timescale for the same problem for an NHS patient. I raised this in an e-mail in June 2015 and also December 2015 to Michael Young and Martina Corrigan. It was an irritation for me that I had patients waiting much longer for the same problem. His waiting times seemed out of keeping with everyone elses. I believe Mr Young spoke to him about it. It is difficult to challenge a view and opinion with Mr O'Brien.

27. I am aware the previous AMD Mr Mackle raised issues with Mr O'Brien and this had become very difficult. Operationally Martina Corrigan knew of the issues and I anticipate she escalated these concerns. The problems were well known in medical records. Other people must have known such as anesthetists, he was taking people to theatre without clear notes and at times with no pre-op done. He has been here a long time and its just been accepted. I haven't worked anywhere else where a consultant would have been able or allowed to say I am not doing that, or have that accepted.

Southern Health and Social Care Trust

APPENDIX 4

Revised November 2016 (Version 1.1)

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: SHSCT	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE Personal information redacted by
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: Personal information redacted by USI	**4.** DATE OF INCIDENT/EVENT **5.** Personal information redacted by USI
6. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: NO ***Please select as appropriate***	**7.** IF 'YES' TO 5. PLEASE PROVDE DETAILS:
8. DATE OF SEA MEETING / INCIDENT DEBRIEF	

9. SUMMARY OF EVENT:

Patient 90 was admitted to Craigavon Area Hospital (CAH) on 09 May 2018 for elective urology surgery (cystoscopy, replacement of ureteric stents and bilateral ureterolysis). Following the procedure on Personal information [redacted] Patient 90's condition deteriorated and he was admitted to the Intensive Care Unit (ICU) critically ill. Patient 90 suffered a cardiac arrest which was managed as per Adult Life Support (ALS) guidelines. Following discussion with Patient 90's wife cardiopulmonary resuscitation (CPR) was stopped and Patient 90 died on Personal information redacted by USI. Patient 90 was discussed with the coroner and a post mortem was requested.

The review team have drafted this report on the information available to them, the review team are aware that some of the clinical notes may not be available to them.

Causative Factor

The review team concluded Patient 90 had an unrecognised haemorrhage post operatively.

The review team note Patient 90's post mortem report. Patient 90 death was discussed with the Coroner who recommended a post mortem.
The Cause of death was reported after post mortem as 1(a) Intra-abdominal and retroperitoneal haemorrhage following cystoscopy, insertion of ureteric stents and ureterolysis. 11 Cardiomegaly
The post mortem reported noted *'Death was due to bleeding, or haemorrhage, into the abdominal cavity itself and into the fatty tissues at the back of the abdomen……..The post-mortem examination also revealed that the heart, and in particular its two main pumping chambers the ventricles, was enlarged. Such enlargement of the heart, termed cardiomegaly, would without doubt have made him less able to withstand the stresses place upon the body by the effects of the blood loss. Indeed the severity of his heart disease was such that it could have caused his death at any time. Therefore as his pre-existing heart disease would have made him more susceptible to the effects of haemorrhage it would be best regarded as a contributory factor in his death'.*

up by the clinical teams.
The review team note there is no formal clinical result sign off guidance for the Southern Health and Social Care Trust (SHSCT), the Acute Directorate are developing guidance to implement clinical result sign off. The review team concluded that all results must be signed off and action taken to further investigate or manage findings.

A BNP blood test collected on 3 January 2017 was 1609pg/ml; this result was not documented on the patient discharge letter. The review team are of the opinion that here was no evidence to support if this was actioned.

Preoperative Assessment
Patient 90 was added to Doctor 1 urgent urology waiting list on 9 June 2017 and was pre-admitted for surgery at 15:50 on Thursday 3 May 2018 by Doctor 1's secretary. The review team noted that Patient 90 did not have a formal outpatient preoperative assessment as per Trust and National Institute for Clinical Excellence (NICE) guidance.
Patient 90 was booked for pre-operative assessment on the 4 May 2018. The review team considered that this referral did not give sufficient time to appropriately pre-operatively assess and optimise Patient 90 for surgery.

Patient 90 was in the emergency department of Craigavon Area Hospital on 4 May 2018 and called with the preoperative team at 09:00, as his preoperative assessment appointment was booked for 13:45 they were unable to assess him. He was advised to contact the preoperative team later that day if he was unable to attend his 13:45 appointment. Patient 90 did not attend this appointment. The anaesthetist was informed by the pre-operative team that Patient 90 had not attended.

The review team note that on 3 January 2017 Patient 90's Brain Natriuretic Peptide (BNP) test was 1609 is a blood test that measures levels of a protein called BNP that is made by the heart and blood vessels. BNP levels are higher than normal when you have heart failure). SHSCT echocardiography in the preoperative assessment clinic guidance highlights heart failure (either systolic or diastolic dysfunction) is a major perioperative risk factor. The presence of heart failure doubles the risk of dying after major surgery (Patient 90 BNP was 1609pg/ml).
National NICE Chronic heart failure in adults: management (CG108) recommended refer patients with suspected heart failure and a BNP level above 400 pg/ml (116 pmol/litre) or an NTproBNP level above 2000 pg/ml (236 pmol/litre) urgently, to have transthoracic doppler 2D echocardiography and specialist assessment within 2 weeks. This guidance has been superseded by NICE guideline chronic heart failure in adults: diagnosis and management published: 12 September 2018 (nice.org.uk/guidance/ng106). However the review team noted that certain medications and medical conditions such as atrial fibrillation can affect BNP levels even in the absence of heart failure.

NICE guideline routine preoperative tests for elective surgery published: 5 April 2016 (nice.org.uk/guidance/ng45) recommends not routinely offering resting echocardiography before surgery. However, consider resting echocardiography if the person has:
a heart murmur and any cardiac symptom (including breathlessness, pre-syncope, syncope or chest pain) or signs or symptoms of heart failure. SHSCT guidance recommends a patient with known heart failure with a significant change in symptoms and an increase in BNP should have a preoperative echocardiogram.

Consultant 1 noted '*I do not regret the surgery as his quality of life was terrible due to the effects of indwelling ureteric stents. I do however regret not sending him for cardiac workup, including echo*

and coronary angiography. When he did have CT scanning performed in December 2016, he was reported to have gross enlargement of his atrium, and appeared to have a haemodynamically significant, atheromatous plaque in his left main stem'.

The review team considered that waiting lists for elective urology surgery and a cancellation could lead to a significant delay in relisting of a patient, however doctor 2 noted '*There was no push/ pressure to get the case done regardless'*

The review team concluded particularly in view of his comorbidities that Patient 90 should have had a formal preadmission pre-operative assessment with optimisation of his clinical condition prior to surgery. This assessment should have been organised sufficiently in advance of the surgery to allow for all appropriate investigations to be completed. This allows for patient optimisation and discussion regarding specific anaesthetic risk.

The review team noted that the consultant anesthetist Doctor 2 noted on the preoperative assessment on the day of surgery the Patient 90 comorbidities including ischaemic heart disease. The review team noted that Patient 90 had had previous anaesthetics which were uneventful.
Doctor 2 reported that '*induction of anaesthesia and intra-operative progress was largely uneventful'* and that Patient 90 was anaesthetically stable throughout the procedure. *'Blood pressure became more labile in the last 20 minutes of the case, although not to a major degree – he responded to small doses of metaraminol. Emergence from anaesthesia and extubation was uneventful. The patient did not look particularly unwell on transfer to his bed (of note, not clammy/pale.)'*
Doctor 2 highlighted there were serial arterial blood gases that showed that the haemoglobin and lactate were stable throughout the operative procedure. The review team concluded that these blood tests were missing from the notes.

The review team noted doctor 2's preoperative plan for an arterial line and venous access, and the anaesthetic management. The team notes a small amount of inotropes was administered during the procedure but these were not significant. The procedure was relatively long with the total procedure time 3 hours 45 minutes and the anaesthetic time 4 hours 27 minutes. The review team notes that there were no previous clinical notes available to doctor 2 on the day of surgery.
The review team considered that with the information available to the anaesthetist it was reasonable to progress with the surgery, the anaesthetic assessment and management of Patient 90 was appropriate.

Management of Patient 90 post-operative care

Post operatively he developed a labile blood pressure. He subsequently became agitated, tachycardic (fast heart rate) and hypotensive (low blood pressure) (NIBP 51/37). Patient 90 required further boluses of phenylephrine and 2x doses of haloperidol 2.5mg for agitation. Noradrenaline for inotropic support and amiodarone were administered. Patient 90 initially responded well but he developed anuria (no urinary output) and confusion. He was requiring increasing doses of inotropes. Patient 90 was transferred to theatre for intubation and insertion of dialysis line. There was ongoing intensive care including supra-maximal doses of inotropes and other resuscitative measures. Patient 90 was transferred to ICU at approximately 22:30.
The review team note the plan was to attempt to stabilise the patient and transfer to ICU for haemofiltration/ dialysis. However, despite maximal efforts lost cardiac output and cardiopulmonary resuscitation (CPR) was commenced. Despite CPR there was no return to spontaneous circulation and Patient 90 died at 23:10.

The review team noted the clinical team's differential diagnosis of a sudden cardiac event.

Please let me know which option you would prefer. If it is the 1st July, I will ask Dr Chada to confirm a time as soon as practicably possible.

Many thanks

Siobhan

From: Aidan O'Brien [mailto [redacted]
Sent: 19 June 2017 00:33
To: Hynds, Siobhan
Subject: Re: Meeting on Wednesday 28 June 2017

Siobhan,

I become urologist of the week from 09.00 am on Thursday 29 June 2017, obviously for one whole week.
An important component of that whole week is the handover ward round from one consultant to the next, beginning at 09.00 am that morning.
I do not know how important it is that I meet with Dr. Chada around that time, rather than later.
If it is, then the most suitable day to have the meeting would be on Saturday 01 July, as one of my colleagues would probably be available to cover my absence, particularly with regard to operating, though I have not asked any of them yet.
Would that be possible?
Otherwise, I will be on leave the week beginning 10 July 2017, and would be available all of that week,

Aidan.

-----Original Message-----
From: Hynds, Siobhan [redacted]
To: Aidan O'Brien [redacted]
CC: Chada, Neta [redacted]; Khan, Ahmed [redacted]
Sent: Fri, 16 Jun 2017 10:15
Subject: RE: Meeting on Wednesday 28 June 2017

Dr O'Brien

There is no difficulty with rescheduling. Dr Chada was holding the 29am also and the 30th may be possible – would either of these dates in the morning suit you?

I am in a meeting this morning but will aim to give you a call before the end of the day.

Regards,

Siobhan

From: Aidan O'Brien [redacted]
Sent: 15 June 2017 22:53
To: Hynds, Siobhan
Cc: Chada, Neta; Khan, Ahmed
Subject: Meeting on Wednesday 28 June 2017

Siobhan,

I received your email this evening.
Regrettably, Wednesday 28 June 2017 would not be suitable for me to meet with Dr. Chada for two reasons.
Firstly, I would certainly wish to be accompanied by my son, Michael, as previously.
However, he will be in Court that day, a commitment he cannot avoid.
Secondly, I have scheduled operating that day, and have already committed to a number of patients.

I would be grateful if you would contact me on [redacted] to see whether there are other dates possible,

Sent: Fri, 30 Jun 2017 15:40
Subject: Meeting on 31 July 2017

Mr O'Brien

Can I check if this date is suitable and if you are able to attend in Armagh?

Many thanks

Siobhan

From: Hynds, Siobhan
Sent: 23 June 2017 12:58
To: 'Aidan O'Brien'
Subject: RE: Meeting on Wednesday 28 June 2017
Importance: High

Mr O'Brien

I can confirm the meeting for 31st July at 10am. Would it suit you to come to the Hill Building in St Luke's, Armagh for this meeting?

Many thanks

Siobhan

From: Aidan O'Brien [mailto: Personal Information redacted by the USI
Sent: 19 June 2017 15:05
To: Hynds, Siobhan
Subject: Re: Meeting on Wednesday 28 June 2017

Siobhan,

I appreciate Dr. Chada's flexibility regarding this meeting.
I believe it would be better to defer meeting to later in July.
We have also scheduled our clinical commitments until end of July 2017, and so would prefer not to have to cancel appointments, admissions etc.
The only day prior to end of July when i could have attended, Thursday 27, my son cannot.
Therefore, I propose that we could meet with Dr. Chada on any day during the week beginning Monday 31 July 2017.
I do have a clinic on Monday 31 July 2017, but it has not been booked yet, so it can be rescheduled.
I would be grateful if you would advise, as soon as possible, which day it would be, so that my son can block that day, providing that it suits Dr. Chada to meet that week,

Aidan.

-----Original Message-----
From: Hynds, Siobhan Personal Information redacted by USI
To: Aidan O'Brien < Personal Information redacted by the USI
Sent: Mon, 19 Jun 2017 12:24
Subject: RE: Meeting on Wednesday 28 June 2017

Good morning Mr O'Brien,

I have been in contact with Dr Chada this morning regarding your e-mail below. In terms of when she can meet with you, Dr Chada had hoped to meet with you before July in order to avoid annual leave arrangements of all parties. However, if you would rather meet later in July when both yourself and Dr Chada are back from leave this can be facilitated.

Alternatively, Dr Chada is happy to try to facilitate Saturday 1 July if this is your preference? Dr Chada has a number of pre-planned appointment on Saturday 1 July am and if she is unable to change these, she would be happy to meet in the afternoon of the 1st July.

From: Aidan O'Brien [redacted]
To: Siobhan.Hynds [redacted]>
Subject: Formal Investigation
Date: Mon, 31 Jul 2017 10:06

Siobhan,

In preparation for the interview on 03 August 2017, I would be grateful if you would provide me with the following:

- A copy of the minutes of the meeting in December 2016 of the Oversight Group
- A copy of correspondence and / or communication with NCAS in December 2016
- An amended copy of the Note of the Meeting of 30 December 2016 (previously requested)
- An amended copy of the Note of the Meeting on 24 January 2017 (previously requested)
- A copy of the Trust's Policy and Procedure regarding Triage (previously requested)
- A list of the Witnesses and their statements

Thank you,

Aidan O'Brien

From: Aidan O'Brien [redacted]
To: Siobhan.Hynds <[redacted]
Subject: Re: FORMAL INVESTIGATION
Date: Mon, 31 Jul 2017 13:16

Siobhan

In addition to my earlier request, could you please add the details of the 9 Private Patients included in the investigation and the name or names of those who identified them.

Aidan O'Brien.

that he wants -- that he is to respond to in detail beyond the points in the terms of reference before he would date his witness statement if you like?

SIOBHAN HYNDS: There will be an opportunity to do both. So we will provide -- we are in the process of agreeing all of those statements and they are -- so there is a volume of paperwork going back and forth in terms of the agreement of those. Once that is settled, and witness statements are agreed, we will absolutely share that with you if there is issues there that you wish to come to us with before this process concludes. But the witness statements are only a matter of us taking a view from a particular witness in the same way we would ask the same information of yourself, Mr O'Brien. So you will absolutely have an opportunity before the process concludes to have sight of those witness statements. If there is anything that you wish to put on record as part of the information before it goes to the case manager in respect of any of those witness statements, absolutely you would have an opportunity to do that.

DR CHADA: Today is really about addressing the terms of reference. So it is not really about responding to what other people have said or whatever. This is an opportunity, Mr O'Brien, for us to gather from you and to put to the case manager your view on these terms of reference. In the same way as we have spoken to witnesses and they will have put their view, this is an opportunity for you to put your view. You will see those witness statements but this is an opportunity for us to gather your view of what happened here and things like that. Okay.

MR O'BRIEN: But I do entirely appreciate the distinction that you are drawing between what we are doing today and the whole process. Nevertheless, for example, when you wrote to me by way of Siobhan you told me that you had sent me a list of the witnesses, I have not received a list of the witnesses.

SIOBHAN HYNDS: A list of witnesses was shared with --

MR O'BRIEN: It wasn't. I have never -- I have only received a list of seven people at an earlier time from Dr Khan.

SIOBHAN HYNDS: As part of an update? More than happy to share with you.

DR CHADA: Apologies.

SIOBHAN HYNDS: I thought we had sent you a list of the witness statements.

DR CHADA: Sorry, the witness list.

MR O'BRIEN: I have searched for it in every conduit.

SIOBHAN HYNDS: (Inaudible).

DR CHADA: We will certainly share that with you and apologies for that. But, as I said, it brings me back to what we are here to do today. And certainly you can have that list and

DR CHADA: Yes. The investigation -- I know, Mr O'Brien, that there are a number of other things that you have raised with the case manager and so on and I know you copied me into the letter that you sent to the case manager. Those are issues you addressed quite appropriately to the case manager and not to me. Those are not issues for me. Those are issues for the case manager that the case manager -- I think the case manager is on annual leave at the minute. When the case manager returns, the case manager presumably will respond to a lot of those issues that you have raised in that. So those issues are not pertinent to today except in terms of how they might relate to any of the terms of reference.

MR O'BRIEN: Okay.

DR CHADA: So I say, thank you very much for copying me into that because I think that was very kind of you.

MR O'BRIEN: The only reason I did that was because when I sent it to the case manager then I got an automatic reply to say he was on leave until tomorrow.

DR CHADA: Is it tomorrow? I knew he was on leave. He will respond. It is quite appropriate -- you quite appropriately addressed it to him. He will respond to you in terms of that. So in terms of what we're addressing today, we are addressing today the terms of reference. So do you have a copy of the terms of reference?

MR O'BRIEN: I am just looking for those.

DR CHADA: There is a copy there.

MICHAEL O'BRIEN: Have you spoken to all of the other witnesses now that you will be speaking to that you said you were going to be speaking to?

DR CHADA: Sorry, Mr O'Brien, I think it is really important that we are clear about what this process is about. Okay. I am very happy for you to be here to support your dad but really a lot of this is for your dad and for Mr O'Brien to raise queries or to raise questions. You are here primarily for support really and --

MICHAEL O'BRIEN: If you prefer (inaudible) my dad to ask you the question I will (inaudible).

DR CHADA: Okay. What was the question then?

MICHAEL O'BRIEN: Of the other witnesses that you will be speaking to have you spoken to them --

DR CHADA: Yes.

MICHAEL O'BRIEN: -- already?

DR CHADA: Yes.

MICHAEL O'BRIEN: Would you not have provided what they -- the evidence or the points

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 14 September 2017 09:02
To: Hynds, Siobhan
Cc: Chada, Neta
Subject: RE: MHPS Investigation - Request for Information
Attachments: Update AOB all surgery 2016 5 May 2017.xlsx; clinically should they have been sooner.docx; Scan from YSoft SafeQ (5.27 MB); Scan from YSoft SafeQ (5.54 MB)

Importance: High

Siobhan,

The process undertaken was that Ronan had requested Wendy Clayton, Operational Lead to request a report to be run on all Mr O'Brien's surgery during 2016. See attached.

Any patients that had a short wait time between being added to the waiting list and been operated on had their record checked on NIECR to see if they had a private patient letter, i.e. Hermitage letter. Out of this list there were 11 patients, for which all the letters were printed off.

I then asked Mr Young if he could look at these letters and gauge from his clinical opinion should they have been as soon as they had been or should they have been added to the NHS waiting list to wait and be picked chronologically.

Mr Young agreed and he took away the letters and using NIECR (i.e. checking lab results, imaging and any other diagnostics available), made his decision on whether in his opinion they were sooner than they should have been. (letters attached with Mr Young's comments which he went through with me and advised which he felt was reasonable or not)

Regards

Martina

From: Hynds, Siobhan
Sent: 13 September 2017 09:30
To: Corrigan, Martina
Cc: Chada, Neta
Subject: MHPS Investigation - Request for Information
Importance: High

Martina

Could you please clarify for Dr Chada the process undertaken to assess the clinical priority of the TURP private patients. Who assessed the clinical priority and what was this based upon.

Can you also please provide me with a copy of the information pertaining to each private patient assessed.

Could I please have this information as a matter of urgency. If you have any queries please come back to me.

Many thanks

Siobhan

Patients seen privately by Mr O'Brien and added to waiting list and came in for procedure within a short timeframe.

Casenote	Consultant Name	Date on Waiting List	Date Operation	Days between Added to WL to Operation Date	Is there a clinical reason why they should have waited such a short time
Personal Information redacted by USI	O'Brien A Mr	22/02/2016	22/03/2016	29	No
	O'Brien A Mr	25/04/2016	04/05/2016	9	Reasonable – Red Flag
	O'Brien A Mr	11/04/2016	15/04/2016	4	No
	O'Brien A Mr	01/04/2016	27/04/2016	26	No
	O'Brien A Mr	08/07/2016	09/08/2016	32	No
	O'Brien A Mr	29/07/2016	21/09/2016	54	No
	O'Brien A Mr	04/12/2015	24/02/2016	82	Reasonable
	O'Brien A Mr	11/07/2016	17/08/2016	37	No
	O'Brien A Mr	08/10/16	02/11/16	25	No
	O'Brien A Mr	31/10/16	04/11/16	5	No
	O'Brien A Mr	16/02/2016	24/02/2016	8	No

AIDAN O'BRIEN FRCSI

Consultant Urologist

[redacted]

30th Jan OP?
5 Feb u/s
12 Feb IVP
16 Feb urodyn
24th Feb ureter + hydro

3/52 trim. ocd.
Dict on admission for Δ ureteroscopy not RF. ? urg out.

23rd February 2016

[redacted]

Dear [redacted]

[redacted]

DOB [redacted]
UN [redacted]

I write to you regarding [redacted] who presented with persistent left flank pain in 2012. The pain was consistent with ureteric colic but it had not been possible to determine whether small opacities seen in the left hemi-pelvis were indicative of left lower ureteric calculi. As a consequence, [redacted] was admitted in February 2013 for left ureteroscopy when I found her to have a stenosis of the intramural segment of her ureter, above which the ureteric lumen was dilated, containing urothelial debris. The stenosed intramural segment was effectively dilated by advancement of the ureteroscope.

Dilatation of the intramural segment resulted in complete relief of the left flank pain. She had a recurrence of that same pain in October 2014. There was no evidence of any left ureteric calculi or of left upper tract dilatation on CT scanning of her urinary tract at that time. The pain then was not as severe as it had been in 2012. Urinary microscopy and culture then were both normal, though later she did have a coliform infection in December 2014.

[redacted] has had recurrence of the same pain since January 2016. She had remained effectively free of pain during 2015. When I reviewed her on 30th January 2016, she reported that the pain radiated from her left loin to her left labium majus. I noted that she had been found to have pyuria and bacteriuria on urinary microscopy on 12th January 2016. However, both were normal when repeated on 30th January 2016. In any case, I had empirically prescribed Trimethoprim 200mgs to be taken twice daily for a period of 3 weeks.

I arranged for [redacted] to have ultrasound scanning of her urinary tract performed on 5th February 2016. Ultrasound scanning was normal. As the pain persisted, I had intravenous urography performed on 12th February 2016. Whilst this was also normal, there was just a hint that there may have been a mild degree of left ureteric dilatation. By then, her pain was increasingly localised to the left lower abdominal area, and was increasingly accompanied by lower urinary tract symptoms, which included hesitancy of micturition, a reduced urinary flow and post micturitional incontinence in addition to urgency and quite severe nocturia, having to rise 4 or 5 times each night to pass urine. Prior to considering any endoscopic reassessment, I had [redacted] attend on 16th February 2016 for urodynamic studies when she was found to have a hypersensitivity of her bladder resulting in a compromised cystometric capacity of 190mls. There was no evidence of detrusor muscular overactivity.

6 November 2017

FILE REFERENCE: 12

AIDAN O'BRIEN
Accompanied by MICHAEL O'BRIEN
(SIOBHAN HYNDS & DR CHADA: 2nd MEETING)

Audio Transcription Prepared by:

Angela Harte
Personal information redacted by USI
[redacted]

Hynds, Siobhan

From: O'Brien, Aidan [redacted]
Sent: 22 February 2018 19:12
To: Hynds, Siobhan
Subject: RE: MHPS Process

Follow Up Flag: Follow up
Flag Status: Flagged

Siobhan,

It would appear that I have misunderstood the arrangements and commitments agreed at our last meeting.
I was of the understanding that I would next receive your Note of that meeting in November 2017, and that then I would reply with suggested amendments to both Notes, and with comments upon witness statements etc.
I had been checking emails to ensure that I had not overlooked a further communication, and wondering why there had been such a long delay.
I now understand why that has arisen.
I have not had time to attend to the process since November 2017.
I would be grateful if you would provide me with the Note of the Meeting in November 2017, and any other documentation which I have previously requested.
I will then endeavour to revert to you as soon as possible thereafter, and within a specified timeframe, such as by 31 March 2018,

Aidan.

From: Hynds, Siobhan
Sent: 22 February 2018 18:43
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: RE: MHPS Process
Importance: High

Good Evening Mr O'Brien

Can you please update as per my e-mail below.

Many thanks

Siobhan

From: Hynds, Siobhan
Sent: 15 February 2018 13:25
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: MHPS Process
Importance: High

Good Morning Mr O'Brien

I hope you had a good Christmas and New Year break.

It has been some weeks now since we last engaged about the ongoing investigation process under the MHPS Framework. When we last met with you, Dr Chada and I had advised that we were at the conclusion stage of our investigations and the meeting with you in November was the last meeting we felt was required.

At that meeting we had outlined that we would require your first statement to be agreed and returned. You indicated that you had comments to make and undertook to do that before returning it to us. I am checking to see if you have this now finalised and are in a position to return this to us?

You had also indicated that you wished to make comment on the witness statements shared with you and you indicated you would also do this and provide those comments to us. Can you advise if this is complete and if you are in a position to share this with us.

I appreciate that when we met you had indicated you had a number of priorities to deal with in December outside of the MHPS process and would not be in a position to return your comments prior to January. We would like to try to bring this process to a conclusion and I would be grateful if you could come back to me as soon as possible on these matters.

I have the notes of our meeting in November to share with you which will also require your agreement. We do however have your written statement on those issues in full so that is a smaller matter to be finalised.

I look forward to hearing from you.

Kind Regards,

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: Personal Information redacted by USI Mobile: Personal Information redacted by USI Fax: Personal Information redacted by USI

Click on the above image for SharePoint: Employee Engagement & Relations information

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Having said that, we fully accept that the pace required in such a complex investigation needs to be set by the investigators. However, date provision and availability need to be reciprocated and it was not until 2 April 2018 that Mr O'Brien submitted the outstanding inputs.

It is our finding that Mr O'Brien was not inclined to progress and he controlled this by his inaction. We observe with the benefit of hindsight now in 2020, that there ought to have been a more assertive management of Mr O'Brien even thought he would have been unlikely to have welcomed that. If he considered he "*had no time*" and valued faster progression of the matter with the certainty he expressed at his grievance, he ought to have asked if space could be created to allow him to progress his inputs.

Regrettably in this section we saw a similar pattern to the wasted time frame from 23 March 2016 onwards, i.e. Mr O'Brien appears to withdraw and then takes the view that he had no role in that delay.

F. Mr O'Brien appears to suggest that there were no actions from him in the period up until February 2018. This is not the case (see **E.** above and in the table). Having requested, and the panel agreeing, to exclude November and December 2017 for any actions from him, there was no curiosity from Mr O'Brien about how he could progress without a draft of his statement which he then said was essential to his comments. It appears to us that he lost interest in the investigation during this time and it was only when Mrs Hynds reminded him about outstanding matters on his part that he expressed that he had "*misunderstood the arrangements and commitments ... and wondering why there had been such a long delay.*"

In considering this grievance in its entirety, we do not find the lack of understanding on Mr O'Brien's part to be credible.

By February 2018, the required inputs were Mr O'Brien's i.e. to expedite his comments back to the Trust and to do this by 9 March 2018. Mr O'Brien was not able to meet this deadline because of work commitments. Mrs Hynds extended the deadline to 16 March 2018 and, on no receipt of comments on 16 March 2018, extended it to 26 March 2018. When this deadline was also missed by Mr O'Brien, it was extended to 29 March 2018 and finally to 30 March 2018. Mr O'Brien submitted his comment on 2 April 2018. These were available to the investigators on 4 April following the Easter Bank Holiday break.

Mr O'Brien stated at **F.** in the table above that this delay was because of him not being provided with his draft statement until 4 March 2018. We do not accept that Mr O'Brien was unable to reflect on matters raised at the meeting on 6 November and earlier, on 3 August 2017. While we do not need access to the investigation report and notes of meetings with Mr O'Brien (we cannot re-investigate the formal MHPS investigation itself), we do not find it credible that there were no matters put to him at

5.5 An example of this is at paragraph 6.2 which relates to the use of the MHPS framework by the Trust. While it is acknowledging that there were issues on the part of both the Trust and Mr O' Brien which compromised the operation of the Framework in the way it was intended, as regards the setting aside of the timescales, and the failure of Mr O' Brien to actively participate in the early resolution of the issues which were brought to his attention in March 2016, the finding in this regard is unjustifiably in our view, more supportive of the Trust.

5.6 It has been evidenced that Mr O' Brien had been advised at a meeting and subsequently received a letter confirming the nature of the concerns. While this letter advised that these governance issues must be addressed and asked for a response with a commitment and immediate plan to address these, it is also established that this letter brought no response. No follow up was initiated, there appears to be no-one to whom the responsibility to do that was assigned and for months nothing happened. The inaction in relation to follow up while not excusing Mr O Brien's interpretation in this regard does in our view suggest that the seriousness of this was not as was later argued and gives more weight to his inaction.

5.7 In paragraph 6.3 of the grievance panel report the failure to follow up on the March letter to Mr O' Brien is referenced, and the fact that he was not made aware of the approach being suggested by Ms Gishkori to address the problems did not take away from the Medical Directors responsibilities to have concerns examined and the "time for informal resolution had passed". We accept that the Medical Director has the right to escalate a problem that he judges merits formal investigation, however the reference to these two sets of facts in the one paragraph seems to create a diversion to the seriousness of the failure to make Mr O' Brien aware of the outcome of the oversight committee in October, the subsequent discussions which were going on around that and of the plans to tackle the problems. The Medical Directors right to act in this way in no way excuses the inaction of all parties up to this point. We would contend that where "informal resolution" of any issue is proposed it is predicated by the parties involved being at least aware of the issues.

5.8 At 6.4 in the report of the grievance panel report the delays in progressing this grievance and progressing the MHPS investigation are referenced. We have previously commented on this. It is recognised that there was a contribution to the delay by both the Trust and Mr O' Brien. In relation to concluding the MHPS investigation, we find that this should have been concluded in a timelier manner. If this investigation were as serious as it is purported to be the investigator should have been given time out of her normal commitments to carry out the interviews necessary and have the report completed. This did not happen but is not referenced. There was no one pressing the completion of these matters irrespective of the breach of the published timeframes.

5.9 While Mr O Brien complains about the timescale of these matters, he too contributed to this and while some delays are understandable and acceptable other simply are not. The Trust has contributed to this and while one might argue that the parties are equally culpable, the Trust as the Employer has the responsibility take control of the process and the timescale for completion. It's general acceptance of the slow pace and failure to seek to have the grievance closed out at an earlier point deserves mention.

5.10 At 6.8 of the findings of the grievance panel the failure of Mr O' Brien to "engage meaningfully" at an "early point" is referenced as being a significant factor in the failure to find a resolution to the concerns. It notes that any chance of resolution and support may have avoided all that subsequently followed. We do not agree that this is a fair assessment. It relies again on the March 2016 meeting with him and subsequent letter as the evidence to support this and ignores the discussions that were held subsequently at which dialogue and discussion were held by other senior colleagues and which were not shared with him.** That the panel concluded the events which unfolded may have had some opportunity for resolution is quite disturbing. To lay the responsibility for this completely at the door of Mr O'Brien is disproportionate. There was an absence of concise and proper management of the concerns held about Mr O'Brien by Trust management which was not just an issue at the time but appears to have been known of for years.

5.11 At 6.9 of the findings the grievance panel references 3 key facts as the catalyst for the initiation of the formal investigation. These were noted as:

- The absence of a response from Mr O' Brien as requested
- The lack of active follow up within the Directorate to Ms Gishkori's alternative plan in September and October 2016
- The potential for an SAI

We note these to be different to the points which were referenced at 2.2.32 in the panel report in which it is stated were the factors in the decision by Dr Wright to proceed with the formal investigation:

- The absences of assurances about progress made to manage and attend to the concerns.
- The serious adverse incident
- The information provided on the quantum of the alleged performance matters.

5.12 At 6.10 of the grievance panel findings it concludes that in the absence of an assurance of a viable alternative and given that all earlier "intended interventions" outside of the formal MHPS had failed to deliver progress let alone closure, that his actions were reasonable. We have commented earlier that we accept the right of the Medical Director at any point to initiate a formal MHPS investigation, where he feels the circumstances merit such. On this occasion it was the "potential for an SAI" that is noted, and while initially pointing to the responsibilities of others, this is changed to the absences of assurances which is nonspecific and suggests responsibility lies wholly with Mr O Brien.