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 5.1 WIT 23771 I have stated *In this particular case, appropriate advice was appropriately sought from a specialist within the field (the Clinical Director, Mr Young) in cases where questions of clinical judgement were raised*. This should be changed to *In this particular case, appropriate advice was appropriately sought from a specialist within the field (the ~~Clinical Director~~ Clinical Lead, Mr Young) in cases where questions of clinical judgement were raised*.

3. At paragraph 11.3 (WIT-23778), I have stated '*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.'* This should be changed to '*I am not aware of the exact parameters under which Mr O'Brien returned to work but I was aware that there was an action plan in place relating to the areas of concern. I was told that the action plan was ~~or whether they were~~ adhered to during my investigation. ~~This~~ Monitoring adherence to the action plan was not my role under MHPS.'*

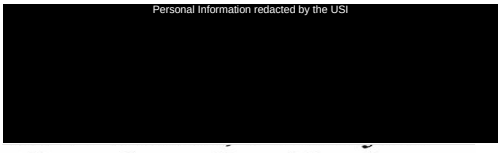
4. At paragraph 18.4 (WIT-23787). I have stated '*I am unaware of how he progressed on his return as I was not advised of that*.' This should be changed to

Urology Services Inquiry

'I am unaware of how he progressed ~~on his return~~ after I completed my investigation as I was not advised of that.'

Statement of Truth

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

Signed: 

Consultant Psychiatrist

Date: 22.03.2023

Corrigan, Martina

From: Chada, Neta [redacted]
Sent: 09 April 2018 09:03
To: Hynds, Siobhan
Subject: FW: Investigation
Attachments: Comments relating to the Respondent Statement of Thursday 03 August 2017.docx; Comments concerning the Respondent Statement of the Meeting of 06 November 2017.docx; Comments concerning Witness Statements.docx

Hi Siobhan – is he really referring to things from march last year?

Are these reasonable to look at, or can we say we have given him ample time to raise this before now?

neta

From: Aidan O'Brien [redacted]
Sent: 02 April 2018 21:14
To: Hynds, Siobhan
Cc: Chada, Neta
Subject: Investigation

Siobhan,

Thank you for your email of 04 March 2018.
Thank you for the draft Respondent Statement relating to the meeting of 06 November 2017.

I have attached comments concerning the proposed Respondent Statements of 03 August 2017 and of 06 November 2018.
I have also attached comments relating to the Statements of Witnesses.

I also take this opportunity to remind you that I had written to Dr. Wright on 14 February 2017 with details of factual errors and omissions in the Note of the Meeting I had with him and Ms. Hainey on 30 December 2016.
You had written to me on 01 March 2017, advising that you would arrange an amended Note to be sent to me, taking consideration of my comments.
I still have not received an amended Note.

You had also provided me on 06 February 2017 with a Note of the Meeting of 24 January 2017 with Mr. Weir and with yourself.
I submitted proposed amendments to that Note on 28 March 2017.
I still await an amended Note.

I particularly would be grateful if you would clarify whether it is intended to provide amended Notes, and if so, when I might expect to receive them.

Thank you,

Aidan.

Comments concerning the Respondent Statement of the Meeting of 06 November 2017

The following are comments regarding the draft Respondent Statement of 06 November 2017, received upon request on 04 March 2018:

- The draft Respondent Statement did not include any reference to a lengthy discussion concerning the difficulty in responding to allegations made of witnesses in their statements without being provided with documentary evidence of those allegations. One such allegation was used to exemplify this difficulty. It has been alleged that I had been allocated more administrative time in my job plan than my colleagues had. Not only was I unaware of having been so, I am unable to clarify whether the allegation is true as I do not have any knowledge of the job plans of my colleagues. It would therefore have been useful to be provided with that clarification in order to be able to make an informed comment upon the allegation.

- Paragraph 5 requires amendment. I was first made aware of a concern having been raised regarding patients who had attended privately and who had subsequently been admitted for TURP after a waiting time that was significantly less than for other patients, when I met with Mr. Weir and with Ms. Hynds on Tuesday 24 January 2017. I was informed in writing that there were nine such patients. The concern had been added to the initial three concerns as Issue Four. It, and the number of patients concerned, were reiterated in the Note of that meeting. Both were again repeated in writing in the Return to Work meeting with Dr. Khan on 09 February 2017. When Dr. Wright wrote to me on 30 March 2017, he claimed that it had been established that there were at least 9 TURP patients who had been seen privately, who were routine in terms of clinical priority, but appeared to have had their NHS procedure done in non-chronological order. Lastly, in his witness statement of 06 April 2017, Mr Carroll reported that he and Martina Corrigan had looked to see if there was a trend for TURP patients to be 'seen out of sequence and there were *(sic)* a number identified'. He did not specify the number.

- As indicated by the draft Respondent Statement, I had been provided, on 03 August 2017, with a list of 11 patients who had procedures performed, having previously had a private consultation. The list included the details of the date upon which each patient had been entered on the waiting list and the date of the procedure performed. It also included a judgement provided by a senior clinician as to whether there had been a clinical reason why each patient had waited such a short period of time. As indicated, I provided copies of a synopsis of each case, including the clinical reasons and circumstances pertaining to the management of each case.

- In doing so, I clarified that the date on which each case had been placed on the waiting list had been correct in only two cases. It did appear that the patients may have been placed on a waiting list on the date upon which their GP was being advised of their admission, with no relation to the date upon which they had had a private consultation. As a consequence, it did appear that one patient was admitted for surgery 54 days after entry on a waiting list rather than 428 days after the consultation when it was agreed to proceed with surgery. However, I also pointed out that another patient had been entered on the waiting list 12 days before he had had any consultation.

- In the course of doing so, and as inadequately indicated in the draft Respondent Statement, I drew attention to the inadequacy of having waiting lists with only two categories of urgency (urgent and routine), instead of four, as had been the case previously. I advised that there is no separate category for red flag patients. Instead, they are added to the urgent waiting list which is almost four years long. I advised that patients awaiting TURP provide an example of the inadequacy of the current categorisation. For example, it could not justified to have patients with indwelling catheters following acute urinary retention, often complicated by acute renal injury or urosepsis or both, waiting four years for admission for TURP.

- Also, in the course of doing so, I expressed concern that another clinician could have arrived at a judgement regarding the clinical justification for admission after any period of time, on the basis of a letter alone. I was particularly concerned that it had not been considered reasonable to have an Personal Information redacted by the USI old woman admitted for ureteroscopic laser lithotripsy to a 1.2 cm stone obstructing her left ureter, and doing so after a period of 25days.

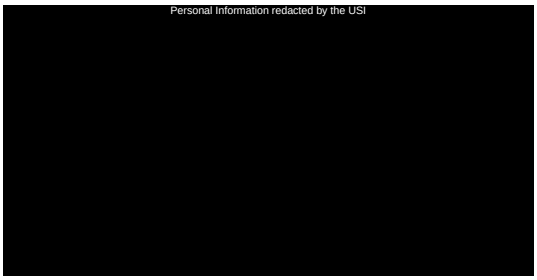
- As inferred by the Respondent Statement, I was asked by Dr. Chada whether there were any further comments I had to make concerning the list provided. I advised that the most striking feature of the list was that it was not a list of nine, or more, patients who has been admitted for TURP after a prior private consultation at all. It did in fact include three patients who had been admitted for TURP after an apparently short period of time following a private consultation, though one of those had been the patient admitted 428 days following that consultation, rather than 54 days.

- At the meeting with Dr. Chada on 03 August 2017, I requested to be advised of the manner in which that conclusion had been reached. I was advised by Ms. Hynds on 28 September 2017 that it had been so by having a report run on all of the surgery performed by me in 2016. I advised Dr. Chada and Ms. Hynds at the meeting of 06 November 2017 that I had since reviewed all of the surgery performed by me during that same period. I reported that a total of 46 patients had prostatic resection (TURP) during 2016, and that indeed nine previously had an private outpatient consultation with me. I advised that the mean time from the consultation when it was decided to proceed to TURP for those nine patients (whether that consultation was the earlier private consultation or an intervening NHS review consultation) was 202 days. The mean waiting period for the remaining 37 patients was 219 days. Also, five (56%) of the nine patients who had had a private consultation had waited more than 100 days, in contrast to fourteen (38%) of the remaining 37 patients. I provided Dr. Chada with these figures, asserting my belief that they do not reflect a preference given to those with whom I had had a private consultation previously.

- The draft Respondent Statement does not include my expressed concerns regarding the above. It does not include my expressed concern regarding the failure to have undertaken a comparative analysis of the periods of time awaited by those admitted for TURP, having had a previous outpatient consultation and those who had not. Since this issue was first raised on 24 January 2017, I had enquired whether such a comparative analysis had been undertaken. In fairness, I had been advised that it had not. Instead, and according to the

Witness Statement from Mr. Carroll, following receipt of one email received from Mr. Haynes, he and Mrs. Corrigan had had a look to see if any such patients were 'seen out of sequence' and that 'there were *(sic)* a number identified'. I expressed my concern that, on the basis of this 'look', a non-comparative conclusion may have been made without any reference to the clinical circumstances. I further expressed my concern that Dr. Wright had then been advised of that conclusion. Indeed, Dr. Wright had additionally stipulated that all nine TURP patients had been categorised as routine! I expressed my concern that the Oversight Group would also have been similarly informed by the time it had met on 26 January 2017 to consider my exclusion.

- Lastly, the draft Respondent Statement does not include my expressed request that this matter be investigated, and that I be advised of its outcome.



Aidan O'Brien
31 March 2018.

Comments relating to the Respondent Statement of Thursday 03 August 2017

The following is a list of comments relating to the interview conducted by Dr. Chada on Thursday 03 August 2017:

- The statement did not include my enquiry relating to my failure to receive amended Notes of previous meetings following my submission of those proposed amendments. (This related to the Note of the meeting with Dr. Wright and Ms. Hainey on 30 December 2016 and to the Note of the meeting with Mr. Weir and Ms. Hynds on 24 January 2017.)

- Paragraph 3 relates that I have been asked to provide this statement in respect of an investigation in response to concerns about my conduct / clinical practice being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework. Paragraph 3 is incorrect as I was not asked to provide this statement in accordance with either the Trust Guidelines or the Framework, nor could I have possibly been asked to do so, for the reasons as detailed in my letter of 30 July 2017, addressed to Dr. Khan. Succinctly, the Trust formulated its Guidelines in September 2010 in response to its obligation to do so, in order to implement the Framework. Therefore, such an investigation can only be conducted by the Trust in accordance with its Guidelines, and as the investigation was not completed by 30 January 2017, its continuation since then cannot have been, and has not been, in accordance with its Guidelines.

- Paragraph 7 should read: 'Of the non-personalised referrals allocated to me, i.e., those allocated to me as Consultant Urologist of the week, I triaged all red flag referrals during 2015 and 2016, but did not triage the remaining referrals during 2015 and 2016.

- Even though later paragraphs elaborate further, Paragraph 8 requires some amendment by way of clarification. The practice of allocating referrals to be triaged by the Consultant Urologist of the week, whilst being Consultant Urologist of the week, was introduced concurrent with the introduction of the Consultant Urologist of the week model in 2014. Whilst I did agree with it being so, I soon found it impossible to do, and in did advise by early 2015 that I had found it impossible to do. The possibility or otherwise of doing so was not assisted by the complete lack of any clarity or agreement regarding the detail of the triaging process.

- Paragraph 9 referred to the number of referrals which I had not triaged during 2015 and 2016. I have been provided with the details of 319 referrals which I had not triaged during that time, and agree that that number is factually correct.

- The second sentence in Paragraph 13 should read: 'The *quantity* of referrals is such that cannot properly triage them'.

- Paragraph 14 is very important. Did I ever say that I was no longer doing this. I believe that I did by advising that I had found it impossible to do. I did not use the words 'I am no longer

doing this' as I did not appreciate that those words were required in addition to advising that I had found it impossible to do, but nevertheless, I do regret not additionally doing so.

- The second sentence of Paragraph 16 should read 'I had endeavoured to get colleagues to do *advanced* red flag triage'.

- Paragraph 20 should also have included my assertion that I am aware that inpatient care has been compromised by Consultants of the week conducting triage while being Consultant Urologist of the week, and patients have suffered as a consequence.

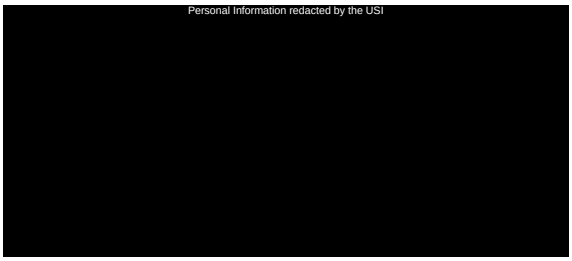
- The first sentence of Paragraph 29 should read 'It was noted that I had returned *288* sets of notes from home, *on 03 January 2017,* on request from the Medical Director in *December 2016'.*

- The first three sentences of Paragraph 31 should read 'I returned a total of 288 charts from my home. These included 77 Trust charts of patients who had attended privately and 211 Trust charts of NHS patients, the latter consisting of 22 patients who had been discharged, and 189 patients who had attended clinics, without dictation.

- Paragraph 34 should read 'I shared a copy of the outcome sheets I returned to Martina Corrigan in January 2017. I accepted that there were *41 clinics for which dictated outcomes had not been done for all patients who had attended those clinics. A total of 450 patients had attended those clinics. Following their clinical prioritisation, 261 (58%) patients had clinical outcomes dictated and implemented, 189 patients had not.'*

- The first sentence of Paragraph 41 should read 'I accepted that outcome sheets for the *41* clinics were not returned on time'.

- The third sentence of paragraph 43 should read '*There are 189 of the patients with less clinical priority, some of whom are waiting long periods of time to be reviewed.'*



Aidan O'Brien
30 March 2018

Comments concerning Witness Statements

In commenting upon the statements of witnesses, I have endeavoured to restrict them to those which I have considered pertinent to the substantive issues of concern, while avoiding repetition unless relevant to do so. Lack of comment on all said does not infer acceptance.

Comments concerning the Witness Statement of Ms. Katherine Robinson

- Paragraph 5 relates that Mr. O'Brien's triage was raised every Tuesday morning at Dr. Rankin's meeting, as she would have tabled the issue, and that triage was always discussed every Tuesday morning. I find it remarkable that management would have discussed an issue every week during the tenure of Dr. Rankin, and failed to have discussed that issue with me as frequently as it was discussed about and without me.

- In Paragraph 8, Ms. Robinson relates that copies of referrals to Mr. O'Brien were kept in case they were not triaged, and so that they could go to other consultants. This is a new revelation for me. I have not been aware of this having been done. I would have thought that I would have been advised of such by my colleagues if it had been the case, or have read reference to it in their Witness Statements.

Comments concerning the Witness Statement of Mrs. Heather Trouton

- I am alarmed to read in Paragraph 5 that Mrs. Trouton asserted that she was aware that I did not agree with triage, and that I made it clear that I did not agree with the three categories of referral, that red flags were important but that the others were not. This is of course completely untrue. I have never disagreed with triage. On the contrary, I believe that triage is most important, and so important that it requires time to do properly. Ironically, the triaging of red flag referrals is less important and less time consuming by the very nature of their clinical urgency which will dictate that they will be assessed in an appropriately, timely manner. It is the remaining majority of referrals that are even more important and time consuming, particularly in the context of an urgent referral having to wait over 80 weeks for an outpatient consultation, and a routine referral having to wait over 100 weeks for a similar consultation. It requires time to request investigations, give advice, initiate treatment and review reports, so that such patients may have some progress made in their investigation and management during those periods of time.

- On the contrary. I do believe that Mrs. Trouton was absolutely correct when she asserted that I did not agree with the system in place, and for all of the reasons which I have alluded to above and previously.

- I am pleased to note in Paragraph 9 that Mrs. Trouton related that I had possibly said that I was not doing triage. At least one person has been able to equate my reporting that I had found it impossible to do, with not doing so. In relating that it was never agreed that he could not do it, I assume that she may have meant to say that it was never agreed that I was permitted not to do so. It is indeed true that I did not receive a permission not to do

APPENDICES

Appendix 1	Letter to Mr A O'Brien from Mr Eamon Mackle and Mrs Heather Trouton	23 March 2016
Appendix 2	Note of Meeting with Mr O'Brien	30 December 2016
Appendix 3	Letter to Mr O'Brien re immediate exclusion from Dr Richard Wright	6 January 2017
Appendix 4	Letter to Mr O'Brien re Formal Investigation process	20 January 2017
Appendix 5	Note of Meeting with Mr O'Brien 24 January 2017 and Mr O'Brien's amendments	24 January 2017
Appendix 6	Preliminary Report from Case Investigator for consideration by Case Manager/Case Conference	26 January 2017
Appendix 7	Letter to Mr A O'Brien re outcome of Case Conference	6 February 2017
Appendix 8	Return to Work Management Plan	9 February 2017
Appendix 9	Terms of Reference for Investigation	
Appendix 10	Mr O'Brien's comments re witness statements	
Appendix 11	Witness Statement – Mrs Martina Corrigan	15 March 2017
Appendix 12	Witness Statement – Mr Michael Young	23 March 2017
Appendix 13	Witness Statement – Mrs Claire Graham	3 April 2017
Appendix 14	Witness Statement - Mr Ronan Carroll	6 April 2017
Appendix 15	Witness Statement – Mr Eamon Mackle	24 April 2017
Appendix 16	Witness Statement – Mr Anthony Glackin	3 May 2017
Appendix 17	Witness Statement – Mrs Anita Carroll	19 May 2017
Appendix 18	Witness Statement – Mr Colin Weir	24 May 2017
Appendix 19	Witness Statement – Mr Mark Haynes	24 May 2017
Appendix 20	Witness Statement – Ms Noeleen Elliott	24 May 2017
Appendix 21	Witness Statement – Mrs Helen Forde	5 June 2017
Appendix 22	Witness Statement – Mrs Heather Trouton	5 June 2017

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- On the contrary. I do believe that Mrs. Trouton was absolutely correct when she asserted that I did not agree with the system in place, and for all of the reasons which I have alluded to above and previously.

- I am pleased to note in Paragraph 9 that Mrs. Trouton related that I had possibly said that I was not doing triage. At least one person has been able to equate my reporting that I had found it impossible to do, with not doing so. In relating that it was never agreed that he could not do it, I assume that she may have meant to say that it was never agreed that I was permitted not to do so. It is indeed true that I did not receive a permission not to do

so, but I was advised of the implementation of the default process of reverting to the category of referral stated in the letter of referral, for that very reason.

- Mrs. Trouton is mistaken in paragraph 11 in asserting that most referrals are red flag referrals, which have always and still do comprise a minority of the total of referrals

- I was surprised to learn in Paragraph 13 that a meeting had been held with Dr. Wright on 11 January 2016 regarding the issues raised in the letter given to me on 23 March 2016. I was surprised particularly as I had had a meeting with Dr. Wright on Friday 01 April 2016 concerning unrelated matters. I would have considered that concerns of such import would have been raised with me at that time.

- Mrs. Trouton is mistaken in relating in Paragraph 14 that a complaint had been received from me, accusing Mr. Mackle of bullying. I did not submit any complaint of bullying on the part of Mr. Mackle. Instead, I had submitted on 30 January 2012 a formal written grievance concerning deductions that Mr. Mackle had unilaterally made to payments owed to me for extra-contractual work undertaken by me. The grievance was upheld. As Mr. Mackle's wife was terminally ill at that time, I suspended further proceedings, reserving the right to resume doing so, if the need arose.

- In Paragraph 20, Mrs. Trouton asserted that nothing was recorded in patients' charts concerning consultations. This I would entirely dispute. I have never in my career not entered a legible, hand-written note in a patient's chart concerning their consultation, in sharp contrast to many who have written nothing.

Comments concerning the Witness Statement of Mr. Colin Weir

- I have found it remarkable, if not alarming, to read in Paragraphs 6 -9 that discussions were being regularly held between so many people regarding the issues contained in the letter of 23 March 2016, and over a period of months thereafter, and including Dr. Mc Allister, Mr. Weir, Mr. Haynes, Mr Young, Mrs. Corrigan and Mr. Carroll, and that during all of that time, no one had managed to discuss the issues with me, with a view to arriving at a supported plan to assist in addressing and resolving the issues.

- I certainly have found it alarming to read in Paragraph 10 that Mr. Weir was told at a point not to meet with me concerning the issues. As I have previously asserted, there has been a complete failure of management to provide support to me after 23 March 2016 to address and resolve the issues. To learn that the Clinical Director was directed not to do so, is a more serious matter altogether.

- In paragraph 15, Mr. Weir related that Dr. Mc Allister felt that the correspondence of 23 March 2016 had not addressed the problem. I agree.

Comments concerning the Witness Statement of Mr. Eamon Mackle

- In Paragraph 10, Mr. Mackle relates that he had to deal with the appropriateness of Mr. O'Brien's use of antibiotics. In fact, this issue related to the practice of both Mr. Young and I electively readmitting patients, who regularly suffered from recurring urosepsis, for intravenous hydration and antibiotic therapy, in order to minimise the frequency and severity of infection. This practice was disapproved by the Trust. However, our experience was subsequently published, having proven to be successful in its purpose, and without emerging antibiotic resistance.

- In Paragraph 10, Mr. Mackle relates that they had been alerted by nursing staff that Mr. O'Brien had removed notes from a patient's chart and dumped them in a bin in the ward. In fact, I had removed fluid balance charts of years previously from the chart [redacted] as there was not enough space in her chart to file continuation sheets on which I had written clinical notes while the patient was an inpatient. I had formed the judgement that the fluid balance charts of years previously were not likely ever to be required, while the current clinical notes were pertinent. I did place them in the confidential waste bin in the ward. My doing so was reported by a ward clerk, not by nursing staff.

- It is worthy of note that, in Paragraphs 11 and 12, Mr. Mackle relates that I had complained that he was bullying / harassing him, while omitting to report that the single complaint that I had formally submitted related to the deduction of payments and the resulting breach of contract referred to above.

- In paragraph 14, Mr. Mackle relates that I had stopped seeing new patients to clear a backlog and that 18 months previously, I had asked for another month free to similarly do so. Again, this is untrue.

- Most importantly of all, Mr. Mackle certainly did not set out to me the actions I needed to take when he gave me the letter of 23 March 2016, and as he claims to have done in Paragraph 21. He has been correct in his statement that no supports to address the issues were discussed.

Comments concerning the Witness statement of Mrs. Martina Corrigan

- Mrs. Corrigan relates in Paragraph 12 that the issues of concern had been verbally addressed with me by Dr. Patrick Loughran and by Dr. John Simpson. I only had one meeting with Dr. Loughran during his tenure as Medical Director, and that was in the company of Mr. Young and in relation to the elective readmission of patients for intravenous hydration and antibiotic therapy. The only occasions when in the company of Dr. John Simpson was on interview panels. I have never had a meeting with Dr. Simpson. Neither spoke to me at any time regarding these issues. Even though I had had a meeting

with Dr. Wright on Friday 01 April 2016, these issues were not raised by him. The first time he raised these issues with me was on 30 December 2016.

- In Paragraph 14, Mrs. Corrigan relates that I was offered help. Mr. Young did indeed carry out triage for me from February 2014 to June 2014, and which I very much appreciated at that time as I had to spend so much time on preparing the Trust for Peer review of Urological Cancer Services. I gain the impression that other help was offered. None was.

- In Paragraph 14, Mrs. Corrigan asserts that I would always have said that I was determined to give a Rolls Royce service to his patients. This assertion is just patently untrue. I have never used the metaphor and have never considered that the service which I have provided, has been to some unnecessary standard of luxury or perfection. This is a good example of a perception of me being attributed to me.

- Mrs. Corrigan incorrectly states in Paragraph 15 that I needed 30 minutes consultation with each patient. The only patient cohort for which I claimed to need 30 minutes of consultation time was cancer patients, whether new or review. The BAUS guidelines 2016 state that 20 minutes be provided for the new, generic patient and 10 – 15 minutes for the review generic patient. For new patients attending a specialist clinic, the BAUS guidelines recommended 30 – 45 minutes per patient and 15 – 45 minutes for the review patient.

- In Paragraph 15, Mrs. Corrigan states that I 'see' on average 10 patients where others will have 14 – 16 patients booked to their clinics. However, it is my understanding that 9 new patients attend each New Clinic per consultant, and that 12 patients attend each general review clinic per consultant. At oncology review clinics, I review 7 or 8 patients in additional to 2 or 3 patients for urodynamic studies, with or without flexible cystoscopy. I believe that this is in accordance with BAUS guidelines. If I have been 'seeing' less patients than my colleagues, then perhaps it is my colleagues who may not be practising in accordance with BAUS guidelines.

- In Paragraph 16, Mrs. Corrigan asserts that it was preference to operate rather than do outpatient clinics, and that I would sometimes agree and do a 9 am to 8 pm list (always my choice). Indeed, I always agreed to do a 9 am to 8 pm operating session if available, and without remuneration, foregoing annual leave on those days, only due to having 280 patients awaiting surgery for up to four years.

- In Paragraph 17, Mrs. Corrigan states that I have been allocated additional administration sessions because of my attention to detail. As stated previously, I have been unaware of having additional time allocated to administration.

- In Paragraph 17, Mrs. Corrigan relates that I spent large amounts of time preparing for the chairing of Urology MDM and that others considered was unnecessary. I believe that it was necessary, and I have never been advised by others that it was unnecessary.

- In Paragraph 19, Mrs. Corrigan refers to 365 charts returned to my office from my home in January 2017. For the sake of accuracy, 288 were returned from my home, the remainder having been on shelves in my office.

- In Paragraph 22, Mrs. Corrigan relates that 668 patients did not have letters dictated. I do not recognise this figure, and I have not been provided with documentary evidence in support of it.

- In Paragraph 25, Mrs. Corrigan repeats the assertion that there were 66 clinics not dictated. As I have submitted in detail, there were only 189 patients for whom letters had not been dictated from 41 clinics

Comments concerning the Witness Statement of Mr. Ronan Carroll

- In Paragraph 6, Mr. Carroll states that at one time, in 2007, I told him that I did not agree with the cancer standards, and that I would continue to practise as I had always done. For the sake of clarification, I only reservation I had in relation to cancer standards was the complete lack of any standards relating to the rest of urological pathology. If I had not agreed with the cancer standards per se, I would not have dedicated so much of my time over a period of four years being Lead Clinician and Chair of the NICaN Urology Clinical Reference Group, and Lead Clinician of the Southern Trust urology MDT and Chair of its MDM.

- In Paragraphs 7 and 8, Mr. Carroll states that either Mr. Haynes or Mr. Glackin felt that the Patient 10 [redacted] should have been upgraded to red flag based on the symptoms. As detailed in my response to the SAI relating to this patient, the symptom of pain could not have been considered a reason to upgrade to red flag status a patient reported to have a simple renal cyst.

- In Paragraph 18, Mr. Carroll states that Mr. O'Brien never said that he was not doing triage. I find Mr. Carroll's omniscience remarkable.

- In Paragraph 26, Mr. Carroll states that my colleagues follow the two categories of urgency allocated to patients on waiting lists. I certainly hope that they are not doing so!

Comments concerning the Witness Statement of Mr. Mark Haynes

- I do agree with Mr. Haynes' assertion in Paragraph 10 that triage should by definition be conducted and categorised by the referrer, rather than by the secondary care clinician to ensure that the referrer has done so properly. However, I do not anticipate that allocating the proper category of referral to the referrer will gain much traction. Nevertheless, I do believe that it should be possible to raise the threshold for referral, as much more investigation and management could, and should, be carried out in primary care, particularly in the light of long waiting times for a first outpatient consultation.

- Also in Paragraph 10, Mr. Haynes correctly asserts that triage takes up an inordinate amount of consultant time. We receive approximately 176 referrals per week. If five minutes were spent on each referral, that would require almost 15 hours, almost two working days. Though I have referred to this matter previously, undertaking triage while

being Urologist of the week, has resulted in triage being conducted instead of patient management. Patients have been acutely admitted and discharged without ever having been seen by the Consultant, have had unsupervised surgery performed by the registrar with suboptimal outcomes, have been discharged without surgery which could have been done. It has appeared to me that triage has assumed a primacy whilst being urologist of the week, because of its associated standards, whilst the management of inpatients has lost that primacy, because it does not have standards related to it.

Comments concerning the Witness Statement of Mr. Anthony Glackin

- In Paragraph 17, Mr. Glackin refers to the referral which gave rise to the SAI. I believe that this Paragraph is of central importance to the issue of triage. I do agree that it had been entirely reasonable for the GP to have referred this patient routinely. I do still contend that it can only be logical that the referral would have been triaged as routine, if triage is confined to the information contained in the referral. I then find it most interesting that Mr. Glackin asserts that we had agreed as a team to arrange investigations before attendance at clinics, and if this had been done, it would have been appreciated that there were other aspects to the case which would have resulted in upgrading to red flag status. I have already submitted documentary evidence that I had been unable to obtain a commitment from my colleagues to do so for red flag referrals which constitute a minority of referrals. In Paragraph 14 of her Witness Statement, Mrs. Corrigan stated that I had wanted to conduct advanced triage, but that advanced triage had not been agreed. This lack of agreement to a standard of triage in every case, and the complete failure of Trust management to address this issue, persists. I do believe that the waiting times relating to urgent and routine referrals should mandate that proper, complete, advanced triage be conducted on each case. I believe that the time required to do so, whilst Urologist of the week, has been and remains untenable and unsafe. It was for that reason that I advised that I had found it impossible to do.

- In Paragraph 18, Mr. Glackin relates that my written response to the SAI was very lengthy and written in an adversarial and legal manner. I agree that it was very lengthy indeed, and was so because it was forensic, and being so led to conclusions which I reached, and which have been highlighted once again in the Comment above.

- In Paragraph 35, Mr. Glackin relates that I had requested administration time on the Tuesday morning which followed the monthly Monday clinic at SWAH, and that this caused dissent among other members of the team. I have not appreciated that doing so could have caused dissent. I still do not understand how it is that not undertaking either of the twice monthly, day case surgical operating list on the morning after the SWAH clinic could have done so.

- In Paragraph 36, Mr. Glackin asserts that productivity at the SWAH clinic has been poor. It has been my understanding that it was agreed that Mr. Young and I would have 16 patients attend our clinics in SWAH. I have had no appreciation that the numbers attending my SWAH clinic has been lower than those attending Mr. Young's clinic, and have been provided with evidence to that effect.

Appendix 23	Witness Statement – Ms Katherine Robinson	5 June 2017
Appendix 24	Letter to Mr O'Brien re investigation meeting	14 June 2017
Appendix 25	Respondent Statement – Mr A O'Brien	3 August 2017
Appendix 26	Respondent Statement – Mr A O'Brien and comments	6 November 2017
Appendix 27	Integrated Elective Access Protocol Executive Summary	April 2008
Appendix 28	Un-triaged Referral Lists and Photos	
Appendix 29	Referrals	
Appendix 30	Notes stored at Home – Photos	
Appendix 31	Letter to Mr O'Brien re missing notes and Mr O'Brien's Response	23 January 2017
Appendix 32	Sample of Outcome Sheets from clinics	
Appendix 33	Private Patient Letters	
Appendix 34	M Young's Assessment of Private Patient priority	
Appendix 35	Mr O'Brien's Response to Private Patients Concern	
Appendix 36	Sample of Urology Outcome Sheets	

because SWAH is a long day and I would have to do admin work after that. I did administrative work all the time.

38. I provided a folder to Dr Chada in terms of additionality and time required to organise work, I did clinics over and above my requirements. I explained I was at a point asked to lower my number of Pas in my job plan. I explained that for me the greatest thing is theatre time over and above admin time. This pales to virtual insignificance in terms of patients who are getting procedures done. For example in 2016 I didn't take 1 operating day off on leave.

39. Dr Chada stated that it is important that we must meet what the Trust requires of me. That we cannot decide what we want to do.. She stated that we can raise issues but we can't just not do aspects of our work. I explained that I had written and raised this over 25 years to outline delays but this is what happens when the Trust doesn't address it. Patients ring me when they can't be seen, not the Trust. GPs are desperately begging for surgery to be done.

40. I have a frustration with the preoccupation about dictating at end of clinic by some of my colleagues. Sometimes it needs to wait 24/48 hours for results.

41. I accepted that outcome sheets for the 68 clinics were not returned on time. I explained that I introduced clinical outcome sheets years ago as a fail safe if e.g. medical records misfiled or take chart and outcome sheet missed. I gave the outcome sheets to my secretary as cross check to ensure things are done. I accept there is no outcome/dictation for a particular point in time – this is the 211 patients on the sheet. I would have dictated on charts before they were returned to the Trust but the outcome sheet wasn't returned until all of the clinic was processed. I accept that by doing this the safety measure of the outcome sheet was not in place – that is true.

42. Dictation was done for urgent patients. I may not have had an outcome for clinic but there would be an outcome on the dictated letter for the patients completed. I may have done one outcome and amalgamated letters. Until this investigation arose, I was entirely unaware of any obligation to dictate on every episode. I am not aware of any explicit requirement to dictate on each contact. I have looked at the GMC guidance on this. I feel dictation has gone overboard, I was quite taken aback by the requirement to dictate on every contact. It is important but not the most important thing I have to do within the next hour after seeing a patient. I might have to go theatre, I simply don't have enough time to complete all work. I have watched a colleague do triage at 11pm when he should be sleeping.

43. I returned all outcomes on 9th January. I accept a number of the people who have had to be added to lists were not dictated contemporaneously. There are 211 of the patients with less clinical priority who are waiting long periods of time to be reviewed. This has been lengthened by 6 months because of this investigation.

Angela Kerr

From:
Sent:
To:

-----Original Message-----
From: Hynds, Siobhan [redacted]
To: Aidan O'Brien [redacted]
CC: Chada, Neta [redacted]; Khan, Ahmed [redacted];
Wilkinson, John [redacted]
Sent: Sun, 10 Jun 2018 20:01
Subject: RE: Investigation

Mr O'Brien

My apologies if you were waiting on a response in respect of the matters below. Your e-mail was a response to a number of e-mails I had sent to you requesting your comments to both your own statements and the witness statements. Despite a number of e-mails to you including one which notified you of the fact that the report was being finalised you hadn't responded to my requests within any of the timescales requested by me to you.

As a result and as notified to you, the Case investigator proceeded to write the investigation report. As I received your comments after I had notified you of the drafting of the report, rather than delay any further, your comments have been appended in full to the final report for the Case manager to consider. This was done in the interests of moving the matter forward as I had been requesting your comments as far back as November 17.

The Case investigator report is completed and a meeting is being held with the Case manager this week. It will be for the case manager to share the report with you for your comments on factual accuracy once he has had time to consider it.

Regards,

Siobhan

From: Aidan O'Brien [mailto:[redacted]
Sent: 10 June 2018 17:08
To: Hynds, Siobhan
Cc: Chada, Neta; Khan, Ahmed; Wilkinson, John
Subject: Investigation

Siobhan,

I refer to my email of 02 April 2018, attached below.
I have not yet received a reply, acknowledging its receipt.
I would appreciate if you would provide an acknowledgement as soon as possible.
I would also be grateful if you could provide me with a time frame in which I will receive a substantive response to the points raised in the Comments attached.
I would also appreciate if you would provide me with the amended minutes of meetings as requested, and promised, over one year ago.

Finally,17 months have elapsed since this investigation was initiated, and 16 months in breach of Trust Guidelines.
I would be grateful if you could provide an update on when the report on the investigation is likely to be completed and when I am likely to receive it.

MHPS RESPONSE
APPENDIX 11

Inpatient Operating 2013 - 2016

2013:	Job Plan	70 sessions
	Actual done	113
2014:	Job Plan	70 sessions
	Actual done	101.25
2015:	Job Plan	70
	Actual done	95.5
2016:	Job Plan	61
	Actual done	83.25

All of this additional operating was directed to those patients in most need.

All of this additional operating resulted in scores of patients having less poor outcomes than they would have had otherwise.

There remain 30 patients on my waiting list at risk of suffering poorer clinical outcomes as a consequence of their delayed admissions.

MHPS RESPONSE
APPENDIX 12

DATE	CLINIC	CLINIC CODE	PATIENTS	COMPLETED	UNDONE
24/11/2014	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
22/12/2014	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
12/01/2015	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
23/02/2015	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
09/03/2015	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
13/04/2015	SWAH	EUROAOB	15	8	7
11/05/2015	SWAH	EUROAOB	17	10	7
22/06/2015	SWAH	EUROAOB	16	7	9
06/07/2015	SWAH	EUROAOB	15	5	10
28/09/2015	SWAH	EUROAOB	15	6	9
19/10/2015	SWAH	EUROAOB	15	8	7
02/11/2015	ARMAGH CLINIC	AAOBU1	RETURNED BEFORE 30TH DECEMBER 2016		
06/11/2015	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
24/11/2015	NEW CLINIC	CAOBTDU	RETURNED BEFORE 30TH DECEMBER 2016		
30/11/2015	SWAH	EUROAOB	16	9	7
04/12/2015	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
0 .2/2015	ARMAGH CLINIC	AAOBU1	RETURNED BEFORE 30TH DECEMBER 2016		
22/12/2015	NEW CLINIC	CAOBTDU	7	4	3
08/01/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
11/01/2016	SWAH	EUROAOB	17	10	7
15/01/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
08/02/2016	SWAH	EUROAOB	18	10	8
07/03/2016	SWAH	EUROAOB	16	5	11
21/03/2016	ARMAGH CLINIC	AAOBU1	16	13	3
01/04/2016	UROONCOLOGY CLINIC	CAOBUO	9	8	1
04/04/2016	REVIEW CLINIC - CAH	CAOBTDUR	13	7	6
08/04/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
15/04/2016	UROONCOLOGY CLINIC	CAOBUO	7	5	2
18/04/2016	ARMAGH CLINIC	AAOBU1	13	8	5
19/04/2016	NEW CLINIC	CAOBTDU	6	3	3
22/04/2016	UROONCOLOGY CLINIC	CAOBUO	5	4	1
27/04/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
2 /04/2016	UROONCOLOGY CLINIC	CAOBUO	9	3	6
29/04/2016	URODYNAMICS CLINIC	CAOBUDS	3	1	2
03/05/2016	REVIEW CLINIC - CAH	CAOBTDUR	RETURNED BEFORE 30TH DECEMBER 2016		
06/05/2016	HOT CLINIC		2	0	2
23/05/2016	REVIEW CLINIC - CAH	CAOBTDUR	16	12	4
27/05/2016	UROONCOLOGY CLINIC	CAOBUO	10	8	2
27/05/2016	URODYNAMICS CLINIC	CAOBUDS	5	4	1
03/06/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
10/06/2016	UROONCOLOGY CLINIC	CAOBUO	12	11	1
13/06/2016	ARMAGH CLINIC	AAOBU1	15	7	8
20/06/2016	SWAH	EUROAOB	21	13	8
04/07/2016	REVIEW CLINIC - CAH	CAOBTDUR	17	10	7
22/07/2016	UROONCOLOGY CLINIC	CAOBUO	12	11	1
26/07/2016	NEW CLINIC	CAOBTDU	7	4	3
09/08/2016	NEW CLINIC	CAOBTDU	10	6	4
12/08/2016	UROONCOLOGY CLINIC	CAOBUO	9	7	2
19/08/2016	URODYNAMICS CLINIC	CAOBUDS	3	2	1

19/08/2016	UROONCOLOGY CLINIC	EUROAOB	5	4	1
22/08/2016	SWAH	EUROAOB	16	4	12
19/09/2016	SWAH	EUROAOB	18	7	11
07/10/2016	URODYNAMICS CLINIC	CAOBUDS	3	2	1
11/10/2016	NEW CLINIC	CAOBTDU	9	8	1
14/10/2016	URODYNAMICS CLINIC	CABOUDS	3	2	1
14/10/2016	UROONCOLOGY CLINIC	CAOBUO	5	3	2
21/10/2016	URODYNAMICS CLINIC	CAOBUDS	4	2	2
28/10/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
28/10/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
04/11/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
04/11/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
			PATIENTS	COMPLETED	NOT PROCESSED
	TOTAL OF 41 CLINICS		450	261	189

BREAKDOWN OF UNPROCESSED	REVIEW	DISCHARGES	DNA	THORNDALE	DAY SURG	INPATIENT W/L
189	110	35	10	13	7	14

Corrigan, Martina

From: Hynds, Siobhan [redacted]
Sent: 23 May 2018 00:41
To: Chada, Neta
Subject: Report of Investigation - MHPS Mr A O'Brien - DRAFT MAY 2018 c
Attachments: Report of Investigation - MHPS Mr A O'Brien - DRAFT MAY 2018 c.docx

Importance: High

Dr Chada

I am unfortunately still not complete with this……..

There are some investigation findings and conclusions which need to be finished. However – could you make a start with this version and let me know what you are happy with / not happy with…….

Anything you want to change / amend – please feel free. Happy for you to re-write if needed……..

I am in CAH tomorrow in Trust HQ until lunchtime but am free after that – would you have any time to get a quick catch up?

Siobhan

Southern Health and Social Care Trust

Quality Care - for you, with you

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

O'Brien provides a clear account of the concerns at that time. Within the letter of 23 March, it seeks action to be taken by Mr O'Brien to address the concerns.

It is Mr O'Brien's contention that no support or management plan was discussed with him to assist him to address the concerns highlighted. I was unable to find any supporting evidence to suggest that any of Mr O'Brien's managers had met with him to discuss what was expected of him in terms of addressing the concerns. In fact, it would appear that when this letter was issued to Mr O'Brien, the extent of the issues of concern had not been assessed. Most witnesses described an awareness of the concern but described shock at the actual extent of un-triaged referrals discovered in December 2016. The 23 March 16 was a missed opportunity by managers to fully review and understand the extent of the issues. There was no management follow up to the letter of 23 March 16 with Mr O'Brien.

Nonetheless,, the responsibility for triage of the referrals was that of Mr O'Brien's. He is clear that he was aware of the agreed process and that during the course of at least 2015 and 2016, he undertook red flag triage only. All other referrals were set aside and triage was not completed.

I am in no doubt that Mr O'Brien knew a default process was happening, otherwise it would beg the question as to what he believed was happening to those patients.

There is no dispute to the fact that Mr O'Brien complained many times about triage. It is however accepted by Mr O'Brien, that he never said he was not completing triage. His colleagues were aware that he complained about doing triage but they did not have knowledge of the fact that he was not undertaking any routine or urgent referral triage. As a senior experienced Consultant, there was a responsibility on Mr O'Brien to make it clear and known that he was not doing triage and to seek assistance.

Mr O'Brien did however provide a context to why he was unable to triage routine and urgent referrals. Mr O'Brien outlined that the workload within the urology service and his own personal workload was unmanageable with long review lists. Mr O'Brien's review list, along with Mr Young's were longer than more recently appointed Consultants and he had requested on a number of occasions to refrain from seeing any new patients. This is something that did not happen. I accept that workloads within Urology, like many other specialties are heavy, and it can be difficult to manage all aspects of the workload.

I did however refrain from exploring this in any significant depth as the issue of concern relates to the fact that Mr O'Brien failed to properly highlight to the Trust that he was not undertaking this agreed aspect of his role. While there are differing views on what is a

manageable workload, all other Urology Consultants, managed triage alongside their other competing priorities. At no point did Mr O'Brien make it clear that he was only undertaking red-flag triage.

Therefore, in response to the specific term of reference:

It is accepted by Mr O'Brien that he did not undertake non-red flag referral triage during 2015 and 2016 and he also accepted that there were 783 un-triaged referrals during this period.

As outlined above, the reason for triage by the Consultant Urologist, is to ensure that, as the specialist, they review the referral information to ensure all referrals are properly categorised prior to being added to the waiting lists. The fact that this was not completed had the potential for all 783 patients to have been added to the incorrect waiting list.

We now know that of the 783 patients, 24 would have been upgraded to red flag status by other consultant urologists (and this has now been actioned.) The fact that they weren't upgraded on receipt of referral means the timescales for assessment and implementation of their treatment plans was delayed.

Of the 24 patients upgraded, we know that 5 of these patients have a confirmed cancer diagnosis. All 5 patients have been significantly delayed commencing an appropriate treatment plan.

Term Of Reference 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.

Witnesses indicated it was well known Mr O'Brien did not always return case notes. This was a particular issue in relation to SWAH clinics, as noted above. Managers were not aware of the number of notes, and nor could medical records staff identify that there were a large volume of notes tracked out to one individual.

Personal Information redacted by the USI		Personal Information redacted by the USI	Closed	
			Closed	
			Closed	
			Closed	
			Closed	
			Closed	
			Closed	

Patient 10 – is a [redacted] year old female patient diagnosed with renal cancer. There was a 64 week delay from when the referral was received to the patient being seen. This patient also was diagnosed with breast cancer.

Patient 11 – is a [redacted] year old male patient diagnosed with prostate cancer. There was a 207 day delay from when the referral was received to the patient being seen.

Patient 13 – is a [redacted] year old male patient diagnosed with aggressive bladder cancer. There was a 179 day delay from when the referral was received to the patient being seen. This patient should have been on the 62 day pathway and with treatment started within that timeframe.

Patient 12 – is a [redacted] year old male patient diagnosed with prostate cancer. There was a 151 day delay from when the referral was received to the patient being seen.

Patient 14 – is a [redacted] year old male patient diagnosed with prostate cancer. There was a 238 day delay from when the referral was received to the patient being seen.

UROLOGY RED FLAG OUTCOMES AND DELAY

Patient 10				
Patient 14				
Patient 11				
Patient 13	28-Jul-16	8 – 15 Aug 2016	23-Jan-17	179 days
Patient 12	08-Sep-16	18 – 22 Sept 2016	06-Feb-17	151 days

SAI investigations are on-going in respect of the additional 4 patients with confirmed cancer diagnoses.

All referral documentation was provided to Mr O'Brien for his comment as part of the investigation. His response to this matter is contained within section 6.

clear managers knew there was a significant problem with Mr O'Brien completing triage, given that a default system was put in place to address this very issue. It seems managers were not aware of the extent of the undone triage. Failure to triage has resulted in delays of diagnosis and treatment, given the diagnosis of cancer in five patients reviewed. This must be interpreted as harm.

Mr O'Brien stored excessive numbers of case notes at his home for lengthy periods. 288 charts were brought by him from his home and returned in January 2017. This is outside normal acceptable practice. There were 13 case notes missing but the review team is satisfied with Mr O'Brien's account that he does not have these.

There were 66 clinics (668 patients) undictated and 68 with no outcome sheets, some going back a few years. This is unacceptable practice. Mr O'Brien gave an explanation of doing a summary account of each episode at the end. He indicated patients were added to waiting lists at the point they should have been in any event. It was difficult to be clear if this resulted in delays in treatment given the lengthy waiting time in this specialty in any event. Nonetheless, I feel this delay with clinic letters was unhelpful in keeping GPs up to date with what was happening with their patients as often, despite lengthy discussions with the patient, they would go to the GP for further explanations/ clarification which the GP could not then provide. Further, it means the waiting list was not an accurate reflection of waits.

From the information available it does seem some patients were added to the theatre list schedule earlier than their clinical priority would have dictated.

Many of the problems outlined in the terms of reference were known to managers before 2016 and as a consequence I feel that there were earlier opportunities to address concerns (prior to 2016) and these opportunities were not taken in a consistent, planned or robust manner. Mr O'Brien indicated he raised concerns about triage repeatedly, and that managers were aware of the fact he had notes in his home. Nonetheless, as a senior and experienced Consultant, it was incumbent upon Mr O'Brien to ensure it was fully and clearly known that he has stopped undertaking all triage.

Whilst, there is little doubt Mr O'Brien is a skilled and conscientious doctor, a number of managers and colleagues reported he was felt not to be a team player, and chose to work in his own way, e.g. preferring to add on theatre lists rather than complete outstanding administration. I would conclude that Mr O'Brien did not always work to the Trust's expectations/requirements.

Stinson, Emma M

From: Clayton, Wendy < Personal Information redacted by the USI
Sent: 06 January 2017 10:47
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: TURP audit

Ronan – this is what you need? All the below pts had a Personal Information redacted by the USI private letter on NIECR. Doesn't mean there could be more but no private letter on NIECR

Casenote	Health & Care Number	Hospital Description	Date on Waiting List	Date Operation	Days Between Added to WL and Operation Date	Proc Category
Personal Information redacted by the USI		Craigavon Area Hospital	07/09/2015	06/07/2016	**303**	TURPT
		Craigavon Area Hospital	13/10/2015	16/03/2016	**155**	TURPT
		Craigavon Area Hospital	25/04/2016	04/05/2016	**9**	TURBT
		Craigavon Area Hospital	05/05/2016	15/06/2016	**41**	TURBT
		Craigavon Area Hospital	30/10/2015	17/08/2016	**292**	TURPT/TURBT
		Craigavon Area Hospital	18/01/2016	27/01/2016	**9**	TURPT
		Craigavon Area Hospital	27/05/2016	29/06/2016	**33**	TURPT
		Craigavon Area Hospital	29/06/2016	27/07/2016	**28**	TURPT

Regards

Wendy Clayton
Operational Support Lead
ATICS/SEC
Tel: Personal Information redacted by USI
Mob: Personal Information redacted by the USI

-----Original Message-----
From: Carroll, Ronan
Sent: 06 January 2017 10:10
To: Clayton, Wendy; Corrigan, Martina
Subject: FW: TURP audit

Wendy
Tks can u display so that we can see the pts timeline Eg when seen, operated on - total waiting time

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

-----Original Message-----
From: Clayton, Wendy
Sent: 05 January 2017 15:53

6.	Personal Information redacted by the USI	Patient seen on 11 April 2016, letter dictated on 22 February 2017
7.		No Urology entries in the Chart or on PAS
8.		No Urology entries in the Chart or on PAS

Mr O'Brien provided a response to this concern and this is contained in section 6 of the report.

Private Patients

During the preliminary review of the concerns, a further concern was identified by Mr Mark Haynes, Consultant Urologist. Mr Haynes was concerned that Mr O'Brien may have added some of his private TURP patients to the Trust lists for procedures / surgery ahead of NHS patients with the same or greater clinical priority.

It was initially advised to Mr O'Brien that a review of his TURP patients had been undertaken however during the course of the investigation it was established that a full review of Mr O'Brien's private patients had been undertaken.

Of the patients reviewed, there was concern about 11 of Mr O'Brien's private patients who appeared to have had their procedure / surgery done on the NHS within much shorter timeframes than would be expected given their clinical priority. **(Appendix 33)**

Mr Michael Young, Lead Consultant Urologist was asked to review the 11 patients to determine if, in his opinion, there was a clinical need for the patients to have been treated in the timescales identified. **(Appendix 34)**

Mr Young's assessment is outlined in the table below:

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

Casenote	Date on Waiting List	Date Operation	Days from Added to WL to Operation Date	Is there a clinical reason why the patient should have been treated within such a short time? M Young
Personal Information redacted by the USI	22/02/2016	22/03/2016	29	No

Personal Information redacted by the USI	25/04/2016	04/05/2016	9	Reasonable – Red Flag
	11/04/2016	15/04/2016	4	No
	01/04/2016	27/04/2016	26	No
	08/07/2016	09/08/2016	32	No
	29/07/2016	21/09/2016	54	No
	04/12/2015	24/02/2016	82	Reasonable
	11/07/2016	17/08/2016	37	No
	08/10/16	02/11/16	25	No
	31/10/16	04/11/16	5	No
	16/02/2016	24/02/2016	8	No

Mr O'Brien was provided with the list of patients and the clinical information reviewed by Mr Young in order to respond to the issue of concern. **(Appendix 35)**

Mr O'Brien's response to the concern is documented in section 6 of the report.

7. Mr O'Brien's responses to the concerns

Meeting with Mr O'Brien – 30 December 2016

This was the initial meeting with Mr O'Brien. The meeting was an opportunity to advise Mr O'Brien of the concerns and to advise him of the management action to be implemented initially to allow further scoping of the extent of the concerns.

A copy of the note of the meeting was shared with Mr O'Brien**.** Mr O'Brien wrote to Dr Wright on 21 February 2017 with a number of suggested changes to the notes. Dr Wright amended the notes to the extent he accepted the representations made by Mr O'Brien and shared an amended copy of the notes **(Appendix 6).**

TURP 2016

Patient	Hosp No.	Date of Surgery	Waiting Time
[redacted]		27/01/16	12 days (Attended Privately 28/02/15)
		27/01/16	705 days
		10/02/16	23 days
		10/02/16	12 days
		24/02/16	26 days
		26/02/16	14 days
		09/03/16	32 days
		09/03/16	83 days
		16/03/16	23 days
		16/03/16	155 days (Attended Privately 07/03/15)
		23/03/16	24 days
		13/04/16	400 days
		13/04/16	14 days
		04/05/16	54 days
		04/05/16	58 days
		17/05/16	581 days
		18/05/16	15 days
		25/05/16	61 days
		01/06/16	17 days
		15/06/16	65 days
		15/06/16	443 days (Attended Privately 01/11/14)
		29/06/16	427 days
		06/07/16	305 days (Attended Privately 15/08/15)

Personal Information redacted by the USI

PRIVATE PATIENTS

Personal Information redacted by the USI Personal Information redacted by the USI

This man attended privately on 20 February 2016. I found him to be a very anxious man concerned, if not convinced, that his right scrotal swelling was an indication of cancer. His concern at that time was in the context of his mother being gravely ill in hospital, requiring laparotomy for bowel obstruction. He was her main carer. I am unaware of her outcome. I was unable to convince him that the right scrotal swelling was benign, and felt that it was justified in the context of his anxieties and his mother's illness to be able to eliminate his concern by arranging his admission to the Day Surgical Admission for hydrocoelectomy **(after 31 days).**

Even though I did so on 22 March 2017, he returned again on 25 June 2017, his persistent concern regarding cancer centred on persistent left abdominal pain for which reason I arranged for him to have a CT scan of his abdomen and pelvis on 20 July 2017, finding no evidence of any such pathology. Instead, it was evident that he had significant degenerative pathology throughout his thoracolumbar spine. I believe that he was then adequately relieved of his anxiety. However, I note that he has been urgently referred to Mental Health in August 2017 because of worsening depression. I have attached my review letter of16 August 2016.

Personal Information redacted by the USI Personal Information redacted by the USI

Personal Information redacted by the USI was an [redacted] year old lady brought to see me privately by her daughters on 19 March 2016 as they were concerned by their mother's visible haematuria. She was found on CT scanning to have a bladder tumour obstructing her right ureter resulting in a deterioration of her global renal function. She was admitted on 04 May 2017 **(after 46 days)** for resection of the bladder tumour and ureteric stenting. Following subsequent stent removal and intravesical chemotherapy, she has had no recurrence of carcinoma since.

Personal Information redacted by the USI Personal Information redacted by the USI

Personal Information redacted by the USI had been referred by his GP in December 2014 for assessment of troublesome urinary symptoms, and later referred by a Dermatologist in February 2015 for assessment of balanitis. He attended privately on 02 May 2015 when he reported that he was most troubled by urgency and urge incontinence. Even though anticholinergic therapy reduced the severity of the incontinence, the persistent urgency made it very difficult for him to care for and visit his Personal Information redacted by USI It was for that reason that I expedited his further assessment by flexible cystoscopy and urodynamic studies on 15 April 2016 **(after 349 days)** and as an additional patient in SPA time.

I am not persuaded by the justifications provided by Mr O'Brien for why the 9 private patients highlighted above were seen in the timeframes outlined. I would conclude that these patients seen privately by Mr O'Brien were scheduled for surgeries earlier than their clinical need dictated. These patients were advantaged over HSC patient's with the same clinical priority.

Mr O'Brien's explanation for patient Personal Information redacted by the USI was that he undertook surgery for this patient, a personal friend, in an additional theatre session and therefore no HSC patient was affected. If an additional session was available in Theatre, patients from the waiting list should have been seen in chronological order.

Term Of Reference 5

To determine to what extent 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.

It was confirmed by a range of witnesses that they were aware of the difficulties in respect of Mr O'Brien's administrative practices.

Senior managers indicated they were aware of issues with regards to triage but not the extent of the issues. There had been attempts to raise this before 2016 with Mr O'Brien and in response, things would have improved for a while but then reverted again. I believe managers must have known there were significant ongoing issues of concern, given that a default system was put in place in 2015. However it was noted the default system meant this issue was no longer escalated to senior managers as the default system meant the triage was allocated as per the GP's impression. It was noted senior managers agreed with Mr Young that he would undertake Mr O'Brien's triage for 6-8 months whilst Mr O'Brien chaired a regional group. Clinics were also shortened to allow more admin time, extra PAs were paid for, admin time and no day surgery was scheduled after a SWAH clinic. It was indicated MDM letters which were always dictated were very long and detailed, and if theatres were unused Mr O'Brien would ask to increase his theatre time, i.e. additional time for his admin was being used in other ways.

Senior managers were aware Mr O'Brien took clinic notes to his home after the SWAH clinics and there were delays in notes being brought back. However, there is not a robust system in place for determining how many charts are tracked out to one consultant, nor how long the notes were gone for; as such managers were not aware of the extent of the problem.

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

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.

Corrigan, Martina

From: Young, Michael
Sent: 27 May 2015 21:36
To: Haynes, Mark; Corrigan, Martina
Subject: RE: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15

Internal email for those on this circulation only

Point taken
Agree
Play a straight honest game.
We are best placed defining our lists but at risk if above comments not taken on board.
Management not playing straight either by resetting patients clock.

But this is not the approach I want for the Dept

Few issues not prepared to put on paper about process = so discuss later.
Discussion required.

Mark's points very valid – I fully appreciate the questions raised

MY
Lead

From: Haynes, Mark
Sent: 27 May 2015 20:54
To: Young, Michael; Corrigan, Martina
Subject: FW: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15
Importance: High

Dear Michael / Martina

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

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

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

after the Erne clinic. A further point noted in relation to the clinic administration is that I was unaware that outcome sheets had not been returned either. We had previously agreed that charts, dictation and outcome sheets should be regarded as separate in case something got lost.

Mr Young was unable to complete his interview on Thursday 23 March 2017 and it was agreed to re-schedule to complete the interview. Mr Young met again with Dr Chada on Monday 3 April 2017.

33. In respect of TOR 4, I am aware that Mr O'Brien does private consultations at home, he doesn't see private patients in the hospital at all to my knowledge. I know this through conversations with Mr O'Brien. As far as I am aware Mr O'Brien does not perform surgery privately, patients convert to the NHS for their treatment.

34. I can't comment on the placement of private patients in the NHS queue. I don't track Mr O'Brien's patients. Any concerns I heard about private patients were just hearsay. I had no idea when patients were seen by Mr O'Brien at his home. I would have thought patients go on to the NHS list as per clinical priority. I have subsequently heard that some private patients might have been given dates sooner on the list but I was not aware if this was down to clinical priority. While I have recently heard this, I personally had no evidence of it.

35. In respect of patients with no dictated outcome letters, I was involved in the 'look back' excercise and I have completed 3 to 4 clinics so far. I was asked to review charts to work out the outcome of the patients. I reviewed the chart on its own without the 'outcome sheet'. I was asked to see if I could determine what action was required and if an outcome could be assessed from the available written documentation. The initial priority however was to clear up the un-triaged letters and that work is now complete.

36. On review of the clinics there was a mix of things in terms of outcomes. The vast number had no dictated letter to cover the attendance at clinic. The GP certainly and the hospital doctors would therefore have had no outcome from the consultation / referral. If the chart was available, working out what had happened with the patient could be possible as Mr O'Brien does generally write a lot of information in the chart so as to determine a care pathway. This would be the case in most but not all the cases.

37. Because of the lack of communication, I suspect there would probably have been GPs sending another referral. One example I came across had 5 consultations with an individual without any outcome letters from any of the contacts. Even without a letter the Outcome sheets would have allowed a secretary to action any plans.

38. I found out about the issue of undictated outcomes on 14 December 2016. Mr O'Brien's secretary hadn't received an outcome sheet for a period of time. It appears to me that Mr O'Brien seems to

14. Ideally all triage should be completed within 24 hours. I feel this is reasonable. The reality is that on-call week is busy and comes down to what is reasonable for that week. I might not get all triage done and might have to complete some of it the following week. Some Consultants work quicker than others and so each Consultant has to take responsibility for the referrals during their week on-call, otherwise it would roll into the next week and the next Consultant can't pick up outstanding triage.

15. In my view, what's reasonable depends upon the original referral category so for example red flags should be done within 24 hours. For urgent and routines within 3-7 days is fine.

16. I know at least one patient, Patient 10 who could have come to harm because Mr O'Brien did not triage and I believe there is another delayed cancer diagnosis for a bladder cancer patient so potentially, yes, patients have come to harm. As it turned out Patient 10 had the breast secondaries picked up because of the delay.

17. In respect of TOR 2, I have completed IR1's in the past because of notes. I recall 2 patients both of whom were seen in clinic by Mr O'Brien where there was no dictation. I picked up one patient because I was asked by Martina Corrigan. The 2nd was a lady from Omagh seen in clinic who was told she was coming to me. It didn't happen and so the GP sent another referral in. the first referral had not been triaged anyway. When I took her to theatre to do a nephrectomy there were no notes. I put an IR1 in about that.

18. I am also aware that there were times when notes were not available. This is when I was doing backlog review clinics. I have seen patients with no dictation from previous attendances and no notes available. That's very difficult. At times I was told the notes were not available so I said I wouldn't see patients without notes. (There would have been no letter on ECR either.)

19. At one point notes were found in Enniskillen clinic and there was a referral to me done 4 to 5 months after I operated on the patient. There was clearly no check that things were improving. When notes were returned in December I had already operated on the patient. There was a letter done then, dated December though the letter didn't take account for the surgery already done. (ie the dictated letter was done prior to notes being brought in to the hospital in December and not at the time.) That shows a lack of insight.

20. Mr O'Brien's patients were added to the waiting lists at the time they should have joined based on the GP referral. Unlike the other Consultants, Mr O'Brien managed his own waiting list. Mr O'Brien would have all his patient's organised himself, his secretary did not do this. It was not always clear why he added people to his waiting lists as he did. He did all the phoning/ planning and arranging himself. Other consultants let their secretary do that. No-one knows whats on his wating list as he manages it himself.

21. I know there has been an issue with undictated clinics and I know this stretches back further than 2015. I know of one patient who attended clinic 6 times dating back to 2013 and there was no no

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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

Comments relating to the Respondent Statement of Thursday 03 August 2017

The following is a list of comments relating to the interview conducted by Dr. Chada on Thursday 03 August 2017:

- The statement did not include my enquiry relating to my failure to receive amended Notes of previous meetings following my submission of those proposed amendments. (This related to the Note of the meeting with Dr. Wright and Ms. Hainey on 30 December 2016 and to the Note of the meeting with Mr. Weir and Ms. Hynds on 24 January 2017.)

- Paragraph 3 relates that I have been asked to provide this statement in respect of an investigation in response to concerns about my conduct / clinical practice being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework. Paragraph 3 is incorrect as I was not asked to provide this statement in accordance with either the Trust Guidelines or the Framework, nor could I have possibly been asked to do so, for the reasons as detailed in my letter of 30 July 2017, addressed to Dr. Khan. Succinctly, the Trust formulated its Guidelines in September 2010 in response to its obligation to do so, in order to implement the Framework. Therefore, such an investigation can only be conducted by the Trust in accordance with its Guidelines, and as the investigation was not completed by 30 January 2017, its continuation since then cannot have been, and has not been, in accordance with its Guidelines.

- Paragraph 7 should read: 'Of the non-personalised referrals allocated to me, i.e., those allocated to me as Consultant Urologist of the week, I triaged all red flag referrals during 2015 and 2016, but did not triage the remaining referrals during 2015 and 2016.

- Even though later paragraphs elaborate further, Paragraph 8 requires some amendment by way of clarification. The practice of allocating referrals to be triaged by the Consultant Urologist of the week, whilst being Consultant Urologist of the week, was introduced concurrent with the introduction of the Consultant Urologist of the week model in 2014. Whilst I did agree with it being so, I soon found it impossible to do, and in did advise by early 2015 that I had found it impossible to do. The possibility or otherwise of doing so was not assisted by the complete lack of any clarity or agreement regarding the detail of the triaging process.

- Paragraph 9 referred to the number of referrals which I had not triaged during 2015 and 2016. I have been provided with the details of 319 referrals which I had not triaged during that time, and agree that that number is factually correct.

- The second sentence in Paragraph 13 should read: 'The *quantity* of referrals is such that cannot properly triage them'.

- Paragraph 14 is very important. Did I ever say that I was no longer doing this. I believe that I did by advising that I had found it impossible to do. I did not use the words 'I am no longer

Comments concerning the Respondent Statement of the Meeting of 06 November 2017

The following are comments regarding the draft Respondent Statement of 06 November 2017, received upon request on 04 March 2018:

- The draft Respondent Statement did not include any reference to a lengthy discussion concerning the difficulty in responding to allegations made of witnesses in their statements without being provided with documentary evidence of those allegations. One such allegation was used to exemplify this difficulty. It has been alleged that I had been allocated more administrative time in my job plan than my colleagues had. Not only was I unaware of having been so, I am unable to clarify whether the allegation is true as I do not have any knowledge of the job plans of my colleagues. It would therefore have been useful to be provided with that clarification in order to be able to make an informed comment upon the allegation.

- Paragraph 5 requires amendment. I was first made aware of a concern having been raised regarding patients who had attended privately and who had subsequently been admitted for TURP after a waiting time that was significantly less than for other patients, when I met with Mr. Weir and with Ms. Hynds on Tuesday 24 January 2017. I was informed in writing that there were nine such patients. The concern had been added to the initial three concerns as Issue Four. It, and the number of patients concerned, were reiterated in the Note of that meeting. Both were again repeated in writing in the Return to Work meeting with Dr. Khan on 09 February 2017. When Dr. Wright wrote to me on 30 March 2017, he claimed that it had been established that there were at least 9 TURP patients who had been seen privately, who were routine in terms of clinical priority, but appeared to have had their NHS procedure done in non-chronological order. Lastly, in his witness statement of 06 April 2017, Mr Carroll reported that he and Martina Corrigan had looked to see if there was a trend for TURP patients to be 'seen out of sequence and there were *(sic)* a number identified'. He did not specify the number.

- As indicated by the draft Respondent Statement, I had been provided, on 03 August 2017, with a list of 11 patients who had procedures performed, having previously had a private consultation. The list included the details of the date upon which each patient had been entered on the waiting list and the date of the procedure performed. It also included a judgement provided by a senior clinician as to whether there had been a clinical reason why each patient had waited such a short period of time. As indicated, I provided copies of a synopsis of each case, including the clinical reasons and circumstances pertaining to the management of each case.

- In doing so, I clarified that the date on which each case had been placed on the waiting list had been correct in only two cases. It did appear that the patients may have been placed on a waiting list on the date upon which their GP was being advised of their admission, with no relation to the date upon which they had had a private consultation. As a consequence, it did appear that one patient was admitted for surgery 54 days after entry on a waiting list rather than 428 days after the consultation when it was agreed to proceed with surgery. However, I also pointed out that another patient had been entered on the waiting list 12 days before he had had any consultation.

Dr Neta Chada, Case Investigator met with Mr O'Brien on 6 November to seek a response to term of reference 4 and to seek any final comments in respect of any issue related to the investigation. Mr O'Brien has provided recent commentary in respect of the statement drafted for his agreement. Given the timing of receipt of this commentary and to avoid further delay with conclusion of the investigation, the drafted statement along with Mr O'Brien's comments have been included for completeness. **(Appendix 26)**

Mr O'Brien raised a number of concerns in respect of this matter, these included:

- At the outset of the investigation and at a number of subsequent meetings it had been advised to Mr O'Brien that the issue of concern related to his TURP private patients. Upon enquiry by Mr O'Brien and further investigation by the Case Investigator, it was established that a review had taken place of all Mr O'Brien's private patients. The 11 private patients highlighted as concerning were not solely TURP patients.

- The list of 11 patients provided to Mr O'Brien for comment highlighted the date upon which each patient had been entered onto the waiting list and also the date the procedure was performed. Mr O'Brien disputed the dates on which the case had been placed on to the waiting list in the majority of cases. He advised that, for example, in one case there was a difference between the date a patient was added to the waiting list versus the date of consultation when a decision to proceed to surgery was made.

- Concern that another clinician could have arrived at a judgement regarding the clinical justification for admission, after a period of time, on the basis of a letter alone.

- Concern that a comparative analysis of the periods of time awaited by those patients admitted for procedure having had a previous outpatient consultation and those who had not, had not been undertaken.

In response to Mr Young's assessment of clinical need and the timescales identified Mr O'Brien provided a comprehensive response for each patient which is included in **Appendix 35**.

The table below highlights Mr O'Brien's analysis of the dates and waiting times in RED.

In January 2017, as part of the MHPS process, a management plan was put in place in order to safeguard patients and ensure there was no further risk to patient's while these matters were investigated. From January 2017, Mr O'Brien has worked rigidly to the action plan out in place and has met all requirements of the action plan on an on-going basis. I can only conclude therefore, that Mr O'Brien is capable of adhering to the required acceptable administrative practices continuing.

At no point during the investigation has any concern been highlighted about Mr O'Brien's hands on patient care / clinical ability.

Lastly, during interviews and in correspondence, Mr O'Brien has displayed some lack of reflection and insight into the potential seriousness of the above issues. His reflection on the patients with delayed diagnoses was disappointing and is noted above. He did not seem to accept the importance of administration processes – he did not feel regular dictation was important and he does his own thing about replacing administration time with extra operating lists, whilst at the same time reporting lack of administration time. He felt he couldn't do the triage in the way it was expected, but was also clear that he didn't agree with it anyway. I believe it appropriate and relevant to raise this with the case manager.

Dr Neta Chada
Consultant Psychiatrist / Associate Medical Director
Case Investigator

Corrigan, Martina

From: Hynds, Siobhan [redacted]
Sent: 11 June 2018 22:52
To: Chada, Neta
Subject: Report of Investigation - MHPS Mr A O'Brien - FINAL June 2018
Attachments: Report of Investigation - MHPS Mr A O'Brien - FINAL June 2018.docx

Dr Chada

I have accepted all final changes and this should be the final document. If you read over it tomorrow morning and want to make any changes – I can change and print an updated version before 12 noon so just let me know. Otherwise, this is a final copy for your records.

Siobhan

In January 2017, as part of the MHPS process, a management plan was put in place in order to safeguard patients and ensure there was no further risk to patient's while these matters were investigated. From January 2017, Mr O'Brien has worked rigidly to the action plan out in place and has met all requirements of the action plan on an on-going basis. I can only conclude therefore, that Mr O'Brien is capable of adhering to the required acceptable administrative practices continuing.

At no point during the investigation has any concern been highlighted about Mr O'Brien's hands on patient care / clinical ability.

Lastly, during interviews and in correspondence, Mr O'Brien has displayed an apparent lack of reflection and insight into the potential seriousness of the above issues. I believe it appropriate and relevant to raise this with the case manager.

Dr Neta Chada
Consultant Psychiatrist / Associate Medical Director
Case Investigator

Corrigan, Martina

From: Chada, Neta [redacted]
Sent: 12 June 2018 11:10
To: Hynds, Siobhan
Subject: Report of Investigation - MHPS Mr A O'Brien - FINAL June 2018
Attachments: Report of Investigation - MHPS Mr A O'Brien - FINAL June 2018.docx

See last paragraph ??? too harsh

neta

In January 2017, as part of the MHPS process, a management plan was put in place in order to safeguard patients and ensure there was no further risk to patient's while these matters were investigated. From January 2017, Mr O'Brien has worked rigidly to the action plan out in place and has met all requirements of the action plan on an on-going basis. I can only conclude therefore, that Mr O'Brien is capable of adhering to the required acceptable administrative practices continuing.

At no point during the investigation has any concern been highlighted about Mr O'Brien's hands on patient care / clinical ability.

Lastly, during interviews and in correspondence, Mr O'Brien has displayed some lack of reflection and insight into the potential seriousness of the above issues. His reflection on the patients with delayed diagnoses was disappointing and is noted above. He did not seem to accept the importance of administration processes – he did not feel regular dictation was important and he does his own thing about replacing administration time with extra operating lists, whilst at the same time reporting lack of administration time. He felt he couldn't do the triage in the way it was expected, but was also clear that he didn't agree with it anyway. I believe it appropriate and relevant to raise this with the case manager.

Dr Neta Chada
Consultant Psychiatrist / Associate Medical Director
Case Investigator

Mr O'Brien advised that he felt that how triage was being undertaken by some of his colleagues was unsafe. He further advised that he believed inpatient care has been compromised by Consultants of the week conducting triage while being the Consultant of the week and quality of patient care had suffered as a consequence.

On commenting upon the 5 cases which have confirmed cancer diagnoses, Mr O'Brien was surprised that there were such a small number upgraded. He advised that it was heartening in a number of ways to find 2 of the cases are at an early stage. He noted the irony that one of the patients may have benefitted from the delay. Mr O'Brien commented that Patient 13 was really the only one patient of concern.

Mr O'Brien advised that he has read the referral for patient Patient 10 and he would have kept the triage category as routine as the only way the referral could have been upgraded would have been to review the digitalised images of the patient.

Patient notes

Mr O'Brien clarified for the purposes of accuracy that 288 charts were returned from his home in January 2018, the remainder were located on shelves in his office. He confirmed that the oldest chart held at his home was from April 2015.

Mr O'Brien stated that storing the notes at home didn't affect other specialities as he would always have returned the notes when requested.

Mr O'Brien advised that he did not believe there was any issue of concern for the patients as he had processed 62% of all patients seen at the clinics and these were the most urgent patients. The charts returned unprocessed amounted to 211. Mr O'Brien advised that there was no detriment to any patient as the patient would go back onto the waiting list at the point they should have been seen. Mr O'Brien advised that it needs to be considered in context – 'what is urgent today in terms of a referral may not been seen until next August in any event'.

Un-dictated clinics

Mr O'Brien accepted that there were 41 un-dictated clinics – these outcomes were returned to Martina Corrigan in January 2017.

Mr O'Brien explained that his practice was to record the outcome for a patient at the end of their attendances. Mr O'Brien advised that he would always have given a full update to the

unilaterally advised Payroll to halve agreed, remunerative payments for additional clinical work. The grievance was upheld. I suspended further action as [redacted] at the time.

In Section 8, page 36, the Report states that Mr. O'Brien acknowledged that there were 66 undictated clinic and no dictated outcomes for these. This is untrue. As stated above, the number of clinic incompletely dictated was 51, and the number of patients affected was 189. Even though this information had been submitted to the Case Investigator on 06 November 2017, the Report still includes the wrong information, and claims that I had agreed with it.

In Section 9, Page 45, the Report states that Mr. O'Brien has worked rigidly to the action plan out in place and has met all of requirements of the action plan on an on-going basis. However, this has been at considerable cost. IAs I have continued to find it impossible to complete triageewhile Urologist of the Week, I have had to take an Annual Leave Day on the Friday following completion of the Week to enable me to complete the week's triage. That has also resulted in a reduction in the number of cancer review clinics, normally conducted on Fridays.

Lastly, The Report states that Mr. O'Brien displayed some lack of insight and reflection into the potential seriousness of the above issues. This I would completely dispute this contention. I believe that this impression has been gained due to my disbelief at the lack of insight on the part of the Trust into the harm and risk of harm suffered by patients already on the longest waiting list. It has also been disappointing to read the Report, after 18 months of investigation, concluding that Iedid not agree with triage anyway.e

Terms of Reference

1. Triage

I do accept that I was not undertaking triage of non-red-flag referrals. I have been clear since the outset of this investigation that I was not doing so because I found it impossible to do so. The background to that is explained above in detail.

I agree that triage is a vitally important process to ensure that patent management is initiated effectively and to ensure that patients are correctly categorised. It is my belief that some time with triage is necessary if the Consultant Urologist is to bring the value of his/her specialist expertise to the process and this means that triage becomes time consuming. I believe that it would be beneficial for the department to allocate sufficient time for the Consultants to complete triage effectively. I have raised this issue as part of my response to the SAI and I hope that the Trust will address the issue as soon as possible.

The investigation report states that the issue of concern relates to the fact that I failed to properly highlight to the Trust that I was not undertaking this aspect of the role. I accept that there are steps that I could have taken to more clearly state that I was not undertaking triage of routine or urgent referrals. I regret not having done so. That said, it is relevant to point out that senior management were aware of the fact that I was not completing Triage of non-red-flag referrals. This is demonstrated by the fact that everyone acknowledges that I repeatedly raised the fact that I found it impossible to complete triage, that they knew that triage was not being done and in fact a process was introduced to deal with the fact that it was not being done through the

managers. I was asked to confirm the Trust's responses to questions posed were accurate and complete. I did so for the areas of which I had knowledge.

14.2 With reference to these determinations, I am not aware of who was responsible for the implementation of any action plan/Dr Khan's determination. My involvement in this process ceased once the Investigation Report was handed over to Dr Khan. I am therefore unable to comment on Dr Khan's action plan or how it was implemented.

14.3 I was later (June 2019 email from Mrs Hynds to me located at *Relevant to PIT/ Evidence Added or Renamed 19 01 2022/ Evidence no 77/ No 77 – Dr Neta Chada/ 20190609 – E Urgent response for tomorrow* contacted to provide answers to queries from the General Medical Council about the investigation and did so by email to the then Medical Director, Dr Maria O'Kane.

Implementation and Effectiveness of MHPS

15. Having regard to your experience as Case Investigator, in relation to the investigation into the performance of Mr Aidan O'Brien, what impression have you formed of the implementation and effectiveness of MHPS and the Trust Guidelines both generally, and specifically as regard the case of Mr O'Brien?

15.1 The issue with Maintaining High Professional Standards and the Trust Guidelines are the timeframes which are unrealistic (one might even say impossible unless it is a very straight forward investigation) and don't seem to consider the varying demands on peoples' time. Indeed, as happened in this process, people are being asked to continue with their clinical work and day to day demands, and to gather the information for these processes outside of that. i.e., mostly these investigations are not part of anyone's job plan, and this leads to delays causing frustration/upset for the person under investigation. It is my view that the effectiveness of the investigation process under Maintaining High Professional Standards and the Trust Guidelines depends on the commitment of the people involved, the thoroughness of the investigation (which needs time to do it properly), the information that can be provided to inform the investigation and the resource available (time and secretarial time). For example, whilst my secretary (who was very obliging) kindly did some of the

17. Having had the opportunity to reflect, outline whether in your view the MHPS process could have been better used in order to address the problems which were found to have existed in connection with the practice of Mr O'Brien.

17.1 As a Case Investigator I formed the view issues with Mr O'Brien's practice had been identified in the past and not fully addressed. It is my view this happened for several reasons. Secretaries, managers (at various levels) and colleagues were aware of some of the issues. However, I formed the impression no-one appeared to be aware of all of the issues. I understood there were difficulties in addressing issues in the past as Mr O'Brien had made complaints and this appeared to have led to anxieties within the system about how concerns could be progressed, being mindful to ensure everyone's rights were upheld. There were also changes of personnel in various management posts which I think also added to the difficulties in recognizing the extent of issues and addressing them.

17.2 It seems appropriate to address issues initially informally and then to progress down more formal routes if informal processes don't result in the desired outcome. I think the MHPS process might have been used earlier in this case, however, I am aware one of Mr O'Brien's complaints to us was that it was being used at all. He believed it was used too soon, and without other avenues being exhausted. It seemed to me from the time these processes started in March 2016, a long period of time passed as the Trust tried to ensure the process was properly adhered to in an effort to prevent any future criticism or threat of legal action. The Trust management's level of anxiety about this was clear to me. Mr O'Brien had already made complaints and he had accused a previous medical manager, who was trying to address Mr O'Brien's practice, of harassing him. (Refer to MHPS witness statements by Mr Mackle and Mr Weir.) *Relevant documents can be located at Relevant to HR/ Reference No 1/ MHPS Investigation/ Appendix 15 Witness Statement – Mr E Mackle 240417 and Appendix 18 Witness Statement – Mr C Weir 240517.* I believe there had been a threat of legal action, though I am not sure from where I heard that.

17.3 It does seem having dedicated time for staff, both from a Case Investigator/HR point of view and from an admin point of view, would speed up the process, however, there would still be a requirement for data gathering, comparison with standard practice etc., some of which can only be carried out by clinicians. The process was aided by being able to speak to

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

Summary of concerns

Have you discussed your concerns with an employer liaison adviser? Yes ☒ No ☐

If yes, did the ELA advise you to make a referral to us? Yes ☒ No ☐

Please use the box below to provide the following details:

- summary of the concern(s) including location and who else was involved
- a chronology of events
- details of risk to patient safety (if applicable)e
- summary of all local action taken and on-going investigations (if any)e
- please indicate where you have been unable to verify information contained within this referral (eg where the information is from a source outside of your remit, where a local process is on-going or where you believe there is an evidential conflict)e
- details of any other relevant concerns or previous complaints you are aware of at this time (and local actions and outcomes). This will help us assess whether this incident is parte of a pattern of behaviour.

The concerns

A Serious Adverse Incident (SAI) investigation was commenced within the Trust in April 2017 in respect of a patient 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 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 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.

The Timeline

A full chronology is within the attached formal investigation report.

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.

44. The titles of all training courses undertaken by them in the conduct of formal investigations, the date upon which they were taken and copies of their accreditation.

45. The number of investigations that have been conducted by the above persons, and their respective roles in each of those investigations.

On Page 35, paragraph 3, of Dr Chada's report, it is stated that Datix reports were completed by medical records staff when charts were not returned by Mr. O'Brien. I request the following information:

46. A copy of all the Datix reports referred to above.

On Page 36 of Dr Chada's report, it is stated that Mrs. Corrigan reported complaints from GPs and an MLA about the lack of information concerning patients. I request the following information:

47. A copy of all records of the complaints referred to above.

Dr Chada, in her report, and Dr Khan, in his determination, both persisted to refer to 668 patients who had no dictated outcomes, even though detailed evidence had been submitted to Dr Chada that 189 patients had not had outcomes dictated. I request the following information:

48. The unit numbers or H&C numbers of all 668 patients who allegedly had no dictated outcomes.

On page 37, paragraph 3, of her report, Dr Chada stated that an extensive review exercise was undertaken by Mr. O'Brien's colleagues of all the undictated consultations. I request the following information:

49. A copy of the complete report of this exercise.

In the same above paragraph, Dr Chada claimed that the exercise ensured that all patients had an outcome dictated and a clear management plan for treatment. I request the following information:

50. A copy of the dictated outcomes and the clear management plans for treatment for all of the patients reviewed by my colleagues in the above extensive review exercise.

51. Dr Chada failed to interview Mrs. Gishkori, Mr. Gibson and Dr Wright in her investigation. I request an explanation for her failure to do so.

Ms. S. Hynds

Ms. Siobhan Hynds claimed that Dr Wright had written to Mr. O'Brien advising him of the amendments that he had been prepared to make to the Note of the Meeting of 30 December 2016,

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 38 of 2022

Date of Notice: 29th April 2022

An addendum to this statement was received by the Inquiry on 28 March 2023 and can be found at WIT-91941 to WIT-91942. Annotated by the Urology Services Inquiry.

Witness Statement of: Mr John Wilkinson

I, William John Wilkinson, will say as follows:-

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

1. I was a school principal for 20 years in a post primary school. My qualifications are: M.Sc.in Ed. Man; B.A.; Diploma in Advanced Secondary Education; and PGCE with Commendation. I was Chair of the Classroom 2000 (C2K) curriculum committee and the C2K Board. From my retirement in 2015, I have continued to act as an educational consultant, performing work for various educational bodies. Prior to joining the Southern Health and Social Care Trust ('the Trust') I was a member of the Northern Ireland Council for the Curriculum, Examination and Assessment (NICCEA). During this time, I chaired the Curriculum Committee and the Audit, Risk and Assurance Committee. This was for a period of about 8-10 years. In addition, I was the post primary schools representative on the Southern Education and Library Board for 8 years. On 15th February 2016 I was appointed as a Non-Executive Director to the Board of the Trust. I undertook induction training between 22nd September and 1st December 2016. I received training in Maintaining High Professional Standards on 22nd September 2016.

Urology Services Inquiry

Statement of Truth

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

Personal Information redacted by the USI

Signed: _____

Date: ____30th June 2022_____

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No.38 of 2022

Date of Notice: 29th April 2022

Addendum Witness Statement of: Mr John Wilkinson

I, John Wilkinson, will say as follows:-

1. I wish to make the following amendments to my existing response, dated 30th June 2022, to Section 21 Notice number 38 of 2022.

2. At **WIT-26092** para 2 I state that *"On 19th January I was appointed as the Designated Non-Executive Director…"* I note from **WIT-41952 WDB 49** that it appears that Roberta Brownlee approached me on 9th January 2017 and this should state "*On ~~19~~th January 2017 I was appointed as the Designated Non-Executive Director…"* .

3. At **WIT-26093** para 7 I state that *"on 2 February 2017 I telephoned AOB and arranged a date to meet."* Having considered the document **TRU-261883** I note that on 1 February 2017 Mr O'Brien emailed me asking for the opportunity to meet. This should state *" AOB emailed me on 1 February 2017 requesting an opportunity to meet. On 2 February 2017 I telephoned AOB and arranged a date to meet."*

4 At **WIT-26093 para 9** I state that "*…AOB speculated that if he was to be found wanting in his practice then he would bring a degree of embarrassment to the SHSCT."* This should state "*AOB speculated that if he was to be found wanting in his practice then he would bring a degree of embarrassment to the SHSCT. I have been provided with **AOB-56102**, which is Mr O'Brien's transcript of the covert recording which he made of his meeting with me on 7 February 2017 without my consent. This transcript indicates that I stated "I think what you are saying is that, irrespective of the outcome of this, there could be reputational damage which you. would be concerned about is that what you are saying?" Mr O'Brien responded by stating that "Reputational damage or there could be a disciplinary outcome. The Trust have had the privilege of initiating and carrying out an investigation into me…I don't have the privilege of initiating an investigation into their failures, which in my view are stark and in terms of patient outcomes have consequences that are a multiple of anything that could emanate from mine."*

Urology Services Inquiry

5. At **WIT-26096 para 20** I state that *"on 2nd March 2017 I telephoned and texted AOB seeking a meeting to discuss progress and any other concerns that he might have had. I received no response."* This should state *"On 2nd March 2017 I telephoned and texted AOB seeking a meeting to discuss progress and any other concerns that he might have had. ~~I received no response~~. AOB contacted me on 6 March 2017"*

6. **At WIT-26104 para 55** I provided a list of Trust Board meetings at which AOB was discussed. I state "*On 24th September 2020, 14th October 2020, 15th October 2020, 23rd October 2020 and 10th December 2020 the Trust Board was informed of the progress of the AOB issues at Trust Board meetings and via Early Alerts."* This should state "*On 24th September 2020, 14th October 2020, 15th October 2020, ~~23rd~~ 22nd October 2020, 12 November 2020 and10th December 2020 the Trust Board was informed of the progress of the AOB issues at Trust Board meetings and via Early Alerts".*

Statement of Truth

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

Signed: Personal Information redacted by the USI

Date: 28.03.2023

4. Outline your relevant experience to the Inquiry addressing principally your employment history and the dates during which you served as a non-executive board member of the SHSCT.

59. My employment history prior to joining the Trust Board is set out at above in response to Question 1.

60. I was appointed to the SHSCT Board on 15th February 2016.

61. I received broad general training on Trust policies, procedures and committees between 22nd September 2016 and 1st December 2016. I received specific training on MHPS via DLS on 22nd September 2016.

62. I was appointed as a designated NED in respect of the O'Brien MHPS on 19th January 2017.

5. Outline any prior experience or knowledge you had of the MHPS framework & the Trust Guidelines before being appointed as the designated Board member for an investigation into concerns raised in relation to Mr Aidan O'Brien (Consultant Urologist).

63. I had no other than knowledge of the MHPS and Trust Guidelines except that gained at training as outlined at Questions 4 and 6.

6. Outline and provide documentation of any training or guidance you received with regard to the role of designated Board member with regard to:

I. The MHPS framework;

II. The Trust Guidelines; and

III. The handling of performance concerns generally.

I. MHPS framework

64. I received broad general training on the MHPS framework from DLS during my induction period. This covered the generality of the framework. The role of the Designated NED was unclear and was highlighted as such by the trainer who on several occasions stated that the role was indistinct and that the

- if the case can be progressed by mutual agreement consider if an NCAS assessment would help;
- if a formal approach under conduct or clinical performance procedures is required, appoint a case investigator;
- consider whether further action is required under the conduct, clinical performance or health procedures.

PROTECTING THE PUBLIC

5. From the outset, a fundamental consideration is the continued safety of patients and the public. Whilst exclusion from the workplace may be unavoidable it should not be the sole or first approach to ensuring patient safety. Alternative ways to manage risks, avoiding exclusion, include:
   - arranging supervision of normal contractual clinical duties;
   - restricting the practitioner to certain forms of clinical duties;
   - restricting activities to non clinical duties. By mutual agreement the latter might include some formal retraining;
   - sick leave for the investigation of specific health problems.

6. In the vast majority of cases when action other than immediate exclusion can ensure patient safety the clinician should always initially be dealt with using an informal approach. Only where a resolution cannot be reached informally should a formal investigation be instigated. This will often depend on an individual's agreement to the solutions offered. It is imperative that all action is carried out without any undue delay.

DEFINITION OF ROLES

7. The Board, through the Chief Executive, has responsibility for ensuring that these procedures are established and followed. Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the board should only be sufficient to enable the board to satisfy itself that the procedures are being followed. Only the "*designated Board member* "should be involved to any significant degree in the management of individual cases.

8. The key individuals that may have a role in the process are summarised below:-
   - Chief Executive (CE) – **all** concerns must be registered with the CE who, should a formal investigation be required, must ensure that the following individuals are appointed;
   - the "*designated Board member*" – this is a non-executive member of the Board appointed by the Chairman of the Board, to oversee the case to ensure that momentum is maintained and consider any

Case Manager

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. 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.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.

Please provide your comments in response to each of the instances cited above by Mr. Wilkinson where he draws attention to your engagement with him in the context of the MHPS process, and your engagement with Mr. O'Brien or his family or others, providing all relevant details, as appropriate.

I had no formal contact made to me by Mr O'Brien or any family member that I can recall, and I never met with Mr O'Brien to discuss this investigation.
I do remember Mr O'Brien (or possibly his wife, my PA was in her adjoining office to me) phoning the office and speaking with me about the long-drawn-out process and Trust not meeting its timescales as outlined in the policies. I then informed John Wilkinson of this. On the call Mr O'Brien was upset and I think his wife may have been listening in and she said how stressful and upsetting this lengthy process was.

This was the only call I received and hence why I informed John Wilkinson. John Wilkinson, like other NEDs who had been involved in MHPS, had concerns about a NEDs role in this process. I spoke at least on two occasions to the CX and then the HR Director for a need for urgent training on their role when conducting the MHPS. This training was then arranged and delivered to all NEDs and myself by June Turkington from DLS on 1 December 2019. I did speak with John Wilkinson on the telephone not only about Esther Gishori but about the length of time the process was taking for Mr O'Brien.

I had asked John Wilkinson to call Mr O'Brien to offer additional support. John explained that he didn't feel that he needed to call Mr O'Brien; that he was overwhelmed with the detail in this case, and that he couldn't push HR any more on Mr O'Brien's behalf. I accepted his position on this and that he wouldn't be calling Mr O'Brien.

Mr O'Brien knows I never could or would advocate on his behalf, so I informed John Wilkinson of this call from Mr O'Brien.

56. As regards paragraph 55 above at point (i), did you play or attempt to play any part in any aspect of the process or decision-making regarding the MHPS or

Contemporaneous Notes of

Mtg @ V.T. + J.W

Date: 7.3.17.

Question from AOB handed over

Progress report given by HR.

Clarify the Role
Protect the Role.

Contemporaneous note 7.3

Neves, Joana

From: Wilkinson, John
Sent: 07 March 2017 18:53
To: Aidan O'Brien
Cc: Wilkinson, John
Subject: RE: Update

Dear Aidan
Further to my meeting today, to receive an update as agreed, I can report the following:

1. I was given assurances that the case is progressing.
2. The terms of reference re the investigation will be issued to you imminently .
3. In addition you will be provided with a list of the people, at this stage, with whom the Case Investigator will interview.
4. I am assured that you will be given the opportunity to state your case as part of the process.
5. As the list of people being interviewed will take place over the next 3-4 weeks you could expect to be interviewed by mid to late April '17.
6. The questions you emailed to me last night I have passed on to HR for a response. The questions will be addressed by appropriate persons. I am assured these will be responded to as quickly as possible.

As per my role I will continue to ensure that the momentum is maintained.
If you have any further representations which you would like me to make on your behalf re the investigation, you should forward them to me using this email or using [redacted]
I hope this is helpful.

Regards
John

From: Aidan O'Brien [redacted]
Sent: 06 March 2017 20:08
To: Wilkinson, John
Subject: Questions to be asked

Dear John,

I thank you for taking my call earlier today and I regret disturbing you during your other work commitments.
I wish to emphasise to you how much I appreciate your efforts on my behalf.

However, I had expected or assumed that I would receive a communication from you informing me of answers which you had received to the questions which we had raised with you when we met on 07 February 2017.
I was entirely taken aback and disappointed that a response should come from the Case Manager.
That it did implied to me that your role on my behalf does not enjoy an autonomy.

Since speaking with you earlier today, I have reviewed the Trust Guidelines forensically.
I have attached a list of questions which I require to be answered concerning the conduct of the Trust in handling the concerns raised prior to the decision to formally investigate and immediately exclude.
As these questions pertain to the period prior to the appointment of the Case Manager, I will regard any reply from the Case Manager to be entirely inappropriate,

Many thanks,

Neves, Joana

From:	Aidan O'Brien [redacted]
Sent:	31 July 2017 15:00
To:	Khan, Ahmed
Cc:	Wilkinson, John; Chada, Neta
Subject:	Re; Formal Investigation
Attachments:	Letter to Dr. Khan 30 July 2017.docx

Dear Dr. Khan,

As you will be aware, I have been invited to interview by Dr. Chada on 03 August 2017.
I take this opportunity to register concerns which I have had in relation to the conduct of the above investigation.
I attach a letter addressing those concerns.
I would be grateful if you would acknowledge receipt,

Aidan O'Brien.

whether patients who had had private consultations and who still awaited prostatic resection had been identified, or whether NHS patients who had prostatic resections performed after a similarly short waiting time would be included in a comparative manner in such an investigation. Indeed, in a further communication from the Medical Director, dated 30 March 2017, he advised that all nine patients were classified as routine. I do not know how he could have come to such a conclusion, or who did so, on his behalf. Now, six months later and four days before interview by the Case Investigator, I have still not been advised of any further developments in the investigation of this fourth concern.

On 06 February 2017, I received from Mrs. Hynds a Note of the Meeting of 24 January 2017, inviting me to advise her of any amendments required to the factual accuracy of the Note. On 28 March 2017, I submitted to Mrs. Hynds amendments to be made as a consequence of factual errors and omissions. I still have not received an amended Note.

I was provided with the Terms of Reference for the investigation on 16 March 2017, though NCAS guidelines stipulate that the terms of reference be provided to the practitioner when advised of the formal investigation. On the same date, I was provided with a list of seven witnesses. Dr. Chada advised in her letter of 14 June 2017 that I will have received a witness list from her at an earlier date. I have not received any such list from Dr. Chada. I have not been provided with the testimonies of any witnesses. I have not yet been provided an opportunity to see all relevant correspondence, as obliged by Trust Guidelines.

I had considered deferring this record of my concerns until after interview by Dr. Chada. However, I have decided to do so at this time after a recent experience. I had taken annual leave the week commencing Monday 10 July 2017, but had agreed upon request to be on call on Saturday 15 July and Sunday 16 July 2017. On Friday 14 July 2017, I received calls from colleagues advising me of patients acutely admitted for surgery over the weekend. There were a total of eight patients requiring urgent surgery but I was only able to operate on four due to lack of theatre capacity. Some days later, I was approached by a member of staff whom I presume has not known of this investigation but was concerned enough to advise me that an investigation was being conducted into the cases upon whom I had operated, as it had been reported that I had arranged for one or more of these patients to be admitted electively. I was shocked by this revelation. I reported this experience when I

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.

Neves, Joana

From: Wilkinson, John
Sent: 01 November 2017 09:59
To: Hynds, Siobhan
Cc: aidanpobrien[redacted] Wilkinson, John;[redacted]

Sent from my iPad
Hi Siobhan
I was copied into an email you should have received from Dr O'Brien.
I was simply impressing the importance of receiving this information prior to the meeting on Monday. I hope this can be expedited appropriately.
Regards
John

From: aidanpobrien Personal Information redacted by the USI
To: Siobhan.Hynds Personal Information redacted by the USI
CC: neta.chada Personal Information redacted by the USI Ahmed.Khan Personal Information redacted by the USI John.Wilkinson Personal Information redacted by the USI
BCC: johnwilkinson Personal Information redacted by the USI
Subject: Investigation
Date: Sun, 10 Jun 2018 17:07
Attachments: Comments relating to the Respondent Statement of Thursday 03 August 2017.docx (41K),
Comments concerning the Respondent Statement of the Meeting of 06 November 2017.docx (65K),
Comments concerning Witness Statements.docx (72K)

Siobhan,

I refer to my email of 02 April 2018, attached below.
I have not yet received a reply, acknowledging its receipt.
I would appreciate if you would provide an acknowledgement as soon as possible.
I would also be grateful if you could provide me with a time frame in which I will receive a substantive response to the points raised in the Comments attached.
I would also appreciate if you would provide me with the amended minutes of meetings as requested, and promised, over one year ago.

Finally,17 months have elapsed since this investigation was initiated, and 16 months in breach of Trust Guidelines.
I would be grateful if you could provide an update on when the report on the investigation is likely to be completed and when I am likely to receive it.

Aidan.

-----Original Message-----
From: Aidan O'Brien Personal Information redacted by the USI
To: Siobhan.Hynds Personal Information redacted by the USI
CC: neta.chada Personal Information redacted by the USI
Sent: Mon, 2 Apr 2018 21:14
Subject: Investigation

Siobhan,

Thank you for your email of 04 March 2018.
Thank you for the draft Respondent Statement relating to the meeting of 06 November 2017.

I have attached comments concerning the proposed Respondent Statements of 03 August 2017 and of 06 November 2018.
I have also attached comments relating to the Statements of Witnesses.

I also take this opportunity to remind you that I had written to Dr. Wright on 14 February 2017 with details of factual errors and omissions in the Note of the Meeting I had with him and Ms. Hainey on 30 December 2016.
You had written to me on 01 March 2017, advising that you would arrange an amended Note to be sent to me, taking consideration of my comments.
I still have not received an amended Note.

You had also provided me on 06 February 2017 with a Note of the Meeting of 24 January 2017 with Mr. Weir and with yourself.
I submitted proposed amendments to that Note on 28 March 2017.
I still await an amended Note.

I particularly would be grateful if you would clarify whether it is intended to provide amended Notes, and if so, when I might expect to receive them.

Thank you,

Aidan.

* Can't prolong this but I'm interested in the role of the ~~in general~~ Covid Partners? - Blog - inpatient...

NED Mtg 3pm

JUNE 2020

Thursday 11
163-203

~~SHSCT 1.30~~

8.00
9.00
10.00
11.00
12.00
1.00
2.00
3.00
4.00
5.00
6.00
Evening

Webinar @ 5pm.

Be the manager you always wanted to have!
viz photo on phone.

SHSCT NED Briefing @ 4pm ✓

Received Emails re Aidan O'Brien. - Chair - CX - V. Toal
~~Chair - not part / will reply~~
~~We need to know what has happened.~~
Tel call c Chair, I explained again my role.
(Cx to bring a paper.

- viz Scripted in 19th wrong date

G.P. CNI

Canal

Friday 12
164-202

8.00
9.00
10.00
11.00
12.00
1.00
2.00
3.00
4.00
5.00
6.00
Evening

[redacted] 10.00 am.

Mr AOB

Contact c V. Toal. Explained situation as it stands. Operationally retirement processed However desire to come back requires a conversation. Original issue not dealt c. Still trying to get Grievance done! There have been delays caused both by AOB requests for further info + detail + Trust inability to reach deadlines. Role of NED discussed. [redacted]

Saturday 13
165-201

Sunday 14
166-200

(•) Need assurance around our reaction to another surge - esply if this comes thro' winter pressures.

(•)

July 2020

M	.	6	13	20	27
T	.	7	14	21	28
W	1	8	15	22	29
T	2	9	16	23	30
F	3	10	17	24	31
S	4	11	18	25	.
S	5	12	19	26	.

August 2020

M	.	3	10	17	24	31
T	.	4	11	18	25	.
W	.	5	12	19	26	.
T	.	6	13	20	27	.
F	.	7	14	21	28	.
S	1	8	15	22	29	.
S	2	9	16	23	30	.