centre and any letters that have been addressed to Mr O'Brien and delivered to his office. For these letters it must be ensured that the secretary will record receipt of these on PAS and then all letters must be triaged. The oncall week commences on a Thursday AM for seven days, therefore triage of all referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends.

Red Flag referrals must be completed daily.

All referrals received by Mr O'Brien will be monitored by the Central Booking Centre in line with the above timescales. A report will be shared with the Assistant Director of Acute Services, Anaesthetics and Surgery at the end of each period to ensure all targets have been met.

CONCERN 2

- That, 307 sets of patient notes were returned by Mr O'Brien from his home, 88 sets of notes located within Mr O'Brien's office, 13 sets of notes, tracked to Mr O'Brien, are still missing.

Mr O'Brien is not permitted to remove patient notes off Trust premises.

Notes tracked out to Mr O'Brien must be tracked out to him for the shortest period possible for the management of a patient.

Notes must not be stored in Mr O'Brien's office. Notes should remain located in Mr O'Brien's office for the shortest period required for the management of a patient.

CONCERN 3

- That 668 patients have no outcomes formally dictated from Mr O'Brien's outpatient clinics over a period of at least 18 months.

All clinics must be dictated at the end of each clinic/theatre session via digital dictation. This is already set up in the Thorndale Unit and will be installed on the computer in Mr O'Brien's office and on his Trust laptop and training is being organised for Mr O'Brien on this. This dictation must be done at the end of every clinic and a report via digital dictation will be provided on a weekly basis to the Assistant Director of Acute Services, Anaesthetics and Surgery to ensure all outcomes are dictated.

An outcome / plan / record of each clinic attendance must be recorded for each individual patient and this should include a letter for any patient that did not attend as there must be a record of this back to the GP.

Stinson, Emma M

From: Carroll, Ronan
Sent: 15 December 2021 22:32
To: Stinson, Emma M
Subject: FW: triage not returned

Section 21

Ronan Carrroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob - Personal Information redacted by USI .

From: Corrigan, Martina Personal Information redacted by USI
Sent: 11 July 2017 17:40
To: O'Brien, Aidan
Cc: Weir, Colin; Carroll, Ronan
Subject: triage not returned

Aidan

As per your return to work Action Plan:

Concern 1

Mr O'Brien, when Urologist of the week (once every 6 weeks), must action and triage all referrals for which he is responsible, this will include letters received via the booking centre and any letters that have been addressed to Mr O'Brien and delivered to his office – for these letters the secretary will have to record receipt of these on PAS and then these letters must all be triaged. The oncall week commences on a Thursday AM for seven days, therefore triage of all referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends.

Red Flag referrals must be completed daily.

All referrals received by Mr O'Brien will be monitored by the Central Booking Centre in line with the above timescales. A report will be shared with the Assistant Director of Acute Services, Anaesthetics and Surgery at the end of each period to ensure all targets have been met.

Any deviation from compliance with the targets will be referred to the MHPS Case Manager immediately.

I have been advised by the booking centre that there are 30 'paper' outpatient referrals not returned from your week oncall and this must be addressed urgently please.

Regards

Martina

Hynds, Siobhan

From: Carroll, Ronan <Personal Information redacted by USI>
Sent: 11 July 2017 17:55
To: Hynds, Siobhan
Subject: FW: Charts in Office
Attachments: charts in office (11.7 KB)

FYI

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

From: Corrigan, Martina
Sent: 11 July 2017 17:40
To: O'Brien, Aidan
Cc: Carroll, Ronan; Weir, Colin
Subject: Charts in Office

Aidan

As per your return to work action plan:

Notes should never be stored off site and should only be tracked out and in your office for the shortest time possible - having checked on PAS today there are 90 charts stored in your office dating back to January 2017. I had emailed you 21 June 2017 (attached) and these charts are still tracked out to you.

Therefore, Colin has asked that I arrange for you to meet with him, Ronan and myself on your return from Annual Leave next week and we can discuss when this best suits on Monday.

Regards

Martina

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

INTERNAL: EXT Personal Information ***if dialling from Avaya phone. If dialling from old phone please dial*** Personal Information redacted by USI
EXTERNAL : Personal Information redacted by the USI
Mobile: Personal Information redacted by USI

Buckley, LauraC

From: Corrigan, Martina
Sent: 25 October 2019 09:28
To: Hynds, Siobhan
Cc: Buckley, LauraC
Subject: FW: triage not returned

Regards

Martina

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

Telephone:
EXT Personal Information (Internal)
Personal Information redacted by USI (External)
Personal Information redacted by the USI (Mobile)

From: Corrigan, Martina Personal Information redacted by the USI
Sent: 13 July 2017 08:32
To: Carroll, Ronan; Weir, Colin
Subject: FW: triage not returned

Please see Aidan's response below

Martina

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

Changed My Number

INTERNAL: Personal Information redacted by USI ***if dialling from Avaya phone. If dialling from old phone please dial*** Personal Information redacted by USI
EXTERNAL : Personal Information redacted by USI
Mobile: Personal Information redacted by the USI

From: O'Brien, Aidan
Sent: 12 July 2017 13:59
To: Corrigan, Martina
Subject: RE: triage not returned

Martina,

I have just read this email, finding it so demoralising.

I deferred returning these referrals as each day's bundle included patients who needed to be contacted so that the appropriate triage decision could be made.
Whether because of it being the holiday period, it proved difficult, and in some cases, impossible to contact patients.
I therefore returned the referrals, making fail safe decisions, but having kept a record of patients who may require a more immediate management.
One such was [redacted]) who has a stone in her left ureter and who returned my calls this morning to advise that she was in pain, which I expected her to be.
I had returned her triaged referral to have an Urgent Appointment at a New Clinic, whenever that would have happened.
However, I have arranged her admission today for left ureteroscopic lithotripsy on the emergency list.
By virtue of the returned referrals not having been collected today, 12 July, I have been able to amend the triage decision.

I came in to the hospital today to review a couple of patients admitted since their referrals.
Having done so, I thought I would do some work in my office.
Then I read your emails.

I know how referrals are triaged and returned on time!
It is most certainly not by taking the time to ensure that each patient's current state is most appropriately and expeditiously assessed and managed.
As a consequence of my doing so, I have dictated letters to the referring doctors, and to the patients if I have been unable to speak to them by telephone, in over 50 cases, requesting scans, having conditions treated appropriately, and so forth.
By doing so, investigation is progressing and patients are hopefully deriving benefit from treatment.

Having done all of that. I personally would have been better off ticking the box, being at home on my leave.
And [redacted], she would also be at home, with persistent colic, awaiting the urgent outpatient appointment.

Aidan.

From: Corrigan, Martina
Sent: 11 July 2017 17:40
To: O'Brien, Aidan
Cc: Weir, Colin; Carroll, Ronan
Subject: triage not returned

Aidan

As per your return to work Action Plan:

Concern 1

Mr O'Brien, when Urologist of the week (once every 6 weeks), must action and triage all referrals for which he is responsible, this will include letters received via the booking centre and any letters that have been addressed to Mr O'Brien and delivered to his office – for these letters the secretary will have to record receipt of these on PAS and then these letters must all be triaged. The oncall week commences on a Thursday AM for seven days, therefore triage of all referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends.

Red Flag referrals must be completed daily.

COLIN WEIR: Aidan.

MR O'BRIEN: Hello, Colin.

COLIN WEIR: All right. Right. How's things?

MR O'BRIEN: Tired.

COLIN WEIR: ~~(Inaudible)~~ collect me I did a colectomy at 5 o'clock this morning.

MR O'BRIEN: Oh my goodness.

COLIN WEIR: A bleeding. No source found. We couldn't find it.

MR O'BRIEN: What was it do you think? Some kind of angiodysplasia?

COLIN WEIR: ~~(Inaudible) colectomy~~ Polypectomy two weeks ago. She was too sick for an angiogram at 5 o'clock in the morning, so we just had to go and take the whole colon out. Okay. Right.

MARTINA CORRIGAN: Hello, Aidan.

MR O'BRIEN: Hello, Martina.

COLIN WEIR: Me or you? (Inaudible) that's all this is about.

MR O'BRIEN: Okay.

COLIN WEIR: It is just the number of charts that are sitting in your office sort of are -- I think you've clawed back a bit of late but at one point there was kind of a back log. I think your results -- you do our own results on the charts. Go to your office pending some sort of outcome or dictation or something ~~assist.~~ Correct me if that's wrong. And it is just that we were starting to see a back log back five -- at one point in June you had five charts back to February, 11 in March, 37 April, 39. So that was building up into quite a sizeable number of charts in your office.

MR O'BRIEN: Mmm.

COLIN WEIR: Waiting on an outcome or a dictation. So really that's just kind of -- we don't want -- I suppose you don't want that to accumulate I suppose to that.

MR O'BRIEN: I don't want it at all because I don't know why charts are coming to my office at all. There's no need for them to come into the office.

COLIN WEIR: Right. So what -- so how do we stop that happening, Aidan?

MR O'BRIEN: Just return result without charts. I don't want the charts to be there.

COLIN WEIR: Okay. Do they need -- do they all need a result or what -- why is that -- I don't know what way your practice works but ...

MARTINA CORRIGAN: I suppose whenever you look at the comments, Aidan, on PS against the chart it'll say Mr O'Brien to view result or Mr O'Brien to see for result is the

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574. The return-to-work plan required that dictation was required to be completed after completion of each clinic. This remained a problem because of the limited time actually available to remain on location at outreach clinics for reasons related in response to Question 66.

575. The return-to-work plan required that my secretary would actually choose who would be admitted for surgery. As my secretary was unable to do this, I continued to select patients for admission while my secretary continued to conduct all the administrative tasks which arose as a consequence.

576. The one aspect of the return-to-work plan which could have been done differently was in relation to triage. I believe that it was an opportunity to review the conduct of triage in relation to UOW and in the context of increasingly longer periods for patients awaiting first consultation appointments. I believed then that it was a missed opportunity to appreciate that triage did not need to be conducted by consultants at all and could well have been undertaken by clinical nurse specialists, empowered to request investigations, if not limited prescribing. Instead, the return-to-work plan was a triumph of process over purpose.

577. No issue was raised by the Trust with me in relation to any potential breach of any plan until November 2019 when I received emails from Ms Corrigan, Head of Service, as follows [see AOB-02259 – AOB-02261]:

Email of 5 November:

"Dear Aidan
[Unclear] and I have been asked to meet with you to discuss a deviation from your return to work action plan when you were on call in September…

Email of 6 November:

amended Note to be sent to me, taking consideration of my comments. I sent a further email to Mrs. Hynds on 19 April 2017, advising her that I still awaited receipt of an amended Note of the meeting of 30 December 2016. I have yet to receive a reply, or an amended Note.

As a consequence of my contacting the Case Investigator on 16 January 2017, and of my letter to the Medical Director on 17 January 2017, I was advised by the Case Investigator, by telephone on 19 January 2017, that a meeting was arranged with him and with Mrs. Hynds on 24 January 2017. I was advised that the purpose of the meeting was to discuss alternatives to exclusion. I was then advised by the Case Investigator, in writing on 20 January 2017, that the purpose of the meeting was two-fold, an opportunity to state my case and to propose alternatives to formal exclusion, even though I had not yet been provided an opportunity to discuss alternatives to immediate exclusion. On 23 January 2017, the Medical Director confirmed in writing that a date for the meeting had been proposed. The Medical Director did not advise me of any specific reasons or justifications for immediate exclusion as requested. He did however avail of the opportunity to opine that the Trust Guidelines created an expectation that investigations are completed in four weeks, even though the Guidelines explicitly assert that investigations must be completed within four weeks. That the investigation was in breach of Trust Guidelines was acknowledged at the meeting with the Case Investigator and with Mrs. Hynds on 24 January 2017. That acknowledgement was not included in the Note of the Meeting.

At that meeting, I asked for specific reasons for my immediate exclusion. None could be given. I asked for specific reasons why exclusion should be continued. None could be given. That none could be given was not included in the Note of the Meeting.

It was at that meeting that it was claimed that a fourth issue of concern was identified during the initial scoping exercise and relating to nine patients who had private outpatient consultations, and who then had prostatic resections performed as NHS patients, after waiting times significantly less than for other patients. However, it was not possible for this fourth concern to be identified during scoping of triage of NHS referrals, NHS outpatient consultations and NHS charts retained at my home. I requested how this concern had been raised or who had raised it. I was advised that I would be advised of the source. Six months later, I have still not been advised. I requested the identity of the nine patients concerned. I still have not been advised of their identity. I asked

Of course, I appreciate that the Trust would have needed to review the patients in question. However, the question of whether or not any patients came to harm is not pertinent to the issue of whether there were concerns about my administrative practices that warranted further action. This decision to enlarge the scope of the investigation unnecessarily had the effect of lengthening the duration of the investigation and in fact, the investigation concluded before the conclusion of investigations into harm caused to patients.

2.6.3 Length of Investigation

The Trust Guidelines state at Appendix 2 that the "Case Investigator must complete the investigation within 4 weeks and submit to the Case Manager within a further 5 days. Independent advice should be sought from NCAS." The time limit is therefore compulsory and any investigation longer than 4 weeks is in breach of the Trust's policy.

I have raised this issue on several occasions throughout this process. The one, only and last time any reference was made to the Trust Guidelines was when I was provided with a copy at the meeting with Dr. Wright and Ms. Hainey on 30th December 2016. In Dr Khan's response to my concerns dated 24th February 2017, he ignored the Trust Guidelines and instead referred to the MHPS framework. MHPS allows for an investigation to take longer than 4 weeks in exceptional circumstances. However, MHPS does not form part of my contract. The Trust Guidelines are the relevant guidelines and they do not allow this extension.

The Trust has continued to ignore and thereby breach its own Policies and Procedures and in doing so, have breached my contract of employment.

The length of the extension of time beyond 4 weeks in this case has also been particularly egregious. The investigation took approximately 18 months to complete. Despite this fact, the findings in relation to the numbers of untriaged patients or undictated letters to GPs has not changed since the meeting on 24th January 2017.

It took a period of 3 months to interview 13 witnesses between March and June 2017. No explanation has been offered for the length of time taken to undertake these interviews.

I eventually was interviewed on 3rd August 2017. This was the first time I had met Dr Neta Chada, who had been appointed as Case Investigator some 6 months earlier. This too was contrary to NCAS Guidelines as these advise that the practitioner should be the first to be interviewed. This interview could not cover all of the issues in the case because on the morning of the interview, Dr Chada had just been provided with an anonymised list of patients whom the Trust alleged had been electively admitted for surgery after a shorter period of time because they previously had had a private consultation (see Tab 39). Dr Chada explained that she herself had just received the list of patients. This resulted in a further delay to conclude my interview. This meeting was not scheduled until 6th November 2017.

This delay is unexplainable and unreasonable. The delay has compounded the stress and anxiety that I have contended with since 30th December 2016. It is a breach of contract and has caused personal injury and damage.

2.7 The Investigation into Patients seen privately

O'Brien, Aidan

From: Hynds, Siobhan
Sent: 28 September 2017 23:28
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: Strictly Confidential - MHPS Investigation
Attachments: PRIVATE PATIENtS - 11 Patient letters.pdf; PRIVATE PATIENtS - List and Review Opinion.docx

Importance: High

Mr O'Brien

At our meeting on 3 August it was agreed that the information related to TOR 4 – private patients - would be shared with you for your review before Dr Chada seeks a response to the concern raised. It was also agreed that an explanation of the process of reviewing these patients would be advised to you.

Please find attached information as requested. If you require any further information please let me know.

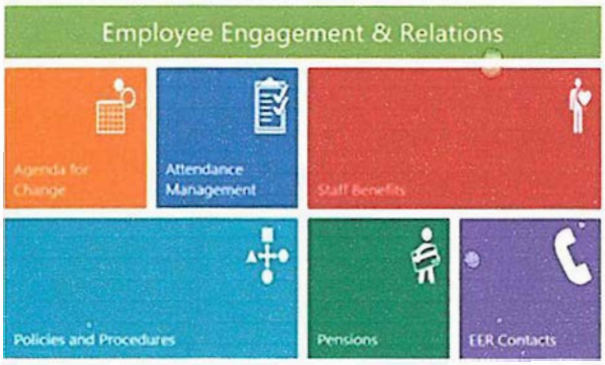
In terms of the process undertaken I can confirm that:

- a report was run on all your surgery during 2016
- the report was reviewed to identify if any patients had a shorter than expected wait time between being added to the waiting list and been operated on
- their record was checked on NIECR to see if they had a private patient letter
- of these there were 11 patients
- the letters were reviewed by Mr Young and a clinical opinion sought as to whether the patient had been placed on the NHS waiting list chronologically given their clinical priority. This was done using the letters and NIECR

Regards,

Siobhan

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



Irrelevant information redacted by the USI

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 28 September 2017 22:59
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: Strictly Confidential - MHPS Investigation
Attachments: Witness Statement - Mrs A Carroll190517.pdf; Witness Statement - Mrs C Graham 030417.pdf; Witness Statement - Mrs H Forde 050617.pdf; Witness Statement - Mrs M Corrigan 150317.pdf; Witness Statement - Ms N Elliott 240517.pdf

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Mr O'Brien

At our meeting on 3 August you had requested a full list of all witnesses interviewed as part of the current MHPS investigation and you sought a copy of all statements.

I can confirm that 13 witnesses in total have been interviewed. This is the full list of witnesses identified by Dr Chada. They are:

- Mr A Glackin, Consultant Urologist
- Mr C Weir, Clinical Director
- Mr E Mackle, Consultant Surgeon
- Mr M Haynes, Consultant Urologist
- Mr R Carroll, Assistant Director
- Mrs A Carroll, Assistant Director
- Mrs C Graham, Head of Service
- Mrs H Forde, Head of Service
- Mrs H Trouton, Assistant Director
- Mrs M Corrigan, Head of Service
- Ms K Robinson, Referral & Booking Centre Manager
- Ms N Elliott, Secretary

I have attached 5 statements I have in PDF format and will attached the remaining statements as soon as I am able to convert them to PDF.

Should you feel there are any witnesses relevant to the current investigation that have not been interviewed, I would be grateful if you could let Dr Chada and myself know. It would be helpful if you could advise the relevance of any suggested further witness/es.

Regards,

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ

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.

Of course, I appreciate that the Trust would have needed to review the patients in question. However, the question of whether or not any patients came to harm is not pertinent to the issue of whether there were concerns about my administrative practices that warranted further action. This decision to enlarge the scope of the investigation unnecessarily had the effect of lengthening the duration of the investigation and in fact, the investigation concluded before the conclusion of investigations into harm caused to patients.

2.6.3 Length of Investigation

The Trust Guidelines state at Appendix 2 that the "Case Investigator must complete the investigation within 4 weeks and submit to the Case Manager within a further 5 days. Independent advice should be sought from NCAS." The time limit is therefore compulsory and any investigation longer than 4 weeks is in breach of the Trust's policy.

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The Trust has continued to ignore and thereby breach its own Policies and Procedures and in doing so, have breached my contract of employment.

The length of the extension of time beyond 4 weeks in this case has also been particularly egregious. The investigation took approximately 18 months to complete. Despite this fact, the findings in relation to the numbers of untriaged patients or undictated letters to GPs has not changed since the meeting on 24th January 2017.

It took a period of 3 months to interview 13 witnesses between March and June 2017. No explanation has been offered for the length of time taken to undertake these interviews.

I eventually was interviewed on 3rd August 2017. This was the first time I had met Dr Neta Chada, who had been appointed as Case Investigator some 6 months earlier. This too was contrary to NCAS Guidelines as these advise that the practitioner should be the first to be interviewed. This interview could not cover all of the issues in the case because on the morning of the interview, Dr Chada had just been provided with an anonymised list of patients whom the Trust alleged had been electively admitted for surgery after a shorter period of time because they previously had had a private consultation (see Tab 39). Dr Chada explained that she herself had just received the list of patients. This resulted in a further delay to conclude my interview. This meeting was not scheduled until 6th November 2017.

This delay is unexplainable and unreasonable. The delay has compounded the stress and anxiety that I have contended with since 30th December 2016. It is a breach of contract and has caused personal injury and damage.

2.7 The Investigation into Patients seen privately

52. The 23 March 2016 letter I remember well. It was on a Thursday, may have been a day or so after the 23rd I got it. I was asked by Martina Corrigan to meet Mr Mackle. I was concerned because of a previous complaint I had about him, I had lodged a grievance about him. But I went along and it was very courteous. He said he appreciated my hard work and preferred to give me the letter personally rather than send it by post. He raised issues, which were in the letter and I asked 'What do you want me to do?' he shrugged. Martina Corrigan was there in place of Heather. They left and I concerned myself with people suffering poor clinical outcomes. There was no particular action plan put in place.

53. After I got the letter I just worked harder. I looked at the review backlog and did entire clinics. I find it distressing to look back over those 9 months. There were times before I had my surgery when I was in so much pain but I worked when I was ill.

54. I did additional review lists and sacrificed my admin time. I wish it was otherwise, but it was for the good of the patients. It was better to have relieved discomfort of a patient.

55. I have spent time operating from 9am to 8pm for years when it was not part of my job plan. Michael Young has also done it. All the additionalities that have been done were additional to my job plan activity which was in place of SPA time, admin time and my own time. I had to do this activity when I was recovering from my surgery. Management did not offer any support.

56. Dr Chada enquired if I work differently from my colleagues. I advised that yes I do, we all work differently. Some ways can be irritating. Some colleagues refused to provide clinical summaries for MDM as is required, they would just have sent the cancer tracking letter. It all led to me believing I had enough and stepping down from a management role.

57. I know triage is an issue for people but they are doing it. Other activities are suffering as a consequence. It is a tick box. You can do it if you don't do a 3 hour ward round and know every detail about each patient. Some colleagues get their registrar to do the ward round.

58. Since I have returned to work with the action plan in place, I come on a Thursday and have to have everything returned by 4pm the next Friday so I take an annual leave day and spend all night doing all what is needed. As I sit here, I still don't know what is expected of me in respect of triage. This month on the 18th I'm at a wedding, so I will tick the boxes and complete triage.

59. Dr Chada advised that I am required to review the referral information only and make a decision about the appropriate category. Dr Chada stated that she appreciated there was not enough time to do enhanced triage and that would be a good way of doing it, but it was not what was being expected I advised that this is the first time I have ever had it clarified in terms of what is expected of me. I confirmed that I am doing enhanced triage on current referrals. Last week on

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

TRU-283442

CLINIC – OUTCOME FORM

Clinic: CAGBLDS

Date: 06.05.16

NAME	PATIENT SEEN BY:	ACTION *Please tick*				COMMENTS
		Review With Results	Review Later	Add to W/L	Discharge	
CAHE [redacted] M [redacted]			Review CAGBTDUR August 2016			
CAHE [redacted] F [redacted]			Review CAGBTDUR August 16			

HOT CLINIC – 06 MAY 2016

(2)

P.T.O.

13 sets of notes are still missing. Dr O'Brien confirmed he did not have these and this has since been accepted by the Trust and the review team.

Mr O'Brien accepted he had kept notes at home but asserted that this did not impact on patient's clinical management plans/care.

Term Of Reference 3

(a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'Brien in 2015 or 2016.

(b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'Brien in dictating outpatient clinics.

(c) To determine if there have been delays in clinical management plans for these patients as a result.

Mrs Robinson reported that she became aware in December 2016 from Noeleen Elliott, Mr O'Brien's secretary, that there were clinics which had not been dictated by Mr O'Brien. She reported this to be unusual for a Consultant. Mrs Robinson reported that Ms Elliot as Mr O'Brien's secretary would have known the extent of dictation not completed and that she should have been raising this with managers in the Acute Services Directorate. Ms Elliott, indicated that when she arrived to work with Mr O'Brien, the lack of clinics being returned seemed to be a long-standing way he worked and therefore she felt this issue was known. She therefore did not raise or report the issue.

When I interviewed Mr O'Brien he accepted that he did not dictate an outcome for every attendance by every patient at every clinic. I noted with Mr O'Brien that undictated clinics mean GPs don't know what is happening with their patients and there is nothing on NIECR for other Specialists to look at. Martina Corrigan indicated there had been a complaint from a GP and contact from an MLA as a GP didn't know what was happening with a patient.

Mr O'Brien acknowledged there were 66 undictated clinics and no dictated outcomes for these. There were no outcome sheets for 68 clinics. He noted he may have typed updates on the CAPP system for cancer patients, or they may have been discussed at MDM. Mr O'Brien stated that GPs have access to CAPP and that he personally explains all matters to the patient. Mr O'Brien reported that he didn't feel letters were that important. He went as far to say that he was frustrated by the obsession regarding dictation of outcomes for every attendance.

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

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

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

Angela Kerr

From: O'Brien, Aidan [redacted]
Sent: 12 July 2016 11:12
To: Cunningham, Andrea
Cc: Corrigan, Martina; Heaney, Linda; Rankin, Christine; Elliott, Noleen
Subject: Clinic Templates

Andrea,

The reason I raised this issue recently has been the progressive increase in the total numbers of patients attending my outpatient clinics.
The issue is the total number!

The clinic in SWAH is a good example.
When established in January 2013, it was a clinic conducted during the morning only, with 8 patients appointed, with the first appointment at 10 am.
As it seemed such a waste not to spend a longer period of time there, I had the clinic doubled, in 2014, to 8 before lunch and 8 after, a total of 16 patients.
At the last clinic which I did in SWAH on 20 June 2016, 21 patients were appointed, of whom 2 did not attend.
This required me to conduct a clinic from 10 am until 5.15 pm, without a break, without anything to eat, and one cup of coffee to drink.
Then the dictation and administration begins!

The last Armagh clinic had 15 patients appointed rather than 12, to which I agreed previously.
The last review clinic in Craigavon, an extended clinic at which it had been agreed only one month previously to have 15 patients appointed, had 19 patients appointed!

Moreover, this is not a new occurrence.
It has all happened before, several times.
It has been my experience before that no one has been requested to give approval, and no approval has been given.
Patients get appointed from a range of sources, under pressures to do so, and one additional patient becomes five.
Then the patients complain to the Nursing Staff for having to wait, and both complain to the clinician for keeping them all waiting, as though it were the clinician's fault.
It has also been my experience that the only effective way of limiting the total number of patients attending any clinic has been to notify that I will not attend any clinic unless the total numbers appointed have to limited to those that I have approved.

The total numbers of patients to be appointed to clinics are as follows:

- CAOBTDUR: 12 patients (say 6PR and 6R)
- AAOBU1: 12 patients (say 6PR and 6R)
- SWAH clinic: 16 patients (I do not know the clinic code or the make-up)
- CAOBTDU: 9 patients (This is the New Patient clinic on Tuesday afternoons)

I have asked Noleen to preview all clinic during the week prior to their occurrence, to notify Appointments of any excesses and to have the total numbers appointed limited to the agreed numbers,

Thank you,

Aidan

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 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

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 Patient 124 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.

Corrigan, Martina

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

Importance: High

Siobhan,

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

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

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

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

Regards

Martina

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

Martina

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

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

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

Many thanks

Siobhan

TURP 2016

Patient	Hosp No.	Date of Surgery	Waiting Time
[redacted]	Personal Information redacted by the USI	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)

On 30 July 2017 I wrote to D. Khan, Case Manager, detailing my concerns regarding the Investigation to date (Appendix 9).
I did not receive a response.

On 31 July 2018, I submitted to Ms. Hynds, by email, a request for a copy of the minutes of the meeting of the Oversight Group in December 2016, a copy of the correspondence / communication with NCAS in December 2016, an amended copy of the Note of the Meeting of 30 December 2016 (previously requested), an amended copy of the Note of the Meeting on 24 January 2017 (previously requested), a copy of the Trust's Policy and Procedure regarding Triage (previously requested) and a list of the Witnesses and their Statements (Appendix 10).
I did not receive a response until 28 September 2017 when I was provided with a list of Witnesses and their Statements. I was not provided with any of the other requested documentation.

On 03 August 2017, I met with Dr. Chada and Ms. Hynds, accompanied by my son, who wished to advise that we would have considered it reasonable to expect that the Witness Statements would have been provided prior to the Meeting, to enable me to address and respond to them, but he was advised initially that he was not permitted to speak.

On 03 August 2017, I also submitted to Dr. Chada and Ms. Hynds, detailed documentation of all additional inpatient and day case operating during the years 2012 to 2016, and all additional outpatient clinics during 2012 to 2016, in addition to all additional time spent in the roles of Lead Clinician of Urology MDT and of Chair of Urology MDM from 2012 to 2016, (Appendix 11).
None of this documentation has been included in the Report of the Investigation.

At the meeting of 03 August 2017, I was provided with a list of 11 patients who had attended privately, had been added to the waiting list and had been admitted after a short time frame. I was surprised to find that another two TURP patients had been added to the list, as I was certain that only nine patients had been admitted for TURP during 2016, having previously attended privately. Upon review, it was evident that the new list provided on 03 August 2017 contained only three patients who had TURP performed during 2016, the remaining eight patients having other diagnostic or surgical procedures performed. I then reviewed all 46 patients who had TURP performed during 2016. This figure included the 9 patients who had previously attended privately and 37 who had not. The mean time on waiting list for the nine patients who had attended privately was 202 days whilst the mean time for the remaining 37 patients was 219 days. In fact, 5 (56%) of those who attended privately had waited more than 100 days while 14 (38%) of the remaining 37 patients had done so.

On 06 November 2017, I met for the second time with Dr. Chada and with Ms. Hynds to discuss the issue of the private patients. I submitted a detailed account of the management of each of the eleven patients. I also shared my conviction that an analysis of all the TURP patients of 2016 had not complied with the anecdotal allegation that those who had attended privately, had had their surgery performed after a significantly shorter period of time, and that this finding had laid those compiling the information for the Case Investigator to find patients who had had other procedures performed following prior private consultation, and who better fitted the allegation. Regrettably, I

Appendix 4

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

APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
H&C Number:	
Name of Consultant	
Date of Last Private Consultation	

I have been seeing this person as a private patient. He/she has now been referred to Hospital as an NHS patient.

		Clinical Priority
Inpatient Referral	☐	
Outpatient Referral	☐	
Day Case Referral	☐	

Signed Consultant	
Effective Date	

Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private Practice.

PLEASE FORWARD TO PAYING PATIENTS OFFICE Personal Information redacted by USI

(v) **Prescription of drugs**

24(v) -1 I had no involvement in the prescription of drugs.

(vi) **Administration of drugs**

24(vi)-1 I had no involvement in the administration of drugs.

(vii) **Private patient booking**

24 (vii)-1 I had no input into any Consultant's private practice. I would have received phone calls from patients/relatives enquiring into private appointments and these were re-directed to the Consultant's private telephone number.

24(vii)-2 Mr O'Brien was the first consultant I had worked for who also had a private practice. He had a private consultation practice in his home. These patients would have been then transferred to the NHS for their surgery.

24(vii)-3 Mr O'Brien would have given me a list of patients for his Wednesday theatre list. On receipt of this list of patients I would have pre-admitted the patients accordingly. However, the patient(s) Mr O'Brien had seen privately were not on the Trust Patient Administrative System Waiting List (PAS). I was able to check the "Chart Tracker" on PAS to see when the patient's chart was tracked to "Mr O'Brien's PP Filing Cabinet" by Leanne Hanvey (who did all Mr O'Brien's Private Patient typing) and this was the date I used to put the patient, originally seen as a private

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

Casenote	Consultant Name	Date on Waiting List	Date Operation	Days between Added to WL to Operation Date	Is there a clinical reason why they should have waited such a short time
Personal Information redacted by USI	O'Brien A Mr	~~22/02/2016~~ 20.02.16	22/03/2016	~~29~~ 31	No
	O'Brien A Mr	~~25/04/2016~~	04/05/2016	~~0~~ 46	Reasonable – Red Flag
	O'Brien A Mr	~~11/04/2016~~	15/04/2016	~~4~~ 349	No
	O'Brien A Mr	~~01/04/2016~~	27/04/2016	~~26~~ 25	No
	O'Brien A Mr	08/07/2016	09/08/2016	32	No
	O'Brien A Mr	~~20/07/2016~~ 20.07.15	21/09/2016	~~54~~ 428	No
	O'Brien A Mr	~~04/12/2015~~ 21.11.15	24/02/2016	~~82~~ 94	Reasonable
	O'Brien A Mr	~~11/07/2016~~ 23.07.16	17/08/2016	~~37~~ 25	No
	O'Brien A Mr	08/10/16	02/11/16	25	No
	O'Brien A Mr	~~31/10/16~~ 01.10.16	04/11/16	~~5~~ 34	No
	O'Brien A Mr	~~16/02/2016~~ 30.01.16	24/02/2016	~~8~~ 25	No

Anaesthetics & Surgery
Personal Information redacted by USI

From: Haynes, Mark
Sent: 23 December 2016 10:39
To: Carroll, Ronan
Subject: Management of PP's / non chronological listing

Morning Ronan

I mentioned in discussion the management of PP's by Mr O'Brien. I suspect that he is not the only individual who brings patients into the NHS and onto NHS theatre lists. However, given recent events I feel this practice should also be looked into.

Attached is a PP letter from Mr O'Brien. This patient was seen by Mr O'Brien on 5th September privately (given the headed paper the letter is on) and placed on his NHS theatre list on weds 21st September, waiting a total of 16 days. His actual NHS waiting list has many other patients awaiting a routine TURP (which this man had) waiting significant lengths of time. I believe, if his theatre lists were scrutinised over the past year a significant number of similar patient admissions would be identified. This practice has a negative impact on our overall waiting times and is in my view totally unacceptable.

Do you think this should be fed into the overall investigation?

Mark

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by USI

Tel: Personal Information redacted by USI

5th September 2016

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

Dear Personal Information redacted by USI

Patient 119
Personal Information redacted by USI
DOB Personal Information redacted by USI
UN Personal Information redacted by USI

I write to you regarding this Personal Information redacted by the USI man whom you referred to Kathy Travers, Continence Nurse Specialist in 2015 for assessment of severe, lower urinary tract symptoms which he had had for several years, and which had not been significantly improved as a consequence of having remained on Tamsulosin for some time. When assessed by Kathy in May 2015, he reported a poor and intermittent urinary flow usually followed by a sensation of inadequate voiding, post micturitional incontinence and severe nocturia, having to rise at least 3 times each night to pass urine and not unfrequently having to rise up to 5 times. She found him to have a poor, maximum flow rate of 6 mls/sec and to have a post micturitional, residual urine volume of 170mls. He had then been recently prescribed Finasteride in addition to Tamsulosin. She initiated clean, intermittent, self catheterisation.

When I met Patient 119 as an outpatient in July 2015, his urinary symptoms had improved since the addition of Finasteride. His flow remained reduced, he still did have a sensation of unsatisfactory voiding following micturition, but the nocturia was less severe, he having to rise once or twice each night to pass urine. On clinical examination I found him to have a moderately enlarged and clinically benign prostate gland, in keeping with very normal serum total PSA levels of 1.1 ng/ml in 2013 and 1.4 ng/ml in 2015. I was also pleased to note that his biochemical renal function was normal in April 2015.

Patient 119 had ultrasound scanning of his urinary tract performed on 20th July 2015 when both upper urinary tracts were found to be normal and when bladder voiding was found to be much improved and normal with a residual volume of 14mls only.

I advised Patient 119 in July 2015 that he would be better served by having his prostate gland resected. As you may be aware from recent correspondence from Kathy Travers, she has found his flow rate to remain very poor, even though bladder voiding has remained satisfactory. I have therefore arranged for Patient 119 to be admitted to our Department on Wednesday 21st September 2016 for endoscopic resection of his prostate gland later that day.

dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist

Date dictated: 5th September 2016
Date typed: 5th September 2016/LH

«PTFNAMES» «PTSNAME» **DOB:** «PTDOB» **H+C:** «PTNHS»

Patient 117 CAHE: Personal Information redacted by USI

This Personal Information redacted by USI lady was referred on 24 March 2016 for assessment and management of intermittently severe, left loin pain, microscopic haematuria and a left renal stone found on ultrasound scanning. As suspected, CT scanning confirmed that the 1.2 cm stone had become impacted in her upper left ureter, causing renal outlet obstruction. She was admitted on 27 April 2016 **(after 25 days)** for left ureteroscopic laser lithotripsy and ureteric stenting.

Patient 118 CAHE: Personal Information redacted by USI

This Personal Information redacted by USI man was twice referred by his GP, in February and in June 2016, for assessment and management of increasingly severe urinary symptoms including urge incontinence and nocturia. In fact, when I met him on 25 June 2016, with some significant difficulty, he advised me that he additionally had nocturnal enuresis, causing him and his wife to sleep in separate rooms, and resulting in significant marital strain. He advised that he had not advised his GP. It was for that reason that I expedited further investigation of his symptoms by flexible cystoscopy and urodynamic studies on 08 July 2016 **(after 45 days),** and without including that reason in my letter to the GP. For the same reasons, I believed that it was reasonable to expedite his admission to the Day Surgical Unit on 09 August 2017 for hydrostatic dilatation of his bladder **(after a further 32 days).**

Patient 119 CAHE: Personal Information redacted by USI

This Personal Information redacted by USI man attended privately as an outpatient on 20 July 2015 for further assessment and management of severe lower urinary tract symptoms, due to bladder outlet obstruction, resulting in chronic urinary retention, necessitating self-catheterisation. I advised him then that he would be best served by having his prostate resected. I arranged his admission on 21 September 2016 **(after 428 days).**

Patient 120 CAHE Personal Information redacted by USI

This man was Personal Information redacted by USI when he attended privately on 21 November 2015 for assessment of severe urinary symptoms, including urinary incontinence, accompanied by microscopic haematuria. CT urography on 30 November 2015 revealed that he had a large bladder stone, measuring 3.5 cm in diameter. I arranged his admission on 24 February 2016 for endoscopic bladder lithotripsy **(after 94 days).**

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by USI

Tel: Personal Information redacted by USI

11th April 2016

Personal Information redacted by USI

Dear Personal Information redacted by USI

Patient 116

Personal Information redacted by USI

DOB Personal Information redacted by USI

UN Personal Information redacted by USI

I write to you regarding this Personal Information redacted by USI gentleman who was referred by your colleague, Dr Paisley, in December 2014, for assessment and management of troublesome urinary symptoms. By the time that I met Personal Information redacted by USI as an outpatient in May 2015, he had additionally been referred by Dr McMillan, Locum Consultant Dermatologist, for assessment of a balanitis.

When Patient 116 attended on 2nd May 2015, the only symptoms which he reported to be of significance were those of urgency and urge incontinence. As Dr Paisley had indicated, Personal Information redacted by USI had been taking Dutasteride and Tamsulosin for some time. With regard to the erectile dysfunction, Patient 116 reported that he had been taking Tadalafil 10mgs daily for some time, and with a degree of effectiveness that was just about satisfactory. On clinical examination, I found him to have minimal preputial adhesions and associated balanitis. I felt that he had a moderately enlarged, clinically benign prostate gland. I noted that Patient 116 biochemical renal function has been normal to date and that his serum PSA had been very normal at 0.26 ng/ml in December 2014.

In any case, I advised him to discontinue taking Dutasteride to see whether its discontinuation with further enhance the efficacy of Tadalafil in the management of his erectile dysfunction. As his dominant urinary symptoms were storage in nature, I prescribed Oxybutynin in the modified release formulation, 10mgs to be taken once daily. I advised him to remain on Oxybutynin and Tamsulosin and Tadalafil until further review. I also arranged for him to have ultrasound scanning of his urinary tract which was performed in September 2015 when he was found to have a simple right renal cyst measuring 2.5cms in diameter, a mildly enlarged prostate gland with a volume of 35mls and very adequate bladder voiding, with a residual volume of 26mls.

I spoke with Patient 116 by telephone recently when he reported that the Oxybutynin had probably contributed significantly to his avoidance of urge incontinence. However, he still does have severe urgency of micturition and to the extent that it severely compromises his quality of life to the extent that he does not allow himself to be far from a toilet at any time. The only other urinary symptom was that of nocturia, having to rise once each night to pass urine. I therefore felt that it would be reasonable to proceed with urodynamic studies. I have therefore arranged for him to attend our Department on Friday 15th April 2016 for urodynamic studies and flexible cystoscopy. I will advise you of the findings and of plans for his further management in due course.

Yours sincerely

PRIVATE PATIENTS

Patient 114 CAHB Personal Information redacted by 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 Personal Information redacted by USI 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.

Patient 115 CAHB Personal Information redacted by USI

Patient 115 was an Personal Information 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.

Patient 116 CAHE Personal Information redacted by USI

Patient 116 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 the 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.

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by USI

Tel: Personal Information redacted by the USI

23rd February 2016

Personal Information redacted by USI

Personal Information redacted by USI

Dear Personal Information redacted by the

Patient 124

Personal Information redacted by USI

DOB Personal Information redacted by USI

UN Personal Information redacted by USI

I write to you regarding Patient 124 who presented with persistent left flank pain in 2012. The pain was consistent with ureteric colic but it had not been possible to determine whether small opacities seen in the left hemi-pelvis were indicative of left lower ureteric calculi. As a consequence, Patient 124 was admitted in February 2013 for left ureteroscopy when I found her to have a stenosis of the intramural segment of her ureter, above which the ureteric lumen was dilated, containing urothelial debris. The stenosed intramural segment was effectively dilated by advancement of the ureteroscope.

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

Patient 124 has had recurrence of the same pain since January 2016. She had remained effectively free of pain during 2015. When I reviewed her on 30th January 2016, she reported that the pain radiated from her left loin to her left labium majus. I noted that she had been found to have pyuria and bacteriuria on urinary microscopy on 12th January 2016. However, both were normal when repeated on 30th January 2016. In any case, I had empirically prescribed Trimethoprim 200mgs to be taken twice daily for a period of 3 weeks.

I arranged for Patient 124 to have ultrasound scanning of her urinary tract performed on 5th February 2016. Ultrasound scanning was normal. As the pain persisted, I had intravenous urography performed on 12th February 2016. Whilst this was also normal, there was just a hint that there may have been a mild degree of left ureteric dilatation. By then, her pain was increasingly localised to the left lower abdominal area, and was increasingly accompanied by lower urinary tract symptoms, which included hesitancy of micturition, a reduced urinary flow and post micturitional incontinence in addition to urgency and quite severe nocturia, having to rise 4 or 5 times each night to pass urine. Prior to considering any endoscopic reassessment, I had Patient 124 attend on 16th February 2016 for urodynamic studies when she was found to have a hypersensitivity of her bladder resulting in a compromised cystometric capacity of 190mls. There was no evidence of detrusor muscular overactivity.

Patient 121 CAHE Personal Information redacted by USI

This frail, Personal Information redacted by USI man was found to have urinary retention, accompanied by hyponatraemia, requiring catheterisation, following his acute admission in June 2016. He failed a trial removal of the catheter. He was brought to see me privately on 23 July 2016 due to his discomfiture due to indwelling catheterisation. It was for that reason that I believed it reasonable to admit him on 16 August 2016 **(after 25 days)** for TURP on 17 August 2016.

Patient 122 CAHE Personal Information redacted by USI

This Personal Information redacted by USI man was acutely admitted in July 2016 in acute urinary retention, resulting in bilateral upper tract obstruction and acute renal injury, urinary infection and coliform bacteraemia. He attended privately on 08 October 2016 due to urethral discomfort caused by continued catheterisation. He was found to have recurrence of coliform infection on urinary culture. I therefore expedited his admission on 02 November 2017 **(after 25 days)** to minimise the risk of recurrence of the previous morbidity.

Patient 123 CAHE Personal Information redacted by USI

This man attended privately on 01 October 2016 for assessment of severe urinary symptoms. Even though he had had a satisfactory outcome following TURP in 2013, by 2016 he had to strain to pass urine and had to rise up to hourly each night to pass urine. Because of the severity of his symptoms, I arranged for him to attend on 04 November 2016 **(after 34 days)** for flexible cystoscopy and urodynamic studies, which confirmed that he was in chronic urinary retention due to detrusor hypocontractility, and for which he was taught to practise self-catheterisation.

Patient 124 CAHE Personal Information redacted by USI

Patient 124 is the Personal Information redacted by USI of Personal Information redacted by USI who not only has been one of my closest friends Personal Information redacted by USI he has also been the Personal Information redacted by USI In that capacity, he has worked closely with our department in the delivery of urological cancer services.

Patient 124 has suffered left flank pain of the nature of ureteric colic throughout 2012 until she was found to have stenosis of the intramural segment of her left ureter in February 2013. Dilatation of the intramural segment resulted in complete resolution of pain until Christmas

CONFIDENTIAL: PERSONAL

NHS
Resolution

Practitioner Performance Advice (formerly NCAS)
2nd Floor, 151 Buckingham Palace Road
London
SW1W 9SZ
Advice line: 020 7811 2600
Fax: 020 7931 7571
www.ncas.nhs.uk
CST-B@resolution.nhs.uk

21 September 2018

PRIVATE AND CONFIDENTIAL

Dr Ahmed Khan
Medical Director
Southern Health and Social Care Trust
Beechfield House
68 Lurgan Road
Portadown
BT63 5QQ

Ref: 18665 (Please quote in all correspondence)

Dear Dr Khan,

Further to our telephone conversation on 20 September 2018, I am writing to summarise the issues which we discussed for both of our records. Please let me know if any of the information is incorrect.

Practitioner Performance Advice (formerly NCAS) encourages transparency in the management of cases and advises that practitioners should be informed when their case has been discussed with us. I am happy for you to share this letter with Dr 18665 if you consider it appropriate to do so. The practitioner is also welcome to contact us for a confidential discussion regarding the case. We have recently launched a new guide for practitioners, which sets out information about our role and services which may be of interest and is available on our website under publications.

In summary, this reopened case, which I had previously discussed with your colleague, Dr Wright, involves Dr 18665, a senior consultant urologist about whom there had been increasing concerns. An investigation, for which you are the Case Manager, has now been completed – it was very delayed because of the complexities and extent of the issues – and you are considering the options as set out in paragraph 38 of Part I MHPS (Maintaining High Professional Standards in the Modern HPSS). You wanted to seek advice around this. You indicated that since February 2017, Dr 18665 has been working

to an agreed action plan with on-going monitoring so that any risks to patients have been addressed.

There were 5 Terms of Reference for the investigation (although the last related to the extent to which the managers knew of or had previously managed the concerns). You told me that having read the report, the factual accuracy of which Dr 18665 has had a chance to comment on, you have concluded that there was evidence to support many of the allegations with regards to Dr 18665. Specifically, following detailed consideration, you noted that:

a)o There were clear issues of concern about Dr 18665's way of working and hiso management of his workload. There has been potential harm to a large number ofo patients (783) and actual harm to at least 5 patients;o
b)o Dr 18665's reflection throughout the investigation process was concerning and ino particular in respect of the 5 patients diagnosed with cancer;o
c)o As a senior member of staff within the Trust Dr 18665 had a clear obligation too ensure managers within the Trust were fully and explicitly aware that he was noto undertaking routine and urgent triage as was expected;o
d)o There has been significant impact on the Trust in terms of its ability to properlyo manage patients, manage waiting lists and the extensive look back exercise whicho was required to identify patients who may have been affected by the deficiencieso in Dr 18665's practice (and to address these issues for patients);o
e)o There is no evidence of concern about Dr 18665's clinical ability with individualo patients;o
f)o Dr 18665 had advantaged his own private patients over HSC patients on at least 9o occasions;o
g)o The issues of concern were known to some extent for some time by a range ofo managers and no proper action was taken to address and manage the concerns;o

You told me that the SAI (serious adverse incident) investigation, which has patient involvement, is looking at the issue where patients have, or may have been, harmed as a result of failings. You are aware that patients are entitled to know this.

We discussed the current situation and the overriding need to ensure patients are protected. I note that you have a system in place within the Trust to safeguard patients, but we discussed that this needs to be mirrored in the private sector. You explained that Dr 18665 saw private patients at his home and did not have a private sector employer. I would suggest that as paragraph 22 of Section II MHPS states that *"where a HPSS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer"* Dr 18665 should not currently be working privately.

We discussed that the issues identified in the report were serious, and that whilst there are clearly systemic issues and failings for the Trust to address, it is unlikely that in these circumstances the concerns about Dr 18665 could be managed without formal action. We also discussed that whilst the issues did have clinical consequences for patients, as some of the concerns appear to be due to a failure to follow policies and protocols, and possibly also a breach of data protection law, these might be considered to be matters of conduct rather than capability. We noted therefore that it would be open to you in your

February 2017. The purpose of this action plan was to ensure risks to patients were mitigated and his practice was monitored during the course of the formal investigation process. Mr O'Brien worked successfully to the action plan during this period.

It is my view that in order to ensure the Trust continues to have an assurance about Mr O'Brien's administrative practice/s and management of his workload, an action plan should be put in place with the input of Practitioner Performance Advice (NCAS), the Trust and Mr O'Brien for a period of time agreed by the parties.

The action plan should be reviewed and monitored by Mr O'Brien's Clinical Director (CD) and operational Assistant Director (AD) within Acute Services, with escalation to the Associate Medical Director (AMD) and operational Director should any concerns arise. The CD and operational AD must provide the Trust with the necessary assurances about Mr O'Brien's practice on a regular basis. The action plan must address any issues with regards to patient related admin duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time and an enhanced appraisal programme.

b. An exclusion from work

There was no decision taken to exclude Mr O'Brien at the outset of the formal investigation process rather a decision was taken to implement and monitor an action plan in order to mitigate any risk to patients. Mr O'Brien has successfully worked to the agreed action plan during the course of the formal investigation. I therefore do not consider exclusion from work to be a necessary action now.

3. There is a case of misconduct that should be put to a conduct panel

The formal investigation has concluded there have been failures on the part of Mr O'Brien to adhere to known and agreed Trust practices and that there have also been failures by Mr O'Brien in respect of 'Good Medical Practice' as set out by the GMC.

Whilst I accept there are some wider, systemic failings that must be addressed by the Trust, I am of the view that this does not detract from Mr O'Brien's own individual professional responsibilities.

During te MHPS investigation it was found that potential and actual harm occurred to patients. It is clear from the report that this has been a consequence of Mr O'Brien's conduct rather than his clinical ability. I have sought advice from Practitioner

Performance Advice (NCAS) as part of this determination. At this point, I have determined that there is no requirement for formal consideration by Practitioner Performance Advice or referral to GMC. The Trust should conclude its own processes.

The conduct concerns by Mr O'Brien include:

- Failing to undertake non red flag triage, which was known to Mr O'Brien to be an agreed practice and expectation of the Trust. Therefore putting patients at potential harm. A separate SAI process is underway to consider the impact on patients.

- Failing to properly make it known to his line manager/s that he was not undertaking all triage. Mr O'Brien as a senior clinician had an obligation to ensure, this was properly known and understood by his line manager/s.

- Knowingly advantaging his private patients over HSC patients.

- Failing to undertake contemporaneous dictation of his clinical contacts with patients in line with GMC 'Good Medical Practice'.

- Failing to ensure the Trust had a full and clear understanding of the extent of his waiting lists, by ensuring all patients were properly added to waiting lists in chronological order.

Given the issues above, I have concluded that Mr O'Brien's failings must be put to a conduct panel hearing.

4. There are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer.

There are no evident concerns about Mr O'Brien's health. I do not consider this to be an appropriate option.

5. There are concerns about the practitioner's clinical performance which require further formal consideration by NCAS (now Practitioner Performance Advice)

Before coming to a conclusion in this regard, I sought advice from Practitioner Performance Advice.

The formal investigation report does not highlight any concerns about Mr O'Brien's clinical ability. The concerns highlighted throughout the investigation are wholly in respect of Mr O'Brien's administrative practices. The report highlights the impact of Mr O'Brien's failings in respect of his administrative practices which had the potential to cause harm to patients and which caused actual harm in 5 instances.

I am satisfied, taking into consideration advice from Practitioner Performance Advice (NCAS), that this option is not required.

6. There are serious concerns that fall into the criteria for referral to the GMC or GDC

I refer to my conclusion above. I am satisfied that the concerns do not require referral to the GMC at this time. Trust processes should conclude prior to any decision regarding referral to GMC.

7. There are intractable problems and the matter should be put before a clinical performance panel.

I refer to my conclusion under option 6. I am satisfied there are no concerns highlighted about Mr O'Brien's clinical ability.

6.0 Final Conclusions / Recommendations

This MHPS formal investigation focused on the administrative practice/s of Mr O'Brien. The investigation report presented to me focused centrally on the specific terms of reference set for the investigation. Within the report, as outlined above, there have been failings identified on the part of Mr O'Brien which require to be addressed by the Trust, through a Trust conduct panel and a formal action plan.

The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O'Brien. No-one formally assessed the extent of the issues or properly identified the potential risks to patients.

Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there are wider issues of concern, to be considered and addressed. The findings of the report should not solely focus on one individual, Mr O'Brien.

In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes

The response that I comprised (Tab 5) provided an historical background to my work at the Urology Service, detailed a criticism of the investigation and provided a response to the specific terms of reference. In addition, the response provided detail of the points in mitigation that I wished to make. I provided substantial detail of the additional workload that I had undertaken in the years before my exclusion. I provided detail of the physical discomfort that I faced whilst waiting for the opportunity to take time for my own surgery in November 2016. In addition, I noted that I was additionally assisting Mr Suresh, at the Trust's request, by providing support when he was Urologist of the Week.

None of this mitigation finds its way into the Case Manager's determination. The Case Manager did make a solitary note at an earlier part of the document that I had "*provided a detailed context to the history of the Urology Service and the workload pressures he faced*". However, it does not appear that the Case Manager has considered this relevant to his determination whatsoever.

The failure to consider these factors is prejudicial to any determination of these issues, and represents a breach of the Trust Guidelines and of sections 3 and 17 of my contract of employment, a breach of natural justice, and a breach of Article 6 of the European Convention.

2.9.4 Wrongful Classification of Misconduct

It is my view that the determination has wrongly classified the issues of concern as Misconduct. Appendix 3 of the Trust Guidelines states as follows:

> *"If the Practitioner considers that the case has been wrongly classified as misconduct, they are entitled to use the Trust's Grievance Procedure or make representations to the designated Board Member"*

Accordingly, this grievance filed pursuant to the Trust Grievance Procedure should also be treated as a Grievance in relation to the classification of the case as a case of misconduct. For the reasons outlined at Paragraph 2.7 above, it would be unreasonable to refer the issue relating to private patients to a Conduct panel in any case. In relation to the other concerns, my reasons follow.

At section 3 of the determination, the Case Manager has found that there are no concerns about my clinical ability. I agree that the concerns should not be considered as concerns about my clinical ability. However, the Case Manager goes on to state:

> "It is clear from the report that this has been a consequence of Mr O'Brien's conduct rather than his clinical ability."

It is my view that the Case Manager has erred in coming to the view that if the issues are not a related to my clinical ability, then they must be related to conduct. I contend that it does not follow that these issues are acts of misconduct, even taken at their absolute height.

I believe that it should be clear that I have and continue to work extensive hours over and above my job plan to try to meet the needs of patients as part of a service that is known to be severely stretched. Referring back to the letter given to me on 23rd March 2016, senior management stated, "We are fully aware and appreciate all the hard work, dedication and time spent during

the course of your week as Consultant Urologist". I do not believe that the Case Manager has shown that same awareness.

The reason I was unable to undertake triage of all referrals was because I found that did not have the time to do it. I appreciate that the Case Manager is critical that I did not "ensure managers within the Trust were fully and explicitly aware that [I] was not undertaking routine and urgent triage as was expected", but it is also noted that I had raised on numerous occasions the fact to colleagues and management that I found it impossible to complete triage and that it was known to a range of staff within the Directorate that I did not complete triage and that as a consequence, a default system had been put in place to deal with this. The Investigation report provides examples of individual witnesses relating that I said, on numerous occasions that I could not complete triage. This could not be considered to be a case where any reasonable decision maker could conclude that I was wilfully failing to meet any expectation or deliberately failing to inform management.

Taken at its very height, a reasonable employer would not consider this to be a misconduct issue but rather a performance issue. Furthermore, to the extent that it could be considered a performance issue, it is a performance issue that has been resolved. Since my return to work on 20th February 2017, I have completed all triage in a timely manner. I have done this by taking a day of annual leave after my week as Urologist of the Week to undertake triage, in my own time. In doing so, I have conducted up to 65 virtual consultations with patients, advising them of investigations requested and treatment to be initiated, in addition to dictating letters to referrers, GPs and patients. This has been equivalent to conducting up to nine additional New Patient Clinics, whilst Urologist of the Week and during the days following Urologist of the Week. Latterly, during this past month of November 2018, the Trust has accepted that additional time was required for consultants to undertake triage, and that new job plans for all consultants will include additional sessions, out of hours, to complete triage.

With regard to the dictation of GP letters and outcomes, it is my belief that the Case Manager has fundamentally misunderstood the issue. His reference to the GMC Good Medical Practice indicates that he is of the belief that there was a failure to record work following reviews of patients. However, I have always made legible, written notes of consultations in the patient's charts, and, in addition, as a clinical summary or update on CaPPS (the Cancer Patient Pathway System), as required by the National Cancer Plan. The issue that was being investigated was whether I was also dictating letters following each patient consultation. The Trust was certainly aware that there was a backlog with regard to this administration. As stated at Paragraph 2.3.4 above, I had agreed an action plan with the Head of Service on 14th November 2016 to resolve this issue and I had already made substantial progress in entirely addressing the issue before my exclusion on 30th December 2016.

Accordingly, this was not an issue about misconduct. I was working to the best of my ability to clear this backlog and I had been open about asking for time to address it. Taken at its height, a reasonable employer would have considered this to be a performance issue and a performance issue that has been resolved since I returned to work. There are a number of reasons why I have been able to resolve this. The first reason was that the backlog that had built up was taken away from me as a direct consequence of the investigation. For the first month of my return to work, I was unable to undertake clinics or operating sessions because the schedules had already been completed prior to my return. This enabled me to complete any outstanding administration work that had not been taken away as part of the investigation. I have been able to avoid any further backlog developing because I have declined to take on extra theatre sessions and extra

INTRODUCTION

1. This document introduces the new framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist, and any subsequent action when deciding whether there needs to be any restriction or suspension placed on a doctor's or dentist's practice.

2. Throughout this framework where the term "performance" is used, it should be interpreted as referring to all aspects of a practitioner's work, including conduct, health and clinical performance. Where the term "clinical performance" is used, it should be interpreted as referring only to those aspects of a practitioner's work that require the exercise of clinical judgement or skill.

3. Under the Directions on Disciplinary Procedures 2005, HPSS organisations must notify the Department of the action they have taken to comply with the framework by 31 January 2006.

4. The framework is in six sections and covers:

   I. Action when a concern first arises

   II. Restriction of practice and exclusion from work

   III. Conduct hearings and disciplinary procedures

   IV. Procedures for dealing with issues of clinical performance

   V. Handling concerns about a practitioner's health

   VI. Formal procedures – general principles

5. Local conduct procedures will apply to all concerns about the conduct of a doctor or dentist.

Background

6. There has been some concern in the past about the way in which complaints about doctors and dentists have been handled. Developing new arrangements for dealing with medical and dental staff performance has become increasingly important in order to address these concerns and to reflect the new systems for quality assurance, quality improvement and patient safety being introduced in the HPSS.

7. The National Clinical Assessment Authority (NCAA) was established to improve arrangements for dealing with poor clinical performance of doctors. The Department entered into a service level agreement with the NCAA in October 2004 to provide advice and guidance to the HPSS. Since April 2005,