A. In all honesty, no, I wouldn't say that. I met them in all walks of life. They are not all doctors either but I don't appraise them. You can meet them anywhere. I think the mistake of the system is to let that go unchallenged. If you challenge that at an early stage of their careers when they are trainees or when they are junior consultants or newly appointed GPS, you have the opportunity to change behaviours and to help them through that. I think the difficulty is when something has become entrenched for 25, 30 years, you're really going nowhere with it. 16:10 16:10

CHAIR: It is the old dog, new tricks situation really, is it?

A. It is really hard. And I know as I get older it is harder to change my ways. I think the system, never mind Mr. O'Brien, but the system has let people down here in that we've tolerated this for a long time before we really seriously tried to address the issues. And that has been a big mistake. I think if anything comes out of this, I hope that the system learns that that is not a good approach. 16:10 16:11

CHAIR: I've just digressed from some of the questions I did want to ask you.

One of the things I wanted to explore with you was we heard last week from Mrs. Gishkori, who you will -- well, we have seen all the evidence of the fact there was this first Oversight Committee which she attended and she said then she came away from that -- I think it 16:11

wouldn't be a misrepresentation of the impression that she gave, but in panic mode. Because if -- here was a surgeon on her watch, as it were, who she needed to deliver the service that needed delivered, and if he left, what might happen. But she felt unable to express any of that at the meeting with yourself and Mrs. Toal. I just wondered if you can maybe shed any light on her lack of ability to do that or to raise those issues with you at that meeting? She talked about coming to the meeting with just having been given Simon Gibson's report to you and not really having had much time to it digest it, I suppose. I just wondered what your reflection were on that position? 16:12 16:12

A. I would normally expect a director to come to a meeting like that fully briefed on what was going on on their patch, having considered the outcome they want from the meeting, and with a plan for resolving the issues. So, for whatever reason, Mrs. Gishkori didn't have the time to put that together. But that's usually what I would expect and usually that's what would have happened. I can't think of another situation where somebody would come to a meeting not knowing the degree of the problem and not knowing what their preferred potential solution would be. So I'm at a loss. But my normal experience would be the directors come knowing much more about the problem than I would. They have often asked for the meeting in the first place and they have a fair idea what they want to do about it. That was very different with Mrs. Gishkori. 16:12 16:13 16:13

Stinson, Emma M

From: Gishkori, Esther <[redacted]>
Sent: 14 September 2016 13:17
To: McAllister, Charlie
Subject: FW: Confidential - AOB
Attachments: Confidential letter to AOB - updated March 2016 final.docx

Thanks Charlie.
At least you have a starting point.
I am clear that I wish you and Colin to take this forward and explore the options and potential solutions before anyone else gets involved.
We owe this to a well respected and competent colleague.
I can confirm that you will have communication in relation to this before the end of the week.
Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] **Mobile** [redacted]
[redacted]

From: McAllister, Charlie
Sent: 14 September 2016 12:25
To: Gishkori, Esther
Subject: FW: Confidential - AOB

Hi Esther

Further to our meeting today here is the only communication that I have received on this subject.

Regards

Charlie

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

I would be grateful if you could respond to this e-mail, even if you have not received any plans or proposals.

Given the sensitivity of this subject, I would be grateful if you would respect the confidentiality of this e-mail.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
DHH: Personal Information redacted by the USI

Corrigan, Martina

From: Corrigan, Martina
Sent: 16 September 2016 18:08
To: Weir, Colin
Subject: FW: Urgent for investigation please

Hi Colin

I am not sure if I had forwarded this to you already?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Young, Michael
Sent: 08 September 2016 17:32
To: Corrigan, Martina
Subject: RE: Urgent for investigation please

Few points
1/ GP probably should have referred as RF in first place. A PSA of 34 is well above normal
2/ if booking centre has not received a triage back then I agree that they follow the GP advice
3/ if recent scan had shown secondaries then they were present at referral. As such then this was at an advanced non curable stage even then.
4/ I think the point here is that although non-curable I would have thought that treatment would still have been offered in the form of anti-androgen therapy at some stage over the subsequent few months.
5/ So to follow this to the next step means that if still following our current Routine waiting time would have resulted in the patient not being seen for a year. Some clinicians would have regarded this as resulting in a delay in therapy.
6/ It is not clear if arrangements were made, but the triage letter was not returned ?
7/ The patient was in fact seen within a few months.
8/ The apparent delay of just a few months has however not impinged on prognosis.

My view

MY

From: Corrigan, Martina
Sent: 07 September 2016 12:14
To: Young, Michael
Subject: FW: Urgent for investigation please
Importance: High

As discussed this afternoon

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Corrigan, Martina
Sent: 02 September 2016 14:51
To: Young, Michael
Cc: Weir, Colin
Subject: Urgent for investigation please
Importance: High

Michael,

Please see email trail and Charlie's comments below.

Can you please discuss with Colin when you are back from Annual Leave and advise course of action ?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Carroll, Ronan
Sent: 01 September 2016 13:09
To: Corrigan, Martina
Cc: McAllister, Charlie
Subject: FW: Patient 93
Importance: High

Martina
Please see Charlie's comments and direction of travel for this issue – can I leave with you to progress and feedback to Charlie and myself when action/decisions have been reached/need to be taken – can we address this asap
Ronan

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

From: McAllister, Charlie
Sent: 31 August 2016 18:37
To: Carroll, Ronan
Subject: Re: Patient 93

My thoughts are that this should go through Mr Young (as Urology lead) first and Mr Weir second (as the CD).

Then happy to become involved.

C
Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Wednesday, 31 August 2016 17:40
To: McAllister, Charlie
Subject: FW: Patient 93

Charlie
Please can you read the series of emails. Suffice to say that although the outcome for the pt would not be any different, this as you know is not the issue that needs to be dealt with.
Await your thoughts
Ronan

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

From: Corrigan, Martina
Sent: 31 August 2016 13:17
To: Carroll, Ronan
Subject: FW: Patient 93
Importance: High

Can we discuss please?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Haynes, Mark
Sent: 31 August 2016 09:34
To: Corrigan, Martina
Subject: Fw: Patient 93
Importance: High

Ignore the hcn but the story here is raised PSA referred by GP on 4th may. GP referral as routine. Not returned from triage so on wl as routine. If had been triaged would have been RF upgrade (PSA 34 and 30 on repeat). Saw Mr Weir for leg pain and CT showed metastatic disease from prostate primary. Referred to us and seen yesterday. As a result of no triage delay in treatment of 3.5 months. Wouldn't change outcome.
SAI?

Sent from my BlackBerry 10 smartphone.

From: Coleman, Alana Personal Information redacted by USI
Sent: Wednesday, 31 August 2016 08:34

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training | Clinical Director SEC
Southern Health and Social Care Trust

Secretary Jennifer Personal Information redacted by USI

From: Gishkori, Esther
Sent: 15 September 2016 14:59
To: Weir, Colin; McAllister, Charlie; Carroll, Ronan
Subject: FW: meeting re Mr O'Brien.

FYI below.
.....and my response will be?

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted by USI Mobile Personal Information redacted by USI
Personal Information redacted by USI

From: Wright, Richard
Sent: 15 September 2016 14:52
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Re: meeting re Mr O'Brien.

Hi Esther. As director of the service naturally we have to listen to your opinion. Before I would consider conceding to any delay in moving forward with what was our agreed position after the oversight meeting I would need to see what plans are in place to deal with the issues and understand how progress would be monitored over the three month period.
Perhaps when we have seen these we could meet again to consider. regards Richard

Sent from my iPad

On 15 Sep 2016, at 14:40, Gishkori, Esther Personal Information redacted by USI wrote:

> Dear Richard and Vivienne,
> Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
> I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.
>
> Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
> Now that they both work locally with him, they have plenty of ideas to try out and since they are both relatively new into post, I would like try their strategy first.

Southern Health & Social Care Trust

Medical Directors Office

Screening report on Dr Aidan O'Brien

Context

The Medical Director sought detailed information on a range of issues relating to the conduct and performance of Dr O'Brien. This report provides background detail and current status of these issues, and provides a recommendation for consideration of the Oversight Committee.

Issue one – Un-triaged outpatient referral letters

When a GP refers a patient into secondary care, the referral is triaged to consider the urgency of the referral. If triage does not take place within an agreed timescale as per the Integrated Elective Access Protocol (IEAP), then health records staff schedule the referral according to the priority given by the GP. This carries with it the risk that a patient may not have their referral "upgraded" by the consultant to urgent or red flag if needed, if triage is not completed. This may impact upon the outcome for a patient.

In March 2016, Dr O'Brien had 253 untriaged letters, which was raised in writing with him and a plan to address this was requested. No plan was received and at August 2016, there were 174 untriaged letters, dating back 18 weeks; the rest of the urology team triage delay is 3-5 working days.

Issue two – Outpatient review backlog

Concerns have been raised that there may be patients scheduled to be seen who are considerably overdue their review appointment and could have an adverse clinical outcome due to this delay.

In March 2016, Mr O'Brien had 679 patients in his outpatient review backlog, which was raised in writing with him and a plan to address this was requested. No plan was received and at August 2016, there were 667 patients in his outpatient review backlog, dating back to 2014: whilst outpatient review backlogs exist with his urological colleagues, the extent and depth of these is not as concerning.

Issue three – Patients notes at home

Mr O'Brien has had a working practice of taking charts home with him following outpatient clinics. These charts may stay at his home for some time, and may not be available for the patient attending an appointment with a different specialty, making the subsequent consultation difficult in the absence of the patients full medical history.

For a period in 2013/14, instances when charts were not available were recorded on the Southern Trusts Adverse Incident Reporting (IR) system: there were 61 consultations where charts were not available. In speaking to the Health Records Manager, Mr O'Brien is currently continuing this practice although this is not now recorded on the IR system.

Mr O'Brien was spoken to about this issue in 2012 by Dr Rankin, and twice in 2014 by Mrs Burns, the Directors of Acute Services at the time, seeking a change in behaviour, although none of these meetings were formally recorded.

Issue four – Recording outcomes of consultations and inpatient discharges

Whilst there has been no formal audit of this issue, concern has been raised by his urological colleagues that Mr O'Brien may not always record his actions or decisions regarding a patient following a period of inpatient care or outpatient consultation. This may cause subsequent investigations or follow up not to take place or be delayed.

Summary of concerns

This screening report has identified a range of concerns which may be counter to the ***General Medical Councils Good Medical Practice*** guidance of 2013, specifically paragraphs 15 (b), 19 and 20:

15. ***You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:***

- *a. Adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
- *b.* ***Promptly provide or arrange suitable advice, investigations or treatment where necessary***
- *c. Refer a patient to another practitioner when this serves the patient's needs.*

19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. ***You should make records at the same time as the events you are recording or as soon as possible afterwards.***

20. ***You must keep records*** *that contain personal information about patients, colleagues or others securely, and* ***in line with any data protection requirements.***

Conclusion

This report recognises that previous informal attempts to alter Dr O'Brien's behaviour have been unsuccessful. Therefore, this report recommends consideration of an NCAS supported external assessment of Dr O'Brien's organisational practice, with terms of reference centred on whether his current organisational practice may lead to patients coming to harm.

Toal, Vivienne

From: Gishkori, Esther [redacted]
Sent: 16 September 2016 13:37
To: Toal, Vivienne
Subject: RE: meeting re Mr O'Brien.

Vivienne,
I spoke with Richard this morning.
He is happy with the direction of travel and I will be asking the AMD and CD to record their plans and actions.
Mr O'Brien isn't back On Call for 6 weeks, however work will begin immediately to address the back log.
I have promised Richard a written plan of how we will be proceeding and have asked for a period of 3 months to address.
Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] **Mobile** [redacted]
[redacted]

From: Toal, Vivienne
Sent: 16 September 2016 08:57
To: Wright, Richard; Gishkori, Esther
Subject: RE: meeting re Mr O'Brien.

Esther – I am conscious you go off on leave today; how do you wish to handle Richard's request below?

Vivienne

From: Wright, Richard
Sent: 15 September 2016 14:52
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Re: meeting re Mr O'Brien.

Hi Esther. As director of the service naturally we have to listen to your opinion. Before I would consider conceding to any delay in moving forward with what was our agreed position after the oversight meeting I would need to see what plans are in place to deal with the issues and understand how progress would be monitored over the three month period.
Perhaps when we have seen these we could meet again to consider. regards Richard

Sent from my iPad

On 15 Sep 2016, at 14:40, Gishkori, Esther [redacted] wrote:

Dear Richard and Vivienne,
Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.

Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
Now that they both work locally with him, they have plenty of ideas to try out and since they are both relatively new into post, I would like try their strategy first.

I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.

I appreciate you highlighting the fact that this long running issue has not yet been resolved. However, given the trust and respect that Mr O'Brien has won over the years, not to mention his life-long commitment to the urology service which he built up singlehandedly, I would like to give my new team the chance to resolve this in context and for good. This I feel would be the best outcome all round.

Happy to discuss any time and I will of course brief the oversight committee of any progress we make.

Many thanks
Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
<image001.png> **Office** [redacted] **Mobile** [redacted]
<image002.png> [redacted]

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Francis / Richard / 16.9.16 9am.

① Background.

② Director responsible for everything operational.

③ → Professional implications:-

④. Very

⑤ → Meetings → fortnightly: (Emma Lara)

⑥ → CDs → development programme:-

↓

EG.

⑦.

Vivienne → SMT → Nigel.

Toal, Vivienne

From: Wright, Richard [redacted]
Sent: 16 September 2016 13:44
To: Toal, Vivienne
Subject: RE: meeting re Mr O'Brien.

Hi Vivienne. I had a meeting scheduled with Francis and Esther this am and this topic came up. Esther agreed in principle to provide the info requested and to ensure that there was a documented meeting with Me OB outlining the implications of not getting this sorted within 3 months. Francis was keen to pursue this a under those circumstances but not to let it run further than the three months if still non compliant. Happy to discuss further. Richard

---

From: Toal, Vivienne
Sent: 16 September 2016 08:57
To: Wright, Richard; Gishkori, Esther
Subject: RE: meeting re Mr O'Brien.

Esther – I am conscious you go off on leave today; how do you wish to handle Richard's request below?

Vivienne

From: Wright, Richard
Sent: 15 September 2016 14:52
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Re: meeting re Mr O'Brien.

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Happy to discuss any time and I will of course brief the oversight committee of any progress we make.

Many thanks
Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
<image001.png> **Office** Personal Information redacted by the USI **Mobile** Personal Information redacted by the USI
<image002.png> Personal Information redacted by the USI

<image003.png><image004.png><image005.png>

Since I can't improve on this I am forwarding in toto.

Thanks

Charlie
From: Weir, Colin
Sent: 16 September 2016 14:41
To: McAllister, Charlie
Subject: Action Plan

Charlie
These are my initial thoughts. Anything to add? Change?

Dear Dr McCallister

Further to discussions I propose that I as CD and you as AMD implement the following action plan in relation to outstanding issues in respect of Mr O'Brien

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien
2. To implement a clear plan to clear triage backlog.
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation
5. All patient notes to be return from home without exception
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training |Clinical Director SEC
Southern Health and Social Care Trust

Secretary Jennifer Personal Information redacted by USI

From: Gishkori, Esther
Sent: 15 September 2016 14:59
To: Weir, Colin; McAllister, Charlie; Carroll, Ronan
Subject: FW: meeting re Mr O'Brien.

FYI below.
……and my response will be?

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted by USI **Mobile** Personal Information redacted by USI

Stinson, Emma M

From: Carroll, Ronan <Personal Information redacted by USI>
Sent: 22 September 2016 15:41
To: McAllister, Charlie; Gishkori, Esther; Weir, Colin
Subject: RE: meeting re Mr O'Brien.

Importance: High

Charlie/Colin
So can I ask and offer some suggestions/solutions as to how we may monitor progress against the action listed below. The clock is ticking now toward December
Come back to me if you wish me to action anything/all

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien – At the first meeting obviously after the context of the meeting being explained the proposed plan/actions need to be shared with AOB and agreed
2. To implement a clear plan to clear triage backlog. – is this the outpatient referral letters, including RF's? How are you planning to monitor that this is cleared? I would propose with regard to the RF's that I would ask the cancer team to monitor the triage turnaround, with regard to outpatients I would ask Anita to put a process in place to monitor
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this – RBL validation – are we offering additional Pas for this to be done? If not, then something in his job plan will have to stop for this clinical validation to happen. Then when this task has been completed the remaining on the RBL can only be dealt by as your suggestion the template being adjusted, this has a lead in time of 6 weeks due to partial booking process. When this is implemented we will monitor the progress of AOBs RBL (I can have this run at anytime)
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation – I will speak to Anita to ensure AOBs secretary receives digital dictation following any consultation
5. All patient notes to be return from home without exception NA
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed absolutely
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

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

From: McAllister, Charlie
Sent: 21 September 2016 11:55
To: Gishkori, Esther; Weir, Colin; Carroll, Ronan
Subject: RE: meeting re Mr O'Brien.

Hi Colin

Thank you very much for this. Apart from the fact that you spelt my name wrong (!) this is absolutely excellent and I agree completely. It would be important to do this in a positive/constructive/supportive role and that Mr O'Brien would be aware of this. I think that this approach will give the best chance to achieve this. And for improving the current situation.

Directors and Associate Medical Directors. They were not unique to me. During the Review of (Adult) Urology services I can confirm that the weekly Monday evening meetings could become quite fractious as the Department of Health were trying to get the Trust to agree to clinic activity. Mr O'Brien would not agree to the BAUS guidelines of 20 minutes for a new patient and 10 minutes for a review patient (this had been accepted in the other two Urology 'Teams' in Northern Ireland) and, whilst agreement was eventually reached, Mr O'Brien was in the minority as he wouldn't sign up to this activity and would quote this back to me over the years.

30.10 Mr O'Brien was very aggrieved with the Review of Urology Services (2009), particularly the removal of radical pelvic surgery from Craigavon Hospital and it was his view, and he said it on a few occasions, that patients had died as a result of this decision. Mr O'Brien would have openly said that Mark Fordham (external author of the paper) should never have been allowed to be involved in suggesting this recommendation.

30.11 Mr O'Brien didn't hide the fact that he didn't work well with Dr Rankin and Mr Mackle. Both of these managers tried to manage him through the IV fluids and antibiotic review, through radical pelvic surgery moving to Belfast, and through his continuous non-compliance to triaging the new outpatients. Dr Rankin and Mr Mackle would have persevered in holding Mr O'Brien to account which, in my opinion, Mr O'Brien didn't like as he was used to 'doing it his own way'.

30.12 Mr O'Brien would often mention his legal connections through his brother and his son both being barristers and, in my opinion, made some of the medical and professional managers nervous and I would suggest was a reason for not challenging some of his practices.

30.13 I have an awareness of at least two occasions where managers had been asked to step back from managing Mr O'Brien. In approximately 2011/2012 Mr Mackle had been advised that he was being accused of bullying

Book 8

June 2016

- Oct 2016

inappropriate

Roberta :- omitted / delay :-
?? have date :-
errors / - - - - - /

Update → Tracey →
Ask Tracey →
!!! Defensive language → percentage

44. If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

44.1 I would like to add information about a telephone call that I inadvertently witnessed as it I think it may be evidence of some level of pressure on one of the Acute Services Directors who did not fully investigate Mr O'Brien's practice.

44.2 I cannot remember the date of the meeting and I did not make a note of the incident at the time. However, I know that it must have been after the concern in relation to Mr O'Brien's triage practice was identified, as I understood the context of the call without it having to be explained.

44.3 I was in a 1:1 meeting with Mrs Esther Gishkori, Director of Acute Services, in her office on the CAH Administration floor, updating her on my pharmacy responsibilities. The telephone rang and Mrs Gishkori answered it whilst I was in the room. I realised she was speaking to the Chair of the Trust (Mrs Roberta Brownlee) and, while I indicated to Mrs Gishkori that I would leave the room to give her privacy, she told me to stay.

44.4 I could not hear what Mrs Brownlee was saying however I recall that Mrs Gishkori did not say very much in response to Mrs Brownlee during the call and that she became very flustered.

44.5 When the call ended Mrs Gishkori told me that the Chair had asked her to *"leave Mr O'Brien alone"* as he was an excellent doctor and a good friend of hers who had saved the life of one of her friends.

44.6 I remember saying to Mrs Gishkori that I thought that the Chair's behaviour was unacceptable and that she should document the call and speak to the Chief Executive about it, as her line manager.

Please provide all relevant documentation.

Mr O'Brien never made a complaint to me about Mr Mackle, bullying or otherwise.

48. **Martina Corrigan** has provided information to the Inquiry as follows:

(i) "*I have an awareness of at least two occasions where managers had been asked to step back from managing Mr. O'Brien. In approximately 2011/2012 Mr. Mackle had been advised that he was being accused of bullying and harassment towards Mr. O'Brien and that he needed to step back from managing him. I was not present when Mr. Mackle was told this, but he came straight to me after this happened, told me about it, and was visibly annoyed and shaken and said to me that he would no longer be able to manage Mr. O'Brien. I also understand that, in mid-2016, Mrs Gishkori received a phone call from the then Chair of the Trust, Mrs Brownlee, and was requested to stop an investigation into Mr. O'Brien's practice. Once again, I did not witness this, but I was told later by Mr. Carroll that it happened as my understanding is that Mrs Gishkori had told some of her team*." **WIT 26224 - 26225**.

This account from Martina Corrigan is third hand. Martina states that she heard from some unnamed member of Esther Gishkori's team that I had asked Esther to halt an investigation into Mr O'Brien? I would never interfere in due process in this way patient safety was always my top priority, and I have absolutely no doubt that Esther will confirm that this never happened. I never made any phone call to Esther Gishori about Mr O'Brien

(ii) At 24/22 at para 67.5 – "*It is my opinion, on reflection, that outside influence from the Trust Chair (Mrs Brownlee) in dealing with Mr.*

Personal Information redacted by USI

19th September 2016

Corporate Complaints Officer
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Dear Sir/Madam,

Patient 84
DOB: Personal Information redacted by USI
H&C No.: Personal information redacted by USI

I am writing to make an official complaint about the neglect towards myself resulting in my total dissatisfaction on how I have been treated over the past few months.

To give you the background into my situation, I was phoned by a consultant (Mr Puyson I believe) on Friday 25th March 2016 (Good Friday) to say that I had a blockage in my ureter, noticed on a recent CT scan, and that it would be best that I come into hospital as soon as possible to get surgery. I was informed that the Easter weekend would be a good time as there was some capacity to do the surgery as I was on an emergency list. I was obviously a bit alarmed and was in the middle of packing for the Easter weekend away. Of course, I realised the seriousness of my condition so I cancelled my plans and the consultant and I agreed that I would receive a telephone call on the Saturday morning to confirm bed availability. I didn't receive this call and then had to do some chasing myself. The staff currently on weren't aware of the plans for surgery. I eventually got confirmation on Easter Sunday morning to come to hospital for the surgery planned on Monday but when I arrived the staff were surprised as I shouldn't have needed to stay pre-operatively and therefore could have just came to hospital on Monday morning. This is just to highlight the severe lack of communication from the start and the fact that my weekend plans were cancelled unnecessarily. However, in saying all that, what followed is the real reason for this letter.

After the surgery by Mr O'Brien, I was told that the blockage had been removed (although the stone escaped back up to the kidney) and that I did have a lot of stones in both kidneys and a stent was placed in the right ureter. I understood the logic for a stent and I was informed that it will be uncomfortable at first and that I may feel the urgency to pass urine a bit more frequently as the stent protrudes inside the bladder slightly. I was informed that the stent should be removed in 6 weeks' time. I felt that this was fine and that this would be good timing for my pre-booked holiday at the end of May.

Unfortunately, from the beginning I had persistent pain with the stent at the tip of my penis particularly when passing urine, and I was passing fresh red blood post exercise and had severe urgency and severe frequency. This clearly had a major impact on my life both at home and in work. I was on regular Ibuprofen and Paracetamol to alleviate the pain but the pain was not being controlled. I was worried about my severe signs and symptoms so I contacted Mr O'Brien's secretary and asked could I speak to him or a member of his team for some medical advice and to discuss the symptoms I was

feeling as I was concerned something was wrong. Unfortunately the secretary said I would not be able to speak to anybody in the medical profession but I should contact my GP and that she would send an email to Mr O'Brien. I felt my issues were not being taken seriously and I was being neglected.

I contacted my GP who kindly offered some general advice but obviously it was a specialist opinion that I needed at this time. I re-contacted Mr O'Brien's secretary to ascertain where I was on the waiting list for my stent removal but this information was not even available. Again, I was informed that an e-mail would be sent to Mr O'Brien.

My symptoms as mentioned were getting worse and I was getting increasingly concerned at this point as I was going on holidays to [redacted] and didn't want get ill abroad. Mr O'Brien's team were aware of my concerns regarding the stent still being in situ while I was abroad as by this stage the stent had been in for 6 weeks. So again I had to contact my GP, who prescribed Amoxicillin based on signs of a urinary infection.

On holidays the pain was unbearable at times. I had severe urgency so it meant finding public toilets whenever we were out and making sure I was near one or knew the location of one at all times. I had severe frequency especially at night. I was determined not to let this ruin my holidays with my [redacted]. I went to the local chemist and had to get more Ibuprofen equivalent and continued to drink as much water as I could, being very aware of the fact I was in a warmer climate.

I phoned the secretary again on my return expressing my concerns, again the same response. She'll send an email and Mr O'Brien will phone me directly to let me know when the appointment is arranged. I also phoned my GP who was concerned and I believe a letter was sent to Mr O'Brien.

In desperation from knowing I was unwell I had to continue making calls to the secretary but I was made to feel like a nuisance and never actually got to speak to a medical professional or get an appointment for surgery. I was informed that the waiting list was over 200, this however is not acceptable and I do feel like I was severely neglected.

Three courses of antibiotics (Amoxicillin (x2) and Ciprofloxacin) and regular paracetamol and ibuprofen brought me to the weekend of 6th August, 5 months later. I felt lethargic on Saturday but felt it was due to another disturbed sleep as I woke 3 times to pass water. I endured it as usual as this had been daily since discharge but when I woke on Sunday I felt very unwell and had pain in my right side. At this stage I had been unwell and had the stent in for 5 months and I had an increasing concern that the stent could affect the long-term function of my kidneys. I went to A&E at 11am, and was later taken up to 3 South at around 7pm because the urine sample I submitted had "all kinds of things in it" and my white blood cell count and CRP count were very high. I was relieved to be finally admitted as I wanted the stent removed and my kidneys cleared of stones. However I was very frustrated that my concerns of being unwell had not been taken seriously and I had to basically wait until I became so unwell that I had to attend A&E and be admitted to hospital, all of which could have definitely been avoided.

I was told by my new consultant Mr O'Donaghue that potentially surgery would be on Tuesday 9th August but thought it was best to postpone it until Wednesday due to the infection. Although a minor point, I was still fasted from 12pm on Monday night; but this again highlighted the miscommunication within the Urology department. On Tuesday the ward got a call from the microbiologists saying that I had "very nasty bacteria" in my urine that produced Extended-Spectrum Beta-Lactamases (ESBLs). This was likely a result of the overuse of antibiotics taken to date which all could have been avoidable if the stent had been removed in the appropriate timeframe. As a result the current IV antibiotic wasn't

working so I was given Tazocin and that the surgery would need to be postponed to a later date until the infection cleared as it could be very dangerous if they were to continue, all of which was very concerning as I was starting to hear the word 'Septicaemia'. I also learned from a further CT scan that a stone was still in my Ureter and it lay next to the stent.

Following this I grew more annoyed however as I am certain this all could have been avoidable. Even during the pre-operative assessment on 11th August this thought was at the forefront of my mind. The doctor informed me that the stent may not be so easily removed and that there may be damage to the Ureter etc. I know the stent was the route of my long-term pain and I am absolutely convinced it was the sole reason for my infections to date. During my stay I was wide-eyed in disbelief what I was hearing from other consultants that they don't favour stents and where they are needed they target the removal in 5 weeks, for the exact reason of potential UTIs etc. I am aware that they can sometimes stay in for 6 months, but given my known complications and my signs and symptoms, I should have been taken more seriously before I became so unwell.

I was in hospital (3 South) from 7th – 14th August for this period. I was discharged on the Sunday 14th August, but I hadn't felt well afterwards, which I put down to being a bit tired after the surgery. However I had tenderness in my kidneys on Monday night affecting my sleep, Tuesday I felt quite lethargic but by Wednesday I had a high temperature. I got a GP appointment for 4pm that day who sent me straight to A&E. I was very worried about the issue of blood poisoning at this point. Following a blood test in A&E, my white blood cell was high as was my CRP level, so I was put on another antibiotic called Meropenum based on the advice that the doctor sought from the microbiologists. I was then transferred to 3 South, with possible Sepsis and I was on another IV antibiotic for 7 days. I was in hospital (3 South) from 17th – 24th August for this third period. I was discharged on Wednesday 24th and was given further antibiotics that I needed to take for 10 more days. It also led me to question if I should have been discharged without further antibiotics the previous time.

I want to make it clear that the staff during my stays were excellent but the duty of care potentially with serious implications between March and August was incredibly poor. If I had been dealt with in the correct manner after the insertion of the stent with it being removed after a 5-6 week period, not only could I have avoided enduring all that pain for 5 months but I wouldn't have to stay in the hospital for 2 full weeks to clear up a serious infection and the procedure could obviously have been much more straightforward.

I suggest you vastly improve consultant and patient communication when the patient is not in the hospital, particularly knowing they are required to return to finish a procedure. Medical concerns should be addressed by the consultant or a member of his/her medical team, not by administrative staff. I understand there is a risk that the consultant could find all his time taken up with external patient concerns, but maybe this is where his/her administrative team and a member of his medical team work together to screen non-urgent/ less important issues, then a window in the day is left for the consultant to phone patients with real urgent concerns. If Mr O'Brien hadn't ignored my many calls and failed to return any of them, I wouldn't have been in this situation and the tax payer's money would be better spent. I can't understand in this cost conscious NHS system why it seemed a better plan to ignore my issues for so long and wait until I needed to be admitted to hospital for a 2 week period; taking up a bed, using up time, resources and antibiotics in addition to the impact on my health.

I look forward to hearing from you and hope for the sake of others, this letter makes a difference to patient care, so there is no future repeat in this type and level of care.

Yours Faithfully,

[redacted] Patient 84

[redacted] Patient 84

Southern Health and Social Care Trust

1 December 2016 **Our Ref:** AS206.16/17

Private & Confidential

Patient 84
Personal Information redacted by USI

Dear Patient 84

I refer to your complaint in respect of the care provided to you by the Urology Department at Craigavon Area Hospital. Thank you for taking the time to highlight your concerns and for providing me with the opportunity to address them.

Firstly may I begin by apologising for the delay in responding to your letter. As part of the investigation into your concerns I have spoken to Mr O'Brien Consultant Urologist, about your complaint.

Mr O'Brien advises me that you had haematuria assessed in 2002 and 2003 at which times you were found to have renal calculi associated with a left hydronephrosis. In September 2015, the radiology department received a referral from your GP requesting a plain radiograph of your urinary tract; this xray was performed on 25 September 2015 and reported on 17 November 2015. The reporting radiologist suggested that most likely you had bilateral renal calculi with a probable right upper ureteric calculus. On 29th January 2016 your GP made a referral to the Urology Department for further management.

On receipt of this referral, Mr Glackin triaged the letter and then wrote to you on 2nd February 2016 advising that he had requested a CT scan of your urinary tract to assess for stones and that you would be sent an appointment to attend as an outpatient to the stone clinic. On the 4 March 2016 you were seen by Mr Young Consultant Urologist. You had an xray done during this appointment and whilst the bilateral renal calculi were evident on this xray, the right ureteric calculus was not. So when you had your CT scan on 22 March 2016 it was reported that you had a gross right hydronephrotic kidney and hydroureter. It was from this report that Mr O'Brien deemed that you needed to be admitted to have a ureteroscopy performed as an emergency.

Mr O'Brien asked for his Registrar, Mr Tyson to contact you and ask that you come in for admission on the Sunday. Mr O'Brien then emailed the Ward to give them your details and advise them that you would be admitted on the Sunday for your procedure on Monday. I would like to apologise for the misunderstanding when you arrived on the Ward as Mr O'Brien's email hadn't been picked up on this occasion and therfore the ward were not expecting you. As learning from this I have asked that Mr O'Brien and his Registrars follow up with a phone call to the Ward and also that the ward ensures that they check their emails at least a few times daily.

Clinical and Social Care Governance Team
Directorate of Acute Services
Ground Floor, The Maples, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Telephone: Personal Information redacted by the USI

I am advised that on Monday 28 March 2016 you had a right ureteric stenting performed following an ureteroscopy and migration of the obstructing stone into the hydronephrotic right kidney.

Mr O'Brien confirms that ideally patients who have a stent inserted should have this removed and have an ureteroscopic lithotripsy performed four to six weeks later. However, the demand on the Urology Service is unrelenting with an increased number of patients with suspected and confirmed cancer diagnoses requiring progression along their cancer pathway. The result of cancer urgent demand is that the waiting times for other procedures such as yours are increasing on a monthly basis. For this wait we would like to apologise and whilst not ideal nor what we want for you or any of our patients it is something that is currently outside of our control.

I note from your complaint that you have contacted Mr O'Brien's secretary on a number of occasions. Mr O'Brien confirms this and advises me that an email was sent to him via his secretary advising that you had a holiday in [Personal Information redacted by the USI] booked from 13 May to 28 May 2016 and that you were enquiring whether you could have surgery performed before then. Unfortunately as explained in the previous paragraph with the clinical prioritisation of patients, Mr O'Brien unfortunately could not accommodate your request. At the time of your request Mr O'Brien had 232 patients awaiting inpatient admission of which 136 of them were categorised as urgent. Mr O'Brien apologies that you had to contact him on a number of occasions but with his clinical commitments and the number of patient enquiries that he receives daily it is not possible for him to respond to them all individually, but advises that you did the correct thing by going to your own GP for advice.

I understand that you had two emergency admissions to 3 South in August 2016 under the care of Mr O'Donoghue and Mr Glackin who were the Urologists oncall during these admissions. I would like to apologise that you had to fast unnecessarily whilst you were in the first time but I have been advised that this was a precaution in case you were well enough to go to theatre and there was a slot available on the Tuesday and I am sorry that this wasn't communicated properly with you at the time.

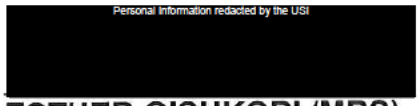
The Urology Department are currently working at improving the pathway for patients experiencing similar symptoms such as yours. This will involve having a 7 day week stone service with detailed information leaflets for patients with more access to health care professionals if advice is needed. It is hoped through the development of this service it will mean that patients will have their treatment and follow-up done in a timelier manner and hopefully avoid the poor experience that you had endured.

On behalf of the Urology Service I would like to apologise again for your poor experience and I am advised that you have a follow-up outpatient appointment with Mr Glackin on 20 December 2016 and I hope that your health issues have improved.

I hope that you will find this response has addressed the issues that you raised. However, if you are unhappy with any aspect of this response you should contact a member of our Clinical & Social Care Governance Team on [Personal Information redacted by the USI] or email: [Personal Information redacted by the USI] within 3 months of the date on this letter so that we can attempt to resolve any outstanding issues.

Should you remain dissatisfied at the end of the complaints process, you can then refer your complaint to the NI Public Services Ombudsman at the following address, "Freepost NIPSO", Freephone: 0800 34 34 24 or email nipso@nipso.org.uk within 6 months of the completion of the Trust's internal complaints process. Further information on the role of the NI Public Services Ombudsman can be found at www.nipso.org.uk. Please note that the Ombudsman will not normally accept your complaint until the complaints process with the Trust has been exhausted.

Yours sincerely



ESTHER GISHKORI (MRS)
Director of Acute Services

For Mr F Rice, Interim Chief Executive

Personal information redacted by USI

28th February 2017

Corporate Complaints Officer
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Dear Sir/Madam,

Patient 84
DOB: Personal Information redacted by USI
H&C No.: Personal information redacted by USI

I appreciate your apology on behalf of the Urology Service but an apology direct from Mr O'Brien would have been more acceptable.

Mr O'Brien had the opportunity to call in to see me during either of my two emergency admissions to 3 South in August 2016 to try and explain his decision not to remove the stent. He owed me that at least and treat me with some respect and have the common decency to do so, or simply a returned call would have sufficed to allay my concerns with the stent in place at any time over the 5 month period. I find it hard to believe he couldn't spare me 5-10 minutes during this time.

I fully appreciate the demand is unrelenting on the Urology Service with 'an increased number of patients with suspected and confirmed cancer diagnoses requiring progression along their cancer pathway' and 'the result of cancer urgent demand is that the waiting times for other procedures such as yours are increasing on a monthly basis'. However, to me this is all more reason to deal with my issue there and then so the Urology Service can concentrate their time and efforts to these cancer patients. The insertion of the stent to me seemed like a very short sighted decision, while I was grateful the blockage was detected in my ureter, it felt like the minimum action possible was taken. To insert a stent to temporarily mitigate the effects of the blockage i.e. the pressure on my kidney, felt like a kind of 'that will do for now' scenario but there was never no plan or intention to aim for the 4 to 6 week target for stent removal with ureteroscopic lithotripsy.

Also, I should not be made to feel guilty because of the more urgent cancer demand, as I waited in excess of 3 and a half months more than I should have and endured this pain for this length of time which is ample time to wait for this situation to be rectified for me. If I hadn't have presented myself to A&E in August through a severe infection, I feel I'd still be waiting months later. This response has not acknowledged once the severe infection I had that Mr O'Brien's decisions had led to, and rounds of strong antibiotics I needed to rid me of this infection. You have carefully avoided this area altogether in your response which in effect minimised the pain, suffering and nuisance I suffered for five months.

Furthermore, after my procedure on 28th March 2016 I was led to believe that the offending stone causing the blockage had disappeared back up into the kidney during the procedure but the scans during my emergency admission in August 2016 highlighted that a stone was embedded in my ureter alongside the stent. Either this was the same one from earlier that wasn't adequately removed, hence

Gibson, Simon

From: Gibson, Simon <[redacted]>
Sent: 28 September 2016 16:03
To: Wright, Richard
Cc: Gishkori, Esther; Stinson, Emma M; McAllister, Charlie
Subject: Dr A O'Brien
Attachments: leto_160913_to+rb_advice+letter_18665.pdf

Dear Richard/Esther

You will recall that as part of the collation of evidence in relation to the above, I sought advice from NCAS which was discussed when the Oversight Committee met.

The written advice from NCAS has now come in and is attached. Whilst the informal work is underway with Dr O'Brien, this NCAS advice will be placed on file for reference should we need it at the end of the informal piece of work.

I hope this is useful

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
[redacted]
Mobile: [redacted]
DHH: [redacted] Ext [redacted]

From: Gibson, Simon
Sent: 28 September 2016 15:53
To: Gibson, Simon
Subject:

NHS
National Clinical Assessment Service

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

Tel: Personal information redacted by the USI

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

13 September 2016

PRIVATE AND CONFIDENTIAL
Sent by email only

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

NCAS ref: 18665 (Please quote in all correspondence)

Dear Mr Gibson

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

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

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

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

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

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

Southern Health & Social Care Trust

Oversight Committee
12th October 2016

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Esther Gishkori, DAS

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager

Discussion:

Mr A O'Brien
Mrs Gishkori reported that Mr O'Brien was going for planned surgery in November and was likely to be off for a considerable period. It was noted that Mr O'Brien had not been told of the concerns following the previous Oversight Committee. It was also noted that a plan was in place to deal with the range of backlogs within Mr O'Briens practice during his absence.

Mrs Gishkori gave an assurance that, when Mr O'Brien returned from his period of sick leave, that the administrative practices identified by the Oversight Committee would be formally discussed with him, to ensure there was an appropriate change in behaviour. It was agreed that this would be kept under review by the Oversight Committee.

Corrigan, Martina

From: O'Brien, Aidan [redacted]
Sent: 18 October 2016 13:23
To: Weir, Colin
Subject: RE: Job plan

Grand!

Aidan

From: Weir, Colin
Sent: 18 October 2016 13:20
To: O'Brien, Aidan
Subject: RE: Job plan

That's great

No if you want to put on paper what you think a reasonable representative job plan looks like for you
If you work different patterns in different weeks I will need to see that say you went to SWAH week 2 and 3 out of a 7 week cycle to include urologist of the week. It all sounds very complicated but not really once we get started.

Will need to ensure you include SPA and CPD activity and any private work even if outside normal day (in that case it doesn't affect your calculation)

I can do the electronic bit

Colin

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training |Clinical Director SEC
Southern Health and Social Care Trust

Secretary Jennifer [redacted]

From: O'Brien, Aidan
Sent: 18 October 2016 12:14
To: Weir, Colin
Subject: RE: Job plan

Thank you, Colin.

I will be in contact with you on Monday 24 October to arrange a time on Tuesday 25 October when we can meet. As I have not previously had such a meeting, is there anything that you would wish me to bring to the meeting in preparation?

Aidan.

From: Weir, Colin
Sent: 18 October 2016 08:44
To: O'Brien, Aidan
Subject: RE: Job plan

From:	Boyce, Tracey
Sent:	09 November 2016 15:39
To:	Gishkori, Esther
Cc:	Stinson, Emma M
Subject:	FW: Emailing: sc of partial SAI
Attachments:	sc of partial SAI.pdf
Importance:	High
Sensitivity:	Confidential

Hi Esther
I had my weekly update with the governance leads today and they shared a draft of an SAI that is nearing completion as they are concerned about its implications - I have attached the first page to give you the gist. I think we may need to discuss this one with Richard as the cause seems to be directly attributable to one of the consultants (AOB)?

.sically this lady's GP sent in a referral in relation to an incidental finding on a CT in relation to her kidneys - it came in as routine.
The urologist consultant of the week collected that week's letters to do triage, as per the urology arrangements but from what the investigation team has found out that letter was never seen again and no instruction were received re triage appointment booking.

Apparently this had happened before with this consultant so the booking team's way of dealing with these type of 'lost letters' was to book them a routine appointment (because letters were lost before they had started keeping copies to work from). As a result there was a 16 month delay in diagnosing this ladies renal carcinoma. The triage consultant is meant to look at the CT as part of triage process but the SAI team found that it hadn't been looked at. The urologist on the SAI team has said if it had been reviewed at triage it would have been immediately obvious it was a tumour. (there was also an issue in relation to the reporting of a subsequent MRI back in 2014 that meant the GP or breast team did not pick up that it was potentially a red-flag or urgent referral was needed)

Although this was an SAI about a single case it has come to light that the other 7 urology referral letters received that week are also missing - as an initial action I have asked Trudy and Connie to try and track them via PAS to check they have been seen and pull their notes if necessary. I haven't asked the question yet whether we know if any ure of that consultants weeks triage letters have been lost - but it is probably something we need to discuss.

I am conscious that I haven't spoken to Ronan about this yet as AOB's AD - but I wanted to get your take on it before I shared it with anyone else.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Personal information redacted by the USI

Gibson, Simon

From: Richard.Wright[Personal Information redacted by the USI]
Sent: 30 November 2016 09:36
To: Esther.Gishkori[Personal Information redacted by the USI]
Cc: Vivienne.Toa[Personal Information redacted by the USI]
Subject: Confidential

Hi Esther.
Thank you for keeping me informed of some of the issues that have come to light from an ongoing SAI investigation re Mr OBrien.
I'm sure you are as disappointed as I am that there seem to be outstanding issues with regard to his behaviour. Can your team provide reassurance that the immediate issues re patients notes have been rectified and update me as to the state of the SAI investigation as at first glance it appears there may have been a patient data breach to be considered?
Clearly In my role as data guardian I need to be informed if there has indeed been a breach.
Have we clearly established why Mr OBrien is on leave? if he is on leave has a sick line be submitted? If not can we refer him to occupational health to establish his current status?
Regards Richard

Sent from my iPad

From: Boyce, Tracey
Sent: 02 December 2016 11:52
To: Wright, Richard
Subject: Confidential re AOB

Hi Richard
For info – I got a chance to ask Esther about the AOB SAI this morning.

She said that she had some assurances from the urology team that notes had been returned – however she asked me to get the acute governance team to go through the spreadsheet the secretaries had been keeping to make sure every patient has been triaged and that all missing notes are now accounted for.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Personal information redacted by DoI

Learn more about mental health medicines and conditions on the Choiceandmedication website http://www.choiceandmedication.org/hscni/

Gibson, Simon

From: Wright, Richard [redacted]
Sent: 06 December 2016 10:52
To: Gishkori, Esther
Subject: RE: Confidential

Thanks Esther. That sounds very reasonable. Any ideas when that is likely to be? Richard

-----Original Message-----
From: Gishkori, Esther
Sent: 06 December 2016 09:31
To: Wright, Richard
Cc: Toal, Vivienne
Subject: RE: Confidential

Dear Richard,
I can confirm that Mr O'Brien has had surgery and that sick lines are being submitted appropriately. I do not think that an occupational health referral is indicated at this point although it may well be in the coming weeks as Mr O'Brien is likely to return before he is well. We shall see in due course.

Patient notes are being returned as requested from Mr O'Brien however, Trudy Reid (governance facilitator) is not sure if all notes taken off the premises have been returned. The governance team are in the process of checking this out. It is difficult to be completely sure until notes cannot be found but we are doing our best.

The SAI review continues and will no doubt produce its own recommendations.

I have been having conversations in relation to Mr O'Brien's "return to work" interview. We thought that this would be a good time to set out the ground rules from the start.
Since [redacted] are both off sick, Mark wondered if you and I could do this. Since there are both professional and operational issues here, I feel that this is entirely reasonable.

Will chat to you about it as we will have until the new year to think about it.

Best,
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] Mobile [redacted]
[redacted]

-----Original Message-----
From: Wright, Richard
Sent: 30 November 2016 09:36
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Confidential

Hi Esther.

Stinson, Emma M

From: Gishkori, Esther [redacted]
Sent: 16 December 2016 16:45
To: Boyce, Tracey; Carroll, Ronan
Cc: Stinson, Emma M
Subject: RE: Concerns raised by an SAI panel

Yes Tracey,
I think we had better.
You may know that there had been an oversight committee established in relation to this Dr and it had been stood down as he was on sick leave.
I do however think we now need to inform the committee as things do seem to be fairly serious and potentially harmful for patients here.
We will try to meet on Tuesday. Perhaps before SMT?
E.
Thanks
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] Mobile [redacted]
Esther.Gishkori[redacted]

-----Original Message-----
From: Boyce, Tracey
Sent: 16 December 2016 16:34
To: Carroll, Ronan; Gishkori, Esther
Cc: Stinson, Emma M
Subject: Concerns raised by an SAI panel

Hi Ronan and Esther
Could we have chat about this next week - I am at a regional strategy day on Monday - perhaps we could get together on Tuesday?

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
[redacted]

15 December 2016

Dear Tracey

As you are aware the SAI review and report in relation to [Patient 10] reference number [Personal Information redacted by the USI] is complete.

The remit of [Patient 10]s Serious Adverse Incident was to fully investigate the circumstances which contributed to her clinical incident. The Review Team was comprised Mr Anthony Glackin Consultant Urologist, Dr Aaron Milligan Consultant Radiologist, Mrs Katherine Robinson Booking and Contact Centre Manager, and Mrs Christine Rankin Booking Manager. To provide context, part of the work included a look-back exercise for 7 Urology patients who managed in the same manner as [Patient 10] in October 2014. This was to satisfy the panel that there was a management plan in place and no harm had come to the other 7 patient (letters) which were not triaged on the week ending 30 October 2014. The manual look-back was done using the 6 available patient charts on 14 November 2016. These 6 patients all have been discharged or management plans in place. The 7th (patient initials [Patient 99]) chart was not able to be found on Trust property at this time [Patient 99]s chart arrived to the Governance office on week commencing 28 November 2016. The look-back exercise was completed on13 December 2016. There is clinical detail within the dictated letter in relation to the [Patient 99]s consultation which requires clinical validation. This has been given to Mr Anthony Glackin to review on 15 December 2016.

Upon conclusion, the Review Team agree there are a number of relevant and related issues/themes causing concern for the panel which have been exposed during the SAI investigation. The Panel would like to clarify that all relevant enquiries made while undertaking this report have been solely limited to the information which were independently provided by members of the Review panel in conjunction with Mrs Andrea Cunningham, Service Administrator. There have not been any approaches made directly to the Urology Clerical team, the Urology Head of Service or the Assistant Director of Surgery and Elective Care for any information or evidence of communication.

Discussed in Karen/Tracey Esther 20/12/16

Hand delivered to TB Friday 16/12/16

Southern Health & Social Care Trust

Oversight Committee
10th January 2017

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Esther Gishkori, Director of Acute Services

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Siobhan Hynds, Head of Employee Relations
Ronan Carroll, Assistant Director, Acute Services
Tracey Boyce, Director of Pharmacy, Acute Governance Lead

Dr A O'Brien

Dr Wright summarised the progress on this case to date, following the meeting with Mr O'Brien on 30th December, including the following appointments to the investigation:

- John Wilkinson is the Non-Executive Director
- Ahmed Khan is the Case Manager
- Colin Weir is the Case Investigator
- Siobhan Hynds is the HR Manager supporting the investigation

Ronan Carroll summarised the meeting with Urologists, who were supportive of working to resolve the position. Ronan Carroll updated the Oversight Committee in relation to the three issues identified, plus a fourth issue subsequently identified.

Issue one - Untriaged referrals
It was reported that, from June 2015, there are 783 untriaged referrals, all of which need to be tracked and reviewed to ascertain the status of these patients in relation to the condition for which they were referred. All 4 consultants will be participating in this review, which was now commencing.
Action: Ronan Carroll

There are 4 letters which hadn't been recorded on PAS which have been handed over by Dr O'Brien (consultant to consultant referrals).

Issue two – Notes being kept at home
307 notes were returned by Mr O'Brien from his home.
88 sets of notes located within Mr O'Briens office
27 sets of notes, tracked to Mr O'Brien, were still missing, going back to 2003. Work is continuing to validate this list of missing notes. It was agreed to allow an additional seven days to track these notes down, in advance of informing the CEx and SIRO, and Information Governance Team.
Action: Ronan Carroll

It was agreed that Dr Khan would write to Mr O'Brien, informing him who the NED was and, if necessary, asking him whether the 27 sets of notes were still at his house.
Action: Siobhan Hynds to draft letter

Issue three – undictated outcomes
It was reported that 668 patients have no outcomes formally dictated from Mr O'Briens outpatient clinics.
272 From the SWAH clinic
289 From other clinics.
The remaining 107 patients were still being investigated
Action: Ronan Carroll

Issue four – private patients
A review of TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients appear to be significantly less than for other patients. It would appear that there is an issue of Mr O'Brien scheduling his own patients in non-chronological manner.

It was recognised that the Ronan Carroll would continue to lead the operational team in working through the issues identified to reach clear outcomes for all patients. It was agreed by the Oversight Committee that this work would be recognised at WLI rates, with consultants undertaking additional 4 hour sessions to progress the issues identified.
Action: Ronan Carroll

independently or with supervision or administrative support, which would be reasonable to allow him to return to work. I have not yet had this discussion with Ronan.

This is as far as we have got.

No decision has been made; we are doing the preparatory work to allow an informed discussion to lead to a decision.

Ronan – I am sorry if this was somehow unclear, but this is the current position.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Simon.gibson[redacted]
Mobile: [redacted]
DHH: [redacted] Ext [redacted]

From: Gishkori, Esther
Sent: 19 January 2017 15:31
To: Gibson, Simon; Hynds, Siobhan; Toal, Vivienne; Wright, Richard
Cc: Carroll, Ronan
Subject: RE: Terms of Reference for Investigation

Dear Simon,
Ronan was telling me just now that you have been in touch to say that Mr O'Brien will be returning to work.
He said that the investigating panel has made this decision after a barrister's letter came into the Trust.

Can you update me please?

I need to know how the issue of potential harm to patients will be managed should Mr O'Brien return.
We have not yet had time to scope the potential impact on our patients or organisation yet. This notwithstanding, we know of two red flags that have waited since 20015. They have been asked to come in and we will soon know the outcome of these consultations and investigations.

Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] **Mobile** [redacted]
Esther.Gishkori[redacted]

Gibson, Simon

From: Gibson, Simon
Sent: 20 January 2017 15:09
To: Wright, Richard
Subject: FW: Terms of Reference for Investigation

Dear Richard

Are you OK if I adopt the "less said, the better" on this matter?

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Simon.gibson[redacted],
Mobile: [redacted]
DHH: [redacted] Ext [redacted]

From: Gishkori, Esther
Sent: 20 January 2017 11:46
To: Carroll, Ronan; Gibson, Simon; Hynds, Siobhan; Toal, Vivienne; Wright, Richard
Subject: Re: Terms of Reference for Investigation

Simon,
I have some concerns in relation to you speaking to Mr Young about anything in relation to this case. However, given the serious misinterpretations between Ronan, you and I, I think another meeting of the oversight committee may be the best next step. Not least to discuss the latest findings of the case. Mr Young would not be aware of any of this.
Just so as I'm clear, did the oversight committee meet since the letter from Mr O'Brien's barrister came in?
I will be in DHH this afternoon so may see you there.
Esther.

Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Friday, 20 January 2017 09:58
To: Gibson, Simon; Gishkori, Esther; Hynds, Siobhan; Toal, Vivienne; Wright, Richard
Subject: RE: Terms of Reference for Investigation

Thank you Simon

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

Southern Health & Social Care Trust
Personal Information redacted by USI
Mobile: Personal Information redacted by USI
DHH: Personal Information redacted by USI Ext 2421

From: Gishkori, Esther
Sent: 03 January 2017 15:17
To: Carroll, Ronan; Gibson, Simon; Corrigan, Martina
Cc: Hainey, Lynne; Wright, Richard; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB

Ronan,
I'm sure Simon will be able to answer the queries below but I just wanted to comment on point 4. Mr O'Brien is at liberty to do what he wants off ST premises but he cannot use the services of the Trust in the carrying out of his own private work. Not unless
the secretarial staff do the work outside core hours and don't use any facilities of the Trust.
Thanks
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted by USI **Mobile** Personal Information redacted by USI
Personal Information redacted by USI

From: Carroll, Ronan
Sent: 03 January 2017 14:49
To: Gibson, Simon; Corrigan, Martina
Cc: Gishkori, Esther; Hainey, Lynne; Wright, Richard; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB
Importance: High

Richard/Simon/Esther
Colin & Martina & I met with the urology consultants this am, at which we shared with them all the events that had been taking place and the decisions that had been taken.
From this meeting we need to answer a few questions

1- What are the ToR for the investigation/review
2- How long would you expect the review to last?
3- What was Mr O Brien advised re the undictated outpatient clinics i.e. can he dictate or has he to cease having anything to do with the outstanding backlog
4- What is the Trust's position on Mr O Brien undertaking private work and in particular using Trust secretarial staff to type private patient work whilst off?
5- What is the Trust position in regard to notes being transported in staff's private car to and from SWAH? Clinics run twice mthly (2nd & 4th wks)

Mr O Brien contacted Martina and advised that the notes which were not on Trust's premises have been left in his office. Martina has checked and this is confirmed, these notes will be transferred to the med exe office asap to be tracked to Martina on PAS and then a refreshed report will be ran to see if there are any more outstanding.

The Team are going to think/discuss and come back to Colin & I on thurs with how they proposed to complete the actions required associated with review.

Hainey, Lynne

From: Gibson, Simon
Sent: 04 January 2017 12:09
To: Gibson, Simon
Cc: Hainey, Lynne; Wright, Richard; Corrigan, Martina; Carroll, Ronan; Gishkori, Esther; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB

Dear Ronan and Esther

Following discussion with Richard, responses to your queries are below, coloured for ease of reference:

1- What are the ToR for the investigation/review
In line with the MHPS Framework, the TOR will be determined following the 4 week scoping exercise during which the scale of the potential problems are being considered by the Investigating Team

2- How long would you expect the review to last?
As indicated below, the scoping exercise is expected to be completed by 27th January. Once the formal investigation is commenced, it also expected to complete within 4 weeks, but this is dependent upon the complexity of the investigation and could well be extended

3- What was Mr O Brien advised re the undictated outpatient clinics i.e. can he dictate or has he to cease having anything to do with the outstanding backlog
As Mr O'Brien is excluded from work, he is unable to participate in the backlog. As indicated in the action notes from the Oversight Committee on 22nd December, it is expected that a plan for how this backlog will be managed will be presented to the Oversight Committee on 10th January.

4- What is the Trust's position on Mr O Brien undertaking private work and in particular using Trust secretarial staff to type private patient work whilst off?
In line with the MHPS Framework, Mr O'Brien is not completely at liberty to undertake private practice outside the Southern Trust. As his Responsible Officer, Dr Wright advised Mr O'Brien not to undertake private work during the period of this investigation, and to inform any private providers that he was currently excluded from his main employment. The exception to this would be if Mr O'Brien felt there were any patient safety issues; if this was the case, Mr O'Brien was advised that he should arrange transfer of care to a colleague.
However, I would agree with Esthers comments below in relation to secretarial issues.

5- What is the Trust position in regard to notes being transported in staff's private car to and from SWAH? Clinics run twice mthly (2nd & 4th wks)
This should be undertaken in line with Trust procedures; possibly these may need to be reviewed in light of the issues identified

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office

[redacted]

25 January 2017.

Private and Confidential

Mrs. Esther Gishkori,
Director of Acute Services,
Southern Health and Social Care Trust,
Craigavon Area Hospital,
Portadown,
County Armagh,
BT63 5QQ.

Dear Mrs. Gishkori,

Re: Serious Adverse Incident Review – Patient [redacted]

Thank you for your letter of 13 January 2017 and for providing me with the opportunity of returning comments concerning the final draft report of the Review Panel investigating the above serious adverse incident.

I have enclosed my report and comments.

Yours sincerely,

[redacted]

Aidan O'Brien

Conclusion

Patient 10 had a complex right renal cystic lesion since December 2012. During the next two years, its potential significance had either not been appreciated, or had been appreciated but not reported by at least two radiologists, and not reported to the urological service. Similarly, the potential significance of the lesion had not been appreciated by at least two clinicians who had requested further imaging which had been advised by radiologists in the investigation of the lesion from June 2014 to March 2015, and had similarly failed to refer Patient 10 to the urological service. I believe that the Review Panel may have failed to appreciate the significance of the cyst having changed between 2011 and 2012.

Even though there were failures on the part of clinicians and radiologists who had assessed and investigated Patient 10 and the index right renal lesion, I found the Review Panel's emphasis on the lack of triage of the letter of routine referral as the main cause of delay in Patient 10 having a urological appointment, as remarkably asymmetric. I do believe that it would have been reasonable and defensible to have relied upon the information contained in the letter of referral, and to have maintained the referral as routine. Therefore, lack of triage did not impact upon the time to consultation.

I also do believe that the triage on non-red flag referrals should be revisited, with a commitment to accommodate all views, to discuss who, when and how this challenge can be satisfactorily resolved.

Aidan O'Brien.

25 January 2017

I did not know Mr O'Brien at all nor did I know his history in the ST. However, Mr Mackle and Heather Trouton did know him well. In fact, Mr Mackle stated he had been having issues with Mr O'Brien "dating back a number of years". I understand that Mr O'Brien accused Mr Mackle of bullying (p32 para 4 and 5 Investigation report; Dr Neta Chada) Mr Mackle left his post soon after the sending of said letter.

Mr O'Brien was always described to me as an excellent clinician who was trusted with patient safety issues by his colleagues. They never doubted his clinical ability. This was a surgeon who had been instrumental in setting the service up. He agreed as to how referrals would be triaged and never, to the best of my knowledge, said he was not going to do these referrals.

Paragraph 8

After there was no response to the AMD and AD's letter of March 2016 and after Mr O'Brien protested profusely to a member of the legal team, blaming unnecessary administration on his late response, Mr O'Brien became an item on an already existing Oversight committee. I was first aware of this when I looked at the agenda on my way to the meeting and his name was included on that.

Sensing real and meaningful remedial action was necessary, I spoke with both Mr O'Brien's CD, Mr Colin Weir and AMD (now Dr Charlie McAllister) and asked if they could suggest an efficient solution to address Mr O'Brien's issues with administration in particular. Being an Anaesthetist and having worked in theatre for a long time with Mr O'Brien, Dr McAllister said he was almost certain that if Mr O'Brien was "relieved of his theatre lists" until his administration was up to date, he would soon catch up. Mr O'Brien loved the operating theatre. I understand that he would be prepared to spend all day and into the evening there if he could. If someone else did his lists, he would consider this intolerable. Both clinicians thought that it would take 3 calendar months to rectify.

Mr Weir was to meet Mr O'Brien and discuss the plan. It was to be supportive, constructive, and low key but very clear with no room for deviation. This plan was set out in an e mail from Colin Weir to Charlie McAllister on 16th September 2016. I was hopeful about it, but when I told him, the Medical Director was reticent. The Medical Director and Vivienne Toal (Director of HR) preferred to continue with the oversight Committee deciding on what action was to be taken next. I was invited to this committee and was a member, completing actions and reporting back to the committee as appropriate.

Mr O'Brien went off for surgery in November 2016. He was due to return to work in January 2017. However, it had latterly come to light that there had been further issues of concern with a possibility of actual patient harm, again in relation to the referral process. It was therefore decided at an oversight committee meeting in December (at which I was represented by one of my assistant directors, Ronan Carroll) that Mr O'Brien be excluded from work for the duration of what was now a formal investigation.

Paragraph 8

On 13th January 2017, in my capacity as the Director of Acute Services, I wrote to Mr O'Brien, giving him the opportunity to review and return comments on the SAI review into patient [redacted] Patient Id. He replied on 25th January with 11 pages of comments.

Mr O'Brien's 11 pages of comments and questions sent people in all directions answering and gathering comments. For me, he simply didn't follow a system which had been religiously and ably followed by ALL the other team members.

Toal, Vivienne

From: Carroll, Ronan [redacted]
Sent: 27 January 2017 15:15
To: Gishkori, Esther; Wright, Richard; Toal, Vivienne
Cc: Gibson, Simon
Subject: FW: upgrade Red Flags
Attachments: Scan from YSoft SafeQ (935 KB); Scan from YSoft SafeQ (961 KB); Scan from YSoft SafeQ (923 KB); Scan from YSoft SafeQ (1.04 MB); Scan from YSoft SafeQ (1.04 MB); Scan from YSoft SafeQ (477 KB); Scan from YSoft SafeQ (1.36 MB); Scan from YSoft SafeQ (729 KB)

FYI – this is now a running total of 17 upgrades to RF

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

From: Corrigan, Martina
Sent: 27 January 2017 15:13
To: Graham, Vicki; Muldrew, Angela
Cc: Glenny, Sharon; Clayton, Wendy; Carroll, Ronan; Trouton, Heather; Reddick, Fiona
Subject: upgrade Red Flags

Hi Angela/Vicki

Please see attached a further 8 patients that have been upgraded to Red Flag.

Please book one extra on to each of the Consultant New OP Clinics next week and again if you can advise when this is sorted.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

Hynds, Siobhan

From: Corrigan, Martina [redacted]
Sent: 07 June 2017 18:25
To: Hynds, Siobhan
Cc: Carroll, Ronan
Subject: undictated clinics
Attachments: OC 1.pdf; OC2.pdf; OC3.pdf; OC4.pdf; OC5.pdf; OC6.pdf; OC8.pdf; OC9.pdf

Hi Siobhan

To update on the findings from the undictated clinics:

There are 110 patients who are being added to a Review OP waiting lists – a number of these should have had an appointment as per Mr O'Brien's handwritten clinical notes before now, however I would add that Mr O'Brien has a Review Backlog issue already so these patients even if they had of been added timely may still not have been seen.

There are 35 patients who need to be added to a theatre waiting lists, all of these patients he has classed as category 4 which is routine and again due to the backlog.

I have attached Mr O'Brien's sheets that he had given me in January after he had returned the charts.

I have now gone through all of the charts that were in the AMD office and will be back in Health Records tomorrow.

Katherine Robinson's team are currently recording the outcomes from these and these will all be backdated to when the clinics happened.

There were 3 patients whom the consultants have concerns on and I had arranged urgent appointments for them. One has since been sorted and no further concerns. The other two have cancelled their appointments themselves and have been rearranged for beginning of July so I will keep an eye on these and make sure there is no more concerns.

Other comments made by the consultant were:

1. Patient seen by 6 times at clinic and notes written in the patients chart but no dictated letter
2. Patient seen initially as a private patient and there is a letter in chart for private visit but none for NHS visit
3. Patient seen x 14 times at clinics (so well looked after) but no letters so how does the GP know what is going on?
4. Patient seen at clinic on 19/9/16 letter dictated retrospectively on 28/02/17.
5. According to PAS the patient attended the clinic but according to handwritten notes they DNA and Mr O'Brien had asked that they be sent for again
6. Patient seen on 11/04/16 but letter was dictated on 22/02/17.

If there is anything further in respect to this please do not hesitate to contact me

Regards

Martina

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

This is a very important meeting and requires senior representation from Acute Services.

Given Ronan's involvement in the parallel process in relation to the scoping of the impact (actual or potential) on patients I think it is more appropriate to keep him separate from the oversight committee role in relation to deputising for you to ensure there is clear separation in relation to these processes.

Could you please arrange for another AD to deputise for you on Thursday to ensure Acute Services input to this process.

Many thanks
Vivienne

Sent from my BlackBerry 10 smartphone.

From: Stinson, Emma M
Sent: Monday, 23 January 2017 08:59
To: Toal, Vivienne; Hynds, Siobhan; Wright, Richard
Cc: Weir, Colin; Khan, Ahmed; White, Laura; Mallagh-Cassells, Heather; Gishkori, Esther
Subject: RE: Meeting of Oversight Committee - Mr A O'B

Dear all

Unfortunately Esther will be unable to attend as she is on annual leave on Thursday however is happy for the meeting to go ahead in her absence and be updated later.

Many Thanks
Emma

Emma Stinson

PA to Mrs Esther Gishkori
Director of Acute Services
SHSCT, Admin Floor, Craigavon Area Hospital

Direct Line: Personal Information redacted by USI **Direct Fax:** Personal Information redacted by USI

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From: Toal, Vivienne
Sent: 22 January 2017 20:33
To: Hynds, Siobhan; Wright, Richard; Gishkori, Esther
Cc: Weir, Colin; Khan, Ahmed; White, Laura; Mallagh-Cassells, Heather; Stinson, Emma M
Subject: Re: Meeting of Oversight Committee - Mr A O'B

Great, thanks very much.
V

Dr Khan asked whether there was any historical health issues in relation to Mr O'Brien, or any significant changes in his job role that made him unable to perform the full duties of Urologist of the Week. There was none identified, but it was felt that it would be useful to consider this.

Decision
As Case Manager, Dr Khan considered whether there was a case to answer following the preliminary investigation. It was felt that based upon the evidence presented, there was a case to answer, as there was significant deviation from GMC Good Medical Practice, the agreed processes within the Trust and the working practices of his peers.

This decision was agreed by the members of the Case Conference, and therefore a formal investigation would now commence, with formal Terms of Reference now required.
Action: Mr Weir

Formal investigation
There was a discussion in relation to whether formal exclusion was appropriate during the formal investigation, in the context of:

- Protecting patients
- Protecting the integrity of the investigation
- Protecting Mr O'Brien

Mr Weir reflected that there had been no concerns identified in relation to the clinical practice of Mr O'Brien.

The members discussed whether Mr O'Brien could be brought back with either restrictive duties or robust monitoring arrangements which could provide satisfactory safeguards. Mr Weir outlined that he was of the view that Mr O'Brien could come back and be closely monitored, with supporting mechanisms, doing the full range of duties. The members considered what would this monitoring would look like, to ensure the protection of the patient.

The case conference members noted the detail of what this monitoring would look like was not available for the meeting, but this would be needed. It was agreed that the operational team would provide this detail to the case investigator, case manager and members of the Oversight Committee.
Action: Esther Gishkori / Ronan Carroll

It was agreed that, should the monitoring processes identify any further concerns, then an Oversight Committee would be convened to consider formal exclusion.

It was noted that Mr O'Brien had identified workload pressures as one of the reasons he had not completed all administrative duties - there was consideration about whether there was a process for him highlighting unsustainable workload. It was agreed that an urgent review of Mr O'Brien's job plan was required.
Action: Mr Weir

It was agreed by the case conference members that any review would need to ensure that there was comparable workload activity within job plan sessions between Mr O'Brien and his peers.
Action: Esther Gishkori/Ronan Carroll

Following consideration of the discussions summarised above, as Case Manager Dr Khan decided that Mr O'Brien should be allowed to return to work.

This decision was agreed by the Medical Director, Director of HR and deputy for Director of Acute Services.

It was agreed that Dr Khan would inform Mr O'Brien of this decision by telephone, and follow this up with a meeting next week to discuss the conditions of his return to work, which would be:

- Strict compliance with Trust procedures and policies in relation to:
    - Triaging of referrals
    - Contemporaneous note keeping
    - Storage of medical records
    - Private practice
- Agreement to read and comply with GMCs "Good Medical Practice" (April 2013)
- Agreement to an urgent job plan review
- Agreement to comply with any monitoring mechanisms put in place to assess his administrative processes

Action: Dr Khan

It was noted that Mr O'Brien was still off sick, and that an Occupational Health appointment was scheduled for 9th February, following which an occupational health report would be provided. This may affect the timetable of Dr O'Brien's return to work.

It was agreed to update NCAS in relation to this case.
Action: Dr Wright

Cc: Carroll, Ronan
Subject: RE: Action note - 26th January - AOB draft SH comments

Dear Siobhan,
Thank you for this and Anne McVey briefed me fully the day following the meeting.
I just have a few questions.

1. Is there a time scale for the developing of the monitoring process which Ronan and I will assume responsibility for?
2. Is it OK therefore for us to involve the other clinicians in developing the above? I am aware that Colin Weir is part of the investigative team but is also the CD for Mr O'Brien. Mark Haines is the other CD for surgery but also works as a urologist in the team.

Sorry for the basic questions but I would rather be crystal clear about my roles and responsibilities at the beginning.

Many thanks
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted by USI **Mobile** Personal Information redacted by USI
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From: Hynds, Siobhan
Sent: 02 February 2017 16:24
To: Gibson, Simon
Cc: McVey, Anne; Toal, Vivienne; Gishkori, Esther; Wright, Richard; Weir, Colin; Khan, Ahmed
Subject: Action note - 26th January - AOB draft SH comments

Simon,

I have tracked some minor changes to the notes for your consideration. I have changed the terminology to reflect the MHPS framework.

Regards,

Siobhan

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

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Southern Health and Social Care Trust

Quality Care - for you, with you

MR A O'BRIEN, CONSULTANT UROLOGIST
RETURN TO WORK PLAN / MONITORING ARRANGEMENTS
MEETING 9 FEBRUARY 2017

Following a decision by case conference on 26 January 2017 to lift an immediate exclusion which was in place from 30 December 2017, this action plan for Mr O'Brien's return to work will be in place pending conclusion of the formal investigation process under Maintaining High Professional Standards Framework.

The decision of the members of the case conference is for Mr O'Brien to return as a Consultant Urologist to his full job role as per his job plan and to include safeguards and monitoring around the 4 main issues of concerns under investigation. An urgent job plan review will be undertaken to consider any workload pressures to ensure appropriate supports can be put in place.

Mr O'Brien's return to work is based on his:

- strict compliance with Trust Policies and Procedures in relation to:
    - Triaging of referrals
    - Contemporaneous note keeping
    - Storage of medical records
    - Private practice
- agreement to comply with the monitoring mechanisms put in place to assess his administrative processes.

Currently, the Urology Team have scheduled and signed off clinical activity until the end of March 2017, patients are called and confirmed for the theatre lists up to week of 13 March. Therefore on immediate return, Mr O'Brien will be primarily undertaking clinics and clinical validation of his reviews, his inpatient and day case lists. This work will be monitored by the Head of Service and reported to the Assistant Director.

CONCERN 1

- That, from June 2015, 783 GP referrals had not been triaged in line with the agreed / known process for such referrals.

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

Personal Information redacted by the USI (DHH)

From: Carroll, Ronan
Sent: 23 October 2018 15:34
To: Gibson, Simon; Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne
Cc: Gishkori, Esther
Subject: RE: AOB notes and dictation
Importance: High

Re the outcome of today's meeting can I ask are we to continue monitoring AOB against the 4 elements of the AP?
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by USI
Ext Personal Information redacted by USI

From: Carroll, Ronan
Sent: 23 October 2018 15:05
To: Gibson, Simon; Khan, Ahmed; Hynds, Siobhan; Kerr, Vivienne
Subject: RE: AOB notes and dictation

Yes

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
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Ext Personal Information redacted by USI

From: Gibson, Simon
Sent: 23 October 2018 15:05
To: Carroll, Ronan; Khan, Ahmed; Hynds, Siobhan; Kerr, Vivienne
Subject: RE: AOB notes and dictation

P.S - Maybe should have gone to Viv Toal?

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
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Personal Information redacted by USI
Personal Information redacted by USI

From: Carroll, Ronan
Sent: 23 October 2018 15:02
To: Khan, Ahmed; Hynds, Siobhan; Gibson, Simon; Kerr, Vivienne
Subject: FW: AOB notes and dictation
Importance: High

Please see updated position – apologies for the delay

Ronan Carroll

Gibson, Simon

From: Carroll, Ronan [redacted]
Sent: 24 October 2018 15:48
To: Khan, Ahmed
Cc: Gishkori, Esther; Gibson, Simon; Hynds, Siobhan; Toal, Vivienne; Weir, Colin
Subject: RE: AOB notes and dictation

Importance: High

Dr Khan
Happy to ensure AP is monitored.
Could I ask that the oversight committee write to Mr O'Brien reminding him of his obligations/responsibilities to comply with this AP and that it will be monitored.
Regards
Ronan

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

From: Khan, Ahmed
Sent: 23 October 2018 16:08
To: Carroll, Ronan
Cc: Gishkori, Esther; Gibson, Simon; Hynds, Siobhan; Toal, Vivienne
Subject: RE: AOB notes and dictation

Ronan, The action plan must be closely monitored with weekly report collected as per AP. Can you also clarify that yesterday, 22/10/18 there were 91 outstanding dictations and today only 16 (Oldest 28/9/18)?

Thanks,
Ahmed

From: Gibson, Simon
Sent: 23 October 2018 15:57
To: Carroll, Ronan; Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne
Cc: Gishkori, Esther
Subject: RE: AOB notes and dictation

Dear Ahmed

I assume that would be a question for you as Case Manager (or the Oversight Committee)?

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
[redacted]
[redacted]

Southern Health and Social Care Trust

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Strictly Confidential

Maintaining High Professional Standards Formal Investigation

Case Manager Determination

Dr Ahmed Khan, Case Manager

Stinson, Emma M

From: OKane, Maria
Sent: 10 February 2020 15:29
To: Carroll, Ronan
Cc: McClements, Melanie
Subject: FW: MHPS & System Review Recs
Attachments: FW: RQIA response

Ronan – thanks. I am sorry that this has come so late to you. As you know it predated me. I had discussed with Esther on a number of occasions , on the first occasion at her request, and she was in possession of it as she showed it to me. I wrongly assumed that you would have automatic access. As you might know, it hadn't been shared with Mark Haines either by the MDO or Esther.

Could I ask, given that it is highly confidential report could the relevant recommendations be circulated rather than the entire report?

Simon emailed me to say that at a recent meeting the current system which has been in use since 2016 was discussed and hasn't changed and is being used to provide assurance.

Many thanks Maria

From: Carroll, Ronan
Sent: 10 February 2020 14:44
To: OKane, Maria
Cc: McClements, Melanie
Subject: RE: MHPS & System Review Recs

Maria
Yes I am now aware of same. Prior the email attached I was unaware
Ronan

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

From: OKane, Maria
Sent: 10 February 2020 14:36
To: Carroll, Ronan
Cc: McClements, Melanie
Subject: MHPS & System Review Recs

Dear Ronan,

As you are aware in the case Management Report dated Autumn 2018, it was recommended pages 9/10 that an organisational review of systems and processes (see page 9/10 for exact information) be undertaken on progress of this please as this information has now been requested by GMC and RQIA.

Many thanks
Lauren
on behalf of Dr O'Kane

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

with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings.

III. AOB was the only one who could do some of the dictations because he saw the patients and sometimes nothing was written in the notes. His colleagues therefore undertook an extensive exercise to ensure all the patients had an outcome dictated and a plan of care outlined. This was overseen by Martina and reported on to me by Ronan Carroll.

IV. Martina Carroll dealt with this and I understand if Mr. O'Brien wanted to take notes home he had to check same out and there was a formal process in place which was overseen by Martina.

19. The monitoring arrangements were still in place when I ceased employment at the Trust. I have no knowledge of an end date. Martina (Head of Service) was responsible for overseeing it.

20. I do not believe there were any divergences.

21. As the director of acute services, I do not know of any factors, attributed to us, as to why a. – d. may have been delayed. I know that Mr. O'Brien requested extension to comply and that he was unwell at the time of the investigation and underwent surgery which caused delay. I was also on Personal information redacted leave during this period. I had no formal contact with any of the parties listed at (i)-(vi). As I was on leave, the ADs who deputised fed back to me on my return.

22. I really don't recall much about the investigation process. There were always minutes and notes sent out from the oversight committee, and I attended/sent a representative where appropriate. The oversight committee met monthly and occasionally held more frequent meetings. Minutes were always recorded at the oversight committee and the Trust would retain these. Whilst I was on Personal information redacted by leave Anita Carroll attended the oversight committee in my place.

23. Please see below:

I. Martina Corrigan was responsible for oversight. This was reviewed by Ronan Carroll who then reported directly me. These actions were implemented.

II. The medical director was responsible and I have no further information in relation to this action as it was beyond my remit.

III. This was the responsibility of Anita Carroll's team and I have no further information in relation to this however Anita would be able to provide this.

24. I do believe the guidelines to be fair, comprehensive and fit for purpose. I believe the guidelines could be better implemented by staff; for example, I believe the issues with Dr. O'Brien when they came to light could have been practically resolved at a lower level.
Within the Trust there are issues of individuals going outside their roles and responsibilities and not communicating with the right people. There is a culture of the Trust that not everyone followed the guidelines as they should be followed. There was no policy on writing guidelines for the Trust for example. There was also no process to update any policy.

Urology Services Inquiry

25. I am no longer the Director of Acute Services. I do however believe that the Trust would be more effective and efficient if it observed the fundamentals of multi-disciplinary working and ensuring each individual understands their own role and responsibilities as well as those of others. Throughout my tenure I believed this worked very well within my directorate.
I believe a meaningful, non-judgemental meeting with Mr O'Brien in March 2016 would have been beneficial. This would have allowed attempts to give him the help that was ultimately provided through the formal action plan which was developed months later. The suggestion from Charlie McAllister would again have been a more efficient method to resolve this issue. Operationally therefore, those patients who had not had their referral actioned may have been reviewed at an earlier stage.

Statement of Truth

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

Signed: [redacted]

Date: 27:6:22

return to work the Head of Service and AD would have reported to me and confirmed that Mr. O'Brien was complying with the action plan.

67. No.

68. Here, in my opinion are some of the reasons:

- Not many people wanted a nurse or AHP to deal with their urological problems which were very personal and important to them so referrals continued to be made to the consultant (The gold standard). This contributed to the growing waiting lists.
- GPs often referred everything as a red flag just to get their patients seen. That's one of the reasons why the urology consultants started to re triage the referrals.
- It took a long time for primary and secondary care to begin to work seamlessly. This still was not working as well as it should have as set out in the urology review of 2010.
- The elderly population is increasing steadily and therefore so is the demand for urology services.
- There was a general moving away from custom and practices which would have been how Aidan O'Brien operated at the beginning of his career and a reluctance to adopt to the modern demands of medical practice.

69. Governance is about quality and safety. It could be argued that it is difficult to deliver a quality service that is "free at the point of need" for a growing population with a very limited budget. The ack of resources and limited capacity of Doctors is difficult to rectify. I would suggest that a review of administrative processes at operational level was required in hindsight.

70. The problems as I knew them related to the backlogs and increasing waiting times. This was being engaged with across the board as It was a regional problem. I was unaware of any issues in respect of staffing. Aidan O'Brien engaged with the actions which were decided upon by the committee at that time and the issues were resolved going forward.

71. Prior to the issues regarding Mr. O'Brien coming to light ongoing concerns were identified and dealt with in the best way they could.

In relation to the specific concerns relating to Mr. O'Brien which came to light I believe the process was more prolonged that it should have been. The Health Service was on its knees and Mr O'Brien was a really good practical surgeon who had been excluded from work at a time when we really needed his skills. There were no concerns about the clinical side of his practice. The oversight committee resolved the backlog and he was essentially returned back to baseline but I think this could have been done faster had the suggestion by Charlie been implemented at first instance. The review was also carried out by his colleagues within the Urology department which left a negative feeling going forward. It is my view this could have been avoided by having the review carried out by other Urology Consultants from other Trusts.