(v) How you assured yourself that any systems and agreements put in place to address concerns were working as anticipated?

(vi) How, if you were given assurances by others, you tested those assurances?

(vii) Whether, in your view, the systems and agreements put in place to address concerns were successful?

(viii) If yes, by what performance indicators/data/metrics did you measure that success? If no particular measurement was used, please explain.

Other Medical Practitioners in Urology

57.1 There were four doctors with whom concerns were raised with me in addition to Mr O'Brien (who I shall deal with later, from Q61 onwards). A further doctor was under supervision.

Personal Information redacted by the USI

57.2 I produced a competency assessment report on Personal Information redacted by the USI for Mr Brown, Clinical Director, in July 2012 noting that, although he had interviewed for the post of a staff grade in urology, he had subsequently not been proven to be up to the level expected and had not coped well with the intensity of the post. This had been spotted by several nursing colleagues initially and followed through by myself and Mr O'Brien. The Trust HR were involved via Zoe Parks. Personal Information redacted by the USI was taken off the on-call rota and only undertook outpatient clinics and flexible cystoscopies ***(relevant document located at S21 No 55 of 2022, 129. statement from Mr M Young 5 7 12 re*** Personal Information redacted by the ***).***

Personal Information redacted by the USI

considered the matter to have been properly managed by Mr Mackle and assumed that he would follow up, this being his responsibility.

b) I was invited by an email on the 2nd Sept 2011 entitled 'meeting re a consultant urologist' (doc ref 20211206) (this can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20211206_FW Meeting re a consultant urologist) to a meeting by Gillian Rankin, Director of Acute Services along with Kieran Donaghy, Director of HR, Helen Walker Assistant Director for HR in Acute and Eamon Mackle AMD to discuss 'current issues around a consultant urologist'. I have no record as to whether the meeting took place and cannot recall any other detail or which consultant urologist it concerned.

c) I sent an email on 25th Nov 2011 (doc ref 20211207) (this can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20211207_FW C and SC Gov) to the chief executive Mairead McAlinden in her capacity as Director for Clinical Governance, Deborah Burns as assistant Director for clinical governance and the Operational Directors (Francis Rice for Mental Health and Disability, Gillian Rankin for Acute, Paul Morgan for Child Health, Angela McVeigh for Older People). It was also copied to Anne Brennan as senior manager in my Medical Directorate. This was to explain my piloting of mortality reports, which covered all of the Acute Directorate were a work in progress (see Governance Committee Report Mortality Review Sept 2010 for the Dec 2011 meeting re Hospital Standardised Mortality Ratios, benchmarked across the UK by a private company, CHKS). (This can be located at Attachment folder S21 26 of 2022- Attachment 15a and 15b). I also advised that the SHSCT should follow the example of Trusts in England by producing an annual quality report bringing together all of the intelligence on clinical and social care governance.

d) I was involved in a series of emails on the 17th Feb 2012 (doc ref 20120217 and 20120220) (These can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20120217_RE Urology Job Plans and Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20120220_RE Urology Job Plans)regarding negotiations with Mr Patrick Keane (the specialty advisor for urology) on the job plans for the upcoming new consultant urology posts, specifically the proportion of SPA's (supporting professional activities). This was resolved satisfactorily with the support of Eamon Mackle, AMD for surgery.

e) I was copied into an email on 2nd March 2012 (doc ref 20120302) (this can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20120302_RE Personal Information redacted by (Urology) - Strictly Private and Confidential.pdf) from Margot Roberts of NIMDTA (Northern Ireland Medical and Dental Training Agency) to Colin

Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

TRU-250599

staff grade urology

Simpson, John

Tue 13/03/2012 11:32

To:Rice, Francis <[redacted]>;

Francis,
this was kicked off by a letter I got from GMC to inform me this doc is under investigation. Our urology consultants thought he was just about ok.
It seems the nurses have a totally different view. My guess is that there is something amiss in urology re M/D working never mind professional governance,
john

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

TRU-250600

RE: re staff grade urology

Rice, Francis [redacted]

Tue 13/03/2012 14:06

To: Simpson, John < [redacted] ; Brown, Robin [redacted] ; O'Brien, Aidan [redacted] ; Rankin, Gillian [redacted] ;

Cc: Parks, Zoe [redacted] ;

John,Happy to discuss with you and Gillian tomorrow at SMT.Regards Francis

From: Simpson, John
Sent: 13 March 2012 11:30
To: Brown, Robin; O'Brien, Aidan; Rankin, Gillian; Rice, Francis
Cc: Parks, Zoe
Subject: re staff grade urology

Robin/Aidan,
Further to discussions re [redacted] could you provide me with something in writing regarding any concerns re performance.
Aidan,
Could you provide something in writing re your discussion today with said doctor. In particular please detail any proposed restrictions on his practice.
Gillian,
Concerns were expressed verbally to Robin by a senior nurse. Is it possible to have this documented.
Gillian/Francis,
It is a matter for concern that a senior nurse would have significant concerns about the performance of a doctor that don't seem to have been followed through. I think there must be some learning here re clinical governance.
John

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

57.3 I was requested to supply a letter to the GMC on Personal Information redacted by the USI in March 2014. This related to decision making and care pathway issues. I was supportive of Perso nal Infor Personal Information redacted by the USI at that stage with his management of our patients and the GMC letter predated the incident in our hospital. ***(Relevant document located at S21 No 55 of 2022, 130. Personal Information redacted by the reference 21 03 14).***

57.4 Personal Information redacted by the USI was employed as a locum Speciality Doctor. He was a competent doctor and well educated in urology for outpatient activity. He was offered a substantive post but had not signed up to the post due to a pay scale enquiry with the Trust. His temperament was noted by myself to be abrupt in his thought processing but he was an attentive Doctor to patients. An incident occurred in January 2013 when he failed to attend a pre-planned clinic which had been changed on the day in question by myself, in my role as Lead Clinician, to accommodate another clinic's activity. I was informed by the senior nurse at lunchtime that there may be a potential issue about Personal Information redacted by the USI not appearing for the afternoon clinic, which indeed was the case. On contacting Personal Information redacted by the USI when the clinic was due to start, I found that he had actually left the hospital and was at home. He did not give a reasonable answer as to why he was not at the clinic. Mr Clegg, HR manager, happened to be in my office discussing other issues, when I had phoned Perso nal Infor Personal Information redacted by the USI and Mr Clegg agreed with my approach that the conversation should be terminated at that point but it was arranged that Personal Information redacted by the USI would meet with myself in my office the following lunchtime. We found this behaviour bizarre. I contacted the consultant with whom Personal Information redacted by the USI was due to help in theatre the following day and asked that the consultant perform all the theatre duties including consenting of the patients for the afternoon list. The following day, Personal Information redacted by the USI contacted me by phone with an ultimatum. I told him to meet me in my office. Just prior to this meeting I had contacted Mrs M Corrigan, Head of Service, to enquire about his contract. On returning to my office, I found Personal Information redacted by the USI sitting in my office chair. I asked if this was his usual approach to being asked to meet at a consultant's office, to be sitting in the consultant's chair and he replied that it was 'on this occasion', he had taken 'the liberty'. At this stage, I informed him that his actions the previous day were unacceptable, had put patients at risk, that he had not informed me as his line manager and had not arranged cover. He did not offer an explanation. I regarded that I had no other option than to terminate his contract immediately, which he

accepted. The full transcript of this event is referenced in a letter ***(Relevant document located at S21 No 55 of 2022, 131. my ltr re*** [redacted] ***26 01 13)***

[redacted]

57.5 [redacted] was appointed as a substantive Consultant Urologist in December 2013. In September 2015, there was a clinical incident relating to renal trauma mismanagement. There was a delay in the recognition of the condition and the therapeutic pathway to be taken. Mr O'Brien dealt with the case promptly when he identified the problem and raised concerns about the handling of the case at the time and subsequently at the Audit meeting ***(Relevant document located at S21 No 55 of 2022, 132. 20151022 urology departmental Governance Meeting 22102015 minutes).*** Mr O'Brien raised the issue with all the Consultants (MY MH AG JOD and MC) at the time. I spoke with [redacted] in regards to his experience of handling renal trauma. As a unit we were aware that renal trauma was an entity that is challenging in view of its rarity and the complex surgical training and expertise required to treat. After a consult with [redacted] it was clear his exposure to this form of surgery was deficient as such cases in his previous unit would have been transferred to another unit. As a collective unit we raised the issue of the surgical assessment of the situation and ability to follow through with the necessary intervention with the hospital management, firstly with Mrs M Corrigan Service Lead Administrator along with Mr Mackle AMD. A meeting with Mr Mackle and the urology Consultants was held to define the way forward. An action plan was put in place to have a second on-call consultant available for such cases and to mentor ward rounds for [redacted] week on-call. In addition to this, arrangements were made for [redacted] to attend a surgical skills course focusing on this type of surgery.

57.6 The urologist held Meetings in December 2015 and March 2016 with Mr Mackle to discuss these arrangements. Mr Mackle and myself met with [redacted] to outline the necessary expectations for progress and the Medical Director, Dr Wright, was informed by myself of the actions to be taken by our unit ***(Relevant documents located at S21 No 55 of 2022 133.*** [redacted] ***cover 2016 and 120. 20151217 – confidential meeting*** [redacted] ***).***

[redacted]

Confidential

Meeting on 17 December 2015
Associate Medical Director's Office – Admin Floor – Craigavon Area Hospital

Present:
Mr Mackle (chair)
Mr Young
Mr O'Brien
Mr Glackin
Mr Haynes
Martina Corrigan

Apologies: Mr O'Donoghue (on annual leave)

Mr Mackle outlined that the purpose of the meeting was to put a plan in place to support Personal Information redacted by the USI and assist him fulfil all aspects of job in a safe supported manner, and to determine his fitness and ability on all aspects of the job but in particular the ability to perform 'open' surgery.

Mr Mackle advised that he had outlined the Team's concerns to Dr Wright the Medical Director and he has asked that a documented plan is put in place in particular with respect to:

a) What training and courses needs to be identified and booked
b) What are the timescales
c) Support for when on call

TG = difficult for provide to cover by team in day to day.
Deficiency in open surgery e.g. injured bladders, injured uterus.

Personal Inform: doesn't recognise deficiencies – his perception different from Team (TG)

Surgery is not the only one element
Registrars – decision making on WR
"Lack of decision-making"

Long term. Here and now – how do we manage?

Process of defined training,
Second on call = MY tonight up on ward at 5pm to check patients.

Need to meet with Personal Inform and explain training + pro-active about patients.

More international.
Ward rounds to be accompanied by another consultant. (paid ½ PA)

6months. Consultants to do a supportive ward round:
Wed PM going to AOB in place.
Alternative Tuesday , AOB/TG.

Courses……..

1. MY to talk- decision making
2. EM to talk- decision making
3. Go to theatres
4. Talk to people
5. Courses

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Re : Personal Information redacted by the USI Urology cover

June 2016

Dear Medical Director

Although you will be aware of this issue, I write to keep you up to date of meetings and progress in relation to urology emergency cover for our colleague Personal Information redacted by the USI. Due to circumstances arising last autumn, it was felt that additional senior cover was required in the event that emergency 'open' urological procedures would be needed. Mr Mackle has discussed this with you already but further clarification was to be defined.

The consultants in the department have had two meetings with Mr Mackle, (Dec15 and in March 16) to discuss arrangements. All consultants have been present at either or both the meetings. Two areas of cover were deemed necessary to cover. These were for emergency theatre cover for open urological procedures and day time supervision of ward work.

A rota was to be put in place so that these two areas where covered. Although it was clear what cover emergency theatre meant, it was up to each consultant to provide daytime cover as they felt to be required. Some consultants felt uneasy about too high a profile cover but they were there for advice. Support, cover and mentorship were in essence the backbone of our approach. Mr Young and Mr Mackle had separate meetings with Personal Information redacted by the USI to outline and reaffirm the needs and expectations for progress. These included surgical skills training courses and attend other consultants theatre lists where appropriate.

Personal Information redacted by the USI has fully engaged with the process. He has recognised the areas that require attention and has added additional ideas for training opportunities. He has recognised that the patients under his 'wing' of on-call are his responsibility yet other consultants are available for consultation. During the last six months he has appropriately availed of this facility.

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

of urologists completing their training would be able, or expected, to do so. Overall, I felt that Personal Information redacted by the USI had made excellent progress and was keen to improve his surgical competence. I felt that he deserved and had earned the ongoing support of the Urology Service and his colleagues.

405. I continued to provide support to Personal Information redacted by the USI until he returned to take up another post in Personal Information redacted by the USI. I did not receive any remuneration for having done so. I have since had reason to contrast the support offered to him in 2016 to that offered by the same persons to me in 2016.

406. I attach a chronology entitled "*Trust Concerns / Consultant Concerns*" which cross references documents my legal team and I have been able to review to date which are relevant to issues related to the questions above in terms of complaints about the practice of others. Some contain summaries and extracts from various documents. The documents have been cross referenced and should be read in full as the summaries may not fully reflect all relevant matters. If the Inquiry has any further queries in respect of any concerns raised in respect of any medical practitioner referred to within the attached chronology, I would be happy to provide further details as required.

407. My response at Questions 1, 9, 10, and 21-25 sets out in detail my concerns in relation to patient safety in urology services and clinical governance in urology services, as well as concerns being raised and not being adequately addressed by the Trust.

408. I have no doubt that the concerns identified and raised by me, and others, impacted on patient safety, and indeed I have provided various examples above of individual patients coming to harm as a result of the issues underlying these concerns. While I believe that concerns were identified, both by me and by others, I do not believe that their nature and impact were adequately appreciated by the Trust, nor do I believe that their potential risk to patient safety was adequately considered by the Trust, and steps were not taken to adequately address and mitigate the risks posed to patients.

13.1 Triaging of letters has evolved over the course of time in my tenure. Up until the introduction of the Urologist of the Week, this was undertaken as part of general administration. When I first took up my consultant post the number of referrals did not appear as many as is noted currently. Referrals were sent to the consultant recorded as being on-call that day or sent to a named consultant as per a GP's request. My understanding of the situation was that there had not been a time limit on the triage return timetable prior to the introduction of this Protocol, (this was some time ago, however).

13.2 With the increase in referral numbers and this Protocol introduction, there was indeed an impact on my role as a consultant. The need to return Red Flag and Urgent referrals following triage within a short period of time, impinged on other clinical priorities. For instance, triage was not possible if I had an all-day theatre list, had an all-day outpatient clinic or was in an outreach location and not receiving the letters. Other administration, such as results and responding to urgent communication, may have been regarded as more pressing. The time allocation to administration has remained fairly unchanged in duration throughout my tenure. The precise time specified for administration was job planned and this was not on a daily basis. There had been no increase in administrative time allocated in my job plan to compensate during the early phase of this process. It has only been in recent years that electronic computer-based triage has been used regularly in conjunction with paper-based letters. It is noted that the document does comment on E-triage but this was not used by myself, nor I suspect by the other Consultants, as the mode of communication was solely via hardcopy paper letters for a number of years after this process was introduced. As such, the paper version of returning triaged Red Flag letters within 24 hours was unachievable in my view as was the expectation of returning Urgent referrals within 72 hours. This had been discussed at departmental meetings on several occasions between the consultants and the management, who would have been led by Mrs Corrigan. ***(Relevant document located at Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/reference 77 Martina Corrigan/20110819-email triage escalation).*** The reason for this would have been the fact that the letter would have been sent to the booking office and then sent to the consultant. In my case all referrals were known to be sent to my secretary and/or put into my 'Black Triage A4 Box'. This I believe was done daily. After triage my

To: Young, Michael [redacted]
Cc: Mackle, Eamon [redacted] Gibson, Simon
[redacted]
Sent: Wed Dec 03 09:51:37 2008
Subject: FW: URGENT - Urology ICATS referrals

Dear Michael

What solutions could you propose to this continuing problem?

Kind regards

Simon

Simon Gibson
Assistant Director of Acute Services - Surgery & Elective Care Southern Health & Social Care Trust
[redacted]

P Please consider the environment before printing this e-mail.

-----Original Message-----
From: Cunningham, Teresa
[mailto:[redacted]
Sent: 02 December 2008 17:22
To: Gibson, Simon; Mackle, Eamon
Subject: URGENT - Urology ICATS referrals
Importance: High

Dear Simon/Eamon

Please see attached a spreadsheet showing the numbers of referrals which have not as yet been triaged.

As you know this problem has been raised on a number of occasions and for a short while, the situation had improved. Mr O'Brien was triaging the referrals last week and I appreciate that he only returned from a week's leave last Monday. Unfortunately however, as we are working to a
6 week target, the current situation is intolerable.
When I ran the PTL's yesterday, there were only 12 patients on the PTL to be appointed for January, because the referrals have not been triaged. This will undoubtedly lead to a panick situation later on this month in the run up to the Christmas holidays, trying to get patients booked. I think it is unfair that undue pressure is being exerted on me to ensure patients are treated within target dates, and subsequenty on the appointments staff, because I put pressure on them to ring patients to get them appointed.

The service is not manageable under these circumstances and I feel I can not continue to manage it unless this issue is properly addressed. If Mr O'Brien is constantly facing difficulties triaging his referrals within the timeframes specified within the IEAP, then we need to put something else in place to faciitate the smooth operation of the service and to ensure that we can offer patients reasonable notice.

I would appreciate if you could let me know what action will now be taken to resolve this problem once and for all.

Regards

Received from Simon Gibson on 27/06/2022. Annotated by the Urology Services Inquiry.

Willis, Lisa

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

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Both

In confidence please see below.

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

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

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

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

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

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

Thank you for your assistance

Heather

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

Dear both

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

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

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

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

Thankyou all for your help

Heather

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

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

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

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

Robin

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

Understand
I will speak

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

Dear Both

In confidence please see below.

Received from Mr Eamon Mackle on 12/04/22. Annotated by the Urology Services Inquiry.

diversion. Though I cannot recall the patient's name, she was an elderly lady who had had two or more unsuccessful attempts by gynaecologists to manage her severe urinary incontinence by surgery. She had then been referred to me for consideration of a urinary diversion as she remained totally incontinent of urine. I agreed and considered that it would be reasonable to remove her bladder at the time of urinary diversion. I was instructed by Dr Rankin and Mr Mackle that I would not be permitted to undertake her surgery, as simple cystectomies had been centralised to Belfast. I asked whether I would be permitted to perform an ileal conduit urinary diversion for her, without cystectomy. Both were happy for me to do so. I found it remarkable that I was not permitted to perform a simple cystectomy, but that there was no concern whatsoever in performing an ileal conduit urinary diversion, without simple cystectomy, the reconstructive component of the operation accompanied by greater risk than simple cystectomy.

278. I hope that I am correct in relating that Dr Rankin was succeeded by Ms Debbie Burns whom I found to be as supportive of me as she could be during the years when I was Lead Clinician of the NICaN Clinical Reference Group in Urology and when I was additionally Lead Clinician of the Trust's Urology MDT and Chair of its MDM, particularly in the lead up to National Peer Review in June 2015. As I have related elsewhere, Ms Burns appreciated the additional workload that emanated from these roles, particularly in the advent of National Peer Review of the Trust's urological cancer service and of regional urological cancer services in 2015. She relieved me of having to conduct triage in early 2014 and my colleague, Mr Young, generously undertook this for a period of six months or more during 2014.

279. Ms Burns was succeeded by Ms Giskhori whom I never met. Ms Giskhori was succeeded by Ms McClements whom I have never met.

280. The Assistant Directors that I recall were Ms Heather Trouton and more recently Mr Ronan Carroll. I certainly did have a number of meetings with Heather Trouton during the years prior to 2016 concerning a number of issues relating to the

467. At a consultant's meeting on 18 July 2013, it was recorded that "*The current triage process was discussed with its dangers of patients being delayed in triage due to current workloads. Tony has suggested we develop a similar system to that used in Wolverhampton and Guys hospital which we will take forward with our IT and booking centre colleagues"* [AOB-06748]. This demonstrates that others had concerns in relation to the triage system at that time, yet the Trust failed to address and change the system.

468. On 8 October 2013 Ms Trouton noted the serious delay in triage at that stage, whilst understanding the pressures within urology [AOB-06960 – AOB-06962]. I made the Trust aware in an email of 26 November 2013 that I was sorry I was behind in triage and had arranged to catch up on it during leave [TRU-01666-TRU-01672]. Surely the response to that should have been to provide adequate time to carry out the tasks within my job plan, rather than simply raise the issue, know the cause was overwork, yet do nothing substantive to address it, leaving me to address and resolve the backlog while on leave.

469. In early 2014 temporary measures to relieve me of triage commenced [AOB-00611] as Mr Young had agreed to help out at that time [AOB-00646]. That, however, was not only temporary but failed to address the underlying cause, which was progressively exacerbated by the additional burden of my roles with NICaN and with the Trust's Urology MDT and MDM at that time.

470. I was not the only consultant who struggled with the demands of triage whilst on call [see email 13 March 2014 AOB-70484 - AOB-70485].

471. I highlighted a number of issues in relation to red flag triage to colleagues on 16 March 2014 [see AOB-70487 - AOB-70488].

472. In March 2014 I again referred to pressure of work in the context of the referring to the triage backlog [see AOB-70605 - AOB-70606].

others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.

58.1 In respect of concern (i) *not returning GP letters from triage*, it is my understanding that, during the 11 years that I worked with Mr O'Brien, he was afforded many opportunities and support to comply with normal practice. In terms of agreed ways forward:

a. On at least two occasions (2012 and 2014) Mr Young did his triage for him to allow him to get caught up on his admin. Whilst he agreed to this for a short period of time, on both occasions I was led to believe by Mr Young that Mr O'Brien asked to have triage given back to him. In addition, on 19 September 2014 I received an email from the booking centre advising that Mr Young was no longer doing Mr O'Brien's triage On both occasions this had been done without mine or any of the senior managers' knowledge.
   Documents attached namely:
   356. 20140919-email urology triage
   357. 20140919-email urology triage
   and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

b. Mrs Burns agreed the default mechanism of adding patients to the waiting list I line with the GP's clinical priority so that pressure would be taken off Mr O'Brien and the patient would not be disadvantaged.

58.2 In my opinion, the letter that Mrs Trouton and Mr Mackle gave to Mr O'Brien in March 2016 in respect of review backlog, notes at home, triage, and non-dictation was an opportunity afforded to him to address these concerns which had been ongoing for quite some time. However, it was an opportunity to agree a way forward which Mr O'Brien didn't accept.

Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

secretary would return to the booking office or the booking office team member would visit her office, again possibly daily. Any delays in this process immediately resulted in this timeframe breaching. A further point I and others raised was the fact that, even if the letter was triaged in the specified timeframe, the Trust and our department were not in a position to offer a timely clinic appointment in any case. It was appreciated that Red Flag appointments had a distinctly short time between referral and expected clinic appointment, hence the setting of a 24-hour return, but in practical terms, as noted above, this was going to be difficult. The need to have an Urgent category referral returned within 72 hours, when the patient was not likely to be seen for months, did not, however, appear to be a priority specifically for urology. It was, of course, noted that all letters required to be triaged in a timely fashion to identify if there were any upgrades in the triage priority. This was the initial feeling I sensed from my colleagues in the early phase of its introduction and this topic was a significant component to the subsequent arrangements within our system for on-call.

13.3 I did recognize the importance and governance of this document. In addition to the burden developing in the delivery of the emergency urology service, the triage issues were indeed a major component for the changes within the consultants job plan to move to the ‘Consultant Urologist of the Week’ principle, which incorporated triage. The original plan for the Consultant Urologist of the Week was to cover the emergency workload such as Ward Round and theatre cases and in the afternoon to undertake other activities such as clinics or day surgery. This was the initial plan, but it became obvious that the afternoon activities were not practical due to the volume of emergency work and our departmental thoughts that a system of ‘advanced triage’ would be beneficial. This new system at least provided more of an opportunity to perform triage on a daily basis if the emergency workload allowed. The general impression was that the number of referrals were increasing, again contributing to the overall time required to triage. The timeframe to return all letters did not seem as important, as the time from triage to when the patient would be seen was still going to be long, however the point of a timely triage was to spot the particularly urgent case that special arrangements could be made such as to be seen in a Hot Clinic. As a department we regarded the introduction of ‘advanced triage’ as more important than this initial quick turn-round triage. Advanced triage involved the assessment category the patient was to be allocated, namely Red Flag, Urgent and Routine, and

the agenda or brought up independently on an ad hoc basis in the 'Any Other Business' section.(see Q64.14)

65.4 Triage discussed on a programmed agenda was mainly within the context of setting up the Urologist of the Week change in our working pattern in discussions during 2014. All the consultants had sensed the number of referral letters had increased and were more detailed. Mr O'Brien was not alone in this concern. Mr O'Brien was a great advocate for the principle of Advanced Triage, however, his concern was the depth of the added work involved rather than an emphasis on the number of referrals, which we all knew. The level of triage he was aspiring to achieve was difficult to attain possibly, some may comment that he was almost trying to do it in too much *detail, and as such the totality took too long. He* complained that others may not have done it properly. It was appreciated that triage was taxing but the other consultants felt that, if they were able to complete the task, then they could not understand why Mr O'Brien could not also do so. The nature of these discussions would note the detail of depth of triage as the arranging of first line investigations which were mainly to book a radiological test. This triage was not set to the level of a virtual clinic ***(Relevant document located at Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/reference 77 Martina Corrigan/20180213-email departmental meetings).*** Time to perform triage was discussed and, although the duration was not fully defined, we had noted the current allocation in 2018 had been six hours. Further assessment was to be undertaken. ***(Relevant Document located at S21 No 55 of 2022, 139. 2018 urology departmental meeting Autumn 2018).***

65.5 Relevant discussions with the Management team are documented in Q64 above. This records the emails relating to triage and charts. At the same time as these emails were sent, there may have been conversations in their offices, to my recollection. I had a conversation with Mr Brown, Clinical Director, with regards to Mr O'Brien's triage in late 2013 at the request of Mrs Trouton, Assistant Director. Mr Haynes and myself were involved in the triage of early 2016.(as noted in Q64)

65.6 After Christmas 2016 / early January 2017, my consultant colleagues Mr Glackin, Mr Haynes, Mr O'Donoghue and myself met with Mrs M Corrigan and Mr R

Stinson, Emma M

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

Section 21

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

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

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

Michael,

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

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

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

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

Happy to discuss

Martina

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

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

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

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

to one with a senior clinician could have offered the opportunity for both Mr O'Brien and the Trust to discuss progress.

78. Do you think there was a failure to engage fully with the problems within Urology Services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

78.1 As mentioned previously, there has always been a sense of an uphill struggle in trying to introduce urology systems. The issue of long waiting lists for surgery and outpatients has never been sorted. A clean slate was never achieved. The principle of catch-up always existed. The DoH, although knowing the issue and providing some short-term and incomplete help by financing activity such as waiting list initiatives, was not addressing the bigger picture of long term infrastructural needs.

78.2 The triage issue has been known at the top level of the Trust for years according to the Root Cause Analysis completed in 2020. This was not just one person but a system issue.

79. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

79.1 The team providing the service is not, in my view, at fault.

79.2 I would have expected Mr O'Brien to have come to me and alerted me about the referrals not being triaged. I hadn't spotted that it had been such an issue. I'm not in charge of his practice but I thought he would have afforded me the opportunity to

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 5- HEALTH AND PROBITY STATEMENTS

HEALTH DECLARATION

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.

Professional Obligations
The GMC's guidance *Good Medical Practice* (2006) states that;

77. You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.

78. You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.

79. If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

I accept the professional obligations placed upon me in paragraphs 77 to 79 of *Good Medical Practice* and where they apply am taking the appropriate action.

Signature: Personal Information redacted by the USI Date: 18 December 2016

Name in Capitals: Aidan O'Brien

NB: Additional Health and Probity forms are on the Southern Docs website – click here

Regulatory and Voluntary Proceedings *[Please check relevant box by clicking on it and then sign below]*

☒ Since my last appraisal/revalidation **I have not,** in the UK or outside:

- Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.
- Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

OR

☐ If I have been subject to either of the above, I have discussed these with my appraiser.

Signature: Personal Information redacted by the USI Date: 18 December 2016

Name in Capitals: Aidan O'Brien

Received from SHSCT on 10/01/2022. Annotated by the Urology Services Inquiry

Young, Michael

From: Corrigan, Martina
Sent: 19 February 2016 10:04
To: Young, Michael
Subject: FW: UROLOGY REFERRALS NOT BACK FROM TRIAGE

Importance: High

Michael

See below – in light of previous conversations I am just escalating to you, I have already forwarded to Aidan, but I am under pressure to get this sorted.

Thanks

Martina

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

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

From: Muldrew, Angela
Sent: 18 February 2016 16:22
To: Corrigan, Martina
Cc: Clayton, Wendy; Reddick, Fiona; rf.appointment
Subject: FW: UROLOGY REFERRALS NOT BACK FROM TRIAGE
Importance: High

Hi Martina

See below referrals that we are waiting coming back from triage. Could you please chase these up for us?

Thanks

Angela Muldrew
RISOH Implementation Officer
Tel. No. Personal Information redacted by the USI

From: Personal Information redacted by the USI
Sent: 18 February 2016 16:08
To: Muldrew, Angela
Subject: UROLOGY REFERRALS NOT BACK FROM TRIAGE

Hi Angela I was just looking at the Urology spreadsheet and I noticed that there are 25 referrals missing from last week, there are another 14 referrals from Monday/Tuesday that have not been triaged yet and are not in the Thorndale Unit, so in total there are 39 referrals unaccounted for, could these be chased up? Mr O'Brien was on triage from last Thursday until yesterday and now Mr O'Donoghue is on triage.

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

7. I believe this was sent to me because Dr McAllister (acting AMD), in around June or July 2016 (from personal undated handwritten note) had asked me to try and resolve this outstanding issue. More specifically he asked me to try and resolve this with negotiation with Mr. O'Brien and have him agree to an action plan without recourse to formal investigation or procedures

8. I was not aware of these issues in any way prior to being informed by the acting AMD.

9. I was also informed that the Lead Consultant, Mr. Young, was aware of the issues and that he would be approaching Mr. O'Brien in the first instance.

10. I recorded in my handwritten notebook a meeting with My Young on 9.8.2016. I noted “AIDAN-MY will D/W with him”, meaning that, as Lead Consultant, Mr. Young would discuss with Mr. O’Brien issues in relation to some or all the four concerns raised above *[1. personal handwritten notebook, located in S21 22 of 2022 Attachments].*

11. On 22.8.2016 Simon Gibson, the Assistant Director, emailed more senior managers to enquire if any plans or proposals were received in relation to Mr. O'Brien and the concerns above. [20160823 - E Confidential AOB located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]

12. Dr McAllister suggested by email on 23.8.2016 that we hold off any further actions until the “dust settles on the process.”[20160823 - E Confidential AOB located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]

13. On 31st August Mr. Haynes noted a patient of Mr. O'Brien’s was not triaged. [20160902 - E Urgent for investigation please located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD] The patient was seen by me for leg pain possibly due to a circulation issue, but metastatic disease was noted in keeping with metastatic prostatic

Morning all,

Patient currently on WL with Mr O'Brien for ROS and RT Lithotripsy. Please advise if we need to review this patient or expedite procedure?

Thanks
Alana

Registration and Booking Clerk
Referral and Booking Centre
Ramone Building
CAH

Tracking Code: Personal Information redacted by the USI
Tel : Personal Information redacted by the USI

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

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

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

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

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

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Minutes of Urology Service Development Day

Consultants Meeting

In attendance: Mr Young,
Mr O'Brien,
Mr Haynes,
Mr Glackin,
(Mr O'Donoghue joined later).

1.1 Urologist of the week working model.

This topic was discussed extensively with each consultant able to contribute to the discussion. The consensus was that the inpatient ward round was of prime importance requiring consultant presence. The structure for referral and advice provided needs to be improved. Where possible definitive care should be delivered during the current inpatient stay.

1.2 Triage of new referrals.

The Trust needs to provide a plan detailing what exactly it expects the consultants to do in terms of triage. This must include recognition of the time constraints and time commitment required to complete triage including time spent speaking to patients, booking scans, reviewing results and mitigating risk for patients on the curent long outpatient waiting list. Consideration was given to decoupling the triage activity from that of the Urologist of the week.

1.3 Annual leave.

The team is define the number of consultants and other members of middle grade staff who can be away at any one time. Discussion of Christmas and Summer holidays should be well in advance of holiday time to permit good planning. A process for agreeing leave should be developed and adhered to.

Other business:

Mr O'Brien tabled a written document setting out his issues of concern for discussion at the meeting. Similarly Mr Young provided an email listing topics for discussion. It was suggested that those items not discussed should be given time at the weekly departmental meetings.

- First Out Patient Consultation Waiting Times
- Development of care pathways (bladder cancer, LUTS/BOO)
- Outreach clinics
- Specialty Doctor Clinics
- Consultant Job Planning

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Corrigan, Martina

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

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

Sharing as requested
A

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

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

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

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

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

Young, Michael

From: Corrigan, Martina
Sent: 23 January 2015 16:18
To: Young, Michael
Subject: Mr O'Brien - charts at home

Follow Up Flag: Follow up
Flag Status: Flagged

Michael

See below – another two charts!

This will be escalated through Helen to her AD – Anita Carroll and then onto Heather and I am concerned that it will go to Debbie.

Can you help please?

Thanks

Martina

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

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

From: Lawson, Pamela
Sent: 23 January 2015 12:11
To: Forde, Helen
Cc: Corrigan, Martina
Subject: Mr O'Brien - charts at home

Helen

This situation is getting worse – Mr O'Brien is taking more charts home with him and we are spending more and more time looking for charts that end up at his home.

We are wasting a lot of time that we do not have and, with Dolores Personal Information redacted by the at the minute, I am having to give out overtime to get all charts for the clinics.

The 2 charts we are currently requiring are as follows

Personal Information redacted by the USI – tracked to CAOBS for typing ACH cl 12/11/12 (!!!)

Personal Information redacted by the USI – tracked to EUROAOB 31/12/14

Could you please see what you can do

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

and my, if you like, next step in the safety net is the hard copy paper report that would go to my secretary, and she would check whether that's been signed off by me electronically and actioned. Then the third step is the DARO, so if the first two fail then the DARO list is there as a back-up. 15:56

93 Q. Leaving that specific to one side for the moment, you come into Southern Trust in 2014 and you report in your statement that your experience of Mr. O'Brien is that he has a non-standard way of working. You illustrate that in a number of ways by, for example, indicating that it was your experience that he didn't use administrative services in the way that other clinicians would. He didn't use the dictation facilities. He took notes home so that they weren't available to you when you were seeing a patient, those kinds of things, and this was known to other practitioners? 15:57 15:57

A. As became apparent to me after I started work and working within the Department, it was the way he worked. Progressively as I recognised that that was the way he worked, I would have raised when -- so during them times when we moved up to six when Mr. O'Donoghue started, we would have tried to work as a team and as individuals and as new starters, myself and Mr. O'Donoghue, seeing some patients who Mr. O'Brien had seen previously, and both of us raised a concern, along with Mr. Glackin and Mr. Young when they were doing it that you didn't have any 15:57 15:58

documentation about the decision-making that had gone on before. There wasn't a letter available, and so it made reviewing these patients very difficult. You mentioned that I have raised concerns using the incident reporting system, and indeed that very concern I raised really in respect of two patients, 102 and 103, that there were no letters, and in 103 no letters and hadn't been added to the waiting list although that was the patient's understanding from a consultation previously. 15:58 15:59

94 Q. Yes. Just looking at that issue, I want to just signpost this. I want to look, tortious though it might be, at a range of issues that you became aware of and perhaps reported into the system, just so that the Inquiry has your perspective on the shortcomings in Clinical practice that you were experiencing, but also in respect of some of these examples we will take a deeper dive and expose your reflections on the adequacy of the system for dealing with some of those matters. That's the twin purpose of looking at some of those matters. You have mentioned Patient 103, who you address in your witness statement. If we could have up on the screen WIT-54882. This issue first arose in April 2016. This is Patient 103. You say you saw this lady this morning on your ward round. You had no dealings with her prior to that. You hadn't received a referral there are no letters on the ECR and her notes detailing previous consultations were not available to you on the ward. You have gone on to 15:59 15:59 16:00

Subject: RE: MR O'BRIEN AND CHARTS AT HOME
From: O'Brien, Aidan [Personal Information redacted by USI]
To: Corrigan, Martina [Personal Information redacted by USI]
Sent: 14/11/2016 21:32:12

Martina,

I have already asked Noleen to return [Personal Information redacted by USI] chart to Pamela Lawson, who has requested it.

Thank you,

Aidan.

From: Corrigan, Martina
Sent: 14 November 2016 17:49
To: O'Brien, Aidan
Subject: RE: MR O'BRIEN AND CHARTS AT HOME

Aidan

I am more than happy with this plan, please let me know if there is anything I can do to assist.

By any chance could [Personal Information redacted by USI] be left in as I have had governance looking for this chart as well.

Wishing you all the best for Thursday, please take care

Talk soon

Kind regards

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

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

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

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

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

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

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

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

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

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Corrigan, Martina

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

Internal email for those on this circulation only

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

But this is not the approach I want for the Dept

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

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

MY
Lead

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

Dear Michael / Martina

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

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

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

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Lastly, I find it remarkable that your process be clarified with secretarial staff without consultation with or agreement with consultants who, by definition, should be consulted!

I would request that you consider withdrawing your directive as it has profound implications for the management of patients, and certainly until it has been discussed with clinicians.
I would also be grateful if you would advise by earliest return who authorised this process,

Aidan O'Brien.

From: Elliott, Noleen
Sent: 01 February 2019 13:17
To: O'Brien, Aidan
Subject: FW: Patients awaiting results
Importance: High

From: McCaul, Collette
Sent: 30 January 2019 12:33
To: Burke, Catherine; Cooke, Elaine; Cowan, Anne; Daly, Laura; Hall, Pamela; Kennedy, June; McCaffrey, Joe; Mulligan, Sharon; Nugent, Carol; Wortley, Heather; Wright, Brenda; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Neilly, Claire; Robinson, NicolaJ; Troughton, Elizabeth
Cc: Robinson, Katherine
Subject: Patients awaiting results
Importance: High

Hi all

I just need to clarify this process.

If a consultant states in letter " I am requesting CT/bloods etc etc and will review with the result. These patients ALL need to be DARO first pending the result not put on waiting list for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO, this is our fail safe so patients are not missed. Not always does a hard copy of the result reach us from Radiology etc so we cannot rely on a paper copy of the result to come to us.

Only once the Consultant has seen the result should the patient be then put on the waiting list for an appointment if required and at this stage the consultant can decide if they are red flag appointment, urgent or routine and they can be put on the waiting lists accordingly.

Can we make sure we are all following this process going forward

Collette McCaul
Acting Service Administrator (SEC) and EDT Project Officer
Ground Floor
Ramone Building
CAH
Ext Personal Information redacted by the USI

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Hynds, Siobhan

From: Young, Michael [redacted]
Sent: 26 November 2015 12:03
To: Haynes, Mark; Corrigan, Martina
Subject: RE: Queue jumpers

I had spoken before to the person in question re this issue in general and the justification of urgency – and I agree since the waiting list for some things are so long eg urodynamics.
Will have to speak again then

MY

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

Morning Michael

I emailed you on 2nd June 2015 about the ongoing issue of patients on waiting lists not being managed chronologically and in particular private pa

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This item has been archived by HP Consolidated Archive. View Restore

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Corrigan, Martina

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

Morning Michael

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

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

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

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

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

Mark

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Earlier in 2015, in April or May time, Mr. Haynes had written to Mr. Young expressing concerns about how he understood or how he perceived private patients were being given an advantage by you. He alludes to that. He says, 2nd June, just the bottom of the email there: 16:40

"I emailed you on 2nd June 2016 about the ongoing issues of patients on waiting lists not being managed chronologically and in particular private PA". 16:40

Mr. Young responds, 26th November:

"I had spoken before to the person in question regarding this issue in general and the justification of urgency, and I agree since the waiting list for some 16:41 things are so long, for example, urodynamics. Will have to speak again then".

He is saying - he doesn't name you - but he says he has spoken to the person and the justification of urgency and suggesting to Mr. Mackle will have to speak again. 16:41 So, he is suggesting to Mr. Haynes that he will have to speak again to you, assumedly. A suggestion of two possible conversations with you.

A. Yes.

244 Q. We will have to ask Mr. Young for his view on whether 16:41 they happened.

A. Yes.

245 Q. Do you recall Mr. Young --

A. I have no recall of -- if you're asking specifically

Angela Kerr

From: Williams, Marc [redacted]
Personal Information redacted by USI
Sent: 04 August 2016 10:16
To: O'Brien, Aidan
Subject: Private patients at MDT

Aidan
Please can you discuss the issue of private patients being discussed at the urology MDT.
I understand that the trust does not indemnify us for discussing these cases so if an error is made, we are personally liable. This is not withstanding the fact that private patients should be paying for the services of all staff at the MDT.
I have asked for clarification from the medical director and am awaiting discussion. I will not be providing any radiology input into these cases until I receive clarification.
Can I suggest that this is discussed at the MDT AGM or such like.
Thanks

Marc

Received from Tughans OBO Mr Aidan O'Brien on 12/05/2022. Annotated by the Urology Services Inquiry

Angela Kerr

From: Myhillsboro <Personal Information redacted by the USI>
Sent: 15 August 2016 14:46
To: O'Brien, Aidan
Subject: Re: Personal Information redacted by the USI

As far as I am aware there is no mdm facility for private patients. Frankly this is a poor show. It does sound as if certain members of the team are not interested. The ct scans have all been reported by dr rice and I do not get a chance to be present when my patients are being discussed.

I will speak in person about all of this on my return.

Sent from M.Y. iPhone

On 14 Aug 2016, at 22:29, O'Brien, Aidan <Personal Information redacted by the USI> wrote:

> Michael,
>
> Today, on reviewing and amending the outcome of the MDM of 04 August 2016, I realised that I had not been in contact with regard the above case.
> I regret that it was not possible to have the case discussed at MDM for the sake of the patient.
> Marc declined to make any comment upon the CT images imported from UIC as he is not indemnified to do so.
> It probably did not help that there was no report imported with the images.
> Mark Haynes was of the view that we should not be discussing her at our MDM as she was not under review by our NHS department, and conversely, that there should be an MDM available for her discussion in the private sector where she is under review.
>
> For what it is worth, I have reviewed the CT images.
> It could be interpreted that she has an expansile lesion of her third left rib, though I think that the marginal sclerosis present is unusual for metastatic renal cell carcinoma.
> I do believe that Steven Vallely's comment in his report of the bone scan in worthy of note in that he described the lesion as indistinguishable from a fracture.
> I note that she has been found to be osteoporotic on bone densitometry and has sustained a fracture of her right wrist during 2015.
> It would not be inconceivable that she has had a costal fracture.
>
> By the way, Steven has incorrectly reported the lesion as of the right third rib on bone scanning.
> The lesion is definitely of the left third rib.
> It may be prudent to ask Steven to review and amend his report.
>
> A solitary costal metastasis five years postoperatively is possible.
> For what it is worth, I think that it probably is a metastatic lesion.
> On the other hand, if it is indistinguishable from a fracture, then a fracture may be more probable, though it may just be the radioisotope features of the lesion that were considered to be indistinguishable from a fracture, without taking into considered the CT features.
>
> It does seem to me a radical step to resect this Personal Information redacted by the USI lady's third rib without more conclusive evidence of the nature of the lesion.
> What about repeating the CT of chest alone at CAH in September 2016 to determine whether the lesion has increased in size and consideration of a biopsy if it has,
>
> Aidan.

Received from Tughans OBO Mr Aidan O'Brien on 12/05/2022. Annotated by the Urology Services Inquiry

Medical Director following confirmation that the practitioner undertakes such work outside his/her programmed activities as per their agreed job plan.

6.3.2 Other than in the circumstances described above, staff are required to assist the consultant to whom they are responsible with the treatment of their private patients in the same way as their NHS patients. The charge paid by private patients to the hospital covers the whole cost of the hospital treatment including that of all associated staff.

7. CHANGE OF STATUS BETWEEN PRIVATE AND NHS

7.1 Treatment Episode

7.1.1 A patient who sees a consultant privately shall continue to have private status throughout the entire treatment episode.

7.2 Single Status

7.2.1 An outpatient cannot be both a Private and an NHS patient for the treatment of the one condition during a single visit to an NHS hospital.

7.3 Outpatient Transfer

7.3.1 However a private outpatient at an NHS hospital is legally entitled to change his/her status for any a subsequent visit and seek treatment under the NHS, subject to the terms of any undertaking he/she has made to pay charges.

7.4 Waiting List

7.4.1 A patient seen privately in consulting rooms who then becomes an NHS patient joins the waiting list at the same point as if his/her consultation had taken place as an NHS patient.

7.5 Inpatient Transfer

7.5.1 A private inpatient has a similar legal entitlement to change his/her status. This entitlement can only be exercised when a significant and unforeseen change in circumstances arises e.g. when they enter hospital for a minor operation and they are found to be suffering from a different more serious complaint. He/she remains liable to charges for the period during which he/she was a private patient.

7.6 During Procedure

7.6.1 A patient may request a change of status during a procedure where there has been an unpredictable or unforeseen complexity to the procedure. This can be tested by the range of consent required for the procedure.

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Corrigan, Martina

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

Importance: High

Siobhan,

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

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

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

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

Regards

Martina

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

Martina

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

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

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

Many thanks

Siobhan

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

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

Casenote	Consultant Name	Date on Waiting List	Date Operation	Days between Added to WL to Operation Date	Is there a clinical reason why they should have waited such a short time
Patient 114	O'Brien A Mr	22/02/2016	22/03/2016	29	No
Patient 115	O'Brien A Mr	25/04/2016	04/05/2016	9	Reasonable – Red Flag
Patient 116	O'Brien A Mr	11/04/2016	15/04/2016	4	No
Patient 117	O'Brien A Mr	01/04/2016	27/04/2016	26	No
Patient 118	O'Brien A Mr	08/07/2016	09/08/2016	32	No
Patient 119	O'Brien A Mr	29/07/2016	21/09/2016	54	No
Patient 120	O'Brien A Mr	04/12/2015	24/02/2016	82	Reasonable
Patient 121	O'Brien A Mr	11/07/2016	17/08/2016	37	No
Patient 122	O'Brien A Mr	08/10/16	02/11/16	25	No
Patient 123	O'Brien A Mr	31/10/16	04/11/16	5	No
Patient 124	O'Brien A Mr	16/02/2016	24/02/2016	8	No

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by the USI

Tel: Personal Information redacted by the USI

11th April 2016

Personal Information redacted by the USI

Patient 116

2.5.15
11.4.16 left
15.4.16 flex + wood
not sure - time limit
accept.

Dear Personal Information redacted by the USI

Patient 116

Personal Information redacted by the USI

DOB Personal Information redacted by the USI

UN

I write to you regarding this Personal Information redacted by the USI gentleman who was referred by your colleague, Personal Information redacted by in December 2014 for assessment and management of troublesome urinary symptoms. By the time that I met Patient 116 as an outpatient in May 2015, he had additionally been referred by Dr McMillan, Locum Consultant Dermatologist, for assessment of a balanitis.

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

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

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

Yours sincerely

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

benefit of this doubt, I reached the view that I would 'accept' this case as reasonable and therefore concluded my brief note on the letter with the word 'accept'.

iii. I have revised my opinion in respect of 4 of the 11 patients, 3 in light of Mr O'Brien's responses and 1 in response to my own reflections. This revision is summarised in the Table below in ease of the Inquiry:

Patient	Previous Opinion	Revised Opinion	Rationale
Patient 118 TRU-01079	Not reasonable	Reasonable	In light of the fact that his symptoms were so severe that they were leading to he and his wife sleeping in separate beds, with resulting marital strife. This information was not contained within the Personal Information redacted by the USI letter reviewed by me.
Patient 119 TRU-01078	Not reasonable	Reasonable	In light of the fact that the correct timescale for this patient was apparently 14 months rather than 2 months.
Patient 124 TRU-01070	Not reasonable	Reasonable	Patient was the daughter of a colleague. She was seen quickly as a professional courtesy

assume that I did not do this but opted instead to write to Mr O'Brien. My approach would have been informed by the fact that Mr O'Brien had acknowledged the incorrect dosage (and the risk posed by it) and corrected it. I therefore believe that I would have viewed the matter as a one-off incident with a low risk of recurrence.

8. I also wish to provide some updated evidence in respect of the 11 private patient cases considered in the MHPS process in light of the responses provided by Mr O'Brien, including in his evidence to the Inquiry this year.

    a. I believe that I carried out my consideration of the 11 cases in around April 2017.

    b. The process was as described in Martina Corrigan's email to Siobhan Hynds and Dr Chada of 14 September 2017 (TRU-283681) save that I believe that I only considered the 11 Personal Information redacted by the USI letters and not NIECR.

    c. Between the point when I engaged in that process and the point when I was asked questions about the issue by the GMC in October 2022, I had no further involvement in the issue nor did I consider it or the 11 patients again.

    d. The points I wish to make in respect of the 11 patients are as follows:

        i. The Table at TRU-01069 is not my work. Rather, I believe it was created by Martina Corrigan to summarise my opinion.

        ii. I believe that there is an error in the Table in the third row. The patient, whose reference is Patient 116 and whose Personal Information redacted by the USI letter with my comments on it is at TRU-01082, was one in respect of whom I was unable to form a view of the correct timeline. I therefore could not reach a conclusion that the patient had had their procedure unreasonably quickly and, allowing Mr O'Brien the

Patient 117 CAHE Personal Information redacted by the USI

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

Patient 118 CAHE Personal Information redacted by the USI

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

Patient 119 CAHE Personal Information redacted by the USI

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

Patient 120 CAHE Personal Information redacted by USI

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

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by the USI

Tel: Personal Information redacted by the USI

5th September 2016

Personal Information redacted by the USI

Patient 119

Dear Personal Information redacted by the USI

Patient 119

Personal Information redacted by the USI

DOB Personal Information redacted by the USI

UN

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

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

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

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

dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist

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

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

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

December of 2016 and that was the catalyst for private patients becoming an issue within the MHPS investigation?

A. Yes.

167 Q. The document, as I've said, is populated by answering the question, "Date on Waiting List". And for this particular patient, Patient 119, you have replaced 20th July '16 with 20th July '15 and you've made a calculation of 428 days. Now, does that mean that this patient was placed on the NHS waiting list on 20th July 2015? 12:36 12:37

A. No.

168 Q. Help me with that. That is the intention of that column, isn't it? It's asking the author to insert the date the patient is placed on the waiting list? 12:38

A. The third column?

169 Q. Yes.

A. Yes. Yes, and that was -- in that particular case -- when I saw the date that the patient was placed on the waiting list in real-time after this issue arose, I thought, actually, that's a typographical error because it really should be 2015 because that's when I -- it was the only time I met this patient, in July 2015, when I advised him that he should have his prostate resected, or he would be best served by having his prostate resected. But in fact, actually, it turned out that one year later is when I requested his hospital chart and it went into the filing cabinet, and that's the date that Noleen used to actually 12:38 12:38

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

Mr O'Brien's explanation for patient Patient 124 was that he undertook surgery for this patient, a personal friend, in an additional theatre session and therefore no HSC patient was affected. If an additional session was available in Theatre, patients from the waiting list should have been seen in chronological order.

Term Of Reference 5

To determine to what extent any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.

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

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

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

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