arose in relation to the various concerns that were raised within the context of the formal investigation.

(Q 72)

584. Issues which arose in relation to my practice were inextricably linked to the inadequate system I was working within. That led to recurring issues, for example, in relation to triage as detailed above in my response to Questions 66-67. These issues could have been prevented had the Trust ensured that the Urology Service had adequate staffing and capacity so that a practicable system could have been put in place to deal appropriately with triage.

585. During my tenure, there was a recurring issue with records being kept at my home and office as well as non-dictation of clinics. Again, that could have been prevented had the system within which I was working been adequately staffed and properly run by the Trust.

586. If there was any recurrence in the failure to ensure oncology patients had access to a Clinical Nurse Specialist (CNS), that could have been prevented by those responsible, namely the MDT Lead Clinician and the MDT Core Nurse Member, complying with their responsibilities as stated in the MDT Operational Policy to ensure that such patients had access to a CNS.

587. It could not be said that any issue in respect of my prescribing Bicalutamide recurred during my tenure, as no issue was ever raised with me in respect of my prescribing that medication during my tenure as a consultant urologist with the Trust. As stated elsewhere in this statement, the use of Bicalutamide was known to both the Urology and Oncology Service and no issue was ever raised in respect of Bicalutamide until after the termination of my contract with the Trust.

Datix

David Cardwell

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	Personal Information redacted by the USI
Submitted time (hh:mm)	12:53

Incident IR1 details

Notification email ID number	Personal Information redacted by the USI
Incident date (dd/MM/yyyy)	06/01/2016
Time (hh:mm)	09:30
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient ID HCN Personal Information redacted by the USI DOB Personal Information redacted by the USI Had a CT scan 24/6/2014 as follow-up of bowel cancer. CT showed an abnormal renal cyst with two further cysts in the right kidney. US performed 24/7/2014 showed solid elements within the anterior lower pole cyst and recommended an MRI to further evaluate. MRI performed 2/9/2014 reported 'Comparison to previous ultrasound dated 24/07/2014 and CT dated 24/06/2014. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3 cm in size. This lesion is T2 hyperintense, T1 hypointense, and demonstrates no abnormal enhancement. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had concerning features on CT and US. Had a further CT on 29/10/2014 as follow-up for breats cancer which again reported '3.6 cm exophytic complex cyst is seen in the lower pole of the left kidney anteriorly containing solid and cystic component. Simple cyst seen in the upper pole measuring 7 cm. Left kidney show no focal lesion...Complex cyst right kidney.(previously investigations noted)' Patient ID was referred to the urology department on 29/10/2014 for assessment and advice regarding the cyst with the MRI report. referral was marked as routine byt the IGP (on basis that MRI had reported a benign cyst). Referral was not triaged on receipt. Patient ID sent OP appointment for 6/1/2016. Consultant had noted in clinic preperation that the MRI report had not commented on the abnormal cyst and requested a further review by a consultant radiologist who reported the abnormal cyst as a likely cystic renal cancer. Patient ID was seen in clinic on 6/1/16. the sequence of events was outlined and surgical treatment of a suspected cystic renal cancer recommended after completion of up to date staging with a further CT scan.
Action taken Enter action taken at the time of the incident	There has been a resultant 18 month delay in OP review and recommendation of treatment for a suspected kidney cancer. Patient and husband fully informed of events and shown reports and imaging.
Learning Initial	
Reported (dd/MM/yyyy)	06/01/2016
Reporter's full name	Mark Haynes
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	06/01/2016
Were restrictive practices used?	
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 10

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Outpatient Clinic
Loc (Exact)	Urology Clinic
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	General Surgery
Speciality / Team	Urology Surgery

Staff initially notified upon submission

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job Title
Contact ID Personal Information not found	Eamon.Mackle Personal Information redacted by the USI	06/01/2016 12:54:12	Personal Information redacted by the USI		
Smyth, Paul MR	paul.smith Personal Information redacted by the USI	06/01/2016 12:54:11			Head of Unscheduled Care
Trouton, Heather	heather.trouton Personal Information redacted by the USI	06/01/2016 12:54:11			Assistant Director of Acute Services
Connolly, Connie	connie.connolly Personal Information redacted by the USI	06/01/2016 12:54:11			Acting Acute Governance Co-Ordinator

Southern Health and Social Care Trust

6.0 FINDINGS

assessment is solely dependent on the Urology waiting time- which was a minimum of 42 weeks in 2014. The default management process provides an explanation to why Patient 10 'Routine' referral letter was not upgraded and why Patient 10 was not seen by the Urology Team until 16 January 2016.

Patient 10 is now recovering from a laparoscopic excision of a papillary renal carcinoma which was done on 30 October 2016. This procedure was superseded by breast surgery in 2016 for breast lobular carcinoma on 14 February 2016. It had been agreed by the Oncology and Urology teams that the breast histology was priority and treatment proceeded in advance of renal surgery.

Relevant members of the Review Team completed a 'look-back' exercise in relation to the remaining 7 other GP letters to establish the patient management and outcome. The Panel can confirm that the other 7 patients have been seen by the Urology Team on or before 26 January 2016, and have not been known to have been exposed to significant harm.

7.0 CONCLUSIONS

The MRI report by Dr 2 on 29 September 2014 as previously discussed, was misleading and was inappropriately condensed. The quality of the information resulted in the evolving right renal cyst being overlooked by Drs 3 and Dr 5.

The SHSCT Radiology Team continuously review and audit the quality and accuracy of their reporting. On this occasion, the MRI report irregularities were not detected until viewed by a Urology Consultant.

All available evidence suggests that Dr 6 did not triage Patient 10's GP referral letter on the week ending 30 October 2014. The default triage management process was initiated which resulted in Patient 10 waiting 64 weeks for Urological assessment.

The Review Panel agree that in relation to Patient 10, the opportunity to upgrade the referral to red flag was lost by the omission of triage, this resulted in a 64 week delay to diagnosis of a suspicious renal mass.

While the remit of this Serious Adverse Incident (SAI) Review was to examine the factors in Patient 10's delayed management of papillary renal cancer. The Review Panel were provided evidence that a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team.

73.5 No mechanism exists to monitor any individual clinician's decision making in outpatients. Issues only come to light when concern is raised by another clinician – be it a GP or a colleague. In Mr O'Brien's case, the ability of GPs or consultant colleagues to identify issues will have been impaired by the absence of letters. Additionally, the workload placed on the consultant urologists by virtue of the capacity:demand mismatch would have impacted on their ability to recognize issues. Single consultant practice also impacts, as for many outpatient conditions only one consultant may see a patient during a long disease natural history.

73.6 The absence of an induction process or handover for incoming AMDs was also a factor. For example, it was only after the identification of the untriaged referrals in 2017 that I was made aware that this had been an issue previously with Mr O'Brien. The resultant lack of continuity within the system resulted in, effectively, a clean slate each time there was a change in the medical management personnel at Clincial Director and Associate Medical Director level.

73.7 Being aware now of the clinical issues, in particular with regard to Mr O'Brien's prostate cancer management, it is in my opinion clear that conformance with external recommendations / guidance was a factor – be they MDM recommendations, NICE Guidelines or other external recommendations. I am told individual oncologists had raised concerns directly with Mr O'Brien regarding his use of low dose bicalutamide but Mr O'Brien did not change his practice. On reflection, other behaviours (such as his continued use of monopolar / glycine for transurethral surgery despite external recommendations) should have alerted others to the likelihood that he was not following other forms of external guidance. I am aware that similar behavior from Mr O'Brien regarding external recommendations was encountered following the 'Improving outcomes guidance' which recommended centralization of specific cancer related surgery within cancer networks. For Urology this covered Cystectomy for bladder cancer, radical prostatectomy for prostate cancer, penile cancer surgery and nephron sparing / IVC thrombectomy surgery for kidney cancer. After cystectomy surgery was centralized to Belfast, despite (I understand) having been told that no further

Corrigan, Martina

From: Corrigan, Martina
Sent: 20 November 2014 16:34
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; Suresh, Ram; Young, Michael
Subject: FW: Urology Missing Triage
Attachments: Urology - 14.11.14.xlsx

Importance: High

Dear all

Please see attached there are 206 outstanding triage letters on this list this and this has been escalated to Anita Carroll, Assistant Director, Functional Support and she will most likely escalate to Heather, can I ask if there are any outstanding for you can these please be returned urgently to the booking centre.

You will see the longest outstanding is 263 days and then down to 16 days.

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: martina.corrigan Personal Information redacted by the USI

From: Browne, Leanne
Sent: 20 November 2014 14:53
To: Corrigan, Martina
Subject: Urology Missing Triage

Hi Martina – attached is the up-to-date Urology Missing Triage file.
Can you please arrange for the referrals to be triaged and returned to RBC as soon as possible.

Many thanks

Leanne

Leanne Browne
Acting Supervisor – Gynae, Urology, Urology ICATS, Orthoptics Referral & Booking Centre Ramone Building
Craigavon Area Hospital Ext Personal Information redacted by the USI

Corrigan, Martina

From: Haynes, Mark <Mark.Haynes[redacted]>
Sent: 27 May 2015 20:54
To: Young, Michael; Corrigan, Martina
Subject: FW: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15
Attachments: UROLOGY LONGEST URGENT WAITERS WITHOUT DATE FOR SURGERY - FOR SCHEDULING - 27.05.xlsx; UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15.xls

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 ([redacted] HCN [redacted]) 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.

Happy to discuss and plan a strategy for taking this forward.

Mark

From: Glenny, Sharon
Sent: 27 May 2015 14:32
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Cc: Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Robinson, NicolaJ; Troughton, Elizabeth
Subject: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15
Importance: High

Hi Everyone

Following the departmental meeting last week and discussion re urgent waiting times and volumes with consultants for elective surgery – I have attached a total urgent waiting list for your review.

Corrigan, Martina

From: Haynes, Mark <Mark.Haynes[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

From: Carroll, Ronan
Sent: 28 December 2016 11:15
To: Boyce, Tracey; Wright, Richard; Gibson, Simon
Subject: FW: Management of PP's / non chronological listing
Attachments: [redacted].pdf

Importance: High

Please see email received from Mr Haynes which is self-explanatory. Mr Haynes came across this letter as a result of reviewing this pt with AOB being off sick & pulled this letter off NIECR
AOB Waiting time for routine – 149wks & urgent 139wks for TURPs
I have asked Wendy to run a report on all AOB TURP's completed (which is what this man had) to see are there others who have been listed the same way.
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
[redacted]

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

Morning Ronan

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

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

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

Mark

61. ~~55.~~ **When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?**

61.1 Fairly soon after commencing work in Southern Trust I became aware that Mr O'Brien had different ways of working compared with others. It was apparent that many of these were embedded in his working patterns and widely accepted across the Trust as 'his way'.

61.2 Concerns were regularly voiced by all members of the consultant team regarding the frequent lack of clinical information (in the form of letters) following outpatient consultations as this had the potential to impact on us when patients had unplanned (emergency) admissions. This voicing of concerns would have occurred during informal conversations and within departmental meetings including with the HoS. I also recognised that, regularly, patient notes were unavailable in the hospital when patients were admitted and this, coupled with the lack of dictated letters (which would have been available on the patient's electronic care record even if their notes were unavailable), presented a potential for risk during a patient's emergency care.

61.3 I submitted an IR1 regarding such a case ([Patient 102]) in October 2015 (please see *87. 20141120 -IR1* [Patient 102] *)* , and also commented in an email regarding another patient ([Personal Information redacted by the USI]) who, in addition, did not appear to have been added to the waiting list after outpatient appointments *(please see 88. 20170111 E re PATIENT* [Personal Information redacted by the USI] *).* These concerns were also voiced by other members of the urology consultant team and, in discussions, it was apparent to me that these were long-standing issues and were essentially recognised as normal practice for Mr O'Brien. I did not receive any feedback following submission of the IR1.

61.4 There were also issues in relation to timely responses from Mr O'Brien regarding complaints and litigation. I recall these were an issue at the time Dr

69.7 Mr O'Brien also expressed concern at various points regarding the amount of time it took him to arrange things (e.g., elective admissions). It was clear from his descriptions that the issue he was facing was as a direct result of him not engaging with the wider support team available to him and electing to undertake many of the administrative tasks himself (e.g., phoning patients to advise them of planned admission dates / times, a task that the secretarial team undertake for all others). This was not due to a lack of available support but an unwillingness / inability to delegate these tasks appropriately to members of the wider team.

69.8 He expressed concern regarding volume of patient and GP enquiries, and yet could not recognize that, if he provided comtemporaneous written documentation to GPs, many of these enquiries would not have been necessary. As has subsequently been identified it would have also been the case that if he had ensured that every cancer patient had been seen with a CNS, many patient enquiries would have been able to have been addressed through the CNS team.

69.9 Mr O'Brien had raised a concern in an email regarding the DARO process (*please see 145. 20190207-email-patients awaiting results*). This is a 'safety-net' process whereby patients who have investigations requested are added to a list on the Patient Administration System which is then reviewed on a regular basis by secretarial staff to check if the investigation has been done and, when result is available, that it is passed on to the consultant for review and action. Although this email was not directed at me, I replied advising that the process was required for patient safety and should be followed. It has since become apparent that, despite this, Mr O'Brien and his secretary did not utilize the DARO list, and I believe this is a factor in patients who did not get test results reviewed and acted upon in a timely manner (e.g., Patient 5, Patient 92).

69.10 In August 2015, HSS(MD)14/2015 required trusts to take action with regard to a regional policy on the surgical management of endoscopic tissue resection. For urology teams this related to switching from monopolar transurethral resection (in glycine) to bipolar resection (in saline), with the work on the policy having been commissioned following a coroners verdict in October 2015. Mr

O'Brien engaged in the process of assessment of new bipolar resection equipment. However, he subsequently expressed the view that he would be continuing to use monopolar resection in glycine, thereby not conforming with the policy. On reflection, this unwillingness to conform with recommendations from others should have provoked concern regarding wider aspects of his practice, especially with regards to delivering treatment in line with NICE guidance / MDM recommendations. *Please see 7. 20181205 E re Transperineal Prostate Biopsy Equipment, 8. 20171120 E re Saline TUR, 9. 20171120 E re Saline TUR A1, 10. 20171120 E re Saline TUR A2, 11. 20171120 E re Saline TUR A3 and 12. 20171120 E re Saline TUR A4.*

69.11 Previously, concerns regarding the clinical decision making relating to emergency admissions were raised within the consultant urology team regarding a former consultant colleague (Mr Suresh). I believe it was Mr O'Brien who raised this concern following an emergency re-presentation of a patient he had operated on. These concerns were also backed up by some concerns from other members of the consultant team regarding some emergency admissions. These concerns were raised with the consultant in question and additional support was provided in addition to the consultant attending some educational courses regarding emergency urology. *Please see 77. 20151217 - Confidential Meeting RS.*

70. ~~**64.**~~ **Did you raise any concerns about the conduct/performance of Mr O'Brien?**

If yes:

(a) outline the nature of concerns you raised, and why it was raised

(b) who did you raise it with and when?

(c) what action was taken by you and others, if any, after the issue was raised

(d) what was the outcome of raising the issue?

If you did not raise any concerns about the conduct/performance of Mr. O'Brien, why did you not?

(ii) Current Review Backlog up to 29 February 2016.

9.14 For this aspect of Mr O'Brien's performance, I can confirm that I ran a report from 'Business Objects', which is the system which can interrogate the information held on the Patient Administrative System. I put in the query of patients waiting a review appointment up to and including 29 February 2016 and I provided Mrs Trouton and Mr Mackle with the figures:

Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

(iii) Patient Centre letters and recorded outcomes from Clinics

9.15 I can confirm that in 2014/2015, when this issue was first raised, it was very difficult to quantify how many patients didn't have a clinic letter as there was no electronic system to capture this information. When Mr Haynes and Mr O'Donoghue took up their consultant posts in 2014 they agreed with the urology team that, until they had their own cohort of patients, they would help with review backlog validation by reviewing the last clinic letters on Patient Centre of the longest waiters for all of the existing consultants (Mr Young/Mr O'Brien/Mr Suresh and Mr Glackin). Both Mr Haynes and Mr O'Donoghue advised me at various times during the course of this validation exercise that, for Mr O'Brien's patients, they noted that there were a number of clinic letters not on Patient Centre which meant they were unable to make a decision and they either needed the hospital notes or to see the patient to put a management plan in place or discharge the patient if needed. I discussed this issue on a few occasions with Mr Mackle and Mrs Trouton and it was agreed that this needed to be included in the correspondence to Mr O'Brien.

121. The Complaints Department received concerns from patients and relatives. A complaint would be sent out to the relevant team for completion, a reply would be drafted by, I believe, Heather Trouton and then ultimately signed by the Acute Director. Significant clinical complaints would be discussed at the Divisional and/or Acute Directorate governance meetings.

122. For the most part, the system worked. However, on reflection it is easy to see that, for example, our systems for monitoring triage were not sufficient. Because of repeated breaches, a system was introduced by Debbie Burns whereby the booking centre placed the patient on the out-patient list according to their GP's grading to ensure chronological booking. Following this, however, oversight of the triage compliance by Aidan O'Brien was not performed. The system for tracking of referrals has now been improved by the introduction of electronic triage using NIECR (Northern Ireland Electronic Care Record). Following the changes re booking of outpatient referrals I was not made aware of any delays in triage and it was only the raising of concerns by Aidan O'Brien's colleagues, while performing validation clinics in late 2015, that ultimately led to the investigation into his practice.

[37] Did those systems or processes change over time? If so, how, by whom and why?

123. I don't recall any significant changes in the systems with time.

[38] How did you ensure that you were appraised of any concerns generally within the unit?

124. I held regular meetings with the Head of Service, Assistant Director, Director and Lead Clinician. I had good working relations with nearly all staff including both medical and non-medical. With Heather Trouton and I reviewed any DATIX and any significant complaints received in the directorate.

Southern Health and Social Care Trust

APPENDIX 6

Revised November 2016 (Version 1.1)

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: [redacted] Personal Information redacted by the USI

Date of Incident/Event: January 2016 – September 2016

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer: Dr J R Johnston

Designation: Consultant Medical Advisor

Report Author: The Review Team

Date report signed off:

TRU-162114

Mr Chris Wamsley

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	Personal Information redacted by the USI
Submitted time (hh:mm)	14:54

Incident IR1 details

Notification email ID number	Personal Information redacted by the USI
Incident date (dd/MM/yyyy)	02/03/2017
Time (hh:mm)	17:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient Patient 13 HCN Personal Information was referred to Urology Outpatients on 28 Jul 2016 for assessment and advice on episode of haematu refer ed routine by the GP. Referral was not triaged on receipt. As a result of a look-back exercise the referral was upgraded to red flag and was seen in clinic in day 179, on day 187 there was decision to treat and on day 217 the patient had a confirmed cancer diagnosis
Action taken Enter action taken at the time of the incident	There has been a resultant 6 month delay in OP review and recommendation of treatment for a bladder cancer. Patient is aware of diagnosis but not delay and has been referred to Belfast City Hospital for further treatment
Learning Initial	
Reported (dd/MM/yyyy)	12/05/2017
Reporter's full name	Mr Michael Young
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	05/12/2017
Has safeguarding been considered?	
Were restrictive practices used?	
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 13

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Outpatient Clinic
Loc (Exact)	Urology Clinic
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	Outpatients
Speciality / Team	Outpatients

Staff initially notified upon submission

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job Title
No notification e-mails sent					

Management of Incident

Handler Enter the manager who is handling the review of the incident	Martina Corrigan
Additional/dual handler If it is practice within your team for two managers to review incidents together use this field to record the second handler	
Escalate You can use this field to note the incident has been escalated to a more senior manager within your Service/Division- select the manager from this list and send an email via the Communication section to notify the manager the incident has been escalated to them.	
Date of final approval (closed date) (dd/MM/yyyy)	
Date Notification Sent to External Agency	21/09/2017
Date Terms of Reference Due	
Date SAI Report Due	16/11/2017
SAI Level (1,2 or 3)	3.00
External Agency SAI Ref No.	Personal Information redacted by the USI
Date SAI Report Sent to External Agency	29/05/2020

Southern Health and Social Care Trust

Causal Factors

1. Referral letters did not have their clinical priority accurately assigned by the GP. Referral letters were not triaged following receipt by the Hospital.

HSCB

Recommendation 1

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

Recommendation 2

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

Recommendation 3

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

HSCB, Trust and GPs

Recommendation 4

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

TRUST

Recommendation 5

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

Recommendation 6

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

Recommendation 7

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

Recommendation 8

Southern Health and Social Care Trust

The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

Recommendation 9

Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

Recommendation 10

The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

CONSULTANT 1

Recommendation 11

Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

Recommendation 12

Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

2.0 THE REVIEW TEAM

Dr J R Johnston - Consultant Medical Adviser

Mr M Haynes - Consultant Urologist

Mrs K Robinson - Booking & Contact Centre Manager

Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

3.0 SAI REVIEW TERMS OF REFERENCE

1. To undertake an initial investigation/review of the care and treatment of patients Patient 15, Patient 13, Patient 12, Patient 14 and Patient 11, in the period after referral to the SHSCT Urology service using National Patient Safety Agency root cause analysis methodology.
2. To determine whether there were any factors in the health & social care services interventions delivered or omitted to Patient 15, Patient 13, Patient 12, Patient 14 and Patient 11 that resulted in an

Comments concerning the RCA Report on Review of SAI 69120

In submitting this commentary regarding the RCA Report of SAI 69120, I have reviewed all retained correspondence relating to the issue of triage, all retained documentation relating to other issues impacting upon triage and all retained documentation relating to other issues referred to by others interviewed during the course of the Root Cause Analysis. Having done so, I believe that the Recommendations outlined in the Report are its most important component, though I believe that at least one additional recommendation is required to ensure that the others could be effectively implemented. I have endeavoured to be concise.

Having been interviewed by Dr. Johnston and having read the above Report, I do believe that the singular and significant flaw of the Review has been to investigate the failure to triage urgent and routine referrals in isolation of other pressures and clinical priorities which I believe are evidently more important. As a clinician and a clinical department, I believe that these greater clinical priorities cannot be compromised for the sake of triage, as they have been and continue to be.

Urologist / Consultant of the Week

While agreeing that triage is indeed a serious issue and very important, I was concerned to being expected to agree that triage of referrals has 'number one ranking in the overall scheme of things'. I believe that it is vitally important to fully appreciate the significance of this claim, especially as triage has been aligned with the duties of the Urologist of the Week (UOW). If, as has been my experience during my last week as UOW, one does a ward round from 09.00 am to 11.30 am, prior to going to theatre to undertake seven emergency / urgent operations, is triage the most important concern that day, or the day after, if it is similar?

I most earnestly urge the Review Team to review the wording of Recommendation 6, urging the Trust to re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW. I believe that it is important to appreciate that the Trust has never examined or assured itself in the first place, never mind do so again. I believe that it is crucially important that the duties and priorities of the CoW and the expectations of the Trust of the CoW in the conduct of those duties and priorities, be clearly agreed and expressed in a written Memorandum of Understanding, or similar. I do so as there has been an ambiguity since its inception as to those duties and priorities.

Following a long period of gestational discussion, the UOW came into existence in late 2014. The major reason for the length of that gestational discussion was the belief, particularly on the part of our Lead Clinician, that the duties of the UOW could not possibly take up a whole day. This belief was borne out of his perception that the UOW would essentially be on call. When subsequently persuaded and convinced that it would be a good for inpatient management that the UOW would conduct an ward round each morning, it was then proposed that we could then undertake a clinic in the afternoon each day, as the duties of UOW could be confined to the morning, as one would rarely be called to theatre in an emergency. When successfully disabused of that proposal which would have necessitated the disorderly cancellation of outpatient attendances, the proposal of

Southern Health and Social Care Trust

APPENDIX 6

Revised November 2016 (Version 1.1)

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: [redacted]

Date of Incident/Event: 10/07/2016

HSCB Unique Case Identifier: [redacted]

Service User Details: (*complete where relevant*)
D.O.B: [redacted] Gender: (M) Age: [redacted]

Responsible Lead Officer: Dr J R Johnston

Designation: Consultant Medical Advisor

Report Author: The Review Team

Date report signed off: 27 January 2020

Patient 16

6.0 FINDINGS

have been waiting to hear that information, prior to removal/replacement of the stent, as agreed back in March/April 2105.

Acknowledging receipt and sight of correspondence

In the medical chart, there is evidence that some Consultants signed letters from other specialties and on occasions annotated the letter with instructions including ConsSurg9 and COnsUrol11.

There is no evidence of the letters sent to ConsUrol13 being initialled to acknowledge receipt. The important 26th November 2015 letter from ConsOnc10 to ConsUrol13 initially requesting change of the stent was date stamped in the CAH chart, 11th December 2015, but there is no Consultant note/signature/handwriting evident on letter to acknowledge receipt. This calls into question whether ConsUrol13 was made aware, at that time, that the stent change was required.

However, there were several email communications received shortly afterwards that should have brought this to his attention. This series of communication issues could be characterised as indicating a lack of acknowledging, reviewing and/or actioning correspondence.

Assurance for tracking correspondence

The Review Team noted that letters to Consultants are not tracked and there is no process in place to ensure they have been reviewed and actioned by Consultants.

Correspondence on NIECR

The Oncology service is based in Belfast City Hospital Cancer Centre and the Oncology medical team visit CAH to do clinics. The Oncologists do not have access to Southern HSC Trust intranet services. The Oncologists highlighted, '*Dictated, typed, verified and recorded letters remain the preferred method of communication between disciplines, though admittedly delays can occur due to shortages of administrative staff. On occasions where was a clinical imperative for urgent communication, phone calls and emails were made from Oncologists to the Urology service*'. [Source = Complaint response]

Oncology letters were not available on the NIECR which made reviewing the full patient journey difficult for clinicians.

The Booking Centre Manager has highlighted that on occasions letters may have been filed or held in a backlog with no evidence of Consultant review. On the 4th April 2017 correspondence was sent by the Booking Centre Manager to Operation Support Leads for action by secretaries, this stated '…… *if not on NIECR, filing is a priority. Also, please ensure all your staff know that no letters or results should ever be filed in charts without a Consultant's signature. For example, Oncology letters are not on NIECR and when they are sent to Consultants here, it is up to the Consultant to read the letter, and sign before the*

2. There is no formal Trust guidance/process on what is expected of clinicians when dealing with clinical matters using paper correspondence; particularly for recording receipt, acknowledgement, reviewed and actioned. This should include what is expected of clinicians when triaging referral letters including Consultant to Consultant written documentation. This includes letters where the action required could be the addition to either inpatient or outpatient waiting lists by clinical priority.

3. The SHSCT does not have formal guidance on managing letters e.g. by tracking, to ensure they are managed in a consistent, timely and appropriate way by all clinicians. Good practice was noted by some clinicians.

4. The above lessons learnt also applies to the use of correspondence by email.

5. Correspondence and communication between clinical teams, especially when they involve 'visiting' clinical teams, should include all the SHSCT teams/clinicians directly involved in the patient's care, particularly when they are referred to in the correspondence.

6. Long Urology waiting lists mean that some patients are often unable to be treated in a clinically appropriate time, leading to delay in treatment and care and possible adverse outcomes.

9.0 RECOMMENDATIONS AND ACTION PLANNING

TRUST

Recommendation 1

The Trust will explore and evaluate methods of communication between clinicians; other than paper. This will be especially for 'visiting' clinical teams not based in the SHSCT and also especially when their clinic letters are not available on NIECR.

Recommendation 2

The Trust should develop written policy/guidance for clinicians and administrative staff concerning writing clinic or discharge letters, to ensure all clinical teams/clinicians, directly involved in the patient's care, are copied into the correspondence, especially if they are referred to in the letter.

Recommendation 3

The Trust will develop written policy/guidance for clinicians and administrative staff on managing clinical correspondence, including email correspondence from other clinicians and healthcare staff.

This guidance will outline the systems and processes required to ensure that all clinical

Report of a Root Cause Analysis of SAI [redacted]

Comments regarding Factual Accuracy

[redacted] was [redacted] years old when he developed colonic obstruction due to an adenocarcinoma of his sigmoid colon necessitating sigmoid colectomy and a Hartmann's end colostomy in July 2012. He subsequently declined adjuvant chemotherapy. He required a small bowel resection in August 2014 for small bowel obstruction due to metastatic colonic adenocarcinoma. On CT scanning on 11 March 2015, it was evident that he had metastatic disease progression in the form of a left pulmonary nodule which had increased in size, and of a left pelvic mass causing left upper urinary tract obstruction. Following discussion at the Lower GI MDM on 12 March 2015, his primary colorectal surgeon (ConsSurg9) wrote to Consultant Urologist 11 (ConsUrol11) with a view to considering left ureteric stenting. Even though referred to ConsUrol11, he attended a clinic of Consultant Urologist 15 (ConsUrol15) on Thursday 26 March 2015, when his Specialist Trainee wrote in her letter to [redacted]'s family doctor that they had arranged his elective admission on 31 March 2015 for insertion of a left ureteric stent.

The report then states that [redacted] was admitted to Craigavon Area Hospital on 31 March 2015 under the care of Consultant Urologist 13 (ConsUrol13). Having reviewed the record of his admission both on NIECR and PAS, it is evident that I am Consultant Urologist 13. However, the record is untrue. I had undertaken to conduct an additional operating session on the morning of Tuesday 31 March 2015. As I have retained records of all admissions arranged by me, currently back to and including 2010, I can confirm that I arranged the admissions of four patients for surgery that morning. [redacted] was not one of them. I have cross checked with my secretary who has provided a copy (attached) of the operating list entered on the Theatre Management System. [redacted] is not included on the list. It is a matter of concern that the Review Team have been prepared to rely upon the record of NIECR and PAS without checking its veracity.

However, even though I do arrange admissions with the agreement and commitment of the patients involved, one of those four patients was unable to be admitted that morning. Though entirely speculative on my part now, I suspect that it is most probably the case that I had time as a consequence to supervise the procedure undergone by [redacted], in another theatre that morning, particularly as the same Specialist Trainee was not rostered to my operating session that morning.

As a consequence, as detailed in the Report, I agreed to have [redacted]. placed on my waiting list on 02 April 2015 for Removal of Left Ureteric Stent, Ureteroscopy and ? Restenting, with an indicative date for his readmission being October 2015, though the intent was that the stent would not be removed or replaced until the patient had completed chemotherapy.

The Report records that Consultant Oncologist 10 wrote to me, (ConsUrol13), on 26 November 2015 advising that palliative chemotherapy had been completed, and enquiring whether this would have been an appropriate time to arrange stent removal / replacement. The Report notes that the letter was filed in the patient's Craigavon Area Hospital chart with a stamp denoting the date of receipt, but without a note or signature to indicate that I had read the letter prior to its filing. This letter is the only communication or event typed in bold in Section 6.0 of the Report, which stated that there was no evidence that I had either received and / or acknowledged the letter, and asks the question 'Did he receive this letter?'. Then, without actually asking me the question posed, the report states that the Review Team were unable to conclude if I reviewed my letters. Then most egregiously, the Review Team noted that I did not routinely triage referrals where there was a formal process in place for triage, and that this lack of triaging may have extended to documentation from other consultants. Indeed, for good measure, it could also be extended to reviewing and / or actioning (sic) email correspondence!

On placing so much emphasis upon this letter, and having reviewed the letter as filed in the patient's chart when provided to me upon my request, I was struck by three details. The first was that the patient's CAH unit number was handwritten on the top right hand corner of the letter. My secretary has since confirmed that it was written by her. Even though my name and address is typed in the top left hand corner of the letter, the second detail is that the salutation was 'Dear [redacted]'. The third detail was that the letter was copied to ConsSurg9 and to the GP.

I therefore decided to attempt to find an answer to the question raised by but apparently not explored by the Review Team. My secretary has advised me that even though the letter had been received by her, she mistakenly did not appreciate that it was actually addressed to me, in view of the salutation and in view of the fact that it had not been copied to me, and that she had filed it in his chart without showing it to me. This course of action was obviously regrettable, but supports my contention that I have had no memory of ever having received the letter of 26 November 2015.

I find it interesting to note in the Report that ConsSurg9 wrote to ConsUrol11 on 09 May 2016. There is no copy of that letter filed in the patient's Craigavon Area Hospital chart, whether noted, signed, actioned or otherwise. The absence of any comparable commentary or generalisations is remarkable. It was not even typed in bold!

The subsequent emails which I received from my secretary or audiotypist of 30 December 2015, of 04 March 2016 and of 10 May 2016 are typical of requests and enquiries which I have received every day for years from patients, relatives, GPs, MLAs, MPs and personnel in Trust Management, regarding dates for admission. For years, I have had approximately 280 patients awaiting elective admission and readmission. I currently have 228 patients awaiting urgent elective admission dating back to August 2014, prior to [redacted] having first been referred to our department in March 2015! The failure to respond positively to any request

for admission is a consequence of the lack of operating capacity provided by the Trust. The failure to respond in any way to every request is additionally a consequence of the lack of time provided and available to do so. The Report would imply that the Review Team are of the view that, if it is intended that a stent will be replaced in six months' time, that it will be, irrespective of the number to be replaced at that time, in addition to the even more numerous patients with even greater clinical priorities.

Patient 16 's further management proceeded as detailed in the Report. It is certainly the case that encrustation of the lower end of the ureteric stent would have caused the patient pain or discomfort referred to his bladder. It was worthy of note that it had not been possible to restent the left upper tract satisfactorily on 29 June 2016 due to the fixed adherence of the left ureter. His upper tract remained obstructed, necessitating nephrostomy drainage. The combination of the operative intervention and persistence of obstruction resulted in [redacted] Patient 16 suffering a Bacteroides bacteraemia. Even though his left upper tract was later satisfactorily stented on 10 August 2016, it did not adequately relieve upper tract obstruction. It was for that reason that the left nephrostomy drain was replaced, rather than removed, on 01 September 2016.

I have then found it most remarkable that the Review Team failed entirely to include any reference to the email of 01 December 2016 from me to my secretary regarding the patient's admission on 06 December 2016 and which I arranged while recovering from prostatic resection on 16 November 2016. I find it equally remarkable that the Review Team omitted any reference of my emails of 02 December 2016 to ConsUrol11 and to ConsOnc2. In particular, in my email to ConsUrol9, I asserted that Patient 16 had completed palliative chemotherapy in March 2016. This underscores my understanding at the time, as I had not received any correspondence to the contrary. These emails have been provided.

General and Concluding Comments

Patient 16 's daughter, Patient's Daughter , submitted a letter of complaint, dated 05 December 2016, and endorsed by her father on 11 December 2016. The letter was received in the Governance Office of the Trust on 21 December 2016. Mr. Cardwell enquired by email on 22 December 2016 whether the complaint needed to be screened as an SAI. Dr. Boyce enquired of Mr. Carroll by email on 23 December 2016 whether he considered it should be an SAI, enquiring whether the 'delay in the stent issue be down to the urologist or is that a process under radiology's control?' I was advised on 30 December 2016 of the possibility of an SAI. Mrs. Gishkori wrote to Patient's Daughter on 17 April 2017 to advise that her father's management would be the subject of a SAI investigation.

At 15.58 on 28 October 2019, over 2½ years later, an email is sent to me by the Governance Team, attaching the Reports of the Root Cause Analyses of SAI Personal Information redacted by the USI and SAI Personal Information redacted by the USI

TRU-162123

Mr Chris Wamsley

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	Personal Information redacted by the USI
Submitted time (hh:mm)	07:37

Incident IR1 details

Notification email ID number	Personal Information redacted by the USI
Incident date (dd/MM/yyyy)	17/07/2018
Time (hh:mm)	12:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Inpatient admission 29/11/17 - 7/12/17. FU CT Renal in 3 months. CT performed 13/3/18 (reported 20/3/18) showed suspected renal cancer. GP referral 17/7/18 as no review / FU had occurred after CT scan. Subsequently underwent surgical treatment of renal cancer.
Action taken Enter action taken at the time of the incident	Upon receipt of referral, OP assessment and further management was arranged.
Learning Initial	Robust mechanisms for clinican review and action of results is required.
Reported (dd/MM/yyyy)	12/03/2019
Reporter's full name	Mark Haynes
Reporter's SHSCT Email Address	mark.haynes Personal Information redacted by the USI
Opened date (dd/MM/yyyy)	12/03/2019
Has safeguarding been considered?	
Were restrictive practices used?	
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 92

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Outpatient Clinic
Loc (Exact)	Urology Clinic
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	General Surgery
Speciality / Team	Urology Surgery

Staff initially notified upon submission

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job Title
Carroll, Ronan MR	ronan.carrol Personal Information redacted by the USI	12/03/2019 07:37:52	Personal Information redacted by the USI	Personal Information redacted by the USI	Assistant Director of Acute Services
Kelly, Brigeen	brigeen.kell Personal Information redacted by the USI	12/03/2019 07:37:52		Personal Information redacted by the USI	Head of Trauma and Orthopaedics
Young, Michael	Michael.Young Personal Information redacted by the USI	12/03/2019 07:37:52			Consultant
Haynes, Mark Mr	mark.haynes Personal Information redacted by the USI	12/03/2019 07:37:52			Consultant Urologist
McAloran, Paula	Paula.McAlora Personal Information redacted by the USI	12/03/2019 07:37:52			Senior Governance Officer
Kingsnorth, Patricia Mrs	patricia.kingsnorth Personal Information redacted by the USI	12/03/2019 07:37:52		Personal Information redacted by the USI	Risk Midwife
Corrigan, Martina	martina.corrigan Personal Information redacted by the USI	12/03/2019 07:37:51			Head of ENT and Urology

Management of Incident

Handler Enter the manager who is handling the review of the incident	Martina Corrigan
Additional/dual handler If it is practice within your team for two managers to review incidents together use this field to record the second handler	
Escalate You can use this field to note the incident has been escalated to a more senior manager within your Service/Division- select the manager from this list and send an email via the Communication section to notify the manager the incident has been escalated to them.	
	21/10/2019

scheduled that far ahead. With no outpatient clinic scheduled it would have being impossible for medical staff to ascertain Patient 92 would be appointed an outpatient appointment in six weeks' time. Patient 92 was therefore added to Dr 3's urgent urology waiting list which at the time had a waiting time of 96 weeks. Conversely, the Review Team concluded had Patient 92 been reviewed six weeks post discharge the management plan may not have changed given the recent CT scan result reporting an infected renal cyst and treatment received.

On 13 March 2018 Patient 92 attended CAH X-ray department for a CT renal with contrast. The Review Team note the report was finalised on the 20 March 2019 at 14:05. The Review Team have confirmed communication was emailed to the referring Consultant Urologist Dr 3 and his secretary (secretary 1) and an additional secretary 2 (secratary1 was off on leave) on the same day 20 March 2018 at 14:54.The email advised all correspondents an urgent report for Patient 92 was available on Sectra Radiology Information System (RIS). The Review Team have identified Patient 92 s report was completed in a timely manner and escalated to the referring consultant immediately by the Radiology Team. The Review Team on the other hand cannot confirm Dr 3 read the report. Secretary 2 has advised the Review Team that in incidents like this one whereby an urgent report is emailed, the secretary would print off the report and leave in the consultant's office for follow up. The Review Team therefore can neither confirm or rule out Dr 3 received the email or a paper copy of the actual report.

The Review Team acknowledge the Trust has an escalation policy for urgent/ significant or unexpected findings and although the Radiology Department did notify the referring consultant (Dr 3) that same day, the Radiology Department did not escalate Patient 92 's CT report to the Cancer Tracker Team as per Trust policy. The Review Team note this was a missed opportunity for follow up of Patient 92 's urgent CT report. The Review Team concluded had Dr 3 acknowledged and responded to the email from the Radiology Department and had the Radiology department escalated the result to the Cancer Tracker Team Patient 92 would have received treatment for her cancer at an earlier stage.

The Review Team are aware the Trust has no formal process for tracking letters or emails to ensure they have been received, acknowledged, reviewed or actioned. Although the Radiology Team communicated the CT findings to Dr 3 and the 2 secretaries there was no follow up from the Radiology Department to ensure the correspondence was actually received and actioned. The Review Team recognises consultants receive numerous emails each day and this in itself presents difficulty in identifying priority correspondence. The Review Team therefore conclude the SHSCT should consider updating its current policy to ensure all correspondence relating to urgent/ significant findings are received and actioned by recipients. The Review Team also contemplate consultant secretaries should ensure the consultant has received any paper correspondence left out for them, especially when it is an urgent report needing immediate action.

Current practice regarding tests results is that the clinician who orders the test is responsible for reviewing, following up and signing off the result even if the patient is discharged. The Review Team recognise the SHSCT does not have a single formal process for following up of test results and electronic sign off and therefore conclude the SHSCT should consider developing a system and process that will enable referring consultants to manage requested test results electronically. The system should report back to the referring clinician, highlighting any urgent results and offer options for follow up and electronic sign off. The system should be capable of providing assurance that results are viewed and actioned.

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

The Review Team acknowledges Patient 92 attended CAH ED hospital on the 10 July 2018 and was reviewed by Dr 4. Patient 92 was treated for a urinary tract infection (UTI) and discharged home with antibiotics and referred back to her GP. It was only when Patient 92 attended her GP a few days later with the same complaint, was the missed CT scan report identified and appropriate action was taken by the GP via red flag referral for follow up.

The Review Team conclude there were a number of failings in the Trust's systems and processes which ultimately lead to a delay in diagnosis and treatment and care of Patient 92's cancer. Exacerbated waiting lists, no single formal processes for following up test results, and no formal process for tracking letters or emails were undoubtedly contributing factors. The review team concluded that treatment and care was appropriate following Patient 92's new GP referral on the 17 July 2018 which highlighted Patient 92's overlooked CT report.

14. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

The report will be shared with all staff involved in Patient 92's treatment and care for reflection and learning.

15. RECOMMENDATIONS (please state by whom and timescale)

1. The SHSCT to review its current processes of communicating, recording and signing off suspected cancer diagnosis to patient's consultants. The Trust is to consider a system in which results can be communicated to referring clinicians and electronically signed off by the referring consultant.

2. The Radiology Department is to review their procedure for 'Reporting & Communicating of Critical, Urgent & Significant Unexpected Radiological Findings' to include guidance to outline the processes required to ensure all correspondence is appropriately received and acknowledged.

3. The Review Team acknowledges Urology waiting lists are extensive and this was a contributing factor in this incident. The Review Team therefore advises the Trust to consider implementing a management plan to reduce Urology waiting times.

4. The SHSCT needs to cautiously review and update its current practice for tracking clinical correspondence.

16. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

17. FURTHER REVIEW REQUIRED? NO

Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

From: Trouton, Heather

Sent: 25 July 2011 15:07

To: Reid, Trudy; Devlin, Louise; Corrigan, Martina

Cc: Mackle, Eamon; Brown, Robin; Sloan, Samantha

Subject: Results

Dear All

I know I have addressed this verbally with you a few months ago , but just to be sure can you please check with your consultants that investigations which are requested, that the results are reviewed as soon as the result is available and that one does not wait until the review appointment to look at them.

Thank you

To: Corrigan, Martina
Subject: Re: Results and Reports of Investigations

Martina,

I write in response to email informing us that there is an expectation that investigative results and reports to be reviewed as soon as they become available, and that one does not wait until patients' review appointments. I presume that this relates to outpatients, and arises as a consequence of patients not being reviewed when intended. I am concerned for several reasons:
• Is the consultant to review all results and reports relating to patients under his / her care, irrespective of who requested the investigation(s), or only those requested by the consultant?
• Are all results or reports to be reviewed, irrespective of their normality or abnormality?
• Are they results or reports to be presented to the reviewer in paper or digital form?
• Who is responsible for presentation of results and reports for review?
• Will reports and results be presented with patients' charts for review?
• How much time will the exercise of presentation take?
• Are there other resource implications to presentation of results and reports for review?
• Is the consultant to report / communicate / inform following review of results and reports?
• What actions are to be taken in cases of abnormality?
• How much time will review take?
• Are there legal implications to this proposed action?
I believe that all of these issues need to be addressed,

Aidan.

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

Please see below for your information and action

From: Rankin, Gillian <[redacted]>
Sent: 26 August 2011 16:37
To: Stinson, Emma M
Subject: FW: Results and Reports of Investigations

From: Mackle, Eamon
Sent: Friday, August 26, 2011 4:36:40 PM
To: Rankin, Gillian
Cc: Corrigan, Martina
Subject: FW: Results and Reports of Investigations Auto forwarded by a Rule

Gillian

I have been forwarded this email by Martina and I think it raises a Governance issue as to what happen to the results of tests performed on Aidan's patients. It appears that at present he does not review the results until the patient appears back in OPD.

Eamon

From: Corrigan, Martina
Sent: 25 August 2011 16:22
To: Mackle, Eamon
Cc: Trouton, Heather
Subject: FW: Results and Reports of Investigations

Eamon,

I will need assistance when replying to this email.

Thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: [redacted] (Direct Dial)
Mobile: [redacted]
Email: martina.corrigan[redacted]

From: aidanpobrien[redacted]
Sent: 25 August 2011 15:37

anaesthetist that Patient 90 did not attend his appointment.

The review team concluded that even if Patient 90 had been able to attend this appointment, it was not a timely referral to pre-operative assessment. The referral did not give sufficient time to appropriately pre-operatively assess and optimise Patient 90 for surgery considering his significant comorbidities.

14. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

15. RECOMMENDATIONS (please state by whom and timescale)

Recommendation 1

The Trust should develop and implement guidance for clinical result sign off
Monthly audit of sign off will be presented to the Governance Forums

Recommendation 2

All patients undergoing elective surgery must have a formal pre-operative assessment completed prior to surgery, including liaison with other specialties to ensure maximal optimization of patients prior to procedure. The Trust will update the pre-operative guidance to recommend appropriately timely referral times and escalation of non-attendance.
Audit of surgical patient pre-operative assessment should be undertaken and be presented to the Governance Forums

Recommendation 3

Discussions regarding the risks and benefits of surgery must be clearly documented in the patient record and reflected on the patient consent form, to ensure patients are able to make informed consent.
Audit of surgical patient consent should be undertaken and be presented to the Governance Forums

Recommendation 4

Blood loss during procedure should be escalated during and at the end of the procedure, the blood loss must be recorded on the operation note.
Blood loss post operatively must be escalated to the surgical and anaesthetic teams.
Monthly audits will be conducted and result presented to the Governance Forums

Recommendation 5

VTE risk assessment must be completed for all patients prior to surgical intervention.
Monthly audit of VTE risk assessment in the patient record/medicine prescription and administration record and WHO surgical safety check list blood loss section will be presented to the Governance Forum

16. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

17. FURTHER REVIEW REQUIRED? YES / NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

The purpose of, the reason for, the decision to review a patient is indeed to review the patient.
The patient may indeed have had an investigation requested, to be carried out in the interim, and to be available at the time of review of the patient.
The investigation may be of varied significance to the review of the patient, but it is still the clinician's decision to review the patient.
One would almost think from the content of the process that you have sought to clarify, that normality of the investigation would negate the need to review the patient, or the clinician's desire or need to do so.
One could also conclude that if no investigation is requested, then perhaps only those patients are to be placed on a waiting list for review as requested, or are those patients not to be reviewed at all?

Secondly, if all patients who have had an investigation requested are not to be placed on a waiting list for review, as requested, until the requesting clinician has viewed the results and reports of all of these investigations, when do you anticipate that they will have the time to do so?
Have you quantified the time required and ensured that measures have been taken to have it provided?

Thirdly, you relate that it is by ensuring that the results are 'seen' by the consultant that patients will not be missed.
I would counter that it is by ensuring that the patient is provided with a review appointment at the time requested by the clinician that the patient will not be missed.

Perhaps, one example will suffice.
The last patient on whom I operated today is a Personal Information redacted by the old lady who has been known for some years to have partial duplication of both upper urinary tracts.
She has significantly reduced function provided by her left kidney.
She also has left ureteric reflux.
However, she also has had an enlarging stone located in a diverticulum arising by way of a narrow infundibulum from the upper moiety of her right kidney.
She has been suffering from intermittent right loin and flank pain, as well as left flank pain when she has a urinary infection.
Today, I have managed to virtually completely clear stone from the diverticulum after the second session of laser infundibulotomy and lithotripsy.
She is scheduled for Personal Information redacted by the USI tomorrow.
I planned to have a CT scan repeated in May and to review her in June.
The purpose of reviewing her is to determine whether her surgical intervention has relieved her of her pain, reduced the incidence of infection, and as a consequence, reduced the frequency and severity of her left flank pain.
Review of the CT images at the time of the patient's review will inform her review.
It will evidently not replace it.

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

Corrigan, Martina

From: Haynes, Mark <[redacted]>
Sent: 07 February 2019 06:25
To: OKane, Maria
Subject: FW: Patients awaiting results

Morning Maria

See below email regarding results from my colleague and my response FYI.

Mark

From: Haynes, Mark
Sent: 07 February 2019 06:24
To: O'Brien, Aidan; McCaul, Collette; Robinson, Katherine
Cc: Young, Michael; Glackin, Anthony; ODonoghue, JohnP; 'derek.hennessey[redacted]; Corrigan, Martina
Subject: RE: Patients awaiting results

Morning

The process below is not a urology process but a trust wide process. It is intended, in light of the reality that patients in many specialities do not get a review OP at the time intended (and can in many cases take place years after the intent), to ensure that scans are reviewed and in particular unanticipated findings actioned. Without this process there is a risk that patients may await review without a result being looked at. There have been cases (not urology) of patients imaging not being actioned and resultant delay in management of significant pathologies. As stated this is a trust wide governance process that is intended to ensure there are no unactioned significant findings. There is no risk in the process described.

If the patient described has their scan in May, the report will be available to you and can be signed off and the patient planned for review in June, there is no delay to the patients care. The DARO list is reviewed regularly by the secretarial team and would pick up if the scan has been done but you hadn't received the report, if the scan hasn't been done etc.

It may be ideal that such a patient described would be placed on both the DARO list and a review OP WL but PAS does not allow for this.

I have no issue (as a clinician or as AMD) with the process described as it does not risk a patient not being seen and acts as a safety net for their test results being seen.

Mark

From: O'Brien, Aidan
Sent: 06 February 2019 23:33
To: McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; 'derek.hennessey[redacted]'; Corrigan, Martina
Subject: FW: Patients awaiting results
Importance: High

Dear Ms. McCaul,

I have been greatly concerned, indeed alarmed, to have learned of this directive which has been shared with me, out of similar concern.

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

To: O'Brien, Aidan
Cc: Connolly, Connie
Subject: RE: SAI Reports
Importance: High

Dear Mr O'Brien

I have forwarded your response to the Corporate Office and I have been advised that [redacted] Patient 16 's report is to be reviewed by the end of today 30 October 2019, as the Trust is committed to having the report with the family in the immediate future.

Can you please review the 2nd report which you received by Wednesday 2nd November 2019.

Regards

Carly

From: O'Brien, Aidan
Sent: 29 October 2019 07:39
To: Connolly, Carly
Subject: RE: SAI Reports

Dear Carly,

I received your email yesterday evening.
I have not had time to read the attached reports in detail.
I have incompletely read one, finding a number of factual inaccuracies and untruths.

The main purpose of replying to you so early this morning is to enquire if you genuinely intended to request a response by tomorrow?
If so, why?

Thank you,

Aidan.

From: Connolly, Carly
Sent: 28 October 2019 15:58
To: O'Brien, Aidan
Cc: Connolly, Connie; Cardwell, David
Subject: SAI Reports
Importance: High

Dear Mr O'Brien

I attach for your attention a copy of the SAI reports into the care of [redacted] Patient 16 , [redacted] Patient 11 , [redacted] Patient 12 , [redacted] Patient 13 , [redacted] Patient 14 and [redacted] Patient 15 . As you were involved in these cases I would be grateful if you could read over the reports and confirm their factual accuracy. If you identify any inaccuracies I would be grateful if you would please report these back to me by Wednesday 30/10/2019.

Can you please confirm receipt of this email.

Many Thanks

Witness Statement

NAME OF WITNESS	**Mr Mark Haynes**
OCCUPATION	Consultant Urologist
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Wednesday 24 May 2017
PRESENT AT INTERVIEW	Mrs Siobhan Hynds, Head of Employee Relations
NOTES	The terms of reference were shared prior to the date of statement.

1. My name is Mr Mary Haynes. I am employed by the Southern Health and Social Care Trust as a Consultant Urologist. I was appointed in May 2014 as a Consultant within the Southern Trust having previously worked as a Consultant in Sheffield since April 2010.

2. I have been asked to provide this witness statement in respect of an investigation into concerns about the behaviour and / or clinical practice of Mr Aidan O'Brien, Consultant Urologist being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework.

3. I agreed to answer questions specifically related to the terms of reference previously shared with me.

4. I explained that each Consultant takes all GP referrals to the urology service for a week at a time when they are the Consultant of the Week. Additional referrals can come in for named Consultants but these don't necessarily go through the Referral and Booking Centre and wlll go directly to Consultants. The number of these type of referrals vary.

5. I was initially unaware of any un-triaged referrals. There were long waiting lists and lots of red flags were seen. It became apparent to me as routine referrals came through to be seen that they hadn't been triaged. Patients were booked onto waiting lists irrespective of not being triaged so it wasn't immediately apparent that triage was not being done. It did become apparent however when patient's came to clinics but that could be 70 weeks later because of the waiting list.

6. I know we all work at different speeds and Mr O'Brien works differently to me. I was aware he was not getting through triage like I was but I was not aware that he hadn't gotten through any of it.

7. The bulk of referrals are routine. I think it is good practice to do triage within 24 hours of receipt of the referral but the reality is that the routine waiting list is 70 weeks so a routine patient isn't going to be seen anyway even if triage is done within 24 hours. I became aware of issues about Mr O'Brien's triage when on occasions GPs sent in a second letter and they were then being triaged by someone different..

8. I recall one specific issue – I always go through my patient lists before a clinic and I looked at this particular clinic and a patient was referred for a renal cyst. It became apparent to me that there was a radiology mistake. The patient referral suggested a benign renal cyst and an MRI was recommended. On looking at the report, it said that the lower pole renal cyst was benign but there was no mention of a mid pole cyst. The abnormal cyst was not commented on and because benign cysts would normally be discharged without being seen by urologists, the patient would not have been seen. The patient wasn't triaged and was put on a routine waiting list.

9. Had I received the referral I would have picked it up. I can't say if everyone would have picked it up. There was an opportunity to pick up the issue with the radiology discrepancy but because triage wasn't done it wasn't picked up.

10. I think triage is a nonsense. I don't know why secondary care take responsibility for re-categorising primary care assessment. It is a GP issue. I don't think we should be checking the GP got it right. It takes an inordinate amount of Consultant time. There are generally between 10 to 20 upgraded per week. In the main doing triage is fine. I am not talking about advance triage just checking the GP referral.

11. I am aware that there have been un-triaged referrals because of the SAI process. We were probably all aware of seeing the odd untriaged referral but when they are being seen by 6 different people, seeing the odd one didn't seem like that much. It turns out we were all getting them, so it wasn't just the odd one.

12. Before I met with Patient 10 in the clinic I got the MRI re-reported and I explained to the patient that there as a misreported scan. I was very open and honest with the patient. A CT scan was done which showed an enlarged lymph node. The patient was diagnosed and treated for breast cancer secondaries and then also kidney cancer. I completed an IT1 form because of this case and as a result the SAI process happened. It was Chaired by Mr Glackin.

13. Because we take responsibility for triage there was potential for harm for all patients not triaged.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. It was known that Mr O'Brien stored notes at home by a range of staff within the Directorate.

Undictated clinics

1. Mr O'Brien's secretary did not flag that dictation was not coming back to her from clinics. Mr O'Brien's secretary was of the view that this was a known practice to managers within the Directorate.

2. Mr O'Brien indicated that he did not see the value of dictating after each care contact.

3. Mr O'Brien was not using digital dictation during the relevant period and therefore the extent of the problem was not evident.

5.0 Case Manager Determination

My determination about the appropriate next steps following conclusion of the formal MHPS investigation:

- There is no evidence of concern about Mr O'Brien's clinical ability with patients.

- There are clear issues of concern about Mr O'Brien's way of working, his administrative processes and his management of his workload. The resulting impact has been potential harm to a large number of patients (783) and actual harm to at least 5 patients.

- Mr O'Brien's reflection on his practice throughout the investigation process was of concern to the Case Investigator and in particular in respect of the 5 patients diagnosed with cancer.

- As a senior member of staff within the Trust Mr O'Brien had a clear obligation to ensure managers within the Trust were fully and explicitly aware that he was not undertaking routine and urgent triage as was expected. Mr O'Brien did not adhere to the known and agreed Trust practices regarding triage and did not advise any manager of this fact.

- There has been significant impact on the Trust in terms of its ability to properly manage patients, manage waiting lists and the extensive look back

exercise which was required to address the deficiencies in Mr O'Brien's practice.

- Mr O'Brien did not adhere to the requirements of the GMC's Good Medical Practice specifically in terms of recording his work clearly and accurately, recording clinical events at the same time of occurrence or as soon as possible afterwards.

- Mr O'Brien has advantaged his own private patients over HSC patients on 9 known occasions.

- The issues of concern were known to some extent for some time by a range of managers and no proper action was taken to address and manage the concerns.

This determination is completed without the findings from the Trust's SAI process which is not yet complete.

Advice Sought

Before coming to a conclusion in this case, I discussed the investigation findings with the Trust's Chief Executive, the Director of Human Resources & Organisational Development and I also sought advice from Practitioner Performance Advice (formerly NCAS).

My determination:

1. No further action is needed

Given the findings of the formal investigation, this is not an appropriate outcome.

2. Restrictions on practice or exclusion from work should be considered

There are 2 elements of this option to be considered:

a. A restriction on practice

At the outset of the formal investigation process, Mr O'Brien returned to work following a period of immediate exclusion working to an agreed action plan from

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

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

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

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

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

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

6.0 Final Conclusions / Recommendations

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

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

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

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

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

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

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

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

b. An exclusion from work

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

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

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

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

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

Southern Health and Social Care Trust

Quality Care - for you, with you

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

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

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

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

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

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

CONCERN 1

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

Mr O'Brien, when Urologist of the week (once every 6 weeks), must action and triage all referrals for which he is responsible, this will include letters received via the booking

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

Red Flag referrals must be completed daily.

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

CONCERN 2

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

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

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

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

CONCERN 3

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

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

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

CONCERN 4

- A review of Mr O'Brien's TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients are significantly less than for other patients.

Mr O'Brien must adhere to all aspects of the Trust Private Practice Policy, ' A Guide to Paying Patients' and in particular to 'Referral of Private Patients to NHS Lists which states that '*any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status: patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients'.*

The scheduling of patient's must be undertaken by the secretary, who will check the list with Mr O'Brien and then contact the patient for their appointment. This process is in keeping with the practice established within the Urology team.

Any deviation from compliance with this action plane must be referred to the MHPS Case Manager immediately.

Corrigan, Martina

From: Haynes, Mark <[redacted]>
Sent: 17 June 2017 07:05
To: Evans, Marie; Corrigan, Martina; Robinson, Katherine
Subject: RE: CLINICAL CORRESPONDANCE BACKLOG REPORT - MAY 17

Morning Marie / Martina / Katherine

Thanks for continuing to send this round, it is useful to have a clear picture of the pressures on our admin and clerical team. One minor point relates to the clinics to be dictated / clinics to be typed columns – I assume these should read clinic letters to be dictate / clinic letters to be typed?

However, I am concerned regarding the robustness of this data, particularly in relation to 'results to be dictated'.

Could you advise me of the process whereby this data is collected? From recent experiences I would suggest that the data presented in this column is inaccurate. My concern relates to how this information would be used in the event of a significant issue arising due to a delayed / not acted on result – corporately are we kidding ourselves that all results are acted on / dictated on in a timely manner? That is the conclusion you could draw from the information, particularly in relation to some consultants. If a backlog were identified after an issue were to arise, are the staff who collect the data (I presume our secretaries) liable to be found culpable for not highlighting the backlog through this process? One could argue that the information presented whereby some consultants seem to barely ever have any results to dictate is not untrue – not all of us dictate letters on results! An illustration of the inaccuracy of the data may be seen in last years data in relation to number of clinics to be dictated, which has been proven to be inaccurate.

As stated, I think collection of this information is important and I would like it to continue to be circulated to us but would like to ensure that the data collected is robust. I am happy to be involved in any discussion required.

Thanks

Mark

From: Evans, Marie
Sent: 30 May 2017 11:20
To: Young, Michael; O'Brien, Aidan; Jacob, Thomas; Haynes, Mark; Glackin, Anthony; ODonoghue, JohnP
Cc: Carroll, Ronan; Clayton, Wendy; Corrigan, Martina; Robinson, Katherine
Subject: CLINICAL CORRESPONDANCE BACKLOG REPORT - MAY 17

Dear all

Please find attached the backlog reports for May 17.

Any queries let me know.

Kind Regards
Marie

Marie Evans
Service Administrator
Ground Floor
Ramone Building
CAH

Corrigan, Martina

From: Corrigan, Martina
Sent: 23 January 2018 13:19
To: Haynes, Mark
Subject: RE: UROLOGY

Agrrrrrr!!

Martina

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

INTERNAL: EXT Personal Information redacted by the USI
EXTERNAL : Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

From: Haynes, Mark
Sent: 23 January 2018 12:13
To: Corrigan, Martina
Subject: FW: UROLOGY
Importance: High

I did 3 or 4 from 18th yesterday.

Do you need to have a word?

Mark

From: Graham, Vicki
Sent: 23 January 2018 11:41
To: Young, Michael; Haynes, Mark; Glackin, Anthony; O'Brien, Aidan; ODonoghue, JohnP; Jacob, Thomas
Subject: FW: UROLOGY
Importance: High

Hi,

The red flag appointment team have brought to my attention that there are 7 referrals dating back from 18.01.18 that need to be e-Triaged. Would it be possible to get these triaged today at some point?

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Red Flag Appointment Office
Tel. No. Personal Information redacted by the USI
Internal Ext: Personal Information redacted by the USI *Note: if dialling from the old system please dial* Personal Information redacted by *in front of the extension)*

Corrigan, Martina

From: Haynes, Mark
Sent: 01 February 2018 13:15
To: Carroll, Ronan
Subject: FW: UROLOGY

Importance: High

From: Graham, Vicki
Sent: 23 January 2018 11:41
To: Young, Michael; Haynes, Mark; Glackin, Anthony; O'Brien, Aidan; ODonoghue, JohnP; Jacob, Thomas
Subject: FW: UROLOGY
Importance: High

Hi,

The red flag appointment team have brought to my attention that there are 7 referrals dating back from 18.01.18 that need to be e-Triaged. Would it be possible to get these triaged today at some point?

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Red Flag Appointment Office
Tel. No. Personal Information redacted by the USI
Internal Ext: Personal Information redacted by the USI *Note: if dialling from the old system please dial* Personal Information redacted by *in front of the extension)*

From: rf.appointment
Sent: 23 January 2018 11:32
To: Graham, Vicki
Subject: UROLOGY
Importance: High

Hey Vicki,

There are 7 referrals on E-triage awaiting triage from 18/01/18 and 19/01/18.
Can these be escalated.

Best

Sinéad Catherine Joanne Langley
Higher Clerical OfficerHR Assistant

✉ Southern Health & Social Care Trust

Corrigan, Martina

From: Graham, Vicki <[redacted]>
Sent: 12 October 2018 09:53
To: ODonoghue, JohnP; Young, Michael; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; Jacob, Thomas
Subject: FW: REFS FOR TRIAGE

Importance: High

Hi

I have been advised that there a quite a few Red Flag urology referrals on NIECR to be triaged, dating back to 4th October (36 in total) . Could these please be triaged ? There are also 10 OC referrals round in the Thorndale unit that also need to be triaged.

Many thanks

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC
EXT [redacted]

Davis, Anita

From: Carroll, Ronan
Sent: 15 December 2021 23:19
To: Davis, Anita
Subject: FW: Return to Work Action Plan February 2017 FINAL.

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Section 21

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

From: Carroll, Ronan [Personal Information redacted by the USI]
Sent: 18 October 2018 21:23
To: Haynes, Mark
Subject: RE: Return to Work Action Plan February 2017 FINAL.
Importance: High

Mark
The reality was Martina was tasked with monitoring the 4 elements of Aidan's work plan. She did this each Friday and there were no issues.
simply when Martina went off this was not pick up by anyone. I completely forgot about it. But yes MD and his office did not come asking for it either
Ronan

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

From: Haynes, Mark
Sent: 18 October 2018 20:00
To: Carroll, Ronan
Subject: RE: Return to Work Action Plan February 2017 FINAL.

According to Simon '…there were monitoring and supervision arrangements put in place, which we confirmed to a range of interested parties…'

I wasn't one of these interested parties, neither from Colin's email was he, or Michael from his. So if the clinical lead in the service, the CD and the AMD weren't, I'm not sure who was.

I can only assume, given the trusts previous failings in tackling behaviours in this case, the arrangements were robust, regularly monitored at multiple levels and had clear backstops for sickness etc so that it wasn't reliant upon only Martina??

Mark

From: Carroll, Ronan
Sent: 18 October 2018 12:39
To: Gibson, Simon; Weir, Colin; Khan, Ahmed; Haynes, Mark
Subject: RE: Return to Work Action Plan February 2017 FINAL.
Importance: High

Simon
I think you are stating the obvious.
With Martina having been off since June the overseeing function has not taken place and in the day to day activities was overlooked
But We need to understand why this the dictation has gone out, this could explain the volume of notes or there may be some other reason
Ronan

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

From: Gibson, Simon
Sent: 18 October 2018 12:31
To: Weir, Colin; Khan, Ahmed; Carroll, Ronan; Haynes, Mark
Subject: RE: Return to Work Action Plan February 2017 FINAL.

Dear Ronan

What is most concerning here is that there were monitoring and supervision arrangements put in place, which we confirmed to a range of interested parties.

If he has a backlog of clinic letters and discharges going back to June, have these arrangements fallen down?

Kind regards

Simon

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

From: Weir, Colin
Sent: 18 October 2018 11:33
To: Khan, Ahmed; Gibson, Simon; Carroll, Ronan; Clayton, Wendy; Haynes, Mark
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Ahmed/Simon

Please for your urgent consideration and action

See email correspondence below. Please see attached excel spreadsheet and go to Oct TAB or see below in email trail

Mr O'Brien has accumulated a large backlog of dictated letters and large numbers of charts in his office.

I am his Clinical Director

I have NOT seen the review and results and recommendations into his practice, but I am assuming he is in breach of this given these findings

Can you instruct me on how you would like to proceed.

I can certainly meet his with Ronan to discuss and record outcome from any meeting with him but I need to know if any sanctions need to be put in place if he has breached any of the review requirements or if your office wish to take this over?

Colin

From: Clayton, Wendy
Sent: 18 October 2018 11:07
To: Weir, Colin
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

From: Carroll, Ronan
Sent: 17 October 2018 15:52
To: Young, Michael; Haynes, Mark
Cc: Clayton, Wendy
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Michael/Mark
Please see update from Wendy

1. Dictation to be completed
2. Notes in office

Aidan needs spoken with and asked to address dictation asap & to return notes (possible notes are for dictation)
I am in CAH tomorrow pm

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

From: Clayton, Wendy
Sent: 17 October 2018 15:11
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Return to Work Action Plan February 2017 FINAL.

See below dictation report. There are approx 82 charts in the office on level 2. Do you need me to try and find out how long they have been there?

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to dictated
Mr Jakob					18	25.09.18	30
Mr Glackin	5	6	7	06/06/2018 (1 letter)	11	26.09.18	29
Mr Haynes	0	0	19	26.09.18	0		55
Mr O'Brien	17	0	91	15.06.18	0		
Mr O'Donoghue					15	26.09.18	12