Independent Inquiry into Mr Aidan O'Brien

WITNESS STATEMENT OF
COLIN FITZPATRICK

I, **COLIN FITZPATRICK**, will say as follows:-

1. I am a general medical practitioner. I qualified as a GP in 1992 and have practiced, mostly part time, since then. I have also worked in medical management since 1995, first as a medical adviser in the Eastern Health and Social Services Board and then in the South Eastern Health and Social Care Trust where I was Clinical Director of Primary Care until early 2021.

2. I joined the National Clinical Advice Authority (NCAA) as an adviser in 2004.

3. I have worked for NCAA/NCAS/the Practitioner Performance Advice Service as a part time senior adviser responsible primarily for the service in Northern Ireland.

4. I will be on a sabbatical from the Advice Service from February 2021 and am not expected to return until February 2022.

5. I make this statement in order to provide a summary of my involvement on behalf of NCAS/the Advice Service with the Southern HSC Trust regarding the management of Dr Aidan O'Brien, a Consultant Urologist. The statement has been prepared with reference to the case file and my own memory of events.

<u>NCAS/The Advice Service</u>

6. The Practitioner Performance Advice (formerly NCAA, then NCAS) was established in 2001 and is now a service delivered by NHS Resolution under the common purpose, to provide expertise to the NHS on resolving concerns fairly, share learning for improvement and preserve resources for patient care. It considers concerns about the performance of doctors, dentists and pharmacists. It became part of NHSLA in 2014 and in 2017 NHSLA became NHS Resolution. NHS Resolution is an arm's length body of the Department of Health and Social Care.

Statutory Independent Inquiry into the Urology Services in the Southern Health and Social Care Trust

SUPPLEMENTARY WITNESS STATEMENT OF COLIN FITZPATRICK

I, **COLIN FITZPATRICK** will say as follows:-

1. I make this supplemental statement in order to address some further wider topics raised by the Statutory Independent Inquiry into the Urology Services in the Southern Health and Social Care Trust (the Inquiry), since my witness statement of 22 March 2021. This statement has been prepared with reference to the case file, my earlier witness statement and my own knowledge of the operation of the NCAA/NCAS/ The Advisory Service/Practitioner Performance Advice.

2. Between February 2021 and December 2021, I was on a sabbatical from the Advice Service and worked as a General Practitioner (GP) in Australia. I left the Advice Service in January 2022 and since then I worked for six months as the Interim Deputy Medical Director at Betsi Cadwaladr University Health Board in Wales.

3. Since early July 2022, I have been working as a locum GP and Consultant for various organisations including Practitioner Performance Advice. I am due to re-locate to Personal Information redacted by the USI Personal Information redacted by the USI in November 2022 where I will work full-time as a GP.

Witness Statement dated 22 March 2021

4. My earlier witness statement remains factually correct other than the Practitioner Performance Advice (formerly NCAA, then NCAS) became part of NHSLA in 2013 (not 2014) which was an oversight.

Service Level Agreement

5. NHSLA/NHS Resolution have Service Level Agreements (SLAs) with Northern Ireland, Wales and the Channel Islands as they are outside the scope of the PPA's statutory remit which is primarily for England. The first] NCAS SLA with Northern Ireland

30. Applying the MHPS Framework to this case I consider that there may have been a missed opportunity to deal with capability at an early stage by better understanding the nature of the problem. It is clear that Dr Aiden O'Brien was suffering with workload issues but is not clear whether the concerns could be fully explained by this issue and whether the provision of additional administrative support would be a complete solution. It is not clear how the Trust assessed how his workload may have been putting patients at risk.

31. To me it appears that there was a lack of clarity surrounding what the primary concern was from the outset; as already set out earlier, there were communication gaps, and changes of personnel which may not have helped.

32. The MHPS Framework is, of course, only as good as its application. In my view the most important thing is that Trusts follow MHPS and do so in a proactive and timely way. It seems that in this case there was an emerging problem and MHPS would have been able to support approaching concerns in a sequenced way. MHPS enables an organisation to consider (and perhaps discount) health concerns and then to consider capacity concerns. The concerns about Dr O'Brien did perhaps gravitate towards clinical concerns. Ideally there might have been a greater opportunity to try and understand what the practitioner was facing, to diagnose the issues and to consider solutions. As it was over time an ever increasing number of patients were identified as being at risk of harm (over 700).

33. The MHPS framework overall probably needs updating and re-calibrating, however of greater importance is the implementation of the MHPS framework by the Trusts themselves.

Statement of Truth

I believe the facts stated in this witness statement are true

Signed [redacted]

Dated 6/7/2022

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 104 of 2022

Date of Notice: 5 October 2022

Supplementary Witness Statement of Colin Fitzpatrick

I, Colin Fitzpatrick will say as follows:-

1. I make this further supplemental statement in order to address some further issues highlighted by the Statutory Independent Inquiry into the Urology Services in the Southern Health and Social Care Trust (the Inquiry), since my witness statement of 6 July 2022. This statement has been prepared with reference to the case file, my earlier witness statement and my own knowledge of the operation of the NCAA/NCAS/ The Advisory Service/Practitioner Performance Advice.

2. I re-locate to [redacted] and commence full-time as a GP on 1 November 2022.

3. My earlier witness statements of 22 March 2021 and 6 July 2022 remain factually correct.

Anecdotal Concerns in relation to Dr O'Brien's Capability

4. At paragraph 8 of my Supplementary Witness Statement dated 6 July 2022, I refer to there being "*individuals who worked with Dr O'Brien who had concerns about his capability for a long time*". This anecdotal information surrounding Mr O'Brien's capability was received after he had ceased practise. The source was a (now) very senior doctor in Northern Ireland who had worked with Mr O'Brien as a trainee. The informal comments were made at a meeting about something entirely unrelated. I wish to emphasise that it was a casual conversation that took place around the time that there was media coverage regarding Dr O'Brien.

5. I did not take any action given that it was a passing comment and that Dr O'Brien was not in practice when the conversation took place. I believe that he had either already retired or had been suspended by the General Medical Council. I do not

Urology Services Inquiry

17. I am not aware of any other review of MHPS by the Department of Health or otherwise.

18. I am willing to give oral evidence at the Inquiry by video link from [redacted] assuming that adequate notice is given and a that convenient time can be agreed.

Statement of Truth

I believe t[redacted] in this witness statement are true.

Signed: _____

Date: 20 October 2022

7. The Advice Service provides a range of core services to NHS organisations and other bodies in England, Wales and Northern Ireland such as advice, assessment and intervention, training courses and other expert services.

8. The Advice Service is an independent advisory body. It does not have any statutory powers and as a result is unable to require any party to follow its advice or co-operate with its assessment functions. In respect of its advisory functions, all of the assistance that we provide is based upon information received from NHS bodies and other parties, such as the practitioner concerned.

9. As a result, the NCAS/The Advice Service is dependent on NHS bodies providing all of the relevant information about a case. We cannot and do not adjudicate upon any concerns about the resolution of performance concerns and decisions in relation to the ongoing employment or contractual status of a practitioner are matters for the NHS body to determine, although we are able to advise on the appropriate procedures which must be followed.

10. The role of an advisor is primarily to support NHS bodies in dealing with concerns about the performance of individual practitioners. The support is usually undertaken by an advisor discussing the relevant concern with an NHS body and then providing advice. In the first instance this process is usually undertaken by telephone. Any substantive discussion or advice is then summarised and confirmed in a letter from us to the NHS body or practitioner. Notes made during telephone calls are not retained once the letter has been prepared and sent. This is because the letter represents the agreed outcome of the call. It is possible that in a lengthy telephone call some additional matters may have been discussed but all relevant information is captured in the letter.

11. In advising NHS bodies on how they should deal with concerns about performance of individual practitioner, reference is made to the procedures set out in Maintaining High Professional Standards in the Modern NHS (MHPS). This document sets out the procedures for handling concerns about practitioners including those relating to conduct capability and health also contains specific guidance on how NHS bodies should investigate concerns and procedures they should follow when considering the exclusion of a practitioner.

The role and involvement of NCAS/the Advice Service

12. The first contact from Southern HSC Trust to NCAS was on was on 7 September 2016 when Dr Simon Gibson (Assistant Director) for the Southern Health and Social Care Trust contacted the service with concerns about a Consultant in Urology. The attendance note of that call records that there were *"concerns surrounding clinical practice and administration thereof. The RB is considering whether an external*

NHS
Litigation Authority

SERVICE LEVEL AGREEMENT (SLA)

BETWEEN:

THE DEPARTMENT OF HEALTH, NORTHERN IRELAND

AND

NHS LITIGATION AUTHORITY (NHS LA)

For the provision of specified NCAS services

This Agreement represents a Service Level Agreement ("SLA") between **THE DEPARTMENT OF HEALTH NORTHERN IRELAND** ("the Department") and **NHS LITIGATION AUTHORITY** (NHS LA)

The Agreement is made pursuant to section 28 of the Northern Ireland Act 1998

BACKGROUND:

The Department and NHS LA wish to enter into an arrangement under Section 28 of the Northern Ireland Act 1998 whereby NCAS, an operating division of NHS LA, will provide support to the Department and its Arm's Length Bodies (ALBs).

Subject to and in accordance with the terms of this agreement:

The members and staff of NHS LA will perform the functions set out in Schedule 1 as service to the Department to deal with practitioners whose performance gives cause for concern.

1. DEFINITIONS AND INTERPRETATIONS

1.1 In this Agreement (including the Background), the following terms shall, unless the context otherwise requires, have the following meanings:

"NCAS" means the National Clinical Assessment Service, an Operating Division of the NHS LA;

"the Department" means the Department of Health Northern Ireland;

"HSC" means the Health and Social Care Bodies as defined by Section 1(5) of the Health and Social Care (Reform) Act (NI) 2009;

"In writing" means documented, signed and sent by post or by electronic mail;

"Practitioners" means Doctors, Dentists and Pharmacists;

"Background IPR" means all Intellectual Property used in connection with the NHS LA Services.

1.2 References in this Agreement to numbered clauses are references to the clauses in the Agreement in which the reference bearing that number appears.

2. TERM

2.1 This Agreement shall come into force on the 1 April 2017 and remain in force for a period of 36 months unless terminated in accordance with clause 14 below.

2.2 This agreement will be reviewed at the end of each 12 month period during the term of this agreement for the period set out above at paragraph 2.1. or on an ad-hoc basis where deemed necessary by both parties.

3. FUNCTIONS OF NCAS

3.1 The Department, with a view to accessing the advice and support system for practitioners whose performance gives rise to concern, agrees that NHS LA will exercise the following NCAS functions as more specifically set out in Schedule 1 to this Agreement:

Schedule 2: Service Specification

1. Practitioners Covered

This Agreement covers all doctors, dentists and pharmacists for which the Client has responsibility, including those GPs on the Client GP Performers List.

2. Areas of Clinical Care Covered

- Primary care services
- Secondary care services
- Public Health
- Mental Health and Psychiatric Services

3. Contact/Request for advice

Contact/Request for advice and support to NCAS for any activity/service covered by this Agreement will be made by the Medical Director of the Client or the named designated representative at Schedule 3.

Telephone requests for advice and support directly from practitioners concerned about their own performance are acceptable but NCAS will to make theses callers aware that the relevant employing/contracting body will be informed of the conversation and that no more than telephone advice will be given without the formal involvement of their employing/contracting body.

4. Assessors

NCAS assessments will be carried out by existing members of the NCAS Assessor team. The employing/contracting body may nominate individuals who may be interested in being trained in NCAS assessment methods and, following successful selection and training, may carry out NCAS assessments elsewhere in the UK. All assessors will work within the NCAS assessment framework and guidelines for assessors devised by NCAS.

5. Quality and performance indicators

NCAS will aim to work to the highest standards of quality in all its activities; in particular; all work undertaken by NCAS under the terms of this agreement will be subject to NCAS' programme of evaluation and quality assurance.

6. Timescales

NCAS will undertake to respond to requests from the employing/contracting body in accordance with standard operating procedures. NCAS will complete all case assessments within a reasonable timeframe, taking account of the complexity of each individual case and the requirements outlined within this agreement and the associated service level agreement.

7. Services

Case Management Service

The purpose of the case management service is to provide expert support to local resolution of concerns about the performance of a practitioner. A contact or request for

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

27 July 2020

PRIVATE AND CONFIDENTIAL

Dr Aidan O'Brien
Personal Information redacted by USI

Ref: 18665 (Please quote in all correspondence)

Dear Dr O'Brien,

Thank you for speaking with me on the telephone on 16 July 2020. Your wife also participated in the discussion.

We had a long conversation in which you described the events which have occurred to you in recent years from your perspective. Grainne Lynn has summarised much of the story in her letter but there were a few points which I felt particularly relevant to me. In particular you told me that my initial advice given in September 2016 had not been shared with the decision-making group when they decided how to address issues which were raised at that time. I was disappointed to hear this.

You also pointed out that you had not been re-employed after retirement by the trust because of an ongoing process which had been delayed by the failure to hear your grievance. You pointed out that the human resources department were responsible for both the decision on your re-employment and the management of the grievance and disciplinary process. You told me that you would not have decided to take retirement had you known that you were not to be re-employed.

You and your wife met the very helpful suggestion that our organisation should have an early discussion with practitioners who have been referred to us. Whilst there are some practical difficulties with this I can see that it has benefits. In particular in your case, I suggested that had I spoken to you early in the process, I would probably have advised you to contact the MPS early. That may have been beneficial. I will discuss your suggestion with my colleagues at one of our regular meetings.

NCAS Performance Assessments

In a small proportion of cases NCAS will advise use of a performance assessment. In deciding whether to suggest assessment, NCAS will take into account the criteria set out in its Consideration of Assessment policy. In doing this, key considerations are whether the concerns about the practitioner's performance documented by the employing/contracting body are supported by existing evidence, are significant and/or repetitious but do not appear to be sufficiently serious to warrant an immediate referral to the regulator, and if the employing/contracting body appears to have taken steps to manage the case but has not been successful in clarifying the concern(s) and/or bringing them to a resolution. In these circumstances an NCAS performance assessment may clarify the nature of the concerns, identify the strengths and weaknesses of a practitioner's professional practice and help to identify a way forward.

The assessment process is designed to maintain a common threshold and fair treatment across different practitioner groups. Its validity and reliability is supported by wide sampling across a practitioner's scope of practice, using a range of assessment instruments. The assessment team agrees the sampling approach before the assessment, in discussion with an NCAS Assessment and Intervention Adviser. Sampling takes account of the practitioner's field of practice, and the concerns raised about the practitioner. Full performance assessments include an occupational health assessment, a behavioural assessment and multi-source feedback and is followed by a clinical visit conducted by NCAS trained assessors and a lay assessor.

Modular Assessments

Where a full performance assessment is not thought to be appropriate, NCAS is able to offer a range of other specialist interventions, options available include those listed as additional services in Schedule 1 of this agreement. The NCAS adviser will work with the employing/contracting body to ensure that these are tailored to the circumstances of the case.

Health Assessments

NCAS can provide, or can offer advice to referring bodies who may wish to commission their own, specialised occupational health assessment. NCAS will invoice the employing/contracting organisation, who be responsible costs in relation to these services. If Departmental funding is required by the employing/contracting organisation for these services, they must first submit a business case to the Department, highlighting why routinely available services or resources are not appropriate.

Behavioural Assessments

NCAS can offer an assessment on whether there are behavioural factors that are causing performance concerns and make recommendations for addressing issues identified.

Professional Support and Remediation services

NCAS can offer a wide range of bespoke action plans to support practitioners in their return to safe and effective practice. Action plans are developed following a review of the particular circumstances of each case, taking into account any development needs in areas such as leadership, patient or colleague interaction or other behavioural

The National Clinical Assessment Service

- helping resolve performance concerns

Colin Fitzpatrick

Lead NCAS Adviser (Northern Ireland)

National Clinical Assessment Service

NHS
National Clinical Assessment Service

Toal, Vivienne

From: Vivienne Toal [redacted]
Sent: 14 August 2010 10:36
To: Siobhan Hynds
Subject: MHPS HR Version VT August 2010
Attachments: MHPS HR Version VT August 2010.docx

Siobhan

Please see attached MHPS procedure.

When you are talking to Kieran can you ensure he is happy with role of Oversight Group in that they are endorsing the decision of the Clinical Manager as to action to be taken. In light of NCAS formal advice I think this is safe enough and they can have a sufficient challenge function.

Also will you check with him about copying it to LNC - just in case it gets off on wrong footing because they haven't been advised of the document and the roles that individuals will play.

There is definitely room for more cross referencing of the procedures to the MHPS framework and best practice guidance - will you have a look to see if more references can be entered?

Finally - will you read through to make sure I have not stated anything that is not correct i.e. goes against MHPS framework.

Sorry to dump this on you - but hopefully this gets the bulk of the text done.

Before sharing with Kieran - will you run it past Debbie, and then send to Kieran with copy to Anne and Debbie. Let Kieran send it on to Mairead and Debbie once he is happy with it.

Thanks

Vivienne

Terms of Reference

Terms of Reference are agreed by the case manager, issued to the case investigator, and should define the:

- Issues to be investigated
- Boundaries of the investigation
- Period under investigation
- Timescale for completion of investigation and submission of a report
- Issues which are not disputed

- The TOR document will reference information which has been provided by the case manager

NHS
National Clinical Assessment Service

NHS
National Patient Safety Agency
National Clinical Assessment Service

How to conduct a local performance investigation

3. Managing the investigation

The investigation starts once its terms of reference are finalised and when a case manager and investigator(s) have been appointed. Once the decision is taken to hold an investigation there should normally be discussion with the practitioner to secure as much engagement as possible. The practitioner should be made aware of the terms of reference and who the proposed case manager and investigator(s) are so that any objections can be raised.

The organisation can then:

- **finalise terms of reference;**
- **appoint a case manager;**
- **appoint case investigator(s).**

The investigator(s) will:

- **collect evidence;**
- **interview the practitioner;**
- **weigh the evidence and identify the facts of the case.**

3.1 Finalise terms of reference

These will have been agreed in outline at the time a decision was made to carry out the investigation, but some final drafting may be needed. The terms of reference as finally drafted should be agreed by the organisation's relevant decision-maker(s). The case manager and investigator(s) appointed to manage and carry out the investigation (see next sections) would not normally be involved in this process.

Terms of reference should be tight enough to prevent an unfocused general investigation of everything concerning the practitioner. It may be appropriate to specify areas not to be investigated as well as the areas where evidence and commentary are expected. Box 4 suggests a format.

Box 4 – Terms of reference for an investigation

An investigation is commissioned into the performance of [practitioner's name], working as a [practitioner's job title] for [organisation's name], at [workplace address].

The matters to be investigated are [ ].

The following matters are excluded from the investigation [ ].

It is expected that the investigation will be completed by [date] and that a report will be submitted to [named manager] by [date].

The report should detail the investigation's findings of fact and include a commentary on how the performance of [practitioner's name] compares with that expected from a practitioner working in similar circumstances.

Roberts, Naomi

From: Woods, Paddy
Sent: 24 November 2011 09:10
To: Colin Fitzpatrick
Cc: Lindsay, Jane
Subject: RE: Review of Maintaining High Professional Standards in NI

Colin

Thanks for this.

We will take account in revising documentation.

Regards

P

From: Colin Fitzpatrick [mailto:Personal Information redacted by USI]
Sent: 23 November 2011 07:49
To: Woods, Paddy
Subject: Review of Maintaining High Professional Standards in NI

Paddy,

Further to our recent discussion regarding your review of MHPS, we have a few comments to make.

First, we agree that MHPS would benefit from revision as experience since it was issued has identified a number of areas for improvement. However, we are concerned that awareness of the document and its provisions is not as widespread within HSC managers as we would have hoped. The experience of our advisors is that we frequently have to remind managers of the provisions and processes within MHPS.

A particular concern is the notification and review of exclusions as described in section II. We find that we are generally consulted before exclusion, although this may be after the trust has already made the decision. We are also concerned that regular reviews may not always occur, in particular the formal referral back to NCAS at the third review. I do not know whether the six month report to the Department occurs. It may be that we should have a discussion about how well this process is working.

Section IV, paragraph 7 would benefit from rewording, in particular the part relating to performance which is fundamentally flawed.

I should point out that we find the wording of Section IV, paragraph 2 to be an improvement on its English equivalent.

The description of NCAS and its services would also benefit from revision.

Finally, we feel that the word informal in the flow diagram on page 43 to be counterproductive. We have found that this encourages an overly relaxed attitude to process and could be replaced by another term such as preliminary.

Colin

Dr Colin Fitzpatrick,
Lead NCAS Advisor (Northern Ireland)

National Clinical Assessment Service (NCAS N I)
Office Suite 3
Lisburn Square House
10 Haslem's Lane

- clinical performance falling well short of recognized standards and clinical practice which, if repeated, would put patients seriously at risk;
- alternatively, or additionally, issues which are ongoing or recurrent.

13. A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the HPSS or private sector other than their main place of HPSS employment until the NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals. This can be found at www.ncaa.nhs.uk. See also circular HSS(TC8) 5/04.

14. Failure on the part of either the clinician or the employer to co-operate with a referral to the NCAS may be seen as evidence of a lack of willingness to resolve performance difficulties. If the practitioner chooses not to co-operate with such a referral, and an underlying health problem is not the reason, disciplinary action may be needed.

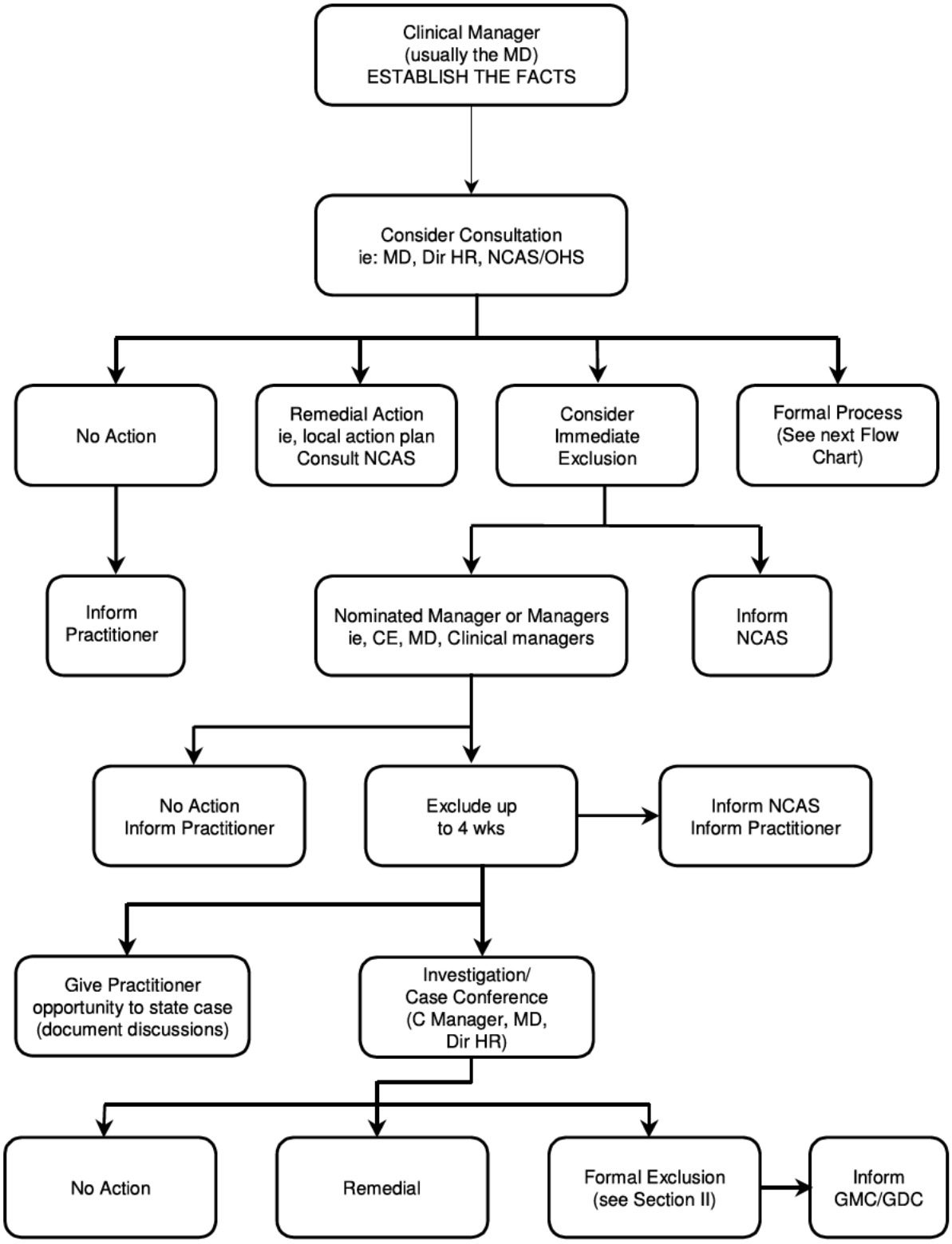
INFORMAL APPROACH

15. The first task of the clinical manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. As a first step, preliminary enquiries are essential to verify or refute the substance and accuracy of any concerns or complaints. In addition, it is necessary to decide whether an informal approach can address the problem, or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary.

16. The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone. Root cause analyses of individual adverse events frequently show that these are more broadly based and can be attributed to systems or organizational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions.

17. In cases relating primarily to the performance of a practitioner, consideration should be given to whether a local action plan to resolve the problem can be agreed with the practitioner. The NCAS can advise on the practicality of this approach. This may involve a performance assessment by the NCAS if considered appropriate – (Section IV paragraph 7 refers). If a workable remedy cannot be determined in this way, the Medical Director, in consultation with the clinical manager, should seek the agreement of the practitioner to refer the case to the NCAS for consideration of a detailed performance assessment.

INFORMAL PROCESS



IMMEDIATE EXCLUSION

18. When significant issues relating to performance are identified which may affect patient safety, the employer must urgently consider whether it is necessary to place temporary restrictions on an individual's practice. Examples of such restrictions might be to amend or restrict the practitioner's clinical duties, obtain relevant undertakings eg regarding practice elsewhere or provide for the temporary exclusion of the practitioner from the workplace.

19. An immediate time limited exclusion may be necessary

- to protect the interests of patients or other staff;
- where there has been a breakdown in relationships within a team which has the potential to significantly endanger patient care.

20. The NCAS must, where possible, be informed prior to the implementation of an immediate exclusion. Such exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis and to convene a case conference involving the clinical manager, the Medical Director and appropriate representation from Human Resources.

21. The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. These should include, where possible, the CE, Medical Director and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director. The number of managers involved should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. The clinical manager seeking an immediate exclusion must explain to the nominated manager why the exclusion is justified.

22. The clinical manager having obtained the authority to exclude must explain to the practitioner why the exclusion is justified (there may be no formal allegation at this stage), and agree a date up to a maximum of four weeks at which the practitioner should return to the workplace for a further meeting

23. Immediate exclusion should be limited to the shortest feasible time and in no case longer than 4 weeks. During this period the practitioner should be given the opportunity to state their case and propose alternatives to exclusion e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction. The clinical manager must advise the practitioner of their rights, including rights of representation.

24. All these discussions should be minuted, recorded and documented, and a copy given to the practitioner.

25. The 4 week exclusion period should allow sufficient time for initial investigation to determine a clear course of action, including the need for formal exclusion.

Timescale and decision

37. The Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days. The Case Manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the Case Investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.

38. The report should give the Case Manager sufficient information to make a decision on whether:

- no further action is needed;
- restrictions on practice or exclusion from work should be considered;
- there is a case of misconduct that should be put to a conduct panel;
- there are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer;
- there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS ;
- there are serious concerns that fall into the criteria for referral to the GMC or GDC;
- there are intractable problems and the matter should be put before a clinical performance panel.

CONFIDENTIALITY

39. Employers must maintain confidentiality at all times, and should be familiar with the guiding principles of the Data Protection Act. No press notice can be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. They may only confirm that an investigation or disciplinary hearing is underway.

40. Personal data released to the Case Investigator for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter.

TRANSITIONAL ARRANGEMENTS

41. On implementation of this framework, the new procedures must be followed, as far as is practical, for all existing cases taking into account the stage the case has reached.

SECTION III. GUIDANCE ON CONDUCT HEARINGS AND DISCIPLINARY PROCEDURES

INTRODUCTION

1. This section applies when the outcome of an investigation under Section I shows that there is a case of misconduct that must be put to a conduct panel (paragraph 38 of section 1). Misconduct covers both personal and professional misconduct as it can be difficult to distinguish between them. The key point is that all misconduct issues for doctors and dentists (as for all other staff groups) are matters for local employers and must be resolved locally. All misconduct issues should be dealt with under the employer's procedures covering other staff where conduct is in question.

2. It should be noted that if a case covers both misconduct and clinical performance issues it should usually be addressed through a clinical performance procedure (paragraph 5 of Section IV refers).

3. Where the investigation identifies issues of professional misconduct, the Case Investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional misconduct proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation. [6]

4. Employers are strongly advised to seek advice from NCAS in misconduct cases, particularly in cases of professional misconduct.

5. HSS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with joint appointment contracts.

CODES OF CONDUCT

6. Every HPSS employer will have a Code of Conduct or staff rules, which should set out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these rules are considered to be "misconduct". Misconduct can cover a very wide range of behaviour and can be classified in a number of ways, but it will generally fall into one of four distinct categories:

   - a refusal to comply with the requirements of the employer where these are shown to be reasonable;
   - an infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required of

[6] Employers are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg for doctors in a hospital trust the local negotiating committee

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 104 of 2022

Date of Notice: 5 October 2022

Supplementary Witness Statement of Colin Fitzpatrick

I, Colin Fitzpatrick will say as follows:-

1. I make this further supplemental (fourth) statement in order to address some further issues highlighted by the Statutory Independent Inquiry into the Urology Services in the Southern Health and Social Care Trust (the Inquiry), since my witness statement of 20 October 2022. This statement has been prepared with reference to the case file, my earlier witness statement and my own knowledge of the operation of the NCAA/NCAS/ The Advisory Service/ Practitioner Performance Advice.

2. My earlier witness statements of 22 March 2021, 6 July 2022 and 20 October 2022 remain factually correct.

3. I have been provided with copies of the following:

    a. an email addressed to me from Anne Brennan (on behalf of Paddy Loughran) dated 16 September 2010 timed 14:26;

    b. the programme for the Southern Health and Social Care Trust Medical Leadership Network training on Friday 24 September 2010;

    c. presentation slides entitled "Medical Leadership Network Handling Concerns Workshop" delivered at the training on 24 September 2010; and

    d. presentation slides entitled "*The National Clinical Assessment Service – helping resolve performance concerns*" (I previously produced this document at exhibit CF10 to my third witness statement dated 20 October 2022).

Urology Services Inquiry

4. My contribution to the training on 24 September 2010 was to describe the role and function of NCAS. I understand that the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance (**the 2010 Guidelines**) had already been written by then and was being presented to senior medical managers at the training day. I believe that I stayed on after my presentation for the part where fictitious case studies were discussed and I probably made comments on the case studies at that time.

5. If I had been asked to provide formal advice on the 2010 Guidelines I would have expected a formal request to comment on a draft or to be part of the group developing the guidance. I have no memory of either and cannot find any documentation to suggest that either happened.

6. If the trust has a record of advice at the time I would be willing to review this.

Statement of Truth

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

Signed: _____

10 December 2022

Date: _____

Chloe Williams

From: CST-C
Sent: 07 September 2016 10:57
To: Colin Fitzpatrick
Cc: CST-C
Subject: 18665 - new SHSCT case: Call-back details as discussed

Importance: High
Sensitivity: Confidential

Follow Up Flag: Follow up
Flag Status: Flagged

Categories: Jill, NEW CASES/CALL BACKS

Dear Colin

Please see below the advice brief for the above mentioned case. Please can you place a call as per the details below:

Referrer name	Dr Simon Gibson, Southern Health and Social Care Trust
Referrer contact number	Personal Information redacted by the USI
Referrer e-mail address	Personal Information redacted by the USI
Call arranged by	Jill Devenney
Call back date requested	Wednesday 7 September 2016
Call back time requested	Available anytime today
Summary of concerns	Concerns about a Consultant in Urology. There are concerns surrounding clinical practice and administration thereof. The RB is considering whether an external evaluation of the doctor's practice may be beneficial. There is reportedly a massive urology backlog; practitioner allegedly not triaging letters and potential late referrals to other departments.
Other notes or comments	Only skeleton details have been provided thus far. It would be helpful during the call-back if you could confirm the Practitioner's name and GMC number. I can then liaise with Dr Gibson to secure other key data in due course (if deemed appropriate following call).

I have assigned you to the case so you should be able to see everything on EKS.

Many thanks for picking up this call-back for me today.

BW

Jill

Jill Devenney | Case Officer, Unit C
National Clinical Assessment Service (NCAS)

Tel: Personal Information redacted by USI

National Clinical Assessment Service

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

Tel: 028 90 690 791

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

13 September 2016

PRIVATE AND CONFIDENTIAL
Sent by email only

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

NCAS ref: 18665 (Please quote in all correspondence)

Dear Mr Gibson

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

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

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

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

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

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

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

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

Issue four – Recording outcomes of consultations and inpatient discharges

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

Summary of concerns

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

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

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

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

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

Conclusion

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

commenced on 1 April 2017 (with a term of 36 months) and is produced at **[CF7].** The current SLA with Northern Ireland commenced on 1 April 2022 (again for a term of 36 months) and is produced at **[CF8].**

6. The SLA enabled to the Southern Health and Social Care Trust to contact NHSLA/ NHS Resolution in the same way that any English Trust could. Advice cases such as this were within the scope of the SLA and there were provisions that if other interventions were requested these could be paid for separately.

Involvement of NCAS/the Advice Service

7. I have taken the opportunity to review further my involvement with this case and comment on some distinct features with regards to both the Investigation by the Trust and the advice provided by PPA.

Prior concerns

8. It occurs to me that there were a number of missed opportunities by the Trust with Dr O' Brien's case. Initially when Simon Gibson telephoned me on 7 September 2016, I recall asking if there were wider concerns with regards to Dr O'Brien's capability and I was told that there were not. My observation is that Simon Gibson cannot have been fully informed at the time he contacted me because find it difficult to believe that there were not prior concerns about capability before this call took place. Anecdotally I understand there are individuals who worked with Dr O'Brien who had concerns about his capability for a long time. I do not have any documentary evidence that these concerns were ever raised formally.

9. I suspect that there had been issues prior to the Trust's contact with NCAS/the Advice Service. I do not know what the Trust was aware of prior to contacting NCAS/the Advice Service but it is possible that within the organisation there may have been concerns relating to Dr O'Brien's capability which ought to have been considered as part of a review. If there were no capability concerns, the matter might have been (and for a period was) viewed as potential disciplinary conduct matter. The process for progressing the case on this basis should have involved a focused and swift investigation. This did not happen. For example issues with regards to taking patients notes home should have been explored immediately upon senior personnel at the Trust becoming aware, strict instructions could have been given to remedy the issues and this did not happen.

10. Whilst I was given an indication of the seemingly disciplinary issues on the initial call in September 2016, I can see that there was then a substantial shift between the initial call and 28 December 2016 by which stage there was a more sizeable problem as by

that point a Serious Adverse Incident had been identified and there was concern about patient harm.

11. Once capability concerns were identified there needed to be a clear diagnosis of the issues and the scope of an investigation defined. That is a stage when the Trust might have taken some wider soundings to be clear it investigated the right issues.

12. Upon being informed of a Serious Adverse Incident and patient harm, I would expect a Medical Director, to carry out a soft investigation in relation to wider concerns around clinical capability, which would then inform the Terms of Reference of any subsequent investigation. This might be considered as another missed opportunity.

13. The categorisation of the initial concern can make a significant difference to how a case progresses, with the distinction between capacity (with options for assessment and remediation) and conduct (which can lead to a disciplinary). If Simon Gibson did not know about any clinical capability concerns in September 2016, that avenue under the MHPS Framework (detailed further below) effectively disappeared.

Failure to progress an effective investigation

14. Even when the case was thought to involve clinical issues and apparent patient harm, there was a failure to progress a timely effective investigation within the Trust. We sent three separate emails chasing progress to the Trust on 1 January, 1 March and 1 May 2017 which were not responded to and as a result the PPA case file was closed in August 2017.

15. The file closure following no response to chasing emails is standard practice. I recognise that this makes the assumption that the Trust is capable of managing the process, however it seems that very little was done in the gap between the call between Richard Wright and my (then) colleague, Grainne Lynn on 28 December 2016 (where patient harm was highlighted) and a call was received from Dr Khan on 17 September 2018.

16. Under the MHPS Framework the investigation should be undertaken within four weeks. The problem with this is that it is almost always unachievable, which results in people having lower expectations about a timely investigation. A much more realistic timetable would be 12 weeks, in order to undertake a proper exploration of all potential concerns.

17. I am familiar with the issue of an investigation getting underway and new concerns coming to light. We now train investigators to think carefully about how to deal with this and whether to modify their Terms of Reference or to start a separate investigation that need not delay or derail the first.

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

Lack of action plan

18. As discussed earlier, in order to formulate an action plan there needs to be a clear diagnosis of concerns. I am aware that the Trust put in place an action plan but it is not clear to me whether they had a sufficient understanding of the deficits in Dr O'Brien's practice to ensure that this was focused and appropriate.

19. As an organisation NCAS/the Advice Service can be asked to do a performance assessment and develop an action plan. We can develop action plans without doing our own assessment, as long as the Trust has done sufficient investigation to know what the real issues to be addressed are i.e. diagnosed the concerns.

20. At no point during this case did the Trust request the PPA to develop a Professional Support and Remediation (PSR) action plan. This is an extra service provided under the SLA. As shown at page 13 of the SLA produced a **[CF8],** *"the purpose of a PSR action plan is to provide the Practitioner with the opportunity to demonstrate (upon successful completion) that they are practising at the standard reasonably expected for the role they will be practicing. The PPA PSR service develops action plans for Practitioners who have been identified as needing support in order to return to safe and effective clinical practice. The reasons for practitioners needing support are wide ranging, and usually involve:*

    - *Remediation - following the identification of deficiencies in aspects of their clinical practice; and*

    - *Return to work / re-integration (following a period of absence from clinical practice)."*

21. Whilst a PSR action plan is a separate service (and additional cost) under the SLA, if I had been asked to review any action plan drafted by the Trust, I would have been more than willing.

22. I have never seen any action plan drafted or produced by the Trust. It is important to note that the PPA is an advisory service only, who can only act on instructions received. The service is not tasked with being proactive, that rests with the Trust. It would be a very different remit, and require different resources, if the PPA was expected to be more proactive.

23. Another unusual feature of this case is the number of Medical Directors or Interim Medical Directors were employed by the Trust and who therefore had responsibility for this case during the relatively short period 2016-2020. It is evident that this impacted both on the continuity of the handling of the case and a lack of communication

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

9 July 2020

PRIVATE AND CONFIDENTIAL

Dr Maria O'Kane
Medical Director
Southern Health and Social Care Trust
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Ref: 18665 (Please quote in all correspondence)

Dear Dr O'Kane,

Further to our telephone conversation of 7 July 2020, I am writing to summarise the issues and action-points we discussed for both of our records. My advice is based upon the information that you shared with me. Please let me know if you feel I have misunderstood the position in any way. Please note that our service is advisory only and responsibility for any management decision rests with employers.

We discussed a consultant in urology where previously we had discussed serious concerns from 2016 onwards which in summary appear to have been related to slowness in triaging patients, poor record keeping, information governance matters, patient case handling and private practice issues as set out in earlier correspondence. At the time the Trust were proposing to convene a disciplinary hearing but this appeared to have stalled pending a grievance raised by the practitioner and with no further update the case was closed in February this year. Since taking over as medical director you had reviewed his case and become concerned at his apparent lack of insight. In particular you were concerned about the interface of his health service and private practice. You had referred these concerns to the GMC.

The doctor has taken further grievance action against the trust. He had recently emailed his AMD complaining about difficulties in booking patients. Following this the AMD

Review date:

7 August 2020

We can review this case in August or earlier if you request.

If you have any further issues to discuss, or any difficulty with these arrangements, please contact Case Support on the line above.

I hope the process so far has been helpful to you.

Yours sincerely,

Dr Colin Fitzpatrick
Case Adviser
Practitioner Performance Advice

Chloe Williams

From: Maria Granata
Sent: 01 December 2020 10:17
To: Maria Granata
Subject: FW: Southern Trust Urologist - case 18665

From: Vicky Voller [redacted]
Sent: 30 October, 2020 9:15 AM
To: Padraig Doran [redacted]
Subject: FW: Southern Trust Urologist - case 18665

Hi – to be updated on your legal spreadsheet pls. Have you had the opportunity to discuss with [redacted] how this might get fed through to COG? V

Vicky Voller
Director of Advice and Appeals
[redacted] (PA)
0207 811 2600 (Advice Line)

NHS Resolution
2nd Floor, 151 Buckingham Palace Road, London, SW1W 9SZ

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resolution.nhs.uk

We have reviewed our assessment services to ensure that we continue to provide an effective service. If you would like to know more about our services, including the changes to our assessments, then please visit Advice or Assessment or contact us on 020 7811 2600 or advice@resolution.nhs.uk

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From: Colin Fitzpatrick [redacted]
Sent: 29 October 2020 11:47
To: Karen Wadman [redacted]; Vicky Voller [redacted]; Grainne Lynn [redacted]
Subject: Southern Trust Urologist - case 18665

Further update.

I spoke to the MD today. They are conducting an extensive review and will be recalling patients. It appears that local GPs were concerned about his practice but didn't report – similar to the neurology issue. The other similarity is extensive private practice and some of the index cases are private. However he did his private work from his house so there are no clinic records available – unlike neurology where MW practiced from a private hospital. The trust have informed GMC who will have to organise the investigation of the private patients as no-one else has jurisdiction.

Dr O'Kane is no longer the RO for this doctor and the GMC are taking his case forward, so I think that it is safe for us to close the case.

Colin

NHS Resolution

Case chronology cover sheet

Case reference	18665
Employing/ contracting organisation (ECO)	Southern HSC Trust
ECO case contacts (including titles)	Maria O'Kane, Medical Director
Chronology prepared by	Colin Fitzpatrick' Senior Adviser
Other staff who contributed information to the chronology (if applicable)	
Chronology prepared for	Practitioner Performance Advice Core Operational Group
Date prepared	27 July 2020

- Cases being referred to COG should also have the COG 'cases to note' cover note completed.
- This chronology should not contain any personal identifiable information relating to the practitioner.
- Practitioner Performance Advice staff should be named in full at first reference and then abbreviated.
- Third party organisations (for example, regulators, and royal colleges) should be named.
- The chronology should be confined to the facts (for example, what advice was given).
- The final chronology must be uploaded to EKS2 using this naming convention: *'Chronology [YYMMDD] [Case reference]'*

Reason for chronology [Tick the relevant box(es) and add explanation if 'other' is selected]	
☒	Significant concern
☐	Significant expression of dissatisfaction or formal complaint
☒	High-profile
☐	Subject of an inquiry or legal hearing
☐	Being managed outside usual procedures
☐	NHS Resolution Responsible Officer involved
☐	Risk that requires escalation
☐	Significant consequences and/or learning potential
☐	Other (please explain reason)

Case background

This case which relates to a consultant in urology was first referred in 2016. The initial concerns related to a backlog of 700 patients, very slow triage of referrals taking up to 18 weeks when the standard was 2 days, poor patient notes, delayed referral to oncology, removing patient notes and taking them home and not always returning them. The advice was to meet with the practitioner to agree a way forward and to relieve him of theatre duty to enable him to clear his backlog. It appears that the trust did not follow our advice initially. They commenced a formal investigation and decided to hold a hearing. The hearing was delayed because the practitioner lodged a grievance. The practitioner retired a few days ago and neither grievance process nor hearing was completed. He had been practicing unrestricted although an "action plan" was set in place in early 2017. This appears to have been a sort of remedial programme composed without our input.

A few days before his retirement, the MD called to say that a review of his cases had shown 46% of over 300 cases reviewed had issues with them. The practitioner disputes this. We have suggested further investigation and notifying DoH.

It is the scale of the issues which could attract publicity.

Practitioner Performance Advice current case status

Open

Practitioner's current status (if applicable)

Retired, not practicing

Narrative and Practitioner Performance Advice action (a chronological summary of the key issues,

	New referral - slow to triage referrals, takes charts home, poor record keeping.
07 September 2016	Advised meeting with doctor and audit of work
22 December 2016	Oversight committee in trust considers concerns and orders action plan to address
28 December 2016	Further call about SAI. Concerns about patient safety. Considering exclusion.
27 January 2017	Email to trust seeking update

between NCAS/the Advice Service and the Trust. It appears some of the gaps in communication were compounded by Dr O'Brien's extended sick leave.

Escalation

24. This case was only flagged by me for escalation on 7 July 2020 when I was told of the review of over 300 case files with a concern in 46%.

25. In fact MHPS only has one requirement to escalate (after 6 months suspension there has to be a notification to the Department). The Advice service, as I set out above, is reactive so if nothing happens at the Trust we would not currently escalate matters. MHPS does not require other notifications but I would suggest this is something that could be revised so that there were obligations to notify the GMC (via the RO and ELA speaking) and possibly to involve RQIA, if a Trust is not progressing an investigation and there are patient safety concerns.

26. It is not uncommon for these cases to become more complicated, for example in the event of a grievance and/or the practitioner taking sick leave. Such events can cause problems with the progression of an investigation. In this case both these events happened which contributed to delays and gaps in progression and communication. I think MHPS could perhaps give greater guidance to employers about dealing with these events so that cases are progressed and potential harm is mitigated.

Engagement with Dr O'Brien

27. As I mention in my first statement, I was directly contacted by Dr O'Brien and had long conversations both on his own and with his wife. Having direct contact with practitioners, can provide a useful additional source of information about the issues in a case and what is happening at a Trust. However as advisers it can also put us in a difficult, perhaps conflicting position advising two people who may be in dispute with one another. The Advice Service does not normally arrange for a different adviser to be involved if the practitioner is in touch directly. We do not put information barriers in place either.

28. Positive engagement with Dr Aiden O'Brien did mean that as an organisation, we were afforded a more rounded narrative of the issues.

Implementation and Application of the MHPS Framework

29. I have been asked to comment on the MHPS Framework. The MHPS framework in Northern Ireland is slightly different to the framework used in England. A comparison of the two frameworks was prepared by my colleague, Grainne Lynn in an email dated 16 December 2019 which I produce at **[CF9].**

Independent Inquiry into Mr Aidan O'Brien

WITNESS STATEMENT OF
GRAINNE LYNN

I, **GRAINNE LYNN**, will say as follows:-

1. I qualified in dentistry from Queen's University Belfast in 1983. In 1990 I obtained Fellowship of the Faculty of Dentistry from the Royal College of Surgeons in Ireland. Having worked in hospital, general practice, and community settings where I had been the clinical director, I was appointed part time to what was then called NCAS in 2005, and initially combined this with providing dental services to prisoners in Magilligan Prison in Northern Ireland, and working with the Health Service Executive in Donegal. I subsequently worked full time for NCAS (now the Practitioner Performance Advice Service), although in the past year have reduced my hours to work part time. Whilst working with PPA, I was awarded an LLM in employment law in 2010.

2. The Practitioner Performance Advice Service ("Advice Service") considers concerns about the performance of doctors, dentists and pharmacists and joined NHSLA in 2014. In 2017 NHSLA became NHS Resolution.

3. NHS Resolution is the operating name of NHSLA, and is an arm's length body of the Department of Health and Social Care.

4. Over the years I have worked for NCAS in a part time and full time capacity as one of its advisers, mainly covering Northern Ireland and England (with occasional work in Wales and Scotland).

5. I will retire from Advice Service on 07 January 2021.

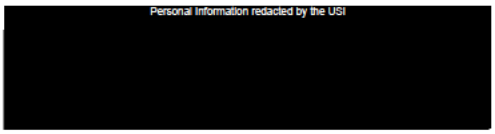
29. The matter was reopened when the Trust contacted the Advice Service in July 2020 and dealt with by both myself and my colleague Dr Colin Fitzpatrick. My involvement was limited to a brief call with Dr O'Brien on 15 July 2020 but he subsequently spoke at greater length to Dr Fitzpatrick.

30. From my perspective the case was not particularly unusual in terms of our involvement as the Advice Service. We provided advice particularly around safeguarding the situation for patients, and left the Trust to progress their investigation which we recognise can be complex and take time. I did note that the issue was considered by the Trust to be a conduct matter relating to breaching policies around files, and failures with reviews. It was my impression that prior to the most recent communications in 2020, the Trust essentially considered Dr O'Brien to be clinically competent– the letter of September 2018 refers specifically to "no evidence of concern about Dr O' Brien's clinical ability with individual patients". In 2018, the Trust had hoped to resolve the matter with conduct processes, but Dr O' Brien was unhappy to proceed on that basis. Dr O' Brien has made many representations to me and to Dr Fitzpatrick about workload issues being at the root of the problem, and has said that he is victimised for being a whistle blower.

Statement of Truth

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

Signed



Dated 23 December 2020

advice or support from an employing/contracting body will be passed to a member of the adviser team who will then make contact with the employing/contracting body at the agreed time. For the avoidance of doubt, the contact or request for advice will be formally logged as an NCAS case if it requires telephone advice followed up in writing, and in some circumstances supported with a facilitated meeting, and requires review until the case reaches a conclusion.

An NCAS Adviser will provide expert advice and support and will be responsible for directing the management of NCAS' input to the case. The level of support will depend on the nature of the case. The progresses of all active NCAS cases are reviewed at monthly meetings between the adviser and a senior colleague. NCAS' lead and senior advisers provide senior support and quality assurance for the work undertaken by the Adviser.

The method of support provided to employing/contracting bodies will include telephone advice, case conferences and detailed work with the employing/contracting body to ensure that best use is made of local governance procedures. Where specialist interventions are required from NCAS, the adviser will work with the employing/contracting body to ensure that these are tailored to the circumstances of the case.

It is not essential for the identity of a practitioner to be shared with NCAS as part of case management work, although NCAS prefers that this is done. Whether or not the identity of the practitioner is shared, local governance procedures will be required to be robustly able to assure patient safety and public protection, and this point will be addressed explicitly throughout the handling of the case.

The decision to close a case rests with the adviser with the exception of exclusion cases, which must remain open until the exclusion has been brought to an end. It is normally appropriate to close a case in circumstances where:

- The employing/contracting organisation has confirmed the case has been resolved
- Local action is likely to resolve the case and the employer/contractor has a clear plan how to achieve this
- There has been no active contact from the employer/contractor despite follow up requests for a period of 3 months (except where exclusion is involved or where there is felt to be particular risk in closing a case)
- The case is in the process of an intervention such as a behavioural impact agreement which does not require direct surveillance or a PSR plan which again does not require further NCAS monitoring or input unless we wish to do so for evaluation purposes
- The case is subject to external proceedings such as legal/GMC which is not likely to require further NCAS support

As a competent advisory body in this area of work, a key feature of NCAS' involvement is to bring constructive challenge to the local management of concerns and support the resolution of disputes between practitioners and their employing/contracting organisation. NCAS support may also include formal facilitation, assisted mediation or structured action planning. NCAS retains staff who are accredited mediators to provide our Assisted Mediation service.

6. I make this statement in order to provide a summary of my involvement on behalf of the Advice Service with the Southern HSC Trust in Belfast and the management of Dr Aidan O'Brien, a Consultant Urologist.

NCAS/The Advice Service

7. The Practitioner Performance Advice Service was established in 2001 and is now a service delivered by NHS Resolution under the common purpose, to provide expertise to the NHS on resolving concerns fairly, share learning for improvement and preserve resources for patient care.

8. The Advice Service provides a range of core services to NHS organisations and other bodies in England, Wales and Northern Ireland such as advice, assessment and intervention, training courses and other expert services.

9. The Advice Service is an independent advisory body. It does not have any statutory powers and as a result is unable to require any party to follow its advice or co-operate with its assessment functions. In respect of its advisory functions all of the assistance that we provide is based upon information received from NHS bodies and other parties, such as the practitioner concerned.

10. As a result the Advice Service is dependent on NHS bodies providing the relevant information about a case. We cannot and do not adjudicate upon any concerns about the resolution of performance concerns and decisions in relation to the ongoing employment or contractual status of a practitioner are matters for the NHS body to determine, although we are able to advise on the appropriate procedures which must be followed.

11. The role of an adviser is primarily to support NHS bodies in dealing with concerns about the performance of individual practitioners. The support is usually undertaken by an adviser discussing the relevant concern with an NHS body and then providing advice. In the first instance this process is usually undertaken by telephone. Any substantive discussion or advice is then summarised and confirmed in a letter to the NHS body or practitioner. Letters to an NHS body are not routinely copied to practitioners but we advise the NHS bodies to share with the practitioner unless this is deemed inappropriate. Notes made during telephone calls are not retained once the letter has been prepared and sent. This is because the letter represents the agreed outcome of the call. It is possible that in a lengthy telephone call some

representations from the practitioner about his or her exclusion or any representations about the investigation;

- Case Manager – this is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority;
- Case Investigator – this is the individual who will carry out the formal investigation and who is responsible for leading the investigation into any allegations or concerns, establishing the facts, and reporting the findings to the Case Manager. He / she is normally appointed by the CE after discussion with the Medical Director and Director of HR and should, where possible, be medically qualified;
- the Director of HR 's role will be to support the Chief Executive and the Medical Director.

INVOLVEMENT OF NCAS

9. At any stage in the handling of a case, consideration should be given to the involvement of the NCAS. The NCAS has developed a staged approach to the services it provides HSS Trusts and practitioners. This includes:
   - immediate telephone advice, available 24 hours;
   - advice, then detailed supported local case management;
   - advice, then detailed NCAS performance assessment;
   - support with implementation of recommendations arising from assessment.

10. Employers or practitioners are at liberty to make use of the services of NCAS at any point they see fit. However, where an employing body is considering exclusion or restriction from practice the NCAS must be notified, so that alternatives to exclusion can be considered. Procedures for immediate and formal exclusion are covered respectively in Sections I and II of this framework.

11. The first stage of the NCAS's involvement in a case is exploratory – an opportunity for local managers or practitioners to discuss the problem with an impartial outsider, to look afresh at a problem, and possibly recognize the problem as being more to do with work systems than a doctor's performance, or see a wider problem needing the involvement of an outside body other than the NCAS.

12. The focus of the NCAS's work on assessment is likely to involve performance difficulties which are serious and/or repetitive. That means:

IMMEDIATE EXCLUSION

18. When significant issues relating to performance are identified which may affect patient safety, the employer must urgently consider whether it is necessary to place temporary restrictions on an individual's practice. Examples of such restrictions might be to amend or restrict the practitioner's clinical duties, obtain relevant undertakings eg regarding practice elsewhere or provide for the temporary exclusion of the practitioner from the workplace.

19. An immediate time limited exclusion may be necessary

- to protect the interests of patients or other staff;
- where there has been a breakdown in relationships within a team which has the potential to significantly endanger patient care.

20. The NCAS must, where possible, be informed prior to the implementation of an immediate exclusion. Such exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis and to convene a case conference involving the clinical manager, the Medical Director and appropriate representation from Human Resources.

21. The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. These should include, where possible, the CE, Medical Director and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director. The number of managers involved should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. The clinical manager seeking an immediate exclusion must explain to the nominated manager why the exclusion is justified.

22. The clinical manager having obtained the authority to exclude must explain to the practitioner why the exclusion is justified (there may be no formal allegation at this stage), and agree a date up to a maximum of four weeks at which the practitioner should return to the workplace for a further meeting

23. Immediate exclusion should be limited to the shortest feasible time and in no case longer than 4 weeks. During this period the practitioner should be given the opportunity to state their case and propose alternatives to exclusion e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction. The clinical manager must advise the practitioner of their rights, including rights of representation.

24. All these discussions should be minuted, recorded and documented, and a copy given to the practitioner.

25. The 4 week exclusion period should allow sufficient time for initial investigation to determine a clear course of action, including the need for formal exclusion.

Chloe Williams

From: CST-C
Sent: 03 January 2017 12:34
To: CST-C
Subject: FW: New call advice brief NCAS 18665 (showing corrected case number - by CO JD)

Sensitivity: Confidential

Categories: Jill, UPLOADS no action

Advice brief resaved to show correct case number of 18665 (new case had been created in error as there was already an existing case on system) – Jill Devenney

---

From: CST-C
Sent: 28 December 2016 11:44
To: Grainne Lynn
Subject: New call advice brief NCAS Red 18665

Dear Grainne

Please see below the advice brief for the above mentioned case. Please can you place a call as per the details below:

Date call taken	28.12.2016
Time Taken	11:30
Case Number	18665
Organisation name	Southern Health and Social Care Trust
Referrer name	Dr Richard Wright
Referrer Landline	Personal Information redacted by USI
Referrer Mobile (if app)	Personal Information redacted by USI
Referrer e-mail address	Personal Information redacted by USI
Call requested by	RB: ☒ RB's PA:☐ Practitioner: ☐ HR:☐ Anonymous:☐
Call back date requested	28.12.12
Call back time requested	Any time today – in the next hour on landline, after that mobile.
Summary of concerns	Rb had a serious adverse event investigation that flagged up a problem with this dr's review of a patient with cancer, the patient came to some harm, due to the delay they may have come to more harm. The review has highlighted some issues with the dr's review system and lack of updating the system with patient notes, possibly taking the notes home and not retuning.
Linked cases	N/A
Assigned to	Grainne Lynn
Other notes or comments	n/a

Please let me know if you have any problems

Kind regards

Stephanie Grant | Case Officer

National Clinical Assessment Service

NCAS
NHS Litigation Authority
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SW1W 9SZ

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Email: casesupport@ncas.nhs.uk

29 December 2016

SENT VIA EMAIL ONLY

PRIVATE AND CONFIDENTIAL

Dr Richard Wright
Medical Director
Southern Health And Social Care Trust
68 Lurgan Road
Portadown
BT63 5QQ

NCAS ref: 18665 (Please quote in all correspondence)

Dear Dr Wright

Further to our telephone conversation on 28 December 2016, I am writing to summarise the issues which we discussed for both of our records. Please let me know if any of the information is incorrect.

In summary, this case which my colleague Dr Fitzpatrick had previously discussed with Mr Gibson, involves Dr 18665, a senior consultant urologist about whom there have been increasing performance concerns. The allegations are of poor record keeping, and slowness of triaging referrals and arranging reviews. Dr 18665 is also reported to have removed a very substantial numbers of charts from the Trust's premises without bringing them back; despite requests that these be returned many charts remain outstanding. Dr 18665's colleagues have, on occasions, seen patients for whom there have been no notes. Dr 18665 is currently on sick leave, but has indicated that he is returning to work in January 2017.

A recent Serious Adverse Incident (SAI) has caused concern that there is potential for patients to be harmed by the ongoing situation. You are awaiting the report of the SAI but on the information available to date, you feel the Trust will need to undertake a formal investigation of Dr 18665. The Trust is also considering exclusion.

As you are aware, the concerns about Dr 18665 should be managed in line with local policy and the guidance in Maintaining High Professional Standards in the Modern HPSS (MHPS). We discussed that as the information to date - no noted improvement despite the matter having been raised with Dr 18665 - suggests that an informal approach (as per paragraphs 15-17 of Section I of MHPS) is unlikely to resolve the situation, a more formal process is now warranted.

NHS
National Clinical Assessment Service

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Tel: 028 90 690 791

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

13 September 2016

PRIVATE AND CONFIDENTIAL
Sent by email only

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

NCAS ref: 18665 (Please quote in all correspondence)

Dear Mr Gibson

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

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

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

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

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

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

Issue two

An issue has been identified that there are notes directly tracked to Dr O'Brien on PAS, and a proportion of these notes may be at his home address. There is a concern that some of the patients seen in SWAH by Dr O'Brien may have had their notes taken by Dr O'Brien back to his home. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Action

Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10th January 2017
Lead: Ronan Carroll

Issue three

Ronan Carroll reported that there was a backlog of over 60 undictated clinics going back over 18 months. Approximately 600 patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

Action

A written action plan to address this issue, with a clear timeline will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

It was agreed to consider any previous IR1's and complaints to identify whether there were any historical concerns raised.
Action: Tracey Boyce

Consideration of the Oversight Committee

In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach.

It was agreed for Dr Wright to make contact with NCAS to seek confirmation of this approach and aim to meet Dr O'Brien on Friday 30th December to inform him of this decision, and follow this decision up in writing.
Action: Dr Wright/Simon Gibson

The following was agreed:
Case Investigator – Colin Weir
Case Manager – Ahmed Khan

Any formal investigation should be undertaken to robust and specific Terms of Reference (ToR) and in line with the guidance in paragraphs 28-40 of MHPS Section II. The Case Manager should write to Dr 18665 as per paragraph 35 informing him of the name of the Case Investigator and Designated Board Member; any objections by Dr 18665 to the appointment of nominated individuals should be given serious consideration. The investigation should not be an unfocused trawl of Dr 18665's work but we discussed that if there are concerns that patients may not have received appropriate treatment, or that there are patients with inadequate records, then this could be managed separately with an audit/ look back to ensure that patients have received the appropriate standard of care. We noted that further preliminary information (such as from the SAI and taking account of Dr 18665's comments) may be helpful in deciding the scope of the investigation and therefore the ToR.

As well as being outwith the Trust's Information Governance policies, the allegations, if upheld, may mean that the legislation (DPA) has been breached, and once more information is available you may wish to take further advice on this. Paragraphs 20 and 21 of the GMC's Good Medical Practice also set out standards for record keeping including a requirement that records are kept in line with data protection duties.

Dr 18665 is due to attend Occupational Health to ascertain whether he is fit for work; if he is not, we noted that there would be no need at this time to consider exclusion but you may then wish to ask the Occupational Physician whether/when Dr 18665 would be fit to participate in an investigative process.

If Dr 18665 is deemed fit for work, we discussed the criteria for formal exclusion, and the option of an interim immediate exclusion for a maximum of 4 weeks (as per paragraphs 18-27 of Section I MHPS). The latter would allow for further information to be collated and to take account of Dr 18665's comments about the allegations, before deciding whether there are reasonable and proper grounds for formal exclusion such as a concern that the presence of the practitioner in the workplace would be likely to hinder the investigation. I note that there had been a concern expressed previously about a record missing for 2 years inexplicably appearing on a secretary's desk. In line with paragraph 22 of Section II MHPS, there is an obligation to inform other organisations, including the private sector, of any restriction or exclusion of a practitioner and a summary of the reasons for it.

Dr 18665 should be encouraged to contact his defence organisation/ BMA for help and advice. He may also benefit from staff support such as counselling, at what is likely to be a stressful time for him. Dr 18665 should be told of the involvement of NCAS and you are welcome to share this letter with him if you think this would be helpful.

As discussed, and as Dr 18665 may be excluded, NCAS will keep this case open and I will review it with you in approximately 1 month. Please call in the interim if you have any queries.

Relevant regulations/guidance:

- Local procedures
- General Medical Council Guide to Good Medical Practice
- Maintaining High Professional Standards in the Modern HPSS (MHPS)

Review date:

27 January 2017

here saying the investigation should not be an unfocused trawl. My experience was that was virtually always their advice. They were very against a wide net because you are more likely to run aground in the investigation and it can be considered unfair, so you need really hard evidence for that. I was confident that the things that we were investigating, we had good grounds to investigate. I was also confident that during the course of an MHPS investigation, should there be other issues of concern arise, they had the ability to widen the remit as they thought. That's a very long winded answer but it's something I have reflected on extensively. I don't personally believe at this point we had the evidence to widen the net further. I certainly don't think it would have been appropriate to go asking all his colleagues whether we should be doing that. 15:56 15:56 15:57

346 Q. I asked the question because the Inquiry, as I have said at the start this morning, is charged with --

A. Yes, I appreciate that. 15:57

347 Q. -- various responsibilities within its own Terms of Reference.

A. Mm-hmm.

348 Q. The public, no doubt, or elements of the public is no doubt thinking, how can you have an investigation under MHPS, with all the time and resources invested in it, it took two years, give or take, to complete, and not come by all of the answers. The Inquiry has to think about whether, is there something inherent to the 15:57

1. Deciding whether to investigate

Performance concerns can come to light in many ways, including routine monitoring of management information, reports from patients and colleagues, appraisal, reports on serious untoward incidents and anonymous complaints or concerns. Anonymous reports may be difficult to verify but should not be dismissed. It is unlikely that on their own they would support formal action, but they may lend support to other evidence.

Any performance concern raises the possibility of a need for further investigation. This section outlines how to decide whether to conduct an investigation, by asking:

- **What is a performance investigation?**
- **How might concerns be screened for investigation?**
- **What should be considered in making a decision to investigate?**
- **What are the alternatives?**
- **When is an investigation likely to be appropriate?**

1.1 What is a performance investigation?

The purpose of a performance investigation is to determine whether or not there is a performance problem requiring action. A performance investigation is not a free-ranging inquiry. It is normally helpful to define the purpose of the investigation using terms of reference.

Terms of reference have to be determined based on what is known at the time an investigation is set up. If, later, a substantial issue comes to light that is outside the initial terms of reference, the terms can be reviewed and, if necessary, changed to ensure that the investigation covers the new issue.

An investigation report then sets out findings and the evidence on which the findings are based. The report informs a decision on whether to take action on the concern and how. It does not make the decision.

A decision to investigate commits the organisation to significant work and expense, so the organisation needs to be sure that a concern is serious enough to warrant an investigation, based on a review of available information.

1.2 How might concerns be screened for investigation?

Regardless of how a concern is identified, it should go through a screening process to identify whether an investigation is needed. Anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

The form that screening takes will vary from organisation to organisation. The essential requirement is that a consistent process is followed, with decisions made by a person or group with appropriate authority. Decisions made should be appropriately recorded and the practitioner kept informed of progress.

In *Handling performance concerns in primary care*, NCAS suggests the use of a decision-making group (DMG) supported by a professional advisory group (PAG), with membership suggestions made for both groups. In a primary care organisation (PCO) using this structure the DMG would usually make the decision to commission a local investigation or to take some other action such as referral to the police or counter fraud agency.
In secondary care, it is the designated responsible manager (often the medical director or deputy) who will determine (in consultation with others, as appropriate) whether or not an investigation is required. In both sectors, the interface with responsible officers for medical practitioners (once appointed) will need to be considered.

The purpose of screening is to identify whether there are *prima facie* grounds for an investigation and, if there are, to set terms of reference which are sufficiently detailed for the investigation to proceed. It is essential that managers set aside dedicated time to progress initial screening so that it can be completed properly and quickly.

1.3 What should be considered in making a decision to investigate?

Before deciding whether a performance investigation is necessary, consider what other relevant information is available. This could include:

- clinical or administrative records;
- serious untoward incident reports or complaints;
- earlier statements or interviews with people with first-hand knowledge of the concern;
- clinical audit and clinical governance data;
- the views of appropriate professional advisers;
- earlier occupational health reports.

The objective is to determine whether an investigation would be likely to produce information which is not already available, not to begin the investigation process itself.

There will normally need to be input from the practitioner too. As a general principle, NCAS encourages employers and contracting bodies to be transparent and to communicate and engage early with the practitioner whose performance is causing concern. NCAS suggests that the case manager or other appropriate person should have a preliminary meeting with the practitioner, explain the situation and what might happen next, and explain that they will be available to answer questions if the case progresses. The practitioner's initial comments can be taken into account in evaluating what further action should be taken. The practitioner should be offered the opportunity to be accompanied by a colleague or a union or defence society representative. A note should be taken and copied to the practitioner as a record of discussions and any case handling decisions.

Exceptionally, contact with the practitioner may have to be deferred if a counter fraud agency or the police advise that early meetings or early disclosure could compromise subsequent investigations. But generally, the practitioner's response will be helpful in deciding whether to carry out an investigation.

1.4 What are the alternatives?

Investigation should be judged unnecessary where:

- the reported concerns do not have a substantial basis or are comprehensively refuted by other available evidence;
- there are clear and reasonable grounds to believe that the reported concerns are frivolous, malicious or vexatious. While very few complaints fall into this category it is important that those that are not genuine are identified as soon as possible to avoid distress to the practitioner and waste of the organisation's time.

Even where there is evidence of concern, the decision may still be to dispense with investigation under the following circumstances:

- The practitioner may agree that the concerns are well-founded and agree to cooperate with required further action. However, if the issues raised are serious enough to suggest that if upheld they might warrant consideration of termination of employment or removal from a performers list, then the organisation may still need to conduct an investigation. The action to be taken subsequently would then be decided in the normal manner.

SECTION 1 – CONTEXT

1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.2 The length of time a patient needs to wait for hospital treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

11.4 Robust data quality is essential to ensure accurate and reliable data is held on PAS, to facilitate clinical and clerical training and to support the production of operational and management information.

1.5 An Executive Director should have lead responsibility for implementing the protocol.

1.6 There a number of underpinning principles:

- Patients should be treated on the basis of clinical urgency
- Patients with same clinical urgency should be treated in turn
- Patients added to lists must be ready for assessment/treatment
- Inpatient care should be exception and not the norm
- Booking systems will be developed to ensure convenience for patients
- Capacity will be linked to Service and Budget Agreements

1.7 Booking principles have been developed to support all areas across the elective pathway where appointment systems are used. Offering patient's

additional matters may have been discussed but all relevant information is captured in the letter.

12. In advising NHS bodies on how they should deal with concerns about performance of individual practitioners, reference is made to the procedures set out in Maintaining High Professional Standards in the Modern NHS (MHPS) in England or Maintaining High Professional Standards in the Modern HPSS in N. Ireland. These documents set out the procedures for handling concerns about practitioners relating to conduct capability and health. It also contains specific guidance on how NHS bodies should investigate concerns, and the procedures they should follow when considering the exclusion of a practitioner.

The role and involvement of NCAS/the Advice Service

13. The first contact from Southern HSC Trust was on 7 September 2016. I was not involved at that stage and the case was assigned to my colleague Dr Fitzpatrick. My first involvement with the case was in December 2016 when I was asked to call Dr Richard Wright (the then Medical Director) about a serious adverse event investigation that had flagged up a problem with Dr O'Brien's review of a patient with cancer. The patient had allegedly come to some harm, and there were concerns about Dr O Brien's review system, including allegations that he was not updating the system appropriately and, possibly taking notes to his home and not returning them.

14. I dealt with the matter instead of Dr Fitzpatrick as he works part time and was unavailable.

15. A summary of my discussions with Dr Wright on 28 December 2016 appears in my advice letter dated 29 December 2016 which I now produce as **GL1**. I explained that any formal investigation would need to be conducted under MHPS, and that given the information to date it was likely a more formal process was now warranted. It was noted that at the time Dr O'Brien was unwell and further steps were being taken to see if he was fit to work and possibly fit to participate in an investigative process. We did discuss at the time the criteria for possible formal exclusion.

16. I left it that given the possible exclusion I would review the case with Trust in about a month's time. I then sent follow up emails in January, March and May 2017 and in August 2017 our file was closed as there was no response to my emails. This is in line with our standard practice. We do not have a proactive role in these matters and

Chloe Williams

From: Grainne Lynn
Sent: 27 January 2017 09:44
To: Richard.Wright [redacted]
Cc: CST-C
Subject: case 18665 confidential

Categories: Jill, UPLOADS no action

Morning Richard,

I was hoping for an update on this case. If there is anything you wish to discuss, I am available today and on Wed/Thurs/Fri of next week on [redacted]; alternatively, if you prefer, I am happy to be updated by email.

Kind regards,
Grainne

Grainne Lynn
Adviser
National Clinical Assessment Service (NCAS)

[redacted]

The **National Clinical Assessment Service (NCAS)** has moved. Our new address is:
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It was noted that Mr O'Brien had identified workload pressures as one of the reasons he had not completed all administrative duties - there was consideration about whether there was a process for him highlighting unsustainable workload. It was agreed that an urgent review of Mr O'Brien's job plan was required.
Action: Mr Weir

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

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

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

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

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

Action: Dr Khan

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

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

November HR, V Toal no 77, 20170106 Ltr for Dr Wrights signature- to AOB

1.15. On 10th January 2017 a further Oversight meeting was held. *Oversight documentation Mr O'Brien 2016 27 01 10 Oversight group notes* ***Bates Reference TRU-00035-TRU-000036.*** I informed the team that, consistent with MHPS guidelines, Mr John Wilkinson had been appointed as the designated Non-Executive Director. Dr Ahmed Khan (Associate Medical Director Paediatrics) had been appointed Case Manager and Mr Colin Weir (Clinical Director Surgery) had been appointed Case Investigator. Mrs Siobhan Hynds was appointed as the Human Resources lead manager. Mr Carroll was to lead on the implementation plan to resolve the issues arising from untriaged patients' notes being kept at home, undictated outcomes and matters regarding private patients.

1.16. At the Oversight meeting on 26th January 2017 Mr Colin Weir's preliminary report *(this can be located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170126 - Attachment - Preliminary report from Case Investigator 26 January 2017)* was presented in accordance with MHPS Section II, para 10. Mr Weir briefed the Oversight group on a meeting that he had held with Mr O'Brien on 24th January. Mr O'Brien had been excluded from work on 30th December for a maximum of up to four weeks i.e., 27th January 2017. As Case Manager, Dr Khan considered that, based upon the evidence presented, there was a case to answer as there was significant deviation from good medical practice.

1.17. At that point Mr Weir reflected that there were no concerns in relation to the clinical practice of Mr O'Brien. Mr Khan recommended that Mr O'Brien could return to work subject to the suggested monitoring and support mechanisms being in place. His immediate exclusion was lifted on 27th January 2017. The Oversight team decided that Mrs Gishkori (Director) and Mr Carroll (Assistant Director) would put measures in place to monitor and support Mr O'Brien's return to work. I informed NCAS of these developments by telephone over the next few days. It was agreed that Dr

Oversight Committee or not, it should have come back to me as Medical Director, I think, certainly, and I would have picked up on that.

150 Q. We'll come back to the monitoring arrangement in just a moment in a slightly different way. In terms of one final action on this list. If we scroll down. It was agreed that you would update NCAS in relation to this case. You've said in your witness statement, WIT-17834, that you informed NCAS of these developments by telephone over the next few days. We don't see any record of that and maybe you didn't make a record. Can you help us with who you spoke with? 14:36 14:36

A. I did notice that. I do recall having a phone call and I think it may have been with Grainne Lynn. The reason I think I recall it is because we discussed the conditions in which Mr. O'Brien would come back from work after his temporary exclusion, which is why I'm pretty sure that that happened. 14:37

151 Q. It is closing that circle?

A. Yes. But it is possible I mixed that up with another -- I mean, I did have that conversation. When that exactly happened I can't be sure. I know then the Case Manager would have taken over the liaison with NCAS after that. But I do have in my mind a conversation with NCAS about Mr. O'Brien's return to work. So, I'm puzzled, but I don't have a written record of it. 14:37 14:37

152 Q. To be clear, they don't have a decision making role and you weren't looking for further advice. The direction

Chloe Williams

From: Grainne Lynn
Sent: 30 March 2017 13:28
To: [redacted]
Cc: CST-C; [redacted]
Subject: CASE 18665 confidential

Hi Richard,

I called for an update on this case but you were unavailable.

As I understand it, there is to be an investigation and there are restrictions on the practitioner's practice.

If there is anything you (or the Case Manager) wish to discuss, I am available on [redacted]

Kind regards,
Grainne

Grainne Lynn
Adviser
National Clinical Assessment Service (NCAS)

[redacted]

The **National Clinical Assessment Service (NCAS)** has moved. Our new address is:
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Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 22 February 2017 15:05
To: Khan, Ahmed
Subject: MHPS

Importance: High

Dr Khan

Following the case discussion with DLS on Friday, it was noted that the action plan agreed for AOB's return to work requires to be shared and discussed with NCAS at this point.

Can you please discuss with Grainne Lynn who is the case advisor in NCAS and share the action plan with her.

If you need anything from me please let me know.

Regards,

Siobhan

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

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Chloe Williams

From: Grainne Lynn
Sent: 30 May 2017 10:42
To: Richard.Wright[redacted]
Cc: CST-C
Subject: Case 18665 confidential

Categories: Jill, UPLOADS no action

Hi Richard,

I was hoping for an update on this case. If you don't need further NCAS input I can close the file; it can easily be reopened at any stage

Kind regards,
Grainne

Grainne Lynn
NCAS Adviser
[redacted] / [redacted] / [redacted]

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NI Office
HSC Leadership Centre, 12 Hampton Manor Drive, Belfast BT7 3EN

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Gibson, Simon

From: Khan, Ahmed [redacted]
Sent: 20 September 2018 15:13
To: grainne.lynn [redacted]
Subject: Re; MHPS case manager advise
Attachments: Case Manager Determination MHPS AO'B v2 (2).docx

Dear Grainne,

Thanks you so much for taking my call and providing very useful advise. As discussed please find attached my draft notes for this MHPS case recommendations. I will await your thought on this.

Thanks,
Ahmed

Dr Ahmed Khan
Case Manager- MHPS
Acting Medical Director
SHSCT
Trust HQ, CAH
[redacted]

Practitioner Performance Advice (formerly NCAS)
2nd Floor, 151 Buckingham Palace Road
London
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Advice line: 020 7811 2600
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21 September 2018

PRIVATE AND CONFIDENTIAL

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

Ref: 18665 (Please quote in all correspondence)

Dear Dr Khan,

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

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

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

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

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

a) There were clear issues of concern about Dr 18665's way of working and his management of his workload. There has been potential harm to a large number of patients (783) and actual harm to at least 5 patients;
b) Dr 18665's reflection throughout the investigation process was concerning and in particular in respect of the 5 patients diagnosed with cancer;
c) As a senior member of staff within the Trust Dr 18665 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;
d) 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 identify patients who may have been affected by the deficiencies in Dr 18665's practice (and to address these issues for patients);
e) There is no evidence of concern about Dr 18665's clinical ability with individual patients;
f) Dr 18665 had advantaged his own private patients over HSC patients on at least 9 occasions;
g) 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;

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

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

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

Chloe Williams

From: Chloe Williams
Sent: 07 June 2022 20:23
To: Chloe Williams
Subject: MHPS England vs MHPS Northern Ireland comparison

Chloe Williams
Solicitor
D: Personal Information redacted by USI

fieldfisher

From: Grainne Lynn Personal Information redacted by USI
Sent: 16 December 2019 08:04
To: Vicky Voller Personal Information redacted by USI; Colin Fitzpatrick Personal Information redacted by USI
Cc: Karen Wadman Personal Information redacted by USI; Sally Pearson Personal Information redacted by USI
Subject: RE: MHPS England vs MHPS Northern Ireland comparison

Hi,

I can give you a broad outline on the issues which I have found to be different (although the 2 documents are very similar). In summary MHPS in NI is in six sections rather than the 5 parts of the English version. Like the English version there are unfortunately a number of inconsistencies

Section 1

The NI version has a more comprehensive section 1. There is much more detail about the role of the CM and CI, much more guidance on an informal approach and an emphasis on informal resolution. In the informal process it is the clinical manager (and not the case manager) who assesses the seriousness of the issue but they are encouraged not to make a decision alone. In the NI version the CM is said to be usually the MD but in contrast to the English version, NI specifically provides for the role to be delegated in any appropriate case (and does not insist that it should be the MD for CDs or consultants). There is a long explanation in the NI version of immediate exclusion – which can last for up to 4 weeks (English version 2 weeks). They do encourage in NI that the regulatory body should be notified of exclusion (paragraph 26) – probably covered now by ELA role . The CM must give the practitioner the opportunity to comment on the factual content of the report produced by the CI (unlike the English version where this is only a requirement in capability cases).

In section II
In exclusion and restriction from practice, the NI version would appear to suggest that the person can undertake paid or voluntary work when excluded in time not paid for by the employer, although they must not engage in any medical duties consistent within the terms of the exclusion. In England you must seek consent to work.
An exclusion of over 6 months must be referred to the DOH.

In section III in NI there is no reference to doctors in training being treated differently (in England there is a paragraph encouraging that allegations of misconduct against a doctor or dentist should be treated initially as a training issue and dealt with via Ed supervisor etc)

Hynds, Siobhan

From: Wallace, Stephen [redacted]
Sent: 21 July 2020 23:02
To: OKane, Maria; Toal, Vivienne; Haynes, Mark; Carroll, Ronan; Hynds, Siobhan; Corrigan, Martina
Subject: FW: General Medical Council - Mr O'Brien

Follow Up Flag: Follow up
Flag Status: Flagged

From: Wallace, Stephen **On Behalf Of** OKane, Maria
Sent: 21 July 2020 23:00
To: Chris Brammall ([redacted]) [redacted] Joanne Donnelly [redacted]
Subject: General Medical Council - Mr O'Brien

Thank you Chris,

Further to previous email below please see an update on additional information has requested.

- Mr O'Brien's solicitor has confirmed that Mr O'Brien will refrain from seeing any private patients at his home or any other setting
- The independent review of relevant administrative processes as recommended by Dr Khan has not yet been completed, this is scheduled for conclusion by September 2020

The medical records for service user A and service user B as identified in the information previously shared in the 'summary of concerns' are still subject to screening for advancement as potential Serious Adverse Incidents, we are awaiting the completion of this process. I will provide an update on this in due course.

I also wish to inform you that Mr O'Brien's contract of employment has now ceased with the Southern Health and Social Care Trust as of the 17th July 2020 as a result of Mr O'Brien's planned retirement.

Regards

Dr Maria O'Kane
Medical Director

From: Chris Brammall [redacted]
Sent: 15 July 2020 07:30
To: OKane, Maria
Subject: RE: General Medical Council - Mr O'Brien

That's great, many thanks Dr O'Kane

Chris Brammall
Investigation Officer
General Medical Council
3 Hardman Street, Manchester, M3 3AW

Email: [redacted]

role as Case Manager to put the matter forward to a conduct hearing, but that Dr 18665 could also be offered support going forward to ensure that in future he is able to meet and sustain the required and expected standards. You told me that the local GMC ELA is aware of the issue and I advised that you may wish to update her on the position. In the majority of cases, the GMC prefers Trust to conclude their own processes before considering referral, and early referral is only indicated in a minority of cases; but the ELA would be best placed to advise on this.

I told you that, whilst there are no noted clinical performance concerns, Practitioner Performance Advice could offer support via the Professional Support and Remediation (PSR) team by drafting a robust action plan with input both from Dr 18665 and the Trust to address some of the deficiencies which have been identified (around the management of workload, administrative type of issues, for example). The purpose of the plan would be to ensure oversight and supervision of Dr 18665's work so that the Trust is satisfied there is no risk to patients, but also to provide support for Dr 18665, to afford him the best opportunity of meeting the objectives of the plan. We noted that this might involve job planning issues such as reducing Dr 18665's workload, and enhanced appraisal.

Since we spoke, I have talked to PSR, and we will arrange for the forms, which must be completed to formally request PSR support with a plan, to be sent out.

I note you said that there are no reported health concerns. However, as this is likely to continue to be a stressful time for Dr 18665, he should be offered any additional support deemed appropriate (access to staff counselling, mentoring, etc.).

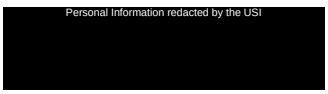
As discussed, we will keep this case open. Please feel free to call at any stage, if you have queries.

Relevant regulations/guidance:

- Local procedures
- General Medical Council Guide to Good Medical Practice
- Maintaining High Professional Standards in the Modern NHS (MHPS)
- The Medical Profession (Responsible Officer) Regulations 2010 and Amendment 2013

Review date: 24 September 2018

Yours sincerely,



Dr Grainne Lynn
Adviser
Practitioner Performance Advice

- 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.

The options open to me therefore are:

a. no further action is needed
   - **not appropriate**

b. restrictions on practice or exclusion from work should be considered
   - **Mr O'Brien has been working to an agreed action plan from February 2017 and any risk to patients has been addressed and monitored.- *Possibly Restrictions and actionplan***

c. there is a case of misconduct that should be put to a conduct panel
   - **knowingly advantaging private patient over HSC patients, failing to properly make it known to his line managers about - *Likely***

d. there are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer.
   - **there are no evident concerns about Mr O'Brien's health**

e. there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS
   - **there are no concerns about Mr O'Brien's clinical ability but his administrative practices have the potential to cause harm to patients.**
     - ***Requested advise from NCAS***

f. there are serious concerns that fall into the criteria for referral to the GMC or GDC
   - **as above**

g. there are intractable problems and the matter should be put before a clinical performance panel.
   - **Mr O'Brien has been working to an action plan and has been safely practicing during the course of the investigation process.**

This MHPS formal investigation focused on the clinical practice of Mr O'Brien. The investigation report presented to me focuses centrally on the confined terms of reference set for the investigation.

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17 October 2018

PRIVATE AND CONFIDENTIAL

Dr Aidan O'Brien
Consultant Urologist
Southern Health and Social Care Trust

Ref: 18665 (Please quote in all correspondence)

Dear Dr O'Brien,

Thank you for ringing me to discuss your case. We spoke by telephone on 1 and again, as scheduled, on 11 October 2018, and I am writing to summarise the issues which we discussed on these occasions. Please let me know if any of the information is incorrect

In summary, you are a senior consultant urologist and have been the subject of a long running investigation after allegations were made about your practise. This investigation has now concluded and the matter is to proceed to a hearing. I note that the investigative report, which identified issues which have led to the matter being put to a hearing, also identified previous failings in management of your case. You told me that you have grave concerns about many aspects of the process. Specifically, you allege that the Trust has misled Practitioner Performance Advice service (formerly NCAS) by implying that you were supported to address concerns in 2016. Whilst you were told about the concerns, you did not receive any support or assistance in managing the difficulties (which you attribute to serious workload issues). You reported that when you asked in 2016 how the issues could possibly be addressed, the manager shrugged his shoulders

You also told me that, despite repeated requests, you have not received any of letters prior to the recent communication with Dr Khan. You are considering legal options.

You are aware of your right to see information which is held about you and will likely submit a Subject Access Request (SAR) to Practitioner Performance Advice service. You know that I cannot act as your advocate and I advised that you seek advice from your

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

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

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

b. An exclusion from work

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

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

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

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

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

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31 October 2018

PRIVATE AND CONFIDENTIAL

Dr Aidan O'Brien
Consultant Urologist
Southern Health and Social Care Trust

Ref: 18665 (Please quote in all correspondence)

Dear Dr O'Brien,

Further to our follow up telephone conversation of 30 October 2018 in which your son, Mr Michael O'Brien, who is a barrister, also participated, I am writing to summarise the issues we discussed for all of our records. Please let me know if any of the information is incorrect.

You explained that you have now been given by the Trust the letter of 13 September 2016 which was written by my colleague, Dr Colin Fitzpatrick, following his conversation with Mr Simon Gibson. You have also received copies of the minutes of the Trust oversight group which identified that the matter should be subject to formal investigation.

You are not able to understand why the advice in Colin's letter was not followed and how, in December 2016, the situation had escalated to the point that a formal investigation and immediate exclusion was deemed warranted. Your recollection is not compatible with the information in my letter of 28 December 2016, as you say, there was no attempt made by the Trust to resolve the matter informally and you were not made aware of the significance of the issues until 30 December 2016. You were concerned that there had been further contact with NCAS (now Practitioner Performance Advice) in the interim. Additionally, despite being told by Dr Wright that he only became aware of the situation in December 2016, Dr Wright was a member of the oversight group which had met on 13 September 2016 and 12 October 2016.

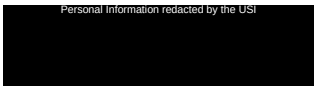
I told you that the information on the file (and I note you will also receive this information, following your Subject Access Request – SAR) should represent the totality of the communication with Practitioner Performance Advice, and that between October 2016 and December 2016 there is no further information on file other than that which you have been given.

I note that whilst Dr Khan had decided that the matter should be put to a conduct panel, Michael expressed surprise that this would be done before the review into the Trust's handling of the case, which Dr Khan has also recommended should be undertaken.

We discussed that it may be helpful, with the Trust's agreement, for all parties, including Practitioner Performance Advice, to meet. I told you that I would liaise with Dr Khan to ascertain dates, if appropriate.

As before, you are welcome to share this letter with the Trust.

Yours sincerely,



Dr Grainne Lynn
Adviser
Practitioner Performance Advice

Chloe Williams

From: Grainne Lynn
Sent: 05 November 2018 15:47
To: Khan, Ahmed
Cc: Hynds, Siobhan; Gibson, Simon; CST-B
Subject: RE: MHPS Investigation case 18665 confidential

Categories: UPLOADS NO ACTION - Edyta

Hi Ahmed,

Thank you for this. in the circumstances I am not sure anything further could be achieved by a meeting.

If you are happy for me to, I will let the practitioner know that we have discussed this and that you feel the points which he has raised have already been considered. In any event, I will need to let the practitioner know it will not be going forward to a meeting.

I will write back to you summarising our discussion of last week but reflecting the up to date position as per these further emails. I will review the case with you in 6- 8 weeks but please get in touch in the interim if you have any queries

Kind regards,
Grainne

From: Khan, Ahmed [redacted]
Sent: 05 November 2018 11:50
To: Grainne Lynn
Cc: Hynds, Siobhan; Gibson, Simon
Subject: FW: MHPS Investigation
Importance: High

Dear Grainne

Further to our telephone conversation on Wednesday 31 October.

Thank you for advising of your recent telephone conversation/s with Mr A O'Brien and his son regarding the on-going process under MHPS within the Trust. My understanding of the main issue raised by Mr O'Brien and relayed by you, is respect of the commencement of the investigation and the decision to move to a formal investigation process rather than manage the concerns informally. Mr O'Brien has outlined that his workload was significantly impacting on his ability to undertake all required work.

As discussed, this is a concern Mr O'Brien raised at the outset of the investigation process. A full and detailed response was provided to Mr O'Brien by letter on 30 March 2017 addressing this issue and setting out the reasons for the decision to manage the concerns through a formal investigation process. As I understand it, this is a judgement for the employer to make under MHPS. Given the serious nature of the concerns, it was considered to be the appropriate course of action. We are now a significant period of time on and have completed a formal investigation, with Mr O'Brien's participation.

I was encouraged to hear from you that Mr O'Brien and his son are not in dispute of the issues of concern. The findings from the formal investigation further outline that the concerns under investigation, and which are now founded, are very serious in nature. After taking further advise, as a Case Manager I remain satisfied that a formal investigation was and is the appropriate course of action in the circumstances. As previously discussed and agreed with you, the next step in the process is to hold a conduct hearing following conclusion of the formal investigation.

I appreciate your offer of a meeting between the trust and Mr O'Brien with you in attendance. Having considered this, we remain unclear as to the purpose of this meeting at this stage. As always we are very happy to be guided by NCAS and if you feel it is useful to meet, we are happy to do so.

We would be very grateful for your advice on the best course of action in this regard and what you feel could be achieved by such a meeting? Please don't hesitate to contact me if required.

Kind Regards,
Ahmed

Dr Ahmed Khan
MHPS Case Manager
Medical Director (Interim)
Personal Information redacted by USI

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9 November 2018

PRIVATE AND CONFIDENTIAL

Dr Aidan O'Brien
Consultant Urologist
Southern Health and Social Care Trust

Ref: 18665 (Please quote in all correspondence)

Dear Dr O'Brien,

Thank you for your letter dated 1 November 2018 setting out some clarifications to my letter following our discussion on 30 October 2018. Practitioner Performance Advice (formerly NCAS) does not usually reissue letters (unless it would change the advice which has been given) but the letter has been added to the file so that the clarifications are on record.

Following our conversation of 30 October 2018, I contacted the Trust to explore issues further with them and to offer to meet. On the 31 October 2018, I had a telephone conference call with Dr Ahmed, Mr Gibson and Ms Hynds, and we discussed the case. The Trust are of the view that a full and detailed response was provided to you by letter on 30 March 2017 setting out the reasons for the decision to manage the concerns through a formal investigation process. It is also considered that, notwithstanding some of the acknowledged management issues, the evidence in the report warrants putting the matter forward to a hearing. I note that it is also likely, as per earlier correspondence with the Trust, that they will want to support you moving forward.

These decisions made by the Trust are ultimately matters for them as your employer, and Practitioner Performance Advice cannot arbitrate on these decisions or take on the role of your advocate. In these circumstances therefore, it was considered that a meeting with Practitioner Performance Advice was unlikely to be of any benefit. I would suggest you seek support from your representative about the options available to you.

not receive any support or assistance in managing the difficulties (which he attributed to serious workload issues). He was concerned that he had not seen any correspondence with NCAS/The Advice Service prior to recent letters with Dr Khan.

23. On 18 October 2018, having sought Dr O Brien's consent, I let Dr Khan know I had been speaking to Dr O'Brien.

24. On 30 October Dr O'Brien called again (together with his son, a barrister) to discuss copy correspondence he had received between our service and the Trust. A summary of my discussions with Dr O'Brien on 30 October 2018 appear in my letter dated 31 October 2018 which I now produce as **GL4**. Dr O'Brien's letter in response, dated 1 November 2019 is produced as **GL5.** He shared his concerns about meetings of the Trust's Oversight Committee in 2016 and the scope of the more recent review.

25. On 31 October 2018 I was able to speak to Dr Khan and he subsequently emailed on 5 November 2018 (**GL6**) when we agreed a meeting with our involvement was unlikely to achieve anything further. A summary of our exchanges appears in my letter dated 6 November 2018 which I now produce as **GL7**.

26. I replied to Dr O'Brien on 9 November 2018 in a letter which I now produce as **GL8**.

27. I next followed up with the Trust with an email to Dr Khan on 2 January 2019 in which asked "I am just checking if this case has come to a conclusion and if so whether you are happy for Practitioner Performance Advice (formerly NCAS) to close its file on it." Dr Khan replied to explain that there was a now a formal grievance issue which had to be dealt with first. There was also a new Medical Director Maria O'Kane

28. I emailed Dr Khan again in February 2019 and he told me that they were still addressing the formal grievance. In June 2019 I emailed Dr Khan and Dr O' Kane, the new Medical Director, to ascertain whether the grievance had been brought to a conclusion and what had happened with regards to the conduct hearing. On 10 June 2019, I received a reply from Dr Khan setting out that the hearing was on hold pending the outcome of Dr O' Brien's grievance. In September 2019 I emailed Dr Khan and Dr O' Kane again for an update, and when I did not receive a reply our file was closed in February 2020. In the meantime Dr O' Brien had contacted us to check if there had been further correspondence with the Trust.

your return to work plan in November 2019 (when it was no longer in place) and when the concern was about a 3 day overdue triage.

Recently you had made plans to retire and return, and were horrified to learn (at a very late stage) that the Trust was not going to allow you to return- reportedly citing ongoing HR processes as the reason. Your employment will now terminate on 17 July 2020 - although the Trust has now indicated that it will hear your grievance after this. You explained how stressed and upset you have been about this, the entire management process and the referral of you by the Trust to the GMC. You were alarmed when you saw the letter my colleague Dr Fitzpatrick had written to the MD following their conversation of 7 July 2020. You consider that the letter is misleading with a number of incorrect facts; for example you said you have not been allowed to see patients, rather than being unable to see them as a result of Covid 19 as was stated. You think that our organisation is being manipulated with misleading information, and that you have been victimised whenever you have raised concerns. You cited the extremely long waiting lists you had earlier highlighted (patients waiting 113 days for red flag referrals, urgent cases waiting 85 weeks and routine cases three and a half years). The greatest risk to patients you believe is due to these waiting lists, but Personal Information redacted by USI and you were very worried that you would suffer reputational damage even if you were subsequently to be vindicated.

Both you and Personal Information redacted by USI wanted to know why PPA did not discuss the matter with practitioners before writing back to Trusts. I explained that our advice is based on the information given to us- and that frequently practitioners and organisations have very different viewpoints. This is why we encourage openness and sharing of our letters and offer to speak in confidence to practitioners. We are not however able to arbitrate on disputed facts, and I advised that you take these matters forward with your representatives and legal advisers- I note you have access to comprehensive advice. They will also wish to raise your concerns about the timeliness of processes and take forward your allegations that you are suffering a detriment for being a whistle blower. I note you no longer have any confidence in Trust policies but I advised you to scrutinise the whistle blowing policy and take advice from your defence organisation / lawyers about what other options may be available to you.

As you requested, I have asked Dr Fitzpatrick to make contact with you.

I hope you find our conversation helpful.

Relevant regulations/guidance:

- Local procedures
- General Medical Council Guide to Good Medical Practice
- Maintaining High Professional Standards in the Modern HPSS (MHPS)
- The Medical Profession (Responsible Officer) Regulations 2010 and Amendment 2013

Yours sincerely

Personal Information redacted by the USI

Dr Grainne Lynn
Adviser
Practitioner Performance Advice