Urology Services Inquiry

UROLOGY SERVICES INQUIRY

Note: An addendum amending this statement was received by the Inquiry on 20 April 2023 and can be found at WIT-91961 to WIT-91998. A further addendum was received on 1 June 2023 and can be found at WIT-96807 to WIT-96808. Annotated by the Urology Services Inquiry.

USI Ref: Notice 77 of 2022

Date of Notice: 23 September 2022

Witness Statement of: Noleen Elliott

I, Noleen Elliot, will say as follows: -

SECTION 1 – GENERAL NARRATIVE

General

1. **Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.**

1.1 I have worked in the NHS since 1987 in various administrative roles. Most of my time was spent in various roles within Governance, having previously worked in Clinical Audit Department prior to the amalgamation of the Armagh and Dungannon HSS Trust with Craigavon and Banbridge HSS Trust to the new Southern HSC Trust. I was transferred to Clinical Audit Department, Craigavon Area Hospital in 2007 and immediately seconded to coordinate the newly established Central Reporting Department. My main duties included establishing processes for the management of adverse

to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

44.1 I have nothing further to report at this stage based on what I currently know or can remember.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

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

Signed: Personal Information redacted by the USI

Date: 28th October 2022

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

Note: A further addendum statement was received by the Inquiry on 1 June 2023 and can be found at WIT-96807 to WIT-96808. Annotated by the Urology Services Inquiry.

USI Ref: Section 21 Notice No.77 of 2022

Date of Notice: 23rd September 2022

Addendum Witness Statement of: Noleen Elliott

I, Noleen Elliott, will say as follows:-

1. I wish to make the following amendments to my existing response, dated 28th October 2022, to Section 21 Notice number 77 of 2022.

2. At **WIT-76351** para 11.3 I state that *"I cannot remember how often these reports were sent prior to the 2017 Investigation under the Maintaining High Professional Standards Framework regarding Mr O'Brien. I could only find the report as of the 14/4/16 in my records prior to 2017. Since the investigation, the reports are sent out monthly for validation*". This should state "*There were 3 reports received prior to the 2017 investigation under the Maintaining High Professional Standards Framework regarding Mr O'Brien. The reports were dated 30/10/14, 21/1/15 and 14/416.*" Please see:

   1. E-mail trail dated 20 October 2014 and list of outstanding disposal codes for clinics under Mr A O'Brien
   2. E-mail trail dated 05 November 2014,
   3. E-mail trail dated 21 January 2015,
   4. E-mail from Andrea Cunningham re e-mail from Katherine Robinson,
   5. E-mail trail dated 14 April 2016 and list of outstanding disposal codes for clinics under Mr A O'Brien
   6. E-mail trail dated 19 September 2018 and list of outstanding disposal codes for clinics under Mr A O'Brien

3. At **WIT-76351** para 26.2 I state that "*The training was mainly provided by an ex-member of staff from the urology team and was provided with an hour here and there through the first few months of my role"*. This should state "*The training was mainly provided by an ex-member of staff who was an audio typist from the urology team and was provided with an hour here and there through the first few months of my role."*

4. At **WIT- 76351** para 26.5 I state that "*During 2016 I was concerned that Mr O'Brien had a backlog in some dictation of clinic letters. However, I was*

Urology Services Inquiry

reassured by Mr O'Brien that all the urgent dictations were undertaken and it was the non-urgent dictations that were still awaiting, e.g., patients who were being discharged from the service or added to the routine waiting lists. This was noted on the Monthly Backlog Reports sent to my Line Manager. Mr O'Brien continued to address the backlog during 2016 and continued to do so while recovering from his own surgery in November/December 2016, dictating 10-15 letters per day. I typed these letters as soon as possible after they were dictated." This should state "*During 2016 I was concerned that Mr O'Brien had a backlog in some dictation of clinic letters. However, I was reassured by Mr O'Brien that all the urgent dictations were undertaken and it was the non-urgent dictations that were still awaiting, e.g., patients who were being discharged from the service or added to the routine waiting lists. Mr O'Brien continued to address the backlog during 2016 and continued to do so while recovering from his own surgery in November/December 2016, dictating 10-15 letters per day. I typed these letters as soon as possible after they were dictated. The delay in dictation was noted on the Monthly Backlog Reports from January 2017.*"

5. At **WIT- 76351** I would like to include the following documents in support of paragraph 26.7 of my witness statement. Please see:

   7. *E-mail received from Collette McCall*

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

Signed: [redacted] Personal Information redacted by the USI

Date: 20.04.2023

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 77 of 2022

Date of Notice: 23rd September 2022

Addendum Witness Statement of: Noleen Elliott

I, Noleen Elliot, will say as follows:-

I wish to make the following amendments to my existing response, dated 28th October 2022, to Section 21 Notice number 8 of 2022.

1. At paragraph 18.3 (WIT-76337), I have stated '*Regarding extra hours worked, Michelle McClenaghan took over as Service Administrator for a short period of time.*' This should state '*Regarding extra hours worked,* ***Michelle McClelland*** *took over as Service Administrator for a short period of time.'*

2. At paragraph 24(vii)-3 (WIT-76345), I have stated '*However, the patient(s) Mr O'Brien had seen privately were not on the Trust Patient Administrative System Waiting List (PAS). I was able to check the "Chart Tracker" on PAS to see when the patient's chart was tracked to "Mr O'Brien's PP Filing Cabinet" by Leanne Hanvey (who did all Mr O'Brien's Private Patient typing) and this was the date I used to put the patient, originally seen as a private patient by Mr O'Brien, on the NHS waiting list.*' This should state '*However,* ***if the patient(s) Mr O'Brien had seen privately were not on the Trust Patient Administrative System Waiting List (PAS),*** *I was able to check the "Chart Tracker" on PAS to see when the patient's chart was tracked to "Mr O'Brien's PP Filing Cabinet" by Leanne Hanvey (who did all Mr O'Brien's Private Patient typing) and this was the date I used to put the patient, originally seen as a private patient by Mr O'Brien, on the NHS waiting list.*'

3. At paragraph 24(vii)-4 (WIT-76346), I have stated '*Then there was the instruction of the Transfer Status Form (not sure of the date).* This should state '*Then there was the* ***introduction*** *of the Transfer Status Form (not sure of the date).'*

Urology Services Inquiry

4. At paragraph 27.3 (WIT-76354), I have stated '*However, Mr O'Brien had dictated on the urgent dictation. These undictated letters were flagged up on the Backlog report. Mr O'Brien went on sick leave in late October 2016 and, during his recovery in November/December 2016, he started to address this backlog.*' This should state 'However, Mr O'Brien had dictated on the urgent dictation ***and continued to address this backlog until he went on sick leave in November 2016. These undictated letters were flagged up on the Data Quality Report "Outpatient with no attendance outcome/disposal recorded" (please see WIT-76373 TO WIT-76604) During his recovery from surgery in November/December 2016 Mr O'Brien continued to work through the backlog in dictation.***

5. At paragraph 42.1 (WIT-76360), I have stated '*He did continue to address this backlog up until he commenced his Sick Leave in October 2016.*' This should state '*He did continue to address this backlog up until he commenced his Sick Leave in* ***November*** *2016.*'

Statement of Truth

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

Signed: Noleen Elliott [redacted]

Personal information redacted by the USI

Date: 1st June 2023

Witness Statement

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

1. My name is Noeleen Elliott. I am employed by the Southern Health and Social Care Trust as a Personal secretary to Mr Aiden O'Brien, Consultant Urologist.

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

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

4. I was supported at the meeting by my trade union representative, Mr Brian Smyth, NIPSA.

5. In respect of TOR 1 I was asked if I was aware of if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process. I explained that in February 2015 the responsibility for triage went to the Trust's Referral and Booking Centre. After this date secretaries were no longer responsible for following up on referrals. I advised that there would previously have been delays with Mr O'Brien's triage prior to February 2015. I would have been advised by the Referral and Booking Centre of delays or lack of response from Mr O'Brien.

6. I advised that the Referral and Booking Centre receive the referral in and log it on PAS, they then would note and record referrals that are sent back following triage by the Consultant. I would

22. I don't know if any charts are missing.

23. I would have received requests for up to 10 charts per day. When I sent an e-mail to Mr O'Brien to request the chart he would have brought it back in. The dictation would have been done it. I am aware there are clinics that have not been dictated. Please refer to the appended list. There were some clinic letters done but not all.

24. In terms of Mr O'Brien's private patients, it is my view that Mr O'Brien has to determine the clinical priority of patients to be seen. Mr O'Brien would have informed me when a private patient was being added onto to a list.

25. The matters I have been asked about were known widely to everyone. Everyone knew what was happening. Mr O'Brien's practice has been the same even when Monica was his secretary. People knew about it so I didn't feel I needed to be flagging anything.

This statement was drafted on my behalf by Mrs Siobhan Hynds, Head of Employee Relations and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.

This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a conduct or clinical performance hearing. I understand that I may be required to attend any hearing as a witness.

SIGNATURE	Personal Information redacted by the USI
DATE	1.8.17

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

Note: An addendum amending this statement was received by the Inquiry on 20 April 2023 and can be found at WIT-91961 to WIT-91998. A further addendum was received on 1 June 2023 and can be found at WIT-96807 to WIT-96808. Annotated by the Urology Services Inquiry.

USI Ref: Notice 77 of 2022

Date of Notice: 23 September 2022

Witness Statement of: Noleen Elliott

I, Noleen Elliot, will say as follows: -

SECTION 1 – GENERAL NARRATIVE

General

1. **Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.**

1.1 I have worked in the NHS since 1987 in various administrative roles. Most of my time was spent in various roles within Governance, having previously worked in Clinical Audit Department prior to the amalgamation of the Armagh and Dungannon HSS Trust with Craigavon and Banbridge HSS Trust to the new Southern HSC Trust. I was transferred to Clinical Audit Department, Craigavon Area Hospital in 2007 and immediately seconded to coordinate the newly established Central Reporting Department. My main duties included establishing processes for the management of adverse

incidents and complaints for the Trust using the Datix, Risk Management System. I was responsible for taking complaints via the telephone and escalating to the relevant Clinical & Social Care Governance Coordinator. Following the restructure of Governance in 2009, I was then appointed as Risk Management Officer in January 2009 where I was responsible for quality assuring adverse incident data inputted onto Datix and producing monthly reports to Director and Assistant Directors and Heads of Service and ad hoc reports for Freedom of Information requests and Parliamentary questions, etc. I was also responsible for updating data for the Corporate, Directorate, Divisional and Head of Services Risk Registers and producing monthly reports regarding same. I facilitated investigating teams for SAIs which included arranging meetings, preparing papers and assisting with RCA report. Following a further restructure of Governance in 2011 I was appointed to the post of Patient Safety & Quality Officer where I was responsible for the management of the Standard & Guideline Database for the Trust from which I produce data for the Annual/6 monthly accountability reports to the Trust Board. I was responsible for facilitating meetings with Heads of Services to determine compliance with Standards and Guidelines and develop action plans if required. I arranged workshops and maintained attendance records for the Management of Medical Devices Committee which was attended by Directors, Assistant Directors, Head of Services and Equipment Controllers.

1.2 I believe that my involvement in, or knowledge of, matters falling within the scope of the Inquiry's Terms of Reference is set out in my various responses to the Questions below (from Question 4 onwards). However, particular points that I believe ought to be made at the outset are set out in the following paragraphs.

1.3 While working in Governance Department I was aware that the Trust strives to provide the "gold standard" of care for its patients. However, when I moved to the clinical side of the Trust in 2012 as Consultant Secretary in Urology I appreciated that this was not always the case. The

said was going to get back to Mr. O'Brien in detail, but that obviously we were taking a statement and that the information that she gave us for that statement, he would have to have sight of. So, trying to --

132 Q. Who was that witness? 14:34

A. Mr. O'Brien's secretary was really very anxious about the whole process, and I think had felt that she was in a difficult position in terms of divided loyalties and those type of things. Doctors and secretaries tend to have a very special relationship, and I think it is 14:35 difficult for secretaries that feel in some way their -- I don't know, just not being loyal. Certainly the secretary found it difficult.

Some of the managers, I felt -- I mean I couldn't tell 14:35 you off the top of my head but I felt some of the managers found the whole process very anxiety-provoking.

133 Q. Is there any work, do you think, to be done around the culture that creates that kind of, I suppose, fear that 14:35 you are describing, or sense of foreboding? I mean, is there a need for colleagues in this context come witnesses to better understand and better buy into the idea that performance issues need to be properly investigated? 14:35

A. I think a lot of progress was made, I hope a lot of progress was made after the Mid-Staff Inquiry because I think it addressed exactly this type of thing, that you have these very senior consultants who tell you how

No major outstanding backlog. The results to be dictated are the from the middle to end of November. Audio typist is currently on results to be typed area of backlog

Collette McCaul
Acting Service Administrator (SEC)
Ground Floor
Ramone Building
CAH
Ext Personal Information redacted by USI

Mark

Apologies about the delay in getting back to you.

We are doing a bit of further looking into this request as we are taking this very seriously if this is the case.

IF you could I would be grateful of an example of patient who has come to your clinic but no result letter or action ever done that would be great so we can see what actually is going on .

Collette

Collette McCaul
Acting Service Administrator (SEC)
Ground Floor
Ramone Building
CAH
Ext Personal Information redacted by USI

From: Haynes, Mark
Sent: 05 December 2018 06:32
To: McCaul, Collette; Corrigan, Martina
Subject: RE: Urology backlogs

Thanks Collette

Sorry if my next question sounds awkward and I appreciate I may have asked this before.

Could you describe the method by which the information is collated. I can see how you obtain the 'waiting to be typed' information. But for instance, how is the information on 'results to be dictated' collected? Is this based on e-sign off data (numbers of results not signed off on ECR) or some other method? I am concerned that the data presented doesn't fit with my impression of practices (I regularly see patients coming to OPA with scan results that have been performed often months earlier, requested by someone else, but no results letter or action ever done, and no sign off either on ECR or of the paper copy).

Similarly, how is the 'clinics awaiting dictation' data obtained?

I have copied Martina as I have spoken to her about this so she will be able to help if my question isn't clear.

Thanks

Mark

From: McCaul, Collette
Sent: 04 December 2018 16:16
To: Corrigan, Martina; Robinson, Katherine; Carroll, Ronan; Carroll, Anita; Scott, Jane M; Jacob, Thomas; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: Urology backlogs

Hi all

Attached are the recent backlogs for Urology as of the 04.12.18.

Ramone Building
Craigavon Area Hospital

t: Personal Information redacted by USI
e: Personal Information redacted by USI

From: Haynes, Mark
Sent: 06 December 2018 12:03
To: Robinson, Katherine; McCaul, Collette
Subject: RE: Urology backlogs

I should add that although this case is an individual who may have had concerns raised about previously, he is not alone.

From: Robinson, Katherine
Sent: 06 December 2018 12:02
To: Haynes, Mark; McCaul, Collette
Subject: RE: Urology backlogs

OK WE WILL GET back to you

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: Personal Information redacted by USI
e: Personal Information redacted by USI

From: Haynes, Mark
Sent: 06 December 2018 12:01
To: McCaul, Collette
Cc: Robinson, Katherine
Subject: RE: Urology backlogs

No problem.

An example; Personal Information redacted by USI Patient 92 (Female / 46 years)

FU CT done 13/3/18, reported 20/3/18. GP letter 17/7/18 brought it to my attention, renal cancer subsequently treated.

Happy to chat through with you. My concern is that there are individuals in the management structure who believe this data to be robust where I'm not certain it is.

Mark

From: McCaul, Collette
Sent: 06 December 2018 11:43
To: Haynes, Mark
Cc: Robinson, Katherine
Subject: RE: Urology backlogs

Corrigan, Martina

From: Haynes, Mark [redacted]
Sent: 11 March 2019 17:03
To: OKane, Maria
Subject: FW: Urology backlogs Confidential

Scroll down for details – result not actioned.

From: Haynes, Mark
Sent: 15 December 2018 05:57
To: Robinson, Katherine; McCaul, Collette
Subject: RE: Urology backlogs Confidential

Thanks Katherine.

The issue for me is not whether or not it was ever received.

My concern that there are individuals who think that the reported 'results for dictation' data is robust. It isn't. The number is generated at best for some as a guess. Because this regular report is taken by senior personnel in the trust as robust it is seen as a monitoring tool within governance processes that results are being actioned and communicated to patients in a timely manner with no risk of unactioned significant results. I fear your team are at risk if we have a situation where a patient comes to harm because a result isn't actioned and subsequent investigation reveals a large number of unactioned results. Your team would be open for criticism for reporting inaccurate information.

For Tony and me Liz / Leanne look at e-sign-off and the number outstanding on here, plus any sets of notes with hard copy reports and this is the number reported. Ironically although we are the most up to date with our admin, we regularly appear to be the ones who are most behind.

A question to all secretaries asking them how they get the numbers that they report would be a starting point, along with a meeting to highlight why this information is collected and the potential consequences of misreporting.

Mark

From: Robinson, Katherine
Sent: 14 December 2018 15:27
To: Haynes, Mark; McCaul, Collette
Subject: RE: Urology backlogs Confidential

Mark

We have looked into this. We cannot establish if the result ever came back to AOB either hard copy or email. I thought Radiology flagged these up to be looked at , am I correct? We cannot find it in Noelene's office. That said the secretary has a huge issue with her management ie collette and I asking her questions etc and is extremely upset and feels we are harassing her. I am trying to get Trudy as I don't know how we can possibly get proper info without the secretary helping. The secretary does not want to be involved but I suspect like all of us there is no choice.

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre

Friday 14th December 2018

Noleen asked to see me in her office. I called up around 2pm. Noleen was visibly upset and she then explained that she cannot cope and is feeling very "harassed" by all the questions asked by myself on a Friday regarding Aidan O Briens backlogs etc. This is information that I have been asked to gather regarding Mr Obrien and I then explained to Noleen I was under instruction from my management to obtain this information , that I was unsure as why and that it was a sensitive matter was all I was aware of . I explained as she was our direct link for this information as his secretary we were obtaining what we could from her. Noleen said she found it all very overwhelming and again used the phrase harassed.

She was crying throughout and just said that not once in the 2 years since all this started has anyone ever asked her how it has affected her. She said she felt "she could not do this anymore" and might need to go off.

I then tried to comfort her and tried to reassure her that I knew very little on the matter but that I was not directly doing this to involve or affect her. She went on to say that she no longer wanted to be involved and if management want the information that they should come and get it themselves that "sitting in their ivory tower and getting us (ie myself and her) to do their dirty work".

She said she had a loyalty to Mr O'Brien as her consultant and it felt that we were trying to get her to "shop" him. She didn't want any part of it and that again management should come and get the information themselves. She also had said Mr Obrien was in his office that I could go over and ask him myself. I explained that is not what I was here to do.

Noleen then handed me a leaflet about inclusion and had highlighted the C area saying we should be clear on why we are doing something (management) but that she felt we were not being clear with our intentions of why this information is needed. I again reiterated that I knew nothing regarding what was going on or why this information was needed and explained if I knew any information I would have made clear the reasons for gaining this information and that I was following out my duty of being asked to carry this task out.

She then went on to show me the working well together policy with a paragraph highlighted about making work harmonious for the staff but felt this was doing exactly the opposite and again said it felt that all the questions was questioning her fitness for her post. I said I would duly note and take this to my manager Katherine Robinson.

Noleen brought up in this as well about an email I had sent regarding AADs and I had put the title in capitals. She said this felt I was directly shouting at her to get something done but I had told her and apologised she felt this way that that was not my intention that it was just a clerical typo and I was probably doing AADs at speed and never took off CAPS lock. I said my intention was never to

Service and subsequently signed off by the Assistant Director and Divisional Medical Director. It is a joint responsibility between Assistant Director and Divisional Medical Director to ensure job plans reflect work to be undertaken.

Q55. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?

557. On 27 August 2019, I first became aware of issues regarding Mr O'Brien. It followed a communication from the GMC Triage Team seeking further information from Dr O'Kane following Dr O'Kane's referral of Mr O'Brien to them on 3 April 2019. 10 points were raised by the GMC seeking a response in advance of 6 September 2019. Dr O'Kane forwarded the email to Mr Simon Gibson, Assistant Director Medical Director's Office, Siobhan Hynds, Deputy Director Human Resources, and Mark Haynes, Divisional Medical Director. I was copied into the email alongside Mrs Vivienne Toal, Director of Human Resources and Organisational Development. On 10 September 2019, I was further copied in to an email reminder for the requested information to the same email recipient as above.

558. On 16 September 2019, an email exchange commenced following two breaches to the post MHPS formal investigation Action Plan. This was from Mrs Corrigan to Dr Ahmed Khan and Mrs Hynds. By 4 October 2019, this email exchange was shared with me by Dr O'Kane who requested an Oversight meeting for 8 October 2019 to prepare the Trust response to the GMC with the attached email trail of the escalated breaches. In preparation for the meeting planned for 8 October 2019, Dr O'Kane forwarded the MHPS Return-to-Work Action Plan for Mr O'Brien which I forwarded on to Mr Carroll following the Oversight meeting taking place. This was the first time either of us had seen the MHPS Return-to-Work Action Plan.

559. Following the Oversight meeting of 8 October 2019, Dr O'Kane shared draft notes of the meeting including discussion on the escalation of concerns with regards the action areas of the agreed MHPS Return-to-Work Action Plan including timely triage processes, undertaking digital dictation immediately following each contact and not holding notes at home.

560. Dr O'Kane noted that Mr O'Brien's secretary had not engaged with the monitoring of the action plan, which required Mrs Corrigan to go on the electronic care record (NIECR) to check if notes have been uploaded. It was also noted that an incident report (1R-1) had been submitted on 3 October 2019 regarding a delay with a cancer patient. This gentleman, Patient 112, had been discussed at MDT on 27 June 2019, and the outcome was Mr O'Brien was going to organise a renal biopsy. On 24 July 2019, Mr Haynes emailed Mr O'Brien and his secretary, Noeleen Elliot, to advise that a further referral had come in about this gentleman's renal lesion which Mr Haynes was triaging. He asked Mr O'Brien in the email *"had you the biopsy in hand?"* On 4 October

Stinson, Emma M

From: OKane, Maria
Sent: 08 October 2019 14:51
To: Haynes, Mark; McClements, Melanie; Khan, Ahmed; Hynds, Siobhan
Subject: AOB OVERSIGHT MEETING - UPDATED
Attachments: URGENT :AOB concerns - escalation- oversight meeting request please ; Action plan

Discussion- draft notes :

1. Concerns re escalation
2. Concerns re process
3. Concerns re pp and making arrangements for investigation through the NHS -?Interface with pp policy – letters no longer on NIECR – now the patients are on list without letter- consider how tracking
4. Plan point :1: How can each be monitored and how is this escalated if concerns? Monitor through the information office

2. concerns re notes at home – weekly spot check? Meant to sign notes out – he has a condition on his action point that he is not to take notes home – make assumption that if notes not in his office or clinic or theatre they are in his home? No transport to take notes between cah and swah. Monitoring difficult
3. Martina can only monitor what she is given – his secretary has not engaged. Martina has had to go onto ECR to check if notes uploaded.
5. IR1 went in from MDT on Wednesday last re 1st delayed cancer patient – AOB letter on patient sent Friday
6. 2nd patient did not come to harm following escalation to MDT by trackers which builds contingency checks in to system for all clincians in urology

Plan :
1. Will ask Mr McNaboe to discuss concerns with AOB to make aware that this has been raised with the MHPS case manager – on leave until Monday
2. Will consider escalation plan including option to exclude
3. Will consider the full system review September 2018 and progress

50.2 At a 1 to 1 in September 2020 Katherine Robinson HOS RBC shared a note of a meeting with me. The meeting took place on 1st September 2020. Katherine Robinson HOS RBC spoke to Noleen Elliott regarding a complaint received from a member of Nursing staff, alleging that Noleen was unhelpful. Katherine Robinson HOS RBC then phoned Noleen who advised Katherine that she was stressed over the investigation. As Mrs Robinson felt this conversation did not end well, she contacted Noleen on 2nd September 2020. During this conversation, Noleen advised she had changed some data on PAS at the request of Mr O'Brien I am not aware of the detail of these changes. Katherine Robinson HOS RBC advised that she should not be doing this and reminded her that she needed to follow instructions from line manager. Noleen said she found this difficult as she worked with Mr O'Brien for a long time and she felt she had loyalty towards him. HOS Urology.

Relevant documentation is located at

175. 20200901-02 Notes of Mtgs KR and NE located at S21 15 of 2022 Attachments

50.3 Melanie McClements DAS asked me to meet with Noleen Elliott Mr O'Brien's Secretary to raise some issues. These were detailed in an email dated 3rd September 2020 from Martina Corrigan HOS Urology to Katherine Robinson HOS RBC and myself. Katherine and myself met with Noleen the same day to go through the issues – see the note of the meeting on the 3rd September 2020. In that meeting Noleen indicated that she would prefer to work in another Speciality and then we arranged that she would join the Breast team. In this meeting on the 3rd September 2020 Noleen Elliott also mentioned oncology letters from the Belfast Trust that she had not got back from Mr O'Brien which were on NIECR .On the 10/9/20 I shared the note of this meeting with Melanie McClements DAS and Ronan Carroll AD SEC and Martina Corrigan HOS Urology .

Relevant documents are located at

176. 20200903 E fMC to ACandKR Issues to raise at mtg with NE located at S21 15 of 2022 Attachments

177. 20200904 E fKR to AC and MC Notes of Mtg KR and NE 20200903 located at S21 15 of 2022 Attachments

178. 20200904 E fKR to AC and MC Notes of Mtg KR and NE 20200903 A1 located at S21 15 of 2022 Attachments

Noelene Elliott 1/9/20

Spoke to Noelene following a complaint from Jeanette Collins whereby NE had been very unhelpful and when a call was put through to her she said “why are you sending your rubbish through to us”?

I advised that really this was not nice and really Jeanette was trying to help a patient out. I advised her she also had set the phone down on Orla Poland recently and that this was not on. Noelene said that was because one minute she was to work with Reem Salman the next the job was given to someone else. I explained the reasoning behind the decision and the reason it was reversed was because Mr O’Brien was going to be replaced and we didn’t know that at the time plus Noelene had expressedly said she would prefer to stay in Urology. Noelene said she was stressed over the AOB investigation/SAI.

2/9/20

On reflection I rang Noelene to see how she was because our conversation did not end well the previous day and that she said she was stressed about the investigation. I advised it was nothing to do with her but as long as she was doing what she was supposed to be doing she was ok. She said AOB had asked her to change some things and she did. I advised she should not have done this and she had to do the right thing and also that she should be taking her instructions from her line management team. She said it was difficult because she worked so closely with AOB. I said I appreciate that but she still should have advised her line manager and she had to the right thing or we could not protect her. I reminded her that I had also told her this before.

I advised now that AOB had left the Trust that she needed to do the right thing at all times no matter what her relationship with the consultant was.

Notes of Meeting with N.Elliott, Anita Carroll & Katherine Robinson via desktop

3/9/20

Anita introduced herself and explained that KR had raised the issue of Noelene's stress with her. Anita advised that these concerns had led her to ask to meet to discuss. Anita asked her how long she had worked for AOB and NE advised 5 years, Anita recognised that the relationship between consultant and secretary but said they needed to discuss admin arrangements and get a clear position on paperwork / admin functions and how things worked in particular as to get a feel for what was stressing Noelene and also the fact that she had advised KR the previous day that AOB had asked her to change some things When asked about this at this meeting, she denied that she changed things but advised she didn't use all admin processes in particular the DARO function.

- **DARO-** Noelene advised that AOB hated using this function so Noelene had only approx. 50 on her Daro list because she only used it when Regs sent patients for results. For AOB's pts she used the outpatient waiting list as per AOB. This method was felt by them to be their safety net. EG

  CT scan requested, 6 mths, this was put on the review w/l to be seen within 7 mths time.

- **Results** – on receipt of paper form of results, these would be passed to AOB and the chart would be tracked to CAOBS – Result for AOB to see (*Awaiting results)*. This was proof that AOB had been passed the actual result. These charts remained in the sec office until a result was returned to Noelene for further action. Routine results never made their way back to Noelene, only urgent ones. Periodically Noelene went through the charts in the Awaiting results section of her office to chase up anything outstanding. It was explained to Noelene that this was not foolproof and this is why DARO was introduced some years ago.

- **Outstanding paperwork for AOB –** Mr Fell was working his way through things and Noelene was using the function DARO per admin policy.

- **Backlog Reports – delays in dictation etc,** Noelene advised that AOB didn't get to tidy everything up due to the way he retired. She advised that there were approx. 100 charts in the Awaiting Results section of her office that need checked. Martina to be informed.

- **Oncology Letters from Belfast –** These letters were passed to AOB and because now they are on NIECR they were not always (never were) passed back to Noelene.

Following discussion Noeleen did advise that she was unhappy with how changes were communicated with her recently (following AOB retirement) she said she was asked to work for Ms Salaman in Breast surgery and then this offer was withdrawn , Anita and Katherine agreed the communication had been poor and then discussed the current role in urology, Noeleen expressed that she would prefer to work in another specialty as

clear that overtime would only be paid for extra contractual work i.e., extra consultant clinics or theatre lists. Please see:

14. REMINDER - OT TOIL SICKNESS ANNUAL LEAVE

17.3 I also had to deal with approximately 20 calls per day from patients, relatives and GPs and I believe this was a consequence of the extremely long waiting times for appointments and surgery in Urology. I was conscientious about my work and always kept it up-to-date and therefore management didn't feel there was a problem as there was very little backlog of typing.

18. **Did you feel supported by staff within urology in carrying out your role?**

Please explain your answer in full.

18.1 Having had several different Line Managers while working in Urology I would say there were inconsistencies regarding support for staff. Some Line Managers were more supportive than others.

18.2 When I commenced working in the Urology Team I was under Jane Scott. I had problems within the office regarding other staff attitudes to me and lack of help with training and I brought these concerns to Jane via face to face meetings. Meetings were set up and subsequently cancelled. I requested a move of office and was told to "stick it out and not let them beat us". I feel I was let down by Management regarding this concern.

18.3 Regarding extra hours worked, Michelle McClenaghan took over as Service Administrator for a short period of time. I had a meeting with Michelle who appreciated the long hours I was working to keep the work up-to-date and she agreed to pay me for these extra hours. This was a

one-off payment. I very much appreciated that Michelle valued the work I was putting in to the job.

18.4 In general, I feel the Service Administrators do not fully understand the pressures the secretaries are under in fulfilling their roles. It has always been the case that, if work is kept up-to-date by whatever means, then it would be assumed that the secretary does not require any help.

Urology services

19. **Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.**

19.1 As Consultant Secretary I was responsible for facilitating the Consultant in his work by the following:

a) Opening post including referral letters from other consultants, results, etc, date stamping them, and leaving them for consultant;
b) Typing dictation for clinics, discharges, triage letters and results and prioritising urgent dictation when necessary;
c) Completing outcomes of clinics on the PAS system and ensuring accuracy of same;
d) Adding patients to the Waiting List for surgery;
e) Booking patients for Theatre and Day Surgery and Flexible Cystoscopy lists, completing TMS and circulating to all relevant staff;
f) Arranging patients' Protected Review appointments as required;
g) Booking patients for Urodynamic Studies;
h) Booking Interpreters for patients when required;

i) Dealing with patient/relatives/GP queries and complaints via phone and escalating to consultant if necessary;

j) Attending monthly Urology Scheduling Meetings and circulating agreed work plan for Consultant to Central Booking Office and other relevant staff.

20. **With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.**

20.1 I would have liaised with the following:

a. Service Administrator – I liaised with my Service Administrator regarding HR issues and access to systems queries. Informal Staff meetings were held on 3/5/17, 30/5/19 and 28/11/19.

15. Notes of Staff Meeting - 03.05.17
16. Notes of Staff Meeting - 28.11.19
17. Notes of Staff Meeting - 30.05.19

b. Mr O'Brien – I would have regular contact with Mr O'Brien on a daily basis by phone and e-mail. I would have had face-to-face contact with him at least twice weekly.

c. Urology Team – Monthly scheduling meetings with all the urology team including Martina Corrigan to schedule the next month's activity.

d. Clinical Nurse Specialist – We liaised on a daily basis, booking biopsy appointments and treatments for patients in the Thorndale Unit.

always strive to do the best for his patients. His style of practice, however, meant that he was slow to discharge a patient from his follow-up and was slow to embrace the use of specialist nurses for non-consultant outpatient review. He was known to take his time for outpatient consultations. This style of practice meant that clinics filled up with review patients, leading to a review backlog and a long waiting time for a new referral.

33. What I was not aware of (but have become aware of in the context of this Inquiry) was that he also did not routinely utilise named Keyworker/Specialist nurses in the cancer pathway. I believe the failure to engage with Keyworker/Specialist nurses reduced the ability to monitor adherence the MDM advice and identify delays in the management of cancer patients.

34. This issue is addressed in more detail below, in particular in my answers to Question 64.

35. At job planning he mentioned the amount of administration he had and how long it took. Much of this extra administration was Aidan O'Brien generated and, when steps were suggested on how to reduce the amount of administration, he would either ignore or object to the proposed process. His discharge summaries were extremely long and often over several pages. Following one GP speaking to me about the excessive length of a discharge summary, I asked Aidan if he could make them shorter and more geared for the GPs. However, he declined, saying that the long summary was for his benefit if he saw the patient again in the future.

36. Several times I suggested to him that triage need not be a large burden and that the majority of referrals can be triaged rapidly. He stated he did an "enhanced triage" and that it was significantly better than any method I suggested. Little did I know at the time that he had effectively stopped performing triage from about 2015.

37. He was slow to embrace technology, e.g., I recall that at one stage his secretary used to have print out emails as he didn't have a computer in his office. Rather than dictate a short note to his secretary he was known to write

long hand. When digital dictation was introduced for clinics, results, and discharge summaries he was slow to utilise it.

38. At various stages he was given support from his colleagues with triage. He was offered help by the Trust after his Job plan went to facilitation but didn't engage. He had twice as much secretarial support as his colleagues. Debbie Burns in 2014 asked him to say what support he needed to help his practice. That summer, he was given a month with no clinics to catch up on his administration. I don't know if it was arrogance or fear of losing face that stopped him from requesting more help / the help he needed to change his style of practice.

39. The failure to investigate the false accusation of bullying and harassment against me was, I believe, done for the best of reasons. I was aware at that time that Roberta Brownlee was very friendly with Aidan O'Brien and was a director of his charitable company 'CURE' from, I believe, 1997. Unfortunately, by not being investigated and exonerated I was told to be very careful in my dealings with Aidan O'Brien and as a result it reduced my ability to challenge him or his practice sufficiently.

40. The prevailing culture at the inception of the Trust was to maximise performance and to maintain financial stability. These main foci were also expected by HSCB. This drive for performance, while maintaining financial stability, may have distracted the Trust from quality issues. There was neither the time in the working day nor the support staff to undertake regular audits of outcomes and the patient pathway either solely within urology or when there was engagement with other departments like the cancer directorate, laboratories, radiology, theatres and outpatients.

41. The organisational structure for Medical Management of urology was Medical Director, Associate Medical Director, Clinical Director and then Lead Clinician. My role as AMD was extensive and demanding but at the same time, I was a full time General Surgeon with a special interest in Oesophagogastric as well as Colorectal Surgery. The nature of my general surgical post and the number of colleagues on the team meant that, if I was to free up extra time for the

e. Specialist Registrars – We liaised on a regular basis on the day to day patient activity within the hospital.

f. Other Consultants – I would liaise with other consultants, especially when Mr O'Brien was not available due to annual leave, etc.

g. Cancer Tracker – I would have liaised with the cancer tracker on a weekly basis regarding Red Flag patients.

h. Pre-Assessment Team – I would have liaised with the Pre-assessment team regarding a patient's fitness for surgery, etc.

i. Booking Office Staff – I would have liaised on a daily basis with the Booking Office staff regarding clinic appointments, etc.

21. **In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?**

21.1 I believe my role was as a facilitator for the operational, clinical aspect of urology service. I provided support for the Consultant to ensure the smooth running of his work and ensuring work was kept up-to-date where possible. I refer in this regard to the more detailed description of my work set out at Question 24 below.

21.2 Regarding governance, I believe everyone is responsible for governance and, when I felt there was an issue that needed addressing, I would raise this with my Service Administrator or Consultant.

21.3 An example of a query raised with a Consultant was when I was concerned regarding the quality/content of the letters generated by Mr Fel,

i) Dealing with patient/relatives/GP queries and complaints via phone and escalating to consultant if necessary;

j) Attending monthly Urology Scheduling Meetings and circulating agreed work plan for Consultant to Central Booking Office and other relevant staff.

20. **With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.**

20.1 I would have liaised with the following:

a. Service Administrator – I liaised with my Service Administrator regarding HR issues and access to systems queries. Informal Staff meetings were held on 3/5/17, 30/5/19 and 28/11/19.

15. Notes of Staff Meeting - 03.05.17
16. Notes of Staff Meeting - 28.11.19
17. Notes of Staff Meeting - 30.05.19

b. Mr O'Brien – I would have regular contact with Mr O'Brien on a daily basis by phone and e-mail. I would have had face-to-face contact with him at least twice weekly.

c. Urology Team – Monthly scheduling meetings with all the urology team including Martina Corrigan to schedule the next month's activity.

d. Clinical Nurse Specialist – We liaised on a daily basis, booking biopsy appointments and treatments for patients in the Thorndale Unit.

did. For example Mr O'Brien sees on average 10 patients in a clinic where others will have between 14-16 patients booked on their clinics. Other consultants were seeing 11 new patients in the time Mr O'Brien was seeing 7. The patient sitting in front of Mr O'Brien would have received an excellent service and would have been given plenty of time but this just backlogged the rest of the patients. Mr O'Brien was seeing many less patients than his Urology colleagues in the same clinic timeslots.

16. Mr O'Brien's job plan was never agreed but there were some requests that he asked for once a month Mr O'Brien had a SWAH outpatient clinic which was from 10am to 4pm on a Monday, it was agreed there would be 8 review patients and 8 new patients. Mr O'Brien always requested an admin session on a Tuesday morning to complete his admin from the clinic. This was mostly facilitated. Mr O'Brien's preference was to operate rather than do outpatient clinics and he would sometimes agree and do a 9am to 8pm list (always his choice). From changes in the Urology service in December 2014, there is protected urology time for discussions between 12 – 1.30 on Thursdays. Mr O'Brien would not be a frequent attender at these departmental meetings.

17. Mr O'Brien's attention to detail is immense. His letters could be pages long. Other colleagues would have said to him that he only needed to do a paragraph of the salient points but his practice didn't change. Mr O'Brien also undertook tasks that should have been passed on to his secretary, for example, he schedules his own patients and phones them personally to arrange for them to come in for a procedure. This is something his secretary should be doing. I am aware of conversations with patients where Mr O'Brien would discuss the care of animals while the patient was in hospital. He has a different prioritisation system so he has different categories so it looks as if he is picking patients out of order. At a point Mr O'Brien was on 15 PA's but was reduced to 13 PA's. He had additional admin sessions because of his attention to detail. When he Chaired MDT he spent large amounts of preparation time that others felt was unnecessary.

18. Mr O'Brien does his private patient work on Saturday's so there is no need to have it scheduled in his job plan. When a Consultant is seeing a patient privately, they should let the referral and booking centre know so the patient comes off PAS. Mr O'Brien's secretary doesn't manage his private work. Leanne Hanvey does some typing for Mr O'Brien's private patients. If a patient is seen privately and then comes back onto the NHS, a form is supposed to be completed and they should be put back on the NHS waiting list according to clinical priority and given no advantage to anyone else on the list. Letters in relation to private patients did appear to be dictated and in the notes. At times it appeared private patients were being operated on out of order.

19. The terms of reference for the investigation have been shared with me. In respect of TOR 1, I am aware that some patients have been adversely affected because triage was not done by Mr O'Brien. The notes for this patient could also not be found and were in Mr O'Brien's house. One patient Patient 10 was a patient who was deemed to be routine by the GP and was then added onto the routine waiting list and when she was seen in clinic. it would appear that her referral should have been a red flag. This concern was screened and I am aware has been investigated as a Serious

6.0 FINDINGS	
	Urological care. ..stent has been in now for about a 1½ year. Could you perhaps review whether or not this could be removed/replaced?"
10 May 2016	email to ConsUrol13 from his secretary, "*Patient ringing....current symptoms related to stent .....give him a date for removal."*
02 June 2016	letter from SpROnc14 to ConUrol11 requesting, "*your intervention to facilitate his ongoing oncological management".*
24 June 2016	email from ConsUro13 to his secretary, "*Please send letters of admission .... admission on 29 June 2016 as follows* Patient 16
29 June 2016	**admission. Operated on for stent removal by ConsUrol13.**

Therefore, after the original stent was inserted on the 31 March 2015 and the patient discharged on the 2nd April 2015, Chemotherapy could start, and the stent would then be removed or replaced 6-9 months later. The last dose of chemotherapy was given on the 8th October 2015 and the letter to ConsUrol13 was sent on the 26th November 2015, (typed on 27th November 2015).

The crucial period regarding any unnecessary delay in treatment and care in this case (as indicated between the entries above in bold) appears to be from the time the patient was deemed ready to have his stent removed or replaced i.e. 26th November 2015, and when he was finally admitted for his surgery i.e. 29th June 2016, a period of 217 days or 31 weeks. Also, did this delay remove a window of opportunity for a course of pelvic radiotherapy?

The 26th November 2015 letter to ConsUrol13 perhaps was not received in CAH until 11th December 2015. There is no evidence that he received and/or acknowledged the receipt of letter. The question is, "Did he ever receive i.e. see, this letter?"

A copy of the 26th November 2015 letter appears to have been received and acknowledged by ConsSurg9 who queried a review date. An entry in red ink (probably secretary) appears to indicate there was an OPD date of 02/16, presumably February 2016. No action seems to have happened following receipt of the 26th November 2015 letter.

An email was sent to ConsUrol13 on the 30th December 2015 indicating the patient was on a waiting list for October 2015 and patient's daughter rang regarding a date for surgery. There appears to be no record of a response to this email.

The next possible reminder to the Urology service was the 21/01/2016 letter. It is uncertain whether SpROnc14 contacted Urology. Letter was copied to ConsSurg9. The letter indicates that palliative radiotherapy was being considered. There is no apparent action taken at this time.

On the 4th March an email to ConsUrol13's secretary indicated the patient had requested a date to come in for removal of stent. There is no apparent action taken at this time.

Patient 16

6.0 FINDINGS

At Oncology clinic review on the 24th March 2016, ConsOnc2 sent another letter to ConsSurg9 indicating disease progression and that nothing further had been heard from Urology. This letter appears to have been typed almost a month later (22/04/2106) and not received in CAH until 5th May 2016. ConsSurg9 seems to have seen this letter.

ConsSurg9 reviewed Patient 16 at Surgical OPD on 9th May 2016 and has then written to ConsUrol11 on the 9th May 2016 asking him to review Patient 16's Urological care.

Then, on the 10 May 2016 a further email sent to ConsUrol13 from his secretary informing ConsUrol13 that the patient rang the office and asked for an appointment to have his stent removed. There is no apparent action taken at this time.

Further letter on the 2nd June 2016 from SpROnc14 to ConsUrol11 asking for his intervention to facilitate oncological management. Letter not copied to ConsUrol13. The Oncology team would consider IMDG chemotherapy once the stent is changed and if his urinary symptoms are stable. This letter, received on the 8 June 2016, has been acknowledged and annotated by ConsUrol11 on the 22 June 2016, which led to an expedited appointment for surgical intervention on 29 June 2016, 454 days after being listed and 217 days after chemotherapy had ceased.

Then, on 24th June 2016 email from ConsUrol13 to secretary requesting admission for Patient 16 on the 29th June 2016 for surgery.

Surgery on the 29th June 2016 proceeds with removal of the stent without replacement. The postoperative course is difficult with a period of urosepsis. Further surgery on 10th August 2016 when stent was inserted with much resistance. Followed by period of disease progression, further Urology surgery in December 2016 with terminal admission shortly afterwards. Patient died on Personal information redacted by the USI [redacted]

In relation to the possibility of missing treatment opportunities, Oncology have commented that with the benefit of hindsight, it is clear that palliative radiotherapy would not have affected the clinical outcome and could have been detrimental. [Source = Complaint response]

<u>Communication between Oncology service, Surgery and Urology</u>

The Oncology medical staff copied ConsSurg9 into GP correspondence. However, the Review Team noted that Urology was not always copied into all Oncology correspondence. On occasion, there was evidence of Oncology letters sent or copied to,

- ConsUrol13 on 26 November 2015, 23 July 2016 and 2 December 2016.
- SpROnc14 sent to ConsUrol11, dictated on 2 June 2016.

but on others it was not. It appears especially odd that on the 8th October 2015, when chemotherapy was stopped, Oncology wrote to ConsSurg9 but not ConsUrol13 who should

already come through all of the, you know, Personal information redacted by USI [redacted], the intensive rehabilitation that that required and his resilience was always incredible and to find then that he wasn't being listened to, that was very, very difficult to watch and he was suffering, and he knew why he was suffering and he could relay that very clearly and he was a very articulate and intelligent man and that was why we found it so difficult to accept that no one was coming back. 14:09

14:09

And the communication, certainly from ourselves, both dad would have rang and I rang and whatever, and you never got a response to that. You know, the message was relayed obviously but no one, the secretary didn't come back to say, well, the consultant, you know, he's on a waiting list, he will be seen in a couple of months, in the meantime maybe you should try this or... So it was that lack of reciprocation of communication which was particularly upsetting. 14:10

1 Q. Can I just ask a little bit about that, if I may? 14:10

A. Yes.

2 Q. You talk about both Oncology and Urology?

A. Yes.

3 Q. Did you experience, or did your father rather, experience the same problems in communicating with both the Oncologist and with the Urologist? 14:10

A. In terms of Oncology, there were very set patterns for reviews. So you usually knew it was kind of within six or eight weeks each time. Now obviously going through

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

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

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

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

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

9.0 RECOMMENDATIONS AND ACTION PLANNING

TRUST

Recommendation 1

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

Recommendation 2

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

Recommendation 3

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

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

9.0 RECOMMENDATIONS AND ACTION PLANNING

correspondence is actioned (receipt, acknowledged, reviewed and actioned) in an appropriate and timely manner.

An escalation process must be developed within this guidance.

Monthly audit reports will be provided to Assistant Directors on compliance with this policy/guidance. Persistent failure to comply by clinical teams or individual Consultants should be incorporated into Annual Consultant Appraisal programmes.

Recommendation 4

The Trust will develop written policy/guidance for the tracking of clinical correspondence, to include relevant email correspondence.

TRUST and HSCB

Recommendation 5

In the same way that the Belfast Trust Cancer service now have their Oncology letters on the NIECR, all other services, including those from other Trusts, should do the same.

Recommendation 6

The Trust, with the HSCB, must implement a waiting list management plan to reduce Urology waiting times.

This will be monitored monthly.

10.0 DISTRIBUTION LIST

In addition to the Review Team, the following.

Mr S Devlin, Chief Executive SHSCT.

Dr Maria O'Kane, Medical Director, SHSCT.

Melanie McClements, Director of Acute Services.

Health & Social Care Board (HSCB).

Chairs of Morbidity & Mortality Groups SHSCT.

Patient 16 ” family

Patient 16

Personal information redacted by USI

19th September 2016

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

Dear Sir/Madam,

Patient 84

DOB: Personal information redacted by USI

H&C No.: Personal information redacted by USI

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

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

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

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

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

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

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

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

Irrelevant information redacted by USI

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

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

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

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

Has the doctor been notified about the concerns and if so when?

Mr O'Brien has been informed of these concerns via his solicitor when the issues where discovered (25th October 2020)

Please provide all relevant documentation to support the concerns raised in this form.

Add another concern

Details about an additional concern

Click here to remove this page ☐

Have you discussed the concerns with an employer liaison adviser? Yes ✕ No

Details about the concern

Record Keeping - Patient Administration System
In an email dated 7th June 2020, Mr O'Brien put forward a list of 10 patients for inclusion on a surgical waiting list. On the booking paperwork some of these patients appeared to have been diagnosed with stents requiring treatment There was concern that the patients had appeared not to have been added to the Trust waiting list for revision of indwelling ureteric stents in a timely fashion. This raised concerns that other patients might not also have been added to the Trust waiting list for revision of their stents in a timely fashion. Delay in this procedure increases the risk of patient morbidity. It appeared that months had gone by since they were recognised as requiring further procedures or investigations and they had not been processed in the interim.

The specific concern was that there had been a failure to adhere to standard administrative processes following stenting and as result these patients would be unduly delayed, not dealt with chronologically or potentially lost to followup until they presented as emergencies.

There were concerns about the attendant risks of delayed treatment; 2 of these patients required urgent attention. This concern triggered a further review of 41 other patients who had stents inserted in the previous 18 months. Of the total of 147 patients who had emergency procedures, 46 patients with stents were reviewed, 5 patients in total were identified as delayed due to failure to adhere to standard administrative processes.

Details about any local actions and outcomes (e.g. local restrictions, investigations, audits, practice reviews, or HR/disciplinary processes)

As a result of these potential patient safety concerns, an initial scoping exercise in relation to the consultant's work was conducted to quickly ascertain if there were other related areas of immediate concern. This initial scoping exercise, which considered cases over a 18 month period of the consultant's work in the Southern Trust (from 1st January 2019 - 30 June 2020), concentrated on whether patients had a stent inserted during a particular procedure and if this stent had been removed within the clinically recommended time frame, during this exercise there were a total of 5 patients who had a delay in the removal of their stent.

Evidence of insight and remediation can reduce the need for us to take action. Please provide details about any remediation, or retraining the doctor has agreed or undertaken, including NCAS assessments action plans, statements from supervisors or mentors, and course certificates.
Mr O'Brien has now retired. Communication with the Trust is via his solicitor

e. Specialist Registrars – We liaised on a regular basis on the day to day patient activity within the hospital.

f. Other Consultants – I would liaise with other consultants, especially when Mr O'Brien was not available due to annual leave, etc.

g. Cancer Tracker – I would have liaised with the cancer tracker on a weekly basis regarding Red Flag patients.

h. Pre-Assessment Team – I would have liaised with the Pre-assessment team regarding a patient's fitness for surgery, etc.

i. Booking Office Staff – I would have liaised on a daily basis with the Booking Office staff regarding clinic appointments, etc.

21. **In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?**

21.1 I believe my role was as a facilitator for the operational, clinical aspect of urology service. I provided support for the Consultant to ensure the smooth running of his work and ensuring work was kept up-to-date where possible. I refer in this regard to the more detailed description of my work set out at Question 24 below.

21.2 Regarding governance, I believe everyone is responsible for governance and, when I felt there was an issue that needed addressing, I would raise this with my Service Administrator or Consultant.

21.3 An example of a query raised with a Consultant was when I was concerned regarding the quality/content of the letters generated by Personal information redacted by USI

Locum Consultant. I spoke with Mr Haynes about this issue and he asked me to print off the letters and leave them for him to action. I am not aware of the outcome of this.

21.4 An example of a query raised with Service Administrator was e-mails regarding a patient dated 4 May 2017, 17 May 2017 and 24 May 2017. Please see:

18. FW WRONG PATIENTS CHART USED AT CLINIC
19. INCIDENT
20. RE WRONG PATIENTS CHART USED AT CLINIC

22. **What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?**

22.1 I have never completed an IR1 form since joining the Urology Team so I have no knowledge of how efficient or effective the governance processes are. Any issues I had were raised with the Service Administrator and/or Consultant to escalate (see my previous answer in this regard). I was not made aware of the outcome and learning from these so I am unable to comment on the efficiency and effectiveness of governance processes and procedures.

23. **Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?**

23.1 I had no engagement with performance metrics while working in Urology. I did use PAS and Patient Centre for patient data. These systems help identify long waiting lists for surgery and long waiting times for new and review patients.

38. **Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.**

38.1 I have since left the Urology Service and therefore cannot comment in that regard. However, since moving to the Breast Service, I am aware that the new technologies (NIECR and e-triage), adequate capacity, and my attendance at Multidisciplinary Meetings all play a part in running a more effective service. The waiting times in the Breast Service for surgery and outpatient appointments are considerably shorter than those of Urology and therefore I feel the Breast Service, which has adequate capacity to care for their patients, is more effective and therefore does not present the same risk or potential for concern.

39. **Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?**

39.1 I feel there wasn't adequate capacity in the Urology Service which led to long waiting times for both outpatients and elective waiting lists. Patients were having to wait too long to be treated in Urology.

39.2 While working in the Urology Service staff were not actively completing Incident Reporting forms (IR1) for any concerns they may have. Instead, staff raised their concerns through the Service Administrator. I am not aware if IR1 forms were completed by the Service Administrator. I feel the reporting of concerns/incidents should all be reported through Incident Reporting on DATIX.

40. **What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services**

14. In December 2016 I was asked by Katherine Robinson in the Referral and Booking Centre for a list of clinics that I had not received outcome sheets for. I provided this list to the case investigator and it is appended to this statement. The clinics are for the period 2015 and 2016.

15. When Mr O'Brien was on sick leave at the end of 2016 he addressed at least 20 clinics and outcomes were completed for those clinics. In all cases, I didn't get an outcome sheet back at the time of the clinic. Mr O'Brien was in touch with me in early February when he was due to come back to work following his sick leave and he asked me about the charts that he had returned from home in January 2017. I told Mr O'Brien that there weren't in his office and he asked about the outcome sheets with the charts. I told him I had never seen the outcome sheets. I explained the charts had been moved to the admin floor during the first week in January 2017.

16. I noticed the delays got worse in or around April 2016 and there were clinics other than SWAH which had no outcomes.

17. I have recently received a call from a patient and when I looked up the patient, they were not on any waiting list for a procedure they were told they needed. I didn't tell the patient they were not on the list but explained that there was a wait for the procedure. I told Mr O'Brien via e-mail.

18. When a patient such as the one I took the call from is added to a list, they are always added to the waiting list at the date they were seen. As generally the lists are so long, they will be seen when they should be but the case is just not captured on the Trust's system or data.

19. On occasion I would have mentioned to Mr O'Brien about typing for his clinics. Mr O'Brien didn't do a clinic letter for every attendance but he would have put all information into one long letter at the end of the episode of treatment. When asked if Mr O'Brien kept the patient's GP informed during the course of a treatment process, I advised that in some cases I don't believe he would have written to the GP until the end.

20. Mr O'Brien was under extreme pressure and he would have advised me that he had a lot of work to do. The typing I did for Mr O'Brien would be very long and it took a long time to do each of his letters. Some dictated letters were 3 or 4 pages long. When asked if Mr O'Brien used his Tuesday morning PA time to do admin I advised that I am not aware of what he did on Tuesday mornings. Mr O'Brien operated one to two Tuesday morning in the month in the Day Surgery Unit. I advised that Mr O'Brien sends e-mails at 2am or can be operating at 10pm. He works very hard and does over and above so I wouldn't question where he was. If he wasn't in the office it didn't mean he wasn't working.

21. I recently had to request a chart from the Head of Urology's office for another clinic. When I received the chart, I noticed the patient should have been put on the waiting list for urodynamic studies. This patient was originally seen in June 2016 and should have been on the urodynamics waiting list. As this waiting list is shorter than some others, this patient could have had their procedure by the end of last year if he/she had been placed on the waiting list.

41.3 In reference to paragraph 26.7 above and the issue of undictated clinic letters, I was aware that the charts for these patients and outcome sheets were held by Martina Corrigan from January 2017 until May/June 2017 without, I believe, any action being taken. I was never made aware if this work was ever completed and, if it was, by whom it was completed. As these duties were within the remit of my role as Secretary, I believe Martina Corrigan should have kept me informed when this work was completed and by whom.

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

42.1 Regarding undictated clinic letters, I was aware this was a growing problem for Mr O'Brien during 2016. Mr O'Brien reassured me that the urgent dictation was completed and it was routine dictation that was outstanding. He did continue to address this backlog up until he commenced his Sick Leave in October 2016. During his recovery from surgery in November/December 2016 Mr O'Brien was communicating with me on a daily basis, by telephone, regarding this backlog and was indeed dictating approximately 10-15 letters per day. I appreciated that he was working through the backlog with maximum effect.

42.2 However, this was all halted in late December 2016 by Management (I am not sure who was directing this) and Mr O'Brien was subsequently suspended from his duty as a Consultant Urologist. The

Subject: RE: Data quality monitoring reports- missing attendance and disposal codes
From: Elliott, Noleen [redacted]
To: Loughran, MarieT [redacted]
Sent: 05/11/2014, 13:26:41

03D-OUTPATIENT WITH NO ATTENDANCE OUTCOME RECORDED.xls

image001.jpg

Marie,

I have attached report with my action recorded. Unfortunately Mr O'Brien has not given me the outcomes for the Enniskillen Clinics therefore I am unable to complete.

Noleen

From: Loughran, MarieT
Sent: 04 November 2014 14:22
To: Elliott, Noleen; Troughton, Elizabeth
Subject: FW: Data quality monitoring reports- missing attendance and disposal codes

Ladies, please see below from Connor.

Kind Rgards
Marie

From: Murphy, Conor
Sent: 04 November 2014 13:51
To: Loughran, MarieT
Subject: RE: Data quality monitoring reports- missing attendance and disposal codes

Hi Marie,

Normally if the clinic passes 6 months it falls off the system and you can't record the AAD via PAS.

You can however record it via PatientCentre, although it can only be recorded as a single attendance and disposal.

Log into PatientCentre
Enter patients casenote number
From the navigator click on clinics
Below this click on Single Attendance and Disosal.

Just enter normal codes that you would use in AAD.

Connor

Connor Murphy

ICT System Support Officer | Southern Health and Social Care Trust | IT Department Ramone Building | Craigavon Area Hospital | 68 Lurgan Road, Portadown | Craigavon BT63 5QQ | Tel: [redacted]

Backlog Information

Specialty: Urology

Secretary's Name : Noleen Elliott

Date of Completion : 18th September 2014

Discharges Awaiting Dictation From Discharge Date	Clinics (no of charts) Awaiting Typing Oldest Clinic Date	Results Awaiting Dictation Oldest Result date	Daro: Validated	Filing – Give details of amount and type of filing, eg lab reports/consultant letters etc	Any Other Relevant Information
31 – Dating back to May 14	NIL	12		Approximately 10 lever arch files	I have a large amount of back filing which was here when I took up post with Mr O'Brien

From:	Carroll, Ronan
To:	Wright, Richard; Kerr, Vivienne; Gishkori, Esther; Gibson, Simon; Boyce, Tracey
Subject:	FW: Backlog report - no clinic outcomes
Date:	23 December 2016 10:24:54
Attachments:	Backlog Report - no clinic outcomes as per 15.12.16.xlsx
Importance:	High

Please see updated position re AoB backlog of undictated clinics

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

From: Carroll, Anita
Sent: 22 December 2016 13:59
To: Carroll, Ronan
Subject: FW: Backlog report - no clinic outcomes
Importance: High

Maybe we can get a chat about this

From: Robinson, Katherine
Sent: 20 December 2016 17:07
To: Carroll, Anita
Subject: FW: Backlog report - no clinic outcomes
Importance: High

See attached list. This is a list of clinics that Mr O,Brien has not dictated on and hence no outcome for some of these patients. There is a risk that something could be missed so I am escalating to you, although I know that a lot of the time Mr O'Brien knows himself what is to happen with patients. Unfortunately this was not highlighted on the backlog report. The secretary assumed we knew because there have always been issues with this particular consultant's admin work from our perspective.

As learning from this discovery I have asked all secretaries to provide this information on the backlog report so that we fully understand the whole picture of what is outstanding in each specialty. The secretary also advises that at present Mr O'Brien is working on some of his backlogged admin work as he is off sick recovering.

Regards

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

of this issue. This was concerning as I was not aware that Mr O'Brien would not have been dictating outcomes from his clinics and I forwarded this email on the 22/12/16 to Ronan Carroll AD SEC, and this should have initiated action by Martina Corrigan HOS Urology and Ronan Carroll AD SEC to follow-up with Mr O'Brien. The list of clinics that had not been dictated on dated back to 24/11/14. This indicated that there had been an issue with Mr O'Brien's dictation of clinics outcomes dating back to 2014.
Relevant documents are located at
127. 20161220 Es fKRandAC Backlog Report No Clinic Outcomes located at 21 15 of 2022 Attachments
128. 20161220 Es fKRandAC Backlog Report No Clinic Outcomes A1 located at 21 15 of 2022 Attachments

24.8 Ronan Carroll AD SEC and I had a discussion on 22/12/16 and he advised that Martina Corrigan HOS Urology was looking into this as some other issues had been brought to his attention. Following a conversation with Ronan Carroll AD SEC on the 5th January 2017 I emailed Katherine Robinson HOS RBC and asked her to run an attendance report starting with the oldest clinic dated 24/11/14 and this was sent to Mr O'Brien and he was advised to start with the oldest clinic date and record the clinic outcomes and dictate letters. All these clinic outcomes (discharged from clinic, or add to review waiting list) were forwarded to the RBC and updated on PAS. Any dictation was sent to Mr O'Brien's secretary Noleen Elliott to type.

Relevant documents are located at
129. 20170105 E fAC Backlog Report No Clinic Outcomes located at 21 15 of 2022 Attachments
130. 20170105 E fAC Backlog Report No Clinic Outcomes A1 located at 21 15 of 2022 Attachments

24.9 This incident demonstrated that this secretary was not following standard process. The standard process to be followed is that a consultant holds his clinic and dictates a clinic letter to the GP on every clinic attendance on a timely basis. I would have expected that Noleen Elliott, Mr O'Brien's Secretary, would have been following up with her Consultant Mr O'Brien to advise that he had not dictated on clinics, also I would have

expected that when she was aware of delays in dictation, she would have brought that to the attention of her SA Andrea Cunningham. If this had happened this would have been apparent on the backlog report and would be visible to myself, Katherine Robinson HOS RBC, Andrea Cunningham SA, Martina Corrigan HOS Urology and Ronan Carroll AD SEC and to the Urology Consultants.

24.10 I was advised in January 2017 by Katherine Robinson HOS RBC that she and Andrea Cunningham SA met Noleen Elliott, Mr O'Brien's Secretary, on 15th December 2016 to explain that unless undictated clinics were included on the Backlog Report management had no way of knowing this. In Katherine Robinson's HOS RBC email of 20/12/16, she advised that as learning from this discovery she had asked all secretaries to provide this information on the backlog report so that the SA had a full picture of what work was outstanding in each specialty.
Relevant documents are located at paragraph 24.7

Question 25

Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure.

25.1 As AD FSS the day-to-day management of the Urology Service was not within my remit, this sat with the, Martina Corrigan HOS Urology and the AD SEC (Heather Trouton /Ronan Carroll).

Question 26

What, if any role did you have in staff performance reviews?

26.1 The Trust has a clear performance review system, known as Personal Development Plans (PDPs) and I conduct annual PDPs for all of my HOS and any staff who report directly to me and this system cascades throughout the organisation. I believe

Urology Services Inquiry

4. At paragraph 27.3 (WIT-76354), I have stated '*However, Mr O'Brien had dictated on the urgent dictation. These undictated letters were flagged up on the Backlog report. Mr O'Brien went on sick leave in late October 2016 and, during his recovery in November/December 2016, he started to address this backlog.*' This should state 'However, Mr O'Brien had dictated on the urgent dictation ***and continued to address this backlog until he went on sick leave in November 2016. These undictated letters were flagged up on the Data Quality Report "Outpatient with no attendance outcome/disposal recorded" (please see WIT-76373 TO WIT-76604) During his recovery from surgery in November/December 2016 Mr O'Brien continued to work through the backlog in dictation.***

5. At paragraph 42.1 (WIT-76360), I have stated '*He did continue to address this backlog up until he commenced his Sick Leave in October 2016.*' This should state '*He did continue to address this backlog up until he commenced his Sick Leave in* ***November*** *2016.*'

Statement of Truth

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

Signed: Noleen Elliott [redacted]

Personal Information redacted by the USI

Date: 1st June 2023

Appointment Month (Full Month)	Hospital of Clinic Code	Specialty of Clinic Code (R)	Specialty of Clinic Description	Consultant of Clinic Name	Clinic Identifier/Code	Referral Date Only	Appointment Date Only	Appointment Type	Doctor Seen by Code	Casenote Number
September	ACH	999	NURSE LED PRE OP ASSESSMENT(N)	PRE-ASSESSMENT CLINICS	APREOPHT	03/09/2014	24/09/2015	PF	APREOPHT	Personal Information redacted by USI
	ACH	999	NURSE LED PRE OP ASSESSMENT(N)	PRE-ASSESSMENT CLINICS	APREOPHT	19/02/2015	24/09/2015	PF	APREOPHT	
	ACH	999	NURSE LED PRE OP ASSESSMENT(N)	PRE-ASSESSMENT CLINICS	APREOPHT	13/03/2015	24/09/2015	PF	APREOPHT	
	ACH	999	NURSE LED PRE OP ASSESSMENT(N)	PRE-ASSESSMENT CLINICS	APREOPHT	13/05/2015	24/09/2015	PF	APREOPHT	
	ACH	999	NURSE LED PRE OP ASSESSMENT(N)	PRE-ASSESSMENT CLINICS	APREOPHT	08/06/2015	24/09/2015	PF	APREOPHT	
	ACH	999	NURSE LED PRE OP ASSESSMENT(N)	PRE-ASSESSMENT CLINICS	APREOPHT	03/09/2015	24/09/2015	PF	APREOPHT	
	ACH	999	NURSE LED PRE OP ASSESSMENT(N)	PRE-ASSESSMENT CLINICS	APREOPHT	15/05/2014	29/09/2015	PF	APREOPHT	
	ACH	999	NURSE LED PRE OP ASSESSMENT(N)	PRE-ASSESSMENT CLINICS	APREOPHT	31/07/2014	29/09/2015	PF	APREOPHT	
	ACH	420	PAEDIATRICS - COMMUNITY(C)	MCBREEN G DR	DMSAGEAC	15/03/2012	30/09/2015	R	DMSAGEAC	
	ACH	420	PAEDIATRICS - COMMUNITY(C)	MCBREEN G DR	DMSAGEAC	08/08/2012	30/09/2015	R	DMSAGEAC	
	ACH	420	PAEDIATRICS - COMMUNITY(C)	MCBREEN G DR	DMSAGEAC	03/07/2014	30/09/2015	R	DMSAGEAC	
	BBH	420	PAEDIATRIC(C)	MILLAR S L DR	BSLMPAED	26/10/2009	03/09/2015	R	BSLMPAED	
	BBH	420	PAEDIATRIC(C)	MILLAR S L DR	BSLMPAED	12/03/2014	03/09/2015	R	BSLMPAED	
	BBH	420	PAEDIATRIC(C)	MILLAR S L DR	BSLMPAED	11/08/2014	03/09/2015	R	BSLMPAED	
	BBH	420	PAEDIATRIC(C)	MILLAR S L DR	BSLMPAED	14/04/2015	03/09/2015	R	BSLMPAED	
	BBH	420	PAEDIATRIC(C)	MILLAR S L DR	BSLMPAED	15/04/2015	03/09/2015	R	BSLMPAED	
	BBH	420	PAEDIATRIC(C)	MILLAR S L DR	BSLMPAED	20/05/2015	03/09/2015	NR	BSLMPAED	
	BBH	420	PAEDIATRIC(C)	MILLAR S L DR	BSLMPAED	22/05/2015	03/09/2015	NR	BSLMPAED	

	CAH	340	THORACIC MEDICINE IHAR (C)	JOHN A DR	CARTCAJ	22/06/2015	29/11/2015	R	CARTCAJ	Personal Information redacted by USI
	CAH	101	UROLOGY(C)	GLACKIN A.J MR	CAJGREG	11/11/2015	25/11/2015	RF	CAJGREG	
	CAH	101	UROLOGY(C)	GLACKIN A.J MR	CAJGREG	12/11/2015	25/11/2015	RF	CAJGREG	
	CAH	101	UROLOGY(C)	HAYNES M D MR	CMDHUDS	19/10/2015	04/11/2015	NR	CMDHUDS	
	CAH	101	UROLOGY(C)	HAYNES M D MR	CMDHHOT	26/11/2015	27/11/2015	NU	CMDHHOT	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	AAOBU1	14/01/2004	02/11/2015	R	AAOBU1	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	AAOBU1	02/12/2011	02/11/2015	R	AAOBU1	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	AAOBU1	09/10/2012	02/11/2015	R	AAOBU1	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	AAOBU1	11/08/2014	02/11/2015	PR	AAOBU1	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	AAOBU1	07/11/2014	02/11/2015	R	AAOBU1	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	AAOBU1	23/06/2015	02/11/2015	PR	AAOBU1	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	AAOBU1	27/08/2015	02/11/2015	PR	AAOBU1	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	AAOBU1	23/09/2015	02/11/2015	PR	AAOBU1	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	AAOBU1	24/09/2015	02/11/2015	PR	AAOBU1	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	CAOBUDS	04/06/2015	06/11/2015	NU	CAOBUDS	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	CAOBUDS	09/10/2015	06/11/2015	NU	CAOBUDS	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	CAOBUDS	16/10/2015	06/11/2015	NU	CAOBUDS	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	CAOBHOT	17/11/2015	17/11/2015	NU	CAOBHOT	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	CAOBUDS	18/11/2014	27/11/2015	NU	CAOBUDS	
	CAH	101	UROLOGY(C)	O'BRIEN A MR	CAOBUDS	15/12/2014	27/11/2015	NU	CAOBUDS	

Backlog Information

Specialty: Urology

Secretary's Name : Noleen Elliott

Date of Completion : 25th May 2017

Discharges Awaiting Dictation **From Discharge Date**	**Clinics (no of charts) Awaiting Typing** **Oldest Clinic Date**	**Results Awaiting Dictation** **Oldest Result date**	**Daro: Validated**	**Filing – Give details of amount and type of filing, eg lab reports/consultant letters etc**	**Any Other Relevant Information**
Nil	Clinic 11/6/17 – 6 patients	4	yes	Approximately 6 lever arch files	Please also see attached list of clinics with no outcomes completed

Backlog Information

Specialty: Urology

Secretary's Name : Noleen Elliott

Date of Completion : 10th October 2019

Discharges Awaiting Dictation	**Triage letters awaiting typing**	**Clinics (no of charts) Awaiting Typing** **Oldest Clinic Date**	**Results Awaiting DICTATION Oldest Result date**	**Daro: Validated**	**Filing – Give details of amount and type of filing, eg lab reports/consultant letters etc**	**Any Other Relevant Information**
Discharges awaiting dictation (handwritten pink discharge letter in chart) – 30 charts Day Surgery List 17/9/19 – 4 charts	nil	20/8/19 – CAOBTDUR – 11 patients 23/8/19 – CAOBUO – 9 patients 23/8/19 – CAOBUDS – 4 patients 30/8/19 – CAOBUO - 9 patients 30/8/19 - CAOBUDS – 3 patients 3/9/19 – CAOBUO - 7 patients 20/9/19 – CAOBUO - 11 patients **Awaiting dictation:** 23/9/19 – EUROAOB – 16 patients 27/9/19 – CAOBUO – 6 patients	11 6 letters awaiting typing	NO	Approximately 6 lever arch files	

41.3 In reference to paragraph 26.7 above and the issue of undictated clinic letters, I was aware that the charts for these patients and outcome sheets were held by Martina Corrigan from January 2017 until May/June 2017 without, I believe, any action being taken. I was never made aware if this work was ever completed and, if it was, by whom it was completed. As these duties were within the remit of my role as Secretary, I believe Martina Corrigan should have kept me informed when this work was completed and by whom.

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

42.1 Regarding undictated clinic letters, I was aware this was a growing problem for Mr O'Brien during 2016. Mr O'Brien reassured me that the urgent dictation was completed and it was routine dictation that was outstanding. He did continue to address this backlog up until he commenced his Sick Leave in October 2016. During his recovery from surgery in November/December 2016 Mr O'Brien was communicating with me on a daily basis, by telephone, regarding this backlog and was indeed dictating approximately 10-15 letters per day. I appreciated that he was working through the backlog with maximum effect.

42.2 However, this was all halted in late December 2016 by Management (I am not sure who was directing this) and Mr O'Brien was subsequently suspended from his duty as a Consultant Urologist. The

Investigation under the Maintaining High Professional Standards Framework was then initiated. This backlog in dictation remained until at least May/June 2017 and I was never informed if the dictations and clinical outcomes were ever completely dealt with. I feel Mr O'Brien should have undertaken this workload and I should have been allowed to complete the administrative work associated with it.

43. **Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?**

43.1 I refer to my response to Question 42 in this regard.

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

44.1 I have nothing further to report at this stage based on what I currently know or can remember.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from

Corrigan, Martina

From: Elliott, Noleen [redacted]
Sent: 14 October 2014 14:16
To: O'Brien, Aidan
Subject: FW: OUT STANDING TRAIGE - AOB

Aidan,

Please see e-mail below regarding outstanding triage letters.

Noleen

From: Coleman, Alana
Sent: 14 October 2014 11:54
To: Elliott, Noleen
Cc: Browne, Leanne
Subject: OUT STANDING TRAIGE - AOB

Hey Noleen,

Outstanding triage for Mr O'Brien:
Please have these returned asap please

CAH

[redacted]

[redacted]

[redacted]

[redacted]

85

[redacted]

URO

AOB

ROUTINE

GPR

23/09/2014

16

CAH

From: Coleman, Alana
Sent: 13 September 2016 18:20
To: Elliott, Noleen; Corrigan, Martina; O'Brien, Aidan
Cc: Cunningham, Andrea; Heaney, Linda
Subject: MISSING TRIAGE

Hi

Please see the list below of current missing triage. If possible could these be returned triage asap.

Personal Information	[redacted]	[redacted]	Personal Information redacted by USI	Personal Information redacted by USI	URO	MY	ROUTINE	OC	13/07/2016	57
[redacted]	Patient 11 [redacted]	[redacted]			URO	GURO	ROUTINE	GPR	18/07/2016	52
Personal Information redacted by USI					URO	GURO	ROUTINE	GPR	21/07/2016	49
					URO	GURO	URGENT	OH	25/07/2016	45
					URO	GURO	ROUTINE	OC	26/07/2016	44
					URO	GURO	ROUTINE	GPR	27/07/2016	43
					URO	GURO	ROUTINE	GPR	27/07/2016	43
					URO	GURO	ROUTINE	GPR	27/07/2016	43
					URO	GURO	URGENT	GPU	27/07/2016	43
					URO	GURO	ROUTINE	GPR	27/07/2016	43
					URO	GURO	ROUTINE	GPR	27/07/2016	43
					URO	GURO	ROUTINE	GPR	28/07/2016	42
					URO	GURO	ROUTINE	GPR	28/07/2016	42
					URO	GURO	URGENT	GPU	28/07/2016	42
					URO	GURO	ROUTINE	GPR	28/07/2016	42
Patient 13 [redacted]	[redacted]	[redacted]			URO	GURO	ROUTINE	GPR	28/07/2016	42
Personal Information redacted by USI					URO	GURO	ROUTINE	GPR	28/07/2016	42
					URO	MY	ROUTINE	GPR	29/07/2016	41
					URO	GURO	ROUTINE	AE	29/07/2016	41
					URO	GURO	ROUTINE	GPR	29/07/2016	41
					URO	GURO	ROUTINE	GPR	29/07/2016	41

Southern Health and Social Care Trust

POLICY FOR THE SAFEGUARDING, MOVEMENT & TRANSPORTATION OF PATIENT/CLIENT/STAFF/TRUST RECORDS, FILES AND OTHER MEDIA BETWEEN FACILITIES

Information Governance
Performance & Reform

POLICY FOR THE SAFEGUARDING, MOVEMENT & TRANSPORTATION OF PATIENT/CLIENT/STAFF/TRUST RECORDS, FILES AND OTHER MEDIA BETWEEN FACILITIES

1.0 INTRODUCTION

1.1 The aim of this policy is to ensure that staff safe-guard all confidential information while travelling from one facility/location to another during the course of their working day.

1.2 This may include confidential information contained within work diaries, notebooks, case papers, patient/client notes, Trust documents, 'lap top' computers etc.

1.3 This may also include from time to time the necessity to store confidential information overnight in staff members own home.

1.4 All Trust staff are bound by a common law duty of confidentiality. (See 9.0)

1.5 It is the responsibility of all staff to familiarise themselves and to implement practice of the contents of this policy.

2.0 GUIDING PRINCIPLE

2.1 The DHPSS Code of Practice on Protecting the Confidentiality of Service User Information (January 2012) states that "staff working within health and social services have an ethical and legal obligation to protect the information entrusted to them by users of the services."

2.2 Staff must notify their line managers immediately on suspicion of loss of any confidential information.

2.3 Line Manager must inform/notify Information Governance Team of any loss and contact Claire Graham, Head of Information Governance, Ferndale, Bannvale Site Gilford. Tel: Personal Information redacted by the USI

2.4 Managers must ensure staff, are aware that disciplinary action may be taken when it is evident that a breach in confidentiality has occurred as a result of a member of staff's neglect in ensuring the safeguarding of confidential information.

3.0 TRACKING / TRACING RECORDS

delivery or registered mail with sender details on the postage franking if not already included.

7.3 In exceptional circumstances where original records are required for court, a copy of the records must be made and the Staff Member must ensure that the original records have been returned. Staff Member must record details of person requesting records so that they can be contacted to ensure return.

7.4 If health records held in electronic format are being sent by post, then the data must be password protected and password sent separately following Trust procedure. (e.g. sending data such as a diagnostic tests or images etc on a CD via special delivery or courier).

7.5 If a Courier service is being used, then it is essential to confirm that the Courier service has tracking systems in place, including recorded delivery and traceability of packages.

In these circumstances and for other personal information sent by external mail the addressing must be accurate, and the senders name and address must be given on the reverse of the envelope.

8.0 TRANSPORT AND STORAGE FOR DOMICILIARY VISITS

- Client records are to be transported in a secure transport briefcase/bag.
- During transport client records are to be kept in the boot of the car and out of sight in a briefcase or a secure transport bag.
- Professional to decide with Line Manager on individual case whether it is best to bring only records pertaining to the client into their home and other client records to be kept in a secure transport briefcase/bag in the boot of car.

- Records should be returned to base when visit is complete as soon as possible.
- Staff should not leave portable computers, medical notes or mobile data devices (e.g. Dictaphones, PDAs, digital cameras) that are used to store patient records/patient identifiable information in unattended cars or in easily accessible areas. staff should store all files and portable equipment under lock and key, when not actually being used.
- Staff should not normally take health/client records home and where this cannot be avoided, procedures should be place to safeguard that information effectively. If records are being held by

Corrigan, Martina

From: Elliott, Noleen [redacted]
Sent: 09 June 2016 16:44
To: O'Brien, Aidan
Subject: FW: [redacted] - [redacted]
Attachments: [redacted].pdf

Importance: High

From: Coleman, Alana
Sent: 09 June 2016 15:32
To: Elliott, Noleen
Cc: Heaney, Linda; Cunningham, Andrea
Subject: FW: [redacted] - [redacted]
Importance: High

Hi Noleen,

This is my fourth time chasing a response to the attached referral. I will leave this for you to sort.

Thanks
Alana

Original in post.

From: Browne, Leanne
Sent: 30 December 2015 12:12
To: Cunningham, Andrea
Cc: Coleman, Alana; Elliott, Noleen
Subject: FW: [redacted] - [redacted]
Importance: High

Hi Andrea

See attached referral for [redacted]. Mr Suresh was on call and asked for the referral to be forwarded to Mr O'Brien for decision.
[redacted] attended EUROAOB on 22nd June 2015, the waiting list has not been updated if a follow up is required.

Please advise.

Thanks

Leanne

From: Browne, Leanne
Sent: 27 November 2015 11:58
To: Elliott, Noleen
Cc: Cunningham, Andrea; Coleman, Alana [redacted]

have received lists from the Referral and Booking Centre highlighting triages which had not been received back. There were no delays with 'red-flag' cases. Red-flag referrals were always dealt with.

7. Around February 2015 a new system was introduced in Urology with the 'Consultant of the Week'. During Consultant of the week, when a Consultant has no scheduled clinical activity they undertake admin and the triage. Prior to 2015, I would have given Mr O'Brien referrals to Mr O'Brien for triage but after February 2015, triage moved to the Booking Centre who allocated the referrals to the consultants each week. I would have been aware of delays with triage through the odd e-mail I got but I always put it back to Leanne Brown in the Booking Centre. Generally when an e-mail was sent to me, it was also sent to Mr O'Brien so I didn't feel I needed to act on anything.

8. Between February 2015 and December 2016 I never saw referrals sitting in Mr O'Brien's office. Mr O'Brien's office is pristine and he doesn't have things sitting around. Prior to February 2015, I would have left referrals in his office for him.

9. I cannot comment if there was a potential for harm or actual harm caused to any patient.

10. Working for Mr O'Brien is different than working for other Consultants. I previously worked for two other Urology Consultants. I had not previously had any previous issue with delays with triage.

11. In respect of terms of reference 2, I confirmed that all notes tracked to Mr O'Brien were not stored within the Trust. It is widely known within the Trust that Mr O'Brien has notes in his house. Leanne Hanvey types Mr O'Brien's private patient's work and Mrs O'Brien would e-mail her looking for charts. Leanne would pull the charts and leave them in Mr O'Brien's office. The notes would be tracked out to Mr O'Brien's private patient cabinet in his office but the notes wouldn't be there.

12. If a chart was requested by someone for another clinic, I would have e-mailed Mr O'Brien and asked him to bring in the chart. He would usually bring the chart back the next day or sometimes if he was at home he would bring it back later the same day. The charts could have been requested for various reasons.

13. Mr O'Brien did 2 outreach clinics. The South West Acute Hospital clinic (SWAH) is held in Enniskillen and as there is no transport between Trusts, Martina Corrigan would transport the charts to the clinic and Mr O'Brien took them back with him. The charts were not brought back and generally were at Mr O'Brien's house. The SWAH patient charts were generally not needed elsewhere in the Trust as the patients were Western Trust patients and would have had a separate chart there. The other outreach clinic Mr O'Brien attended was Armagh. The charts were delivered to Armagh by transport and brought back by Mr O'Brien.

Corrigan, Martina

From: Burns, Deborah [redacted]
Sent: 12 November 2013 05:56
To: Carroll, Anita; Trouton, Heather; Corrigan, Martina
Subject: RE: Mr O'Brien and charts

Did the patient get seen? I think if we cant agree with him – John Simpson needs involved. Heather was robin addressing this with him – follow up with robin to check that happened - if it did John is next step
D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Carroll, Anita
Sent: 11 November 2013 13:28
To: Trouton, Heather; Corrigan, Martina
Cc: Burns, Deborah
Subject: FW: Mr O'Brien and charts

Dear all I know we have discussed before and heather I know you met him
Really don't know what we now do
A

From: Forde, Helen
Sent: 11 November 2013 13:07
To: Carroll, Anita
Subject: Mr O'Brien and charts

Just to keep you in the loop as this may be going to Debbie, and I've said to Martina.

A patient was attending Dr Convery's clinic this morning but the chart was tracked to Mr O'Brien in the Thorndale Unit. When records looked for it his secretary said she thought Mr O'Brien had that chart at home and she would ask him to bring it in for the appointment at 9 am this morning. The chart didn't arrive in records and Dr Convery refused to see the patient without the chart. Pamela went to speak to Dr Convery and ask if he would see the patient as she had got as much information as she could for the appointment.

Mr O'Brien's secretary is off today so eventually Pamela got Mr O'Brien's number and phoned him to enquire about the chart. He had brought it in but had taken it over to the old Thorndale unit to have a letter typed. Pamela then went over there this morning and got the chart and then brought it round to Dr Convery, and he informed Pamela that he was going to write to Debbie about this.

Helen Forde
Head of Health Records
Admin Floor, CAH
[redacted]

Corrigan, Martina

From: O'Brien, Aidan [redacted]
Sent: 31 October 2015 17:01
To: Elliott, Noleen
Subject: [redacted]

Noleen,

I have arranged to review [redacted] post-MDM at home on Saturday 07 November 2015.
Shauna may have his chart.
I would be grateful if you would get me his chart for his review,

Aidan.

Corrigan, Martina

From: O'Brien, Aidan [redacted]
Sent: 02 November 2015 18:54
To: Elliott, Noleen
Subject: FW: [redacted]

Noleen,

Just to further expand on this case.
[redacted] is currently the longest urgent waiter on CURWL.
Mark Haynes had reviewed him in June or July 2015 with a view to doing his procedure.
He was unable to commit to doing so, as his chart was not available to him with the findings of urodynamic studies done in January 2014.
I had his chart at home with the intent of discussing the findings with Mark.
In the interim, mark has arranged to have urodynamic studies repeated tomorrow, Wednesday 04 November 2015.
I thought that I still had the chart at home, but I do not have.
I cannot recall bringing it in to the hospital, though it is possible that I did so.

Please ascertain whether it is available,

Thank you,

Aidan.

From: O'Brien, Aidan
Sent: 01 November 2015 19:05
To: Elliott, Noleen
Subject: [redacted]

Noleen,

I would be grateful if you would get me this patient's chart,

Aidan.

Corrigan, Martina

From: Elliott, Noleen [redacted]
Sent: 03 November 2015 11:12
To: O'Brien, Aidan
Subject: RE: [redacted]

Aidan,

I have checked in filing and this patient's chart is not there.

Noleen

From: O'Brien, Aidan
Sent: 02 November 2015 18:54
To: Elliott, Noleen
Subject: FW: [redacted]

Noleen,

Just to further expand on this case.
[redacted] is currently the longest urgent waiter on CURWL.
Mark Haynes had reviewed him in June or July 2015 with a view to doing his procedure.
He was unable to commit to doing so, as his chart was not available to him with the findings of urodynamic studies done in January 2014.
I had his chart at home with the intent of discussing the findings with Mark.
In the interim, mark has arranged to have urodynamic studies repeated tomorrow, Wednesday 04 November 2015.
I thought that I still had the chart at home, but I do not have.
I cannot recall bringing it in to the hospital, though it is possible that I did so.

Please ascertain whether it is available,

Thank you,

Aidan.

From: O'Brien, Aidan
Sent: 01 November 2015 19:05
To: Elliott, Noleen
Subject: [redacted]

Noleen,

I would be grateful if you would get me this patient's chart,

Aidan.

Corrigan, Martina

From: O'Brien, Aidan [redacted]
Sent: 16 October 2015 00:35
To: Elliott, Noleen
Subject: FW: Request for charts

Noleen,

I am now eating very large amounts of humble pie, seeking forgiveness.

I had entirely forgotten that [redacted] had come to see me privately in July 2015.
I have brought in his chart.

I had also forgotten that [redacted] chart had been requested for a private appointment, but I did see him at CAOBUOR.
I have brought in his chart as well.

Sackcloth for the rest of the day,

Aidan.

From: O'Brien, Aidan
Sent: 15 October 2015 23:54
To: Elliott, Noleen
Subject: RE: Request for charts

Noleen,

I have brought [redacted] chart to the clinic this morning.
However, I do not have at home the charts of [redacted] or [redacted].
Whilst it is possible that both are in my office in the hospital, I think that it is more probable that

- [redacted] chart is with Cancer Tracker or Records
- [redacted] is with Records

Aidan.

From: Elliott, Noleen
Sent: 15 October 2015 09:54
To: O'Brien, Aidan
Subject: FW: Request for chart

Aidan,

Can you also bring [redacted]) to the same clinic.

Many thanks.

Noleen

From: Elliott, Noleen
Sent: 15 October 2015 08:56
To: O'Brien, Aidan

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

Red Flag referrals must be completed daily.

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

CONCERN 2

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

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

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

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

CONCERN 3

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

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

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

COLIN WEIR: Aidan.
MR O'BRIEN: Hello, Colin.
COLIN WEIR: All right. Right. How's things?
MR O'BRIEN: Tired.
COLIN WEIR: ~~(Inaudible)~~ collect me I did a colectomy at 5 o'clock this morning.
MR O'BRIEN: Oh my goodness.
COLIN WEIR: A bleeding. No source found. We couldn't find it.
MR O'BRIEN: What was it do you think? Some kind of angiodysplasia?
COLIN WEIR: ~~(Inaudible) colectomy~~ Polypectomy two weeks ago. She was too sick for an angiogram at 5 o'clock in the morning, so we just had to go and take the whole colon out. Okay. Right.
MARTINA CORRIGAN: Hello, Aidan.
MR O'BRIEN: Hello, Martina.
COLIN WEIR: Me or you? (Inaudible) that's all this is about.
MR O'BRIEN: Okay.
COLIN WEIR: It is just the number of charts that are sitting in your office sort of are -- I think you've clawed back a bit of late but at one point there was kind of a back log. I think your results -- you do our own results on the charts. Go to your office pending some sort of outcome or dictation or something ~~assist.~~ Correct me if that's wrong. And it is just that we were starting to see a back log back five -- at one point in June you had five charts back to February, 11 in March, 37 April, 39. So that was building up into quite a sizeable number of charts in your office.
MR O'BRIEN: Mmm.
COLIN WEIR: Waiting on an outcome or a dictation. So really that's just kind of -- we don't want -- I suppose you don't want that to accumulate I suppose to that.
MR O'BRIEN: I don't want it at all because I don't know why charts are coming to my office at all. There's no need for them to come into the office.
COLIN WEIR: Right. So what -- so how do we stop that happening, Aidan?
MR O'BRIEN: Just return result without charts. I don't want the charts to be there.
COLIN WEIR: Okay. Do they need -- do they all need a result or what -- why is that -- I don't know what way your practice works but ...
MARTINA CORRIGAN: I suppose whenever you look at the comments, Aidan, on PS against the chart it'll say Mr O'Brien to view result or Mr O'Brien to see for result is the

Formatted: Left

comments, so it's obviously Noleen that's tracking them out and sending them to your office with the result on the front of the chart. So it's just that --

MR O'BRIEN: There is no need for chart to be there.

MARTINA CORRIGAN: Okay.

MR O'BRIEN: And I've told Noleen that.

MARTINA CORRIGAN: Okay.

MR O'BRIEN: Even, you know, the past two weeks when Noleen was off, there were still charts coming into my office. I don't ask them. If I don't ask for them, I'm not the person responsible for storing them. There's no need for them. It is an obsolete system.

MARTINA CORRIGAN: Okay. Yeah. Yeah. We can --

COLIN WEIR: So is there -- so those charts don't necessarily need anything done with them then or does it need an outcome?

MR O'BRIEN: No. The number as of last Friday actually the number is 25.

COLIN WEIR: Yeah.

MR O'BRIEN: Because I returned so many charts.

COLIN WEIR: All right.

MR O'BRIEN: Completely pointless --

COLIN WEIR: Okay. It's just --

MR O'BRIEN: -- time-consuming exercise people bringing charts into your office, leaving them there on top of your desk with a normal PSA that you -- I just don't understand the reason for it.

RONAN CARROLL: Was that -- I suppose I'm just trying to understand but it's good when you don't need them but why would that -- would that have (inaudible)?

MR O'BRIEN: I was told by the secretaries actually that they're told that's what they have to do by their line managers.

RONAN CARROLL: Oh. So how do we stop?

COLIN WEIR: For me, my practice is no charts in my office at all. They go --

MR O'BRIEN: On Friday I did an audit. There were seven of the charts in my office that I had asked for.

COLIN WEIR: Right.

MR O'BRIEN: Two of them were medico~~al~~ legal. Two are for police reports.

~~MARTINA CORRIGAN~~ MR O'BRIEN: And there's one for reconstruction which is (inaudible).

MR O'BRIEN: And one for reconstruction which I have returned because -- and I don't really need it -- but I have returned it as it seems to be an issue that you retain a chart on Personal information redacted

Formatted: Left