



3fivetwo Healthcare  
Kingsbridge Healthcare Group Administration Centre  
Danesfort Building  
221 Stranmillis Road  
Belfast  
BT9 5UB

24 March 2025

By Email: Personal Information redacted by the USI

Dear Sirs

**Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust**  
**Provision of a Section 21 Notice requiring the production of a Witness Statement & Documents**

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

The Inquiry are currently continuing, its investigations into the matters set out in its Terms of Reference. A key part of that process is gathering all of the relevant documentation from relevant departments, organisations and individuals.

In keeping with this approach, the Inquiry is now issuing a Statutory Notice (known as a 'Section 21 Notice') pursuant to its powers to compel the production of relevant documentation.

This Notice is issued to 3fivetwo Healthcare, as care provider to a named patient relevant to the Inquiry. It is hoped that this Section 21 Notice will alleviate any concerns that your department may have in relation to data protection or confidentiality.

As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

If it would assist you, I am happy to meet with you, your officials and or legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit your organisation must make an application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty. The Inquiry will be pleased to receive your documents in tranches; you do not have to wait until you are in a position to fully comply with the Notice before you begin to send documents. Indeed it will greatly assist the progress of the Inquiry's work if you immediately begin the process of forwarding documents to the Inquiry.

If your organisation does not hold documentation in respect of some of the categories of document specified in the Section 21 Notice, please state this in your response. If it is possible to indicate by whom such information might be held, if it is not held by your organisation, the Inquiry would find that of assistance.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal Information redacted by  
the USI

**Anne Donnelly**  
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI  
Mobile: Personal Information redacted by the USI

THE INDEPENDENT PUBLIC INQUIRY INTO  
UROLOGY SERVICES IN THE  
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 1 of 2025]

pursuant to Section 21(2) of the Inquiries Act 2005

**WARNING**

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

**TO: 3fivetwo Healthcare**  
Kingsbridge Healthcare Group Administration Centre  
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BT9 5UB

## IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.
2. The Notice requires you to do the acts set out in the body of the Notice.
3. You should read this Notice carefully and consult a solicitor as soon as possible about it.
4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.
5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

## DOCUMENTS TO BE PRODUCED

**TAKE NOTICE** that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(b) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry the documents set out in the Schedule to this Notice by **12.00 noon on 14<sup>th</sup> April 2025**

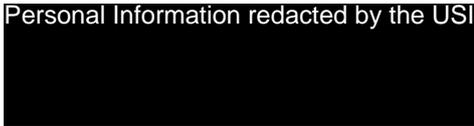
## APPLICATION TO VARY OR REVOKE THE NOTICE

**AND FURTHER TAKE NOTICE** that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **12.00 noon on 7<sup>th</sup> April 2025**

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 24<sup>th</sup> March 2025

Signed:  Personal Information redacted by the USI

**Christine Smith QC**  
Chair of Urology Services Inquiry

**SCHEDULE  
[No 1 of 2025]**Background

At the outset of the public Inquiry into Urology Services in the Southern Trust, the Inquiry undertook outreach work asking that those who felt they fell within the Inquiry's Terms of Reference make contact with the Inquiry to tell their story. One of the people who made contact, [Patient 82's Daughter], did so on behalf of her father, [Patient 82], who died in April 2021. To preserve anonymity, the Inquiry gave [Patient 82] the cipher 'Patient 82'.

In the course of providing evidence to the Inquiry, Patient 82's daughter set out her concerns about treatment received by her father, who was treated by 3fivetwo Healthcare at Downpatrick Hospital in September 2010 for an intravesical botulinum toxin injection as part of a waiting list initiative. [Patient 82's Daughter] made a complaint about her father's treatment both to 3fivetwo Healthcare and to the Trust in 2012. Attached is the relevant correspondences concerning that complaint and replies to it.

Also attached is the extract from [Patient 82's Daughter]'s evidence to the Inquiry, where she sets out her concerns and makes certain comments regarding 3fivetwo Healthcare and the medics who provided care to her father.

We are writing to you to provide you with the opportunity to consider the evidence provided to the Inquiry on behalf of Patient 82 and to respond as you see fit. We have identified below some extracts from the transcript that you may wish to address specifically, however, you should consider the attached documents and respond as you consider appropriate. Your reply does not need be confined to the extracts below and correspondences attached.

Please be advised that all information provided to the Inquiry will be considered within the context of the Inquiry's Terms of Reference and may be included in the final Report of

the Inquiry Panel. This is your opportunity for you to address the issues relevant to you so that the Inquiry may consider your replies within the totality of the evidence.

Please also be advised that the work of the Inquiry is ongoing and this correspondence, and the matters raised in it, should not be taken as meaning this information will necessarily be included in the final Report, save as to do so is in furtherance of the Inquiry Terms of Reference.

## Questions to be addressed by you

1. Please consider the attached correspondences regarding complaints made by Patient 82's daughter by letter dated the 26 October 2012, and the reply from 3fivetwo Healthcare in January 2013, and confirm if the information contained in those replies remains your understanding of events. If not, please explain why not, setting out your answer in full. For ease, the nature of Patient 82's complaint set out in her correspondence was as follows [found at **PAT-001623**]:

- “1. No consultation about transfer to 3fivetwo Healthcare (sic) or consent given
2. Inadequate information RE: surgery and appointment letter
3. Letter from 3fivetwo Healthcare made no reference to stopping medication, even though admission staff is advising patients to stop medication.
4. Admission staff advising on medication prescription
5. No pre operative assessment at 3fivetwo Healthcare
6. No sharing of information between Craigavon Area Hospital and 3fivetwo Healthcare
7. Craigavon Area Hospital and 3fivetwo HealthCare's failure to recognise my father's complex cardiac history
8. Proceeding without notes (surgery/clinics not prepared)
9. Communication barriers between professional and patients
10. No privacy when discussing information with patient

11. And most importantly NO ONE has offered any feedback as to what went wrong at 3fivetwo Healthcare in Downpatrick.”
2. Please review the attached extract of the oral evidence of Patient 82’s daughter, most specifically, the references to 3fivetwo Healthcare at pages **TRA-01856**, **TRA-01858**, **TRA-01861**, and address, should you wish to, the issues raised in these extracts:
- (i) Transfer of her father’s care to 3fivetwo Healthcare without pre-operative assessment [**TRA-01856**, L15-16]
  - (ii) Transfer of her father’s care to 3fivetwo Healthcare without pre-operative assessment [**TRA-01858**, L13-28]
  - (iii) The adequacy of the explanation provided by 3fivetwo Healthcare [**TRA-01861**, L3-7]
  - (iv) The alleged discrepancies in 3fivetwo Healthcare’s reply to [REDACTED] **Patient 82’s Daughter** complaint [**TRA-01861**, L23-29]
3. Please add any further information or responses which you may have on the issues raised by [REDACTED] **Patient 82’s Daughter** and which may not already be before the Inquiry Panel.

**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.

**PAT-001623**

11. And most importantly NO ONE has offered any feedback as to what went wrong at 352 in Downpatrick.

This begs the question what drugs were administered that led to a reaction, given that heart investigation didn't show a heart attack as we were first informed.

Today I have also written to 352 requesting a list of medication administered as to prevent a further episode

Having attended an appointment with the coronary prevention nurse at CAH they had no information on file RE 352 episode and investigations at the Ulster and City Hospital. She was also unable to obtain any informative information from dad's GP as he has no information either. Despite a CAH letter on 11/07/2012 advising that all treatment would be recorded in CAH notes. It would appear that Mr O'Brien is unaware of this entire episode that my father was exposed to.

Dad remains with his urology problem which causes his urge and disturbs his sleep. He has been told not to proceed with further intervention without explanations as to what happened.

Further to writing this letter, I attended a follow up appointment for my own medical condition in CAH and when asked was there any family history of a reaction to an anaesthetic, I informed the nurse of my dad's episode. She said that she would not be able to access my father's notes as there is no transfer of notes between the private company and CAH, despite a previous letter informing me that all information would be passed between the two sites.

Can someone please enlighten me as to what exactly is happening?

Yours Sincerely  
Patient 82's Daughter

CC John Wilson 352 Down Patrick Hospital.

**TRA-01856**

1 Hospital, and actually from there to the City Hospital.  
2 But the outcome was that Daddy had no long-term  
3 effects. But the biggest problem there was trying to  
4 find out what drugs Daddy had been given  
5 pre-operatively so that going forward, while he still 10:20  
6 needed the Botox, we would know not to give those drugs  
7 again.

8  
9 When I went to Mr. O'Brien's clinic to see Daddy, he  
10 was oblivious to the fact of anything that had happened 10:20  
11 with 352 with Daddy. I asked at that time why did he  
12 allow Daddy's files to be transferred out, and he said  
13 that his files were all lifted and the patients that  
14 were allocated out were nothing to do with him; it was  
15 a management decision who went. So, they seemed to go 10:20  
16 to 352 without any preassessment for surgery.

17  
18 Mr. O'Brien then tried to find out what drugs were  
19 used, and he wasn't able to find out. In fact, in one  
20 of his letters he wrote that he expected they would 10:21  
21 never find out, which causes me concern from the point  
22 of view that as commissioners of the service, I felt  
23 the Trust should have been able to find out, and expect  
24 to find out, what took place. Indeed, there was  
25 another letter from the Trust to me that said Daddy's 10:21  
26 notes would go to the private provider but they would  
27 remain belonging to the Trust and would be returned to  
28 the Trust. You know, I would have expected them to  
29 have got a full report.

**TRA-01858**

1 was 20 weeks, and that I would be invited to a meeting.

2 CHAIR: Did that happen?

3 A. No, you know. And as an employee of The Trust as well,  
4 as I say, it wasn't to make a complaint really, it was  
5 to say, look, you know, people need to be assessed  
6 before they go for surgery and there needs to be  
7 sharing of information, and if this isn't done, you  
8 know, it will be to the detriment of further patients.

10:23

9 That was where I was trying to go. Thankfully, Daddy  
10 was okay from the event. You know, he didn't suffer.

10:24

11 CHAIR: Just so that I can be sure that I've got it  
12 clear, Patient 82's Daughter, your father's surgery was

13 outsourced to 352 by the Trust. Our understanding is  
14 his notes and records didn't go with him, as it were,  
15 from the Trust?

10:24

16 A. No, no, no.

17 CHAIR: So 352 were in the dark, as it were, in terms  
18 of what treatment he had had?

19 A. Yes. I suppose even on that morning, when I arrived in  
20 Downpatrick Hospital, it was like a ghost town. There  
21 wasn't even a receptionist in the foyer. We went  
22 upstairs to the area where we were supposed to be and  
23 I observed, as I felt at the time, the anaesthetist  
24 walking around and being shown round; she didn't know  
25 where she was, she was finding her way. Then a nurse  
26 came in and she started to take information from Daddy,  
27 and in the middle of that the anaesthetist took over and  
28 really dismissed the nurse, from memory.

10:24

10:25

29

**TRA-01861**

1           there was an onus to try to find out what had happened  
2           so that it wouldn't happen again.

3           CHAIR: Yes. Now, you wrote, and we have seen the  
4           letters that you wrote and the response you got. You  
5           got a response from 352 which wasn't, perhaps, the best 10:29  
6           of explanations, if I can put it as neutrally as that.

7           A. No. Yes.

8           CHAIR: Then you received a letter also from the Trust,  
9           which we would describe as a holding letter.

10          A. Yes. 10:29

11          CHAIR: Saying that they were going to carry out  
12          investigations?

13          A. Yes.

14          CHAIR: The Inquiry wondered did you ever get that  
15          letter, because we couldn't see it in any papers, the 10:29  
16          result of the Trust investigations?

17          A. No, I never got that letter. That was the one that  
18          said -- well, there was a letter that said I would be  
19          invited to a meeting. It could take 20 weeks, and the  
20          conclusion of it was I would be invited to a meeting. 10:29

21  
22          But no, I never got any explanation from the Trust.  
23          I wrote to 352 and complained and copied that letter to  
24          the Trust as well. Then 352 wrote back out to me  
25          again, and there was discrepancies in that explanation, 10:30  
26          I felt, and I wrote back again to 352 and copied it to  
27          the Trust. Then 352 wrote again. You know, to me,  
28          their last letter was, well, this is the answers and,  
29          really, if you have any more. At that stage, well,



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10 April 2025

Ms Anne Donnelly

Solicitor to the Urology Services Inquiry

Urology Services Inquiry

[info@USI.org.uk](mailto:info@USI.org.uk)

Dear Ms Donnelly,

Thank you for providing 3fivetwo Healthcare, Kingsbridge Healthcare Group, the opportunity to provide comment and feedback relating to this section 21 notice.

Given the length the time that has passed since this patient's appointment with 3fivetwo Healthcare it has been challenging to provide much more information than was provided at the time of response to the compliant.

We have aimed to provide additional comments and context to the questions raised where we have been able to.

Please find responses detailed below to the questions posed.

*Q1. No consultation about transfer to 3fivetwo healthcare (sic) or consent given*

R1. As part of the patient transfer process from referring trust's to 3fivetwo healthcare it would have been standard practice that the referring trust would either write to or phone patients to inform them of their transfer to the independent sector provider. This would have been managed by the individual trust and as such we are unable to say if this process took place on this occasion.

*Q2. Inadequate information RE: Surgery and appointment letter*

R2. In line with the patient's daughter statement and the compliant response issued by 3fivetwo healthcare at the time it was recognised that the pre-operative information provided prior to surgery was not adequate. It was documented in the complaint response that additional measures and training were introduced to improve the quality and consistency of the pre-operative assessment process.

*Q3. Letter from 3fivetwo Healthcare made no reference to stopping medication, even though admission staff is advising patients to stop medication*

R3. It was recognised at the time of this complaint that pre-operative process was not adequate in relation to this patient. It was documented in the complaint response that additional measures and training were introduced to improve the quality and consistency of the pre-operative assessment process, specific reference was made regarding pre-operative management of existing medication of patients. Kingsbridge Healthcare Group continues to provide a full and comprehensive anaesthetic pre-assessment service.

*Q4. Admission staff advising on medication prescription*

R4. It would be common practice that admission staff would relay specific pre-operative advice including instruction on medication to patients prior to an admission on direct instruction from the Surgeon and or Anaesthetist. As was originally documented it was evident that this process appeared to be confusing for the patient and their daughter and as result it was documented in the complaint response that additional measures and training were introduced to improve the quality and consistency of the pre-operative assessment process, specific reference was made regarding pre-operative management of existing medication of patients. Kingsbridge Healthcare Group continues to provide a full and comprehensive anaesthetic pre-assessment service.

*Q5. No preoperative assessment at 3fivetwo Healthcare*

R5. Given the patients' previous medical conditions, age and pre-existing medical condition this patient should have had pre-operative assessment completed prior to admission. This was recognised in the complaint response at the time.

*Q6. No sharing of information between Craigavon Area Hospital and 3fivetwo Healthcare.*

R6. As part of the patient transfer process, it would have been standard to have received appropriate referral information from the referring hospital. This information at the time would have been held within a physical chart that would have been sent to each appointment. It was standard practice that appointment outcome information was then reported by 3fivetwo healthcare to the referring trust at the time this reporting was provided using excel reports. Once a patient pathway was completed or the patient was discharged copies of all relevant clinical notes were shared with the referring hospital for filing within their NHS records.

*Q7. Craigavon Area Hospital and 3fivetwo healthcare failure to recognise my father's complex cardiac history.*

R7. Given the patients complex cardiac history he should have undergone a pre-operative assessment in advance of his admission for surgery. On the date of admission, it was clear that physical chart could not be located at the facility. The surgeon has referred to having access to the patient's electronic care record that would likely have provided details on their past medical history. If there was any concern about proceeding with the surgery, it would be standard practice for Surgeon or Anaesthetist to cancel and postpone the procedure.

*Q8. Preceding without notes (surgery/clinics not prepared)*

R8. At the time of this patients surgery 3fivetwo healthcare would have prepared and delivered sets of patient charts to the location of the clinics and theatres. On the date of admission, as documented the physical chart could not be located at the facility. The surgeon has referred to having access to the patient's electronic care record that would likely have provided details on the past medical history. If there was any concern about the proceeding with the surgery, it would be standard practice for Surgeon or anaesthetist to cancel and postpone the procedure.

*Q9. Communication barriers between professional and patients*

R9. Kingsbridge Healthcare group work to promote and encourage open communication between clinical professionals and patients. It is evident in this circumstance the patient and daughter felt that there had been barriers in the communication. It is difficult to provide a more detailed response given the length and time since this incident and the information available.

*Q10. No privacy when discussing information with patient*

R10. This appointment took place in Downpatrick hospital through an insourcing initiative. Given the length of time since the incident and the lack of information available as to the flow on the day it is difficult to comment. Privacy and patient dignity is a core aspect of patient the centred care that (3fivetwo) Kingsbridge Healthcare group deliver within its hospitals these principles are upheld and are regularly inspected by the RQIA.

*Q11. And most importantly NO One has offered any feedback as to what went wrong at 3fivetwo Healthcare in Downpatrick*

R11. Based on the response provided by 3fivetwo Healthcare Oct 2013, a response detailing the clinical circumstances of the incident were provided. The length of time to provide this response was not in line with normal or existing response time frames for such complaints or incident investigations.



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2. Please review the attached extract of the oral evidence of Patient 82's daughter most specifically, the references to 3fivetwo healthcare at TRA-01856, TRA-01858, TRA-01861

(i) Transfer of her father's care to 3fivetwo Healthcare without pre-operative assessment.

R. As part of the patient transfer process from referring trust's to 3fivetwo healthcare it would have been standard practice that the referring trust would either write to or phone patients to inform them of their transfer to the independent sector provider. This would have been managed by the individual trust and as such we are unable to say if this process took place on this occasion.

(ii) Transfer of her father's care to 3fivetwo Healthcare without pre-operative assessment

As part of the patient transfer process, it would have been standard to have received appropriate referral information from the referring hospital. This information at the time would have been held within a physical chart that would have been sent to each appointment. It was standard practice that appointment outcome information was then reported by 3fivetwo healthcare to the referring trust at the time this reporting was provided using excel reports. Once a patient pathway was completed or the patient was discharged copies of all relevant clinical notes were shared with the referring hospital for filing within their NHS records.

At the time of this patient's surgery 3fivetwo healthcare would have prepared and delivered sets of patient charts to the location of the clinics and theatres. On the date of admission, as documented the physical chart could not be located at the facility. The surgeon has referred to having access to the patient's electronic care record that would likely have provided details on the past medical history. If there was any concern about the proceeding with the surgery, it would be standard practice for Surgeon or anaesthetist to cancel and postpone the procedure.

(iii) The adequacy of the explanation provided by 3fivetwo Healthcare

Based on the response provided by 3fivetwo Healthcare Oct 2013, a response detailing the clinical circumstances of the incident were provided. This response did not address the 11 points that the patient's daughter had outlined. The response provided was not in line with normal or existing response time frames for such complaints or incident investigations.

(iv) The alleged discrepancies in 3fivetwo healthcare's reply to Patient 82's Daughter's complaint.

Based on the transcript and documentation provided it does not outline what these alleged discrepancies are.



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3. Please add any further information or responses which you may have on the issues raised by [REDACTED]  
Patient 82's Daughter and which may not already be before the inquiry panel.

There is no further information to add.

Yours sincerely

Raymond Macsorley  
KHG Chief Commercial Officer